



ISSUE ANALYSIS

Understanding and Responding to the Transgender Movement

By Dale O’Leary and Peter Sprigg EXECUTIVE SUMMARY **

Introduction

In recent decades, there has been an assault on the sexes. That is, there has been an attack on the previously undisputed reality that human beings are created either male or female; that there are significant differences between the sexes; and that those differences result in at least *some* differences in the roles played by men and women in society.

The first wave of this attack came from the modern feminist movement and the second from the homosexual movement. The third wave of this assault on the sexes has been an attack on a basic reality—that all people have a biological sex, identifiable at birth and immutable through life, which makes them either male or female.

The third wave ideology is known as the “transgender” movement. This paper offers a description and critique of that movement and ideology. Part I addresses the psychological and medical issues involved; Part II will address the public policy issues.

Part I: Gender vs. Sex

According to the new gender ideology, the word “sex” is restricted to the biological, while “gender” describes the social and cultural manifestation of sex: how a person feels and experiences his or her sexual identity and how it is shaped by culture.

If individuals are unhappy because they want to be the sex they were not born, they are, according to the American Psychiatric Association, suffering from “gender dysphoria.” Some believe they were born with the body of one sex and the psyche of the other and want their bodies changed to match their internal “wiring.” They want to convince others to see them as the other sex.

Family Research Council (FRC) affirms what has been accepted as both normative and indisputable: that the truth about sexual differences is objectively knowable and that redefining it will be harmful.

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Sidebar: Intersex Conditions

A misleading distraction frequently is raised in the context of this issue. A tiny percentage of people suffer from disorders of sexual development (DSD), sometimes referred to as an intersex condition (or as hermaphroditism). True hermaphrodites—those in whom sexual anatomy is ambiguous or clearly conflicts with their chromosomal make-up—are rare, estimated by one expert as “occurring in fewer than 2 out of every 10,000 live births.” The vast majority of “transgender” individuals are *not* “intersexed.”

No one can change his or her sex.

No one can change his or her sex. The DNA in every cell in the body is marked clearly male or female. Hormones circulating in an unborn child’s brain and body shape his or her development. Psychiatrists and surgeons who have served transsexual clients know surgery does not change sex. George Burou, a Moroccan physician, admitted: “I don’t change men into women. I transform male genitals into genitals that have a female aspect. All the rest is in the patient’s mind.”

Transgender terminology

In this new era of deconstructing and redefining human sexuality, a new set of vocabulary emerges. One pro-transgender activist group has issued a glossary of terms and definitions, explaining the differences between terms such as *transgender*, *transsexual*, and *transvestite [or cross-dresser]*.

“Gender Identity Disorder” Becomes “Gender Dysphoria”

Transgender activists, following the example of the homosexual activists in the 1970’s, have objected to having their condition labeled a “disorder.” They successfully lobbied the American Psychiatric Association to have the diagnosis of “Gender Identity Disorder” (GID) changed to “Gender Dysphoria.” Consequentially, the revised language in the APA’s 2013 *Diagnostic and Statistical Manual (DSM- 5)* says, “*Gender dysphoria* refers to the distress that may accompany the incongruence between one’s experienced or expressed gender and one’s

assigned gender.” But, to avoid the stigma transgender activists say they wish to discourage, why not simply remove the diagnosis from the DSM altogether, as was done with homosexuality? The APA says, “To get insurance coverage for the medical treatments, individuals need a diagnosis.”

Causes of “Gender Dysphoria”

Family Research Council believes that it is politics, not science, which has driven the conclusion that such a condition is not inherently “disordered” and is only problematic if it causes subjective distress. Sander Breiner, a psychiatrist with clinical experience working with transsexuals at Michigan’s Wayne State University, declares, “[W]hen an adult who is normal in appearance and functioning believes there is something ugly or defective in their appearance that needs to be changed, it is clear that there is a psychological problem of some significance.” Paul McHugh, professor of psychiatry at Johns Hopkins, has declared bluntly, “It is a disorder of the mind. Not a disorder of the body.” Another psychiatrist, Rick Fitzgibbons, describes gender dysphoria as “a fixed false belief . . . [which is a manifestation] of a serious thinking disorder, specifically a delusion.” What, then, causes a person to experience such “dysphoria?” While causality is difficult to determine, the transgendered are more likely to have been victims of child sexual abuse and to have a history of trauma, loss, and family disruption.

Patterns of Transgender Desires

There are three major patterns of transgender desire.

- 1) Males with childhood GID, who are usually sexually attracted to men.
- 2) Secret transvestites (also known by some researchers as “autogynephiles”)
- 3) Females with childhood GID, who are usually sexually attracted to women.

Gender Dysphoria in Children

Susan Bradley, M.D., of the University of Toronto, has worked extensively with children with gender identity disorder (GID). She regards GID as one of a number of attachment disorders. Bradley and Kenneth J. Zucker, two of the world’s leading experts in GID in children, have declared that “clinicians should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity.” Even without treatment, the cross-gender behavior generally resolves itself in either selfidentification as homosexual or heterosexual. Roughly 75 percent will later self-identify as gay or lesbian. Only a tiny percent will become transsexual. However, today trans-positive therapists encourage parents to accept GID as normal and allow the child to live as the other sex. As the child matures the therapists prescribe puberty blocking drugs, preparing the child for a total sex change.

Social acceptance is seen as a panacea, but there is no evidence these children will avoid the negative outcomes associated with transgender identification, including higher rates of suicide attempts, completed suicides, overall mortality, and need for psychiatric inpatient care. Zucker and Bradley view failure to treat children in an effort to prevent a transsexual outcome as “irresponsible.” Referring to medical interventions to block puberty in gender-variant children, Dr. McHugh of Johns Hopkins says bluntly, “This is child abuse.”

Who Gets Approved for “Gender Reassignment”?

An association of doctors who perform gender reassignment surgery, the World Professional Association for Transgender Health (WPATH), has developed *Standards of Care for Gender Identity Disorders*. Transgender persons seeking hormone therapy or surgery are supposed to be examined for undiagnosed disorders of sexual development or co-morbid psychological disorders. While the former (DSD) are rare, the latter are common yet necessary and appropriate psychotherapy may not always be offered, and may be resisted by clients determined to obtain surgery. In addition, only a handful of doctors in the U.S. actually perform gender reassignment surgery, leading some transgender people to seek it in other countries, such as Thailand, where conditions are more lenient.

Gender Reassignment Surgery

Full transition involves hormone treatments, breast surgery (removal or implants), other cosmetic surgery, genital reconstruction, and a change of personal identification. However, not every person seeking to live as the other sex will decide to have full reconstructive surgery.

Problems after Surgery

Gender reassignment surgery often does not achieve what patients hope for. Transgender individuals want to “pass” as the other sex. According to a large study of transgendered persons, only 21 percent are able to “pass” all the time.

The surgical procedures are not always successful and can be extremely painful. A lifetime of hormone treatments can also have profound physical and psychological consequences. Jon Meyer, M.D., Associate Professor of Psychiatry and Behavior Science at Johns Hopkins University, concluded, “My personal feeling is that surgery is not a proper treatment for a psychiatric disorder and it is clear to me that these patients have severe psychological problems that do not go away following surgery.” However, not all those who demand that society recognize them as the other sex have or even intend to have surgical alterations to their bodies. The position of transgender activists is that people should be recognized as belonging to whatever gender they choose, *regardless* of the physical condition of their bodies.

High-Risk Behavior

Transgender people are more likely than the general public to engage in high-risk behaviors, which may result from or contribute to psychological disorders (or both). Some of the high-risk behavior is directly related to their desire to change sex. For example, some transsexuals self-mutilate or undergo procedures in non-medical settings. Others engage in high-risk sexual behavior such as prostitution, which places them at risk.

High rates of suicide exist even among those who have already received gender reassignment surgery, which suggests that suicidal tendencies result from an underlying pathology. Ironically, however, some applicants threaten suicide or self-mutilation as an argument *for* the approval of surgery.

“GenderQueer” vs. “the Gender Binary”

To most Americans, it may seem radical to assert that a man can become a woman or a woman can become a man. However, the transgender movement has moved into even more radical territory—attacking what they call “the gender binary,” that is, the idea that everyone should identify as either male or female. Those who adopt this approach sometimes refer to themselves as “genderqueer.”

One of the reasons for the rise of “genderqueer” is that the state of being transgendered is extremely unstable. One source listed over 70 different gender identities.

Rebellion against Reality

Transgender activists blame their problems on “transphobia.” Feminist author Janice Raymond says, “I accept the fact that transsexuals have suffered an enormous amount of psychical and emotional pain. But I don’t accept the fact that someone’s desire to be a woman, or a man, makes one a woman or man.” She refers to “transsexualism” as “the falsification of reality.” Terri Webb was a transgender activist who came to the conclusion that her activism was little more than “an unsuccessful attempt to get others to legitimize my fantasy.”

Mental Health Treatment Options for Gender Identity Issues

A psychologically healthy person accepts the reality of his or her sexual identity. Grief, discomfort, and anger over one’s genetic makeup signal problems that can and should be addressed through counseling. The academic literature includes some clinical accounts of successful efforts to overcome gender identity problems. Decades ago, there were already findings pointing “to the possibility of psychosocial intervention as an alternative to surgery in the

treatment of transsexualism.” One of the most unfortunate results of the transgender movement is that this possibility has not been more thoroughly explored and developed.

Part II: Public Policy Implications of the Transgender Movement

1) Should the government itself (local, state, and/or federal) accept and recognize so called changes in someone’s sex or “gender identity?”

Sex is a biological reality, and is immutable. In reality, a “sex change” is impossible. Biological sex is a more fundamental, more important, and more accurate measure of a person’s intrinsic identity than the purely subjective and often shifting concept of “gender identity.” Ideally, the law would forbid government recognition in any way (whether on birth certificates, driver’s licenses, passports, or any other government-issued identification) of any change in an individual’s biological sex as identified at birth.

In states where such recognition is too deeply entrenched in the law or in judicial precedent for policy-makers to have a serious hope of undoing it, such recognition should be limited to cases where gender reassignment surgery already has been performed. Policy-makers should strenuously resist efforts to legally recognize changes of sex or “gender identity” that are based only on personal choice, psychological feelings, or social experience, rather than on a physical change.

2) Should the government force other, private entities to accept and recognize so-called “sex changes” through the use of non-discrimination laws that include “gender identity” as a protected category?

This question relates to the efforts to pass laws or ordinances at the local, state, and federal level which would outlaw “discrimination” on the basis of so-called “gender identity” in employment, housing, public accommodations, education, and business transactions. Some of the bills or laws that seek to protect “gender identity” acknowledge the importance of appearance, dress and grooming standards in the workplace. However, most ordinary Americans would consider dressing in ways that are culturally appropriate for one’s biological sex to be the most fundamental “appearance, grooming, and dress standard” that could be conceived of.

“Bathroom Bills”

The most extreme application of the principle of “non-discrimination” based on “gender identity” would be to the use of gender-separated restrooms, locker rooms, and showers. Even former U.S. Rep. Barney Frank (D-Md), the homosexual Congressman who sponsored the Employment Non-Discrimination Act (ENDA), acknowledged that what transgender activists want “is for people with penises who identify as women to be able to shower with other

women.”

Here are some additional reasons to oppose laws purporting to outlaw “discrimination” based on “gender identity:”

- Such laws increase government interference in the free market.
- “Gender identity” is unlike other immutable characteristics protected in civil rights laws.
- Such laws would lead to costly lawsuits against employers.
- Such laws mandate the employment of “transgendered” individuals in inappropriate occupations, such as education.

3) Should the government pay for medical treatment designed to create the appearance one is other than the sex he or she was born?

One context in which taxpayers could be forced to pay for “gender reassignment” procedures is through the health insurance provided for public employees. Another avenue is government health insurance programs for the poor and the elderly (Medicaid and Medicare). On May 4, 2015, the federal courts decided a claim by a convicted murderer that the Massachusetts Department of Corrections should pay for his gender reassignment surgery—and that failure to do so was “cruel and unusual punishment.” Fortunately, the court rejected that claim. Government should not pay for gender reassignment (hormone treatments and surgery). Such treatments—involving, as they do, the amputation of healthy body parts—are, arguably, a violation of medical ethics. These are elective procedures rather than necessary health care—just like any other form of cosmetic or plastic surgery.

4) Should the government force other entities to pay for changes in sexual appearance?

The Affordable Care Act (also known as “Obamacare”) has greatly expanded the role of the federal government in dictating to insurance companies (and those who purchase insurance policies, whether employers or individuals) what must be included in those policies. There is no explicit “sex change” mandate in Obamacare. However, some aspects of the law have increased the chances that insurance companies will offer such coverage. Late in 2014, the state of New York imposed a mandate upon insurance companies throughout the state to fund sex reassignment surgery (SRS).

5) Should the federal government permit “transgender” individuals to serve in the military as their preferred sex?

Historically, transgendered persons have not been permitted to serve in the U.S. military.

Transgender status has been considered a disqualifying psychiatric condition, and having had gender reassignment surgery has been a disqualifying physical condition. However, transgender activists are pushing for a change to the policy.

The story of America's most famous transgender service member tends to reinforce concerns that such individuals are not fit for military service. Bradley Manning is the soldier convicted of espionage in 2013 for turning over confidential documents to the website Wikileaks. The day after Manning was sentenced to prison, he "came out" as transgendered.

Conclusion

A person's sex (male or female) is an immutable biological reality. In the vast majority of people (including those who later identify as "transgender"), it is unambiguously identifiable at birth. There is no rational or compassionate reason to affirm a distorted psychological self-concept that one's "gender identity" is different from one's biological sex. Neither lawmakers nor counselors, pastors, teachers, nor medical professionals should participate in or reinforce the transgender movement's lies about sexuality—nor should they be required by the government to support such distortion.

** The Executive Summary does not contain citations as these are embedded in the text of this paper.

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Introduction

In recent decades, there has been an assault on the sexes. That is, there has been an attack on the previously undisputed reality that human beings are created either male or female; that there are significant differences between the sexes; and that those differences result in at least *some* differences in the roles played by men and women in society.

The first wave of this movement came from modern feminism, starting roughly in the 1960's. Certainly some advances from what might be called "moderate feminism" have brought necessary changes, such as the (earlier) step of granting women the vote and the opening of doors of opportunity for women to more fully enter such professions as medicine, law, and politics. However, more radical versions of feminism denigrated women who might freely choose a more traditional, complementary role, such as staying home to care for children while being supported financially by their husband. Nevertheless, no one disputes that the

boundaries of gender roles in terms of occupation and lifestyle have become less rigid, even while discussion over what is best for women and families continues. However, a second wave took aim at a role that might seem less variable than occupational choice. The homosexual movement challenged the idea that men have sex only with women and women have sex only with men. Despite the obvious anatomical complementarity of the male and female bodies for the purpose of sexual intercourse, and despite the absolute necessity of both a male and female contribution to the fundamental human task of reproduction, the homosexual movement insisted that sex between two men or two women was no less natural than the union of a man and a woman.

The third wave of this assault on the sexes has been a questioning of even the most basic biological reality—that all people (with rare genetic exceptions) have a biological sex, identifiable at birth and immutable through life, which makes them either male or female.

Instead, we are now told that sex is not identified at birth but merely “assigned,” that some people have a “gender identity” which is the opposite of (or unrelated to) their biological sex, and that when there is a conflict between one’s “gender identity” and one’s biological sex (sometimes referred to as “gender dysphoria”), we should assume that the flaw is *biological*, not *psychological*. In such cases, we are told, even the surgical amputation of healthy body parts is justified to bring the recalcitrant body in line with the defining mind.

This ideology—the most recent (and one may hope, final) challenge to the reality that human beings are created male and female—is known as the “transgender” movement. This paper is intended as a critique of that movement and that ideology.

Part I of this paper (primarily authored by Dale O’Leary) addresses the psychological and medical issues involved. It will debunk the idea that some people are “born in the wrong body,” that gender dysphoria can only be indulged and not overcome, and that such indulgence is an effective solution to the problems that transgender persons experience.

Part II (primarily authored by Peter Sprigg) will address the public policy issues—whether government entities should recognize and affirm changes in “gender identity,” and whether they should force private entities to do the same by force of law.

Part I Gender vs. Sex

While other disagreements over the nature, identity, and value of human life have dominated the culture wars, the transgender movement has waged its campaign on many fronts—in classrooms, newspapers, counseling textbooks, and statehouses across the nation. Transgender advocates have questioned the inherently binary nature of gender and begun to claim that it is a malleable thing, “free” from the claims of biology and genetics. They have made steady progress in their campaign to add “gender identity” and “gender expression” to antidiscrimination legislation. Why does it matter?

The radical nature of these demands may not be apparent to those who assume that “gender” is a synonym for “sex.” However, those pressing for “gender rights” have helped advance the social redefinitions of these two words. Before the 1950’s “sex” referred to the totality of what it means to be male or female. “Gender” referred to words (in English pronouns –masculine, feminine, neuter). According to the new gender ideology, “sex” is restricted to the biological, while “gender” describes the social and cultural manifestation of sex: how a person feels and experiences his or her sexual identity and how culture shapes his or her expression of sexual identity.

So long as the unity of sex and gender are maintained there is no problem, but gender activists promote the idea that gender can be disconnected from sex and a person of either sex could have a gender identity of the other sex, of both sexes, or of neither.² Thus, a person who has a male body—with XY chromosomes embedded within every living cell of his body— could claim to have a female gender identity.

If individuals are unhappy because they want to be the sex they were not born, according to the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-5)*, they are suffering from “gender dysphoria.” Persons with gender dysphoria are physically (including genetically) normal men and women who are unhappy with their natal sex and want to be the other. They believe they would be more comfortable, safer, or receive more attention or love if they were the other sex. Some believe that they were born with the body of one sex and the brain of the other and they want their bodies changed to match their brains. They want to “pass”—as the other sex. A full transition involves hormone treatments, breast surgery (removal or implants), other cosmetic surgery, genital reconstruction, a complete change of appearance, change of personal identification, reinterpreting personal history, and creating a new persona.

There is nothing inherently wrong with analyzing how culture affects the way people experience being male or female. Nor is there anything wrong with noting that cultural stereotypes can unduly restrict individual freedom. The problem arises when individuals attempt to change their sex. Biologically normal persons of one sex cannot become the other sex. This paper explores the manner in which some gender advocates attempt to redefine the biological reality of sex and impose false definitions upon society. Family Research Council (FRC) believes that the truth about sexual differences is objectively knowable and that redefining it will be harmful.

We also deny that gender and sex should be separated. Therefore, supporting public policy or education programs that perpetuate the myth that people can change their biological sex (or change to a “gender identity” that is not consistent with their biological sex) is harmful because it ignores the reality of what it means to be human and deludes society regarding what is possible or healthy when dealing with mental health issues related to gender dysphoria.

The idea of gender-different-from-sex is being promoted in schools. Parents of freshmen at Acalanes High School in Lafayette Calif. discovered that the Planned Parenthood presented sex education course included a sketch of a “Genderbread Person,” which presented the human

person as a combination of four elements, each offering a range of options and combinations, identity, falling along a multi-level continuum:³

- *Gender identity (woman – genderqueer⁴- man),*
- *Gender expression (female-androgynous-masculine),*
- *Biological sex (female-intersex-male),*
- *Sexual orientation (heterosexual-bisexual-homosexual)*

The goal in the classroom and in society at large is to undermine the public's common sense view that people come in two sexes: Male or female.

Sidebar: Intersex Conditions

Before discussing the transgender movement as it is properly understood, it is essential to dispose of one misleading distraction that is frequently raised in the context of this issue. A very tiny percentage of people suffer from disorders of sexual development (DSD), sometimes referred to as an intersex condition (or in older literature, as hermaphrodites). Their genes, hormones, or body structures differ from the norm. There are scores of conditions which are sometimes classified as falling into this category. In rare cases, the sex of the baby with one of these conditions may be misidentified at birth. The transgender movement uses DSD to argue that the binary system of male/female doesn't cover everyone and sex should be treated as a continuum. Those with DSD aren't lobbying to pass as the other sex, but to discover to which they belong. In the 1990's one writer drew attention with a claim that as much as 1.7% of the population might have an intersex condition.⁵ However, she used a definition so broad that it would include people with no known symptoms. True hermaphrodites—those in whom their sexual anatomy is ambiguous or clearly conflicts with their chromosomal make-up—are rare, estimated by one expert as “occurring in fewer than 2 out of every 10,000 live births.”⁶

The needs of “intersexed” persons should be addressed on a case-by-case basis. They should in no way be confused with the transgendered, because the overwhelming majority of “transgender” persons are *not* “intersexed.”

No one can change his or her sex.

No one can change his or her sex. The DNA in every cell in the body is clearly marked male or female. Hormones circulating in an unborn child's brain and body shape his or her development. A person's internal reproductive organs, external genitalia, and chromosomal make-up all testify to their biological sex—and in the vast majority of people, these indicators are entirely consistent with each other. Psychiatrists and surgeons who have served transsexual clients know that surgery does not change sex. George Burou, a Moroccan physician who has operated on over seven hundred American men admitted: “I don't change men into women. I

transform male genitals into genitals that have a female aspect. All the rest is in the patient's mind.”⁷

Those who want to be the other sex are not, for the most part, delusional about their biological makeup. For example, men who want to be women know they have male DNA and genitals, but insist that they have female brains. They know they can't change their DNA, they just want their genitals to match their brains⁸. They point to studies which show differences in the brains of transsexuals⁹; however, neuro-circuitry is plastic and shaped by behavior. Those who have examined the men who think they have women's brains are skeptical of their claim to “think like women.” Psychiatrist Paul McHugh of Johns Hopkins interviewed some of the men seeking to become women and found them to be quite unlike most women:

“First, they spent an unusual amount of time thinking and talking about sex and their sexual experiences; their sexual hungers and adventures seemed to preoccupy them.

Second, discussion of babies or children provoked little interest from them; indeed, they seemed indifferent to children.”¹⁰ Johns Hopkins was one of the first institutions in the U.S. to perform so-called “sex change” operations, which were later named “sex reassignment surgery” (SRS), and now are called “gender reassignment.” McHugh was skeptical of the surgical solution. When he became psychiatrist-in-chief at John Hopkins, he commissioned a study of the program. Its authors Jon Meyer and John Hoopes found that:

In a thousand subtle ways, the reassignee has the bitter experience that he is not—and never will be—a real girl but is, at best, a convincing simulated female. Such an adjustment cannot compensate for the tragedy of having lost all chance to be male, and of having in the final analysis, no way to be really female.”¹¹

Transgender terminology

In this brave new era of deconstructing and redefining human sexuality, a new set of vocabulary emerges. In ten short years, the social media network Facebook went from offering two gender options to offering fifty-one.¹²

The Gay and Lesbian Alliance Against Defamation (GLAAD), an “LGBT” (lesbian, gay, bisexual, transgender) activist group, has issued guidelines for media to use terminology preferred by the transgender movement. (It should be noted that these names and categories are arbitrarily assigned and subject to change.)

Here are some excerpts:

Transgender (adj.)

An umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with the sex they were assigned at birth. . . .

Transsexual (adj.)

An older term that originated in the medical and psychological communities. Still preferred by some people who have permanently changed - or seek to change - their bodies through medical interventions (including but not limited to hormones and/or surgeries). . . .

Transgender man [FTM]

People who were . . . female at birth but identify and live as a man may use this term to describe themselves. . . . Some may also use FTM, an abbreviation for female-to-male.

Transgender woman [MTF]

People who were . . . male at birth but identify and live as a woman may use this term to describe themselves. . . . Some may also use MTF, an abbreviation for male-to-female.

Cross-dresser [or transvestite]

. . . [T]ypically used to refer to heterosexual men who occasionally wear clothes, makeup, and accessories culturally associated with women. This activity is a form of gender expression, and not done for entertainment purposes. Cross-dressers do not wish to permanently change their sex or live full-time as women. . . . **PLEASE NOTE:** Transgender women are not cross-dressers or drag queens. Drag queens are men, typically gay men, who dress like women for the purpose of entertainment. **Be aware of the differences between transgender women [MTF], crossdressers, and drag queens.**¹³

“Gender Identity Disorder” Becomes “Gender Dysphoria”

In 1973 the American Psychiatric Association, facing intimidation and pressure by homosexual activists, removed homosexuality from its *Diagnostic and Statistical Manual of Mental Disorders* before publication of its third edition. Homosexuality was no longer to be considered a psychiatric disorder. According to Ronald Bayer, a professor at the Center for the History and Ethics of Public Health at the Columbia University, A furious egalitarianism that challenged every instance of authority had compelled psychiatric experts to negotiate the pathological status of homosexuality with homosexuals themselves. The result was not a conclusion based on an approximation of the scientific truth as dictated by reason, but was instead an action demanded by the ideological temper of the times.¹⁴

Since this victory, LGBT (lesbian, gay, bisexual, or transgender) activists and professionals sympathetic to their agenda have accrued ever greater power within professional mental health organizations. As the time for the publication of the DSM-5 approached, the transgender activists, following the example of the homosexual activists in the 1970’s, lobbied to have the diagnosis of Gender Identity Disorder changed to Gender Dysphoria. They objected to having their condition labeled a “disorder.”

The revised language in the DSM-5 says, “*Gender dysphoria* refers to the distress that may

accompany the incongruence between one's experienced or expressed gender and one's assigned gender."15

The DSM-5 definition focuses on incongruity and the *feeling* of unhappiness caused by not being accepted as the other sex or not having access to surgery. The new definition implies that the problem is a *transphobic* culture, rather than a pathological or disordered belief that changing parts of one's body changes one's sex. According to an APA fact sheet on the definition change, "DSM-5 aims to avoid stigma and ensure clinical care for individuals who see and feel themselves to be a different gender than their assigned gender." But, to "avoid stigma," why not simply remove the diagnosis from the DSM altogether, as was done with homosexuality? The APA says that "treatment options for this condition include counseling, cross-sex hormones, [and] gender reassignment surgeryTo get insurance coverage for the medical treatments, individuals need a diagnosis. . . .[R]emoving the condition as a psychiatric diagnosis—as some had suggested—would jeopardize access to care."16

Nature and Causes of "Gender Dysphoria"

For the purposes of this paper, we will use the older term "gender identity disorder" (GID), which appears in some important sources, interchangeably with the revised term "gender dysphoria" in reference to the condition of those who perceive themselves to have a "gender identity" that does not match their biological sex at birth. However, Family Research Council believes that it is politics, not science, which has driven the conclusion that such a condition is not inherently "disordered" and is only problematic if it causes subjective distress.

As Sander Breiner, a psychiatrist with clinical experience working with transsexuals at Michigan's Wayne State University, declares: I, along with other psychoanalyst colleagues, must tell the surgeons that the disturbed body image was not an organic [problem] at all, but was strictly a psychological problem. It could not be solved by organic manipulation (surgery, hormones), no matter how well-intentioned In psychologically evaluating any patient, it is always important to understand how the patient sees himself. . . . [W]hen an adult who is normal in appearance and functioning believes there is something ugly or defective in their appearance that needs to be changed, it is clear that there is a psychological problem of some significance. 14

The more pervasive and extensive is this misperception of oneself, the more significant is the psychological problem. The more the patient is willing to do extensive surgical intervention (especially when it is destructive), the more serious is the psychological problem. . . . [T]he significance of the psychological difficulty should not be minimized by a patient's seeming success, socially and professionally, in other areas. . . . This conclusion became so well established at Wayne State University that the program was eventually discontinued. The much larger and more extensive program at Johns Hopkins University and medical school in Baltimore, Maryland was discontinued for the same reason.17

Instrumental in the Johns Hopkins decision was professor of psychiatry Dr. Paul McHugh, who has declared bluntly, "It is a disorder of the mind. Not a disorder of the body."18

Another psychiatrist, Rick Fitzgibbons, describes what is now called gender dysphoria as “a fixed false belief that a person can be a sex that is not consistent with their biological and genetic identity Fixed false beliefs are identified in the mental health field as manifestations of a serious thinking disorder, specifically a delusion.”¹⁹

Each person has his or her own personal history. It is highly unlikely there is a single cause for all transgender desires. However, complete and truthful case histories often reveal a series of events which help explain how an individual person’s desire to be the other sex developed. While causality is difficult to determine with absolute certainty in individual cases, it is known that the transgendered are more likely to have experienced difficult childhood situations, to have been victims of sexual child abuse, or to have a history of trauma, loss, and family disruption.²⁰

Patterns of Transgender Desires

There are three major patterns of transgender desire.

- 1) Males with childhood GID, who are usually sexually attracted to men.
- 2) Secret transvestites.
- 3) Females with childhood GID, who are usually sexually attracted to women.

Gender Dysphoria in Children

A child with gender dysphoria identifies with and envies the other sex. These children may express a strong, persistent desire to be the other sex or fantasize that they are the other sex. Susan Bradley, M.D., the Psychiatrist-in-Chief at the Hospital for Sick Children and Head of the Division of Child Psychiatry at the University of Toronto, has worked extensively with children with GID. She regards GID as one of a number of attachment disorders and conceptualizes the symptoms of GID, “as a child’s solution to intolerable affects... The GID symptoms, particularly the assumption of the role and behaviors of the opposite sex, act to quench the child’s anxiety and to make him or her feel more valued, stronger, or safer.”²¹

These children insist on wearing clothing associated with the other sex and engage only in activities associated with the other sex. Boys with GID may even talk about cutting off their penises. It is not that these children are confused about sex difference. On the contrary, they are painfully aware of sex difference, and more likely to have rigid stereotypes as to what is appropriate for each sex. While boys with GID are often labeled by others as effeminate or girly boys, they do not resemble ordinary girls. GID children are categorized by an almost phobic lack of emotional and social flexibility. While a normal girl usually will feel equally comfortable in jeans or a dress, a GID boy will be uncomfortable in normal boy clothes and self-comforts with ultra-feminine clothing. A normal girl enjoys both outdoor games and quiet doll play, but the GID boy often avoids outdoor games. GID boys often imitate older women’s walk and

speech, rather than that of girls of their own age.²²

GID in children is easily recognized and treatable. Kenneth J. Zucker and Susan J. Bradley, two of the world's leading experts in GID in children, have declared: It has been our experience that a sizable number of children and families achieve a great deal of change. In these cases, the gender identity disorder resolves fully, and nothing in the children's behavior or fantasy suggest that gender identity issues remain problematic. . . . [W]e take the position that in such cases clinicians should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity.²³

Marc S. Dillworth, Ph.D., has described a treatment model for boys which includes the following elements:

1. Encourage Father/Son Bonding
2. Mother's Distancing Themselves and Affirming Father's Masculinity
3. Extinguishing Feminine Behavior and Play
4. Positive Encouragement for Gender-Appropriate Behavior
5. Encouraging Same-Sex Friends, Play, and Activities.²⁴

Even without treatment, cross-gender behavior in childhood generally resolves itself, with only tiny percent of such children becoming transsexual as adults. However, roughly 75 percent will later self-identify as gay or lesbian.²⁵ The more the child is allowed to pursue the cross-sex behavior, the more convinced the child becomes that being the other sex is the solution to his problems. However, today trans-positive therapists encourage parents to accept GID as normal and allow the child to live as the other sex. As the child matures the therapists prescribe puberty blocking drugs, preparing the child for a total sex change.²⁶ Such therapists invoke the rationale that if the child does not go through puberty, he or she will be able to present a more convincing image of the other sex. The trans-positive therapists insist that if the desire were not frustrated by parents and schools, the child could progress seamlessly to a sex change and avoid all the problems currently faced by transsexuals.

Transgender activists insisted that strong other-sex identification in a child is not a disorder, but "diversity." The child's suffering is caused by the failure of society to accept the child as the other sex. The parents are encouraged to see GID as normal for this child and accustom themselves to a gay or transgender outcome for their child. Transgender-affirming psychologist Diane Ehrensaft, for example, says, "I think that our gender identity is not defined by what's between our legs but by what's between our ears—that it's somewhere in the brain. It's pretty much hardwired." If the parents choose unconditional acceptance of the child's feelings and goals, the dysfunction within the family which may have precipitated the GID is not addressed.

The schools are told to accept the cross-sex behavior. The gay community insists that the undeniable negative outcomes associated with *self-identifying* as transgender are caused by transphobic social attitudes and that the elimination of these will ameliorate the problems. Ehrensaft says gender dysphoric children are sending the message, "I know who I am. And if

you let me be who I am, I will be a healthy person.”²⁷ Acceptance is seen as a panacea, but there is no evidence these children will avoid the negative outcomes associated with transgender identification, including higher rates of suicide attempts, completed suicides, overall mortality, and need for psychiatric inpatient care.²⁸

Referring to medical interventions to block puberty in gender-variant children, Dr. McHugh of Johns Hopkins says bluntly, “This is child abuse.”²⁹ Zucker and Bradley view failure to treat children in an effort to prevent a transsexual outcome as “irresponsible.”³⁰ They cite the following benefits of treatment:

1. A reduction in social ostracism by peers;
2. An opportunity to relieve the psychopathology which has been documented to be associated with GID, both in the child and within the family;
3. The prevention of later transsexualism;
4. The prevention of homosexuality in adulthood. On this controversial point, Zucker believes treatment is justified for social reasons.³¹

Dr. Keith Ablow opposes treating children with GID as though they were the other sex: I believe that children have enough to deal with as they struggle to feel comfortable with their bodies, with the notion of privacy and with later changes involving puberty without urging them to grapple with the notion that their souls may have been born into the wrong bodies.³²

Males with Childhood GID

The majority of boys with untreated GID grow up to become sexually attracted to males; however, a small number are attracted to straight men and find gay men too effeminate. They believe that if they were women, in particular very attractive sexy women, straight men would be attracted to them. These men have been labeled as homosexual transsexuals. Some of them engage in prostitution in order to raise money for surgery.³³

Secret Transvestites

Another common transsexual pattern describes men who showed no evidence of GID as boys, but whose mothers were emotionally unavailable. In adolescence these boys began to masturbate while wearing women’s clothing and looking at themselves in the mirror. They progressed to secret transvestitism, a paraphilia³⁴ in which a man is sexually aroused by dressing in women’s clothing. As adults, these men often chose typical masculine careers, marry, and have children. Later in life, sometimes after a crisis, they want to “come out” and live openly as women. These men are sometimes described as autogynephiles, men in love with the image of themselves as women.

The autogynephile can become obsessed with the belief that a “sex change” will solve all his problems. As Anne Lawrence, an autogynephile who has undergone sex reassignment surgery (SRS), indicates, “...becoming what one loves usually becomes their first priority, while other elements of life—family, friends, employment—typically assume secondary importance at least temporarily. The sex reassignment process is often given first claim on the transsexual’s time, energy and resources.” 35

Some autogynephiles remain attracted to women and decide they are lesbians. This has led to conflict with lesbian feminists like Janice Raymond, who view men pretending to be women as “invading women” by “reducing the real female form to an artifact, appropriating this body for themselves.”36

Females with Childhood GID

Female-to-male transsexuals usually have childhood GID. As little girls many come to believe that women are weak and they would be safer and more appreciated if they were boys. They refuse to wear feminine clothing and prefer boys’ clothes, games, and sports. They are sexually attracted to women and may enter lesbian relationships. As some point being a masculine looking lesbian is not enough and they start taking male hormones and opt to have their breasts removed. Male hormones often cause significant personality change, as well as changes in the body and the growth of body hair. Some FTM’s may have hysterectomies, but relatively few opt for surgery to create the simulation of a penis, since such attempts are not functional nor aesthetically acceptable. Their masculinization can put them at odds with the lesbian communities in which they live and lesbian partners who don’t want “male” partners.37

Some FTM decide they are “gay” men and seek out gay men as sexual partners.38 Some adopt a genderqueer identity.39

Who Gets Approved For “Gender Reassignment”?

Some practitioners of SRS have attempted to develop criteria for deciding who would benefit from such procedures and who would not. Harry Benjamin (1885-1986) was one of the first physicians to advocate the surgical solution to transgender desires. In his honor, the Harry Benjamin International Gender Dysphoria Association was organized (but was later renamed the World Professional Association for Transgender Health, or WPATH40). This organization developed *Standards of Care for Gender Identity Disorders* to help psychiatrists decide which applications they should approve. The guidelines recommend a year of therapy before irreversible treatments are begun, but make clear that: “Psychotherapy is not . . . delivered to the patient to cure the gender identity disorder. Its usual goal is a long-term stable life style with realistic chances for success in relationships, education, work, and gender identity and role.”41

While persons seeking approval for surgery could benefit from psychological therapy, many do not come to the therapist in a sincere effort to work on their underlying psychological problems, but to be approved for surgery. These clients have read the guidelines and know what the therapists want to hear. Some have reportedly lied about their childhood and sexual experiences in order to fit the profile.⁴² If the therapist tries to probe into the root cause of the desire to be the other sex or challenges their defense mechanisms, the client closes down or attacks the therapist for being ‘transphobic.’ In such cases, client resistance makes effective psychotherapy exceptionally difficult.

Unable to alleviate their transsexual clients’ distress and faced with clients who threaten suicide or self-mutilation, therapists approve applications, not because they think it will cure the underlying problems, but as a palliative measure to alleviate other presenting problems like depression. The guidelines caution therapists to inform the clients that their fantasy of being instantly transformed into the other sex after surgery may not be realistic: “Even when these initial goals are attained, mental health professionals should discuss the likelihood that no educational, psychotherapeutic, medical, or surgical therapy can permanently eradicate all vestiges of the person’s original sex assignment.”⁴³

Before hormone treatments or surgery are approved, transsexual persons are supposed to be examined to be sure they are not suffering from an undiagnosed disorder of sexual development or a co-morbid psychological disorder. While undiagnosed DSDs are rare, a survey of psychiatrists in the Netherlands found that of the 584 clients requesting a “sex change” 61 percent were diagnosed with “other psychiatric illnesses including personality, mood, dissociative, and psychotic disorders.”⁴⁴ One of the psychiatrists queried remarked, “the scalpel should not be used to reconcile fantasy with reality.”⁴⁵ Other studies have found that “about 25% of schizophrenics experience cross-gender identification at some point in their lives.”⁴⁶ There is a risk they could be approved for surgery, when treatment of the schizophrenia would eliminate cross-gender desires. In addition, those effeminate homosexual men, heterosexual crossdressers, drag queens, and transvestites who experience erotic genital pleasure are poor candidates for removal of their genitals. Failure to recognize serious psychological disorders can have tragic consequences. Walt Heyer was approved for surgery after a one hour session in which the psychiatrist talked mainly about himself. After surgery Walt later was diagnosed with dissociative disorder. He later recognized that the surgery had been a mistake and is now living as a man.⁴⁷ Writer Stella Morabito has documented the stories of others who have regretted—or even reversed—SRS.⁴⁸ Studies show that up to 20 percent of those who had surgery have some regret over their decision.⁴⁹ In addition, a number of those apply for surgery do not follow through, even if they are approved.

In one study 325 applied for hormone treatment, but only 188 completed it.⁵⁰ Some Americans seeking gender reassignment surgery will turn to foreign doctors to obtain the service. In part, this is due to the relative scarcity of facilities that perform the procedure. Dr. Marci Bowers is unique—a surgeon (previously Mark Bowers) who received SRS, and now performs it on others. Bowers estimates that there may be 25 doctors in the entire country who

have ever performed such surgery, “But in terms of one who [does] them on a regular basis, I would say, fewer than six.”⁵¹ In part, it is due to more lenient conditions for obtaining the surgery in other countries, such as Thailand.⁵²

Gender Reassignment Surgery

As discussed above, full transition involves hormone treatments, breast surgery (removal or implants), other cosmetic surgery, genital reconstruction, a complete change of appearance, change of personal identification, recreating their past and creating a new personal history. However, not every person seeking to live as the other sex will decide to have complete reconstructive surgery. Some will opt for only hormones or breast reconstruction. Because surgeons cannot simulate a functioning and convincing penis, few women who want to be men choose genital surgery, but they still want to be legally recognized as men. In any case, the immense effort needed to create a convincing woman out of a man (or vice versa) is evidence of the profound reality of sex difference.⁵³

Problems after Surgery

Although the goal of surgery is to make the clients more comfortable, after-surgery problems can remain. The *Guidelines* suggest that additional therapy may be needed because, “... when the anatomic obstacles to gender comfort have been removed... the person may continue to feel a lack of genuine comfort and skill in living in the new gender role.”⁵⁴

Immediately after the surgery, many of the clients are ecstatic; but as time goes by the thrill wears off. Transgender individuals want to “pass” as the other sex. According to a large study of transgendered only 21 percent are able to “pass” all the time.⁵⁵

The transsexuals who decide to “pass” as the other sex endure the stress of living a lie. They must deceive their sexual partners or risk rejection by being honest about their true identity and history. For the transsexual, “there is never a day free from fear of discovery or from the struggle with managing the process of passing.”⁵⁶ Respected psychiatrist Robert Stoller explains the dilemma: What she [a Male-to-Female] could never forget –nor can any transsexual ever forget—[is that] that life began as the opposite sex. These patients . . . are not able to deny their past, especially the knowledge that they are forever the sex into which they were born; more than many researchers on transsexualism, these patients know they will never be truly female, [and] therefore can never be, in the depths of their identity, women.⁵⁷

Some find the stress of constant deception exhausting and stop trying. They move into relationships with other transgender persons. Some go back to their birth sex, others even though disappointed with the results, remain in their assumed sex. Renée Richards, the tennis player who became a well-known male-to-female, has made conflicting statements, but at one point expressed a measure of regret, saying: “I would have been better off staying the way I was—a totally intact person. I know deep down that I’m a second-class woman.”⁵⁸

Some clients need multiple surgeries and others find that their reconstructed urinary track is subject to repeated infections. After a few years an artificially constructed vagina can shrink making sexual relations difficult. Failure to remove all hair from male genitals before they are used to create a vagina can make relations painful. A study of 66 post op patients found that 14 had major complications.⁵⁹

A lifetime of hormone treatments can also have profound physical and psychological consequences. A study of 303 MTF transsexuals found 45-fold increase of blood clots, a 400-fold increase in prolactin (a protein involved in breast development), and a 15-fold increase in depressive mood changes.⁶⁰ A study of mortality and morbidity compared 425 transsexual patients treated with cross-gender hormones with a similar reference group of the population. The number of deaths in MTF transsexual populations was five times the number expected, due to increased numbers of suicide and death of unknown cause.⁶¹

Psychiatrists and surgeons who have dealt with transsexual clients know that surgery does not change sex. Charles Ihlenfeld was Harry Benjamin's apprentice and supposed to carry on his work, but Ihlenfeld left the field. He explained, "Whatever surgery did, it did not fulfill a basic yearning for something that is difficult to define. This goes along with the idea that we are trying to treat superficially something that is much deeper."⁶²

Jon Meyer, M.D., Associate Professor of Psychiatry and Behavior Science at Johns Hopkins University, concluded after studying the issue in the 1970's that clients may be able to suppress their natural masculinity or femininity, but the internal conflict required to do so manifests itself in a variety of self-destructive behaviors: "When performing sex reassignment surgery, one is not making the external anatomy congruent with a complete gender reversal in personality. Rather, one is making adjustments in the external anatomy to reflect a façade constructed on what once was a male or female—major portions of the personality having been damaged along the way."⁶³

In an interview, Meyer stated, "My personal feeling is that surgery is not a proper treatment for a psychiatric disorder and it is clear to me that these patients have severe psychological problems that do not go away following surgery." Much more recently, Dr. Paul McHugh, former psychiatrist in chief at Johns Hopkins Hospital, has written, "At the heart of the problem is confusion over the nature of the transgendered. 'Sex change' is biologically impossible. People who undergo sex-reassignment surgery do not change from men to women or vice versa. Rather, they become feminized men or masculinized women. Claiming that this is civilrights matter and encouraging surgical intervention is in reality to collaborate with and promote a mental disorder."⁶⁴

Not all those who demand that society recognize them as the other sex have or even intend to have surgical alterations. The position of transgender activists is that people should be recognized as belonging to whatever gender they choose, *regardless* of the physical condition of their bodies. Therefore, a "woman" could have a penis, scrotum, and testicles, and a "man" could have a vagina, uterus, and lactating breasts.

High-Risk Behavior

Transgender people are more likely than the general public to engage in high-risk behaviors, which may result from or contribute to psychological disorders (or both). Gender reassignment surgery often does little to alleviate these problems. Some of the high-risk behavior is directly related to their desire to change sex. For example, some transsexuals self-mutilate or undergo procedures in non-medical settings. Some become addicted to cosmetic surgery.⁶⁵ In addition, some purchase hormones on the black market.⁶⁶

Others engage in high-risk sexual behavior. Many male-to-females become “sex workers” in order to earn money for their surgery. In addition, the fact that a man will pay them for sex makes them feel like real women. Prostitutes are also often victims of violence, and the risk is particularly high for the pre-surgery male-to-females if the john discovers the person he thought was a sexy woman has a penis.⁶⁷

Young MTFs are more likely than any other population to be HIV positive. This is because they are more likely to engage in prostitution or to have anal sex with multiple partners, to inject hormones without medical supervision, and share needles. A study of 392 MTFs found that 35 percent were HIV positive.⁶⁸ In addition 64 percent said they had been victims of sexual assault and 16 percent had been involved in sex work or drug dealing.⁶⁹

Ironically, some applicants threaten suicide or self-mutilation as an argument for the approval of surgery. However, the fact that high rates of suicide exist even among those who have already received gender reassignment surgery suggests that suicidal tendencies result from an underlying pathology or struggle, and will not be alleviated by surgery.

The National Transgender Discrimination Survey (NTDS) of 6,450 persons who self-identify as transgender found that 41 percent said they had attempted suicide, versus 1.6 percent of the general public. Besides being vulnerable to all the general causes of suicide—drugs and alcohol, failure of a love affair, depression, and untreated mental illness—transsexuals may sooner or later face the fact that their desire to be the other sex is an unrealizable fantasy, one for which they have sacrificed irreplaceable parts of themselves.

While the NTDS study was clearly designed to link negative outcomes with discrimination, a different study of 392 male-to-female and 123 female-to-male transgendered in San Francisco, where the transgendered are *highly* accepted, found similar problems.

Among the male-to-female:

- 35% were HIV positive,
- 22% had mental health hospitalization,
- 32% had made a suicide attempt,
- 62% suffered from depression,
- 65% had been incarcerated;
- 80% had engaged in sex work or survival sex, and

- 59% had been sexually assaulted.

Among the female-to-male,

- 2% were HIV positive,
- 20% had mental health hospitalization,
- 32% had made a suicide attempt, and
- 55% reported depression.⁷⁰

Some transgenders demonstrate the symptoms of pathological narcissism. A lengthy article by Alice Dreger chronicles the vicious attacks made by transgenders on J. Michael Bailey because they felt offended by his book *The Man Who Would be Queen*. MTF Anne Lawrence warns therapists to be careful not to trigger narcissistic rage in their transgender clients.⁷¹ Unfortunately, this can make such clients resistant to therapy.

“Genderqueer” vs. “the Gender Binary”

To many Americans, it may seem radical to assert that a man can become a woman or a woman can become a man. However, the transgender movement has moved into even more radical territory—attacking what they call “the gender binary,” that is, the idea that everyone should identify as either male or female. Those who adopt this approach sometimes refer to themselves as “genderqueer.”

While clothing their agenda in rights language, gender activists rebel against reality. They talk about “transgressing” the “coercive binary” division of human beings into male and female.⁷² They see themselves as “forging a rich cultural ‘transimaginary’ and a vibrant transmaterial culture. This cultural work represents nothing short of an ontological insurgency.” The realization of their “political and social fantasy of nongendered transhuman existence”⁷³ would be a day when no one would notice sex difference.⁷⁴ This sort of fantasy might be amusing if it were relegated to academic gender studies programs, but the gender activists want to introduce it to school children and write it into law.

According to Kelly Coogan, a male-to-female, the term transgender carries a subversive message, “...a presupposition of the term transgender is that seemingly any *body*, irrespective of its anatomically assigned sex at *birth* can circulate *freely* through the *trans*, arriving at some gender identifications and leaving again *momentarily* for others.”⁷⁵

According to Kate Bornstein, a self-proclaimed “gender outlaw” who refuses to be limited to either sex, “Gender fluidity is the ability to freely and knowingly become one or many of a limitless number of genders, for any length of time or rate of change.”⁷⁶

The rebellion against the immutable reality of sex differences has led to the emergence of the Queer or genderqueer, the Q in LGBTQ. According to genderqueer Riki Wilchins, “...gender is the new frontier: the place to rebel, to create new individuality and uniqueness, to defy old, tired, outdated social norms, and, occasionally drive their parents and sundry other authority

figures crazy.”⁷⁷

One of the reasons for the rise of “genderqueer” is that the state of being transgendered is extremely unstable. Those who thought they wanted or had a total surgical alteration discover that some of their birth sex remains. Some older male-to-females remain attracted to women and decide they are lesbians. Some female-to-males are attracted to gay men and decide to identify as gay men. One source listed over 70 different gender identities, including transvestites, drag queens and kings, cross-dressers, two-spirited.⁷⁸

Jack Powell, a female-to-male writes, “When I first started this process, I thought that I was male because I knew I was not female. Once I realize this my life opened up: I didn’t need to take on the identity of male; I could be me, Jack... It allowed me to see gender as fluid.”⁷⁹

Biological Reality Cannot Be Changed

Transgender activists blame their problems on “transphobia,”⁸⁰ which is nothing more than the natural defense of the reality of two sexes and the fact that everyone is either male or female. While the transgendered are free to dress and act as they choose, to change their names and their bodies, and to be intimate with partners of their choice, many movement activists will not be content until they compel all of society to accept their transgender fantasy. The reason for this desired compulsion is the transgender movement’s rebellion against reality. This movement comes at high social, emotional, and physical costs and many gender activists exploit the real suffering of the transgendered. Having other people refuse to accept that they have changed to the other sex is painful, but that does not obligate society to participate in their fantasy, as feminist Janice Raymond points out: What I do accept is that men and some women who undergo transsexual surgery are terribly alienated from their bodies, so alienated that they think little of mutilating them.

I accept the fact that transsexuals have suffered an enormous amount of psychical and emotional pain. But I don’t accept the fact that someone’s desire to be a woman, or a man, makes one a woman or man. Or that the instrumentality of hormones and surgery creates a real woman or man. ...Transsexualism urges us to collude the falsification of reality ...our suspension of disbelief is required as a moral imperative.⁸¹

Terri Webb was a transgender activist who came to recognize the contradictions inherent in transgender rights. Webb notes, “Looking back over the last ten years of my activism I feel that I am looking at an unsuccessful attempt to get others to legitimize my fantasy... The question we should now be asking ourselves is whether we have the right to pretend to be women, not what ‘rights’ the rest of the world should give us in order to go along with our fantasy.”⁸²

Help for Those Struggling with Gender Identity

After studying the practice of sex reassignment surgery at Johns Hopkins, psychiatrist Paul

McHugh decided to discontinue the program: I concluded that Hopkins was fundamentally cooperating with a mental illness. We psychiatrists, I thought, would do better to concentrate on trying to fix their minds and not their genitalia. ...[W]e psychiatrists have been distracted from studying the causes and natures of their mental misdirections by preparing them for surgery and for a life in the other sex. We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.⁸³

A psychologically healthy person accepts the reality of his or her sexual identity. Grief, discomfort, and anger over one's genetic makeup signal problems that can and should be addressed through counseling and possibly medication. Being consumed with envy of the other sex is evidence of disordered thinking and points toward challenges and desires that are not remedied by surgical mutilation or high doses of hormones. The academic literature includes some clinical accounts of successful efforts to overcome gender identity problems. For example, a 1979 article in the *Archives of General Psychiatry* reported on follow-up of the "successful change of gender identity in diagnosed transsexuality . . . in a 17-year-old man." In this and two other cases of biological males reported in the article, treatment was directed specifically at the clients' gender identity through "motor training" (teaching more masculine ways of "sitting, standing, and walking"), followed by training in masculine "social behaviors and vocal characteristics." Treatment then moved on to addressing "sexual fantasies" and "patterns of sexual arousal."⁸⁴

The 17-year-old client reported six and a half years later that "treatment was 'very effective,' since he became 'completely sexually reorientated'"—that is, he overcame both his gender identity issues and his homosexual interests.⁸⁵ The second and third clients remained homosexual, but completely overcame their desire for a sex change. The second client, a 25-year-old man at the time of treatment, reported that "he was '100% comfortable' with his masculinity and had no desire to be feminine or to consider sex change surgery, nor had he experienced any such desires since leaving treatment." The third client, a 26-year-old male, reported three years after treatment that he was "quite capable and comfortable in the masculine role," and said that "the most important result of treatment was the acquisition of male role behavior . . . that gave him self-confidence."⁸⁶

One researcher found that some transsexuals are guilty of "gender-role stereotyping" which may distort their sense of gender identity. Some therapists have found the male role is "anxiety producing for their patients. The patients put masculinity on a pedestal and, falling short of this idealized conception of manhood, assumed they were, therefore, female." In particular, they exhibit "an abhorrence of aggression," with another set of researchers reporting that male-to-female transsexuals "confuse dependency feelings and lack of aggressiveness in social interactions with femininity in sexual behaviors *per se*."⁸⁷

One patient experienced a remission of gender identity problems after becoming involved "in a charismatic religious movement," where he found, "Men in the church were perceived as

being warm and caring without losing masculinity.” The client realized that “a male does not have to be aggressive and stereotypically ‘macho’ and that one is not required to be female to be kind and loving.”⁸⁸ Some researchers concluded “that therapeutic intervention directed at loosening rigid gender-role definitions might in some cases alleviate gender identity problems without sex reassignment.”⁸⁹

A somewhat more recent article (2000) in the journal *Comprehensive Psychiatry* also reported cases in which gender dysphoria was alleviated primarily through treatment not of the dysphoria itself, but of other psychological problems which occurred in conjunction with the gender identity issues. The authors reported: In single case reports, gender dysphoria appeared together with schizophrenia or mania and waxed and waned in parallel with the psychosis. Gender dysphoria and paraphilias have occurred together with depression, suicide attempts, and anxiety and personality disorders and improved in parallel during treatment by medication.⁹⁰

The authors concluded that such “plasticity in gender dysphoria . . . with or without treatment” may be even *more* common than what has been reported: “Subjects who remitted permanently would have no reason to seek help from a clinician, so the frequency of permanent remission may be underestimated in clinical samples.”

As early as 1974, some scholars were warning that “the pendulum has swung too far in the direction of accepting surgery as the treatment of choice,” and authors Barlow, Abel, and Blanchard said their findings “point to the possibility of psychosocial intervention as an alternative to surgery in the treatment of transsexualism.” One of the most unfortunate results of the transgender movement is that this possibility has not been more thoroughly explored and developed.

Resources for People Struggling with Gender Identity and for Their Families⁹¹

Comprehensive Counseling Services/Institute for Marital Healing Dr. Richard Fitzgibbons

<http://www.maritalhealing.com/>

<http://maritalhealing.com/conflicts/genderidentitydisorder.php>

www.ncbcenter.org/page.aspx?pid=1037

Courage – A Roman Catholic Apostolate:

Courage International, Inc.

8 Leonard Street

Norwalk, CT 06850

Phone: (203) 803-1564

<http://couragerc.net/>

Desert Stream Ministries

706 Main Street

Grandview, MO 64030

Phone: 866.359.0500 (toll free)

816.767.1730 (tel)

816.767.7221 (fax)

info@desertstream.org

<http://www.desertstream.org/>

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Harvest USA

<http://www.harvestusa.org/>

Mastering Life Ministries

<http://www.masteringlife.org/>

The National Association for Research and Therapy of Homosexuality

<http://www.narth.com/>

Parakaleo

A Christian ministry in the United Kingdom that reaches out to those with transgender issues.

<http://www.parakaleo.co.uk/>

<http://www.eauk.org/>

Restored Hope Network:

<http://www.restoredhopenetwork.com/>

<http://www.facebook.com/RestoredHopeNetwork>

rhngathering@gmail.com

Sy Rogers Communications

<http://www.syrogers.com/>

Trading My Sorrows

Walt Heyer

<http://www.tradingmysorrows.com/>

<http://www.sexchangeinfo.com/>

Help 4 Families

Denise Schick

<http://help4families.com/>

NOTE: These organizations and websites often deal with sensitive and difficult issues and may contain content for mature readers. Referral to websites not produced by Family Research Council is for informational purposes only and does not necessarily constitute an endorsement of the entirety of the organization or websites' content.

Part II Public Policy Implications of the Transgender Movement

Public policy questions that have arisen related to “gender identity” and/or the “transgender” movement can be broken down into five key questions. The answers to these questions also provide policy-makers with substantive information from which potential legislative action might be taken.

- 1) Should the government legally recognize sex changes?
- 2) Should the government force others to recognize sex changes?
- 3) Should the government pay for gender reassignment?
- 4) Should the government force others to pay for medical gender reassignment procedures?
- 5) Should transgendered individuals be permitted to serve in the military?

Let's look at each of these individually:

1) Should the government legally recognize sex changes?

A human being's biological sex is one of the most fundamental aspects of his or her identity. There are sufficient physical differences between the sexes that in most cases, a person's biological sex is visually evident as well. Thus, government-issued documents used for identification (such as a driver's license) generally will include not only a photograph, but data as to the individual's height, weight, age (or date of birth), and sex. Should the government recognize the legitimacy of sex changes by allowing an individual to change the sex on government-issued identification documents such as a driver's license or passport?

The first government-issued identification document most Americans receive is something even more fundamental—a birth certificate. Transgender activists often contrast their preferred “gender identity” with the “sex assigned at birth.”⁹² However, this is a classic example of the ideological abuse of language. Sex is not “assigned” at birth—it is *identified*, generally by a medical doctor, and usually based on an examination of the genitals of the newborn baby. In the overwhelming majority of cases, this identifier (external genitalia) is entirely consistent with other indicators of sex (internal sex organs and chromosomal makeup) in demonstrating the *fact* of the child's identity as male or female, not a mere arbitrary “assignment.”

Some transgender activists have demanded changes not merely in the identification documents they may use regularly as adults (such as licenses and passports), but even in the more fundamental record of one's birth. A birth certificate, however, is a record of a historical event. To change the recorded sex of a child whose biological sex was obvious and unambiguous at birth is to falsify an important historical record. No government should rewrite history in this way.

Sex is a biological reality, and is immutable. In reality, a “sex change” is impossible. Biological sex is a more fundamental, more important, and more accurate measure of a person's intrinsic identity than the purely subjective and often shifting concept of “gender identity.”

Therefore, Family Research Council believes that neither the government nor private entities have any moral obligation—nor should they have a legal obligation—to give any recognition to such a change. Indeed, such recognition should be actively discouraged if not forbidden outright, because making concessions to the idea of a “sex change” or “gender identity” would:

- a) Affirm something that is biologically impossible;
- b) Affirm a delusion that some people have regarding their sex or gender, instead of helping them overcome that delusion; and
- c) Be complicit with a radical ideological attack upon the reality of sex difference, and upon human nature as a species of beings who are created male and female.

In policy terms, this means that the ideal legal approach would be to forbid government recognition, in any way (whether on birth certificates, driver's licenses, passports, or any other government-issued identification) of any change in an individual's biological sex as identified at birth. Unfortunately, there is only one state (Tennessee) in which statutory law explicitly forbids altering the sex on a birth certificate. The 1977 statute declares, "The sex of an individual will not be changed on the original certificate of birth as a result of sex change surgery."⁹³ According to Lambda Legal, a leading LGBT legal advocacy group,⁹⁴ two other states also refuse to amend birth certificates to revise the sex: Idaho and Ohio.⁹⁵

Altering the sex designation on a driver's license appears to be somewhat easier than doing so on a birth certificate. The National Center for Transgender Equality (NCTE) reports no states that will deny such a change outright. However, requirements vary widely. According to NCTE, some of the stricter states, such as Montana, require "an amended birth certificate and a court order." Some states (such as Alabama, Georgia, Kentucky, Missouri, New Hampshire, Oklahoma, Virginia, and Wyoming) require gender reassignment surgery (GRS); others (such as Arizona, Delaware, Florida, and Hawaii) clearly do not require GRS.⁹⁶

In some cases, transgender individuals have sued to demand less restrictive policies for changing identification documents. The American Civil Liberties Union (ACLU) filed a case on behalf of a male-to-female transgender who was initially granted a new license, then "was told that her new license would be revoked unless she submitted proof of having surgery." The court ordered the state of Alaska to draft a new regulation governing the issue, and the surgery requirement was removed in 2012.⁹⁷

On some occasions, policies on changing sex on government identification documents have become political issues. In 2014, New Jersey Gov. Chris Christie vetoed a bill which would have liberalized rules for amending birth certificates by dropping the requirement for SRS.⁹⁸ At the federal level, in June of 2010 (explicitly in observation of "Lesbian, Gay, Bisexual, Transgender Pride Month") the U.S. State Department announced a loosening of its policies for changing one's sex on a passport, stating, "Sexual reassignment surgery is no longer a prerequisite for passport issuance."⁹⁹

In states where such recognition is too deeply entrenched in the law or in judicial precedent for policy-makers to have a serious hope of undoing it, Family Research Council (FRC) recommends restricting the extension or liberalization of such recognition. For example, if sex changes *must* be recognized in some instances, it should only be in cases where gender reassignment surgery has already been performed. Policy-makers should strenuously resist efforts to legally recognize changes of sex or "gender identity" that are based only on personal choice, psychological feelings, or social experience, rather than on a physical change.

2) Should the government force others to recognize sex changes?

This question relates to the efforts to pass laws or ordinances at the local, state, and federal level which would outlaw “discrimination” on the basis of so-called “gender identity” in employment, housing, public accommodations, and education. As one would expect, advocates of such laws and policies use language that is most likely to win support for them by focusing on concepts like “fairness” and “equality” and juxtaposing them against the evil of “discrimination.” When one listens to this rhetoric, it may not be immediately obvious we are talking about “government-forced recognition of sex changes,” but that is exactly what such laws represent. In the face of such laws, an individual or an organization (such as an employer) may still be free personally to disapprove of the person’s choice to “change his or her sex,” or to present oneself as the gender opposite to one’s actual biological sex, and may personally disagree with the idea that it is even possible to “change one’s sex.” But individuals or organizations would *not* be free to act on that belief or disapproval. On the contrary, they would be *required by law* to recognize and, in practice, fully to accept the “change.”

In what way would they be *required* to recognize and accept the changed sex/gender identity? A *failure* or *refusal* to recognize and accept the change would in itself constitute “discrimination” of a type that these laws would forbid. For example, even if an employer hired a male-to-female transgender (or retained an existing employee if they transitioned from male to female), the firm could be charged with “discrimination” if it required the employee to use the restroom which corresponds to his biological sex (rather than his chosen identity), or even if employees refer to the employee with the “wrong” pronoun (that is, the one that corresponds to his biological sex, as I am doing here, rather than to his chosen female “gender identity”).

What would be the precise objection that some employers might have to hiring a transgender employee in the first place? Some of the bills or laws that seek to protect “gender identity” acknowledge the importance of appearance, dress and grooming standards in the workplace. For example, a Maryland bill declared that it does not prohibit an employer from “establishing and requiring an employee to adhere to reasonable workplace appearance, grooming, and dress standards.”¹⁰⁰ However, most ordinary Americans would consider dressing in ways that are culturally appropriate for one’s biological sex to be the most fundamental “appearance, grooming, and dress standard” that could be conceived of, yet requiring that is exactly what this kind of bill is designed to forbid.

Likewise, for any job involving customer service or contact with other clients, dressing in a way appropriate for one’s biological sex may be “a bona fide occupational qualification,” because the adoption of the “gender identity” of the opposite sex is often highly unconvincing and, in many instances, profoundly disturbing to witnesses.

“Bathroom Bills”

The most extreme example of government forcing recognition of transgendered individuals involves application of so-called “non-discrimination” based on “gender identity” to the use of gender-separated restrooms, locker rooms, and showers. Interestingly, Rep. Barney Frank, an openly homosexual Congressman who for years was the lead sponsor of the federal “Employment Non-Discrimination Act” (ENDA), warned in 1999, “I’ve talked with transgender activists and what they want—and what we will be forced to defend—is for people with penises who identify as women to be able to shower with other women.”¹⁰¹

Because of this concern, a version of ENDA introduced by Frank in 2007 contained an exemption for “shared shower or dressing facilities in which being seen fully unclothed is unavoidable.”¹⁰² However, such legislation often does not include such an exemption (and it subsequently was dropped from ENDA¹⁰³).

Another limiting provision which could be included in such laws, but often is not, is one which specifies that the law applies to public accommodations only when the individual “publicly or exclusively expresses or asserts” his or her “gender identity.”¹⁰⁴ Without such a provision, there will be nothing whatsoever preventing a *temporarily* cross-dressing male from entering a women’s restroom or locker room and exposing himself. Behavior that has been considered criminal would now be protected as a civil right.

The concern about exposure could exist with respect to any transgender person who has not undergone gender reassignment surgery. However, the concern about such laws being exploited by predators to assault women and girls is *not* based on an assertion that transgender people are more likely to be sexual predators. Instead, the concern is that people who are sexual predators might easily *pretend* to be transgendered in order to gain access to women’s facilities. “Gender identity” non-discrimination laws make this more likely because citizens will be less likely to *challenge* a man dressed as a woman who enters a women’s facility—because citizens will fear that such a challenge could result in a “discrimination” claim against them. For example, recently, a woman protested the presence of a man in the women’s locker room at a Planet Fitness gym in Michigan. She was told that the man’s “sincere, self-reported gender identity” was female—and the *complaining* woman had her gym membership revoked.¹⁰⁵ Here are some additional reasons to oppose laws purporting to outlaw “discrimination” based on “gender identity:”

- **Such laws increase government interference in the free market.**

“Gender identity” laws substitute the judgment of the state for the determination of the employer regarding what qualities or characteristics are most relevant to a particular job. So-called “non-discrimination” laws (in which the coercive power of the government is brought to bear against the freedom of the individual business owner) should represent only the narrowest and most limited possible exception to the principle of liberty.

- **“Gender identity” is unlike most other characteristics protected in civil rights laws.**

The Civil Rights Act of 1964 bars discrimination based on “race, color, national origin, sex, and religion.”¹⁰⁶ The first four of these are included largely because they are inborn, involuntary and immutable. (Religion, while voluntary, is explicitly protected by the First Amendment to the U.S. Constitution.) Transgender behavior meets none of these criteria.

- **Such laws would lead to costly lawsuits against employers.** In the case of public employers, such a law could lead to large settlements being paid at taxpayers’ expense. For example, in 2005 Army veteran David Schroer sued the Library of Congress, alleging that after he applied for and was offered a job, he told them that he would report to work as a woman named Diane Schroer—and the job offer was rescinded. In 2009, a federal judge awarded Schroer \$491,190 in back pay and damages.¹⁰⁷

- **Such laws mandate the employment of “transgendered” individuals in inappropriate occupations.** For example, employers in the area of education and childcare would be denied the right to refuse to hire transgendered individuals, even if they consider such persons to be confusing, disturbing, or inappropriate role models for children and young people. Lily McBeth, a 71-year-old man who became a “woman,” was re-hired as a substitute teacher by a New Jersey *elementary* school. One mother said “she thought McBeth would confuse her sons because McBeth had already taught them when she was male,” but such concerns were discounted by the school board.¹⁰⁸

Since Family Research Council believes that *actual* changes in sex are impossible and that governments should not recognize such changes, we consequently believe that government should not *force* private entities to recognize such changes through “non-discrimination” laws based on protecting “gender identity.”

3) Should the government pay for “gender reassignment”?

Even if the government adopts a policy of accepting and recognizing so-called “sex changes” (by changing identification documents), and even if the government forces others to accept and recognize such changes (through “gender identity non-discrimination” laws), such policies would not and *should* not require the government to actually *provide* the costly medical treatments associated with “gender reassignment” at taxpayer expense. However, transgender activists already demand such financial sponsorship as well.

In July 2014, *Politico* reported on the issue under the headline, “Momentum grows for gender reassignment surgery coverage.”¹⁰⁹ Several events before and after demonstrated that momentum. For example, one context in which taxpayers could be forced to pay for “gender reassignment” procedures is through the health insurance provided for public employees. The U.S. Office of Personnel Management opened the door for such coverage (without mandating it) for federal employees in June 2014, by lifting a previous exclusion of “services, drugs, or supplies related to sex transformations.”¹¹⁰

Another avenue is government health insurance programs for the poor and the elderly (Medicaid and Medicare). Even a liberal state like New York has balked at using Medicaid funds for “gender-reassignment surgery.”¹¹¹ However, in June 2014, Massachusetts became the third state (following California and Vermont) to offer such coverage under Medicaid, and the second (after California) to offer such coverage to its employees.¹¹² Also in 2014, the federal Department of Health and Human Services dropped a longstanding rule barring payment for gender reassignment surgery under Medicare, in response to a request from a 74-year-old seeking “genital reconstruction.”¹¹³

Finally, one of the more shocking contexts in which such claims have been made is prisons. In one long-running battle in Massachusetts, a male convicted murderer who now identifies as female has been seeking to have the state’s Department of Corrections pay for his gender reassignment surgery and claims that its failure to do so constitutes “cruel and unusual punishment” in violation of the Eighth Amendment to the U.S. Constitution. A U.S. District Court judge ruled in this prisoner’s favor; however, the U.S. Court of Appeals for the First Circuit overturned that decision late in 2014.¹¹⁴

Regardless of whether one believes that government or private entities should *recognize* sex changes, there are strong reasons to argue that government should not *pay for* gender reassignment (hormone treatments and surgery).

First, such treatments are, arguably, a violation of medical ethics. It is hard to see how the core principle of “do no harm” is served by amputating perfectly healthy, functioning body parts simply in order to conform the body to an individual’s distorted psychological perception of himself or herself.

Second, such treatments are elective procedures rather than necessary health care. Surgery for the purpose of gender reassignment does not improve the biological health of any individual. Advocates of such surgery argue that it benefits the patient’s *mental* health by making the body more closely match the patient’s subjective, psychological self-image, but this can no more be considered a medical necessity than any other form of cosmetic or plastic surgery.

4) Should the government force others to pay for medical gender reassignment procedures?

The enactment of the Affordable Care Act (also known as “Obamacare”) has greatly expanded the role of the federal government in dictating to insurance companies what must be included in those policies in order to comply with the individual and employer mandates in the Act. One key example is the “HHS Mandate” or so-called “contraceptive mandate,” which requires coverage of a broad range of contraceptive methods, including abortifacient drugs and devices. There is no explicit “sex change” mandate in Obamacare. However, two aspects of the law have greatly increased the chances that individual insurance companies will offer such coverage. First, the Department of Health and Human Services (HHS) has interpreted the law’s provision

barring discrimination in health care based on “sex” to include discrimination based on “gender identity and sex stereotyping.” Although HHS states explicitly that this does *not* “mean that transition related surgery is required to be covered by health insurance,” it remains a “transfriendly” provision.¹¹⁵

Second, Obamacare’s prohibition on insurance exclusions for pre-existing conditions is believed to benefit persons seeking SRS, because in the past, “gender identity disorder” or “gender dysphoria” were sometimes classified as pre-existing conditions and excluded from coverage for that reason. *Kaiser Health News* reported in August 2014 on a male-to-female transgender who was able to use insurance coverage obtained in California under Obamacare to pay for SRS.¹¹⁶

Late in 2014, however, the state of New York went even further, and imposed a mandate upon insurance companies throughout the state to fund SRS. A letter from Gov. Andrew M. Cuomo declared, “An issuer of a policy that includes coverage for mental health conditions may not exclude coverage for the diagnosis and treatment of gender dysphoria.”¹¹⁷

5) Should transgendered individuals be permitted to serve in the military?

Historically, transgendered persons have not been permitted to serve in the U.S. military. A Department of Defense Instruction on “Medical Standards for Appointment, Enlistment, or Induction in the Military Services” includes “History of major abnormalities or defects of the genitalia such as change of sex” as a disqualifying physical condition. Disqualifying “Learning, Psychiatric, and Behavioral” conditions include, “Current or history of psychosexual conditions . . . including but not limited to transsexualism, exhibitionism, transvestitism, voyeurism, and other paraphilias.”¹¹⁸

The 1993 law which had codified the longstanding ban on openly homosexual individuals serving in the military did not say anything explicitly about “gender identity.” The 2010 bill overturning the 1993 law also said nothing about “gender identity.” However, even before the repeal legislation was forced through Congress, the same activists who pushed to allow open homosexuals in the military were also declaring that they support “the right of transgender people to serve openly,” stating, “We are building the arguments—based on modern medicine and mental health care—to address the wrong and outdated way that the military considers transgender people as unfit to serve.”¹¹⁹ A currently serving member who cross-dresses would be in violation of dress and grooming standards, and a person who seeks sex-change surgery could be discharged. However, overturning the law on homosexuality in the Armed Forces has clearly made it easier for transgender individuals to argue that they should not be discharged simply because of their self-perceived “gender identity.” The arguments that transgender activists are relying on are being built by a handful of wellfunded¹²⁰

LGBT think tanks. In August 2013, The Williams Institute, in partnership with the National Gay and Lesbian Task Force, released a “National Transgender Discrimination

Survey,” in which transgender service members and veterans reported on “issues in obtaining corrected identity documents, accessing military health care, and experiences of discrimination.” The report also made the claim that transgendered Americans are twice as likely to have served in the military.¹²¹ In March 2014, a private, non-governmental “Transgender Military Service Commission,” headed by former U.S. Surgeon General Joycelyn
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Elders, released a report through the pro-LGBT think tank the Palm Center at San Francisco State University. It claimed that “there is no compelling medical rationale for banning transgender military service, and that eliminating the ban would advance a number of military interests.”¹²²

Meanwhile, Defense Department officials in the Obama administration began to soften the ground for a change in the military’s policy—which would not require Congressional action, but could be accomplished through executive order alone. In an interview in May 2014, then-Defense Secretary Chuck Hagel said that the transgender policy “continually should be reviewed,” and declared that “every qualified American who wants to serve our country should have an opportunity if they fit the qualifications and can do it.”¹²³ However, Hagel also cautioned, “The issue of transgender is a bit more complicated [than the issue of homosexuality] because it has a medical component to it” and the next day a Pentagon spokesman said that “right now there are not any plans for a review to start.”¹²⁴

In December 2014, however, Air Force Secretary Deborah Lee James went even further than Hagel. She echoed him in saying that “anyone who is capable of accomplishing the job should be able to serve,” but added, “Times change,” and predicted that the policy “is likely to come under review in the next year or so.”¹²⁵

Most recently, Hagel’s successor as Defense Secretary, Ashton Carter, was asked during a trip to Afghanistan in February 2015 about “transgender service members serving in an austere environment like this here in Kandahar,” and responded that it’s something “I’m very openminded about,” adding (in an unintentionally circular argument), “I don’t think anything but their suitability for service should preclude them.”¹²⁶ White House press secretary Josh Earnest jumped on the bandwagon, declaring that “the president agrees with the sentiment that all Americans who are qualified to serve should be able to serve.”¹²⁷

LGBT activists, however, claim that an institutional change has already occurred. The Palm Center issued a report in November 2014 claiming that a previous Defense Department regulation which mandated administrative separation of service members with “sexual gender and identity disorders, including sexual dysfunctions and paraphilias,”¹²⁸ has now been replaced by a new regulation with no such requirement.¹²⁹ Instead, separation for disability would only be allowed if it is shown that the service member “is unable to reasonably perform duties;” “represents a decided medical risk to the health of the member or to the welfare or safety of other members;” or “imposes unreasonable requirements on the military.”¹³⁰ However, a Pentagon spokesman denied that the new regulation signaled, or required, any change in the transgender policy.¹³¹

One journal article (by law student Allison Ross) written to argue in favor of transgender military service ironically highlights several of the reasons why such a change could threaten morale and readiness. For example, it highlights the fact that transgender persons have unique medical problems and demands, such as hormone treatments and surgery, which would place a burden on the military's system of health care. However, Ross attempts to minimize these issues by comparing pill-based hormone treatments with the use of oral contraceptives, use of injectable hormones with the use of insulin by diabetics, and even by comparing genderreassignment surgery with pregnancy and childbirth.¹³² Ross also compares “the average cost of

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a male-to-female sex-reassignment surgery” (estimated at \$20,000) with the cost of surgery for Achilles tendonitis or lower-extremity fractures.¹³³ It would be no surprise if women and diabetics resented these comparisons between their conditions and the elective surgeries and therapies undertaken by transgender persons.

As for readiness, Ross admits that transgender service members might not be able to perform in their assigned roles, but instead would have to “occupy temporary, low-risk jobs that allow them to take time off for the required surgeries”—and she has the gall to assert that this “affects military readiness no differently than allowing non-transgender service members to receive medical care for injuries received in battle.”¹³⁴

Ross's article does not even mention the risks to good order, morale, and discipline from forced cohabitation and shared intimate spaces such as restrooms and showers with someone of the opposite biological sex. Elaine Donnelly of the Center for Military Readiness highlighted these in an interview with the Associated Press, in which she:

predicted that putting transgender people in barracks, showers and other sex-segregated could cause sexual assaults to increase and infringe on the privacy of non-transgender personnel. “This is putting an extra burden on men and women in the military that they certainly don't need and they don't deserve,” Donnelly said.¹³⁵

The story of America's most famous transgender service member tends to reinforce concerns that such individuals are not fit for military service. Bradley Manning is the soldier, assigned to an Army intelligence post in Iraq, who was arrested in 2010 and charged with releasing over 700,000 confidential documents to the website Wikileaks. In 2013, Manning was convicted on 21 counts, including seven counts of espionage.¹³⁶

Prior to his arrest, Manning had done little to conceal his own homosexuality, and his anger over the so-called “Don't Ask, Don't Tell” law against open homosexuality in the military appears to have been one of the motives for his massive security leak.¹³⁷ Manning had a very troubled childhood, with a passive, alcoholic mother and a father who was either absent or abusive much of the time, until the two divorced when Manning was twelve. As early as 2009, a supervisor noticed Manning's “instability,” and he received a mental health screening but no therapy.¹³⁸ It was Manning's own attorneys, at a preliminary hearing, who revealed that Manning was also suffering from gender identity disorder—something he had revealed to a

supervisor, sending a photo of himself in drag and confessing that “the issue was affecting his ability to do his job or think clearly,” as one news report put it.¹³⁹

The day after Manning was sentenced to 35 years in prison for his crimes, however, he “came out” as transgendered, announcing in a statement a new name and gender: “I am Chelsea Manning. I am a female. Given the way that I feel, and have felt since childhood, I want to begin hormone therapy as soon as possible.”¹⁴⁰ However, Army spokesman George Wright told the *Washington Times*, “The Army does not provide hormone therapy or sex-reassignment surgery for gender-identity disorder.”¹⁴¹ In September 2014, the American Civil Liberties Union (ACLU) filed a lawsuit against the federal government on Manning’s behalf, in order to obtain

“hormone therapy, permission to follow female grooming standards and access to a doctor

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trained to deal with [his] condition.”¹⁴² In February 2015, the Army reversed its position and approved taxpayer-funded hormone treatment for the imprisoned soldier.¹⁴³

LGBT activists dismiss any connection between Manning’s sexuality and gender confusion and his crimes; some claim that it was the policies which forced him to maintain secrecy which imposed damaging stress. This rationalization cannot obscure the link between “gender dysphoria” and other mental illnesses, however. Transgender persons—especially those on hormone therapy, as Manning is receiving—face multiple serious health risks, as even the Gay and Lesbian Medical Association acknowledges.¹⁴⁴

While it should be difficult for a post-surgery transsexual to pass the mandatory military physical, since his or her need for hormone therapy and the complications arising from surgery could be considered a pre-existing condition, there is a possibility that lesbian women or older secretly cross-dressing men already in the military who want to be the other sex could demand to have the military pay for their surgery and hormones and to be retained at their current rank. This would be extremely disruptive to unit cohesion.

FRC believes gender dysphoria should be considered a condition which bars one from entering or remaining in the military.

Conclusion

A person’s sex (male or female) is an immutable biological reality. In the vast majority of people (including those who later identify as “transgender”), it is unambiguously identifiable at birth. There is no rational or compassionate reason to affirm a distorted psychological self-concept that one’s “gender identity” is different from one’s biological sex.

No one—lawmakers, counselors, pastors, teachers, or medical professionals—should participate in or reinforce the transgender movement’s distortions about sexuality, nor should they be required by the government to support such distortions. Misguided attempts to change human design will cost those seeking transgender recognition for themselves and society at large dearly, not simply in the public dollars required to remove or mimic healthy reproductive body parts but in the emotional, cognitive, social, and cultural burdens it places on dissenters from the politically correct orthodoxy, who are now pressured or shamed into lying about human dignity and identity.

We believe that governments should not recognize any change in sexual identity from that identified at birth (with the exception of the rare cases in which a biological disorder of sexual development can be diagnosed), and the law should not force any private entities to grant such recognition.

We have only begun to enter this “brave new world,” one that resists the genetic imprint found in every cell in the human body. But such an effort cannot ultimately succeed. It has already claimed its victims—the boy who wants to be a girl and pursues physically and emotionally scarring treatments, but fails to convince himself or his world that he is now “she,” knows this only too well.

The campaign for sexual redefinition likely will claim many more victims. But we advocate for policies that protect the identity and dignity of the human person. We work for policies that

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protect teachers, pastors, counselors, and medical professionals from being required to mar natural and immutable sexual traits, under the false pretense of restoring mental health. And we encourage parents, pastors, and community leaders to celebrate the dignity of every human and offer compassionate mentorship and care for individuals struggling with issues of sexual identity or rejecting the gift of femaleness or maleness she or he has been given.

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