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The Morality of Sex-Conversion

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The following article represents a synopsis of the author's book, A Moral Evaluation of Surgical Sex-Reassignment, which originally was a doctoral dissertation in moral theology for the Angelicum in Rome. Father Mastroeni is affiliated with the University of San Francisco.

It is estimated that in the United States alone there are over 10,000 persons who, though somatically members of one sex, perceive and view themselves as members of the opposite sex. It is further estimated that over 3,000 of these have undergone a form of drastic major surgery to make their bodies conform to the mental image they have of themselves; the ratio of women to men who have undergone the surgery being roughly 1 to 4.2 In 1966, Johns Hopkins Hospital was the only gender identity clinic in the U.S. Today there are over 30. When seen globally, this phenomenon of gender dysphoria, as it has become medically known, has reached proportions that a vast medical technology has been brought to bear upon the problem, prompting one writer to refer to this elaborate outlay of medical services as the "transsexual empire." The seriousness of the problem and the issues which surface from it, especially the medical procedures which are proposed by way of cure, raise critical moral questions deserving of thorough evaluation.4

Transsexualism is properly distinguished from hermaphroditism, or incomplete sexual differentiation attributed to genetic or hormonal defects occurring during embryological development, the results being an unfinished male or female with possible combinations of internal or external sex organs resembling those of the opposite sex. (The existence of the so-called "perfect hermaphrodite" possessing all generative organs properly developed, of both male and female, enabling copulation as either male or female is generally denied in the medical literature.)5 In transsexuals, however, there is no evident physical abnormality. The chief intersexual feature consists in the person's conviction that he or she belongs to the opposite sex, and the desire to dress, behave, and function as such. To achieve that end, the person will undergo serious surgical mutilations.

There are those, however, who hold out for a form of organic causation ranging from alleged genetic predispositions to a neural-endocrinial imbalance occurring during prenatal development.6 While it is impossible to rehearse here the argumentation associated with such theories, suffice it to say that to date no conclusive evidence has been produced to affirm any theory alleging an organic causation of the problem. On the contrary, just as those attempts to attribute a genetic-hormonal predisposition for homosexuality have been generally discredited, so too there is little to suggest any of the same with regard to gender dysphoria. Pertinent here are those animal and human studies involving female fetuses who had been masculinized somatically either neo- or prenatally due to abnormal secretions of androgens on the part of their pregnant mothers, or those whose mothers had taken the hormone progesterin during pregnancy to prevent miscarriage. The results showed that none of these androgenized subjects engaged in what can properly be called homosexual activity, or suffered from sexual misidentity.7

The weight of available evidence strongly supports a psychological causation for transsexualism.8 To explain transsexualism among males there is proposed the theory of a dominant, close-binding mother and a nonassertive, emotionally-withdrawn father, both of whom usually remain within a conflicted marriage relationship. The mothers of male transsexuals are usually described as generally depressed, unhappy, lack-lustre personalities who compensated for their inadequacies by developing an extremely close-binding relationship with their sons, characterized by a great deal of physical contact including, in many instances, sleeping together well beyond the prepubertal years. The early relationship between male transsexuals and their mothers is described as a symbiotic extension of uterine life, causing the child's identification with the mother to become so intensified as to blur his own ego boundaries. The failure to separate socially from the mother results in the inability to develop a separate sexual identity. Transsexualism is seen by some as an unconscious attempt to avoid the anxiety of maternal separation.9 The early childhood behavior of male transsexuals is described as very feminine with acting out in play and cross-dressing, leading in puberty to homosexual activity wherein the transsexual usually assumes the role of passive receptor.

Psychological studies of female transsexuals reveal an identification with a strong, assertive father who may have little to no emotional rapport with either wife or child. The wife is described as generally depressed and showing little emotional affect. The daughter is sometimes cast into the role of a father-substitute, and her masculine acting-out is encouraged as an alleviation for the mother's depression.
Androgens for Female Transsexuals

The conversion for female transsexuals begins with the administration of androgens which, among other effects, arrests menstruation. The surgery includes mastectomy, hysterectomy, and oophorectomy. Afterwards begins a complex and multi-staged construction of an artificial phallus using tissue from the left lower quadrant of the abdomen.

One of the chief attempts to morally justify sex-reassignment is the so-called extended notion of totality, which attempts to broaden the original principle of totality to include not only somatic but psychic well-being as well. An attempt to justify transsexual surgery along these lines can be found in the work, Human Sexuality, researched and published under the auspices of the Catholic Theological Society of America, and in Contemporary Medical Ethics by Rev. John Dedek. Following upon the heels of certain Catholic theologians who attempt to justify direct contraceptive sterilization by invoking the so-called extended notion of totality, these authors claim that the parts of the body exist for the total well-being of the individual, understood not only somatically, but also psychologically and socially. The serious mutilation or direct sterilization which comprises a major part of the surgery involved in sex-conversion is accordingly justified by the claim that such a procedure is done for a greater good, presumably for psychological and emotional welfare of the patient.

Such an extended notion of totality betrays a latent dualism in its understanding of human nature—a tendency, one might add, which pervades much of what passes itself as the so-called “new morality.” It is that tendency which sees the body, its members and functions as belonging to physical nature which, in turn, is not to be identified with the person. Instead, the person is located within the conscious self, the thinking subject. The body becomes simply a material instrument of the thinking self—the “res extensa” of Descartes, if you will—purely a means and in no way an end or good in itself. Relatively little to no personal good, and therefore moral value, inheres in the body, its members or functions, but resides in the thinking, intending, willing subject. A dualistic understanding of human nature can be seen operating in the following situations:

1) If the person is not to be identified with his body, then an attack upon the body, its members or its functions is not necessarily in and of itself an attack upon the human person, or some personal good. If, for instance, personhood is defined purely in terms of intentionality, rationality or the capacity for “meaningful activity” or “interpersonal relationships,” then the destruction of fetal bodies is not necessarily an attack upon real persons.

2) Also, if my body belongs to me as a material possession over which I exercise dominion, then for a woman to do with her body as she chooses becomes a handy justification for the destruction of innocent human life within the womb.

3) “Share your bodies for nine months” was the advice urged upon women by Elizabeth Kane, the first American surrogate mother. Lurking here is that rupture of the body from the personal self which attempts to reduce something as personal and intimate as mothering to a mere manipulative event by viewing it as something purely physical.

4) Furthermore, if the human person is not to be considered as a special type of body with its bodily life and the biological processes which transmit it as constituting of themselves personal values, then there is little to prevent the proposal that human beings be manufactured or fabricated in a petri dish. Here it remains the conundrum of our times how the dissenters to Humanae Vitae can hurl upon it the accusation of “physicalism” when the beam is actually in their own eyes: for in their attempts to justify the direct suppression of the generative function, whether temporary or permanent, they have reduced it to a purely physical event, devoid of any intrinsic good other than that which the thinking, intending subject deigns to place upon it.

5) Lastly, and germane to the topic of transsexualism, if the real self is located only in consciousness, only in the thinking, feeling...
subject, and the body is simply its material instrument, the "subordinate to the good of the whole is clearly unsupported by the Magisterium. Moreover, an examination of the papal teaching on the principle of totality, as it has been invoked throughout the centuries and in more recent times by Pius XII, will show that this teaching cannot be reconciled with such an extended notion of totality. Any attempt either to subordinate the individual to the good of the moral unity (society, community or personal relationship) as a part is subordinated to the good of the whole is clearly unsupported by the Magisterium. Likewise, the papal teaching does not admit an extended notion of totality in which the somatic or corporeal dimension of human existence is seen as subordinate to a more comprehensive personal dimension. The Magisterium does not support the position that parts of the body can be mutilated or bodily functions suppressed for a proposed emotional or psychological good of the whole person.

A wholistic or integrist understanding of man, however, upon which a proper application of the principle of totality is founded, views the human person as a psychosomatic unity; in Aristotelian-Thomistic terms—a substantial unity of body informed by a rational soul. This is consistent with the understanding found in Sacred Scripture and Tradition wherein the unity of man is seen as a corpore-spiritual one. The biblical view of man is not that he has a soul, but that he is a soul; not that he has a body, he is a body. (This is my body" = This is my self, my person). Identification of the person with his body is also apparent from our own ordinary experience of things. If someone steps on my toe or punches me in the nose, he is stepping upon and punching me. It is not so much my optical organs that see, it is I that see. There is the immediate awareness that it is one and the same self or ego that is experiencing or doing these things, that "I" am co-extensive with my body, its parts and its functions; in fact, I am my body, its parts and its functions, rather than I have a body, etc.

Furthermore, an integrist understanding of human nature sees human sexuality as inseparable from the psychosomatic unity that characterizes the human person. To be a person means to be a sexual person, a man or a woman, for there are no asexual human beings. In fact, every single cell of our body tells the story of our being a man or a woman. And while depth psychology makes a credible case for sex being more than skin deep, affecting our thinking, willing, feeling, our spiritual lives, having a psychological as well as a corporeal dimension, nonetheless, it is by certain somatic signs serving as external, objective criteria that we perceive sexual identity. These signs consist of the generative organs, primarily, the testes and ovaries; secondarily, the penis and vagina. Only women can produce ova, only men can produce sperm; therefore, only women can be mothers, only men can be fathers.

True sexual identity is founded upon nature and empirically verified by certain somatic characteristics identifiable at birth, for once separated from reproduction, the whole notion of sexual identity is in danger of becoming totally unintelligible. Just as it would indeed appear that no one, for instance, is really Chinese simply by being raised in the culture, speaking the language, enjoying the cuisine or even by having one's cheek bones surgically raised or eyes slanted—in short by either willing, intending, feeling or making oneself to be Chinese—so too no one is either male or female in a properly objective and real sense simply by being assigned or raised, feeling or willing oneself to be such. If one's racial identity is verified by the fact of being born as such, how much more must sexual identity, which touches more fundamentally at the very core of our personal selves, be verified by similar objective criteria. Moreover, one's sexual identity never changes anymore than a continuous change or recycling of cells over a period of time can substantially change the personal identity of an individual.

Such a notion of sexual differentiation is evident in Sacred Scripture and Tradition wherein one's sexual identity is never seen as something incidental or arbitrary, much less as something to be changed at will. Rather, it is constitutive of our very person, body and soul, and willed by God through creation. "In the beginning God made them male and female . . . ." Intrinsic to one's personal identity and affecting the person's relationship with God, his fellowman and creation, sexual identity will endure in life after death. While there will be "no giving in marriage" in heaven, there will be resurrected, glorified bodies, and as such they will bear the signs of sexual identity.

All of this is by way of saying that what really takes place in transsexual surgery is not a change of sex. At best what occurs when hormone and surgery are administered is the feminization of man and the masculinization of woman—that is, the surgically constructed appearance of a male or female body, the socially constructed stereotype of feminine or masculine behavior. It is not the creation of a man or woman, but rather the fabrication of artifacts pertaining to male and female anatomy (silicone breast implants, artificial vaginas and penises, etc.), in effect, the fabrication of a she-man or a he-woman, feminine-looking man or a masculine-looking woman. For all that a person may look like, behave like, feel like or perceive himself to be a member of the opposite sex, in actuality, he can only be a member of his own sex.

Surgical procedures, then, which involve massive mutilations of perfectly healthy generative organs, represent a massive assault on the
integrity of the human person and betray an attitude of absolute
domination or ownership of the body which is reserved to the Creator
alone. As such, transsexual surgery constitutes a serious, discredited
action and is gravely immoral for those who secure the surgery and
those who by the use of their professional skills cooperate to such an
end.

Even if one were inclined to judge the morality of actions simply in
terms of their consequences, one would no doubt be quite reluctant
to endorse these procedures. It is generally agreed even by those involved
in the work of sex-conversion that the procedures in no way approxi-
mate what can commonly be referred to as a "cure," but rather represent at best only a treatment modality. Dr. Charles L. Ihlesfeld, an
endocrinologist and prominent protege of Dr. Harry Benjamin, the
pioneer of transsexual surgery in the United States, has left the field
after having helped one hundred or more transsexuals to change sex.

He gives the reason for his departure:

Whatever surgery we did, it did not fulfill a basic yearning for something
that is difficult to define. This goes along with the idea that we are trying to
treat superficially something that is much deeper.10

Such admissions raise serious questions for the practice of medicine.
In defining disease and health in the widest possible sense and more on relieving discomfort—gender discomfort, Column-
nist George Will mentions the woman who had a mastectomy because her left breast interfered with her golf swing.21

Lastly, it is interesting to note that while Johns Hopkins University Hospital was the first to embark on sex-reassignment procedures, it was the first to discontinue the program after a longitudinal study on such indices as job, educational, marital and domiciliary stability among converted patients revealed that the surgery conferred no objective advantage. The researchers concluded:

Sex reassignment surgery confers no objective advantage in terms of social rehabilitation, although it remains subjectively satisfying to those who have vigorously pursued a trial period and who have undergone it.22

In conclusion, it ought to be said that while our clinical and pasto-
ral solicitude prompts us to care for those afflicted with so severe a
psycho-sexual disorder, it must not provide the pretext for a retreat
from the rigorous demands of reason into a woolly world of vague
feelings, or, in the name of compassion, to endorse easy, mechanical
nostrums for problems whose implications are far more complex than
first appear, and for which lasting resolutions are born of time,
patience and the pain which attends the process of true self-discovery.
Medicine and Religion:
Battle Ground or Common Ground

Rev. William F. Maestri

The following was the keynote address at a conference sponsored by the Diocese of Lafayette for the State of Louisiana; the conference dealt with medicine and religion.

Father Maestri teaches philosophy at St. Joseph Seminary and medical ethics at Charity Hospital. He has authored two books relating to biomedicalethics and has recorded a series of tapes for Alba House.

It is a privilege for me to offer a few words of introduction as we begin our two days of study, reflection, and prayer. What we do during these next two days offers real hope for a future and continuing dialogue between physicians and clergy and those in hospital-pastoral ministry, between the two communities of medicine and religion. What we do is what sociologist Peter Berger calls "a signal of transcendence" or "a rumor of angels." That is, by our coming together to discuss common concerns, hopes, cares, problems, and dreams, we are continuing the process of bringing healing and reconciliation to the two communities whose major telos or end is healing and reconciliation. We will be talking to one another, rather than about one another. There is the real hope that we will come to see that there is much more which unites us than divides us. The words of the Apostle Paul to the Corinthian community seem appropriate:

So we are ambassadors for Christ, God making His appeal through us. We beseech you on behalf of Christ, be reconciled to God. . . . Christ reconciled us to Himself and gave us the ministry of reconciliation,...