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Also in this issue: "Mainstream Media and Catholic Principles," by Tim Millea

Navigating Treatment of Gender Dysphoric Teens

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Accepted treatments for gender dysphoric teens raise serious ethical issues, including the inability of an adolescent to consent to treatments, the experimental nature of cross-sex hormone treatments, the long-term physical impairments to the human body, the limited scientific data available that determines this course of treatment, and questions about whether these treatments are a proportionate way to address gender dysphoria (GD) in the adolescent. Medical interventions involving cross-sex hormonal treatments that compromise the maturation of an adolescent are under scrutiny for several reasons and are an unethical approach to addressing adolescents who are questioning their biological gender.

Each adolescent experiences and presents differently with GD. The main symptom is significant distress over an ardent desire to be the opposite of their biological sex. The youth who experience this often have anxiety, depression, loneliness, difficulty in social situations, and a higher incidence of self-harming. Not only are the youth of today requesting hormone therapies, but it is the primary recommendation of health care professionals. The typical initial treatment for adolescents is to block puberty with a gonadotropin-releasing hormone that suppresses the release of sex hormones (testosterone and estrogen). For boys, this results in decreased facial and body hair, prevents vocal changes, and limits the growth of the penis. For young girls, puberty blockers stop the breasts from developing and prevent menstruation. Those who support giving puberty blockers to adolescents claim that it improves mental well-being, decreases anxiety and depression, improves social ability, and finally, reduces self-harming thoughts and actions. If chosen, around the age of sixteen this initial treatment would be followed by cross-sex hormone treatments with testosterone for the female to male transition and anti-androgen hormones to decrease testosterone as well as adding estrogen for the male to female transition. This latter treatment is considered a lifelong commitment.[1]

One of the ethical questions cross-sex hormone therapy raises is whether the adolescent has the capacity to understand all the implications of the treatments. The principle of free and informed consent is a foundational ethical requirement for the treatment of any individual, especially therapies that alter the human body. This means that the human subject should not feel undue pressure to have the treatments, have full knowledge and comprehension of the subject matter, be informed of all known treatment options, all possible side effects, and be fully evaluated on the individual's capacity to make life-altering decisions.[2] This principle is widely accepted and utilized by medical professionals throughout the world as a standard of ethical care.

The stages of brain development can be helpful in understanding an adolescent's capacity to make decisions. Catherine Hartley is the Assistant Professor of Psychology at New York University. Hartley and colleagues concluded that although adolescents learned well from direct experiences, reward systems, and context-dependent situations, they struggle with abstract goals, future outcomes, and cost-benefit calculations. An adolescent processes the relationship between the cost of a decision and the resulting value of the benefits with an under-developed lateral prefrontal cortex. Because the prefrontal cortex develops later, these complex, non-context oriented, life altering decisions on cross-sex hormone treatments prove to be too complex for them.[3] The ability to comprehend the permanent nature of cross-sex hormone therapy and its physical, psychological, and social side effects—which include but are not limited to: cardiovascular complications, weight gain, headaches, poor bone growth and density, future fertility issues, and psychological issues related to the delay of puberty in their peer groups—is imperative to true consent. Hartley and colleagues' research also suggested that adolescents are more influenced by what is exciting or dangerous than their own gained wisdom or knowledge about negative consequences. In other words, they take risks more often than an adult would. Adolescents do not typically have the developmental capacity to make a lifelong decision and some of the cross-sex hormone treatments cause permanent changes depending on how long the therapy is employed. With both things in mind, it would be reasonable to assume that an adolescent experiencing GD cannot freely consent with full knowledge to cross-sex hormonal treatments that will cause permanent physical and psychological changes.[4]

Along with the difficulty of full consent, the emotional struggle teens experience when they question their biological gender creates a vulnerability that can escalate to severe anxiety and depression followed by self-harm. Teens and parents are attempting to find solutions to these difficulties. This creates a challenging paradigm for parents to navigate, as they find themselves confronted with therapies that may permanently alter their child's body. Currently, psychotherapy as a treatment for GD is illegal in more than sixteen of the United States,[5] making hormone therapies their only option. Psychotherapy and Conversion Therapy have unfortunately been grouped in the same category. Conversion Therapy tends to be a coercive form of psychotherapy that pressures an individual out of GD. Explorative psychotherapy, on the other hand, is tailored support for the adolescent that includes treatments for any underlying issues, such as depression or anxiety, and talk therapy to give them

space to process. Fully evaluating the needs of each adolescent is a holistic healthcare approach that avoids unnecessary invasive treatments. This is a standard approach to all health care issues in any medical setting and should also be employed in GD therapies.

Adolescent Vulnerability

Another ethical concern is the vulnerability of the adolescent population. Cross-sex hormone therapy is relatively new and there is limited data on its effectiveness. According to Ryan Anderson, Ph.D., president of the Public Policy Center and author of "When Harry Became Sally: Responding to the Transgender Moment," the effectiveness of medical interventions for those with GD is questionable. Anderson says medical evidence suggests that "sex reassignment does not adequately address the psychosocial difficulties … even when the procedures are successful technically." He holds that the scientific facts "show that our sexual organization begins with our DNA and development in the womb, and that sex differences manifest themselves in many bodily systems and organs, all the way down to the molecular level" and therefore, cross-sex hormone therapy and surgeries cannot undo this.[6]

Anderson also rebuts the claim that blocking puberty gives children more time to "explore their gender identity without the distress of developing secondary sex characteristics." He points out that the natural development of sex characteristics may assist in the "natural consolidation of one's gender identity" which puberty blockers will interfere with. He states that 80-95 percent of children will "naturally grow out of any gender-identity conflicted stage" but when hormonally treated, tended to continue into cross-sex hormone therapy at sixteen.[7] The Society for Evidence Based Gender Medicine is also concerned that parents and teens are not aware of the "uncertainty of the permanence or transience of a young person's transgender identity."[8] It would be extremely regrettable if hormone treatments like puberty blockers were the cause of one continuing further in treatment by receiving cross-sex hormone treatments when they would have, on their own, matured into their biological sex. Living within one's biological sex is a healthier choice for one's bodily integrity, and is, therefore, a less burdensome situation for the adolescent and his or her family.

Paul McHugh, MD., agrees that reassigning one's sex is not possible. He pioneered sex-change surgery in the 1960s and in 1979 declared that it "brought no important benefits." McHugh has been a University Distinguished Service Professor of Psychiatry at Johns Hopkins Medical School for 40 years and the former Psychiatrist in Chief at Johns Hopkins Hospital. He says that most young boys and girls seeking sex-reassignment treatments are probably suffering from "psychosocial issue-conflicts over the prospects, expectations, and roles that they sense are attached to their given sex and presume that sex-reassignment will ease or resolve them." He also points out that it is extremely unfortunate that these "youngsters" and their families cannot find therapists to help them address these issues within the context of family therapy as they are guided to "gender counselors" who encourage the idea that they are not their biological sex.[9]

According to the principle of totality and integrity, an individual cannot destroy an organ's ability to function unless it is necessary for the good of the whole body. One could argue that cross-sex hormone therapy is for the good of the whole as its goal is to decrease depression, anxiety, and suicide rates. One could also argue that cross-sex hormone therapy has detrimental life-altering side effects, is experimental, and does not have enough evidence to prove that damaging an adolescent's fecundity will bring them wholeness. In Sweden, a thirty-year follow-up study on individuals treated for GD with sex-resignment surgeries had higher mortality rates and psychiatric complications.[10] Although this study is on individuals that followed cross-sex hormone therapy with sex-reassignment surgery, it supports the need for optional treatments, especially in the vulnerable adolescent. It should be noted that there is little evidence-based research to support invasive medical procedures to treat adolescent GD and health care professionals should therefore diligently seek alternative treatments.[11]

Shunning Psychotherapy as a Treatment

The experimental components of cross-sex hormone therapy create a significant risk to the individual. Because of the underdeveloped capacity of an adolescent to make life altering decisions and the vulnerability of the age-group,[12] there is a significant argument to propose alternative therapies that do not have the life-altering nature of cross sex hormone therapy. Unfortunately, the medical community at large disparages exploratory psychotherapeutic approaches for gender dysphoria. According to the American Psychological Association, exploratory psychotherapy sessions for those experiencing GD are unnecessary since "there is nothing that needs to be fixed."[13] They also claim that it is unsuccessful and causes greater shame and depression. This broad claim that all forms of psychotherapy regarding GD are needless has little grounds.[14]

Because medical professionals have little evidence-based data to rely upon for both cognitive and hormonal therapies in gender dysphoric teens, a disconcerting question is, Why is it acceptable to treat youth with invasive, body-altering, puberty blockers and cross-sex hormone therapies, yet unacceptable and even illegal to utilize conventional cognitive therapies to assess for underlying comorbid mental conditions that may be contributing to a gender identity crisis? We must treat the individual and their unique circumstances to address their specific needs. Laws that tie the hands of healthcare professionals and assert that only societally based treatments are acceptable are an injustice to healthcare professionals and their patients. This approach negates the standard in healthcare practices of an evidence-based approach that considers more than one linear option of therapy.

GD is a genuine struggle in the adolescent population and can be managed with compassion, uncoercive talk therapy, family support, and the gift of time as adolescents fully develop into their adult selves.

We have the benefits of science at our fingertips and yet we discard evidence-based research for the cultural pressures of current times. To ignore the psychosocial aspects of GD and focus on only the physical changes is a grave disservice to families and their children. Allowing the adolescent to be uniquely themselves, expressing their distinctive gifts and talents, recognizing their worth as one made in the image and likeness of God, and encouraging their individuality can help them navigate their experience of GD. Living in the reality of male and female while being uniquely themselves is the adolescent's best alternative to invasive life-altering treatments.

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Endnotes

1. Mayo Clinic Staff, "Pubertal Blockers for Transgender and Gender-Diverse Youth," *Mayo Clinic*, February 19, 2022, https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075.
2. United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 6th ed. (Washington, DC: USCCB, 2018), dirs. 26, 27.
3. Leah H. Somerville and Catherine A. Hartley, "The Neuroscience of Adolescent Decision-Making," *National Center for Biotechnology Information* 5 (October 2015): 108–115, doi: 10.1016/j.cobeha.3015.09.004.
4. USCCB, *ERDs*, dir. 27.
5. Casey Leins, "States That Have Banned Conversion Therapy," *US News and World Report*, April 11, 2019, https://www.usnews.com/news/best-states/articles/2019-04-11/these-states-have-banned-conversion-therapy. See also Rev. James McTavish and Rev. Tadeusz Pacholczyk, "Clarifying Key Issues around Conversion Therapy," *National Catholic Bioethics Quarterly* 21.4 (Winter 2021): 571–586, doi: 10.5840/ncbq202121453.
6. Ryan T. Anderson, "Sex Reassignment Doesn't Work. Here Is the Evidence," *Heritage Foundation*, March 9, 2018, https://www.heritage.org/gender/commentary/sex-reassignment-doesnt-work-here-the-evidence.
7. Ryan T. Anderson, "Parents Just lost Custody of teenage Daughter Who Wants to 'Transition' to a Boy: What You Need to Know," *Daily Signal*, February 19, 2018, https://www.dailysignal.com/2018/02/19/parents-just-lost-custody-of-teenage-daughter-who-wants-to-transition-to-a-boy-what-you-need-to-know/
8. Informed Consent for Gender-Affirmative Care, 2020, https://segm.org/informed-consent-affirmative-care
9. Paul McHugh, "Transgenderism: A Pathogenic Meme," *The Journal of the Witherspoon Institute*, June 10, 2015, https://www.thepublicdiscourse.com/2015/06/15145/.
10. Cecilia Dhejne et al., "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden", *PLOS ONE* 6.2 (February 22, 2011): e16885, doi: 10.1371/journal.pone.0016885.
11. Roberto D'Angelo et al., "One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria," *National Center for Biotechnology Information* 10.1 (October 21, 2021): 7–16, doi: 10.1007/s10508-020-01844-2.
12. USCCB, *ERDs*, dirs. 31, 53.
13. Kirsten Weir, "A Growing Number of States Ban Sexual Orientation Change Efforts," American Psychological Association, March 10, 2020, https://www.apa.org/news/apa/2020/sexual-orientation-change
14. Michael Biggs, "Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria," *National Center for Biotechnology Information* 49.7 (June 3, 2020): 2227–2229, doi: 10.1007/s10508-020-01743-6.

Mainstream Media and Catholic Principles

Tim Millea, MD

The dynamics of the relationship between today's secular media and the Christian community are complex. The common perception that conflict and antagonism exist between them is understandable and often justifiable. Secular media sources may view Christian opinions as out-of-touch with today's world, and either minimize or ignore their positions. Conversely, Christians' confidence in the veracity and objectivity of mainstream media is challenged because of a combination of mistrust and fear of misrepresentation.

The Catholic Church community is not immune from this potential intellectual stand-off. Over the past half-century, Catholicism's visibility and impact in the public square has diminished drastically. However, when an opportunity to express opinions in a large media outlet presents itself, what should we do? As Catholics, should we enter that arena? Or should we decline involvement to avoid further conflict?

In January 2022, the Catholic Medical Association (CMA) faced this decision. The CMA was contacted by reporters with the *Los Angeles Times* developing a story related to COVID-19 vaccines and religious exemptions. They requested either a telephone interview with a CMA representative or a written response to specific topics. It seemed more appropriate and accurate to provide written answers, rather than a potential misquote or misinterpretation from a verbal interview. Subsequently, the reporters submitted five questions for the CMA's consideration, focusing on several themes: religious exemptions from a Catholic viewpoint, the concept of a valid religious exemption and a deeply held religious belief, who should decide what constitutes a valid belief for exemption, the disconnect between anti-vaccine Catholics and the Pope's promotion of vaccines, and the competing interests of public safety and public beliefs with regards to COVID-19 vaccines.

The CMA frequently receives requests for information and comments from Catholic and other Christian media outlets that share common positions on various topics. The request from the *Times* was unexpected, and some initial hesitation with a response was present. As noted above, concerns about the risks of a negative portrayal or misstatement of CMA positions arose, if indeed our comments were used at all. However, in short order, those involved in the eventual response recognized the opportunity as more important than the concerns. The CMA, as well as many other faith-centered organizations, are often limited to the "echo chamber" of dialogue with like-minded media and other information sources. Given the rarity of opportunities to participate in a very open and public discussion, as well as the importance of the issues in question, a decision to respond to the reporters' questions was made rather quickly.

With contributions from several CMA members, especially Marie Hilliard, Ph.D., Greg Burke, M.D., and CMA President Craig Treptow, M.D., replies to the five questions were drafted and edited. Over a three-day period, a final version of CMA's replies was approved and sent to the reporters. The responses reflected applicable Catholic principles and referenced guidance from Vatican documents and the USCCB. Key points of emphasis in the nine-hundred-word response to the questions included the following:

- Refutation of the misconception that faith and science are in opposition; rather, the Catholic view "thrives on the beliefs of our faith in concert with logic and reason."
- Citation of United States Supreme Court decisions regarding First Amendment protection of religious beliefs
- The importance of the Church's principle of subsidiarity

Shortly after the final version of the CMA response was sent to the newspaper, the article was published. We previously did not have an indication of its importance, but on Sunday, February 7, 2022, the article appeared on the front page. Its primary focus was a "cottage

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industry" providing questionable exemptions to vaccine mandates. In addition, the reporters interviewed and quoted individuals who sought exemptions solely on religious grounds, without the use of templated or publicly available letters requesting exemption.

We reviewed the article with interest and found that the CMA text was indeed cited. An accurately quoted sentence from one of our responses was used that discussed the Catholic commitment to "faith in concert with logic and reason." Admittedly, a small portion of our full text was ultimately in print, but that slight disappointment was balanced by the accuracy and non-judgmental use of the quote.

What lessons can be gleaned from this experience that may be helpful to other individuals and organizations? It is appropriate to be cautious when dealing with secular media but given the infrequent opportunities available to contribute to a public forum, it is important to participate. Perhaps with a greater willingness to offer our opinions, such invitations to provide comments will increase. The use of written responses to specific questions seems to be preferable to verbal comments, as the latter means may be quoted out of context. If a written text is misquoted or erroneously presented, the original document can be referenced to correct the article. Finally, utilizing several individuals with varying areas of expertise to develop, edit, and approve the responses lends prudence and clarity to the project.

An important point to remember is that as Catholics we have an advantage in these interactions with the media. Our positions are based on scriptural truths and principles inspired by the Holy Spirit that have guided our Church for two millennia. There will always be a risk of misrepresentation of our views, or perhaps even media attacks on them. However, that does not change the truth of our faith. Our mission of evangelization calls us to proclaim the Gospel message without fear of consequences. In Matthew's Gospel, Jesus commissions the Twelve Apostles, telling them, " … do not worry about how you are to speak or what you are to say. … For it will not be you who speak but the Spirit of your Father speaking through you." (Matt. 10:19-20) With that encouragement and confidence, we look forward with hope to more frequent opportunities to inform the general public about our faith and the graces it offers.

Tim Millea, MD, is a retired spinal surgeon serving on the CMA Board of Directors. He also chairs the CMA Health Care Policy Committee and serves as the CMA State Director for Iowa.

Endnotes

1. Laura J. Nelson and Connor Sheets, "Online Pastors, Form Letters: The Cottage Industry Helping Workers Avoid Vaccine Mandates," *Los Angeles Times*, February 6, 2022, https://www.latimes.com/california/story/2022-02-06/requests-religious-exemptions-covid-19-vaccine-letters.

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