Preparing Catholic Schools to Care for Gender Dysphoric Students

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Gender dysphoria is "a persistent and profound discomfort with one's biological sex and a strong identification with the gender of the other sex".[1] The 'dysphoria' or 'bad feeling' – the opposite of 'euphoria' – is a psychological state of distress at "experienced incongruence between a person's inner perception of her/his gender, and the incongruous bodily reality.'[2] This paper discusses how Catholic schools might best prepare to provide care for 'gender dysphoric' students. It suggests that empirical research often reveals a very different picture from the popular rhetoric, and offers both a conceptual framework and some practical considerations for Catholic schools and education systems.

Introduction

In recent years there has been a sharp increase in the number of children presenting to paediatric gender dysphoria clinics.[3] While the precise reason for this sudden increase remains unclear, education is one of the first social systems to feel the direct impact of the phenomenon as schools are challenged to provide appropriate support for 'gender dysphoric' students and their families. The schools' task is complicated by lack of clarity around the nature of this phenomenon; lack of guidance on providing appropriate care; and in the case of the Catholic school system, a narrative on the nature of gender and sexuality that runs contrary to popular rhetoric.

Central to the gender dysphoria phenomenon is the proposition that one's subjective experience of being male or female is distinguishable from one's objective biological sex.[4] In this paper, 'sex' will refer to one's genetic and genital inheritance by which, normally, one is classified either male or female (XY or XX on the 23rd pair of chromosomes); while 'gender' will refer to one's inner sense of being or 'feeling' male or female – a subjective state of happiness with the way one views oneself as a sexual being. The critical issue isn't whether sex and gender are distinct – which they clearly are –

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[1] Hewitt (2012).

[2] Kaltiala-Heino (2015).

[3] Numbers have more than quadrupled in the last few years: compare Vickery (2015) who reported 26 referrals per year to the Gender Dysphoria clinic at Perth's Princess Margaret Hospital, with O'Leary (2017) reporting 100-150 referrals per year to the same clinic.

[4] One's sex is sometimes referred to, confusingly, as one's 'assigned gender'. This may be an appropriate designation in the case of genuine intersex individuals, but its use in the case of gender dysphoric persons seems to assume a radical disconnection between sex and gender which rather begs the question in focus. It is preferable to avoid the term altogether.

but whether they are radically disconnected from one another.[5] A related question asks whether the naturally binary nature of human sex (male and female) necessarily translates into a binary account of human gender – or indeed whether there is a limitless spectrum of human genders.[6]

In the interests of accuracy this paper proposes consistent use of the terms 'gender dysphoria' and 'gender dysphoric' in preference to those which dominate the popular rhetoric, 'transgender' and 'transsexual'.[7] While all 'transgender' and 'transsexual' persons are such because they experience some form of gender dysphoria, not everyone who experiences gender dysphoria will choose the path of 'transition' from one gender to the other which is implied by these other terms. This language protocol is most important in relation to school-aged children and adolescents: school teachers and staff must be careful to use language which does not pre-empt possible future outcomes or decisions which the child or others may or may not take in later life. This is particularly so in view of what sound research reveals about long-term outcomes for those who do seek to 'transition'. In my view the term 'gender dysphoric student' should always be used in preference to the more common but much less accurate 'transgender student'.

Gender dysphoria is altogether different from 'intersex' conditions ('Disorders of Sexual Development' or DSD) which occur in about 1 in 4500 births and which have well-understood medical causes.[8] This paper will not deal with DSD. Gender dysphoria is also different from sexual orientation, and in particular same-sex attraction: a gay man is usually in no doubt as to his gender.[9] Nor will this paper deal directly with 'transgenderism' in adults except as necessary to understand gender dysphoria in children.[10]

Key stages at which school-aged children and adolescents may experience gender dysphoria or its precursors are: pre-pubertal children (roughly 5-12 years), pubertal children and young adolescents (roughly 12-16 years), and older adolescents (aged over 16 years). Research seems to indicate that

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[5] Allen (2014) notes that the word 'gender' is derived from an ancient root word 'gen' and is implicitly binary because it connects back to human generation which requires both male and female: "in its verb form [gen] is 'to produce' or 'to beget'; in its noun form it refers to offspring or kin." The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth edition (2013) [DSM-V] holds that the term 'gender' first arose in relation to the phenomenon of medical 'intersex' conditions. The implication seems to be that its use in relation to psychological conditions is analogous. While DSM-V is the diagnostic resource most often cited in the literature, the WHO *ICD-10 Classification of Mental and Behavioural Disorders* is still widely used in Australia.

[6] Adams (2017) says that Facebook users are offered over 71 gender options.

[7] Some authors seem to use 'gender dysphoria', 'transgenderism' and 'transsexualism' interchangeably [eg Gooren (2011)], while others [eg DSM-V] distinguish 'gender dysphoria' (as defined above) from 'transgender' (those who simply wish to settle their inner dysphoria) from 'transsexual' (those who opt for radical hormone and surgical therapies to change their bodies to match their psychological experience). This latter is sometimes referred to as a 'sex change' – which in genetic terms is impossible because a natal male will always be 46,XY.

[8] Öçal (2011).

[9] There are indications that prolonged gender role confusion in very young children, while generally resolving naturally, may be associated with higher rates of same-sex attraction in later life. See Steensma (2013). Nevertheless, in the literature the two are usually considered to be totally distinct phenomena.

[10] It will become apparent that the ethical issues around adolescent transitioning are much more complex than those around adult transitioning.

true dysphoria is not likely to emerge until puberty or early adolescence, which are also the stages of development when most cases will resolve naturally (for those known as 'desisters'). The really problematic group are those known as 'persisters', whose dysphoria is definitively diagnosed as it lasts into later adolescence and even adulthood and who may seek puberty-blockers and even cross-sex hormone treatment (described below) while attending school. While research indicates that each stage presents typical characteristics and challenges, it also shows that each case of genuine dysphoria is unique by virtue of its own complex of personal, social and familial factors. Each case will require its own resolution.

This paper is addressed to Catholic schools and the Catholic education sector in Australia. It arises from growing concern that all schools need to offer appropriate and effective support for children and their parents who are, or believe they are, dealing with gender dysphoria. Accordingly this paper will, firstly, explore what sound research tells us of the nature and likelihood of successful long-term treatment of gender dysphoria in school-aged children and adolescents. Conscious of the challenges faced by schools today, some apparent paradoxes that have been identified in treating the younger cohort of students will be discussed and some preliminary recommendations offered. Secondly, it will sketch a theological context or framework that Catholic schools can bring to pastoral care for a gender dysphoric student. This 'Catholic world view' of the dignity and essential integrity of all human beings, it will be suggested, supplies both the form and content of a whole-of-school response to genuine gender dysphoria. Finally, viewing Catholic schools as elements in a much wider Church environment that is challenged to provide appropriate care for all students, we will return to some practical considerations for our dioceses, schools and school systems. The aim is to begin constructing a body of knowledge to inform and guide a pastoral response from Catholic schools which both adequately meets the needs of all students and faithfully reflects Catholic moral traditions.

Part 1 Gender Dysphoria in Children

The rise in referrals to gender dysphoria clinics, and today's apparent media fixation with gender diversity issues, reflect a significant change in thinking that has taken place in Western society in recent years. Where previously we assumed we knew what it means to be male and female as children and as adults, today it seems all of these assumptions are under challenge. It is beyond the scope of this paper to explore the history of this development,[11] but primary and secondary educators in particular need clarity about the nature and current treatment options for gender dysphoria.

This is hotly disputed territory, because different researchers sometimes reach apparently contradictory conclusions. But a close reading of the more solid academic research reveals data which frequently contradict the popular rhetoric. Because managing gender issues in children can have very serious repercussions for them and their families, I believe it is prudent to adopt a more soundly empirical approach to interpreting information about gender dysphoria. However, some of the best available research is based on small sample sizes or is more qualitative in nature (both of

[11] For discussion of these questions, see Allen (2014).

which make generalisation difficult), while some larger studies are retrospective reviews of medical records drawn from a time when there were few if any best practice guidelines. Nevertheless, in such an important question it is essential to be guided by the best available studies which meet, as far as possible, normal academic criteria: objectivity, sound research methods, balanced reporting and discussion of results.

a) G*ender dysphoria in general*

It is difficult to estimate the proportion of truly gender dysphoric individuals (adults as well as children) in Australian society. Internationally, cited figures vary between 1.7% and 0.018% of the total population;[12] most studies accept that 1:10000 or 0.01% is probably reasonable.[13] Sex ratios of natal boys to natal girls range from 2:1 in children, almost 1:1 in adolescents, to around 6:1 in adults.[14]

Gender dysphoria does not seem to have a single cause, much less a purely physical, genetic or neurological cause. There has been considerable research into whether some individuals are more predisposed to develop gender dysphoria if *in utero* their genital development varies from the later neurological development of central structures in the brain[15] – if "the process of genital development and of brain sexual development do not match the same sex"[16] – but so far this remains an unproven hypothesis.[17] Most researchers agree:

> Gender identity is a multifactorial process involving both prenatal and postnatal variables. Psychosexual development is influenced by multiple factors such as exposure to androgens, sex chromosome genes, social circumstances and family dynamics.[18]

b) G*ender variance in school-aged children and adolescents*

For a short time during their years of early development many children evidence 'cross-gender' or 'gender-variant' behaviour – experimenting with play, dress or other behaviours more typical of the other gender – which usually passes naturally.[19] Researchers agree that cross-gender play in early

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[12] Organisation of Intersex International Australia (2013). DSM-V quotes natal adult males in the range 0.005-0.014%, and natal females 0.002-0.003%. A natal male transitioning to female is commonly abbreviated as MtF; a natal female transitioning to male as FtM.

[13] Moore (2013); Gooren (2011); Kruijver (2004); Meyer (2012)

[14] DSM-V.

[15] Barrett (2014); Bakker (2014); Veale (2011); Savic (2010).

[16] Worrell (2010). DSM-V: "current evidence is insufficient to label gender dysphoria without a disorder of sexual development as a form of intersexuality limited to the central nervous system."

[17] Savic (2010); Lombardo (2012); Kruijver (2004); Hines (2015); Bakker (2014); Worrell (2010). Against the trend, Bao (2010) claims that gender identity, sexual orientation and even paedophilia "are programmed into our brains during early development. There is no proof that postnatal social environment has any crucial effect on gender identity or sexual orientation." This view is comprehensively refuted by many including Öçal (2011), Kruijver (2004), and Bechard (2016).

[18] Öçal (2011).

[19] Meyer (2012); Spack (2011).

childhood is in no way predictive of gender dysphoria later in life, [20] and that "there is no test that can tell whether a child experiencing distress about their gender will grow up to be transgender."[21]

If a child persists in 'gender-variant' behaviour over a long time, they may sometimes try an experimental period of 'social role transitioning', defined as adoption of purely social characteristics of the other gender: dress, appearance, name and pronoun change, etc.[22] Note, however, that Endocrine Society guidelines still warn:

> Given the high rate of remission of [gender dysphoria] after the onset of puberty, we recommend against complete social role change and hormone treatment in pre-pubertal children with [gender dysphoria].[23]

Temporary or even longer-term cross-gender behaviour associated with normal childhood play need not progress to 'social role transitioning', and is not in itself sufficient to diagnose the child as 'gender dysphoric'. At this point parents may hold the key to effective resolution of their child's condition: whether they positively affirm cross-gender behaviour and so subtly encourage it, or adopt a more neutral 'wait and see' attitude can be critical.[24] One researcher found that "[p]arental encouragement of gender variance is more common among individuals who later develop a gender-variant identity."[25] Certainly parents should not too quickly conclude that their child's cross-gender behaviour is anything other than a relatively normal and passing phase of growth. A psychiatrist notes

> The more parents hear about childhood Gender Identity Disorder,[26] the more they question if their child may need to change gender. Many of the presentations in the public media concerning childhood GID give the impression that a child with cross-gender behaviour needs to change to the new gender or at least should be evaluated for such a change. Very little information in the public domain talks about the normality of gender questioning and gender role exploration and the rarity of actual change.[27]

Of all children referred to paediatric gender dysphoria clinics for treatment, around 85% find that their 'dysphoria' resolves before or during early adolescence without active treatment other than counselling for child and family.[28] One research group found persistence rates as low as 2%, and reports: "the results unequivocally showed that the gender dysphoria remitted after puberty in the

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[20] Meyer (2012); Steensma (2013).

[21] Boghani (2015).

[22] Steensma (2013).

[23] Hembree (2009).

[24] ACP (2017); Whitehall (2016). DSM-V notes that there is yet insufficient empirical evidence on this point.

[25] Veale (2010).

[26] 'Gender Identity Disorder' was the former designation of the phenomenon now known as 'gender dysphoria'. The change was made to 'de-stigmatize' the condition.

[27] Meyer (2012).

[28] Vickery (2015); Cohen-Kettenis (2008); Steensma (2013); Hewitt (2012). On this figure, of the 100-150 children referred annually to the clinic in Perth, one would expect only 10-15 to enter active treatment.

vast majority of children."[29] For this reason most experts warn against early medical intervention, particularly puberty-blockers or other hormone treatment, for 'gender dysphoria' in children.[30]

c) ***Diagnosis and treatment of gender dysphoria***

The key diagnostic feature for gender dysphoria is an experience of extreme, prolonged and deepening distress at felt incongruence between sex and gender.[31] Parental concern at their child's gender variant behaviour, even when sometimes accompanied by expressions of unhappiness, are insufficient to support a formal diagnosis.

Medical experts agree that a formal diagnosis one way or the other cannot be made without a thorough assessment by an experienced multidisciplinary team including psychology, psychiatry, endocrinology, paediatrics, and (as appropriate) gynaecology or andrology.[32] Only diagnoses made by such teams of experienced and recognised experts can be considered reliable – neither community gender clinics, nor individual general practitioners, have the expertise to make a formal diagnosis.[33] Of particular importance is the psychological assessment, because (i) gender dysphoria seems fundamentally to be a psychological condition, and (ii) research shows again and again that it is very often accompanied by, and sometimes confused with, other psychological conditions or 'comorbidities' of varying severity.[34]

Current clinical practice is that, upon formal diagnosis as 'gender dysphoric', an older child or young adolescent may commence a three-stage 'transition' pathway:

- Stage One: hormonal suppression of puberty to relieve the child's fears that their body is permanently taking on characteristics of the non-preferred gender (generally, development of more adult genitalia and body morphology). This could begin just prior to the onset of puberty so that permanent physical change can be held at bay while the child receives ongoing psychological support to help decide their future. This treatment is largely reversible on cessation (when the child's own hormones usually resume) although some longer term risks including effects on bone growth and density have been noted.[35]

- Stage Two: commencement of a life-long regime of cross-sex hormones to develop and sustain anatomical and other features characteristic of the preferred gender. Since this regime

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[29] Steensma (2010): "Feelings of gender dysphoria persisted into adolescence in only 39 out of 246 children (15.8%) who were investigated in a number of prospective follow-up studies". The range of persistence between the ten studies in question was 2% to 27%. DSM-V cites persistence rates for natal males as 2.2%-30%, and for natal females as 12%-50%, but offer no references for these figures.

[30] Cohen-Kettenis (2008); Kaltiala-Heino (2015); Hembree (2009); Spack (2011). Hembree (2009) explains this is because "a diagnosis of transsexualism in a pre-pubertal child cannot be made with certainty."

[31] DSM-V.

[32] Hewitt (2012). DSM-V lists criteria for diagnosis of gender dysphoria in children (302.6), and in adolescents and adults (302.85).

[33] In Australia, the few expert clinics are attached to major paediatric hospitals. In the United States of America, only recognised 'centres of excellence' can provide accurate diagnosis.

[34] Kaltiala-Heino (2015).

[35] American College of Pediatricians [ACP] (2016). Cohen-Kettenis (2008) offers a good analysis of arguments for and against delaying puberty.

produces irreversible changes in the patient (often including permanent sterility),[36] and carries other both known and unknown long-term risks, [37] it usually requires the child to have attained 16 years, the age of legal competence to consent to any medical treatment.

- Stage Three: permanent reconstructive surgery to further bring the body into line with the individual's preferred gender. For both legal and medical reasons this step is not usually considered for anyone younger than mid-twenties.

Only Stages One and Two, and steps preceding them, are relevant to the focus of this paper.

d) *Comorbidities*

Gender dysphoria in both children and adults is very often accompanied by other psychological and even psychiatric comorbidities[38] which in many cases the accepted regimen of treatment does not resolve.[39]

> Clinically referred children with gender dysphoria show elevated levels of emotional and behavioural problems – most commonly, anxiety, disruptive and impulse-control, and depressive disorders. . . . Autism spectrum disorder is more prevalent in clinically referred children with gender dysphoria than in the general population. Clinically referred adolescents with gender dysphoria appear to have comorbid mental disorders, with anxiety and depressive disorders being the most common.[40]

One Finnish study found that 68% of 47 adolescents attending a gender dysphoria clinic over four years had previously been attending psychiatric services for reasons other than gender identity issues – rising to 75% upon admission. Of these, 64% had depression, 55% had anxiety disorders, 53% engaged in suicidal or self-harm behaviours; 13% had had psychotic episodes, 9% had conduct disorders, 26% were being treated for autism spectrum disorder and 11% had ADHD.[41] Taking the Finnish study cohort as a whole, the proportion of gender dysphoric children and adolescents who presented with accompanying psychopathologies was 96%.

One issue of particular interest in education is the incidence of bullying targeting gender dysphoric children. The Finnish study cites a general incidence of bullying across whole school populations as 10-15%. Of the 47 students in this study, 57% said they had been bullied – but the number who said the bullying was related to their gender issue was within the general range: only 7 individuals, or 15% of the cohort.[42] Of particular note to educators, the researchers found that social isolation was the single most significant predictor of gender identity confusion, although the meaning of this correlation is unclear.

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[36] ACP (2016), Hembree (2009).

[37] Boghani (2015); Hewitt (2012).

[38] Meybodi (2014); Bechard (2016);

[39] Gooren (2011); Moore (2013); Dhejne (2011); Spack (2012); Kaltiala-Heino (2015).

[40] DSM-V.

[41] Kaltiala-Heino (2015). See also DSM-V.

[42] Kaltiala-Heino (2015).

The same study found that in most of the young people assessed, "gender dysphoria presented in the context of wider identity confusion, severe psychopathology and considerable challenges in the adolescent development."[43] This suggests that in some cases presumed 'gender dysphoria' may in fact be a developmental disorder, or even an adjustment disorder (that is, difficulty adjusting psychologically to the physical reality of the natal body) – the term 'anatomic dysphoria' has been used.[44]

e) ***Long-term outcomes of treatment***

What seems clear in the research is that today's standard model of treatment for gender dysphoria (puberty suppression, cross-sex hormones, possibly surgery) has limited success and does not address the full range of needs of these young people in the long term. [45]

A Melbourne study of 17 young people deemed suitable for Stage Two (cross-gender hormone) treatment found that while behavioural problems and depression seem to improve in the early stage of treatment, there is evidence that "anxiety, anger and gender dysphoria remain unchanged".[46] Furthermore, the "long-term psychological and health outcomes of cross-sex hormone treatment are unknown, as is the rate of 'regret' with reversal of gender identity." [47] An American paediatrician agrees: "The bottom line is we don't really know how sex hormones impact any adolescent's brain development." [48]

A related concern for young people is the prospect of having to take cross-sex hormones for the rest of their lives:

> While transgender adults have taken hormones sometimes for years, the generation growing up now is among the first to start taking hormones so young. Since most people who start taking hormones take them for life, doctors say there also isn't enough research into the long-term impact of taking estrogen or testosterone for what could end up being 50 to 70 years.[49]

While several studies suggest positive outcomes after gender reassignment procedures in the first year or two after treatment,[50] a much longer term study in Sweden following 324 sex-reassigned persons matched to controls across 30 years found "substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalisations in sex-reassigned transsexual individuals compared to a healthy control population."[51] It found that

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[43] Kaltiala-Heino (2015).

[44] DSM-V.

[45] DSM-V: "Adolescents and adults with gender dysphoria before gender reassignment are at increased risk for suicidal ideation, suicide attempts, and suicides. After gender reassignment, adjustment may vary, and suicide risk may persist."

[46] Hewitt (2012).

[47] Hewitt (2012).

[48] Boghani (2015).

[49] Boghani (2015).

[50] de Vries (2014); Johansson (2009).

[51] Dhejne (2011).

transsexual individuals had been hospitalised for psychiatric comorbidities other than gender dysphoria about four times more than controls, and overall had a three times higher risk of mortality, including a 19 times higher risk of death by suicide.[52]

As one researcher states:

> Although several studies have shown amelioration of gender dysphoria and improvements in social and sexual functioning in transsexuals who have undergone sex reassignment, none have conclusively demonstrated that medical interventions resolve gender dysphoria.[53]

f) ***Discussion***

Research indicates that gender dysphoria is a psychological rather than a physiological condition; that individuals reporting gender dysphoria very often have a range of other serious psychological issues; and that the accepted three-step treatment regime has not yet been proved successful in the long-term. These findings cast serious doubt on many claims made about gender dysphoria in children and adolescents, and should sound alarm bells for schools asked to provide special care and conditions when a student is presented as 'gender dysphoric'.

But while the data of sound research raise many serious questions about the nature and treatment of gender dysphoria, they do not dissolve the problem. It seems clear that in a very small number of cases – perhaps 1 in 10,000 of the general population – gender dysphoria is a very real and clinically serious condition that threatens a young person's growth toward mental and psychological health and wholeness.

It is incontestable that psychological disorders are real.[54] They can be persistent, vary in severity, and prove extremely difficult to manage. Successful treatment (defined as restoring the sufferer to a relatively 'normal' range of functioning) can be frustrated by unique factors and circumstances that prevent an individual from ever achieving a 'conventional' way of life. In some instances of gender dysphoria in adults, especially in the absence of more practicable alternatives, interventions which include "supporting a non-conventional manner of life" may be a reasonable option. So one Catholic authority wonders whether Stage Three (surgical) treatment might be ethically defensible for an adult if it is "deemed to be an effective means of freeing the patient from an intolerable psychological conflict and obtaining peace of mind."[55]

However, in the case of children a number of factors confound this very nuanced approach.

First, it is difficult to predict a child's "psychosexual outcome" over time: of those who are assessed as requiring referral to gender dysphoria clinics for treatment, the overwhelming majority (around 85%) find that their experience of gender variance or dysphoria resolves more or less naturally with

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[52] Dhejne (2011).

[53] Gooren (2011).

[54] For the observations in this paragraph I am indebted to Prof David Albert Jones, Director of the Anscombe Centre in Oxford, England (in personal communication).

[55] Navarette (2014). At the same time, because resolving juridical and moral issues requires a high degree of objective certainty, he holds unequivocally that, "the interior perception that someone has of his own sex is not and cannot be a criterion [for legal resolution], since this is something subjective that is imperceptible to the senses". (108)

appropriate psychosocial support (ie psychological and/or psychiatric counselling) – that is, without hormonal or surgical intervention of any kind.[56]

Second, many health professionals believe that even purely social (ie non-hormonal) transitioning in the home environment can create problems if it is attempted at too early an age.[57] One research team suggests that those whose later adolescent experiences naturally alleviate their feelings of gender dysphoria risk 'double jeopardy' if, after resolution, they subsequently wish to 'transition back' to their natal gender:

> It is conceivable that the drawbacks of having to wait until early adolescence [to transition] (but with support in coping with the gender variance until that phase) may be less serious than having to make a social transition twice.[58]

Therefore, in respect of even purely social transitioning in childhood, some professionals recommend that

> parents may want to present this [purely social] role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (eg only when on vacation). It is also important that parents explicitly let the child know that there is a way back.[59]

Others are less sure about the wisdom of even purely social transitioning at a young age. They believe that in too many cases social transitioning is proposed and accepted far too willingly, and becomes a kind of 'self-fulfilling prophecy': encouraged by his/her parents to experiment with gender variant roles, the child comes to believe that this is his/her true identity – when in fact it may not be so. And the risk compounds with the possibility of future 'unnecessary medical interventions', all in the absence of any real clarity about the long-term consequences for the child.[60]

At this point it is important to emphasise that all experts agree: any form of treatment of gender dysphoria, if it is to be successful, must be accompanied by sustained psychosocial counselling and other psychological support, as discussed further below. Medical treatments alone (hormone therapy, surgery) do not directly address the central characteristic of gender dysphoria – namely, psychological distress – and so are very unlikely to succeed in isolation.

Third: while it is true that "[n]either puberty suppression nor allowing puberty to occur is a neutral act",[61] research shows that personal experiences during puberty and early adolescence (roughly the age range 10-13 years) are critical in settling (or not) the individual's gender variance or dysphoria.[62] Curiously, the same three factors emerge as critical in either relieving or exacerbating gender

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[56] Steensma (2010), (2011).

[57] WPATH (2011), noting that this is a question on which "divergent views are held by health professionals".

[58] Steensma (2011). WPATH relies heavily on Steensma (2010) on this point.

[59] WPATH (2011).

[60] Shaban (2017); Heyer (2017b). Shaban cites doctors who believe some members of their own profession are among those too willing to accept claims of gender dysphoria on insufficient empirical evidence.

[61] WPATH (2011).

[62] Steensma (2010).

dysphoria: (i) changes in the child's social environment (eg new personal interests and friendships) as they 'grow into' their natal sex; (ii) physical changes occurring during puberty (actual or anticipated feminisation or maculinisation of their bodies); and (iii) the first experience of falling in love and of sexual attraction. These moments seem to play critical roles in either weakening the cross-gender identification of those whose variance or dysphoria resolves over time (the 'desisters'), or strengthening the cross-gender identification of those who eventually progress to Stage Two treatment (the 'persisters').

The significance of these three developmental experiences – each of which depends on the child experiencing puberty to some degree – may explain researchers' reluctance to recommend medical intervention at too early an age: puberty suppression is very likely to skew the child's experience of the first and third factors, and of its nature will totally disrupt the second. To deprive the adolescent of these developmental experiences could be to deprive them of key elements in the natural resolution of their condition.

Nevertheless an alternative view – that puberty blockers 'buy time' for the child to explore their 'preferred gender' without the trauma of dealing with physical changes in their natal gender – persists in the literature. On one hand this seems to create a dilemma: whether to block puberty in the interests of temporary relief from dysphoria, even though that will prevent natural resolution of the dysphoria in some cases; or, while providing the child with as much psychosocial support as possible, to allow puberty to unfold in the hope of natural resolution. While some clinicians favour the former approach, there is good research evidence that the latter option may be preferable in at least some cases.[63] The difficulty, as noted, is that most researchers agree there are no clinical markers to indicate in advance which patients will derive most benefit from which option.[64]

However the child's own report of their experience may provide some clues. One project uncovered a possible distinction between persisters and desisters as young as 6 or 7 years of age:

> Although both persisters and desisters reported cross-gender identification, their underlying motives appeared to be different. The persisters explicitly indicated they felt they *were* the other sex, the desisters indicated that they identified as a girlish boy or a boyish girl who only wished they were the other sex.[65]

Warning that such differences could be the result of 'biased recall', this research nevertheless offers a tantalising possibility:

> The persisters attributed their gender dysphoria primarily to the discrepancy between their body and their gender identity and a true longing for having a different body. The desisters, however, indicated that their desire to have the body of the other sex (if present at all) or the desire to be the other sex was more related to the opportunity to fulfil the preferred gender roles, than to a true aversion against their bodies per se. These accounts imply that

[63] Steensma (2010).

[64] Meyer (2012); Steensma (2013); Boghani 92015); Vickery (2015); Cohen-Kettenis (2008).

[65] Steensma (2010); emphasis original. Interestingly, both those who believe they *are* the other gender, and those who *wish they were* the other gender, qualify as gender dysphoric in DSM-V. The research in question may have uncovered a clinically significant distinction.

> the presence of body discomfort may contribute significantly to persistence or desistence of childhood gender dysphoria.[66]

So it may be that the dilemma in question is only either apparent or temporary: while it seems insoluble at the moment, it is possible that further research along these lines may provide a way to distinguish in advance those who would benefit from puberty blockers on one hand from, on the other hand, those for whom puberty blockers are likely to cause more harm than good. In the absence of this evidence, however, it would seem wise to proceed with extreme caution: until the child or adolescent's experience of distress elevates to become genuinely pathological, when the administering of these hormones may be truly medically indicated, it may be more prudent to allow puberty to begin and proceed for some time – that is, to withhold puberty blockers altogether.

Finally, and in any event, those with experience in treating gender dysphoria insist that "[b]efore any physical interventions are considered for adolescents, extensive exploration of psychological, family and social issues should be undertaken", the depth and duration of which "may vary considerably depending on the complexity of the situation."[67]

> Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psycho-diagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioural problems are relatively common, and unresolved issues in a child's or adolescent's environment may be present.[68]

An effective care plan for the gender dysphoric student must therefore include care for his/her family as well. Clearly the school can play a central role in facilitating care of its student; a truly holistic approach will extend to addressing familial and other significant relationships as well, for which the school will probably need to collaborate with external agencies. Alert school authorities will naturally be wary of parents who seem to promote the gender dysphoria agenda aggressively, or who are unaware of research into the risks of early intervention. They will also beware of parents and others who assume that the problem lies with the student alone. While it may initially be uncomfortable for the parents and other family members, some exploration of the student's family and social functioning would seem an obvious step in helping all parties achieve mutual understanding and collaboration in providing care.

Perhaps the least that can be said is that many very serious questions around gender dysphoria and its treatment remain unanswered. It may be 20 years or more until some of these questions can be resolved, as the current 'bubble' in referrals to paediatric clinics works its way through the medical system and researchers using prospective case-controlled methods can assess more definitively the real effectiveness or otherwise of today's treatment regimes.[69] In any event, we of course need to

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[66] Steensma (2010). This 'body discomfort' seems to correspond to the 'anatomic dysphoria' noted in DSM-V, and above.

[67] WPATH (2011).

[68] WPATH (2011).

[69] Heyer (2017b) references such research underway at present.

remain open to whatever truths are eventually uncovered by future objective research, and allow ourselves to be led forward by these truths.

In the meantime, however, educators require practical guidance on appropriate care for students who present as gender dysphoric. Given the extreme vulnerability of these children and their families, and the possibly irreparable harm that can be done to both by inappropriate medical interventions, educators must tread very carefully. In my view it would be prudent to follow the lead of medical professionals in this case: when faced with any uncertainty in diagnosis, the best medical professionals opt for more conservative rather than more interventionist treatments.

g) ***Recommendations for schools***

The following suggestions should be read in conjunction with further recommendations in Part 3 below.

- The school should not consider a student to be gender dysphoric if parents cannot provide a formal diagnosis from a recognised specialist clinic. If parents have not already obtained a formal diagnosis, they should be required to obtain one before taking the conversation further. Without such a diagnosis it is impossible for the school to know exactly what their duty of care might require.

- As with other children in special circumstances, the school may benefit from external expert advice on day-to-day management of a gender dysphoric student, especially as the student gradually either desists or persists over time. It may be for the education office to identify an external consultant with relevant experience.

- Because they can prevent rather than facilitate resolution of the condition, puberty blockers should not be prescribed or administered to children or early adolescents unless their psychological distress has progressed to become truly pathological, when use of these medications may be medically indicated.

- Even if a student has an initial formal diagnosis, current practice requires a further medical assessment and diagnosis before they can access Stage Two treatment (cross-sex hormones). Because these produce irreversible effects, the young person is required to provide formal consent or assent to such treatment, usually in line with a court order made for this purpose. Schools should not agree to support cross-sex hormone treatment of a student without external legal advice on their own exposure to potential present and future risk. They may also wish to consider formal agreements or 'contracts' with parents covering legal and ethical elements relevant to each case.

Part 2 Catholic Schools

As diocesan education systems and individual schools grapple with these issues, some have begun developing frameworks or protocols to guide school principals and other authorities toward best practice in pastoral care for gender dysphoric students. Appropriate guidance will be built not only on accurate knowledge of gender dysphoria but also on a profound and committed grasp on the world-view proposed by the Christian tradition, beginning with its rich and holistic vision of the human person.[70] Behind all of this lies the mission of the Catholic school – and indeed, the mission of the Church.

a) ***Schools share the mission of the Church***

The Catholic Church has reflected regularly on the nature and mission of Catholic education in a series of documents from the Sacred Congregation for Catholic Education which now runs back over 40 years.[71] These firmly ground the mission of a Catholic school, as "a privileged means of promoting the formation of the whole person",[72] within the mission of the universal Church. In a sense, to paraphrase one missiologist, "The school does not have a mission: the mission has a school."[73]

Most fundamentally the mission of the Church is an extension of the mission of Jesus, who came 'that they may have life, and have it to the full' (John 10:10). In Jesus' own time, as today, there were many people who for one reason or another experienced diminishment, marginalization, or alienation in life: the poor who were financially unable to participate fully in society because they lacked the necessary resources; those whom the self-righteous despised because they were perceived to be less than virtuous – tax collectors, prostitutes, and the like; the sick, who suffered doubly from physical incapacity and social isolation; those who held different beliefs, came from other countries, or who otherwise were 'outsiders'. Sometimes one's diminishment is a result of poor life choices; sometimes it is a function of unjust social practices or policies; sometimes it is an accident of birth; and sometimes it is imposed by the selfishness of others, or by one's illness, advanced age, or other circumstances. No matter how each person's diminishment comes about, the Gospels reveal that Jesus' ministry consists in healing and restoring them to wholeness, the fullness of life, which God intends every human being to enjoy.

It is easy to see how a young person's feelings of distress about their experienced gender might adversely impact many aspects of their life, including their hope of finding happiness and fulfilment in close personal relationships. To that extent, this young person suffers diminishment and stands in need of 'the fullness of life' that the school can offer. Indeed, their very youth and inexperience position *all* young people as vulnerable and in need of help to grow into wholeness. This is precisely the work of the school. As 'formation of the whole person' the Catholic school's project is meant not only to touch the students' intellectual and spiritual life, but impact their physical, social, emotional and psychological well-being too. The aim is to develop in each student a capacity and desire for ongoing growth toward wholeness.

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[70] Second Vatican Council, *Pastoral Constitution 'Gaudium et spes' On the Church in the Modern World* (7 December 1965) 12-18.

[71] There is a chronological list of these documents in the References at the end of this paper.

[72] SCCE (1977), 8.

[73] Originally: "The church does not have a mission: the mission has a church". Attributed to Stephen Bevans SVD and Roger Schroeder SVD in their *Prophetic Dialogue: Reflections on Christian Mission Today.* Maryknoll: Orbis Books 2011.

b) ***Sex and Gender in the Catholic World-View***

Because they share in the mission of the Church and belong very much at the heart of that mission today, Catholic schools are not value-free zones. They share the Catholic world-view, which forms both a lens through which they see the world, and a source of truth and life which it is their mission to offer students. The Catholic school's approach to pastoral care, and the wisdom that informs that care, must reflect the understandings of the Catholic tradition.

A great deal has been written and taught in the Catholic world about sex and gender, especially during the pontificate of St John Paul II. Prior to and since that era, the Catholic Church has questioned contemporary use of the word 'gender' as though it were completely independent of sex.[74] At risk is a rational understanding of what it means to be a human being at all. It is not possible here to assess the arguments on both sides, nor even to offer a comprehensive summary of the Catholic view. Rather we will briefly attempt to sketch the outlines of that view, indicating where the current rhetoric around gender departs from the view held for centuries both within and without the Christian tradition.

In that view, humankind has naturally evolved as binary in structure: male and female are normative and complementary modes of human existence in the world.[75] This is true in many aspects of life: biologically, emotionally, psychologically and even spiritually, male and female are different but complementary. And it is our common experience that human beings flourish best when we establish and sustain complementary relationships. None of us was created as a wholly autonomous being, each radically independent of all others:

> . . . the human being . . . is not a 'monad', an isolated being who lives only for himself and must have life for himself alone. On the contrary, we live with others, we were created together with others and only in being with others, in giving ourselves to others, do we find life.[76]

This 'being with others' and 'giving ourselves to others' is inclusive of our sexuality, which encompasses all the male and female ways we exist in creation.[77] Human beings, both as individuals and as societies, naturally seek happiness and fulfilment in and through our human relationships. Stable, committed relationships offer security both personally and socially, for ourselves and for our children. When a committed relationship is between a male and a female who also share the gift of fertility, it emerges as the natural human way – in terms of both process and structure – that the next generation is not only created but also sustained and nurtured through to maturity. So typically, both personal happiness and the generative cycle of human social life depend on our binary sexual complementarity. This is the usual way our personal and social need for security is met and our

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[74] For summary and analysis, see Allen (2014).

[75] For an excellent summary, see Tobin (2016).

[76] Pope Benedict XVI, *Homily in Rome's 'Casal del Marmo' Juvenile Prison*. 18 March 2007.

[77] Recognising that it completely omits essential elements such as complementarity, relationship and commitment, we can nevertheless view 'sexuality' in terms used by the Australian curriculum: "*A central aspect of being human throughout life. Sexuality encompasses sex, gender identities and roles, sexual orientation, pleasure, intimacy and reproduction, and is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.*"

human story continued. Catholic schools are privileged to play an important part in forming young lives to enter this cycle.

To this scant account of our natural law tradition, three comments should be added immediately.

a) This world-view expresses the Catholic Church's commitment to serve the genuine good not only of its own constituents but also of the societies and cultures in which it is embedded. Christian concern about sex, gender and family life is not primarily about promoting a sectarian view of the world. It is, rather, grounded in anthropological observation: these understandings and relationships were not created by any religion, for they vastly predate all religions. If anything, they are structures that evolved naturally with human beings themselves, proving their value through many generations. In proposing this view the Church seeks to preserve the conditions which have proved to be most apt to ensure the survival and flourishing of entire societies and cultures, and the happiness and fulfilment of members of those societies. Just as Jesus came to bring the fullness of life to all people, so the Church has long recognised its vocation 'in the world and for the world'.[78]

b) The fact that some individuals and couples do not experience relationships, sexuality or gender as sources of happiness and fulfilment but rather as causes of distress, grief and pain does not invalidate the vision proposed by the Christian tradition. Relationship failure and the personal and social harms that accompany it are always tragic. They call forth care, compassion and healing. In religious terms, they remind us that we all need the grace of God. The Catholic view of the integrity of human sexuality and gender embraces both universal (whole human race) and particular (individual human beings) perspectives, which the sad experiences of some do not invalidate.

c) At the same time, while human evolutionary history proves that our sexual structure is binary – male and female – this does not mean that natural variations within that structure are impossible.[79] Quite apart from medically-defined intersex conditions, it is obvious that there is a spectrum of ways of 'being male' and 'being female' within our culture: thus some males (while remaining certainly male) seem to exhibit some traits more commonly associated with females, and vice versa. If natural variations in male and female sexuality are relatively common and pose no threat to the fundamentally binary structure of humanity, is it possible that individual instances of discontinuity between sex and gender may fall within the same natural spectrum of human sexuality, albeit extremely rarely and always as variations from the norm? Any physiological basis of this hypothesis, as noted earlier, remains unproven to date but may eventually yield – one way or the other – to long-term prospective research. In the meantime it would seem unwise to discount this possibility prematurely: I do not believe the Catholic view of the integrity of human sexuality would necessarily be threatened by this possibility.

[78] See for example the Second Vatican Council's *Pastoral Constitution Gaudium et spes. On the Church in the Modern World.*

[79] I am indebted to Rev Charles Bouchard OP (in personal communication) for observations in this paragraph.

So what do these considerations contribute to our understanding of gender dysphoria? Today's default position on gender dysphoria is sustained by a popular rhetoric built on three claims that merit close scrutiny. They are:

(i) Sex is separate from gender;

(ii) There are many genders;

(iii) In order to respect the gender dysphoric person, we must 'normalise' their experience of gender dysphoria.

To each of these claims the Christian tradition proposes alternative views.

(i) The human person is an integral whole, a single nature at once physical and spiritual.[80] Every non-corporeal aspect of a person exists and is reflected in and through the physical body. A person does not 'possess' a body: he or she IS their body. We natural speak of different aspects of the person in different ways – our tradition is very used to thinking about ourselves as 'body and soul', for example – but equally we are careful not to fall into an essentially dualist account of the person, which in history has always led to patterns of thinking and behaviour which are ultimately destructive of human dignity.[81]

The claim in popular rhetoric that 'sex' and 'gender' are not only distinct but so radically separate that the latter can be a matter of purely personal choice, simply is not sustained by either empirical research or wider human experience. It is undeniable that some individuals feel that their psychological sense of self does not match their physical experience of self, but this may be an expression of natural variance in their experience of sexuality with which the individual is struggling to deal. There are more rational explanations for this phenomenon than the popular rhetoric would admit; certainly the claims of that rhetoric are simply not supported by reliable research.

(ii) If the experience of gender is indeed a psychological correlate of one's sex and not a radically disconnected reality, and if human beings have evolved an essentially binary sexual structure, then in its natural sense gender is also essentially binary. The fact that some individuals (often accompanied by other psychological stressors) do not experience themselves this way does not invalidate the natural paradigm. There are more rational ways to explain their experience than proposing a multiplicity of genders.

(iii) True healing is never brought about by normalising the cause of suffering, but by seeking effective means to alleviate it.

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[80] *Catechism of the Catholic Church* 362-368, especially 365.

[81] One thinks, for example, of the destructive influence of Manicheism and Jansenism, both of which elevated the spiritual and played down the physical aspects of the human person – to the detriment of both individuals and societies.

Perhaps more profoundly than any other institution, the Christian tradition well understands the nature of human suffering, having provided health and humanitarian care to suffering people for almost all of its two millennia of history. The Church has learned that suffering occurs when a person realises there is "a good in which [they] do not share, from which in a certain sense [they are] cut off".[82] The 'good' may be physical health, or inclusion, or acceptance, or psychological or emotional peace; 'suffering' is experienced by those who, one way or another, become aware that they are lacking this 'good'.

In the case of gender dysphoria, the 'good' which is lacking is harmony between one's physical body and one's psychological sense of being male or female. To care for such a person means helping them to achieve the harmony they are missing. A caring person will not use ineffective means of helping – they will choose effective and life-giving means of helping, means which hold real promise of restoring health and wholeness to the one in need. Current research strongly suggests that, in the long term, this is not achieved by medical treatments that seek to alter one's physical body to match one's psychological sense of self, because gender dysphoria is not a physical but a psychological problem. Real care and respect for the person, care that truly honours not only the individual in need but also the structure of human life itself, will seek to bring psychological experience into harmony with physical reality, not vice versa. It will seek to treat the phenomenon in its cause, and not merely in its symptoms.

c) ***Providing Pastoral Care***

'Care' is a living expression of an attribute that belongs perfectly only to God, that '*hesed*' or 'loving-kindness' which Pope Francis refers to as 'mercy': the life-giving goodness and kindness characteristic of God, of Jesus, and therefore of the Church and the Catholic school. The evocative image of Jesus the Good Shepherd who offers 'the fullness of life' (John 10:10) is an incarnation ("making flesh") of divine loving-kindness.

Jesus always had something to offer those in need. He was never prepared to leave people as he found them, or to let them find their own way, but rather took pains to propose a more life-giving way and invite (and sometimes challenge) them to embrace a richer, fuller, more life-giving vision of themselves and of their future possibilities. His pastoral method has been described as "accompaniment – inclusion – restoration to wholeness",[83] which sets a pattern for all Christian pastoral care. It is the mission of Catholic schools, likewise, to invite and empower students to develop and strive after a fuller, more life-giving vision of themselves. They are called to accompany, include and encourage growth in all of their students. Therefore Catholic schools cannot approach the gender dysphoric child empty-handed or value-free: true respect for their human dignity requires a school to bring to bear the life-giving understandings and practices of its faith tradition, grounded in Jesus' own vision of the fullness of life, and aimed at encouraging each student's growth into wholeness as a person.

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[82] John Paul II, *Apostolic Letter Salvifici doloris, On the Christian meaning of human suffering*. 11 Feb 1984. 7.

[83] This formulation attributed to the Ministry Leadership Center, Roseville California.

What does the fullness of life look like to the gender dysphoric child or adolescent? What characteristics might it include? To answer these questions one would need to ***accompany*** the student first of all, to 'get inside' the feeling of dysphoria and explore the individual's expectations of their sex-gender experience. These are influenced by numerous factors such as personal and familial history, exposure to popular conceptions of sex and gender, and the influence of peers and of the media (including social media). The Catholic tradition recognises that the school is but one powerful factor shaping the life of the young person, whose growth will continue for many years under the influence of many other social and cultural factors.

School ***include*** when they build with their students relationships of care and trust. In the context of those relationships, pastoral care in the school setting will affirm those aspects of the gender dysphoric student's experience that favour openness to ongoing personal growth and stability, while gently challenging those which threaten to limit this possibility prematurely. In light of the empirical evidence about gender dysphoria, pastoral carers will not take the easy option of simply affirming the student's self-perceived condition. They will strive to establish a safe and trusting relationship with the student capable of sustaining a sensitive, mature and hope-filled exploration of future possibilities for growth. Finally, schools ***bring wholeness*** when they help students come to see their growth toward adulthood as an ongoing process with many questions and challenges, and help them grow in confidence that over time they will find the authentic self-knowledge and inner serenity they seek.

Bringing the content of the Catholic world-view together with this concept of the formative mission of the school, the following images might describe core characteristics of good pastoral care in Catholic schools.

- The Church's integral and holistic understanding of the human person, sexuality and gender may be thought of as an objective '***map'*** that provides guidance for all of us: it helps us grasp in general terms the promise of our sexuality, and it provides sound direction in moral decision-making. This understanding of the human person lies at the heart of moral teaching and pastoral care in the Catholic tradition.

- But as valuable as it is, the ***map is not the terrain***: [84] each individual, enriched by the Church's general teaching about sexuality, still needs to enter the unique personal ground of their own experience, life-situation and self-understanding. The unique 'terrain' of each individual student is shaped by multiple factors including genetic inheritance, family life, social and cultural situation, and their opportunities for education and personal growth. Sexuality and gender are part of that terrain: the way an individual identifies him- or herself as a gendered person at any point in time, and the way this influences their self-confidence and capacity to form friendships and relationships, is unique to each individual.

- And the ***terrain is not the journey***: individual students, with their own capacity for learning and integrating the experiences of life, are each on their own inner journeys subject to the law of

[84] This saying is attributed to Alfred Korzybski (1879-1950).

growth and 'gradualness' famously articulated by Pope St John Paul II.[85] The experienced teacher or pastoral carer will listen to the journey-story of each individual because it alone reveals the *meaning* of their experience in the context of their growth toward wholeness. In that story the teacher or pastoral carer can identify seeds of hope, positive elements they can help the student to appreciate and nurture, acknowledging that the turmoil they presently experience is not the end of their journey but a necessary and probably transitory stage along the way.

- Because sex and gender are so intimately tied up with personal identity, which is an ever-unfolding reality, the ***journey*** of growth is also in some senses the ***destination.*** In many respects our whole life's journey is one of unending self-discovery, a constant invitation to keep on growing toward the fullness of life. No-one's experience of being male or female is unequivocally good or bad, but a blend of both which constantly shifts and reshapes us as our lives move through stages of ageing, evolving relationships and growing wisdom. The Christian tradition acknowledges the value of the journey – the Road to Emmaus is the archetype (Luke 24:13-35). One gift we can offer every student is confidence that they never journey alone.

Ultimately the way the school chooses to respond to the challenge of transgenderism will say as much about the school as it says about the student. It is in the compassionate way we respond, as much as in the content of that response, that we convey Christ's offer to this student of 'the fullness of life'. In the way we approach pastoral care for gender questioning students, we can reflect the image of Christ or deflect it. The choice is ours.

d) *In summary*

The data of objective research strongly suggests that for the vast majority of children and adolescents, gender dysphoria is a psychological condition through which they will pass safely and naturally without active treatment other than psychological support. If this is so, then it would be quite inappropriate for a school to affirm unquestioningly a student's sense of dysphoria, which would be to risk locking the student into a belief that, in the majority of cases, will simply not be true.

A more responsible approach will be built on sound knowledge of the developmental processes inherent in youth, on genuine respect for the profound mystery that each student represents, and on a robust and holistic concept of the human person. Rather than passively acquiesce to the popular rhetoric, the school will bring its professional educational wisdom to the richness of the Christian vision of the human person, offering the student and his or her family a more grounded and hope-filled alternative. Where genuine medical needs exist and are supported by a certain diagnosis, the role of the school working within its Christian vision of life is to act in the best interests of the student and to support the parents' efforts to do likewise.

The final section of this paper explores some practical aspects of an approach which seeks to be professional and compassionate, authentically Christian, and genuinely respectful of the student's human dignity.

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[85] Pope St John Paul II (1981), *Apostolic Exhortation 'Familiaris consortio' on The Role of the Christian Family in the Modern World*. (22 November 1981), 34.

Part 3 Structuring Pastoral Care

Dioceses, diocesan education offices and individual Catholic schools required to provide appropriate care for gender dysphoric children and adolescents face a daunting series of challenges. While gender dysphoria certainly presents as a psychological disorder, there is enough uncertainty around its etiology and treatment in general, and enough complexity in particular cases, to make each instance quite unique. The particular circumstances of each affected student and the needs of individual families, along with the need to protect the family's privacy and confidentiality, demand constant individualised attention from school authorities and others. So it is prudent to establish protocols and processes for managing these situations, and several dioceses and diocesan education offices have made good progress in this regard.[86]

This paper so far has focused on two building blocks of an appropriate response to the needs of gender dysphoric students: (i) what sound research tells us about gender dysphoria (recognising that there is much that we still don't know about it); and (ii) a cognitive faith-based context which both motivates and informs an adequate pastoral response in Catholic schools. As we move now to describe some processes and other practical considerations, it may be useful to capture these learnings in two 'general principles':

1. Until sound research provides a better understanding of the true nature of and best treatment options for gender dysphoria in children and adolescents, Catholic schools should exercise extreme caution and prudence in establishing how best to respond to each student's need. Those providing pastoral care in Catholic schools will not automatically simply affirm the student's self-perceived condition; rather, building on an authentically Christian vision of the human person, they will strive to establish a safe and trusting relationship with the student capable of sustaining a sensitive, mature and hope-filled exploration of all future possibilities for growth.

2. Informed by the Catholic tradition around sexuality and relationships, the school is always committed to act in the best interests of the student and of their family. This begins with creating a whole-of-school culture that reflects the Catholic tradition which, while we hold it confidently, must include acknowledging the uncertainties inherent in our empirical knowledge base and in the students' dynamic of growth into wisdom and maturity known as the 'law of graduality'. But when a certain medical diagnosis has been obtained and the student's parents have committed to be guided by it, the school must endeavour to assist wherever possible, within the constraints imposed by the best interests of the particular student and the needs of the whole school community.

Those directly involved in managing gender dysphoric students in schools will no doubt develop more complete and integrated guidance as time goes by, but meanwhile it may be useful to consider the following suggestions.

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[86] In this section I acknowledge with gratitude the generous advice provided by several Catholic education offices who have shared their work with me, in particular Perth, Wollongong and Maitland-Newcastle.

a) ***General Principles***

The way a school responds to gender dysphoric students must be informed and guided by the mission of Jesus, who came 'that they may have life, and have it to the full'. Therefore the school has a serious **duty of care** for each of its students, which it interprets in light of Jesus' own ministry. In all circumstances the school will endeavour to ensure that all parties act **truthfully**, **charitably**, with **good will**, and with absolute **respect for the human dignity** of all parties.

Given conflicting research data around the nature of gender dysphoria and substantial concerns around its treatment, parents and schools alike need to be committed to seek and to be **guided by the truth** even if they find that very challenging. In the Christian metaphysical tradition, truth, goodness, beauty and unity are interchangeable and all are expressions of the divine. Those who seek to do what is truly good will sincerely wish to discover the truth, and to let that guide their subsequent decisions and actions. They will try always to act with love and respect for others, even when they disagree with them. Guided by the truth, they will strive to build and maintain peace and unity among all parties.

Collaboration in the best interests of the student will certainly demand **good will** from all participants. School authorities should make it a priority to establish and maintain mutual trust and good will with the parents: if parents are able to understand the challenges a school faces in caring for a gender dysphoric child, and if schools can understand the parents' challenges, and if all parties are intent on finding a way forward in the best interests of the child, then almost anything is possible.

In a given instance the school might consider entering a formal **contractual arrangement** with parents aimed at maintaining good will in challenging times and providing clarity for the future should the student's or family's circumstances change. The partnership between school and family can be thought of as a **'community of care'** for the student, into which it may be appropriate from time to time to invite others who can contribute effectively. In the interests of continuity it will be particularly important that older gender dysphoric students are connected into wider health and social networks of care as they prepare to leave school.

Managing gender dysphoria will always be a difficult journey for parents and students, so it is essential that their **privacy and confidentiality** are strictly protected by the school. From the very beginning of any process, and regardless of the direction it eventually may take, schools must protect and control the flow of information so that confidentiality is assured.

Of course, diocesan authorities as well as school administrations are charged with looking after the best interests not only of individual students with particular needs, but **whole school communities**. As with any other student requiring specific care, the school principal must constantly weigh the balance between the needs of the individual and the needs of the whole community. Often these can be accommodated well, but sometimes it may be necessary to prioritise one over the other. It is usually the school principal, taking advice from other relevant authorities, who will make this determination in any given case.

b) ***Remote preparation***

Managing a gender dysphoric student is evidently very complex, with many 'moving parts' to the puzzle. The most appropriate structures and processes, accordingly, take time to establish and bed down. Every school, diocese and diocesan education office needs to recognise the importance of

'remote preparation', which aims to establish core understandings and structures that can be employed quickly and efficiently when required.

i) Diocese

The diocesan bishop, as leader of the Catholic community which includes the school, may wish to be consulted in each instance of gender dysphoria as it unfolds; or he may prefer to delegate management to school and education authorities, being consulted or kept informed only as circumstances require. It is important that the **bishop's preferences** are known and taken into consideration as the education authority prepares its management processes.

However, if overall management is to be led by education authorities, it is important to clarify the basis on which a bishop might wish to influence outcomes. It may be more advisable, for example, for the bishop not to participate directly in managing cases but to receive regular updates from the education authority. This will be for each bishop to discern, but a case can be made for the bishop to remain at least two or three steps removed from decision-making and management in particular instances: one role the bishop alone can play is the '**final arbiter**' or 'court of appeal' should there be significant disagreement between parents and school authorities. It is arguable that a bishop can only make genuinely impartial judgements if he has not been part of the process up to that point.

In any event, education authorities should strive for **a 'no surprises' policy**: if it is possible that the bishop may receive a direct inquiry (especially a media inquiry) about a gender dysphoric student, then he should be fully informed as early as possible, and helped to develop consistent messaging before the inquiry arrives.

The bishop will always play a leading role in preparing his **clergy and other diocesan staff** to understand and respond appropriately to the needs of gender dysphoric Catholics. In this sense the whole diocese can be thought of as a 'community of care' which must be formed intentionally and motivated by the demands of the Gospel. Some clergy or staff may require more personalised preparation to play their part in the pastoral care offered by the diocese.

Importantly, it is widely recognised in the Catholic tradition that the diocesan bishop must be consulted, and has the final responsibility for decision-making, when there is a risk of **scandal** to the local church.[87]

ii) Education Office

All education offices should consider establishing formal **policies and/or procedures** to guide schools and school authorities toward just and reasonable outcomes for students, parents and schools. Effective procedures will bring together and leverage the wisdom of all parties who have a legitimate interest in achieving optimal outcomes, including diocesan authorities, education office staff, school and parish leadership, medical experts and parents. While pastoral care remains a central focus, these procedures should also consider legal, ethical and educational elements of each individual case. They can, for example, create template 'contracts' between parents and schools, to encourage

[87] Catholic Health Australia (2001). *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*. Canberra: CHA 2001. See n. 8.16. Scandal here has the technical meaning of 'an action potentially leading the faithful into error', in which sense it is far removed from merely prompting a malicious reaction from others ('pharisaic scandal'). See Davis (1959).

both parties toward ongoing cooperation and collaboration in the best interests of the individual student, the whole of the student body and school community, and educational authorities.

Education offices can also play a role in encouraging all schools to put in place '**preventative measures**' aimed at reducing the stress levels experienced by gender variant and gender dysphoric students and their families.[88] One major stressor in both primary and secondary schools is the issue of **school uniform**: where a school offers only male-specific and female-specific uniform options, a gender dysphoric student and his/her family may experience significant psychological stress in managing even temporary social transition successfully. Schools could be encouraged to create or extend a 'non-gender-specific' uniform option open to all students, which may help to reduce these stressors. Likewise the practical issue of **toileting and showering** after sports can be hostage to gender-specific options only. Following the lead of many public buildings today, education offices could encourage all schools to create a small number of 'unisex' toilet/shower rooms accessible to all students.

Diocesan education authorities can greatly support the mission of Catholic schools by ensuring that expert advice is available to schools and others whenever it is required. For example, an education office may consider creating an **expert advisory role** within its own structure, as an accessible source of guidance and information for schools. This may be an employee who has been well prepared for the role, and who can be tasked with overseeing and coordinating local management of gender dysphoric students. They could become a 'first port of call' for schools seeking advice at any time.

As noted above (Part 1 g), it may be be advisable for a diocese or province of dioceses to have access to an **independent medical expert** who can provide external professional advice to support schools caring for students with gender dysphoria. Schools and education authorities need a high degree of certainty about any student's medical facts if they are to exercise their duty of care responsibly, and already routinely access independent expert advice on day-to-day management of other students with particular needs such as autism or ADHD. Parents seeking to secure the best possible care for their child may agree to release their child's medical record to an independent authority such as a suitably experienced paediatric psychiatrist, psychologist or general paediatrician who could provide independent expert advice to the school.

Perhaps the most important role for a diocesan education office, however, might be to ensure that all school staff receive timely and appropriate **in-service education** around (i) the mission of the Catholic school, and (ii) sex and gender, in the wider context of the Church's vision of marriage, relationships and sexuality. These are both the context and bedrock of a whole-of-school response if it is truly to meet the needs of students and remain creatively faithful to the tradition of the Catholic community. If appropriate care of gender dysphoric students rests on whole school communities offering a credible account of the Catholic vision, then teachers and other school staff have a right to expect targeted formation in this area. Education offices have a central role to play in sourcing or developing opportunities for this formation, and for ensuring that schools receive it in a timely manner.

iii) <u>Catholic School</u>

[88] I am indebted to Rev Paul Russell, a school psychologist in the Archdiocese of Perth, for some of the suggestions in this section.

Preparation in the school can also be considered under 'remote' and 'proximate' rubrics, describing (a) work the school can do to prepare in general and then, if a positive diagnosis of gender dysphoria is made, (b) work the school will need to do in the particular case. Remote preparation includes:

- **Leadership**: Good pastoral care calls for a whole-of-school response, and this has to be led actively by the principal. Ultimately it is the principal who is responsible to see that the school community (ie staff) receive whatever formation is needed for them to provide appropriate care for gender dysphoric students.

- **Delegation**: where a principal feels that he or she is not the most appropriate person to lead the school response, this responsibility should be formally delegated to another senior member of school staff. This delegated person must be given not only the responsibility but also the authority to lead the school in this task: he or she must be able to make commitments on behalf of the school as and when appropriate, and know that the principal will support their decision completely. This is necessary to engender hope and confidence in the student and his or her family.

- **Communication** between parents and school (and externally) should pass through only one channel – preferably the principal or senior leader delegated to manage the situation. All communication needs to be as open and transparent as possible, but confidentiality must also be protected carefully: all parties need to respect the privacy of the child and family, and not admit others unnecessarily to the circle of knowledge.

c) ***Proximate preparation in schools***

If independent medical advice confirms a diagnosis of gender dysphoria, then more **proximate preparation** is needed in the particular school. The school principal or delegate (with the support of the education office) will need to determine what level of care can reasonably be provided to this student at this time. Key questions include:

- Is the student under ongoing psychological care as part of his/her medical treatment? This should be a *sine qua non* if the school is to accept responsibility for supporting the parents' duty of care.
- Can the school provide on-site psychological support if required?
- What other needs might the student have that the school can reasonably meet?
- What needs would require considerable adjustment of current arrangements?
- Critically, can these needs be balanced with existing and likely immediate future needs of the whole school community?

The principal has a duty to provide care for the individual student but also for the whole school community. It will often be possible to accommodate the needs of an individual student in the wider structures and functioning of the school: practical issues such as special toileting and change-room arrangements can often be accommodated by imaginative use of existing facilities. However many schools may struggle to meet all of the needs indicated by the student's condition, or indeed the expectations of the student's parents. At some point the principal or delegated senior leader may have to prioritise the whole school over the individual student. This will need to be negotiated and communicated very carefully.

Students and their parents should never be discriminated against on the basis of the student's real or felt gender issues. However, in given circumstances it may be a legitimate exercise of the school's duty of care to recommend that another school may be better able to provide a more appropriate environment for the student's needs to be met. If this is the case, the principal or other responsible person should actively assist parents to make the change of school as seamless and stress-free as possible: parents and children, who are particularly vulnerable in such moments, must never be abandoned or left to fend for themselves.

If the principal does accept responsibility for making provision for this student in this school, the following should be considered carefully:

- **Staff formation** does not need to be exhaustive, but all staff need the opportunity to understand the dimensions of the challenge of caring for a gender dysphoric student. This is in addition to guidance teachers may need in how to address specific moral questions in terms of the Church's vision of sexuality, as noted above.

- **Preparation of the student's year cohort** is a priority, in particular in view of the student's emotional and psychological vulnerability. The year levels either side of the student's cohort may also need particular preparation, to reduce the risk of inappropriate interactions (eg bullying).

- To some extent **the whole student population** needs to be prepared as well. This can be done over time, and in the context of more general formation around tolerance, diversity and acceptance. It will inevitably raise more general questions around sexuality, which are always teachable moments.

- Conduct an **audit of school resources** in all teaching areas to ensure that appropriate language and concepts of sexuality are used consistently. This includes language used in all learning areas, but also extends to language used informally in the school, between students or between students and teachers. This may include defining some words or phrases as unacceptable.

- **Messaging**: Develop clear messages around sensitive pastoral issues. These may take the form of 'scripts' to be used by teachers with inquiring parents or others who have some right to be informed but who are not within the defined circle of knowledge. Everyone within the circle of

knowledge should be provided with these pre-prepared texts and encouraged to use them at all times.

- Open and transparent communication with **the wider community of parents** is critical, within the bounds of confidentiality noted already.

Those directly engaged in decision-making and managing gender dysphoric students will have much to contribute to developing appropriate processes for dioceses, education offices and schools. Good processes will help them remain focused on seeking the truth and striving to act in the student's best interests; they will help engender a degree of confidence that a complex situation can be managed successfully. But the best processes cannot substitute for a fundamental attitude of charity and respect, of care and compassion. In this matter, as in all associated with Catholic education, we can do no better than to extend into every moment of every day the healing love of Jesus, who came that we all might 'have life, and have it to the full'.

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