Gender Reassignment

Nicholas Tonti-Filippini
John Paul II Institute for Marriage and Family
Melbourne, Australia

1. Disorders of gender development

There has been a tacit acceptance of medical interventions that seek to normalize the physical condition of children born with intersex disorders or disorders of sex development. Disorders of sex development disorders include a group of conditions where there is a discrepancy between the external genitals and the internal genitals (the testes and ovaries).

Disorders of sex development may have a genetic cause or they may be a result of problems that occur during development such as exposure to hormones before birth.

There are both male (46 chromosomes, XY) and female (46 chromosomes XX) sex development disorders in which the person has normal genes but a problem has developed in the expression of the genes such that a female has ovaries but external male genitalia or a male has external genitals that are incompletely formed, ambiguous, or clearly female and internally the testes may be normal, malformed, or absent.

Some children are born who are what is called true gonadal intersex disorder in which they have both ovarian and testicular tissue. Genetically they may be normal or they may have an extra sex chromosome.

There are many many genetic disorders involving chromosome configurations other than simple 46, XX or 46, XY. These include 45, XO (only one X chromosome), and 47, XXY, 47, XXX -- both cases have an extra sex chromosome, either an X or a Y. These disorders do not result in an intersex condition where there is discrepancy between internal and external genitalia. However, there may be problems with sex hormone levels, overall sexual development, and altered numbers of sex chromosomes.

The symptoms associated with disorders of sex development will depend on the underlying cause, but may include:

- Ambiguous genitalia at birth
- Micropenis
- Clitoromegaly (an enlarged clitoris)
- Partial labial fusion
- Apparently undescended testes (which may turn out to be ovaries) in boys
- Labial or inguinal (groin) masses -- which may turn out to be testes -- in girls
- Hypospadias (the opening of the penis is somewhere other than at the tip; in females, the urethra [urine canal] opens into the vagina)

- Otherwise unusual appearing genitalia at birth
- Electrolyte abnormalities
- Delayed or absent puberty
- Unexpected changes at puberty [1]

In the past the practice has been to intervene surgically to make the person definitely one sex or the other depending on a judgement made as to which was dominant, though often the interventions seem to favour making the child female this being easier to achieve in terms of appearance. Often people with sex development disorders may be infertile.

In more recent times there has been a tendency to delay intervening. Greater respect for the complexities of female sexual functioning has led medical experts to conclude that suboptimal female genitalia may not be inherently better than suboptimal male genitalia, even if the reconstruction is "easier." In addition, other factors may be more important in gender satisfaction than functioning external genitals. Chromosomal, neural, hormonal, psychological, and behavioral factors can all influence gender identity. Many experts now urge delaying definitive surgery for as long as healthy, and ideally involving the child in the gender decision.[2]

Delay in intervening may mean that the intervention happens to a child who is attending school. In some circumstances it may be difficult to explain the difference between the treatment of these conditions and what is popularly known as sex change hormonal treatment and surgery in the circumstances of what is known as gender dysphoria.

Ashley and O'Rourke claim that intersex conditions differ from gender identity disorder and that there is no objection to procedures to improve the normal appearance or function of sexually ambiguous children before puberty in accordance with the sex in which they are to be or have been raised.[3] They say that the reasoning behind this traditional position is that a person must "live according to nature" insofar as this is humanly possible.

An issue that can arise for people who have been treated as children for an intersex condition is that they can find that they identify with the opposite gender to the one to which they were assigned by the surgeon as children. Often it can be the case that a genetic male may have been assigned female gender by the surgeon based on the phenotypic appearance, despite having the opposite genotype. There would seem to be no ethical difficulty with later attempts to establish appearance and function consistent with the genotypic gender.

2. Gender Dysphoria.

The Diagnostic and Statistics Manual of Mental Disorders 4th Edition (DSM-IV) of the American Psychiatric Association describes gender dysphoria as a persistent discomfort

---

[1] Medline Encyclopedia accessed at http://www.nlm.nih.gov/medlineplus/ency/article/001669.htm
[2] Ibid.
[3] Ibid. p. 112

with gender role and identity and distinguishes between gender identity disorder (GID) and transvestic fetishism. The latter involves sexual arousal through cross-dressing. The former involves a strong and persistent cross-gender identification.

GID occurs in children with the onset of cross-gender interests and activities usually between ages 2 and 4 years. Some parents report that their child has always had cross-gender interests. However, only a very small number of children with GID will continue to have symptoms that meet criteria for GID in later adolescence or adulthood.

Commonly treatment of GID in children and adolescents involves psychotherapy and sexual reassignment surgery is not attempted. However in recent times there have been attempts to hormonally suppress the development of gender characteristics during puberty in adolescents with GID. There have been some controversial Family Court cases in which the Court has approved hormonal suppression.

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

The DSM-IV reports that by late adolescence or adulthood, about three-quarters of boys who had a childhood history of GID report a homosexual or bisexual orientation, but without concurrent GID. Most of the remainder report a heterosexual orientation, also without concurrent GID.

The corresponding percentages for sexual orientation in girls are not known. Some adolescents may develop a clearer cross-gender identification and request sex-reassignment surgery or may continue in a chronic course of gender confusion or dysphoria.[4]

There are no recent epidemiological studies to provide data on prevalence of Gender Identity Disorder. Data from smaller countries in Europe with access to total population statistics and referrals suggest that roughly 1 per 30,000 adult males and 1 per 100,000 adult females seek sex-reassignment surgery.[5]

The treatment of chronic GID in adults involves psychotherapy which may result in recommendation for gender reassignment. In the latter case, a period of living as other sex precedes hormonal treatment, cosmetic surgery and sexual reassignment surgery.[6]

With or without sexual reassignment surgery there are very high levels of self-harm, suicide and unemployment in people with chronic GID that does not respond to psychotherapy. A proportion of those with GID spontaneously revert to normal gender identity.[7]

---

[4] American Psychiatric Association *Diagnostic and Statistics Manual of Mental Disorders* 4th Edition (2000) Accessed from ttp://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1
[5] Ibid.
[6] Ibid.
[7] Ibid.

The National Health Service in the UK has recently declared that the condition was traditionally thought of as a purely psychiatric condition, which meant that its causes were considered to originate only within the mind. However, recent studies have challenged this, and suggested that gender dysphoria may have biological causes associated with the development of gender identity before birth. The claims are that gender dysphoria should be seen as a disorder of sex development during gestation and related to abnormal expression of the sex chromosomes and that GID may be caused by hormones not working properly within the womb. The NHS concludes that more research needs to be done before the causes of gender dysphoria can be fully understood, but it is widely agreed that it can no longer be thought of as just a psychiatric condition.[8]

3. The Church and Gender Reassignment

There seems little doubt that the Catholic Church is likely to regard hormonal treatment and surgery to change gender characteristics of a person who is physically healthy and normal as a mutilation of the body resulting in an unjustifiable loss of healthy function. However the author is not aware of any official teaching on the subject other than teaching on the matter of the obligation to retain healthy bodily functions unless life is endangered and they are removed as a side effect of a treatment to save life. The Catechism of the Catholic Church states at n. 2297:

> "Except when performed for strictly therapeutic medical reasons, directly intended *amputations*, *mutilations*, and *sterilizations* performed on innocent persons are against the moral law."

Well respected theologians Benedict Ashley and Kevin O'Rourke in the fifth edition of their *Health Care Ethics: A Catholic Theological Analysis*[9] conclude that the good of the person cannot be achieved at the expense of the destruction of a basic human function, in this case the sterilization of the person, except to save the person's life and they add that the studies by no means give reassurance that sexual reassignment solves the problems of personality from which most with gender identity disorder suffer. Those who support sexual reassignment point to the high suicide rates. Some claim that the suicide rate is this group may be as high as fifty per cent and that the treatment may therefore be seen as life saving.[10]

4. Is GID a Delusion?

In Schizophrenia, there may rarely be delusions of belonging to the other sex. However, insistence by a person with GID that he or she is of the other sex is not considered a

---

[8] National Health Service (UK) *Causes of gender dysphoria* Accessed 21/12/09 http://www.nhs.uk/Conditions/Gender-dysphoria/Pages/Causes.aspx

[9] Benedict Ashley and Kevin O'Rourke in the fifth edition of their *Health Care Ethics: A Catholic Theological Analysis* Georgtown University Press, Washington 2007 p. 111

[10] Ibid. p. 110

delusion, because what is invariably meant is that the person feels like a member of the other sex rather than truly believes that he or she is a member of the other sex. In very rare cases, however, Schizophrenia and severe Gender Identity Disorder may coexist.[11]

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

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

Justice Ormrod in *Corbett v. Corbett (1970)* held that three facts determined the sex of a person:

- The chromosomes (XY - male; XX - female)
- The gonads (testes/ovaries)
- The genitals (penis/clitoris, including internal sex organs)

In other words the judge took an entirely physiological view of gender and that view survived in Australia until 1988 when Justice Matthews in the NSW Court of Criminal Appeal in *R v Harris and McGuiness* (1988) 17 NSWLR 158 held that Lee Harris, a post-operative male to female transgender person convicted of procuring 'another' male person to commit an act of indecency, to be female for the purposes of criminal law. The judges decision was based on the fact that the persons reconstructed genitalia was functionally female rather than male.

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

On 21 February 2003, the Full Court of the Family Court of Australia upheld Justice Chisholm’s decision in which he concluded that for the purpose of ascertaining the validity of a marriage under Australian law, the question whether a person is a man or a woman is to be determined as at the date of the marriage, not as at birth and that in Australian law specifically the law relating to marriage, the terms ‘man’ and ‘woman’ include transsexuals in accordance with their sexual reassignment. [12]

---

[11] American Psychiatric Association DSM-IV Op Cit.

[12] The Attorney-General for the Commonwealth & "Kevin and Jennifer" & Human Rights and Equal Opportunity Commission [2003] FamCA 94 (21 February 2003)

From the perspective of the American Psychiatric Association, GID is not a delusion and from the perspective of the Australian Courts a person's gender can be changed by sexual reassignment surgery which would seem to indicate that the Court's do not accept that GID is delusional. In fact in the case just described the Court took into account factors such as the person's life experiences, including the sex in which he or she is brought up and the person's attitude to it, the person's self-perception as a man or woman; the extent to which the person has functioned in society as a man or a woman; any hormonal, surgical or other medical sex reassignment treatments the person has undergone, and the consequences of such treatment; and, the person's biological, psychological and physical characteristics at the time of the marriage, including (if they can be identified) any biological features of the person's brain that are associated with a particular sex.[13]

There have been two Australian cases involving children being treated for GID, *Re Alex: Hormonal Treatment for Gender Identity Dysphoria* (2004) FLC ¶ 93-175 ("*Re Alex*") and Re Brodie (Special Medical Procedure) [2008] FamCA 334 (15 May 2008).

In the case of 12 year old Brodie born a female, the Family Court authorised Brodie's mother to consent to the administration of a gonadotrophin releasing hormone analogue on a continuous basis subject to the medical opinion of the child's treating specialists from time to time. The effect of the treatment would be to suspend the development of puberty indefinitely, but the Court was advised that the effect would be reversible. The Court also ordered that Brodie undergo regular psychotherapeutic counselling with a psychiatrist experienced in gender identity disorder cases with the view (*inter alia*) to the child exploring any issues arising from the treatment and to improving the child's general well being. It is worth noting that Judge Carter was not satisfied that the treatment plan is a procedure "for the purpose of treating a bodily malfunction or disease", but nevertheless concluded that the present and future psychological benefit to the child in being permitted to begin the treatment sought outweighs the psychological risks to her in not receiving the treatment and is therefore in her best interests. He made that decision in the knowledge also that the treatment was the first stage of a package of interventions which would include irreversible interventions.[14]

In the case of Alex, a 13-year-old biological girl, Chief Justice Nicholson ruled that she was able to commence treatment for gender dysphoria. In *Re Alex* the child had always identified as a male, wore male clothes, used the male toilets and otherwise presented as a male. The Chief Justice found that the child was able to enrol at school using a male name, and commence administration of the oral contraceptive pill to stop menstruation immediately. He further ordered that the child, in consultation with his treating medical practitioners was able to commence irreversible hormonal treatment at a later date but prior to his 18th birthday. The proposed treatment would stimulate facial hair growth, masculinisation of his voice and physique and lengthening of the clitoris.

---

[13] New South Wales Council for Civil Liberties *Transexual Marriage in Australia* Accessed from http://www.nswccl.org.au/unswccl/issues/transexual.php#StateOfLaw
[14] http://www.austlii.edu.au/au/cases/cth/FamCA/2008/334.html

In both cases the Court relied on the uncontested evidence of doctors who are engaged in transexual reassignment. In neither case did the Court seek opinions from what might be called mainstream psychiatry which holds with the American Psychiatric Association that such treatments should not be administered to children[15]. In fact mainstream psychiatry recommends psychotherapy for GID in adults rather than sexual reassignment.[16] The British Psychological Society holds that counselling and supportive system establishment are thought to be the best approaches to treating this disorder.[17]

5. Is Gender Reassignment Corrective or Mutilating?

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

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

If a parallel is drawn between developmental sex disorders and chronic gender dysphoria then the psychological condition might be considered in the same light as the failure to develop normal genitalia, ovaries or gonads. In the latter case there has been an acceptance of seeking to establish as normal a condition as possible by corrective medical intervention. Sex development disorders are thought to happen fairly early in the development of the embryo. Normally the Y-chromosome does not have effect until about the seventh week when the testes develop and produce testosterone that then brings about male rather than female development.[18] Sex development disorders are thought to have their origin around that time and may be the result of environmental causes.

There may be a parallel between sex development disorders and GID if in the case of GID it could be established that there were biological factors involved in the failure to develop normally psychologically in relation to gender.

That raises the issue of what might be considered corrective intervention in the case of gender dysphoria. The medical reality is that in a biological male, medicine has not been able to reconstruct the reproductive tract so that it can function as a female reproductive tract. At best, surgery can create a vagina that can function for the purposes of sexual intimacy but with no reproductive capacity. In a biological female medicine can with some difficulty produce a pseudo-penis for the purpose of penetrative sexual intimacy but

[15] American Psychiatric Association DSM-IV Op Cit
[16] Ibid.
[17] http://www.psychnet-uk.com/dsm_iv/gender_identity_disorder.htm
[18] Ashley and O'Rourke Op Cit p. 112

with no reproductive function. In both cases the hormonal and cosmetic changes assist the person to assume the role and appearance of the opposite gender.

In both cases the interventions would destroy what would otherwise have been healthy fertile reproductive systems. In this respect the intervention is different from the interventions to treat the more conventionally recognised sex development disorders many of which are naturally infertile. The aim in the latter interventions is to restore as much normal function of one gender or the other as possible given that gender is at least phenotypically and sometimes genotypically ambiguous.

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

Beyond congenital biological determinants, there are at least three well-published theories on gender development in children. The *biological theory* is based on evidence that high levels of the male hormone testosterone are associated with high levels of aggression in boys and tomboyishness in girls. *Social learning theory* proposes that gender typing is the result of a combination of observational learning and differential reinforcement. A third, *Cognitive-Developmental theory*, states that gender understanding follows a prescribed time line. The pattern put forth is that children recognize that they are either boys or girls by the age of two or three, followed shortly by recognition that gender is stable over time. By the age of six or seven children understand that gender is also stable across situations.[19]

No matter what theory one adopts, for most children, whose sex and gendermap are congruent, this insight typically goes unnoticed. However, if there is a sex/gendermap incongruency, some children will be left perplexed about his or her gender status and begins a lifelong, often compulsive search for resolution of the discrepancy[20].

Though it may have biological causal elements, the problem still seems to be a psychological problem and the treatments that seek instead to find a biological remedy in sexual reassignment would seem to be addressing the wrong problem and by means that will in fact destroy normal healthy reproductive functions. Because the Church regards the body as a unity of soul and body[21] it regards gender also as a unity. Gender is not

[19] Anne Vitale *Notes on Gender Identity Disorder*. Accesssed from http://webhome.idirect.com/~beech1/GENDERID.HTM
[20] Ibid.
[21] Gaudium et Spes n. 14

merely a psychological or social concept but is grounded in the physical reality of the body.

The Church therefore rejects the idea that gender can simply be chosen without regard to the biology. Pope Benedict expressed it in the following way:

> "What is often expressed and understood by the term "gender" ultimately ends up being man's attempt at self-emancipation from creation and the Creator. Man wants to be his own master, and alone – always and exclusively – to determine everything that concerns him. Yet in this way he lives in opposition to the truth, in opposition to the Creator Spirit."[22]

If the evidence existed that showed that GID does have a biological cause and is a developmental condition in much the same way as the developmental sex disorders are, the Church would still be unlikely to endorse gender reassignment surgery firstly because the treatment should seek to restore normality and the abnormality would seem to be the psychological disorder, not the body itself. Radical treatment of the body to try to make the body congruent with the disorder would not seem appropriate and the fact that the body seeks to revert to the phenotype associated with the genotype if hormonal treatment is stopped, that the treatment is more cosmetic than a real change and that the evidence about its success as a treatment for the psychological disorder is equivocal, would be reasons why the Church would not support sexual reassignment. Second the fact that the treatments destroy healthy functions would seem to exclude any possibility that the Church would support it. It is inconceivable that the Church could endorse the destruction of healthy biological functions, particularly when the Church attaches meaning to the gift of sexual intimacy in part because of the procreative meaning. It may be that, as part of instituting adequate psychological care, the Church might permit temporary measures to suspend puberty in the circumstances in which the onset of puberty hindered treatment, but one would not envisage the Church endorsing the permanent loss of healthy functions.

The hormonal treatment alters some physiological characteristics, surgery can construct a sexually but not a reproductively functioning vagina or penis and cosmetic surgery may alter the appearance allowing the person to more easily adopt the role of the other gender, but the Karyotype remains unchanged and if the hormone treatments are stopped it will reassert its dominance in the biology of the individual.

The reality is that physically a change from one gender to the other is not medically possible. What happens is in fact the destruction of normal healthy organs, leaving the

---

[22] ADDRESS OF HIS HOLINESS BENEDICT XVI TO THE MEMBERS OF THE ROMAN CURIA FOR THE TRADITIONAL EXCHANGE OF CHRISTMAS GREETINGS Clementine Hall Monday, 22 December 2008, Accessed from http://www.vatican.va/holy_father/benedict_xvi/speeches/2008/december/documents/hf_ben-xvi_spe_20081222_curia-romana_en.html

person as essentially the gender of their birth and requiring constant hormonal interventions to try to suppress the natural tendency of the body to revert to gender type.

The proposal to undergo sexual reassignment would seem to conflict with the notion of gender expressed in clauses 2331-2334 of the Catholic Catechism:

> "God is love and in himself he lives a mystery of personal loving communion. Creating the human race in his own image . . .. God inscribed in the humanity of man and woman the *vocation*, and thus the capacity and responsibility, *of love* and communion."[115]
>
> "God created man in his own image . . . male and female he created them";[116] He blessed them and said, "Be fruitful and multiply";[117] "When God created man, he made him in the likeness of God. Male and female he created them, and he blessed them and named them Man when they were created."[118]
>
> *Sexuality* affects all aspects of the human person in the unity of his body and soul. It especially concerns affectivity, the capacity to love and to procreate, and in a more general way the aptitude for forming bonds of communion with others.
>
> Everyone, man and woman, should acknowledge and accept his sexual *identity*. Physical, moral, and spiritual *difference* and *complementarity* are oriented toward the goods of marriage and the flourishing of family life. The harmony of the couple and of society depends in part on the way in which the complementarity, needs, and mutual support between the sexes are lived out.
>
> "In creating men 'male and female,' God gives man and woman an equal personal dignity."[119] "Man is a person, man and woman equally so, since both were created in the image and likeness of the personal God."[120]

and with the depth of meaning of gender as encompassing not just biology but our innermost being in Clause 2361:

> "Sexuality, by means of which man and woman give themselves to one another through the acts which are proper and exclusive to spouses, is not something simply biological, but concerns the innermost being of the human person as such. It is realized in a truly human way only if it is an integral part of the love by which a man and woman commit themselves totally to one another until death."
>
> > Tobias got out of bed and said to Sarah, "Sister, get up, and let us pray and implore our Lord that he grant us mercy and safety." So she got up, and they began to pray and implore that they might be kept safe. Tobias began by saying, "Blessed are you, O God of our fathers. . . . You made Adam, and for him you made his wife Eve as a helper and support. From the two of them the race of mankind has sprung. You said, 'It is not good that the man should be alone; let us make a helper for him like himself.' I now am taking this kinswoman of mine, not because of lust, but with sincerity.

> Grant that she and I may find mercy and that we may grow old together." And they both said, "Amen, Amen." Then they went to sleep for the night."

and finally the divine creation of gender in clause 372:

> "Man and woman were made "for each other" - not that God left them half-made and incomplete: he created them to be a communion of persons, in which each can be "helpmate" to the other, for they are equal as persons ("bone of my bones. . .") and complementary as masculine and feminine. In marriage God unites them in such a way that, by forming "one flesh", they can transmit human life: "Be fruitful and multiply, and fill the earth." By transmitting human life to their descendants, man and woman as spouses and parents cooperate in a unique way in the Creator's work."

The Church understands that each human being exists for a purpose and communion with God and the capacity to become a mother or a father is part of that vocation. The importance of procreation is expressed in Clause 1652

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

The Church thus regards gender as having a specific meaning that is determinative of vocation and is unchangeable. This is acknowledged particularly in the restriction of priesthood to men in clause 1577:

> "Only a baptized man (*vir*) validly receives sacred ordination."[66] The Lord Jesus chose men (*viri*) to form the college of the twelve apostles, and the apostles did the same when they chose collaborators to succeed them in their ministry.[67] The college of bishops, with whom the priests are united in the priesthood, makes the college of the twelve an ever-present and ever-active reality until Christ's return. The Church recognizes herself to be bound by this choice made by the Lord himself. For this reason the ordination of women is not possible.

6. A Teacher in a Catholic School

A case presented to me involved a teacher who had been teaching at the school for sometime and had announced to the principal his intention to cross-dress and live as a woman as the first stage prior to progressing to hormonal treatment, cosmetic surgery and finally sexual reassignment surgery if the treating team agreed.

The legal issue is that a religious school may discriminate if it is necessary to do so to propagate religion that conforms to the doctrines of that religion or is necessary to avoid injury to the religious susceptibilities of the adherents of that religion.

The issue then is whether excluding a teacher who was cross dressing was necessary in order to propagate religion that conforms to the doctrines of the religion or is necessary to avoid injury to the religious susceptibilities of the adherents of that religion.

In a way the issue like the Court cases, cannot treat cross dressing on its own because it is thought to be just a first stage in a likely sequence of events culminating in sexual reassignment. In the case of GID, the cross dressing is an expression of the teacher's strong feeling that he is in fact a woman despite his biology.

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

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

7. A Child in the Classroom

A school principal sought an opinion on the need to respond to an announcement made by the parent of a child at a co-educational secondary school that the child, who is female, would soon undergo hormonal treatment as part of a process of gender reassignment.

The first concern is the wellbeing of the child in circumstances of a mental disorder that carries a significant risk of self harm. There would be a need to ask for advice from the child's psychiatrist concerning how best to respond to her individual circumstances. There are also obvious privacy issues that may be difficult to protect during such a process.

The principal also has an obligation to all the children in the school and one of the issues to be addressed is the impact that the child would have on others as she went through the process.

A major concern would be the impact on other children at a time when gender and gender orientation are matters about which there is often some uncertainty. In that respect there would also be concern about the impact that the circumstances would have on the ability of the faculty to give witness to Catholic teaching in the face of a public rebuttal of that teaching.

The principal would need to make a prudential decision, based on professional medical, psychological and pastoral advice about what may be expected to occur, as to whether the child could remain at the school, and pastoral advice about how best to manage the circumstances. It is not impossible that the circumstances could be managed, but it would be very difficult.