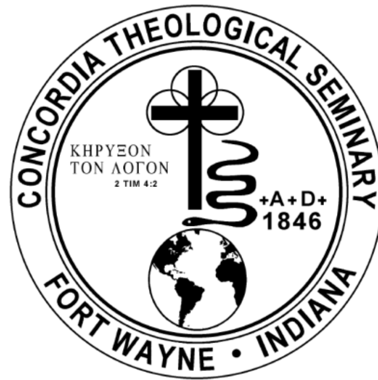
Concordia Theological Quarterly



Volume 79:1–2 **January/April 2015**

Table of Contents

Islam's Future in America
Adam S. Francisco 3

How Do You Know Whether You Are a Man or a Woman?
Scott E. Stiegemeyer 19

God Our Mother?: Biblical and Philosophical Considerations in Feminist God Language
Mark P. Surburg 49

Another Look at *Imago Dei*: Fulfilled in the Incarnate One
Burnell F. Eckardt Jr. 67

The Divine Presence within the Cloud
Walter A. Maier III 79

Not Just Proof-Texting: Friedrich Balduin's Orthodox Lutheran Use of Exegesis for Doctrine
Benjamin T. G. Mayes 103

Confirmation, Catechesis, and Communion:
A Historical Survey
Geoffrey R. Boyle 121

Religious Freedom in America
R. Neely Owen 143

Theological Observer 161

The Sanctity of Marriage
Rev. Dr. Ronald R. Feuerhahn Remembered

Book Reviews 165

Books Received 190

CTQ 79 (2015): 19–48

How Do You Know Whether You Are a Man or a Woman?

Scott E. Stiegemeyer

The transformation of Bruce Jenner into Caitlyn Jenner in 2015 has brought the issue of gender identity into the lives of almost every American. How will Christians respond? Well, we have already begun to think through these issues. In 2014, the Commission on Theology and Church Relations (CTCR) of The Lutheran Church—Missouri Synod published a document entitled: *Gender Identity Disorder or Gender Dysphoria in Christian Perspective.* The CTCR is to be commended for addressing this important issue that has captured the attention of the American public. Given that the CTCR document is simply too brief to address the many issues related to this complex subject, this article will provide supplemental information and observations to shed further light on the subject.[1]

The conclusions of the CTCR document, based on the Holy Scriptures, are sound, but this subject is inherently multi-disciplinary. The Scriptures do not address every imaginable topic; Christians must also, at times, utilize empirical observations and their God-given reason. Our understanding of the natural world is changing and advancing rapidly. Medical knowledge about sexual development, neuroscience, psychology, and ethical theory have relevance here. The very best that these disciplines and others have to offer should be given consideration. Sexuality is not just a religious or moral issue. The CTCR document is aware of the diverse literature but does not engage it in a thorough manner. More can and should be said.

The church understands the meaning of sex and gender foremost as a theological issue, though much further articulation is needed, especially in Lutheran circles. The creation of man as male and female is theologically significant. We make a grave error if we think that moral direction for those suffering with gender dysphoria is confined to the fine print of the Law or the mere rubrics of Christian living. The development of a fully elaborated theology of the body, including but not exclusive to human

[1] The ever-changing theories about the origins and complexities of sexual orientation and attraction are important, but related topics will not be treated here.

Scott Stiegemeyer is Pastor of Redeemer Lutheran Church in Elmhurst, Illinois. He recently accepted the call to serve as Assistant Professor of Theology and Bioethics at Concordia University Irvine, Irvine, California.

sexuality, is the most important theological issue of our time. The human body had become the battleground of conflicting ideas and values. Indeed, our culture is propelled by an inadequate anthropology. This inadequacy distorts the world's understanding of marriage, sex, family, procreation, the treatment of the poor and more. John Paul II once wrote that he believed the root of many of our problems today is the "pulverization" of the dignity of the human person.[2]

The creation of individuals as male or female was an uncontested catholic doctrine, held by all Christians until the late twentieth century. The very title of the CTCR document, *Gender Identity Disorder or Gender Dysphoria in Christian Perspective*, and its corresponding footnote[3] acknowledge this. Gender dysphoria (previously called Gender Identity Disorder) is a rare and puzzling state of extreme and, at times, debilitating discomfort with one's natal sex. In addition to the psychological condition called gender dysphoria, a related matter is intersexuality, which is the group of medical concerns that results in a person having a body that is sexually atypical. Helpfully, the CTCR document includes an excursus on intersex conditions.[4]

The CTCR document focuses on the moral dimension of sex and gender confusion, which is perfectly correct. Less clear is the facet of gender dysphoria as a psychological condition, a mental health issue, or a neurological one. We can maintain that drunkenness is the result of sinful behavior and still acknowledge that medical or psychotherapeutic techniques can be tremendously helpful in overcoming the temptation to drink. The document acknowledges this fact. A pastor is a curate of the soul, a *Seelsorger*, but it is erroneous to think we can treat the spiritual needs with-

---

[2] In a 1968 letter to the French theologian Henri de Lubac, Archbishop Karol Wojtyla wrote: "The evil of our times consists in the first place in a kind of degradation, indeed in a pulverization, of the fundamental uniqueness of each human person. This evil is even much more of the metaphysical order than of the moral order. To this disintegration, planned at times by atheistic ideologies, we must oppose, rather than sterile polemics, a kind of 'recapitulation' of the inviolable mystery of the person . . . ." Henri de Lubac, *At the Service of the Church: Henri de Lubac Reflects on the Circumstances That Occasioned His Writings*, trans. Anne Elizabeth Englund (San Francisco: Ignatius Press, 1992), 172.

[3] "The general perspective of this report . . . is one that is not simply that of the Lutheran theological tradition, but rather stands within the broad (catholic) consensus of traditional Christian teaching." *Gender Identity Disorder or Gender Dysphoria in Christian Perspective*, A Report of the Commission on Theology and Church Relations of The Lutheran Church—Missouri Synod (2014), 1n1.

[4] *Gender Identity Disorder or Gender Dysphoria in Christian Perspective*, 7–8.

out taking the mind and body into account. Pastors are not called to be therapists and physicians, but since human beings are holistic body-mind-Spirit entities, the *Seelsorger*, is, in truth, a little bit of all three. Jesus himself linked physical healing with the forgiveness of sins on several occasions, as does the book of James. The Lutheran church, as a whole, has not dealt with this relationship sufficiently.

The CTCR document makes a point to distinguish gender dysphoria from physiological abnormalities, but it will not be easy or advisable to divide the mind from the body too forcefully. Moods and psychological states are always body related. The mind is not just an isolated passenger carried along by an advanced organic machine. The reason this is a pastoral issue is because Lutheran clergy are not merely concerned with behavior modification. Nor are we able to apply the gospel to disembodied human spirits.[5] Rather, we address the grand questions such as "What am I?" This question must be answered well before we can make sense of subsequent ethical instruction. One must discern what a thing is before knowing what it is for or how it may function properly. This is also true for the human body in the ways that it is manifest, male and female.[6]

I. Sex and Gender

When you meet someone new, you unconsciously decide if the person is male or female. It is automatic. Depending on your culture, determining the sex of a person may have a significant effect on how you are expected to relate to that person. In some corners of the world, it is socially unacceptable, possibly even criminal, for a man to speak in public with a woman who is not a close relative. Apart from social norms, most people feel uncomfortable if they are unable to discern whether the person they have met is male or female. It is in our nature to categorize. Ambiguous things can seem threatening. Anthropologist Mary Douglas says that "the activity of classifying is a human universal."[7]

What are the clues you look at to draw a conclusion, realizing that some of the details might be culturally determined? First, we consider the

---

[5] Confessional Lutheranism is in need of related study on the healing ministry of Jesus and the apostles and its relevance to the church as apostolic today.

[6] Given most pastors' relative unfamiliarity with gender dysphoria and related issues, the author begs the reader's patience as he wades through these sometimes uncomfortable waters, promising a fruitful discussion at the end concerning how the church can respond.

[7] Mary Douglas, *Purity and Danger* (London: Routledge Classics, 2002), xvii.

person's outward presentation, such as clothing, hairstyle, cosmetics, and jewelry to ascertain whether these conform to expected gender norms. Presentation also includes vocal patterns, gestures, stride, how the person sits, etc. At the same time, we are noticing the secondary sex traits of the body: breasts, hips, shoulders, musculature, the Adam's apple, and voice pitch. If these are inconclusive, we have little additional recourse in the typical social encounter.

Within a medical context, an examination of the external genitalia could be done. There are intersex individuals, however, for whom even this level of intimate detail is unclear. Perhaps the internal organs can be examined in an autopsy or using imaging technology, but this will not be an option in all scenarios. Modern science has given us the ability to go so far as to examine people's chromosomes. Even here, however, not every individual person fits neatly into the categories of male or female. What if you do all of these examinations and the evidence is still inconclusive? What if there remains an incongruity between, say, one's chromosomes and the same person's external sex organs? Which takes precedence? The church must not conclude that DNA is always the grand arbiter of human identity. Is one's so-called true sex located in the structures or modes of the brain, as some claim? And which sex, if any, will intersex people be at the resurrection of the body on the Last Day?

Knowing what to count as the finally determinative sexual anatomy (genes, genitalia, internal reproductive organ, the brain, etc.) can be problematic, but most will agree that certain organs are ordinarily found only in either males or females. For instance, though there are individuals born with XXY or XYY sex chromosomes, most females possess the XX chromosomes, and most males possess the XY chromosomes.[8]

How, then, can you tell if a person is male or female? Can we really say that every person fits into one of these two categories? The answers to these questions are obvious for most people. The majority of people never think much about their sex or gender identity. The Scriptures clearly teach that God created man as male and female. But for a number of complex and poorly understood reasons, there are people in the world as we presently experience it for whom a definite either/or answer is elusive. This question is important for those who hold to a traditional Christian perspective that assigns meaning to the fundamental division of humanity into male and female.

---

[8] This is not necessarily meant to give chromosomes ultimate priority, but only as an example.

As we begin, it is necessary to define a few critical terms. Until recent times, the terms *gender* and *sex* were used interchangeably. Current standard usage, however, employs a distinction. Sexologist Dr. John Money claims to be the source of this parlance:

> Because sex differences are not only genitally sexual, although they may be secondarily derived from the procreative organs, I found a need some thirty years ago for a word under which to classify them. That word, which has now become accepted into language, is gender. Everyone has a gender identity/role, one part of which is one's genital or genitosexual gender identity/role . . . . the masculinity and/or femininity of your gender role is like the outside of a revolving globe that everyone can observe and read the meaning of. Inside the globe are the private workings of your gender identity.[9]

In sum, according to current usage, s*ex* refers to a person's anatomical traits. *Gender* is how one views oneself and presents oneself to the world. Gender has become the subjective internal sense that one is male or female, or both (e.g., transgender). A third term, *sexuality,* refers to erotic attraction.

II. Intersexuality

As previously mentioned, there are a variety of medical conditions that lead to atypical development of physical sex characteristics that are collectively referred to as *intersex* conditions. These conditions can involve abnormalities of the external genitals, the internal reproductive organs, sex chromosomes, and/or sex-related hormones. These unusual anatomies can result in confusion within individuals about whether they should be considered male or female or something else. Historically, these people were labeled "hermaphrodites." In Greek mythology, Hermaphroditus was the son of Hermes and Aphrodite. Originally a boy, he was transformed into a creature of both sexes by union with a Naiad. During the twentieth century, the medical designation of "intersexual" has become the more accepted nomenclature. These, and other unusual births, were, in former

[9] John R. Money, *Gay, Straight, and In-Between* (New York: Oxford University, 1988), 77. John Money taught psychology and pediatrics at Johns Hopkins University for over fifty years until his death in 2006. Money was a pioneer in treating intersex patients and for decades held the spotlight as the preeminent authority on such treatment. His philosophy held that gender identity is entirely sociologically constructed and that there may be instances, either due to birth defect or mutilation, when the best course of action is to raise as girls children born as boys. One particular high profile case, Brenda/David Reimer, which called his research and theory into serious question, is discussed later.

times, seen as evidence of God's particular judgment on the parents or the community.

When a baby is born, common practice is to examine the genitalia in order to make a judgment about whether a baby is male or female. The importance of this is indicated by the fact that this is the first question people will ask when a baby's birth is announced: "Is it a boy or girl?" There are births that occur, however, in which a visual inspection alone is insufficient to determine the sex of the baby. This causes a great deal of distress for parents, as one might expect.

While transgender activism is chipping away at society's views regarding the differentiation of the sexes, most people still consider sex determination important in certain contexts, such as which public restroom one can use and the kinds of clothes one may be expected to wear. Just a couple of generations ago, voting rights, property ownership, inheritance, the availability of education, and certain types of employment were strictly dictated by a person's sex.

The International Olympics Committee has felt the need to address this issue. Female athletes are inspected to make sure that there are no men masquerading as women under the assumption that a man would enjoy an unfair advantage in a women's competition. The committee's decisions, however, about how to tell who is a *real* woman keep changing and are regularly challenged. At first, modern Olympic officials relied on the athletes to sort themselves by male and female. In the 1936 Summer Olympics at Berlin, Dora Ratjen was a German athlete in the women's high jump, finishing fourth, and was later determined to be male. Dora was probably not guilty of intentional subterfuge but possessed ambiguous anatomy that resulted in the controversy.[10] After this episode, Olympic officials began to use genital exams to sort male athletes from female. In 1968, Olympic officials started to examine the sex chromosomes, but even at that level of scrutiny, a definitive determination can be elusive.

Intersex births present a unique challenge. Up to the present time, doctors would paternalistically act as the arbiters of the intersex patient's sexual identity. They would assign a sex to them. In the attempt to give their patients a somewhat normal life, including the possibility to marry,

[10] Stefan Berg, "1936 Olympics: How Dora the Man Competed in the Woman's High Jump," *Spiegel Online*, September 15, 2009, http://www.spiegel.de/international/germany/1936-berlin-olympics-how-dora-the-man-competed-in-the-woman-s-high-jump-a-649104.html.

they often recommended surgery as early as possible, an approach that is largely seen now as outmoded.

Even for those with XX or XY chromosomes, there are conditions in which the sexual development of the person is atypical. One example is androgen insensitivity syndrome (AIS), a condition in which the XY chromosomes indicate the person is male, but the body is incapable of accepting the testosterone it produces, resulting in female physical features. AIS can be either partial or complete. In the case of complete AIS, individuals are nearly always assigned a female identity at birth based on visual inspection. It is only when the child grows and never begins to menstruate that further medical examinations occur. The testicles, which remain undescended, are often removed, as they frequently develop cancer later on in this condition. Some intersex conditions can be diagnosed at birth. Others, like AIS, do not become apparent until later in life, often around puberty.

When babies are born with ambiguous or confusing genitals, there are several important goals for treatment. These include preserving fertility where possible, ensuring bowel and bladder function, preserving genital sensation, and cosmetic agreeability. Ensuring that these goals are met, the likelihood of the child's satisfaction with his or her sex later in life is maximized. Immediate surgery is only necessary to correct specific conditions that may be detrimental to the baby's health or endanger his or her life. C*osmetic* reconstruction is not usually medically necessary at birth.

For a boy born with a genito-urinary deformity, the easiest surgical solution oftentimes is to remove the male-specific tissues and to construct a cosmetically satisfactory labial and vaginal configuration. If the intervention occurs early enough, the parents of these children are counseled to raise them as girls, even though they possess the male XY chromosomes and were born with typical, though malformed, male genitalia. The Intersex Society of North America (ISNA) calls this the concealment-centered model of treatment.

It is natural for people to try to find structure in their world. An important clarification is whether the structures we find are inherent to the world or imposed by our desire for order. The discovery of a confusing body raises doubts not just about the particular body in question, but about all bodies. The questioned body forces us to ask what exactly it is—if anything—that makes the rest of us unquestionable. It forces the not-so-easy question of what it means to be a "normal" male or a "normal" female.

In terms of medical treatment, the ISNA acknowledges a shift that is occurring away from the concealment-centered model, exemplified by John Money, to what they call a patient-centered model. Many who advocate this latter approach want to move away from seeing the intersex condition as an abnormality but to see it instead as a natural variation, like eye color.

One does not need to accept intersexuality as normal to acknowledge that the paternalistic approach of doctors making decisions about a patient's "true" sex has caused great harm to patients and their families. The Intersex Society of North America encourages honesty, transparency, and the avoidance of reducing human beings to a disorder or medical oddity. The newer model described by the ISNA that intersex is a natural variation comparable to eye color, however, fails to take into consideration that nature itself tells us that human bodies must be either male or female to reproduce. This must be important. Attitudes toward gender identity these days might not favor the binary, but the human reproductive system does. When organs or tissues are unable to carry out their natural function, it is appropriate to view this as an abnormality. Eye color serves no known function. Not all intersex people are incapable of reproduction, but to do so definitely requires the involvement of one male person and one female person.

Dr. Paul McHugh suggests a third approach, which is to not perform irreversible genital reconstruction in non-life-threatening cases and instead allow the child to grow up as intersex until the child can determine his or her own sex.[11] The parents, at birth, may provisionally assign a sex, with the full intention of explaining to the maturing child how they are different. In most cases, the expectation is that the children will identify more strongly with one sex or the other and can make informed decisions for themselves. Waiting to perform surgery, however, can be difficult for parents. Still, McHugh's recommendation seems like the best way to minimize the suffering of intersex children in the long term.

III. Gender: Fixed or Malleable?

American missionaries in parts of Africa often notice a number of young men walking around publicly holding hands with each other. In some cultures, it is socially acceptable for heterosexual male friends to hold

---

[11] Paul R. McHugh, "Surgical Sex: Why We Stopped Doing Sex Change Operations," *First Things*, November 2004, http://www.firstthings.com/article/2004/11/surgical-sex.

hands in public. In North America, two people of the same sex holding hands in public means something different than in Kenya, for instance. Conversely, in certain cultures, an unmarried man and woman holding hands in public would be considered indecent. To be sure, some aspects of male and female presentation and behavior are culturally directed. This cannot be denied. And yet there are still certain universals that seem to transcend time and place.

There are two main hypotheses about how gender identity, behavior, and preference originate: the psychological hypothesis and the sociological hypothesis. The psychological hypothesis holds that men and women are essentially different. We think and behave differently because our brains develop differently starting *in utero*. This perspective says that a person's subjective sense of being male or female is the result of the nature of his or her brain. The sociological hypothesis, in contrast, says that there are no inborn psychological differences between men and women, nor any meaningful brain differences, but that all apparent differences of behavior and self-image arise from one's upbringing. Many proponents of feminist theory deny essentialism and maintain that gender identity is fundamentally a product of environment. They hold that objectively there are only human beings; male and female are subjective categories determined by society. Phyllis Burke, for example, argues that gender and sex are *completely separate* elements of the person. She believes that gender identity is something that emerges as a result of environmental conditioning and nothing more. She writes: "I have learned that everyone falls along a gender continuum, but where they are on that continuum, which expresses the fullest range of human experience, *has nothing to do with their sex*."[12]

Clearly, gender expression is not fixed. There is a wide array of human psychological and behavioral traits, some considered male-typical and others female-typical. We all possess both sets to varying degrees. Some males are very nurturing. Some females are very assertive. The boundary lines are not crystalline. That having been said, surely it is a critical overstatement to say that one's body has *nothing* to do with one's gender.

J. Michael Bailey, a psychologist from Northwestern University, wrote a divisive but illuminating book in 2003 titled *The Man Who Would Be Queen: The Science of Gender-Bending and Transexualism*, in which he pushes against mainstream academia by offering empirical evidence that concepts such as femininity and masculinity are more than mere cultural con-

---

[12] Phyllis Burke, *Gender Shock: Exploding the Myths of Male and Female* (New York: Anchor Books, 1996), xviii; emphasis added.

structions and do indeed refer to aspects of an individual's essential nature.[13] He is fundamentally saying that certain traits are associated with one sex or the other because of real biological and psychological indications. Bailey explains the etiology of sex and gender differences in this way:

> Just after conception, male and female fetuses are quite similar. What makes them differ are the direct and indirect effects of testosterone, which is present in much higher levels in males . . . . Many scientists believe that there are important brain differences between newborn boys and girls that contribute to later behavioral differences. Other scientists believe that at birth the brains of boys and girls are essentially identical, and that girls and boys behave differently entirely due to the socialization they receive.[14]

The standard politically correct position is that biological sex, sexual orientation, and gender role behavior are discrete categories. Bailey sees them as more interlocking and inter-related. There is a growing scientific evidence to support the position that our sexual identity, including our orientation, is largely formed prenatally.[15]

IV. The David Reimer Case

As noted above, John Money is the formerly celebrated sex expert who argued that children are psychosexually neutral at birth. His writings in the latter half of the twentieth century influenced doctors and mental health professionals around the world to view the psychological and behavioral differences between boys and girls as purely socio-cultural. To support this position, Money frequently cited his work with a particular pair of male twins, one of whom lost his penis from an error committed during his circumcision. This is the case of David Reimer. David's birth name was Bruce. He and his twin brother, Brian, were born in Winnipeg, Manitoba, in 1965.

After the medical accident in his infancy, his distraught parents took him to Johns Hopkins in Baltimore to be treated by Money. He urged the parents to allow his team to remove David's gonads and begin to surgically construct a vagina. He prescribed hormone treatments and he told them that they must unequivocally raise their son as female. He assured

---

[13] J. Michael Bailey, *The Man Who Would Be Queen: The Science of Gender-Bending and Transsexualism* (Washington, DC: Joseph Henry Press, 2003).

[14] Bailey, *The Man Who Would Be Queen*, 44.

[15] Bailey, *The Man Who Would Be Queen*, 45–54.

them that so long as this process was begun early enough, their child, now considered a daughter, would grow up to enjoy a relatively normal life. Bruce was renamed Brenda.

Money met with the Reimer children annually throughout their childhood. In his published works, he referred to this case as a beaming success, proving that gender identity is not biologically or psychologically established at birth. On this basis, many other physicians followed the same course of action when faced with similar conundrums.

The truth, we now know, was far from the rosy picture of success that Money claimed. Brenda was miserable as a girl, acting out constantly at home and school. Teachers and school psychologists knew something was gravely out of sorts. Brenda fought the boys, like a boy. She was exceedingly unladylike in her body language. She wanted to dress as a boy. She was drawn to male typical toys and activities and preferred playing with boys. Trying to do what they thought best for their child, Mr. and Mrs. Reimer assured themselves, at Money's prompting, that Brenda was just a tomboy, and that hormone treatments and further surgeries as she got older would make all things right.

Nonetheless, Brenda Reimer's life did not begin to improve as she entered puberty. Her misery and misbehavior caused tremendous anxiety for the family. Her father drank excessively, and her mother became clinically depressed. No relief could be found until Brenda's parents, against Dr. Money's firm insistence, revealed to her at age fourteen that she was born biologically a boy. Immediately, Brenda chose a male name, David, and began to present himself to the world as a boy. Soon he received reconstructive surgery to reverse, as much as possible, the work of John Money. David began taking testosterone treatments to counter the years of estrogen he had been given and caused his body to masculinize. Eventually, David got married to a woman, got a job in a slaughterhouse with all male co-workers, and attempted to lead a normal life as a man.[16]

David Reimer's saga ended badly. In 2004, at age 38, he took his own life. This remarkable man endured tremendous adversity. His father's recurrent alcoholism and his mother's chronic depression at least partially resulted from their anguish over David's issues. The tragic death of his twin brother, the loss of his job, and separation from his wife were too much for him.

---

[16] This tragic story is recounted in John Colapinto, *As Nature Made Him: The Boy Who Was Raised as a Girl* (New York: Harper Perennial, 2000).

Parents of children with intersex conditions often wonder how much and when they should tell their children about their condition. The Intersex Society of North America recommends telling children about their condition throughout their lives in an age-appropriate manner. The David Reimer case is one tragic example of what happens when this information is kept from a person. Experienced mental health professionals can help parents decide what information is age-appropriate and how best to share it.

In 1979, Paul McHugh, head of the psychiatry department at Johns Hopkins Hospital, put an end to sex reassignment surgery. He identified two flawed assumptions underlying Money's approach to treatment: "(1) that humans at birth are neutral as to the sexual identity, and (2) that for humans it is the postnatal, cultural, non-hormonal influences, especially those of early childhood, that most influence their ultimate sexual identity."[17] McHugh pointed to research that showed that these patients, despite the earnest efforts of their parents to raise them as girls, were almost never comfortable as females as they grew and developed. It was as if their internal subjective sense of themselves as male was hardwired in the mind, in spite of their changed anatomies and powerful social influences.

V. Gender Dysphoria

The newest edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, replaces the diagnostic term *Gender Identity Disorder* with the term *Gender Dysphoria* (GD). Presumably, this new terminology is less pejorative. The problem is relocated from being a disorder in the person's identity to being an unwanted emotional state. The transgender community wishes to divorce their concerns from the stigma of mental illness.[18]

Gender dysphoria has been diagnosed in children as young as three years of age. The diagnostic criteria for children differ somewhat from the diagnosis in adolescents and adults, but in all cases the affected individuals experience extreme discomfort because their internal sense of self as male or female does not correspond with their biological sex.

---

[17] McHugh, "Surgical Sex."

[18] One assumes GD is still included in the manual so that patients may qualify for insurance-covered treatment, if so desired.

The DSM-5 states that gender dysphoria in adolescents and adults is experienced as:

> A. A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:
>
> > 1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
> >
> > 2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
> >
> > 3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
> >
> > 4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
> >
> > 5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
> >
> > 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
>
> B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.[19]

In treating cases of gender dysphoria, there are two possible approaches. One must either attempt to align the body with the mind or the mind with the body. Sex reassignment surgery is the attempt to align the body with the mind. Many point out that, at present, there has been meager success at finding ways to align the mind with the body. There is no form of talk therapy or psychotropic medication that can fully assuage the intense dysphoria felt by many transgender patients. If one of the key aims of medicine is to relieve suffering, some argue that surgery should not be ruled out. Considering the high rate of suicidality in patients with

---

[19] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-5* (Washington, DC: American Psychiatric Association, 2013), 452; hereafter DSM-5.

gender dysphoria, the intensity of their psychological suffering must not be taken lightly.

The great question is whether sex reassignment surgery truly alleviates the psychological suffering of GD patients. Paul McHugh believes there is evidence to suggest it does not, though his basis is anecdotal.[20] In 2004, the *Guardian* newspaper published studies that claim there is no evidence that sex reassignment surgery is successful in terms of improving the lives of transsexuals, with "many remaining severely distressed and even suicidal after the operation."[21] This is not merely based on anecdotal evidence but upon more than one hundred international studies of post-operative transsexuals by the University of Birmingham. The finding says that studies which report patient satisfactions are unsound because researchers lost contact with over half the participants. The doctor in charge of the University of Birmingham review says, "The bottom line is that although it's clear that some people do well with gender reassignment surgery, the available research does little to reassure about how many patients do badly and, if so, how badly."[22]

Given this data, it is questionable that the medical community would ever approve of such a poorly attested practice if politics and social ideology were not factored in. How many doctors would be willing to perform irreversible life-altering surgery with uncertainty about the well-being of more than 50% of patients? The main argument of those in support of the practice point out that there are no other effective treatments for transgender people and that many do, in fact, experience life improvement. Clearly, this *Guardian* publication is now more than ten years old, and since then other studies have addressed the high dropout rate of participants. Let if suffice to say that the claims of the psychological and social benefits of the procedure remain disputed.

When we consider that only 27% of children with gender dysphoria continue to experience these feelings into adulthood, it does appear to be possible for gender dysphoria to diminish apart from surgical intervention, at least for children. For 73% of children with gender dysphoria, the mind becomes congruent with the body over time. It may become possible then for the same congruency to be achieved through psychotherapy and medication for the others.

---

[20] McHugh, "Surgical Sex."

[21] David Batty, "Sex changes are not effective, say researchers," *The Guardian*, July 30, 2004, http://www.theguardian.com/society/2004/jul/30/health.mentalhealth.

[22] Batty, "Sex changes are not effective."

Oliver O'Donovan, a prominent Christian ethicist, argues that when sex traits are unambiguous, male and female identity should be assigned according to those sex traits.[23] The argument is that sex, rather than gender as that has come to be understood, should be the determining factor. Stated in another way, the physical body ultimately provides the limits to the expression of a person's male or female identity. Many transgender activists, however, argue against the prioritization of sex over gender in determining identity. This view holds that a person's true identity (revealed by self-identification) is sometimes masked by the material body, requiring a physical alteration (sex-reassignment surgery) to conform the body to one's gender self-identification.

VI. Transgender and Transsexual

The mental health community defines transgender persons as those "who transiently or persistently identify with a gender different from their natal gender" and transsexual persons as those who seek or undergo "a social transition from male to female or female to male" up to and including hormone treatments and surgery.[24]

There are different kinds of transgender people, and not everyone seeks to transition for the same reasons. Some of them are attracted to people of their own birth sex. That is, they are homosexuals. Others are only attracted to members of the opposite sex. A transgender person may be born a heterosexual male, attracted to women, yet experience the subjective sense of himself as truly a woman inside a man's body. If he has the surgery, he goes from being a heterosexual man to being a self-identified lesbian. It gets confusing because homosexuality is a separate issue from transsexuality, though they can overlap.

Many homosexual men exhibit effeminate characteristics. If so, according to Bailey, they almost certainly displayed these tendencies very early in life. Not all gay men are effeminate, but almost all highly feminine men are gay, he claims.[25] However, the vast majority of gay men do not find effeminacy attractive in a man. Most gay men, like most women, are

---

[23] "If I claim to have a 'real sex,' which may be at war with the sex of my body and is at least in a rather uncertain relationship to it, I am shrinking from the glad acceptance of myself as a physical as well as a spiritual being, and seeking self-knowledge in a kind of Gnostic withdrawal from material creation." Oliver O'Donovan, "Transsexualism and Christian Marriage," *The Journal of Religious Ethics* 11, no. 1 (1983): 147.

[24] DSM-5, 451.

[25] J. Michael Bailey, *The Man Who Would Be Queen*, 62–63.

attracted to masculine men, even hyper-masculine men. There is a quandary. Many gay men have innate effeminate characteristics, which most gay men do not find appealing in a partner. What occurs for some of these men is that they develop a powerful sense that they will never attract the kind of man they want as a partner, which leads to despondency. A fantasy emerges for them of attracting a masculine partner. A very small number of them will come to the point where they feel that the only way they can attract a masculine male is by becoming a sexy female. So that is what they aspire to do.

Bailey's book upset many in the transgender community, because while he is in favor of gay rights and is by no means a social conservative, he does advocate specialized professional treatment for gender-bending children. The activists want to eradicate all notions that there is anything wrong with being transgender at any age. Bailey recognizes the tremendous hardships associated with making the full surgical transition and the adversity many post-operative transsexuals experience in society and believes it would be better to prevent the perceived need, if possible. Few post-operative transsexuals ever find a long-term partner, the very thing that many of them seek. Neither are gay men interested in them erotically, nor are most heterosexual men attracted to them. If the transsexual happens to be one of the very few individuals who could truly pass for being a natural woman and is able to catch the eye of a heterosexual man, the dilemma of whether or not, or when and how, to reveal the truth arises.

Other men who seek sex reassignment surgery are those Bailey refers to as autogynephiles. These are heterosexual men who find tremendous sexual arousal in fantasizing about being a women.

VII. The Ethics of Mutilation

Gender dysphoria has been compared to Body Integrity Identity Disorder (BIID), also known as Amputee Identity Disorder (AID). BIID is a psychological condition, not yet classified in the DSM, in which the patient feels that one or more of his limbs should not be there. They suffer from a persistent desire to amputate healthy limbs in order to match their physical bodies with their idealized image of themselves.

What these disorders own in common is that the sufferers experience intense feelings that their bodies are not right in some way, even though all of their limbs and organs are fully functional. As with transgender persons, BIID causes individuals to feel isolated, believing that no one can

understand them. They may behave as if the limb were gone and express envy of amputees. Patients with BIID have gone to extraordinary lengths to have healthy legs or arms amputated. Some attempt to remove their limbs themselves. Or they may attempt to severely injure the limb in order to cause a surgeon to amputate it. Ethicists are concerned that treating BIID by amputating the offending limb(s) violates the principal of bodily integrity. Oliver O'Donovan's comment on the unacceptability of sex reassignment surgery on account of its rejection of the physical self would also apply here.

Robert Smith, physician of Falkirk and District Royal Infirmary in Scotland, is one who has performed elective amputations for BIID patients. He was subsequently expelled from his hospital. He states:

> It gave me considerable pause for thought and it took me a year-and-a-half of investigation before I agreed to do the first patient . . . . I became increasingly convinced that the patients had had very little success from their treatments by psychiatrists and psychologists over the years. These two patients had been fully assessed by two psychiatrists, one of whom has an interest in gender reassignment disorders, and also by a psychologist.[26]

Michael First of Columbia University was one of the earliest medical professionals to recognize and attempt to define BIID, in the hopes of making treatment available to patients who need it. Proponents of its inclusion in the DSM-5 observe that it would have made the condition easier to treat by making it more widely recognized by the medical community. Patients with BIID hope that someday elective surgical procedures may be available to help them, much like sex reassignment surgery is presently used to treat people with gender dysphoria.

Though BIID is not in the DSM-5, Body Dysmorphic Disorder (BDD) is included.[27] People with BDD experience strong feelings that their bodies are ugly or incorrect in some manner. This is akin to the feelings of those with eating disorders such as anorexia nervosa. Sometimes those with BIID

---

[26] "Surgeon Defends Amputations," *BBC News*, January 31, 2000, http://news.bbc.co.uk/2/hi/uk_news/scotland/625680.stm.

[27] It may be that one reason for the reticence of the psychological community to establish BIID as a disorder in the DSM-5 is the indirect effect this could have. "To use Ian Hacking's term, psychiatric categories have a 'looping' effect: once in play, people use them to construct their identities, and this in turn reinforces their reality as medical conditions . . . . The very awareness of a disorder can contribute to its proliferation." Tim Bayne and Neil Levy, "Amputees by Choice: Body Integrity Identity Disorder and the Ethics of Amputation," *Journal of Applied Philosophy* 22, no. 1 (2005): 85.

or gender dysphoria are compared to those with body dysmorphic disorder. The common thread in these conditions is a specific, usually monothematic, and persistent belief about one's body, a belief that others would objectively dispute. All are also resistant to recognized forms of talk therapy. In all cases, the people feel alienated from a limb or another aspect of their physical selves.

There exists for these persons a discrepancy between their physical bodies and how they subjectively experience them. Tim Bayne of Oxford University and Neil Levy of the University of Melbourne, in an article addressing the desire of some individuals to undergo elective amputation, employ the term "body schema" to describe the subconscious moment-by-moment awareness we all have of the structure, location, and articulation of our body and its parts.[28] Your body schema is what allows you to move yourself and your limbs without always needing to observe visually the relative locations of your parts to your surroundings. For instance, you can usually pick up your phone without looking at either your hand or the phone because your body schema gives you an awareness of where your hand is and what it is doing. When your body schema differs from your objective somatic form, you experience intense unease. More well-known is the inverse phantom limb phenomenon, when a patient senses that a limb is present that has been removed. Here also the subjective body schema differs from the body's actual material structure.[29]

Bayne and Levy offer three arguments in favor of allowing elective amputations that merit our careful consideration because similar arguments are made in defense of sex reassignment surgery. The first argument is harm minimization. This is the lesser of evils argument. It posits that regardless of legality or mainstream acceptance, a certain number of people will still seek amputation, even to the point of taking the matter into their own hands. Cases do exist of patients damaging themselves with a shotgun, a chainsaw, or a wood chipper. Others turned to unscrupulous

---

[28] Bayne and Levy, "Amputees by Choice," 76.

[29] Today there is much talk of body image. Body image is similar to body schema but differs in being the *conscious* impression of the general shape and structure of one's body. People who undergo cosmetic surgery do so because their body does not match some idealized image they have of themselves. What, then, is the qualitative difference between rhinoplasty and sex reassignment surgery or elective limb amputation? I assume most people would indeed have a visceral sense that they are qualitatively different. Perhaps instead of accepting sex reassignment surgery or elective limb amputation as psychotherapeutically beneficial body modifications, we should reconsider the wide acceptance of cosmetic surgery in our society, including, no doubt, among Christians.

black-market physicians to acquire the desired procedures. Given that some individuals will go to such lengths, it can be argued that granting their requests is a way to lessen the degree of harm done.

Their second argument is about personal autonomy. It is a fundamental principle of bioethics that the treatment goals of competent people who possess decision-making capacity should be respected. The principle of personal autonomy is taken so seriously that doctors will even refrain from relatively simple life-saving treatments, such as blood transfusions, if the patient's religion forbids it (i.e., Jehovah's Witnesses). The doctor's religious opinion on the matter is seen as irrelevant. The requirement of informed consent is an inviolable principle in the medical arts. Bayne and Levy propose that the principle of autonomy should guide doctors whose patients request a limb amputation in order to relieve their psychological distress. Such an expansive view of autonomy, however, could lead to unanticipated outcomes that would be even more detrimental to patient well-being and human flourishing.

Bioethicist Arthur Caplan maintains that the request to remove a healthy limb demonstrates that the patient is not thinking rationally and therefore lacks capacity to make this medical decision.[30] The desire to remove a healthy body part may, in fact, reflect an as yet unclassified mental illness, but again, once we stand on this claim, further undesirable outcomes are likely. Ignoring the patient's autonomy because he makes medical choices for himself that one finds disagreeable is a risky precedent. It is not too much of a stretch, for instance, for a doctor with no religious beliefs to respond the same way towards adult Jehovah's Witnesses. To refuse a simple, low-risk and life-saving procedure based on unprovable religious beliefs may be judged a sign of mental incapacity. In Caplan's mind, the BIID patient is evidently delusional. In a time when religious liberties are increasingly threatened, it is best to be cautious before attaching the word delusional to someone who holds a persistent belief that is in contrast to one's own. The word "delusional" has a very specific meaning in the DSM and BIID sufferers do not generally exhibit the determinative symptoms.

Even if these patients are not delusional and can be reckoned to be autonomous and to possess decisional capacity, the principle of autonomy does not obligate physicians to render services if they finds them to be morally objectionable and/or medically futile to do so. Bayne and Levy are correct that these discussions certainly put our notions of autonomy and

---

[30] Bayne and Levy, "Amputees by Choice," 80.

competency to the test. One of the dangers with prioritizing autonomy is that the practice of medicine will move from healing to providing services for cash, a consumerization of medicine that is already occurring.

The therapeutic argument is the strongest of the three from Bayne and Levy. There are four premises underneath this argument:

> (i) [The patients] endure serious suffering as a result of their condition;
>
> (ii) amputation will—or is likely to—secure relief from this suffering;
>
> (iii) this relief cannot be secured by less drastic means;
>
> (iv) securing relief from this suffering is worth the cost of amputation.[31]

The value of the therapeutic argument depends on whether these four premises can be verified. The trouble is the subjectivity of premises (ii) and (iv).

Research data clearly supports the first premise. BIID patients do experience grave psychological unease. In a study cited by Bayne and Levy, 44% of the subjects reported that their condition causes disruption with social functioning and occupational functioning. One is left to wonder, though, whether being an amputee might not cause even more disruptions.

The second premise is more controverted. Even though distinguished psychologists and psychiatrists believe that psychotherapy is the appropriate treatment plan, there is, in fact, a paucity of empirical data about the effects of psychotherapy on those who seek amputations. What little data that does exist suggest it is ineffective. The sample sizes are just too small for conclusions to be drawn from it. Even if psychotherapy is unable to provide relief, that does not mean that surgery would. Here is a catch-22: in order to study the therapeutic effect of elective amputations, these operations must occur. But without this very data, it is unlikely they will be approved any time soon. As with the second premise, the third premise has not been subjected to a controlled study. The fourth premise is purely subjective.

Bayne and Levy believe these surgeries should be permitted in order to alleviate the suffering of the patients. Yet from a strictly therapeutic perspective, there remain too many unknowns to make a sufficient moral

---

[31] Bayne and Levy, "Amputees by Choice," 82.

claim that elective amputations should be allowed. The strongest claim Bayne and Levy can make is that "the costs might be offset by the benefits of amputation in some cases and not in others."[32] No one has even attempted to calculate the costs, not just to the individual, but to the patient's loved ones and society as a whole. Homes will need to be remodeled and medical appliances and prostheses utilized. Workplace productivity may be affected. No one can say what other material and moral costs will be incurred from becoming the type of society that permits elective limb amputations. Given the impairment and irreversibility of amputating a limb, it is difficult to see how the therapeutic case can succeed.

Bayne and Levy suggest that simple repugnance, or the "Yuck Factor" of Arthur Caplan and Leon Kass, is behind most people's general disapproval of elective amputations.[33] They might be correct but, from a natural law perspective, this should not be quickly dismissed. Even when a limb is severely injured and *must* be removed to save the person's life, an amputation is considered tragic. The inherent goodness of the body's form and function is deeply rooted in our consciences.

This does not mean, on the other hand, that every action generally considered repugnant is ethically problematic. The disgust a person feels toward something may be as much a cultural or social bias as an indication of transgressing natural law. Desegregated lunch counters and interracial marriage have both, it is sad to say, generated visceral aversion in the past, but blessedly few today would seek a return to segregation.

In his article on the ethics of mutilation, Robert Song observes in regard to BIID that elective amputations could "represent a further step in the direction of the instrumentalisation and consumerization of the body," and he asks the question, "once we accept the principle that we may provide surgical solutions to emotional distress, what other practices might we also find ourselves legitimating?"[34] If the patients see themselves as consumers and physicians as mere service providers, the cultural pressure will build in ways we do not intend and cannot anticipate.

An expansionist philosophy of personal autonomy, instead of respect for bodily integrity, is, for many, the guiding ethical compass. If the body

---

[32] Bayne and Levy, "Amputees by Choice," 83.

[33] Bayne and Levy, "Amputees by Choice," 84.

[34] Robert Song, "Body Integrity Identity Disorder and the Ethics of Mutilation," *Studies in Christian Ethics* 25, no. 4 (2012): 500.

is not seen as meaningfully integral to the self, there can be no fundamental goodness of the body beyond that which we decide to award it, Song notes.[35]

Christian doctrine affirms the essential goodness of the body as part of God's created order, maintaining a certain dignity that was not obliterated by the fall. "The body is meant . . . for the Lord and the Lord for the body (1 Cor 6:13)," St. Paul writes. In what sense is the Lord meant for the body, if not the everlasting incarnation of the Divine Logos. In light of this, our attitude toward altering or rearranging the body, for no objective medical reason, should remain unacceptable to the church. To treat the human body as merely raw material out of which we may construct for ourselves any product of will and desire diminishes a sense of its intrinsic value. Oliver O'Donovan has stated, "The good is found in and through creation and its fulfillment, not in escape from or denial of it."[36] A natural law argument against permitting elective amputations is still fairly strong. The case must be established that the limbs in question are, in fact, not healthy in some actual sense, beyond the patient's subjective report.

Interestingly, Robert Song points our attention to the *Summa Theologicæ* by Thomas Aquinas. Here Aquinas's Principle of Totality is instructive. He stresses that the form of our bodies which we receive from God must not be violated except under quite specific circumstances. When Aquinas examines the ethics of mutilation, he has in mind three different situations: amputation as a civil punishment, the ascetic practice of making oneself a eunuch for the kingdom of heaven, and surgical removal of an infirm body part to save the person's life.[37]

In the case of civil punishment, Aquinas compares the social body to the individual human body. As a gangrenous toe may be removed to save the foot, so a member of society may be excised (executed) to benefit the community. If the greater excision, depriving a man of his life, is allowed, so a lesser excision, punitive amputation, may be administered by the public authority for a lesser crime to deter further wrongdoing. It is never lawful for a private individual to exact this penalty. In the second case, guided by the conviction that the welfare of the soul is more important than the welfare of the body, there were some ancient Christians who sought to be castrated as a means of guarding their chastity. This practice is condemned in the canons of the Council of Nicea, at least for the clergy

[35] Song, "Body Integrity Identity Disorder," 494.

[36] See quotation in Song, "Body Integrity Identity Disorder," 494.

[37] Thomas Aquinas, *Summa Theologicæ* II-II, 65, 1.

(Canon 1). Aquinas firmly rejects self-mutilation for ascetic reasons. Sin is not constrained by maiming oneself, for sin is not rooted in the body as such but in the inner person. He writes: "It is always possible to further one's spiritual welfare otherwise than by cutting off a member, because sin is always subject to the will: and consequently in no case is it allowable to maim oneself, even to avoid any sin whatever."[38] Aquinas, Chrysostom and the canons of the Council of Nicaea all instruct us that castration is not an approved means of guarding chastity. In the third instance, Aquinas acknowledges that it may become necessary to surgically remove a part to preserve the life of the whole.[39] Surgical removal of a limb, "if it be done with the consent" of the person (autonomy), is permitted in these situations. Song believes that, "the general principle of totality is that mutilation of the body for one's own good is permitted 'when it is proportionately necessary or useful for the good of the whole (i.e., the person) . . . .'"[40] The Latin text of Aquinas says that for the good of the whole, a part may be cut off.[41] Does whole refer to the body alone, or to the whole person? Is mutilation only permissible in response to clearly physical maladies? Song suggests that Aquinas's meant that an amputation may be done if it is for the good of the whole *person.* In fact, the Latin should be understood to refer to the whole *body* because that is explicitly the case in every other instance in the surrounding context. It is not prudent to strain an application of Aquinas beyond cases he might have anticipated, which Song himself acknowledges.

Pope Pius XII, who sat from 1939 to 1958, taught that mutilations could be permitted in order to avoid serious and lasting damage. The Roman Catholic Church once opposed organ transplantation based upon the Thomist Principle of Totality. To remove a healthy kidney from a live man to donate to his son was originally seen as unlawfully mutilating a healthy body. The Church's ethical views on this topic, however, have evolved. It was eventually determined that organ donation, as long as it does not endanger the life of the donor, includes informed consent, and is motivated by altruism does not violate the spirit of the law. If the church evolved in its understanding on this bioethical topic, might such development occur also with regard to elective limb amputations or sex reassignment?

---

[38] Aquinas, *Summa Theologicæ,* II-II, 65, 1.

[39] Aquinas, *Summa Theologicæ,* II-II, 65, 1.

[40] Song, "Body Integrity Identity Disorder," 494.

[41] Aquinas, *Summa Theologicæ,* II-II, 65, 1.

Paul McHugh and others state that we should not resort to surgical answers for psychological questions. Robert Song disagrees. Song believes that the lobotomy is an example of a surgical solution to mental suffering that was fairly widely used in the early twentieth century, even in Roman Catholic institutions, until the arrival of modern psychotropic drugs. His point is that mid-twentieth century Roman Catholic moral theology addresses and does approve of a surgical solution for a psychological problem.[42] The lobotomy, like sex reassignment surgery and limb amputation, involves major and irreversible effects for the patient. Where the comparison struggles is that many of the cases where lobotomies were performed involved maladies considerably more debilitating than BIID or GD. Robert Song argues: "On the face of it, if the objection to surgery in the case of BIID [much the same as for transsexualism] is that it uses a surgical solution to address a psychiatric need, then the same objection ought to obtain in the case of lobotomies that were endorsed for use in Catholic hospitals." Today, it borders on absurdity to argue for the morality of a practice by comparing it to getting a lobotomy. Two wrongs do not make a right. His point, however, is simply that the church has viewed surgical remedies for mental distress as morally acceptable in the past.

For Robert Song, the elective amputation of a healthy limb—and implicitly sex reassignment surgery—does not necessarily imply a docetic denial of the goodness of the body.[43] If the account of the mismatched mind and body is granted, then surgical interventions appear more reasonable. For Song and others, there evidently is something wrong with the health of the body when the internal schema conflicts with the objective form. How this drastic prioritization of the mind over the body is not docetic is difficult to fathom.

VIII. How Shall the Church Respond?

We now know that there are a number of complex and interrelated medical and psychological conditions that cause pain and confusion regarding sex and gender identity. It is important for us to discuss these matters unflinchingly as they touch upon deep elemental questions about human nature. Few pastors are trained to address either transgender advocacy or help those with gender dysphoria. Many theologically liberal churches are rallying around the transgender movement in the name of social justice. Politically motivated activists create more gender confusion

---

[42] Song, "Body Integrity Identity Disorder," 498.

[43] Song, "Body Integrity Identity Disorder," 495.

by counseling the afflicted to affirm themselves rather than exercise self-discipline or seek treatment. Conservative churches hold that at creation, God established the male/female binary as the norm for humanity but show, perhaps, little understanding for those individuals who are genuinely confused about where they fit into the traditional taxonomy.

A chief aim of feminist and gay philosophers and transgender activists is to subvert and destabilize the natural categorization of human beings into male and female. Increasing portrayals, not only of same-sex couples, but now of transgender people, will gradually normalize such things in the minds of American society. As Senator Daniel Patrick Moynihan once said, our society is "defining deviancy down." The church is called by Christ to bear witness to the truth and to suffer inconvenience, torture, imprisonment, or even death rather than depart from it. Yet we must confess God's truth always with gentleness and respect.

In terms of pastoral care, it is tempting but misguided to rely upon compassion as the sole criterion of discernment. Willful disregard for the structures of our bodies must be gently reproved when necessary. Pastors have a responsibility to become well-informed about a wide range of issues and must spend lengthy hours of time listening empathetically to their suffering sheep. They must resist the urge to voice the correct answers and consider the matter sufficiently addressed in every case.

Confession and absolution are powerful means of communicating the forgiveness of God through Christ, but we must recognize that not every spiritual malady can be treated by absolution alone. Guilt before God is not our only trouble. Many people with sexual identity confusion suffer under a tremendous burden of shame, the sense of being unclean or unacceptable. This may not always be tied directly to specific transgressions of God's law on their part. Frequently, they were victims of sexual and other abuse. The pastor does well to offer the body and blood of Jesus to people in these cases, assuming they have been properly prepared to receive the Sacrament. The cleansing nature of Christ's blood can, at such times, provide much healing and comfort. Confession and Absolution and the reception of Christ's body and blood are always beneficial to sinners in mind, body, and Spirit.

The Word of God is, of course, one of the chief resources to which the pastor will turn in his care of souls. Its use not only for reproof and correction but for comfort and hope goes without saying. The pastor will draw from the wide array of biblical themes, highlighting especially those that can assist those troubled by their condition. For example, the *Christus*

Victor understanding of the atonement can provide tremendous consolation for those who battle the flesh, the world, and the devil. Christ as conqueror, as a theme for preaching and pastoral counseling, assures the battle weary of the Stronger One's victory.

Another dimension where the word of God can play a significant role is in the realm of a spoken blessing. As John Kleinig has pointed out, too little attention has been given to the pastoral practice of blessing God's people, both in the Divine Service and in pastoral care:

> When God blesses people, He does not just approve of them and affirm what is good in them . . . . rather, through Jesus Christ, God actually equips them with His good gifts, so that they can do His will; by blessing them He produces what is pleasing in His sight (Hebrews 13:21). His blessing empowers them to do what pleases Him."[44]

The pastoral blessing is more than just well wishing. It is a performative word. God's Word does what it says. When the Christian with gender dysphoria is broken and exhausted from trying to navigate the complicated waters of his condition, he might need something other than advice or instruction from his pastor. The blessing, in this context, is not an approval of sex-reassignment surgery nor does it trivialize the genuine anguish of the person. It is an operation where God is present to comfort and strengthen. "The Lord be with you" is more than the religious version of "Good luck with that." God is with us in his promises, in bread and wine, and in the compassionate embrace of the church. Thus, actual words from the Holy Scriptures adapted into a blessing that is spoken to the individual become a powerful means of comfort and strength.[45]

Gender dysphoria is not a matter of possessing insufficient theological information. Gender dysphoria is an enormous burden that may have little remedy this side of our final glorification. It is a burden that some must carry as a general result of the fall. We remember that Christ's love for the heavily burdened is paramount and that the results of the fall will be undone on the Last Day.

The preaching of Jesus and the apostles was accompanied by miraculous signs, usually of healing. The healing aspect of the pastoral office

---

[44] John Kleinig, "Pastoring by Blessing," *Lutheran Theological Quarterly*, 43, no. 1 (2009), 33.

[45] Consider, for example, how the words of Psalm 33:7 might be crafted into a blessing: "The Lord be with you. Though we are filled with burning with no soundness in our flesh, God has not hid himself from you. He knows your sufferings and forgives you. May he who unites his body to yours continue to bless you and keep you."

has been sorely neglected in LCMS circles. What a delight to see that *Lutheran Service Book* resources include the apostolic practice of anointing the sick.[46] We must see ourselves as healers as well as teachers. Medical professionals, in general, are our allies. Teaching itself is salutary. The gospel works renewal in human beings in every capacity. As for miracles, if Baptism, Absolution, and the Eucharist are not signs of God's healing and re-creating presence, nothing is.

We must become better prepared to offer meaningful guidance, as well, to post-operative transsexuals who may, for instance, regret poor past decisions. It may be difficult for them to feel welcome in our churches. For those with unwanted same-sex attraction, a life of celibacy may be required. These are hard situations that call for a loving and well-prepared clergy.

A person who identifies with and desires to become the opposite sex has a disordered sinful desire. All children of Adam have disordered sinful desires but not all disordered sinful desires are exactly the same in terms of our lived existence. Some sins have a deeper grab on us than others. Some are habits. Others are embedded more deeply. Pastoral care toward all sinful brokenness is not one-sized-fits-all. Helping an alcoholic overcome his temptations might require a different approach than helping a person who struggles with envy or gossip. Baptism, Absolution, preaching, and the Eucharist are effectual to heal us, both in time and for eternity. But Thomas Hopko is exactly right that the techniques of psychologists and psychiatrists should be employed where appropriate as well.[47]

Paul McHugh gets to the heart of things when he writes, "Without any fixed position on what is given in human nature, any manipulation of it can be defended as legitimate."[48] Like it or not, this is where we live and work in our present context: under the assumptions of the plasticity of man. Cultural forces are critiquing the human body, as designed, as suboptimal and ultimately perfectible by us. St. Paul may have found it unthinkable that a person should hate his own body, but we know there are indeed such persons. Antipathy toward the human body emerges in various forms. There are those who pine for an unattainable idealized body

---

[46] *Lutheran Service Book: Pastoral Care Companion* (St. Louis: Concordia, 2007), 31.

[47] Thomas Hopko, *Christian Faith and Same-Sex Attraction* (Ben Lomond, CA: Conciliar Press, 2006), 51. Certainly, this takes for granted that the professionals to whom one might refer a parishioner are not antagonistic to the positions of the church.

[48] McHugh, "Surgical Sex."

and others who think that the future of mankind lies in a physical merger of our bodies with technology in order to attain a type of immortality.[49]

Theologians and pastors care about these topics because issues related to sex and gender touch upon deep elemental questions about human nature. Intersex conditions, gender dysphoria, and transsexualism are evidence that the natural world, as it exists today, does not display a clean binary split of humanity that neatly includes every person. Regrettably, religious communities are not always well informed about the perplexities of human life in a fallen world. The weakness of a common approach is that it fails to venture meaningfully beyond the Scriptures on a topic that is not merely spiritual. Would a statement on anorexia be adequate that attends to vanity while failing to deal with the psychiatric aspect of the condition? Would we address morbid obesity by condemning gluttony without discussing genetics or gastric bypass surgery? Let us make a greater effort to understand the complexity of our problems as they manifest in body, mind, and Spirit. This may require reaching out to disciplines other than theology. Christians must not approach what are at least partially medical issues with the same methodology as if it were simply discussing moral behaviors. More serious and extensive studies of the theological meaning of human embodiment, illness, disability, sex, the mind/body/Spirit relationship, and mental illness are needed.

As referenced previously, Bailey explains that there are several different types of transgender person. Some indeed are erotically motivated, so morality is involved. But it is too undemanding for the Church to analogize gender dysphoria to lust or another sinful desire. The truth is much more puzzling. We would not say that a soldier who had his leg removed in a battlefield hospital has sinful desire because he has the sense that he still possesses a leg that is gone. We should not say or imply that people who have the sense of incongruity between their mind and body are necessarily sinning. They are fallen sinners, yes, but is their confusion itself a sin or the result of their inherited sinful condition? It would indeed be a transgression of natural law and Aquinas's Principle of Totality to undergo the so-called sex reassignment surgery. Alternative medical and psychological treatments for GD should continue to be sought.

Our sex/gender is so constitutive to our identity that we continue as male and female in the resurrection. St. Augustine says in *The City of God* that we will recognize one another as male and female in the eschaton but

[49] Consider Raymond Kurzweil and the Transhumanist movement.

without lust. [50] When asked about marriage in heaven, Jesus teaches that human marriage will no longer exist but says nothing about losing our sex identity, which as Augustine points out, would have been the logical time to mention it, if this were the case.

Since it is a fact that there are people born with ambiguous sex traits, and since we will exist as true men and women at the resurrection, that means every person has a "true sex," even when we are unable to ascertain it in our fallenness. God knows. This must, however, mean that gender identity does not arise exclusively from the reproductive organs or even the chromosomes. If the genitals or sex features were the root of one's sex/gender identity, then those who possess confusing or ambiguous bodies truly do not possess either a male or female identity. The claim that human beings are essentially male or female, even in spite of dubious outward evidence or mental confusion, means that the duality of the sexes is not merely a social convention nor just a characteristic of phenotype. The male/female dichotomy is normative by virtue of God's intention in creation. Both the reality and the significance of the dichotomy persist in the fallen world, however obscured the evidence may be.

The heart of it all is coming to terms with the personal meaning of the human body. Corrupted though it is, the embodied human person is a multi-dimensional visible representation of God in creation and is in the process of becoming something new, by merit of the incarnation of God's Word and his death and resurrection, and our personal incorporation into his corpus by means of Baptism and through the eating of his flesh and drinking of his blood. Satan attacks sexuality with such intensity because it is the conjugal union of man and woman, which is God's most powerful image in the world. Unable to strike God himself, the enemy strikes God's image!

The Platonizing tendencies of our culture must be resisted and the goodness of the objective body confirmed. It is essential to understand that psychological conditions are corporeal afflictions to the extent that our thoughts, will, desires, and memories are grounded in the material substance of the brain. The mind/soul is more than the brain but is not naturally dissociated from the brain. The hypothesis that gender dysphoria is an intersex condition of the mind/brain is consistent with the evidence. It also helps explain the strong resistance GD has to all forms of psychotherapy and all current drug therapies. If this hypothesis is granted, one cannot argue that maleness and femaleness are determined exclusively by the

[50] Augustine, *City of God*, XXII, chap. 17.

genitals, gonads, secondary sex traits, or even chromosomes. Because our confession is that humanity is binary, people born with atypical bodies still presumably, we would say, possess a gender in some sense, confused though it is. The brain is involved. Though changing exterior characteristics is easier than changing the brain, this yet does not make the sex-change surgery acceptable. At present, we must conclude that there is simply no medical solution to GD. Grasping at straws is not an answer.

There will not be marriage in the resurrection, but there will still be men and women. And since our resurrection bodies will be absent every disease and disorder, we can assume intersex people will be raised as men and women, even if, due to the fall, their sex was questioned during their earthly life. Transgender people will finally know a sense of congruity between their objective bodies and their mental experiences of their sex. Human life will only know its fullest expression after the resurrection when all our infirmities of our body, mind, and Spirit will be extinguished forever. In the meantime, our churches are called to be sanctuaries of grace and mercy to all.