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Expert Opinion

Transsexual attractions and sexual reassignment surgery: Risks and potential risks

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Transsexual issues and sexual reassignment surgery (SRS) are receiving a great deal of attention and support in the media, schools, and government. Given the early age at which youth seek treatment for transsexual attractions (TSA) and gender dysphoria and given the serious risks associated with such treatment, it is essential that family and youth be advised about these risks and alternative treatment options. Physicians and mental-health professionals have a professional responsibility to know and communicate the serious risks, in particular risk of suicide, that are associated with SRS; the spontaneous resolution of TSA in youth; the psychological conflicts that have been identified in such patients and in their parents; the successful treatment of conflicts associated TSA and the regrets of those who have been through SRS. SRS and gender theory are also viewed from the faith perspective of Pope Francis and Pope Emeritus Benedict XVI.

***Lay summary**: Transsexuals and sex-change operations are receiving a great deal of attention. Young people may seek treatment for transsexual attractions at an early age even though these attractions may go away on their own. Psychological conflicts have been identified in these patients and their parents and may be successfully treated. There are serious risks associated with sex change. They include the risk of depressive illness and suicide. Physicians and mental-health professionals should know these risks and the regrets of those who have been through sex-change operations. These patients and their families also should be informed of other treatment options.*

Keywords: Transsexual attractions, Gender dysphoria, Sexual reassignment surgery

Transsexual issues and sexual reassignment surgery are receiving a great deal of attention and support in the media, schools, government and in health professionals today.

Dr. Paul McHugh, former chairperson of the Department of Psychiatry at Johns Hopkins Hospital, has written that,

> The idea that one's sex is fluid and a matter open to choice runs unquestioned through our culture and is reflected everywhere in the media, the theater, the classroom, and in many medical clinics. It has taken on cult-like features: its own special lingo, Internet chat rooms providing slick answers to new recruits, and clubs for easy access to dresses and styles supporting the sex change. It is doing much damage to families, adolescents, and children and should be confronted as an opinion without biological foundation wherever it emerges. (McHugh 2015)

Transsexual issues are creating a new controversy in our elementary and high schools

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today as a result of youth and their parents asserting a right to identify the sex of their child without regard to the biological and genetic realities. The parents and child may insist that the child's name be changed to one of the opposite sex and that the child be allowed to wear clothing of the opposite sex and use opposite-sex bathrooms.

These families are often preparing their children for sexual reassignment surgery (SRS) without being given the knowledge of the serious, documented risks associated with such surgery or other treatment options for gender dysphoria, referred to in the past as gender identity disorder (GID). Endocrinologists who are giving hormones to these youth, mental-health professionals who are affirming SRS surgery, and surgeons have a professional responsibility to understand these grave risks; and these patients also should be apprised of these risks.

An early study of these risks included one hundred patients seeking SRS, sixty-six of whom had surgery and 34 of whom did not (Meyer and Reter 1979). The operated-upon groups were followed from the time of surgery, the unoperated-upon group from the time of initial interview at the Gender Identity Clinic at Johns Hopkins. Of those operated on, twenty-one had a trial period (taking hormones and working in the opposite-gender role) while the other thirteen had been well-established in the cross-gender role at the time of surgery but did not have a formal trial period. Follow-up was successful in fifty-two patients, of whom fifty consented to have their data published. Follow-up interviews covered three main areas: adaptation; family relationships and adaptational patterns at major life intervals; and fantasy, dreams, and sexual activity. 73–80 percent of the patients were male. Average follow-up for operated-upon patients was sixty-two months and twenty-five months for the unoperated-upon group.

Residential instability was similar in the groups (average of twenty months between moves in the operated-upon group pre-surgery, eighteen months post-surgery, and twelve months pre-contact and ten months post-contact in the unoperated-upon group). Job levels indicated a slight upward trend in both groups. Changes in psychiatric contacts were also similar in the two groups.

A third group was found that went elsewhere for surgery when this was not performed at Hopkins. Adjustment scores were improved in the surgery and unoperated-upon group to a similar extent, with no significant difference between the groups, but the group that sought surgery elsewhere did less well (although there was no statistical significance to the difference).

As stated by the authors, "At the most simple level, these data suggest that significant change in adjustment scores may be achieved either through surgery or through the passage of time in association with some contact and acceptance into an organized evaluation program" (Meyer and Reter 1979). The conclusion was that SRS was not successful in treating this condition and led to the discontinuation of SRS at Johns Hopkins.

In spite of these early findings, and lack of contravening evidence that SRS conveyed any benefits compared with any unoperated-upon control groups, the practice of SRS has continued and has been extended into younger age groups. In a 2015, Boston study of 180 transsexual youth who had undergone SRS (106 female-to-male; 74 male-to-female), these youth had a twofold to threefold increased risk of psychiatric disorders, including depression, anxiety disorder, suicidal ideation, suicide attempt, self-harm without lethal intent, and both inpatient and outpatient mental health treatment compared

to a control group of youth (Reisner et al. 2015).

(An important research study would be that of determining how many of these youth, and their parents or guardians, were informed about the psychiatric risks associated with the surgery which is described in the mental health literature and which should be known by the treating health professionals. Since the mean age at which youth presented for consideration for SRS surgery in the Boston study was age 9, providing this information in a way that the children would understand would be challenging but nonetheless could be done in regard to discussing suicide risks and successful alternative treatments for gender dysphoria. The primary childhood psychological conflicts that interfere with the appreciation of the goodness of a child's masculinity or femininity should be given.)

The largest study to date of the long-term psychological state of post-SRS persons was an analysis of over three hundred people who had undergone SRS in Sweden over the past thirty years. This 2011 study demonstrated that persons after sex reassignment, have considerably higher risks for mortality, suicidal behavior, and psychiatric morbidity than the general population (Dhejne et al. 2011).

In 2014, Dr. Paul McHugh wrote in *The Wall Street Journal* about this research, "Most shockingly, their suicide mortality rose almost 20-fold above the comparable non-transgender population. This disturbing result has as yet no explanation but probably reflects the growing sense of isolation reported by the aging transgendered after surgery. The high suicide rate certainly challenges the surgery prescription" (McHugh 2014).

In the same article, Dr. McHugh has also described his study of people with gender confusion over the past forty years, twenty-six of which he spent as the psychiatrist in chief of Johns Hopkins Hospital. He wrote, "In fact, gender dysphoria—the official psychiatric term for feeling oneself to be of the opposite sex—belongs in the family of similarly disordered assumptions about the body, such as anorexia nervosa and body dysmorphic disorder. Its treatment should not be directed at the body as with surgery and hormones any more than one treats obesity-fearing anorexic patients with liposuction." He went on, "The treatment should strive to correct the false, problematic nature of the assumption and to resolve the psychological conflicts provoking it. With youngsters, this is best done in family therapy" (McHugh 2014).

Important medical and psychological issues need to be considered before the educational, medical, political, and judicial systems rush headlong into a process of affirming in youth and in their parents a fixed, false belief that a person can be a sex that is not consistent with their biological and genetic identity and that such individuals have the right to transsexual surgery. Fixed, false beliefs are identified in the mental-health field as manifestations of a serious thinking disorder, specifically a delusion. Health professionals should not be supporting this delusional belief in these youth and their parents.

An understanding of what motivates youth to identify with the opposite sex is essential as well as the reasons why parents would encourage or support transsexual attraction. Dale O'Leary, the author of the important book *The Gender Agenda*, has co-authored an important 2015 research paper, "Understanding and Responding to the Transgender Movement" (O'Leary and Sprigg 2015). Parents, youth and adults with TSA and health professionals would benefit from reviewing this important research paper.

GID/Gender Dysphoria: The Most Common Precursor to Transsexual Conflicts

Many youths who identify as persons of the opposite sex meet the earlier DSM criteria for GID. GID is a childhood psychiatric disorder (DSM IV TR) in which there is a strong and persistent cross-gender identification with at least four of the following preferences:

- repeated stated desire to be of the opposite sex,
- in boys, a preference for cross-dressing or simulating female attire and, in girls, wearing stereotypical masculine clothing and a rejection of feminine clothing such as skirts,
- a strong and persistent preference for cross-sex role in play,
- a strong preference for playmates of the opposite sex, and
- an intense desire to participate in games and pastimes typical of the opposite sex.

The DSM 5 has replaced the diagnosis GID with a new diagnosis, gender dysphoria. It also describes the symptoms that arise from the failure to identify with one's biological sex.

Children who seek SRS should be evaluated for psychological conflicts but regularly are not. A Dutch researcher and clinician, who specializes in treating such youth, Dr. Peggy T. Cohen-Kettenis has written in this regard:

> The percentage of children coming to our clinic with GID as adolescents wanting sex reassignment is much higher than the reported percentages in the literature … We believe (psychological) treatment should be available for all children with GID, regardless of their eventual sexual orientation. (Cohen-Kettenis 2001)

A Study of Youth from a Gender Identity Center

A 2013 study from a gender identity service in Toronto, that consisted of a sample of 577 children (ages 3–12) and 253 adolescents (ages 13–20), reported a number of findings and comments. These included:

- A sharp increase in adolescent referrals starting with the 2004–2007 cohort and this increased even more so in the last cohort, 2008–2011.
- For the first six cohorts (1976–1999), the percentage of boys always exceeded 75 percent, with the sex ratio ranging from a low of 4.61:1 (1988–1991) to a high of 12:1 of boys to girls (1992–1995), but for the last three cohorts (2000–2011) hovered around 75 percent, with the sex ratio ranging from 2.77:1 (2000–2003) to 3.41:1 (2008–2011) of boys to girls.
- The adolescent sex ratios were closer to parity. Of note, there were two cohorts (1988–1991 and 2008–2011) in which the number of girls exceeded the number of boys.
- The adolescent cases increased even more from the 2004 to 2007 cohort; and in the 2008 to 2011 cohort, the number of adolescent cases exceeded the number of child cases for the first time since the inception of their clinic in the mid-1970s.
- For the adolescents, data on sexual orientation were available for 248 patients. The percentage of girls classified as homosexual was greater than the percentage of boys classified as homosexual (76.0% vs. 56.7%).

For the children, 66.4 percent were in two-parent families at the time of assessment compared with 45.8 percent of the adolescents (Wood et al. 2013). Another

parameter that struck them as clinically important was that a number of youth commented that, in some ways, it was easier to be transsexual than to be gay or lesbian.

Along similar lines, they have also wondered whether, in some ways, identifying as transsexual has come to occupy a more valued social status than identifying as gay or lesbian in some youth subcultures. Perhaps this social force explains, at least partially, the particularly dramatic increase in female adolescent cases in the 2008–2011 cohort.

Another factor that impressed them in accounting for the increase in adolescent referrals pertained to youth with gender identify disorder who also had an autism spectrum disorder which has been reported by others (de Varies et al. 2010). A center in the Netherlands reported the co-occurrence of GID and autism spectrum disorders (ASD) in a study of children and adolescents (115 boys and 89 girls, mean age 10.8). The incidence of ASD was 7.8 percent. The authors recommended acquiring a greater awareness "of co-occurring ASD and GID and the challenges it generates in clinical management."

Family Conflicts in Youth with Gender Identity Confusion/Gender Dysphoria

Drs. Zucker and Bradley in Toronto have been recognized as leaders in the study of GID. They have identified a number of conflicts in the families of children with GID that included:

> A composite measure of maternal psychopathology correlated quite strongly with Child Behavior Checklist indices of behavior problems in boys with GID.
>
> The rate of maternal psychopathology is high by any standard and includes depression and bipolar disorder.
>
> The boy, who is highly sensitive to maternal signals, perceives the mother's feelings of depression and anger. Because of his own insecurity, he is all the more threatened by his mother's anger or hostility, which he perceives as directed at him. His worry about the loss of his mother intensifies his conflict over his own anger, resulting in high levels of arousal or anxiety. The father's own difficulty with affect regulation and inner sense of inadequacy usually produces withdrawal rather than approach.
>
> The parents have difficulty resolving the conflicts they experience in their own marital relations, and fail to provide support to each other. This produces an intensified sense of conflict and hostility.
>
> In this situation, the boy becomes increasingly unsure about his own self-value because of the mother's withdrawal or anger and the father's failure to intercede. This anxiety and insecurity intensify, as does his anger.
>
> These men (fathers) are often easily threatened and feel inadequate themselves. These qualities appear to make it very difficult for them to connect with sons who display non-masculine behavior." Withdrawing from their feminine sons, "they often deal with their conflicts by overwork or distancing themselves from their families. The fathers' difficulty expressing feelings, and their inner sense of inadequacy are the roots of this emotional withdrawal.
>
> Fathers demonstrate depression and substance abuse disorder.
>
> Parental psychopathology among the parents of children with GID deserves thoughtful consideration. (Zucker et al. 2003)

Also, Dr. Bradley has described additional maternal conflicts in these youth,

> boys with GID appear to believe that they will be more valued by their families or that they will get in less trouble as girls

> than as boys. These beliefs are related to parents' experiences within their families of origin especially tendencies on the part of mothers to be frightened by male aggression or to be in need of nurturing, which they perceive as a female characteristic. (Bradley 2003, 201–202)

Zucker et al. (2012) also found that GID youth had high rates of general behavior problems and poor peer relations.

It should be noted that these observations are not derived from controlled studies. As such, there is no comparison to the prevalence of such conflicts among control groups. Thus the specificity of these conflicts (or their prevalence in children with gender dysphoria) is not clear. There is no conclusive evidence of the role of such conflicts in the development of gender dysphoria or whether treatment aimed at correcting these leads to improvement. However, the comments of Zucker and Bradley do seem relevant to understanding the development of GID.

Additional conflicts that we have seen in engaging in the family therapy recommended by Dr. Paul McHugh include:

In females' relationships with their fathers, observed conflicts may include:

1. Excessive fear of the father's anger or his controlling behaviors, leading to a fear of being hurt due to being a woman, coupled with a belief that being a male would help them feel stronger and safer;
2. Severe mistrust of the father because of his insensitive and angry treatment of the mother, because of his harming the family by abandonment or because of his emotional, personality, or behavioral conflicts;
3. The father's failure to affirm his daughter's feminine goodness and gifts, to critique and protect her from gender theory errors, and to communicate that fulfillment and happiness can be found in being a psychologically healthy female.

In males' relationships with their mothers, observed conflicts may include:

1. The mother's mistrust of and anxiety with males as a result of growing up with a harsh, angry, distant, or addicted father (the child's grandfather);
2. Her desire that her son had been a daughter, leading to initiating or supporting cross dressing and cross-sexual identification;
3. A boy's fears that he does not please his mother as a male, together with his unconscious belief that he might receive more love and acceptance from his mother if he identified with femininity;
4. A mother's failure to support and encourage her son to have same-sex friendships;
5. A failure to critique and protect him from gender theory errors;
6. A failure to communicate that fulfillment and happiness can be found in being a psychologically healthy male.

In males' relationships with their fathers, observed conflicts may include:

1. Failure to develop a secure father–son relationship because of a father's emotionally distant behaviors or severe male insecurity;
2. A father's excessive anger or rejecting behaviors that undermine a son's ability to model after his father or that create a negative view of masculinity;
3. A father's failure to support a son's strong creative and artistic gifts;
4. A failure to protect the son from abusive behaviors by siblings or by same-sex peers that contribute to a son's failure to identify with the goodness of masculinity;

5. A failure to support same-sex friendships in childhood and adolescence;
6. A failure to critique and protect youth from gender theory errors;
7. A failure to communicate that fulfillment and happiness can be found in being a psychologically healthy male.

In females' relationships with their mothers, observed conflicts may include:

1. An emotionally distant, angry, selfish, depressed, or critical mother who failed to bond closely with her daughter for any number of reasons, including unresolved anger with the maternal grandmother that was misdirected at the daughter;
2. The failure to affirm the daughter's goodness and female gifts;
3. A failure to support and encourage same sex friendships;
4. A failure to critique and protect her daughter from gender theory errors;
5. A failure to communicate that fulfillment and happiness can be found in being a psychologically healthy female.

Other factors and conflicts observed in males may include:

1. A keen appreciation and love for beauty that is often associated more with femininity than masculinity and a desire to be what one loves;
2. A poor body image and the belief that one would be more attractive if he were of the opposite sex;
3. Severe childhood rejection by same-sex peers, creating a sense of not fitting in with them, which results in intense fears of rejection and an unconscious belief that one would feel safer if he were of the opposite sex;
4. Repeated failures in relationships with women, associated with a severe loss of self-esteem;
5. A sense of pleasure in rejecting the values and moral code of his parents;
6. The belief that his sex is not a gift, but a constraint that must be overcome;
7. Pressure from a significant other to cross dress, take hormones, and move toward SRS;
8. Severe narcissism and acceptance of gender theory with a delusional belief that he can create himself as he wants.

Other factors and conflicts observed in females may include:

1. The absence of close female friendships and a sense of not fitting in, along with a belief that she would be less lonely and happier if she were a male;
2. In strong, young females, a love for what is perceived as male strength and preferential treatment for males, together with the desire to become what she loves;
3. Poor body image and a belief that she would be more attractive if she were of the opposite sex;
4. In very athletic and strong young females an intense bonding and identification with young males through athletic activities;
5. A sense of failure as a female and a delusional belief that she would feel more confident and happy being a member of the opposite sex;
6. Repeated failures in relationships with males with severe loss of self-esteem;
7. Pressure from a significant other to cross dress, take hormones, and move toward SRS;
8. A sense of pleasure in rejecting the values and moral code of her parents;
9. The view that her sex is not a gift but as a constraint that must be overcome;
10. Acceptance of gender theory, along with a delusional belief that she can create herself as she wants.

The exposure of youth to gender theory in college can result in their embrace of post-modern philosophies focused on freedom as an end in and of itself. Such ideas come from various sources, including the writings of Friedrich Nietzsche and Jean-Paul Sartre. If freedom (some would call it license) is the greatest good in the world, then why should anyone be constrained by biology? One's sex as male and female is seen not as a gift but as a constraint that must be overcome. So if technology can alter one's body, then so be it.

PC Medicine

Some medical centers fail to or refuse to diagnose the psychological difficulties youth have in accepting and appreciating their biological sex. They neglect to provide proper counseling about treatment and the risks of sexual-reassignment surgery. Instead, they support the beliefs of the youths and their parents and initiate hormone treatments in preparation for eventual body-mutilating surgery.

A pediatric specialist at Boston has a program for boys who feel like girls and girls who want to be boys. He offers his patients—some as young as seven years old—counseling about the "naturalness" of their feelings and hormones to delay the onset of puberty. These drugs stop the natural process of sexual development that would make it more surgically difficult to have a sex alteration later in life.

This physician alleges that those whom he labels as transsexual children are deeply troubled by a lack of understanding of their feelings and have a high level of suicide attempts. While this physician is accurate in his interpretation of the literature—that children with GID and transsexual ideation are deeply troubled—his claims of a high level of suicide attempts in children with GID is not substantially supported by the medical literature. In fact, the literature demonstrates a shocking increase in suicide and in psychiatric illness *after* sexual reassignment surgery (Dhejne et al. 2011).

In his 2014 *Wall Street Journal* article, Dr. McHugh wrote that "misguided doctors at medical centers including Boston's Children's Hospital have begun trying to treat" transgenderism in youths "even though the drugs stunt the children's growth and risk causing sterility." He recommends "a better way to help these children: with devoted parenting" (McHugh 2014).

The Treatment of Youth with Transsexual Confusion

According to Drs. Zucker and Bradley:

> The fantasy solution provides relief but at a cost. They are unhappy children who are using their cross-gender behaviors to deal with their distress.
>
> Treatment goal is to develop same-sex skills and friendships.
>
> In general, we concur with those who believe that the earlier treatment begins, the better … It has been our experience that a sizable number of children and their families can achieve a great deal of change.
>
> In these cases, the gender identity disorder resolves fully, and nothing in the children's behavior or fantasy suggest that gender identity issues remain problematic … All things considered, however, we take the position that in such cases clinicians should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity. (Zucker and Bradley 1995, 281–282)

Zucker and Bradley have been providing sensitive treatment to children with the precursor of transsexual conflicts. They

have written that the goal of treatment is to develop skills associated with children of their own biological sex and friendships with such children. We have found a similar treatment approach to be beneficial in treating such children (Fitzgibbons 2015). While data from controlled clinical studies are not available to measure the effectiveness of these therapies, it seems reasonable to follow the recommendations of those with extensive clinical experience until such time as controlled trials are performed.

Also, Dr. McHugh has written that transsexual attractions are often fluid and can change. "When children who reported transsexual feelings were tracked without medical or surgical treatment at both Vanderbilt University and London's Portman Clinic, 70 to 80 percent of them spontaneously lost those feelings" (McHugh 2014). Dr. McHugh has described also his research experiences at Johns Hopkins:

> As for the adults who came to us claiming to have discovered their true sexual identity and to have heard about sex-change operations, we psychiatrists have been distracted from studying the causes and natures of their mental misdirections by preparing them for surgery and for a life in the other sex. We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.
>
> One might expect that those who claim that sexual identity has no biological or physical basis would bring forth more evidence to persuade others. But as I've learned, there is a prejudice in favor of the idea that nature is totally malleable.
>
> A practice that appears to give people what they want turns out to be difficult to combat with ordinary professional experience and wisdom. Even controlled trials or careful follow-up studies to ensure that the practice itself is not damaging are often resisted and the results rejected. (McHugh 2004)

Sexual Reassignment Surgery

SRS violates basic medical and ethical principles and is therefore not ethically or medically appropriate.

1. SRS mutilates a healthy, non-diseased body. To perform surgery on a healthy body involves unnecessary risks; therefore, SRS violates the principle *primum non nocere*, "first, do no harm."
2. Candidates for SRS may believe that they are trapped in the bodies of the wrong sex and therefore desire or, more accurately, demand SRS; however, this belief is generated by a disordered perception of self. Such a fixed, irrational belief is appropriately described as a delusion.
3. SRS, therefore, is a "category mistake"—it offers a surgical solution for psychological problems, such as a failure to accept the goodness of one's masculinity or femininity, lack of secure attachment relationships in childhood with same-sex peers or a parent, self-rejection, untreated GID, addiction to masturbation and fantasy, poor body image, excessive anger and rebelliousness, and severe psychopathology in a parent.
4. SRS does not accomplish what it claims to accomplish. It does not change a person's sex; therefore, it provides no true benefit.
5. SRS is a "permanent," effectively unchangeable, and often unsatisfying surgical attempt to change what may be only a temporary (i.e., psychotherapeutically changeable) psychological/psychiatric condition. (Fitzgibbons, Sutton, and O'Leary 2009)

Regrets over SRS

Dr. Renee Richards, a former professional tennis player, has written that her transition failed to meet even her own expectations. She wrote,

> I wish that there could have been an alternative way, but there wasn't in 1975. If there was a drug that I could have taken that would have reduced the pressure, I would have been better off staying the way I was—a totally intact person. I know deep down that I'm a second-class woman. I get a lot of inquiries from would-be transsexuals, but I don't want anyone to hold me out as an example to follow. Today there are better choices, including medication, for dealing with the compulsion to cross-dress and the depression that comes from gender confusion. As far as being fulfilled as a woman, I'm not as fulfilled as I dreamed of being. I get a lot of letters from people who are considering having this operation … and I discourage them all. (Richards 1999)

Walt Heyer, who went through SRS, also exposes the origins of the practice and its often tragic results in his article (Heyer 2015).

Youth, their parents, and adults who are considering SRS should be informed by their doctors and psychologists about the serious regrets many people have who underwent SRS. This information should also be communicated in schools where SRS is being taught as a healthy step to seeking greater happiness and fulfillment in life.

Parental Responses to Youth with Transsexual Attractions

As the protectors of their children, the first step parents can take is to understand possible reasons why their child is identifying with the opposite sex and has difficulty in embracing the goodness of his masculinity or her femininity. Then parents should learn about the serious health risks associated with SRS. Next, it is essential to do what most health professionals, educators, and the media fail to do, warn their children of the serious psychiatric dangers associated with SRS, especially the risk of suicide.

Many parents report the benefits of limiting time on the Internet for their children with this conflict. They believe that communication with those who are supporting and encouraging SRS reinforces the false belief that their thinking can determine their sex, that they have no emotional conflicts, and that SRS is a path they should pursue.

The leading experts in GID, Zucker and Bradley, have written, "parental ambivalence is, in most cases part of the problem." Parents, particularly mothers, who might rationalize that it is "cute" to have a boy wear female clothing, often ignore or excuse obvious appearances of effeminacy in males. These psychologists encourage early intervention to prevent the suffering of isolation, unhappiness, and low self-esteem in children who fail to appreciate their goodness as boys or girls.

Children are born with a drive to seek love and acceptance from each parent, as well as siblings and peers. If this need is met, children develop a positive identification with their masculinity or femininity. When this developmental task is successfully completed, the child is free to choose gender-atypical activities. Boys and girls with gender-identity problems are not freely experimenting with gender-atypical activities. They are constrained by deep insecurities and fears and are reacting against the reality of their own sexual identity, often as a result of failing to experience secure attachment relationships with the parents, siblings, or same-sex peers.

Mistakes parents make with children who have transsexual attractions (TSA) may include:

- failing to identify a child's weakness in embracing the goodness of his masculinity or her femininity;
- allowing a child unsupervised time on the Internet, especially in the evenings, during which the delusional belief that one can change one's sex can be communicated and affirmed;
- failing to help understand the causes of their conflicts;
- failing to warn about the severe dangers of SRS;
- enabling the delusional thinking that one can change one's sex;
- depending too much on acceptance by a child;
- allowing a child to see a health professional who fails to provide adequate information and who fails to explore possible psychological origins of the failure to embrace the goodness of masculinity or femininity;
- failing to get a professional opinion about the origins of transsexual attractions and the serious risks associated with sexual reassignment surgery;
- supporting the controlling behavior of the child who insists upon being called by a name of the opposite sex at home and at school;
- enabling communication with peers and others who encourage SRS.

Children can also learn to correct their cognitive distortions in regard to their natural goodness and beauty as a male or female. The responses could include thinking:

> "I can grow to appreciate the goodness of my body and masculinity and femininity."

> "I can be thankful for my special masculinity or femininity."

> "I can grow to feel more comfortable and confident in being who I am."

While there are no controlled clinical data to support specific interventions in treating children with transsexual conflicts, the following recommendations could be helpful if incorporated into a family therapy treatment program. For boys with transsexual conflicts:

- increasing quality time for bonding with the father;
- increasing affirmation of the son's masculine gifts by the father;
- bonding with the son in his artistic or creative activities;
- participating in and support for the son's creative efforts by the father;
- encouraging same-sex friendships and diminishing time with opposite-sex friends;
- slowly diminishing play with opposite-sex toys;
- encouraging the boy to be thankful for his special male gifts;
- working at forgiving boys who may have hurt him;
- communicating with other parents whose children have been treated successfully for GID and who have come to appreciate and to embrace the goodness of their masculinity and femininity;
- addressing the emotional conflicts in a mother who wants her son to be a girl;
- in those with faith, encouraging thankfulness for one's special, God-given masculine gifts.

For girls with transsexual conflicts:

- encouraging the daughter to appreciate the goodness and beauty of her femininity, including her body;
- encouraging same-sex friendships and activities;

- increasing the mother–child quality time;
- praising their daughter's special goodness and gifts;
- working with the daughter to forgive peers who have hurt her;
- encouraging pursuit of a balance in athletic activities;
- addressing conflicts in a parent who may want her to be a boy;
- in those with faith, encouraging thankfulness for one's special, God-given femininity.

Transsexual Indoctrination in Schools

Some school districts have been attempting to incorporate transsexual education into the required health programs in junior and senior high schools. In the Fairfax County, Virginia, School District, parents' groups strongly objected to this attempt; and the program was left in the family life section which is not required for students. In an important article, "Gender Free Children: The newest fad in public education," the British Columbia Teachers Federation handbook on gender education was cited. It stated that "gender is a product of the mind … Being transgender or gender non-conforming is normal and healthy."

Author Lee Duigon wrote,

> Coming soon, to a public school near you: the teaching that "gender is a spectrum,' and 'gender identity" a state of mind, a social construct—and it's all part of a top-down campaign to convince your children that they can be "whoever they want to be." Boys can be girls and girls can be boys. (Duigon 2011)

The author noted that the Redwood Heights Elementary School in Oakland, California, has already installed a "gender coach" in the classroom to teach very young children that "you can be a boy or a girl, or both." The "coach" was provided by an organization called Gender Spectrum (http://www.genderspectrum.org) which presumably would not exist if it did not perceive a demand for its services.

In addition, school principals are placing children at risk and are creating confusion in the minds of many children by giving in to the requests of parents to allow young children to change their names to those of the opposite sex, cross dress, and be accepted as being of the sex opposite of their biological sex. These school administrators either do not know or ignore medical and psychological science and research on transsexual issues and SRS. They are participating in a false belief that the children are not of their biological sex. Such a fixed, false belief is identified in the mental health field as a delusion.

Faith and Transsexual Issues

While he has not specifically addressed the issue of transsexualism, Pope Francis has repeatedly criticized gender theory indoctrination of youth. On January 19, 2015, in an in-flight interview returning from Manila, he described the forcing of gender ideology onto students in schools as a form of "ideological colonization" comparable to Hitler youth indoctrination (Westen 2015). Pope Francis commented on April 15, 2015, at his weekly general audience: "if so-called gender theory is not an expression of frustration and resignation, that aims to cancel out sexual difference as it is no longer able to face it. Yes, we run the risk of taking a step backwards. Indeed, the removal of difference is the problem, not the solution" (White 2015). On June 8, 2015, he stated that so-called gender ideology is challenging the complementarity between a man and a woman under the guise of seeking a more just society. He

related, "Let me draw your attention to the value and beauty of marriage. The differences between men and women are not of the order of opposition or subordination, but rather communion and generation, always as the image and semblance of God" (Montagna 2015).

Similarly, Pope Benedict XVI strongly criticized gender theory in his Christmas address to the Roman Curia, December 22, 2008. He stated,

> She [the Church] has a responsibility towards creation, and must also publicly assert this responsibility. In so doing, she must not only defend earth, water and air as gifts of creation belonging to all. She must also protect man from self-destruction … .
>
> 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.
>
> Rain forests deserve indeed to be protected, but no less so does man, as a creature having an innate "message" which does not contradict our freedom, but is instead its very premise. (Benedict XVI 2008)

Youth have the right to be provided, by physicians, mental health professionals, school nurses, and the media, with accurate information about gender confusion, the serious medical and psychiatric associated with SRS, and the excellent prognosis associated with an alternative proven treatment described in the medical literature.

Parents, family members, educators, politicians, and clergy have a moral responsibility to be familiar with medical science and to provide prudent counsel to youth that will protect and not harm them.

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