

Sex Reassignment and Catholic Schools

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Abstract. The author was consulted by two Catholic schools in separate cases of a student and a teacher preparing to undergo sex reassignment. Such cases give rise to special ethical and pastoral concerns. This article discusses the disorders that may lead to sex reassignment, distinguishing between congenital disorders of sex development (intersex conditions) and gender identity disorder (gender dysphoria). It also notes the ethical differences between the correction of congenital anomalies and interventions to relieve dysphoria: in the former, treatment is meant to restore as much normal function as possible; in the latter, mutilating intervention destroys what were otherwise healthy bodily functions. In Catholic schools, concern for the well-being of an affected student or teacher is required, as is a clear understanding of the condition being treated, the ethical implications of treatment, the privacy issues, the effects on other students and staff, and the effects on a teacher's ability to give faithful witness to Catholic teaching. *National Catholic Bioethics Quarterly* 12.1 (Spring 2012): 85–97.

There seems little doubt that the Catholic Church is likely to regard hormonal treatment and surgery to change gender characteristics as mutilation of the body resulting in unjustifiable loss of healthy function. However, I am not aware of any official teaching on the subject other than teaching on the obligation to retain healthy bodily functions unless life is endangered and those functions are lost as a side effect of a treatment to save life. The *Catechism of the Catholic Church* states, “Except when performed for strictly therapeutic medical reasons, directly intended *amputations, mutilations, and sterilizations* performed on innocent persons are against the moral law” (n. 2297).

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In the fifth edition of their *Health Care Ethics: A Catholic Theological Analysis*, well-respected theologians Rev. Benedict Ashley, OP, Jean deBlois, CSJ, and Rev. Kevin O'Rourke, OP, conclude that the good of the person cannot be achieved at the expense of the destruction of a basic human function except to save the person's life; they add that studies by no means give reassurance that sex reassignment solves the problems of personality from which most persons with gender identity disorder (GID, or gender dysphoria) suffer.¹ Those who support sex reassignment point to the suicide rates among transsexual persons, which may be as high as 50 percent,² and claim that sex reassignment may therefore be seen as life-saving treatment.

What should be the position of a Catholic school faced with the issue of child who is undergoing sex reassignment? What should be its position when faced with a teacher who advises that he is changing his gender and will soon begin cross-dressing? After a discussion of sex disorders and relevant Catholic teaching, I offer comment on two such cases recently presented to me.

The issue of whether to exclude a student or a teacher from Catholic school is complex. Here in Australia, the moral situation for the Church requires clarification if the legal exemptions to the equal opportunity law that apply to religious schools in many jurisdictions are to permit exclusion. If a teacher were to be excluded, it would presumably be on the grounds that he was unable to give witness to the teaching of the Church; his continuing role on the teaching staff, with influence on school children, would thus affect the school's capacity to propagate the Church's teachings. Offense of religious sensibilities is a legal ground for exemption from the equal opportunity provisions of state law in Australia.

Disorders of Sex Development

There has long been a tacit acceptance of medical interventions that seek to normalize the physical condition of children born with intersex disorders, or disorders of sex development. Disorders of sex development include a group of conditions in which there is a discrepancy between the external genitals and the internal genitals (the testes and ovaries). The disorders may have a genetic cause, or they may be a result of problems that occur during development, such as exposure to hormones before birth.

There are both male and female sex development disorders. The normal male karyotype is 46, XY, indicating the presence of a full set of twenty-three chromosome pairs, including the X and Y chromosomes; the normal female karyotype is 46, XX. In sex development disorders, there may be genetic abnormalities or it may be that the genes of the affected person are normal but there is a problem in their expression. An affected female may have ovaries but external male genitalia. An affected male may have external genitals that are incompletely formed, ambiguous, or clearly female; internally, the testes may be normal, malformed, or absent.

¹ Benedict Ashley, Jean deBlois, and Kevin D. O'Rourke, *Health Care Ethics: A Catholic Theological Analysis*, 5th ed. (Washington, DC: Georgetown University Press, 2006), 111.

² *Ibid.*, 110.

Some children are born with what is called a true gonadal intersex disorder, in which both ovarian and testicular tissue are present. Genetically, the children may be normal or they may have an extra sex chromosome (X or Y).

Many genetic disorders involve chromosome configurations other than the normal 46, XX or 46, XY. These include 45, XO, in which a sex chromosome is missing, and 47, XXY and 47, XXX, in which an extra sex chromosome is present. These disorders do not result in an intersex condition in which there is discrepancy between internal and external genitalia. Instead, there may be problems with sex hormone levels and overall sexual development.

The symptoms of disorders of sex development may include

ambiguous genitalia at birth, micropenis, clitoromegaly (an enlarged clitoris), partial labial fusion, apparently undescended testes (which may turn out to be ovaries) in boys, labial or inguinal (groin) masses (which may turn out to be testes) in girls, hypospadias (the opening of the penis is somewhere other than at the tip; in females, the urethra ... opens into the vagina), otherwise unusual-appearing genitalia at birth, electrolyte abnormalities, delayed or absent puberty, and unexpected changes at puberty.³

People with sex development disorders are often infertile.

In the past, the practice was to intervene surgically to make a child definitely one sex or the other, depending on which sex was judged to be dominant, though interventions often seemed to favor making the child female, since a female appearance was easier to achieve.

The more recent tendency is to delay intervening:

Greater respect for the complexities of female sexual functioning has led [medical experts] to conclude that suboptimal female genitalia may not be inherently better than suboptimal male genitalia, even if the reconstruction is 'easier.' In addition, other factors may be more important in gender satisfaction than functioning external genitals. Chromosomal, neural, hormonal, psychological, and behavioral factors can all influence gender identity. Many experts now urge delaying definitive surgery for as long as healthy, and ideally involving the child in the gender decision.⁴

Delay in intervening may mean that intervention occurs when a child is attending school. In some circumstances it may be difficult to explain the difference between such interventions and the hormonal treatment and surgery accompanying sex reassignment in cases of GID.

Ashley, DeBlois, and O'Rourke assert that intersex conditions differ from GID and that there is no objection to procedures to improve the normal appearance or function of sexually ambiguous children before puberty in accordance with the sex in which they are to be or have been raised.⁵ They say that the reasoning behind

³ *A.D.A.M. Medical Encyclopedia* (Atlanta, GA: A.D.A.M., 2005), s.v. "intersex," updated August 2, 2011, <http://www.nlm.nih.gov/medlineplus/ency/article/001669.htm>.

⁴ *Ibid.*

⁵ Ashley, DeBlois, and O'Rourke, *Health Care Ethics*, 112.

this traditional position is that a person must “live according to nature” insofar as this is humanly possible.

Another issue that may arise is that, as they mature, people who have been treated as children for intersex conditions may find that they identify with the gender opposite the one to which they were assigned as children. For example, a genetic male may have been assigned a female gender by a surgeon on the basis of phenotypic appearance, despite having the opposite genotype. There would seem to be no ethical difficulty with later attempts to establish appearance and function consistent with the genotypic gender. A factor to consider in this is that usually, because those with intersex conditions are often infertile, the changes do not involve removing healthy, functioning fertile organs. If what was proposed were to do so, then there might be an intrinsic issue.

Gender Identity Disorder

The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) describes GID as characterized by “a persistent discomfort about one’s assigned sex or sense of inappropriateness in the gender role of that sex.”⁶ It also distinguishes between GID and transvestic fetishism:⁷ transvestic fetishism involves sexual arousal through cross-dressing, whereas GID involves strong and persistent cross-gender identification.

GID occurs in children with the onset of cross-gender interests and activities, usually between the ages of two and four years. According to the DSM-IV-TR, “Some parents report that their child has always had cross-gender interests”; however, “only a very small number of children with GID will continue to have symptoms that meet criteria for [GID] in adolescence or adulthood.”⁸

Treatment of GID in children and adolescents tends to be supportive, with a focus on reducing distress, learning coping skills, and managing concurrent problems.⁹ It commonly involves psychotherapy, and sex reassignment surgery is not attempted. However, in recent times there have been attempts to hormonally suppress the development of gender characteristics during puberty in adolescents with GID. In some controversial family court cases in Australia, discussed below, the court has approved hormonal suppression in children with GID.

The justification given for hormonal intervention for GID in adolescents has been the acknowledged high self-harm and suicide rates.

The DSM-IV-TR reports that

by late adolescence or adulthood, about three-quarters of boys who had a childhood history of [GID] report a homosexual or bisexual orientation,

⁶American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, text revision (Washington, DC: APA, 2000), 576 (hereafter cited as DSM-IV-TR).

⁷DSM-IV-TR, 580.

⁸Ibid., 579.

⁹Robert E. Hales, *The American Psychiatric Publishing Textbook of Psychiatry* (Washington, DC: APA, 2008), 736–737.

but without concurrent [GID]. Most of the remainder report a heterosexual orientation, also without concurrent [GID]. The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.¹⁰

The DSM-IV-TR also reports that “there are no recent epidemiological studies to provide data on prevalence of [GID]. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex reassignment surgery.”¹¹

The treatment of chronic GID in adults involves psychotherapy, which may result in a recommendation for sex reassignment. In the latter case, a period of living as a member of the other sex usually precedes hormonal treatment, cosmetic surgery, and sex reassignment surgery.¹²

With or without sex reassignment surgery there are very high levels of self-harm, suicide, and unemployment among people with chronic GID that does not respond to psychotherapy. A proportion of those with GID spontaneously revert to normal gender identity.¹³

The National Health Service in the United Kingdom has recently stated that the condition was traditionally thought of as “a purely psychiatric condition, which meant that its causes were considered to originate only within the mind. However, recent studies have challenged this, and suggest that gender dysphoria may have biological causes associated with the development of gender identity before birth.” The NHS goes on to say that gender dysphoria, or GID, may be due to a disorder of sex development during gestation, related to abnormal expression of the sex chromosomes or to malfunctioning hormones in the womb. It concludes that “more research is needed before the causes of gender dysphoria can be fully understood, but it is widely agreed that it cannot be thought of as a purely psychiatric condition.”¹⁴

Is Gender Identity Disorder a Delusion?

In rare cases, schizophrenic patients may have delusions of belonging to the other sex. According to the APA, “Insistence by a person with [GID] that he or she is of the other sex is not considered a delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, schizophrenia and severe [GID] may coexist.”¹⁵

¹⁰ DSM-IV-TR, 580.

¹¹ *Ibid.*, 579.

¹² Hales, *Textbook of Psychiatry*, 735.

¹³ DSM-IV-TR, 580.

¹⁴ National Health Service [UK], “Gender dysphoria—causes,” *NHS Choices*, April 28, 2010, <http://www.nhs.uk/Conditions/Gender-dysphoria/Pages/Causes.aspx>.

¹⁵ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: APA, 1994), 537.

A delusion is a fixed belief in something untrue. If GID were a delusion, then that would be ethically significant. Hormonal treatment and sex reassignment surgery would be the reinforcement of a delusion rather than the treatment of the underlying condition.

The existence of GID raises a number of questions, including the very basic question, What is gender? Is gender simply physiological, or can it be seen as psychological and separable from the physiology? Is GID essentially dualistic, in that it involves separating the psychology of gender from the physiology of the person?

In the United Kingdom, Justice Ormrod in *Corbett v. Corbett* (1970) held that three tests—"the chromosomal, gonadal and genital"—determine the sex of a person.¹⁶ The chromosomal test refers to the presence of XY (male) or XX (female) chromosomes, the gonadal test to the presence of testes or ovaries, and the genital test to the presence of a penis or clitoris and internal sex organs. In other words the judge took an entirely physiological view of gender. This view survived in Australia until 1988, when Justice Matthews, of the New South Wales Court of Criminal Appeal, held in *R v. Harris and McGuinness* that "Lee Harris, a post-operative male to female transgender person convicted of procuring 'another' male person to commit an act of indecency, to be female for the purposes of criminal law."¹⁷ The judge's decision was based on the fact that the person's reconstructed genitalia was functionally female rather than male.¹⁸

Similar reasoning was used in Australia in *Secretary, Department of Social Security v. HH*.¹⁹ The Administrative Appeals Tribunal upheld a decision of the Social Security Appeals Tribunal "that a male-to-female post-operative transgender person was a woman for the purposes of section 25(1) of the Social Security Act 1947 (Cth) and was therefore entitled to an age pension at sixty, rather than sixty-five."²⁰ In that case the judges referred to "psychological and anatomical harmony," where *Harris and McGuinness* referred to the nature of the reconstructed genitalia.

On February 21, 2003, the Full Court of the Family Court of Australia upheld Justice Chisholm's decision in *Re Kevin*, in which he concluded that "for the purpose of ascertaining the validity of a marriage under Australian law, the question whether a person is a man or a woman is to be determined as at the date of the marriage," not as

¹⁶ *Corbett v. Corbett* [1970] 2 WLR 1306, available at http://www.vanuatu.usp.ac.fj/courses/LA306_Family_Law/Cases/Corbett_v_Corbett.html.

¹⁷ Andrew Sharpe, "One Step Beyond: The New Zealand Judiciary and Transgender Law Reform," *Alternative Law Journal* 26.3 (2001): 130–135, <http://www.austlii.edu.au/au/journals/AltLawJl/2001/48.html>, discussing *R. v. Harris and McGuinness* [1988] 17 NSWLR 158.

¹⁸ *Ibid.*

¹⁹ *Secretary, Department of Social Security v. HH* [1991] 13 AAR 314.

²⁰ Andrew Sharpe, "From Functionality to Aesthetics: The Architecture of Transgender Jurisprudence," *Murdoch University Electronic Journal of Law* 8.1 (March 2001), <http://www.austlii.edu.au/au/journals/MurUEJL/2001/4.html>.

at birth,²¹ and that in Australian law specifically relating to marriage, the terms “man” and “woman” include transsexuals in accordance with their sex reassignment.²²

From the perspective of the American Psychiatric Association, GID is not a delusion, and from the perspective of the Australian courts, a person’s gender can be changed by sex reassignment surgery. This would seem to indicate that the courts do not accept that GID is delusional. In fact, in *Re Kevin*, the court took into account factors such as

the person’s life experiences, including the sex in which he or she is brought up and the person’s attitude to it, the person’s self-perception as a man or woman; the extent to which the person has functioned in society as a man or a woman; any hormonal, surgical or other medical sex reassignment treatments the person has undergone, and the consequences of such treatment; and the person’s biological, psychological and physical characteristics at the time of the marriage, including (if they can be identified) any biological features of the person’s brain that are associated with a particular sex.²³

Two Australian cases involving children being treated for GID are *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* and *Re Brodie (Special Medical Procedure)*.²⁴ In the case of twelve-year-old Brodie, a girl by birth who wanted to become male, the Family Court authorized Brodie’s mother to consent to the administration of a gonadotrophin-releasing hormone analogue on a continuous basis subject to the medical opinion of the child’s treating specialists from time to time. The effect of the treatment would be to suspend the development of puberty indefinitely, but the court was advised that the effect would be reversible. The court also ordered that Brodie undergo regular psychotherapeutic counseling with a psychiatrist experienced in GID cases with a view (*inter alia*) to allowing the child to explore issues arising from the treatment and to improving the child’s general well-being. It is worth noting that Justice Carter was not satisfied that the treatment plan was a procedure “for the purpose of treating a bodily malfunction or disease,” but nevertheless concluded that “the present and future psychological benefit to the child in being permitted to begin the treatment sought outweighs the psychological risks to her in not receiving the treatment and is therefore in her best interests.” He made this decision in the knowledge that the treatment was the first stage of a package of interventions that would eventually include irreversible ones.²⁵

²¹ *The Attorney-General for the Commonwealth and “Kevin and Jennifer” and Human Rights and Equal Opportunity Commission* [2003] FamCA 94, no. 5, http://www.austlii.edu.au/au/cases/cth/family_ct/2003/94.html.

²² *Re Kevin (Validity of Marriage of Transsexual)* [2001] FamCA 1074, no. 158, http://www.austlii.edu.au/au/cases/cth/family_ct/2001/1074.html.

²³ *Ibid.*, no. 329.

²⁴ *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* [2004] FamCA 297, http://www.austlii.edu.au/au/cases/cth/family_ct/2004/297.html. *Re Brodie (Special Medical Procedures)* (2008) FamCA 334, <http://www.austlii.edu.au/au/cases/cth/FamCA/2008/334.html>.

²⁵ *Re Brodie*, nos. 37, 41, and 213.

In the case of Alex, a thirteen-year-old child born a girl, Chief Justice Nicholson ruled that she was able to commence treatment for GID. The judge found that the child had always identified as a male, wore male clothes, used the male toilets, and otherwise presented as a male. Alex was also able to enroll at school using a male name. The judge held that Alex could commence administration of the oral contraceptive pill to stop menstruation immediately and, in consultation with Alex's treating medical practitioners, commence irreversible hormonal treatment at a later date but prior to Alex's eighteenth birthday. The later treatment would stimulate facial hair growth, masculinization of the child's voice and physique, and lengthening of the clitoris.²⁶

In both cases, the court relied on the uncontested evidence of doctors who are engaged in sex reassignment. In neither case did the court seek opinions from practitioners of what might be called mainstream psychiatry, which until recently held with the American Psychiatric Association that hormonal and surgical treatments should not be administered to children.²⁷

Is Sex Reassignment Corrective or Mutilating?

Mainstream psychiatric opinion holds that people who suffer from GID are not delusional in the sense that they have a false belief. They acknowledge the biological gender determined by their genes but feel at a deep psychological level that they belong to the other gender. It is possible that there are biological causes for this feeling and that the condition is due to developmental abnormalities before birth. The evidence certainly suggests a very early onset.

The evidence also suggests that many persons with GID will accept their biological gender, with some developing same-sex attraction and some being heterosexual. It is a minority in whom the condition continues into adulthood and remains fixed.

If a parallel is drawn between developmental sex disorders and chronic GID, then the psychological condition might be considered in the same light as the failure to develop normal genitalia, ovaries, or gonads. Disorders of sex development are thought to happen fairly early in the development of the embryo. Normally, the Y chromosome does not have an effect until about the seventh week after conception, when the testes develop and produce testosterone, which then brings about male rather than female development.²⁸ Disorders of sex development are thought to have their origin around that time and may be the result of environmental influences. Accepted treatment includes corrective medical and surgical interventions to establish a condition as normal as possible for the affected person.

There may be a parallel between sex development disorders and GID if biological factors are shown to be involved in the psychological failure to develop a normal sense of one's gender. This raises the issue of what might be considered corrective interventions for GID. The medical reality is that in a biological male, the reproduc-

²⁶ *Re Alex*, nos. 20, 21, 88, 92, and 136.

²⁷ Hales, *Textbook of Psychiatry*, 736.

²⁸ Ashley, DeBlois, and O'Rourke, *Health Care Ethics*, 112.

tive tract cannot yet be reconstructed so that it functions as a female reproductive tract. At best, surgeons can create a vagina that functions for the purposes of sexual intimacy but lacks reproductive capacity. In a biological female, a pseudo-penis can be constructed for the purpose of penetrative sexual intimacy but not reproduction. In both cases, hormonal and cosmetic changes help the affected person assume the role and appearance of a member of the opposite sex.

For affected men and women, the interventions destroy what were otherwise healthy, fertile reproductive systems. In this respect, the interventions are different from interventions used to treat persons with the more conventionally recognized disorders of sex development, many of whom are naturally infertile. The aim in the latter interventions is to restore as much normal function of one gender as possible, given the phenotypic and sometimes genotypic ambiguity of the person's gender.

The issue for the Church is how to give a teleological response to the circumstances of a person with GID who begins life as one gender and, for reasons that are not fully understood, fails to develop psychologically in accordance with his or her biological gender. There seems to be increasing support for the view that something happens to prevent normal development of psychological gender identity, and the cause may be biological, but it may also be related to socialization and to the nature of relationships with parents and others. Often a person with GID will have a difficult relationship with the parent of their own biological gender, but there is a chicken-egg argument about which comes first, the GID or the difficult relationship.

Several theories of gender development in children have been proposed, in addition to the possibility of congenital biological determinants:

The *biological theory* is based on evidence that high levels of the male hormone testosterone are associated with high levels of aggression in boys and tomboyishness in girls. *Social learning theory* proposes that gender typing is the result of a combination of observational learning and differential reinforcement. A third, *cognitive-developmental theory*, states that gender understanding follows a prescribed time line. The pattern put forth is that children recognize that they are either boys or girls by the age of two or three, followed shortly by recognition that gender is stable over time. By the age of six or seven, children understand that gender is also stable across situations.

No matter what theory one adopts, for most children, whose sex and gendermap are congruent, this insight typically goes unnoticed. However, if there is a sex/gendermap incongruity, some children will be left perplexed about [their] gender status and [begin] a lifelong, often compulsive search for resolution of the discrepancy.²⁹

Catholic Principles

Although it may have biological causal elements, GID still seems to be primarily psychological, and the treatments that seek to provide a biological remedy through sex reassignment seem to be addressing the wrong problem and doing so by means that in fact destroy normal, healthy reproductive functions. Because the Church

²⁹ Anne Vitale, "Gender Identity Disorder: A Brief Description of the Problem," June 10, 1996, rev. April 2, 1997, <http://webhome.idirect.com/~beech1/GENDERID.HTM>.

regards the person as a unity of soul and body,³⁰ it regards gender too as a unity. Gender is not merely a psychological or social concept, but one grounded in the physical reality of the body.

The Church therefore rejects the idea that gender can simply be chosen without regard to biology. Pope Benedict XVI expressed it in the following way: “What is often expressed and understood by the term ‘gender’ ultimately ends up being man’s attempt at self-emancipation from creation and the Creator. Man wants to be his own master, and alone—always and exclusively—to determine everything that concerns him. Yet in this way he lives in opposition to the truth, in opposition to the Creator Spirit.”³¹

If evidence showed that GID had a biological cause and was a developmental condition in much the same way that the disorders of sex development are, the Church would still be unlikely to endorse sex reassignment surgery. The first reason is that a treatment should seek to restore normality. The abnormality seems to be the psychological disorder, not the body. Radical treatment of the body to try to make the body congruent with the disorder seems inappropriate. The following facts support this view: (1) the body seeks to revert to the phenotype associated with the genotype if hormonal treatment is stopped; (2) the treatment provides a change that is more cosmetic than real; and (3) evidence of the success of the treatment for the psychological disorder is equivocal.

The second reason the Church is unlikely to support sex reassignment surgery is that the treatment destroys healthy functions. It is inconceivable that the Church could endorse the destruction of healthy biological functions, particularly when the Church attaches meaning to the gift of sexual intimacy in part because of the procreative meaning of that intimacy. It might be that the Church would permit temporary measures to suspend puberty when the onset of puberty hindered effective psychological treatment, but one cannot envisage the Church endorsing the permanent loss of healthy functions.

Hormonal treatment for GID may alter some physiological characteristics, surgery may provide a sexually but not reproductively functioning vagina or penis, and cosmetic surgery may alter the affected person’s appearance, allowing him or her to more easily adopt the role of someone of the other sex, but the affected person’s karyotype (genetic identity) remains unchanged. If the hormone treatments are stopped, the karyotype will reassert its dominance in the biology of the individual.

The reality is that a physical change from one gender to the other is not medically possible. What happens, in fact, is the destruction of normal healthy organs; the person’s gender is left essentially as the gender at birth, requiring continual hormonal interventions to suppress the body’s natural tendency to revert to gender type.

³⁰ Vatican Council II, *Gaudium et spes* (December 7, 1965), n. 14.

³¹ Benedict XVI, Address to the Roman Curia (December 22, 2008), n. 1.

The Catechism

Sex reassignment seems to conflict with the notion of gender expressed in the Catechism:

“God is love and in himself he lives a mystery of personal loving communion. Creating the human race in his own image . . . God inscribed in the humanity of man and woman the *vocation*, and thus the capacity and responsibility, of love and communion.”

“God created man in his own image . . . male and female he created them”; He blessed them and said, “Be fruitful and multiply”; “When God created man, he made him in the likeness of God. Male and female he created them, and he blessed them and named them Man when they were created.”

Sexuality affects all aspects of the human person in the unity of his body and soul. It especially concerns affectivity, the capacity to love and to procreate, and in a more general way the aptitude for forming bonds of communion with others.

Everyone, man and woman, should acknowledge and accept his sexual *identity*. Physical, moral, and spiritual *difference* and *complementarity* are oriented toward the goods of marriage and the flourishing of family life. The harmony of the couple and of society depends in part on the way in which the complementarity, needs, and mutual support between the sexes are lived out.

“In creating men ‘male and female,’ God gives man and woman an equal personal dignity.” “Man is a person, man and woman equally so, since both were created in the image and likeness of the personal God.” (nn. 2331–2334, original emphases)

Sex reassignment also conflicts with the meaning of gender as encompassing not just biology but our innermost being:

“Sexuality, by means of which man and woman give themselves to one another through the acts which are proper and exclusive to spouses, is not something simply biological, but concerns the innermost being of the human person as such. It is realized in a truly human way only if it is an integral part of the love by which a man and woman commit themselves totally to one another until death.”

Tobias got out of bed and said to Sarah, “Sister, get up, and let us pray and implore our Lord that he grant us mercy and safety.” So she got up, and they began to pray and implore that they might be kept safe. Tobias began by saying, “Blessed are you, O God of our fathers. . . . You made Adam, and for him you made his wife Eve as a helper and support. From the two of them the race of mankind has sprung. You said, ‘It is not good that the man should be alone; let us make a helper for him like himself.’ I now am taking this kinswoman of mine, not because of lust, but with sincerity. Grant that she and I may find mercy and that we may grow old together.” And they both said, “Amen, Amen.” Then they went to sleep for the night. (n. 2361)

Finally, sex reassignment surgery conflicts with the divine creation of gender:

Man and woman were made “for each other”—not that God left them half-made and incomplete: he created them to be a communion of persons, in which

each can be “helpmate” to the other, for they are equal as persons (“bone of my bones...”) and complementary as masculine and feminine. In marriage God unites them in such a way that, by forming “one flesh,” they can transmit human life: “Be fruitful and multiply, and fill the earth.” By transmitting human life to their descendants, man and woman as spouses and parents cooperate in a unique way in the Creator’s work. (n. 372)

The Church understands that each human being exists for the purpose of communion with God; the capacity to become a mother or a father is part of that vocation. The importance of procreation is expressed as follows:

“By its very nature the institution of marriage and married love is ordered to the procreation and education of the offspring and it is in them that it finds its crowning glory.”

Children are the supreme gift of marriage and contribute greatly to the good of the parents themselves. God himself said: “It is not good that man should be alone,” and “from the beginning [he] made them male and female”; wishing to associate them in a special way in his own creative work, God blessed man and woman with the words: “Be fruitful and multiply.” Hence, true married love and the whole structure of family life which results from it, without diminishment of the other ends of marriage, are directed to disposing the spouses to cooperate valiantly with the love of the Creator and Savior, who through them will increase and enrich his family from day to day. (n. 1652)

The Church thus regards gender as having a specific meaning that is determinative of vocation and is unchangeable. This is acknowledged particularly in the restriction of the priesthood to men:

“Only a baptized man (*vir*) validly receives sacred ordination.” The Lord Jesus chose men (*viri*) to form the college of the twelve apostles, and the apostles did the same when they chose collaborators to succeed them in their ministry. The college of bishops, with whom the priests are united in the priesthood, makes the college of the twelve an ever-present and ever-active reality until Christ’s return. The Church recognizes herself to be bound by this choice made by the Lord himself. For this reason the ordination of women is not possible. (n. 1577)

A Teacher in a Catholic School

Two cases involving sex reassignment have been presented to me. The first involved a teacher who had been teaching at a school for some time. He announced to the principal his intention to cross-dress and live as a woman as the first stage of sex reassignment, prior to hormonal treatment, cosmetic surgery, and finally sex reassignment surgery, if the treating team agreed.

The law in Australia permits a religious school to discriminate if it is necessary to do so to propagate religion in conformity with the doctrines of that faith or if it is necessary to avoid injury to the religious susceptibilities of the adherents of that religion. The issue in this case was whether excluding a cross-dressing teacher was necessary to preserve these goals.

We cannot treat cross-dressing on its own here, because it represents the first stage in a sequence of events that were likely to culminate in sex reassignment

surgery. In this case of GID, the cross-dressing was an expression of the teacher's strong feeling that he was in fact a woman, despite his biology.

For a teacher in a Catholic school to cross-dress in the circumstances of GID and as part of a process of gender change would contradict the teaching of the Church in relation to vocation, gender, sexuality, marriage, and the priesthood. The teacher's ability to give witness to the teaching of the Church would be severely compromised. Basically, he would not be able to do his job in relation to propagating the faith.

Pastorally, the circumstances would require very careful handling, because the source of the problem is a recognized psychiatric condition associated with a high risk of suicide. It is important that any dealings with the man would affirm his worth and dignity.

A Child in the Classroom

In the second case presented to me, a school principal sought an opinion on the need to respond to an announcement made by the parent of a child at a coeducational secondary school that the child, who is female, would soon undergo hormonal treatment as part of a process of sex reassignment, presumably due to GID. The possibility that it might have been an intersex condition was not raised. It is unlikely that an intersex condition would be left untreated until the child was in secondary school, though it is not impossible.

The first concern was for the well-being of the child in circumstances of a mental disorder that carries a significant risk of self-harm. There was a need to ask for advice from the child's psychiatrist concerning how best to respond to her individual circumstances. The child's privacy, which would be difficult to protect during such a process, was also an important issue.

The principal also had an obligation to the other children in the school about this matter. One of the issues was the influence that the child undergoing treatment would have on the others as she went through the process. Of special concern was the effect on other children who were at an age when gender and gender orientation are often matters of some uncertainty. There was also concern about how the circumstances would affect the faculty's ability to give witness to Catholic teaching in the face of a public rebuttal of that teaching.

The principal would need to make a prudential decision about whether the child could remain at the school, based on professional medical, psychological, and pastoral advice about what might be expected to occur and how best to manage the circumstance. It would not be impossible to manage the circumstances if the child remained at the school, but it would be, in my view, very difficult.