3. Limiting gender-affirming care runs counter to scientific consensus.

   This raises two critically important issues. First, in our era of increasing polarization, "scientific consensus" is often code for "don't question the white coats." It is a way of isolating ideologically driven policies from scrutiny, in the apparent belief that scientists are incapable of bias. The organizations Johnson mentions have embraced an ideology that is not unambiguously supported by actual science, as Jelsma's paper robustly brings to light. Indeed, when the International Association of Applied Psychology publishes an official statement that a woman is someone who identifies as a woman (defining a term by the same term), science is no longer at the helm (citation #86 in my paper). Second, more generally, admonishment for questioning "scientific consensus" is arguably *anti*-science. Major advancement *requires* challenging consensus understanding.

4. Pain is pain; if gender dysphoria is a mental illness, why limit medical solutions?

   Johnson stops short of conceding that gender dysphoria is a mental illness but asks why those who do view it this way would prevent the use of drugs or surgeries to alleviate that pain, even if treatments "aren't as effective as we'd like." The quoted segment is important, for it reveals an assumption that the only solution for this pain is to affirm the perceived gender. No awareness is offered that it is possible for proffered cures to cause greater harm, or that the misalignment between perception and reality could be the problem that needs fixing. Jelsma's paper offers many examples of harm from puberty blockers and the increasingly challenged claim of improved emotional health. In my paper, I draw attention to the incongruence between what sex transition surgeries claim versus what they actually achieve. From my perspective, truly loving a person is not found in affirming their confusion.

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Jelsma Responds to Johnson

My thanks to Jay Johnson for reading and carefully analyzing the arguments I made in my recent review. We both share a concern for those individuals who are distressed by gender incongruence. Allow me to respond to some of his concerns.

Johnson quotes me as saying, "A fertilized egg has a biological sex but no gender," suggesting that I assume all fertilized eggs are either XX or XY, which isn't true. I agree and freely acknowledge the existence of intersex conditions due to variations on the usual pattern. However, the focus in this section—and indeed the entire paper—was on gender, not sex, so this criticism seems out of place. Moreover, people with intersex conditions generally identify as male or female, not something in between.

Johnson goes on to argue that the reference to male and female in Genesis 1:27 is a merism, which includes not only males and females but everything in between. Again, my paper was about gender, not sex. I am familiar with merisms in scripture, but I don't think this is one. Generally, the context of a merism makes it clear that the passage refers to everything in between, for example, the heavens and the earth in verse 1 is a merism because the text goes on to describe the creation of everything in between. In contrast, scripture consistently describes humans as existing as two complementary sexes. Even the reference to those who are eunuchs from birth (Matt. 19:12) is in the context of men for whom it is better not to marry. Thus, Jesus describes these individuals, who might be intersex, as males.

I fully acknowledge that my conclusion that the evidence on gender-affirming care conflicts with the position of the American Psychological Association, the Endocrine Society, and the World Professional Association for Transgender Health (but not the Cass Review). That is the reason why half my paper is dedicated to showing how I disagree with those organizations and that the evidence (I gave several examples) does not support their position. My goal in this paper was to provide Christians with a balanced review of the science surrounding gender incongruence and gender-affirming care. Legislative actions are beyond the scope of this paper and my expertise, but I did state in my abstract that some cases might be best treated by transitioning.

Finally, I concur with Johnson when he urges that these individuals receive compassionate treatment for their psychological pain. However, we need to understand the underlying causes of this pain before assuming that medicalization is the best course of action. In the second half of my paper I argued, not that gender-affirming care is not as effective as we'd like, but that it was not effective *at all* because the psychological benefits can be accounted for by the placebo effect. Unnecessarily treating these individuals with hormones and surgeries instead of helping them through a traumatic adolescence through counseling is not acting in their best interests.

Tony Jelsma
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