A Review and Analysis of *Understanding Gender Dysphoria: Navigating Transgender Issues in a Changing Culture*

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Introduction

This paper is a review and analysis of *Understanding Gender Dysphoria*: *Navigating Transgender Issues in a Changing Culture*, authored by Mark A. Yarhouse (2015a). I also offer suggestions about complementary and supplemental readings and resources. Some of the authors of this additional material are mental-health professionals, while others are para- or non-professional, including pastoral caregivers and lay caregivers.

Dr. Yarhouse states in the Introduction that he wrote *Understanding Gender Dysphoria* because "there is a need for a resource that is written from a Christian perspective and is also informed by the best research we have to date, as well as seasoned with compassion for the person who is navigating gender dysphoria" (p. 10). Through this book, he has attempted to offer, in particular, professionally and pastorally sound wisdom to persons who experience *gender incongruence* (Yarhouse & Burkett, 2003) and also to youth ministers who try to help their charges to better understand themselves and to act morally and maturely as sexual human beings (Yarhouse & Hill, 2013).

Yarhouse has studied empirically the experiences of persons who self-identify as "transgender." His studies include learning how persons' perceiving that they *are*—that they self-identify as—*transgender* and engaging in transgender activities and behavior have affected their relationships with God *as* Christians and *with* other Christians (Carr & Yarhouse, 2014; Carr, Yarhouse & Thomas, 2014; and Yarhouse & Carr, 2012). Strictly speaking, persons who experience *gender dysphoria* commonly are struggling with what often are qualitatively different issues than many who fit under the "transgender umbrella," and Yarhouse has given the topic of *gender dysphoria*, as well as the formally diagnosed *Gender Dysphoria*,

particular attention in *Understanding Gender Dysphoria* (Yarhouse, 2015a; 2015b).[1]

After describing an anecdote of meeting a certain "male-to-female transgender person" who was also a "conservative Christian," Yarhouse comments that "[t]his experience, together with other personal and professional experiences, led my research group to a series of trainings and consultations around gender dysphoria and eventually the decision to conduct the study of the experiences of transgender Christians" (p. 10). He notes that discovering the sincerely held faith of these persons— sometimes apparently in spite of and at other times because of dealing with gender dysphoria—"was humbling to me as a Christian and a researcher" (p. 11). He invites readers to reflect upon the results of his empirical study in particular, as well as "a broader research literature . . . and other anecdotal accounts." His goal is to help readers "to gain greater insight into the experiences of persons who navigate gender dysphoria, recognizing that there is no one story that can capture the range of experiences that exists today" (p. 11).

I. Gender Incongruence and Distress—Gender Identity Disorder (GID)—*Gender Dysphoria*

In Chapter 1, entitled *Gender Identity, Gender Dysphoria and Appreciating Complexity*, Yarhouse introduces readers "to the language, categories, and key terms associated with the topic" of distressful gender incongruence, i.e. *gender dysphoria* (p. 11). He defines "a person's sex" as his or her "physical, biological and anatomic dimensions of being male or female and a person's "gender" as the "psychological, social and cultural aspects of being male or female" (p. 16). Over several pages, Yarhouse clarifies and distinguishes *biological sex, primary sex characteristics, secondary sex characteristics, gender, gender identity* and *gender role* (p. 17). Several Tables on page 18 offer useful distinctions, such as the *Physical/Biological/Anatomical Facets of Being Male or Female*, in terms of *Chromosomes*, *Gonads*, *Sexual Anatomy*, and *Secondary Sex Characteristics*. He further explains the binary distinctions for *Biological Sex* (male or female), *Gender Identity* (man or woman), and *Gender Role* (masculine or feminine), as well as the exceptions to these binary differences, i.e., *Intersex*, *Androgyny*, and *Outside Cultural Norms*, respectively (p. 18).

The fundamental and foundational definition for the book concerns the meaning of the more common condition of *gender dysphoria* and the diagnosis of the rarer phenomenon of *Gender Dysphoria* (lower and upper case spelling intentional). Yarhouse writes: "Gender identity concerns—or . . . gender dysphoria—refers to experiences of gender identity in which a [man's] psychological and emotional sense of [himself] as female, does not match or align with [his] birth sex as male." Or, when a woman's psychological or emotional sense of herself as male does not match or align with her birth sex as female. In other words, "gender dysphoria [is] the experience of having a psychological and emotional identity as either male or female, and that your psychological and emotional identity does not correspond to your biological sex" (p. 19).

There is a perceived incongruity or mismatch between one's biological sex and one's psychological or emotional identity (e.g., a person is born one biological sex but

[1] Note that whenever Yarhouse mentions *gender dysphoria* (lower case), he is referring to the *distress* which commonly accompanies the experience of *gender incongruence*, the mismatch between a person's biological or "assigned" (see below for further clarification) sex and his or her perceived, felt and/or intended gender. When he mentions *Gender Dysphoria* (upper case), he is referring to formal DSM-5 diagnosis.

feels the psychological or emotional identity of the other, opposite sex). So, in gender dysphoria, a biological female perceives or feels herself to be or have the psychological or emotional identity of a male, and a biological male, perceives or feels himself to have or be the psychological or emotional identity of a female. This "perceived incongruity" between one's birth or biological sex and one's perceived or felt gender or sex can be the source of deep and ongoing discomfort (i.e. psychological or emotional distress or dysphoria). When persons' experiences of "gender incongruence"—the misalignment of one's "birth sex and psychological sense of gender"—causes "them significant distress or impairment, they may meet criteria for the [formal, professional] *diagnosis* of Gender Dysphoria" (p. 19).

On pages 20–21, Yarhouse again makes important distinctions and clarifications, while defining another long list of words. These include *gender dysphoria, transgender, cisgender, gender bending, cross-dressing, third sex* or *third gender, transsexual, male-to-female, female-to-male, genderfluid, genderqueer, drag queen, drag king, transvestism,* and *intersex*. A crucial word to know is *transgender*, which "is an umbrella term for the many ways in which persons might experience and/or present and express (or live out) their gender identities differently form people whose sense of gender identity is congruent with their biological sex" (p. 19, 21).

At the end of this first chapter, Yarhouse mentions two themes that he repeats often later in the book. First, he sees "value in encouraging individuals who experience gender identity conflicts to resolve the conflicts in keeping with their birth sex if possible." Also, he recognizes "the potential value in managing the gender identity conflict or concern through the *least invasive means* (recognizing surgery as the most invasive step toward expression of one's internal sense of identity)" (p. 25, emphasis added).

II. Challenges for (Evangelical) Christian Leaders, Pastors and Laypersons

In the Second Chapter entitled *A Christian Perspective on Gender Dysphoria,* Yarhouse advises that there

> is a need to balance between two hazards when we turn to the Bible to inform our discussion about gender dysphoria. The one hazard is to look to Scripture for answers it is not prepared to provide. The other hazard is to fail to critically reflect on the socio- cultural context in which we live and make decisions about gender identity and dysphoria (p. 30).

Yarhouse advises Christian leaders, pastors, and laypersons that while gender dysphoria, if significantly disabling, is "a mental health issue that is a diagnosable condition," i.e., Gender Dysphoria. But they

> . . . might not view mental health issues and moral issues in the same way as the broader culture views these issues. It might not be enough to just point to a diagnostic manual for confirmation that an issue is strictly a mental health concern and that it has nothing to do with moral and ethical considerations." (p. 30).

In this respect, understanding that the presence of a diagnosable mental health condition may help explain, but does not excuse or condone, the otherwise unacceptable behavior.

After discussing biblical passages which frequently are cited—sometimes properly and helpfully, sometimes not—in response to

concerns about a person's gender dysphoric feelings or behavior, Yarhouse describes the value in considering "The Four Acts of the Biblical Drama." He "tries to think about sexuality and gender in the context of God's redemptive plan for creation," whose four acts are "*creation, the fall, redemption* and *glorification*." After describing these acts in some detail, Yarhouse explains that "a Christian explanation of the biblical drama" offers "an understanding of sin (which also) brings with it a corresponding affirmation of the *inherent goodness of creation"* (p. 45).

Along with observing and understanding "the goodness of our physical existence and ourselves as gendered persons," he advises recognizing and distinguishing the "different aspects of our sexuality: *gender sexuality, erotic sexuality* and *genital sexuality*" (p. 36). Yarhouse encourages the valuable reflection on God's purpose in creating two sexes and teasing out "the meaningful differences between men and women . . . from our sociocultural context." He further asserts that "the view that 'gender enables unity'" between man and woman is important to consider (p. 36).

Yarhouse notes that an authentic Christian perspective of human beings describes and explains both the inherent goodness of man and woman—and men and women—and that this "goodness is *tainted and incomplete in some ways*" (p.45, emphasis in original).

> Christians recognize that we are marred by the fall—we are broken, incomplete and disordered persons. However, the reality of redemption and the hope of resurrection tells us never to give up and that God's grace is sufficient to cover all of what we may encounter (including our own wrongs) if we are in a right relationship with God (p. 45–46).

III. Four Frameworks or Lenses for Perceiving and Conceptualizing Gender Identity Concerns

In Chapter 2, Yarhouse discusses a theme which he frequently repeats in later chapters. He perceives that there are three different frameworks or lenses for perceiving and conceptualizing gender identity concerns. These include the *integrity* framework, the *disability* framework, and the *diversity* framework. And Yarhouse recommends that persons, especially Christians and others who are committed to the *integrity* framework, adopt a fourth: the *integrated* framework, which combines the best of the insights of the other three.

The *integrity* framework "views sex and gender and, therefore, gender identity conflicts in terms of 'the sacred integrity of maleness or femaleness stamped on one's body' (Gagnon, 2007)". By contrast, the *disability* framework considers 'gender dysphoria . . . with reference to the mental health dimensions of the phenomenon." As Yarhouse points out, "a preference for seeing the diagnosis of Gender Dysphoria as a disability of some kind still raises many questions about etiology, prevention, maintenance, and treatment and care" (p. 480). Professionals and non-professionals who view their difficulties primarily through the "lens of disability" may seek palliative care (such as adopting cross-gender dress) or medical interventions (such as hormonal treatments and amputational and plastic surgery), which integrity lens persons understandably find problematic (p. 49).

By contrast, the *diversity* framework views "transgender issues . . . as something to be honored or revered, . . . as reflecting an identity and culture to be celebrated as an expression of diversity." Yarhouse perceives that there are *strong* and *weak* forms of this framework. Diversity *strong* formers, "a small but vocal (and often vey well-educated)

group, often call "for the deconstruction of norms related to sex and gender." Such persons reportedly "wish to recast sex as *just as socially constructed* as gender" (emphasis in original). Diversity *weak* formers, by contrast, focus "primarily on identity and community" (p. 50). Those who adhere to the *weak* form of the diversity framework prioritize the needs of the strugglers for support in answering fundamental, existential questions about their "identity ('Who am I?') and (their) community ('Of which community am I a part?')" (p. 51) or, "To—or with—whom do I belong?"

Christians—as well as, arguably, all persons who genuinely are trying to seek the truth and be of good will—are challenged on the one hand to reject the *strong* from of the diversity framework which clearly is committed to undermining (i.e., deconstructing) the Judeo-Christian and philosophical reality, culture and lifestyles of "sex and gender." Others who may object to this framework include those influenced by pre-Christian (e.g., Chabad-Lubavitch Media Center and Jewish Institute for Global Awareness) and a-religious (i.e., philosophical) perspectives (Rice, 1999; Sullivan, n.d.). On the other hand, Christians, et al. are challenged to learn from the *weak* side diversity framework about the need for and the ways of providing "meaning-making structures for identity and community" for persons suffering with gender incongruence and distress (p. 53).

Finally, Yarhouse describes and recommends for Christians a fourth lens for viewing gender dysphoria: the *integrated* framework. He writes: "My concern is that any of one of these three frameworks—to the exclusion of the best the others have to offer—will likely be an inadequate response for the Christian community." He encourages all readers, especially Christians, to "identify the strengths of each framework and apply to how we approach"—and serve—"the person who is navigating this terrain" of gender incongruence and distress (p. 53).

IV. Phenomenology, Prevalence, Causes, Prevention and Treatment of *Gender Dysphoria*

Throughout *Understanding Gender Dysphoria*, Yarhouse repeatedly calls on professionals (academic and clinical); church leaders; theologians and pastors; public officials; those who experience gender confusion and related distress, including *Gender Dysphoria*, and their families, friends and others with whom they may have contact to consider gender dysphoria with *humility*. Specifically, he invites and challenges all to a *humble* (i.e., honest and realistic) acceptance about what *is* – and is *not* – known about gender dysphoria (and *Gender Dysphoria*, case and italicizing intentional). Also, Yarhouse encourages all whose lives are involved with serving those with gender confusion and related distress to consider how best to help them, including seeking, offering and providing medical, mental health and pastoral remedies which are the "least invasive" as possible (e.g., cf. p. 123–124).

In Chapters 3–5, Yarhouse focuses primarily on the Causes, Phenomenology and Prevalence, and the Prevention and Treatment of Gender Dysphoria, respectively. Overall, he does a masterful job of, in his words, *humbly* reviewing what professionals in contemporary mental and medical health arts and sciences know *and do not know* about what causes—or at least influences—the development of gender incongruence and distress, in general, and *Gender Dysphoria*, in particular.

Yarhouse's *humble* answer to the question (and title of Chapter 3): "What Causes Gender Dysphoria?" is simple and direct. "The most concise answer to the question of causation is this: *we do not know*

what causes gender dysphoria. The reality is that while there are several theories for the etiology of gender dysphoria, the cause(s) is still unknown" (p. 61, emphasis in original). Complicating an accurate understanding of causation are three issues.

First, there is a wide continuum of perceptions, feelings, and behaviors which may be involved. These include the experiences of gender incongruence and distress themselves, as well as a range of behaviors, which may include suffering or acting out privately, as well as more public "cross-dressing, gender-bending, male-to-female transgenderism, female-to-male transgenderism, and so on" (p. 65). Second, "[m]ost of the research on causation has focused on the experience of transsexual persons whose cross-gender identification is profound" and who "typically identify as the other gender and may decide at some point to pursue hormonal treatment and/or sex-reassignment surgery" (p. 65). And third, each of these phenomena may have "its own specific cause(s). It may very well be that there are multiple pathways to the same endpoint (*equifinality*)" (p. 65, emphasis in original).

Yarhouse comments on the differences among the many kinds of degrees of gender incongruence, co-related distress, and their expressions, noting that "transgender" has been used as a heterogenous "umbrella" term which offers more ambiguity than clarity (cf. p. 61–66) And, he describes and mentions the limitations of the major theories of causation of "transgenderism." Specifically, these are Brain-Sex Theory, including the *prenatal hormone* and the *neuroanatomic brain differences* hypotheses; Blanchard's Typology, which attempts to categorize "distinct subtypes of transsexuals based on" persons' preferred object of "sexual attraction/orientation" (p. 74); and various Multifactorial Models with an emphasis on Psychosocial Factors.

Along with a "We do not know" humility about the etiology/causation of phenomena variously entitled *gender incongruence*, *gender identity concerns*, and *transgenderism*, Yarhouse wisely discusses the concepts of "*equifinality* and *multifinality*. *Equifinality* says that there could be multiple pathways to the same outcome *Multifinality* says that a group of people could have the same factors as part of their history but have different outcomes" (p. 79). As he tries to clarify what truths concerning causation may be gleaned from the theories and research which he reviews, Yarhouse comments "that a weighted interactionist model of etiology would consider contributions from both nature and nurture, from both biology and environment without giving too much weight at this point to any one unifying theory." (p. 80).

While not ruling out the possibility of a primarily biologically based causation for some people, he speculates that given the current state of research and the

> . . . wide range of gender variant presentations, . . . [f]or less severe gender identity presentations, perhaps the biological contributions take the form of temperamental and personality differences or sensory reactivity, followed by environmental conditions and social learning, among other factors, including but not limited to parental preferences, indifferences, reinforcement and modeling (Meyer-Bahlburg, 2002, p. 372, referenced in text)" (p. 80).

Relevant to the phenomenology and prevalence, as well as the causation, of gender incongruence, is Yarhouse's observation that "there are so many variations in experience and presentation that knowing one transgender person tells you very little about transgender persons as a

group." Also important, particularly for persons of faith challenged to respond to their own or another's experience of gender incongruence, is answering the question: "What is volitional here?" He offers for reflection his observations that while a "person can choose to engage in cross-gender behavior," his or her "experience of *true gender dysphoria* . . . is not chosen, nor is it a sign of willful disobedience, personal sin, nor the sin of his parents as such" (p. 81).

Overall, Yarhouse's distinguishing between gender incongruence and distress (GInDi), in general, and *Gender Dysphoria* (DP) in particular, highlighting that GInDi occurs on a continuum, and reporting that a DSM-5 diagnosis of GD is a truly rare condition, are significant and noteworthy contributions. Yarhouse's efforts to educate Evangelical Christian pastors and other religious leaders about the implications of the valid knowledge and wisdom of the contemporary mental and medical health arts and sciences for Evangelical Christians also are commendable. Hopefully this scientific knowledge and professional wisdom will be studied and used to guide pastoral practice as appropriate.

V. More Humility Is Needed by Medical and Mental Health Arts and Science Professionals

Yarhouse has done a scholarly and thoughtful job of discussing the subjects of *gender incongruence distress* and Gender Dysphoria from the perspectives of the contemporary Medical and Mental Health Professions and Evangelical Christianity worldviews. While Yarhouse has written "a lot," no book can say "everything," and more deserves to be said.

For example, in spite of prior explanations (Whitehead 2000, 2011) which clearly explain that there is insufficient evidence to assert that gender incongruent and dysphoric—let alone transgender—persons are simply "born that way," research and media commentary to the contrary continue. To illustrate, a recent study (Spizzirri et al., 2018) comparing "treatment-naïve or hormone-treated transgender women" led to public media commentary touting the "born that way" hypothesis (Fernandez, 2018; Jackman, 2018). Other commentary questioning whether people really are transgender and what the research actually and reasonably shows also has appeared (Brown, 2018).

In his efforts to communicate what is generally valid—and perhaps wise to consider in the cases of particular persons—about the *Disability* and *Diversity* frameworks, Yarhouse may have offered more respect than some of the promoters of these frameworks deserve. For example, the worldview and motives of the American Psychiatric Association[2], which was ultimately responsible for composing and publicizing the DSM-5, which included officially retiring the diagnosis of *Gender Identity Disorder* (GID) and replacing it with *Gender Dysphoria* (GD), warrant careful scrutiny.

James Phelan (2014) writes that while advocates of those who publicly promote the practice of gender non-conforming behaviors

> . . . wanted to normalize the condition of gender nonconformity, and felt that mental diagnosis was stigmatizing, they still wanted a formal diagnosis instituted so individuals could have access to [i.e., health insurance and other companies and financial supporters would pay for] cross-sex hormones, gender reassignment

[2] Among non-professionals, the American Psychiatric Association and the American Psychological Association are often confused. Also, each commonly refers to themselves as the "APA." From this point, any use of the initials "APA" will mean the American *Psychiatric* Association.

> surgery and social and legal transition (e.g. defense for transgender people who have experienced discrimination based on their gender identity).
>
> Advocates criticized psychiatry for pathologizing transgenderism and so they pressured the APA to change the name. The APA admits that its change was to be sensitive to special interests [sic] groups, rather than as a result of overwhelming empirical and field data to support changing the diagnosis of GID [Gender Identity Disorder]. This pattern was generally the case for many areas of the DSM-5 (Allen, 2010)" (p. 14–15).

It is sobering to realize that at the same time it was changing the diagnosis of GID to GD, in the initial printing of the DSM-5, the APA either changed significantly the criteria for diagnosing disorders of human sexuality or declined to diagnosis them, without having sufficient research or clinical experience as justifications for these decisions.[3]

VI. The Ethics of (Non)Invasive Medical Treatments for Teens and Youths with Gender Dysphoria (GD)

In reviewing in Chapter 5 the "cutting edge" professional wisdom on the Prevention and Treatment of Gender Dysphoria (GD), Yarhouse clearly reminds readers about the "value in encouraging individuals who experience gender identity conflicts to resolve the conflicts in keeping with their birth sex if possible." He also sees "potential value in managing the gender identity conflict or concern through the *least invasive means"* (i.e., avoiding—as increasingly invasive—hormonal treatment, plastic surgery, and amputation surgery). Yarhouse clearly espouses compassion and empathy for those who experience and struggle with gender dysphoria, which he perceives as the beneficial contributions of the Disability Framework. And he understandably promotes a "choose the lesser of two evils" ethic when helping strugglers find ways to best *manage*—when they have exhausted their efforts to *resolve*—their gender identity distress.

Yarhouse's perspective is wisely supplemented by other expressions of professional and social activist concerns, which assertively challenge contemporary medical and mental healthcare responses to gender incongruence, GD, and transgenderism/transsexualism. Various medical and mental health organizations *do* support the mission of those strugglers and would-be overcomers of gender identity confusion, gender incongruence and distress, and Gender Dysphoria, who want to manage and resolve their difficulties from an Integrity perspective.

[3] For 60 years (1952–2012), the APA officially diagnosed *pedophilia* as an unhealthy psycho-sexual deviation. As with the change in the definition and diagnosis of gender incongruence and distress from Gender Identity Disorder to Gender Dysphoria, similar changes occurred with the definitions and diagnoses of the "paraphilias," particularly "pedophilia." In effect, in the DSM-5's initial publication, persons were not considered diagnosable and treatable for having a *pedophilic disorder* unless they were either distressed about desiring, imagining or acting this way, or had gotten in trouble for doing so. Thankfully, in the text revision of the DSM-5, the APA amended the diagnosis for *pedophilia* to the DSM-IV-TR (APA, 2000) criteria (APA, 2013c). *Pedophilic disorder* is again diagnosable if the person engages in a *pedophilic* act, *even* if he or she is *not* distressed about having imagined, wanting to or having done so, or in trouble for having done so. It is unclear whether the professional trustworthiness of the APA is more questionable due to APA's initial formulation of the DSM-5 diagnosis or its relatively hasty response to "revise the text" in response to "public"—not "professional"—outcry. Also, while the APA identified a number of *sexual dysfunctions* in the DSM-5, "hypersexuality" was not one of them, even though the mental health field has been formally treating *sexual compulsion*, including *sexual addiction,* for over 30 years (Carnes, 1992, 2001, 2015). Ironically, there are many diagnoses in the DSM-5 concerning sexual gratification, which cover unsatisfactory attempts to achieve sexual orgasm or non-pleasurable, including painful, experiences while attempting to do so. But there is *no* diagnosis for persons experiencing "clinically significant impairment or distress" due to engaging in too much sexual activity (i.e. *hypersexuality)* (Grant, 2018; Reid & Kafka, 2014).

For example, the American College of Pediatricians (ACPeds)[4] and its members are explicitly committed to science and the natural moral law principle of "first do no harm." ACPeds has persistently confronted the aggressive, pro-transgender agenda currently dominating mainstream medicine. This organization has warned that many current practices and promotion of *gender ideology* are harming children (Cretella, Van Meter & McHugh, 2017). The ACPeds President has confronted the "suppression of debate" about genuinely humane, medical and mental healthcare responses to gender dysphoria in children (Cretella, 2016) and the large-scale abuse of children, which has resulted from the infiltration of "transgender ideology" into pediatrics (Cretella, 2017).

And, in the ACPeds' *Scribit Veritas* blog, the anonymous Dr. Veritas (January 30, 2017) asserts from an unabashedly *integrity*-based perspective:

> Gender does matter! . . . Though the world we live in may try to blur the lines of gender and confuse children and adults on the importance of their own biological gender, we must continue to help our children see the importance of their being male or female. Gender is not something that should be changed; it is something innate in ourselves . . . an essential characteristic of our identity as human beings.

This blogger explains "why gender matters" by quoting the four foundational principles underlying a monograph by the Australian *National Strategic Summit on Marriage, Family & Fatherhood* (n.d.), which outlines and is entitled: *21 Reasons Why Gender Matters***.** These principles include:

1. Gender differences exist; they are a fundamental reality of our biology and impact our psychology. Our maleness and femaleness is a key aspect to our personhood.
2. Acknowledging, rather than ignoring (or worse denying), gender differences is the only intellectually honest response to this reality.
3. Gender differences are complementary; individuals, our collective humanity, and society as a whole, all benefit from masculine and feminine characteristics. We are better for having men with a clear understanding of their masculinity and women with a clear understanding of their femininity.
4. Gender identity confusion does exist in a small minority of individuals. It is a painful pathology and warrants a compassionate response. However it is not the "normative" experience and is not therefore a paradigm upon which to drive social policy and institutions.

ACPeds actively networks with other medical organizations who share common concerns about how the transgender/transsexuality promotion movement has negatively influenced medical and mental healthcare. Some of these organizations are more explicitly proactive about these concerns and have accessible materials on their websites (see the Alliance for Therapeutic Choice and Scientific Integrity and the Christian Medical & Dental Association), while others (Association of American Physicians & Surgeons and Catholic Medical Association) as of this writing, do not (Cretella, 2018). The NARTH

[4] Website contact information for medical and pastoral ministry organizations listed in this and subsequent sections of this book review may be found in the list of *Resources for Persons with Gender Dysphoria, Families and Churches* at the end.

Scientific Advisory Committee (2007) likewise engaged in a critical review of the Kenneth Zucker research on gender identity disorders in children and adolescents, and NARTH's successor organization, the Alliance for Therapeutic Choice and Scientific Integrity, has a number of Integrity framework supportive documents listed on its website.

Particular psychiatrists also have publicly challenged the medical/mental healthcare establishment's promotion of hormonal and surgical responses to the concerns of persons with gender dysphoria. Dr. Paul McHugh (2016) asserts that the drastic physical changes which result from transgender surgery are *not* the solution for persons with gender dysphoria because they do *not* address the psycho-social troubles which underlie this condition. And psychiatry professor Dr. Corradi (2016) has likened the current influence of and preoccupation with "transgenderism" in contemporary medical/mental healthcare as a "mass hysteria." Feminist activists likewise have challenged the practical implications of the "politics of transgenderism" (Jeffreys, 2014; Pela, 2016). Also, Littman (2017) and Marchiano (2016, 2017a, 2017b & 2017c) have called attention and suggested responsible responses to the current "rapid onset (of) Gender Dysphoria" in adolescents and young adults.

VII. The Need for Humility by Christian Pastors, Leaders, and Professionals

It is valuable and important that Yarhouse writes from an integrated Christian professional and scholarly mental health perspective. In *Understanding Gender Dysphoria*, Yarhouse clearly proposes that Christians take seriously the formal prescriptions and proscriptions of medical and mental healthcare researchers and professionals about gender dysphoria (and Gender Dysphoria). But more caution about the need for the book's readers to consider how valid are these pronouncements would also have been welcome.

It should be recognized that at least one theologian, Robert Gagnon (2009), whom Yarhouse cites in his book, has publicly questioned the validity—or at least wisdom—of some of Yarhouse's attempts to accommodate the Evangelical Christian worldview and practices with the professional/scientific. Responding to Yarhouse's summary of his book (2015a) in *Christianity Today* (2015b, 2015c), Gagnon (2015) offers public commentary on and criticism of some of Yarhouse's assumptions and recommendations in *First Things*. After Yarhouse (2015d) responds to Gagnon's comments in the same journal, Gagnon (2016b) responds directly to Yarhouse's. For example, Gagnon (2015) acknowledges that Yarhouse is "well-intended" and clearly wants all members of the church, including himself, "to be loving to persons experiencing this distress." Yet Gagnon asserts that "it is possible to be sensitive, gentle, and loving without forcing the church to act as if the lie is the truth." Gagnon wonders if—as a "Christian *psychologist*" (emphasis added)—Yarhouse may be trying too hard to "accommodate" a person's needs to have the church "be sensitive, gentle, and loving." Gagnon voices concern that this may force "the church to act as if the lie is the truth."

Gagnon also wonders if Yarhouse seems too ready to have "the church abandon the 'culture wars' . . . [and] stop combating society's efforts to persuade vulnerable children in the schools that one's perceived "gender" need not correlate with one's biological sex." Space limitations prevent a thorough discussion of their interchange, but readers are strongly encouraged to read these articles in their entirety. It is worth noting that Gagnon writes elsewhere, during the time of

his interchange with Yarhouse, that "God *isn't* transgender" (2016a) and that "the Bible *does* reject 'transgender behavior'" (2016c, emphases added).

Moving on, Yarhouse notes that persons accustomed to guiding their thoughts and behavior about gender incongruence and distress from the Integrity framework may abandon it when "the voice of science speaks." This is an example of a "Both . . . And." When an area of human concern is studied scientifically and clinically, it is important and proper BOTH that the proper method of scientific and clinical study be used AND that the worldview(s) of the researchers be clearly explained. This way, the meaning of the results of the research and any recommendations may be properly understood and evaluated in terms of their validity and possible limited generalizability or applicability to persons who were not directly studied.

Chamber, Schlenker and Collisson (2012) caution professionals, researchers, and the lay public that to "the extent that social scientists operate under one set of assumptions and values, and fail to recognize important alternatives, their scientific conclusions and social-policy recommendations are likely to be tainted" (p. 148). There does appear to be a contemporary tendency by lay or professional persons who espouse a secular scientific or professional worldview, especially concerning human sexuality, to discredit researchers or professionals who interpret scientific or clinical data from a Christian or other faith-based worldview. This is simply unacceptable, as well as frankly nonprofessional and unscientific (Abbott & Byrd, 2009; Cummings, O'Donohue & Cummings, 2009; Wright & Cummings, 2005). This perspective is important because society as a whole, and too many of its members in particular, seem often to regard the pronouncements of the medical and mental health arts and sciences as a "professional gospel" (i.e., beyond criticism). The secular and atheistic—or at least agnostic—worldview, underlying many of the scientific and professional papers and pronouncements by so many of the leading national and international medical and medical healthcare professions, researchers and professionals, too often goes unnoticed—and therefor un-critiqued. If "the doctor(s) have spoken," nonprofessionals, or professionals with a particular "theistic" worldview, may feel or be intimated from questioning or debating the findings or professional "wisdom" being promoted—let alone the underlying philosophical assumptions and, at least implicit, worldview beliefs.

Abbott and Byrd (2009) remind the healthcare community—and the nonprofessionals who try to hear and heed what the professionals report and prescribe or proscribe as healthy or unhealthy—that the Christianity is also a legitimate "worldview." As long as Christian scholars and healthcare professionals conduct and report their research responsibly and serve their patient and clients ethically, the broader healthcare researcher and practitioner community must respect their views. Non-professionals, particularly Christians, must consider the possibility that pronouncements by clearly secular—if not anti-religious—researchers and professionals may be biased in ways which may undermine the validity and applicability of their views. Of course, the same may be true of faith-based scholars and clinicians as well.

VIII. Supplementary Resources for Persons Experiencing *Gender Dysphoria* and Their Families Who Want to Live within a Christian or Other Integrity-Based Worldview

Many readers of this book, especially those who are guided most by the *integrity* framework and who *do* want to resolve their gender identity conflicts "in keeping with their birth sex"—or help others to do so—may wish to seek additional, more assertively *integrity*-based resources to help them. Such persons may include non-professional evangelical and other Christians, all non-professional seekers of the truth and persons of good will, and professional and pastoral caregivers of whatever faith orientation. Commonly, they want alternatives to current "politically/culturally correct" professional and religious approaches and resources which celebrate transgender/transsexual lifestyles, including the more "invasive" hormonal and surgical interventions which allow persons to appear to resemble their non-biological sex. As worthwhile as are the case studies and examples which Yarhouse provides, other sources provide additional ones which nonprofessional, non-pastoral strugglers, especially those for whom the *integrity* framework is primary, may find helpful. The *Help4Families* ministry and the writings of its founder and director, Denise Shick (2014, 2016, in press), offer many personal glimpses and practical responses to the challenges which *gender incongruence distress* and GD offer to both strugglers and their families.[5] So do the *Walt Heyer Ministries* and the affiliated *Sex Change Regret* website. Heyer has written many articles on the possible pathways and experiences of persons who are considering or hoping to leave behind a transgender identity and lifestyle (Heyer, 2016). Morabito (2014) likewise has written about the reality of "sex-change regret." The *Restored Hope Network* and *Courage/EnCourage* *Apostolate* websites also are Christian ministries which offer material on their websites in support of persons who want to manage and hopefully resolve their difficulties within an Integrity-based framework.

IX. Concluding Thoughts

Throughout *Understanding Gender Dysphoria*, Yarhouse offers important advice to parents, pastors, medical and mental health professionals, and those who themselves struggle with gender incongruence and distress, the rare diagnosis of *Gender Dysphoria*, and transgender/ transsexuality lifestyle concerns. While respecting what he calls the three frameworks through which concerned persons may perceive the continuum of phenomena dealing with gender dysphoria, he calls for a fourth, *Integrative* framework, which attempts to combine the best of the three. Specifically, Yarhouse invites and challenges the full range of caregivers and the strugglers themselves to respect the latter's needs: to recognize and value the intrinsic, essential, created goodness of their biological-based maleness or femaleness (*Integrity* framework); for empathy and compassion (*Disability*); and for identity/esteem and community/belonging/ fellowship (*Diversity*). Finally, Yarhouse advises all caregivers to listen to and try to understand strugglers, and to help them cope with their distress through the least invasive strategies possible.

[5] Amazon (n.d.) on its author page, quotes Denise Sick, as follows:

> Sometimes people think if they pray or wish hard enough, their transgender tendencies will just disappear. This is an unrealistic expectation. It is not reasonable to expect an overnight change in the area of gender or sexual confusion. The problem takes years to develop. The restoration likewise takes a lengthy healing and restorative process-and some very hard work-which typically involves years of serious commitment.

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