The Ethics of Surgical Interventions for Body Integrity Identity Disorder and Gender Dysphoria

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Introduction

On May 20, 2009, Fox News featured a report that described the life of a man named "John" who had spent his life struggling with Body Integrity Identity Disorder (BIID).[1] In a phone interview, John admitted that he remembers wanting to amputate his leg when he was between seven and eleven years of age, by sticking his leg under the rear wheel of a bus. He never went through with it but continued to experience an intense desire to amputate his healthy limb for the following fifty-plus years. Described for the first time in 1977 as apotemnophilia, BIID was originally thought to be a psychological disorder characterized by sexual arousal associated with the desire to be an amputee. However, it was renamed when Dr. Michael First, a professor of clinical psychiatry at Columbia University, proposed that the primary motivation behind the condition was an issue of identity rather than of sexual desire.[2] This proposal is controversial.[3] Despite much

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1 Jessica Mulvihill Moran and Karlie Pouliot, "Determined to Amputate: One Man's Struggle with Body Integrity Identity Disorder," *Fox News*, May 20, 2009, foxnews.com/story/2009/05/20/determined-to-amputate-one-man-struggle-with-body-integrity-identity-disorder.html.

2 For discussion, see: M. B. First, "Desire for Amputation of a Limb: Paraphilia, Psychosis, or a New Type of Identity Disorder," *Psychological Medicine* 35, no. 6 (2005): 919–28; M. B. First and C. E. Fisher, "Body Integrity Identity Disorder: The Persistent Desire to Acquire a Physical Disability," *Psychopathology* 45, no. 1 (2012): 3–14.

3 For example, for an alternative account that maintains that this condition is still related to sexual desire, see E. Kasten, "Body Integrity Identity Disorder (BIID): Interrogation of Patients and Theories for Explanation" [German], *Fortshritte der Neurologie*

debate, BIID was not included in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*-5), which was published on May 18, 2013.

In this essay, we will consider the ethics of surgical interventions for BIID and Gender Dysphoria (GD).[4] We begin with a discussion of the principle of totality that distinguishes ethical from unethical modifications of the body. We will refer specifically to the latter category of surgical interventions as "mutilations," though the Catholic moral tradition's use of the term is itself ambiguous.[5] This is followed by an extensive moral discussion of (1) amputations of healthy limbs for patients struggling with BIID and (2) sex reassignment surgeries for those who identify themselves as transgender persons. I will propose that an ethical argument can be made to justify the former but not the latter.

The Principle of Totality

Because of the goodness of the human body, its integrity is a good that has to be protected and preserved. The ethical principle that is used to judge the morality of bodily interventions that impinge upon this bodily integrity is the principle of totality.[6] It was articulated by St. Thomas Aquinas in his *Summa theologiae* as follows:

> Since a member is part of the whole human body, it is for the sake of the whole, as the imperfect for the perfect. Hence a member of the human body is to be disposed of according as it is expedient for the body. . . . If, however, the member be decayed and therefore a source of corruption to the whole body, then it is lawful with the consent

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Psychiatrie 77, no. 1 (2009): 16–24. For an argument that BIID should still be considered a mental disorder in itself, see Peter Brugger, Markus Christen, Lena Jellestad, and Jürgen Hänggi, "Limb Amputation and Other Disability Desires as a Medical Condition," *Lancet Psychiatry* 3, no. 12 (2016): 1176–86.

4 This essay is based on the chapter on bodily modifications in the second edition of my *Biomedicine and Beatitude: An Introduction to Catholic Bioethics* (Washington, DC: Catholic University of America Press, 2021).

5 For discussion, see Gerald A. Kelly, S.J., "The Morality of Mutilation: Towards a Revision of the Treatise," *Theological Studies* 17, no. 3 (1956): 322–44.

6 For the discussion of the history of the principle of totality in this section, I am indebted to the following magisterial essays authored by Gerald A. Kelly, S.J.: "Pope Pius XII and the Principle of Totality," *Theological Studies* 16, no. 3 (1955): 373–96; "The Principle of Totality," *Linacre Quarterly* 23, no. 3 (1956): 70–76.

> of the owner of the member, to cut away the member for the welfare of the whole body.[7]

Over the centuries, Catholic moral theologians appealed to the principle of totality to justify three different scenarios that involved the sacrifice of a bodily organ for the sake of the whole human organism. The first case involves a diseased organ that has to be removed to save the life of the soldier wounded on the battlefield—say a gangrenous, decaying limb as in the example of Aquinas. The second case involves the healthy foot of a man who is trapped on a railroad track that has to be amputated to save his life from a collision with a train, and the third case involves the healthy limb of an individual that has to be amputated in response to a tyrant who orders him to cut off his own hand or lose his head to the executioners instead. In these cases, the sacrifice of the part would be morally permitted as a necessary means of preserving the life of the individual. As Fr. Gerald Kelly, S.J., points out, this final case is particularly significant because it involves a healthy limb whose very presence—and not its diseased or trapped condition—becomes a source of vital harm for the organism.[8]

How does one justify the principle of totality? In 1944, Pope Pius XII explained it this way: "Man's power over his members and organs is a direct—though not unlimited—power; because these are parts which go to make up his physical being. Their association in the one being has for goal only the well-being of the whole physical organism, and hence it is clear that each of these organs and members can be sacrificed if it puts the whole organism in danger, a danger which cannot in any other way be averted."[9] In other words, by their very nature, individual organs of the human body are ordered to the health and well-being of the organism. As such they can be sacrificed for the good of the whole, because this would be in accord with their natural end.

Pope Pius XII then articulated the scope of the principle of totality in an address to the 26th Congress of the Italian Society of Urologists in 1953 by listing three conditions that must be met in order to justify a surgical procedure that removes some bodily part of the patient. These physicians were concerned about whether or not the surgical removal of a male patient's testicles to treat his cancer of the prostate could be morally

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7 Thomas Aquinas, *Summa theologiae* II-II, q. 65, a. 1.

8 Kelly, "Principle of Totality," 70.

9 Pope Pius XII, "Allocution to the Italian Medical-biological Union of St. Luke, November 12, 1944," in *The Human Body: Papal Teaching*, selected and arranged by the Monks of Solesmes (Boston, MA: St. Paul Editions, 1960), 51–65, at 55.

justified. Medically, it is known that both testicles are sources of testosterone that drive the growth of the prostate tumor. The Pope responded to them by articulating three necessary conditions that must be present to justify a surgical procedure using the principle of totality:

> Three conditions govern the moral licitness of a surgical operation that causes anatomical or functional mutilation: first, that the continued presence or functioning of a particular organ within the whole organism is causing serious damage or constitutes a menace to it; next, this damage must be remediable or at least can be measurably lessened by the mutilation in question, and the operation's efficacy in this regard should be well assured; finally, one must be reasonably certain that the negative effect, that is, the mutilation and its consequences, will be compensated for by the positive effect: elimination of danger to the whole organism, easing of pain, and so forth. The decisive point rests not in the fact that the organ which is amputated or paralyzed be itself infected, but that its continued presence or functioning cause either directly or indirectly a serious menace for the whole body.[10]

With these three necessary conditions in mind, the Pope taught that the surgical removal of a male prostate cancer patient's healthy testicles can be justified with the principle of totality. First, the continued functioning of the testicles puts the patient's life in jeopardy by hastening the spread of the prostate tumor that could kill him. Next, there is robust medical evidence that shows that their removal substantially mitigates this risk. Finally, the proportionate good of preserving the man's life is great in comparison not only to the loss of his testicles and his prostate, but also to his experiencing the infertility, incontinence, and impotence that could follow.

In sum, the principle of totality has been used to morally justify all the medical interventions that have modified the body in order to preserve the health and well-being of the patient. These include not only the act of surgically cutting open and wounding a patient—which in a non-medical context could be condemned as a gravely immoral attack on the bodily integrity of a person—but also the removal of his organs and other body parts. As we will discuss at great length in this essay, however, there are

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[10] See Pope Pius XII, "Allocution to Delegates at the 26th Congress of Urology, October 8, 1953," in Monks of Solesmes, *Human Body: Papal Teaching*, 277–81, at 277–78. For discussion, see the essay by John Haas, "The Totality and Integrity of the Body," *Ethics & Medics* 20, no. 1 (1995): 1–3.

controversial medical procedures whose moral justification is disputed precisely because it is not clear if the principle of totality applies in a particular case. Any bodily modifications that are not morally justifiable would be considered mutilations, properly so called, because they attack the good that is the integrity of the human body. As such they would have to be morally condemned. Indeed, in his moral encyclical *Veritatis Splendor*, Pope St. John Paul II included mutilation in a list of actions that are "incapable of being ordered" to God.[11] They are intrinsically evil (*intrinsece malum*).

Surgical Interventions for Body Integrity Identity Disorder

As I described in the opening vignette, BIID is a condition where patients believe that there is an incongruity between their physical body shape and their internal body scheme, resulting in an intense desire to be either amputated or paralyzed. It is exceedingly rare, with only one hundred to two hundred or so reported cases in the scientific literature, including a handful of cases from Japan and China.[12] One study of fifty-four BIID patients in the Netherlands has revealed that severe psychiatric conditions co-presenting with BIID is unusual, though depressive symptoms and mood disorders can be present. [13] The authors of the study noted that this could be explained by the enormous distress experienced by BIID patients. The Dutch study also reported that the main rationale given by BIID patients for body modification through amputation is "to feel complete" or "to feel satisfied outside."

Though there is one report that suggests that BIID patients may have altered somatosensory processing in the premotor cortex,[14] and another paper that suggests that they have structural brain abnormalities,[15] the exact cause of BIID remains unknown. Notably, it has been compared to

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11 John Paul II, *Veritatis Splendor* (1993), §80.

12 Rianne M. Blom, Nienke Vulink, Sija van der Wal, Takashi Nakamae, Zhonglin Tan, Eske Derks, and Damiaan Denys, "Body Integrity Identity Disorder Crosses Culture: Case Reports in the Japanese and Chinese Literature," *Neuropsychiatric Disease and Treatment* 12 (2016): 1419–23.

13 Rianne M. Blom, Raoul C. Hennekam, and Damiaan Denys, "Body Integrity Identity Disorder," *PLoS ONE* 7, no. 4 (2012): e34702.

14 M. T. van Dijk et al., "Neural Basis of Limb Ownership in Individuals with Body Integrity Identity Disorder," *PLoS ONE* 8, no. 8 (2013): e72212.

15 Rianne M. Blom et al., "The Desire for Amputation or Paralyzation: Evidence for Structural Brain Anomalies in Body Integrity Identity Disorder (BIID)," *PLoS ONE* 11, no. 11 (2016): e0165789.

clinical scenarios where stroke patients who have suffered a hemorrhage in the parietal cortex ask their nurse to remove "that strange leg" from their bed.[16] Regardless of its etiology, BIID raises the question of whether or not a surgical intervention—specifically the amputation of a healthy limb or limbs—can be morally justified to treat this condition.

Since there has been no official Church teaching on the treatment of this medical condition, in my view, we must begin by determining if the amputation of the healthy limb even alleviates the sometimes-extreme psychological distress experienced by BIID patients. Despite its small size and reliance on patient self-reporting, the Dutch study of fifty-four BIID patients already cited above reveals that amputation of the healthy body part appears to result in remission of BIID.[17] Every single BIID patient who had had a limb amputated—there were seven instances of this in the study—reported a substantial improvement in his or her quality of life. In contrast, only 35 percent of the patients who had undergone some sort of therapy reported that it had helped them. Psychotherapy was supportive, but it did not alleviate the symptoms of BIID.

In light of the scant medical evidence, can the principle of totality justify the surgical amputation of a healthy limb to alleviate the mental distress associated with BIID? Recall that the first condition articulated by Pope Pius XII for properly applying this principle to evaluate a surgical procedure is that the continued presence or functioning of a particular organ within the whole organism—in the case of BIID, the healthy but apparently "alienated" limb—constitutes a menace to the individual. For some BIID patients, especially those patients who experience such extreme mental distress that they are driven repeatedly to self-amputate, putting their life into immediate jeopardy, this condition could apply. Next, according to the Pope, the damage to the human patient—in this case, the extreme mental distress that places his life at immediate risk through self-mutilation—must be remediable, or at least possibly lessened measurably by the mutilation in question. The limited and short-term data from the Dutch study suggests that this second condition would be met, since amputation of the healthy limb leads to a substantial improvement in the quality of life of the BIID patient. Some may object because this Dutch study has a very small sample size, but this is not surprising given the extreme rarity of BIID. It is the only study of its kind and so we have

16 For a review, see Giuseppe Vallar and Roberta Ronchi, "Somatoparaphrenia: A Body Delusion: A Review of the Neuropsychological Literature," *Experimental Brain Research* 192, no. 3 (2009): 533–51.

17 See Blom, Hennekam, and Denys, "Body Integrity Identity Disorder."

to temper our ethical judgments, knowing that more robust evidence is not available at this time. Finally, according to the Holy Father, one must be reasonably certain that the negative effect (the mutilation and its consequences) will be compensated for by the positive effect, including the elimination of danger to the whole organism or the easing of pain. Once again, the Dutch study appears to affirm that there is a proportionate good in the substantially improved well-being of the self-mutilating BIID patient and the preservation of his life, that would compensate for the physical evil of amputating his limb. Therefore, it would seem that we can justify the amputation of a healthy limb of a BIID patient with the principle of totality, as a last-resort treatment for those few individuals whose mental distress is so extreme that it puts their physical well-being and life at substantial risk because of repeated self-harm.[18]

At least two objections can be raised against my proposal. First, an interlocutor could argue that it is unreasonable to treat a psychiatric condition with a bodily intervention, especially the surgical amputation of a healthy limb. Are we not confirming the patient in his delusion that the limb is not properly an integral part of his body? If so, we would be perpetuating a lie, which we cannot do if we are called to live a life of virtue.

In response, I have proposed that the amputation of a healthy limb has to be a treatment of last resort for BIID patients who find their mental distress so overwhelming that they are at significant risk for self-harm. It is chosen as a means to alleviate this extreme mental distress—the fear and repugnance the Catholic moral tradition has called *vehemens horror*, directed in this particular instance at an "alienated'" limb—in order to preserve the patient's life and well-being. It cannot and should not be used to treat every case of BIID. Thus, the surgical amputation is not an act that affirms the false belief that the "alienated" limb does not belong to the patient. Rather, it is a medical procedure that affirms that the healthy limb

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[18] Robert Song has made a similar argument in his "Body Integrity Identity Disorder and the Ethics of Mutilation," *Studies in Christian Ethics* 26, no. 4 (2013): 487–503. E. Christian Brugger has made a parallel argument justifying the surgical removal of healthy limbs if the procedure helped individuals struggling with body dysmorphic disorder (BDD) to resolve their mental distress. These are patients who excessively obsess about a perceived flaw of one of their limbs or body parts. See Brugger, "Catholic Hospitals and Sex Reassignment Surgery: A Reply to Bayley and Gremmels," *National Catholic Bioethics Quarterly* 16, no. 4 (2016): 587–97. Note that, in light of the recent scientific and medical studies described above, I have altered my position on the ethical permissibility of amputation in *extreme* cases of BIID where the lives of patients are in immediate jeopardy because of self-harm. See my earlier essay, "Requests for Elective Amputation," *Ethics & Medics* 36, no. 2 (2011): 1–2.

is the object of life-threatening mental distress that has to be remedied to preserve the well-being and life of the patient. The case is best compared to the healthy limb of a prisoner that is amputated in response to a tyrant who orders him to cut off his own hand or lose his head to the executioners instead. Recall that the Catholic moral tradition found that this classic case could be morally justified with the principle of totality.

Second, a critic, especially one working within the tradition of secular bioethics, could argue that my proposal unjustly limits the autonomy of the BIID patient. Instead, my interlocutor would argue that we should respect every competent patient's decisions rather than refuse them, even when these call for extreme body modifications.[19] Thus, Oxford bioethicist Julian Savulescu argues that "whether an individual's decision is ultimately respected (by doctors, family and friends) turns on whether that individual is competent or incompetent, not on whether the decision is rational or irrational."[20] Here we hear echoes of John Stuart Mill's harm principle that affirms that the free citizens in a liberal society should be free to act in whatever way they wish unless their actions cause harm to another person.

In response, the capacity to choose freely is indeed a great good deserving of respect because it emerges from our natures as rational and free creatures. However, autonomy and the freedom to determine oneself are not absolute goods that can, in themselves, morally justify human action, even if they do not directly injure another. Murderers or adulterers or thieves who freely choose to kill or to betray or to steal not only harm another person but also harm the common good by making themselves vicious individuals. Rather, actions are good because they realize some individual or communal perfection. As we already discussed above, amputating a healthy limb without a proportionate good that would justify the procedure according to the principle of totality would be an unjust attack on the integrity of the human body, which is a great good for the individual. Such an act would harm the common good in two ways, even if it did not directly injure another. First, it would make the BIID patient a vicious person who has mutilated himself, and second, it would encourage vicious acts in others who would be led to think (falsely) that they could do whatever they wished with and to their bodies.

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19 For one example of this argument, see Julian Savulescu, "Autonomy, the Good Life, and Controversial Choices," in *The Blackwell Guide to Medical Ethics*, ed. Rosamond Rhodes, Leslie P. Francis, and Anita Silvers (New York: Wiley-Blackwell, 2006), 17–37.

20 Savulescu, "Autonomy," 27.

Surgical Interventions for Gender Dysphoria

On June 1, 2015, the Olympian athlete Bruce Jenner, who had won the gold medal for the decathlon in the 1976 games in Montreal, announced on Twitter that he had changed his name to Caitlyn Jenner because this was "her true self." He also appeared on the front cover of *Vanity Fair* as a woman.[21] No one with such a high profile had ever self-identified as a transgender person before, and the event has since become a flash point in the culture wars over the nature of sex and gender in many Western societies.[22]

How do we understand the clinical case that is Bruce/Caitlyn Jenner? According to the American Psychological Association, an individual's gender identity is "a person's deeply-felt, inherent sense of being a boy, a man, or a male; a girl, a woman, or a female, or an alternative gender (e.g., gender queer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics."[23] It has to be distinguished from an individual's sex, which refers to the physical, biological, and anatomical dimensions of being a male individual or a female individual of the human species, *Homo sapiens*, and from an individual's gender role, which the European Institute for Gender Equality defines as the "social and behavioural norms which, within a specific culture, are widely considered to be socially appropriate for individuals of a specific sex."[24] Defining gender role in this way acknowledges the impact of cultural expectations on how men and women are supposed to behave in a particular society. A Japanese man has a different gender role, not only from a Japanese woman, but also from an American or a Filipino man.

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, the *DSM*-IV, was published in 1994 by the American Psychiatric

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21 Nick Allen, "Bruce Jenner Introduces Herself as Caitlyn in First Picture on Vanity Fair Cover," *The Telegraph*, June 1, 2015, telegraph.co.uk/news/worldnews/northamerica/usa/11644319/Bruce-Jenner-introduces-herself-as-Caitlyn-in-first-picture-on-Vanity-Fair-cover.html.

22 For discussions of the culture wars over gender identity and sex reassignment surgeries, see: Frank Browning, *The Fate of Gender* (New York: Bloomsbury, 2016); Ryan T. Anderson, *When Harry Became Sally* (New York: Encounter, 2018); Abigail Shrier, *Irreversible Damage* (Washington, DC: Regnery, 2020).

23 American Psychological Association, "Guidelines for Psychological Practice with Transgender and Gender Nonconforming People," *The American Psychologist* 70, no. 9 (2015):832–64, at 834.

24 European Institute for Gender Equality, "Gender Roles," eige.europa.eu/rdc/thesaurus/terms/1209.

Association (APA) and included a psychological diagnosis for "gender identity disorder" that centered on the experience of persistent and pervasive cross-gender self-identification.[25] Nearly twenty years later, in 2013, the fifth edition, the *DSM*-V, replaced "gender identity disorder" with the novel diagnostic term, "gender dysphoria," which highlights the psychological distress or dysphoria experienced by some individuals who struggle with their gender identity rather than their feelings of gender incongruence.[26] This shift in the *DSM*-V represents a change in the APA's earlier view that a patient's experience of gender incongruence constituted a mental disorder. Instead, according to the revisionist account found in the *DSM*-V, the experience of gender incongruence becomes a psychiatric issue only if it is accompanied by psychological distress. The gender incongruence itself, according to the *DSM*-V, is not a problem. Nonetheless, regardless of how we understand the condition, according to one review of the literature, the prevalence of a self-reported transgender identity in children, adolescents, and adults ranges from 0.5 percent to 1.3 percent.[27]

GD remains a condition of unknown etiology. The current scientific consensus for the development of gender identity is that it "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."[28] Thus, as we will discuss in greater detail below, in my view, it is likely that GD will be linked to biological, psychological, and social factors. GD needs to be distinguished from Disorders of Sex Development (DSD), also called "intersex conditions," where a person is born with ambiguous reproductive and/or sexual anatomy that is neither male nor female, and from homosexuality, where an individual is attracted to persons of the same sex. Instead, a transgendered individual feels that he is not a man, even if he is male, or that she is not a woman, even if she is female. For these persons, their gender identity does not correspond to their biological sex. They often explain that they feel trapped in a body that is the wrong sex.

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25 American Psychiatric Association, "Gender Identity Disorder," *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington, DC: American Psychiatric Association, 1994), nos. 302.6 and 302.85 (p. 537).

26 American Psychiatric Association, "Gender Dysphoria," *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Association, 2013), 452.

27 Kenneth J. Zucker, "Epidemiology of Gender Dysphoria and Transgender Identity," *Sexual Health* 14, no. 5 (2017): 404–411.

28 Gönül Öçal, "Current Concepts in Disorders of Sexual Development," *Journal of Clinical Research in Pediatric Endocrinology* 3, no. 3 (2011): 105–14, at 111.

Jason Cromwell, who was born a girl, describes his experience as follows: "I didn't 'desire to be' but rather *I was* a boy, if only in my mind."[29]

Most transgendered adults trace their experience of gender incongruence to their childhood.[30] However, there is one report that suggests that only 37 percent of children who were referred to a Dutch clinic for GD actually persisted and became transgendered adolescents.[31] This finding coheres with earlier studies that had revealed that most children (80 percent or more) who experience GD desist and resolve their gender identity disorder before they become adolescents.[32] At this time, it is unclear why these young desisters are able to reconcile their gender identity with their biological sex while the persisters cannot. Tragically, GD is associated with high suicide rates, especially among young people.[33]

Though most instances of GD manifest in childhood, one study from Brown University has now described teenagers and young adults who report experiencing GD without any pre-pubertal symptoms.[34] The data suggests that this atypical presentation of the condition—called rapid-onset GD—may spread through groups of friends and may be a harmful coping mechanism like taking drugs, consuming alcohol, or self-cutting. It is not clear how this form of GD is related, if it is, to the early-onset GD that first appears in childhood.

Finally, we have to acknowledge, as my pastoral experience has confirmed, that different individuals experience and manage their GD in different ways. For example, some men with GD may be able to cope with their psychological distress simply by wearing women's panties underneath their men's trousers and shorts every day. Others may choose to dress in

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29 Jason Cromwell, *Transmen and FTMs: Identities, Bodies, Genders, and Sexualities* (Urbana: University of Illinois Press, 1999), 145 (emphasis original).

30 T. O. Nieder et al., "Age of Onset and Sexual Orientation in Transsexual Males and Females," *The Journal of Sexual Medicine* 8, no. 3 (2011): 783–91.

31 Thomas D. Steensma et al., "Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study," *Journal of the American Academy of Child & Adolescent Psychiatry* 52, no. 6 (2013): 582–90.

32 For discussion, see Thomas D. Steensma and Peggy T. Cohen-Kettenis, "More Than Two Developmental Pathways in Children with Gender Dysphoria?" *Journal of the American Academy of Child & Adolescent Psychiatry* 54, no. 2 (2015): 147–48.

33 Russell B. Toomey, Amy K. Syversten, and Maura Shramko, "Transgender Adolescent Suicide Behavior," *Pediatrics* 142, no. 4 (2018): e20174218

34 Lisa Littman, "Rapid-Onset Gender Dysphoria in Adolescents and Young Adults: A Study of Parental Reports," *PLoS ONE* 13, no. 8 (2018): e0202330. Also see Littman, "The Use of Methodologies in Littman (2018) is Consistent with the Use of Methodologies in Other Studies Contributing to the Field of Gender Dysphoria Research: Response to Restar (2019)," *Archives of Sexual Behavior* 49, no. 1 (2020): 67–77.

women's attire for one weekend, and only for one weekend, once a year during an escape vacation in Las Vegas. This is enough for them to live out their lives in peace. However, still others may decide that the only way that they can properly manage their GD is by choosing to undergo transitioning, the process whereby they change their physical appearance so that it coheres better, not with their biological sex, but with the gender identity that they experience as a given. This process involves surgical modifications of the body, including cosmetic interventions that alter the form of the face and the body; "top" surgeries that involve mastectomies for female-to-male transgendered persons and breast augmentation for their male-to-female transgendered counterparts; and "bottom" surgeries that require reconstructing the urinary and reproductive structures of transgendered patients so they resemble those of their chosen gender identity rather than those of their biological sex. These surgical procedures would be supplemented with lifelong hormonal treatments that alter the secondary sexual characteristics of the transgendered patient.

Are the surgical procedures involved in gender transitioning morally justifiable? The Catholic Church has not yet made a definitive statement regarding these procedures.[35] Nonetheless, the majority of Catholic moralists oppose these surgical interventions because they see them as bodily mutilations that cannot be justified by the principle of totality.[36] They argue

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35 Notably, the Charter for Healthcare Workers published by the Pontifical Council for Pastoral Assistance to Health Care Workers in 1995 stated the following: "The physical integrity of a person cannot be impaired to cure an illness of psychic or spiritual origin. . . . And this is why the principle of totality cannot be correctly taken as a criterion for legitimatizing anti-procreative sterilization, therapeutic abortion and transsexual medicine and surgery" (§145; available on the Vatican website). However, the new edition of the Charter published in 2016 makes no mention of gender transitioning surgery. See Pontifical Council for Pastoral Assistance to Health Care Workers, *New Charter for Health Care Workers*, trans. The National Catholic Bioethics Center (Philadelphia: The National Catholic Bioethics Center, 2017).

36 For recent examples, see the following essays: Richard P. Fitzgibbons, Philip M. Sutton, and Dale O'Leary, "The Psychopathology of 'Sex Reassignment' Surgery," *National Catholic Bioethics Quarterly* 9, no. 1 (2004): 97–125; Benedict M. Guevin, O.S.B., "Sex Reassignment Surgery for Transsexuals," *National Catholic Bioethics Quarterly* 5, no. 4 (2005): 719–34; Guevin, "Augmentation Mammaplasty for Male-to-Female Transsexuals: A Case Study for Catholic Hospitals," *National Catholic Bioethics Quarterly* 9, no. 3 (2009): 453–58; Christopher Gross, "Karol Wojtyła on Sex Reassignment Surgery," *National Catholic Bioethics Quarterly* 9, no. 4 (2009): 711–23; Nicholas Tonti-Filippini, "Sex Reassignment and Catholic Schools," *National Catholic Bioethics Quarterly* 12, no. 1 (2012): 85–97; Tad Pacholczyk, "Changing My Body To 'Match' My 'Identity'?," Making sense of Biothetics Column 121, The National Bioethics Center, July

that the removal of healthy tissues and sexual organs during gender transitioning are illicit because they are neither diseased nor life-threatening. They also point out that some gender-transitioning procedures—and they mean here especially, "bottom" surgeries—could never be justified because they are acts of sterilization that remove normal tissue that is required for procreation. Sterilization is morally illicit because it undermines the integrity of the gift of self, for here the spouse not only withholds his fertility from his wife but also refuses to accept her fertility, and vice versa. Finally, several of these scholars argue that gender transitioning is morally unjustifiable because it involves the rejection of the God-given personhood that is manifested through our sexuality. For all these scholars, all the surgical procedures involved in gender transitioning are intrinsically evil. They could never be morally justified in any circumstance.

In contrast, a handful of faithful Catholic moral theologians are exploring the possibility that the surgical procedures associated with gender transitioning may be justifiable in certain cases.[37] In their view, these interventions would not be intrinsically evil. I will summarize one recent proposal here to illustrate the general structure of these arguments.

Citing the example of Pope Pius XII's use of the principle of totality to justify the removal of a cancer patient's healthy testicles to prevent his prostate tumor from killing him we described above, Becket Gremmels notes that the removal of healthy organs can be justified if these organs are life-threatening, even if it sterilizes him.[38] The sterilization would be a foreseen but unintended side effect justifiable by the principle of double

30, 2015, https://www.ncbcenter.org/making-sense-of-bioethics-cms/column-121-changing-my-body-to-match-my-identity; Moira McQueen, "Catholic Teaching on Transgender (Gender Dysphoria)," *Bioethics Matters* 14, no. 1 (2016): 1–4; Brugger, "Catholic Hospitals and Sex Reassignment Surgery"; Travis Stephens, "The Principle of Totality Does Not Justify Sex Reassignment Surgery," *Ethics & Medics* 41, no. 11 (2016): 1–2; John F. Brehany, "Pope Pius XII and Justifications for Sex Reassignment Surgery," 24, no. 4 (2016): 18–21. Additionally, see National Catholic Bioethics Center, "Brief Statement on Transgenderism," *National Catholic Bioethics Quarterly* 16, no. 4 (2016): 599–603.

37 For recent examples, see the following essays: Carol Bayley, "Transgender Persons and Catholic Healthcare," *Health Care Ethics USA* 24, no. 1 (2016): 1–5; Becket Gremmels, "Sex Reassignment Surgery and the Catholic Moral Tradition: Insight from Pope Pius XII on the Principle of Totality," *Health Care Ethics USA* 24, no. 1 (2016): 6–10; Gremmels, "More Insight from Pius XII, a Reply to Brugger and Brehany, and a Clarification," *Health Care Ethics USA* 24, no. 4 (2016): 7–17; David Albert Jones, "Gender Reassignment Surgery: A Catholic Bioethical Analysis," *Theological Studies* 79, no. 2 (2018): 314–38.

38 Gremmels, "Sex Reassignment Surgery," 8.

effect. He then proposes that the removal of a transgendered individual's sex organs and other tissues, even if they are healthy, is morally licit because these organs were causing the patient mental distress that was so extreme that they threatened the spiritual well-being of "the whole person."[39] In this scenario, a surgical intervention could be justifiable if it were known that these procedures could remedy and alleviate the threat to the spiritual good of the whole transgendered patient. As Gremmels explains it, citing other Catholic moral theologians who have proposed this view in the twentieth century, this is an account of the principle of totality that does not see the whole of the patient only a bodily reality, but expands "totality" to encompass a personal good that includes the physiological, psychological, and spiritual aspects of the patient that are all necessary for his personal well-being. If the surgical procedures involved in gender transitioning do in fact promote this good of the whole person, then in Gremmels' view, they could possibly be justified by the principle of totality.

In my view, we have to consider four points as we think through this disputed question. First, I think that it is important to emphasize that these surgical interventions cannot change a person's sex. Sex is a biological characteristic of every single cell of the human body, and it cannot be altered by the superficial alteration of select body parts. It is also clear that there is scientific data that reveals that biological factors influence, mold, and inform the gender-specific behaviors that we observe early in childhood.[40] In other words, some dimensions of an individual's gender role are shaped by his or her biological sex. This should not be surprising, since it is known that male and female monkeys have toy preferences similar to those seen in boys and girls, suggesting that appeals to socialization alone cannot explain these sexual dimorphic characteristics in humans.[41] Clearly, then, a person's sex is part of his human nature. It is something that is given and received. It is not, as Pope Benedict XVI explained, "a social role that we choose for ourselves."[42] Therefore, the surgical procedures involved in gender transitioning do not change sex. They are attempts to conform the form of the body to the transgendered individual's gender identity as he understands it.

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39 Gemmels, "More Insights," 9.

40 V. L. Pasterski et al., "Prenatal Hormones and Postnatal Socialization by Parents as Determinants of Male-Typical Toy Play in Girls with Congenital Adrenal Hyperplasia," *Child Development* 76, no. 1 (2005): 264–78.

41 Janice M. Hassett, Erin R. Siebert, and Kim Wallen, "Sex Differences in Rhesus Monkey Toy Preferences Parallel Those of Children," *Hormones and Behavior* 54, no. 3 (2008): 359–64.

42 Benedict XVI, Christmas Greetings to the Roman Curia, December 21, 2012.

Second, I do not think that it is correct to say that a transgendered individual is a male soul in a female body or a female soul in a male body. Classically understood, the human soul as the substantial form of the human body is neither sexed nor gendered. Rather, it is the human body informed by the human soul as an integral whole that is male or female. To claim otherwise—to claim that the human soul is either male or female—would be to affirm that human males and females belong to different kinds because they have different kinds of souls.

How then do we explain the experience of the apparently mismatched gender-identity and biological sex reported by transgender persons? One way, I think, is to consider the tragic story of David Reimer, who was born Bruce Reimer, on August 22, 1965. David was born male but was raised a girl after a penile amputation during a botched circumcision. Between nine and eleven years of age, David came to the realization that he was not a girl, and he transitioned to living as a male at age fifteen. He committed suicide several decades later after suffering years of severe depression, financial instability, and a troubled marriage.

How did David Reimer "know" that he was born a boy? It is clear from the publicly available evidence that his family and everyone around him had treated him and had raised him as a girl.[43] I would propose that he "knew" that he was a boy because he had a normal male brain. This would explain how he "knew" he was a boy. Human brains are sexed in the same way that our genitalia are sexed.[44] In my view, this suggests that David's gender identity—how he understood himself as a boy rather than as a girl despite the cultural and social disinformation that he had received throughout his childhood—has a biological basis. But if this proposal is true, and I think that it has much explanatory power, then it is reasonable to posit that the biological processes that inform one's gender identity in a way that it conforms to one's biological sex could go awry. This is the very nature of biological processes. They are always prone to mutation and malfunction. If David Reimer could "know" that he was a boy, then he could also have failed to "know" his gender identity had his brain not been correctly sexed. Though this is an area of active research with much we still

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43 For details, see John Colapinto, *As Nature Made Him: The Boy Who Was Raised as a Girl* (New York: Harper Perennial, 2006).

44 J. Sacher et al., "Sexual Dimorphism in the Human Brain: Evidence from Neuroimaging," *Magnetic Resonance Imaging* 32, no. 3 (2013): 366–75. Also see Margaret M. McCarthy, Bridget M. Nugent, and Kathryn M. Lenz, "Neuroimmunology and Neuroepigenetics in the Establishment of Sex Differences in the Brain," *Nature Reviews Neuroscience* 18, no. 8 (2017): 471–84.

do not understand,[45] I will not be surprised if a neurological cause will be identified to explain the incongruence experienced by some. I emphasize that this will be for only some transgendered individuals with early-onset GD. According to this account, a transgendered person would not have a sexually mismatched body and soul, but a sexually mismatched body and brain. I doubt that a similar thing can be said about rapid onset GD, which appears to have a social etiology.

Third, returning now to the surgical procedures associated with gender transitioning, I agree with those scholars who point out that the surgical removal of healthy tissues and organs, even if they are healthy, can be justified by the principle of totality as long as this protects and promotes the well-being of the patient. This is the first criterion of Pope Pius XII for the scope of the principle of totality. As we saw above, this position has long been embraced by Catholic moralists who justify the amputation of the healthy limb of a prisoner that is severed in response to a tyrant who orders him to cut off his own hand or lose his head to the executioners instead. Whether or not an organ or a limb is healthy should not be the point of the ethical dispute. Rather we should determine whether or not that organ or limb, in the words of Pope Pius XII already cited above, "is causing serious damage or constitutes a menace" to the human patient.

In response, it is not clear if GD can be attributed to a single organ or a limb. The surgical procedures involved in gender transitioning seek to remold the entire patient's body so that it more resembles the bodily form that reveals the gender identity that he believes is truly his own. For the male-to-female transgendered person, for example, these include facial feminization surgery, breast augmentation surgery, hip augmentation surgery, vocal surgery, removal of the Adam's apple, and vaginoplasty. Thus, it is impossible to point to any one bodily part that is causing serious damage or constitutes a menace to the GD patient.

However, as Gremmels has noted, there is a precedent in the Catholic moral tradition for interpreting the "totality" of the principle of totality as encompassing not only his biological and bodily integrity, but in addition, also his psychological, emotional, and spiritual well-being. This would be a totality read in the context not of the human organism, but of the human person. It is a minority theological position, but it remains a plausible interpretation of the principle of totality that would expand its scope. Appealing to this theological argument, a Catholic bioethicist could claim

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[45] Charles E. Roselli, "Neurobiology of Gender Identity and Sexual Orientation," *Journal of Neuroendocrinology* 30, no. 7 (2018): e12562.

that the surgeries involved with gender transitioning would be justifiable if they were in fact able to alleviate the mental distress experienced by transgendered individuals, especially in those extreme cases where GD individuals have already tried to take their own lives. These then would be surgeries that involve the sacrifice of many bodily parts for the sake of the psychological well-being of the total patient. This argument would obtain, however, only if these surgeries did in fact enhance the well-being of the patient.

Finally, we conclude with the second and third criteria proposed by Pope Pius XII for the scope of the principle of totality. Recall that, for a surgical intervention to be morally justifiable, in the words of the Pope, "this damage [to the well-being of the patient] must be remediable or at least can be measurably lessened by the mutilation in question, and the operation's efficacy in this regard should be well assured."[46] Do the bodily modifications associated with gender transitioning fulfill these criteria? Do they alleviate the extreme mental distress associated with GD? In my view, this is the most important ethical question to raise regarding these surgical procedures.

Many Catholic bioethicists have noted that it is unclear if the surgical procedures to facilitate gender transitioning would meet the threshold of these two criteria of the principle of totality. One systematic review and meta-analysis concluded that around 80 percent of those interviewed in twenty-eight independent studies reported subjective improvement in terms of GD, quality of life, and psychological symptoms, though the same review acknowledged that there are many studies in the medical literature

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[46] To anticipate an objection, some critics may propose that the criteria described by the pope do not apply for GD because the mutilations associated with gender transitioning do not actually treat GD. In response, I make the following explicit comparison. First, in some patients, prostate tumor micrometastases, if allowed to grow, will interfere with vital organ function, killing the patient. Removal of the healthy testicles prevents the prostate tumor micrometastases from interfering with vital organ function, by mitigating tumor cell growth, preserving the life of the patient. The tumor micrometastases remain in the body but their lethal effects are mitigated. (We know the tumor cells remain because, if these cells mutate, and become testosterone independent, then the tumor micrometastases will relapse, which we see in some fraction of patients.) Next, to compare: In some patients, GD triggered by self-hate of the sexed body, if allowed to persist, will lead to self-harm, killing the patient. Removal of the healthy sexed organs prevents the GD from triggering self-harm, by mitigating the self-hate of the sexed body, preserving the life of the patient. The GD remains but its lethal effects are mitigated. I propose that, if one thinks that Pius XII's criteria apply in the first scenario, then they should also apply to the second scenario. In both cases, you have mitigated the lethal effects of a pathology though the presenting condition remains.

that also report high rates of psychiatric deterioration and suicide after gender reassignment.[47] However, the authors admitted that the evidence for their conclusions "is of very low quality due to the serious methodological limitations of included studies." One particular challenge is that many of the studies that were reviewed relied on patient self-reports to determine if the individual has benefitted from gender reassignment. It is difficult to ensure that patients are accurately describing themselves: Can patients who have spent years anticipating health and well-being after gender reassignment be expected to self-report after surgery that they are experiencing disappointment and regret?

In light of these methodological concerns, a population-based matched cohort study of all the patients in Sweden who underwent gender reassignment surgery between 1973 and 2003 is significant.[48] Using publicly available national registries in Sweden rather than patient self-reports, this robust study was able to capture and analyze an entire population of transgendered patients without exception to determine the long-term medical consequences of the surgical procedure. Do these surgical interventions enhance the physiological and psychological well-being of patients with GD? It appears that they do not:

> The study found substantially higher rates of overall mortality, death from cardiovascular disease and suicide, suicide attempts, and psychiatric hospitalizations in sex-reassigned transsexual individuals compared to a healthy control population. This highlights that post-surgical transsexuals are a risk group that need long-term psychiatric and somatic follow-up. Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons.[49]

Though the Swedish authors claimed that their study "does not, however, address whether sex reassignment is an effective treatment or not," I think that their data speaks for itself. Though it is only one study, it is a robust one, unlike so many of the other studies that interrogate this question, and

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47 M. H. Murad et al., "Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes," *Clinical Endocrinology* 72, no. 2 (2010): 214–31.

48 C. Dhejne et al., "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS ONE* 6, no. 2 (2011): e16885.

49 Dhejne et al., "Long-Term Follow-Up," e16885.

the numbers reveal that gender-reassignment surgeries do not substantially improve the overall well-being of transgendered patients.[50] It certainly does not eliminate the risk of self-harm and suicide. It is striking that one transgendered individual has admitted publicly in a *New York Times* op-ed that she does not expect her gender-reassignment surgery to make her happy.[51] Tragically, her expectations are corroborated by the best medical studies available.

BIID, GD, and the Common Good

The ethical analysis of surgical interventions to treat both BIID and GD described above focus on their impact on the individual good of the patient. To recapitulate the argument made earlier, there appears to be some medical evidence that suggests that these surgical interventions can ameliorate the mental distress experienced in the former condition but not in the latter. As such those surgical amputations used to treat BIID could possibly be justified while those for GD cannot.

At this time, however, I also think that it is important to briefly consider the impact of these proposed surgical treatments on the common good of society. The *Catechism of the Catholic Church* describes the common good as "the sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily."[52] The human person has a natural order and finality. This finality is revealed in each person's body, which is created either male or female in a manner that is ordered both towards the good of the individual who is called to enter into communion with a person of the opposite sex, and towards the common good of society that is structured to preserve itself through human procreation. In order to sustain the viability of human

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50 A more recent study from Sweden has suggested that gender reassignment surgery does improve the mental health outcomes of patients: Richard Bränström and John E. Pachankis, "Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study," *The American Journal of Psychiatry* 177, no. 8 (2019): 727–34. However, this study has been criticized—convincingly, in my view—by Mark Regnerus, who demonstrates the weakness of the study's conclusions: "New Data Show 'Gender-Affirming' Surgery Doesn't Really Improve Mental Health, So Why Are the Study's Authors Saying It Does?," *Public Discourse*, November 13, 2019, thepublicdiscourse.com/2019/11/58371/.

51 Andrea Long Chu, "My New Vagina Won't Make Me Happy," *The New York Times*, November 24, 2018, nytimes.com/2018/11/24/opinion/sunday/vaginoplasty-transgender-medicine.html.

52 *Catechism of the Catholic Church* §1906.

communities, men and women must be able to identify and to find each other in order to create human families that engender the children needed as future members of society. The social conditions that catalyze the formation of these human families is part of the common good.

Another difference between surgical interventions that are used to alleviate BIID from those used to try to alleviate GD is that the former have no impact on the common good while the latter do. Gender reassignment surgeries not only radically undermine the fundamental ordering of the body that is created male or female so that the human person can enter into communion with another person of the opposite sex, but also attack the ordering that is in place so that human society can preserve itself through human procreation. To put it another way, gender reassignment surgeries and the gender ideology from which they flow destabilize the conceptual and relational structures needed for human societies to more fully and more easily form the families needed to ensure the long-term viability of our communities. This uniquely distinguishes them from the many other surgical interventions that alter the human body's form and function, all of which solely impact the individual good of the patient, and maybe, the good of his family members and loved ones who care for him. As such, gender reassignment surgeries can also be rejected because of their negative impact on the common good.

Conclusion

I have proposed that surgical interventions could be justified in some cases of Body Integrity Identity Disorder. The amputation of a healthy limb has to be a treatment of last resort for BIID patients who find their mental distress so overwhelming that they are at significant risk for self-harm. In contrast, the medical evidence suggests that gender reassignment surgery cannot be morally justified by the principle of totality, whether this is understood to be either the physical or the personal totality of the patient, because the benefits of the procedure are not proportionate to the significant harms involved. In the long-term, it does not appear to alleviate the profound mental distress associated with Gender Dysphoria.

Instead, transgendered individuals should receive the psychiatric, social, and pastoral care that they will need to shoulder the heavy burden that is the profound suffering that comes with GD. And though this challenge may appear to be unbearable at first, transgendered individuals, especially those who profess to be Christian, need to be told that in Christ, all things are possible, for it is he whose yoke is easy and whose burden is light (see

Matt 11:30). Finally, the Church too must live up to her vocation to be a sign of God's compassion and mercy in the world by working to mitigate and to remove the social stigma and profound shame associated with this condition. Transgendered individuals must know that they are loved. N&V