ITEST Webinar

Scientific, Clinical, and Theological Problems with the Affirmation Model for Gender Dysphoria

Presenters
Stephen Rouhana, Ph.D.
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The following are answers to questions unaddressed due to time constraints.

Question from Fr. Skip Thompson, MSA
Several major clinics that provide "gender affirming care," such as the Tavistock in England and the Center for Trans-youth Health in Los Angeles, have shut down recently. What do you suppose caused their decisions?

Response from Dr. Paul Hruz
The initial closing of the Tavistock clinic was contributed by several factors. One was the feeling that there were too many patients coming to the clinic and wait times for care were too long. The UK planned to decentralize gender affirming interventions. There were also a growing number of people working in the clinic who recognized that the interventions were not producing the desired outcomes. Patients continued to suffer despite application of the model. The work that led to the Cass report further sealed the fate of the clinic as it was recognized that the Dutch experiment could not be replicated with the current demographic of patients coming to the clinic for help. The accounting of the failure is documented in a paper by Carmichael et al. (PLoS One. 2021 Feb 2;16(2):e0243894).

In the US, closure of most of the gender clinics has been driven by state and federal legislation and fear of lost Medicaid funding and lawsuits.

Question from Vinny
How can a therapist practice this? Would they be labeled as an outcast in the psychiatric community?

Response from Dr. Paul Hruz
Many therapists understand the problems with the affirmative model and support the conclusions discussed at today's webinar but are indeed fearful of raising any public objections. However, there are many therapists who are properly investigating prior and current psychological trauma and psychiatric comorbidities as a primary form of intervention. Most do not advertise their practice. There are resources available to find such therapists, e.g. https://biologicalintegrity.org/.

Response from Dr. Stephen Rouhana
I'm not a therapist or a clinician, so this is easy for me to say. Life demands difficult choices. In my career in the auto industry, I fought against designs that might pass government tests but not be in the best interest of the human being in the vehicle. That did not make me popular in some

circles, but I stood up for what I believed was right. I did make mistakes, but my faith was my anchor and what spurred me on.
There are many individuals and families out there that are literally and figuratively being torn apart by this disorder. Many are being railroaded by the providers who say their child will commit suicide if he or she is not affirmed. Some data shows that they may be even **more likely** to commit suicide **after going down the affirmation path** when they realize that their problems haven't magically disappeared.

It's clear from many studies that real psychotherapy is needed, where the person's life is examined in depth by a trained psychologist to explore why they feel the way they do. And this is not a three-visit process. Studies indicate many months of therapy are often needed to help the patients.

I would try to find like-minded psychologists to form a support network. Then, I wouldn't take patients looking for a quick trip to puberty blockers or cross-sex hormones. I would tell them I'd like to help them with their co-morbidities through psychotherapy, but I don't practice by going straight to puberty blockers and hormones. If that's what they want I would refer them somewhere else. I would imagine there are many parents who would rather see their child in therapy than racing down the transition path. Admittedly, as I mentioned in my talk, if the patient doesn't think he or she has a disorder, they likely won't do well in therapy, but the literature shows it should definitely be the first line treatment.

Question from Wava Morrow
Much of the presentation is focused on biomedical evidence and limitations in the research, which are important. But how do you integrate the evidence with the realities of clinical practice, where we are working with an individual person's lived experience, psychological distress, developmental context, family systems, and therapeutic relationships? Specifically, what does good clinical care look like when neither automatic affirmation nor automatic rejection adequately addresses the complexity of the person sitting in front of us?

Response from Dr. Paul Hruz
The best advice on how to integrate understanding of the problems with the affirmative model into real life care of affected patients is to use the same medical standards and ethical principles in addressing gender dysphoria as one would use in other areas of medicine. The model of accompaniment which includes meeting patients where they are at, building a relationship with the patient and their family, demonstrating compassion for their suffering, and then leading them toward a helpful response. The desire is often to "fix the problem" as soon as possible. Often, the reality is that there is no quick fix. The path toward restoration to health can be long and arduous. Having realistic expectations and as alluded to during the conference, patience and humility are necessary components of effective care.

Response from Dr. Stephen Rouhana
As I mentioned at the beginning of my presentation, I'm neither a therapist nor a clinician, so take the following with a grain of salt. All I can say is what I've learned from the research I have read. Since nearly all gender dysphoric people have co-morbidities (some very many and some very severe), I would work to address the co-morbidities. Some research shows that if the co-

morbidities are addressed, the gender confusion subsides. My understanding is that you first work to create an atmosphere that is perceived by the patient as safe and non-judgmental. If the client feels respected and heard they will open up their world to the therapist. From that point, research shows that psychodynamic therapy can work to elicit past childhood experiences. Most gender dysphoric individuals have suffered from many adverse childhood experiences, so this can be helpful in resolving inner conflicts which in turn help with their co-morbidities and their dysphoria.

Question from Bill Weisrock
I realize this talk has been about gender identity, but I am curious about your opinions on same-sex attraction and whether it is also amenable to psychotherapy.

Response from Dr. Paul Hruz
There are many psychologists and psychiatrists who can better address this question (e.g. Laura Haynes, Karl Benzio). Contrary to popular belief, there is extensive literature showing that same-sex attractions can be fluid over time and there are some who desire change who do indeed benefit from psychotherapy. The difficulty in adopting this approach is perhaps even greater for same-sex attraction than with gender dysphoria due to conflation of such approaches with unethical "conversion therapy" approaches of the past.

Response from Dr. Stephen Rouhana
There is research showing that some of those who were uncomfortable with their same-sex attraction have benefited from psychotherapy. I refer to a paper from *Psychological Reports* published in 2000 by Nicolosi, Byrd, and Potts. They presented the results of a survey of 882 people who were dissatisfied with their homosexual attraction, most of whom benefited from psychotherapy. Dr. Nicolosi, who is now deceased, has many publications at this website: https://www.josephnicolosi.com/published-papers/.

Nicolosi's work shows that some people who wanted to change their sexual orientation could be helped. Same-sex attraction, like "gender dysphoria," suffers from the fact that since it is widely accepted in society nowadays, many people don't see a need to change. I suspect that the only people who do want to change are those who are deeply committed to our faith.

Question from Dell
Can you comment on the role of Courage and Encourage groups?

Response from Dr. Paul Hruz
Fr. Bochanski, former director of Courage, co-hosted a prior ITEST webinar ~5 years ago. See Male and Female He Created Them: Understanding Gender Dysphoria. This organization has been extremely helpful to a great number of affected people and their families.

Response from Dr. Stephen Rouhana
The following is **from Fr. Peter Ryan, SJ** who is the Chaplain for the Detroit Chapter of Courage, and serves on the Board of Directors of Courage International. Fr. Ryan was kind enough to endorse my book, and I sought his advice on this question given his expertise.

> “Regarding the question about Courage and EnCourage, an important distinction needs to be made. Courage is specifically an apostolate for men and women who experience same-sex attraction and who desire to live according to the Church’s teaching on chastity. It is not intended for people whose principal struggle is gender dysphoria or gender confusion, since that presents a different set of issues and pastoral needs.
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> EnCourage, however, is open to parents, spouses, and other family members and loved ones of persons who experience gender dysphoria or identify as transgender. Although same-sex attraction and gender dysphoria should not be conflated, the experiences of their families often have a great deal in common. Parents in particular may be deeply distressed, may fear alienating or losing their child if they do not affirm the identity the child has adopted, and may find themselves under considerable pressure to endorse choices they believe are harmful. These parents and families need understanding and support.
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> That is where EnCourage can be especially valuable. It provides Catholic fellowship and support from others facing similar circumstances and helps family members remain faithful to the truth while continuing to love the person who is struggling. The underlying pastoral principle is important: genuine compassion does not require us to treat a person's feelings about his or her identity as determining what is true. At the same time, our response must be genuinely compassionate: listening to people's stories, helping them bear their crosses, and assuring them of God's personal love.
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> I do think there is a real pastoral need for an apostolate something like Courage specifically for persons struggling with gender dysphoria. They need the kind of faithful Catholic fellowship and mutual support that Courage provides to persons with same-sex attraction, but adapted to the distinct challenges involved in gender dysphoria. Those who struggle with gender confusion need to know that they are not alone and should be encouraged to pray, frequent the sacraments, and seek out Christian fellowship. An apostolate designed specifically for them could be a very valuable way of providing precisely that fellowship.
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> So, briefly: Courage itself is not the appropriate apostolate for persons struggling with gender dysphoria; EnCourage can be an appropriate source of support for their families and loved ones; and it would be very worthwhile to develop a comparable Catholic apostolate specifically for persons struggling with gender dysphoria.”

This last sentence is one of the actions I recommended in my book.