AUSTRALIAN PERSPECTIVES ON **TRANSGENDERING CHILDREN & ADOLESCENTS:** POLICY & PRACTICE IMPLICATIONS

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Section 1: EDITORIAL

Across the world, in at least 136 countries[1], women's rights are under attack. A recent upsurge in the activities of internationally funded transgender lobbies has seen a proliferation of aggressive strategies and tactics aimed at dismantling women's hard-won sex-based rights.

Australia has not avoided this surge in the anti-women regulatory capture of governments and public and private institutions. But local mainstream media outlets (apart from *The Australian*) have not been prepared to even consider critical discussion of transgender issues. Their acquiescence to the ideals and proscriptions of gender ideology has further bolstered the trans lobby's dominance in our culture.

This publication is not a treatise on women's rights, but a compilation of articles and submissions made by a number of Australian professionals concerning the transgendering of children and adolescents. They raise questions about the lack of a scientific evidence base, the lack of data on the long-term consequences of medical/surgical gender affirmation protocols, and the surreptitious avoidance of the key medical ethic, 'First, do no harm'[2]. They consider legal issues and the consequences of embodying 'trans rights' in law and policy – for example, the impact on girls' and women's sports of allowing trans identified males to compete with, and against, female people.

One of the key objectives of this publication is to promote the campaign for a national, public inquiry into the transgendering of children and adolescents. Litigation is inevitable unless there is a well-informed consent process and alternatives to the affirmation model are fully explored before considering any transition process.

A wide-ranging government sponsored inquiry is needed as a matter of urgency. The initial proposal to undertake this compilation elicited 500 pages of articles and submissions from a range of individuals and groups. The compilation, as published here, includes a representative selection of those articles and submissions. There is, in fact, an enormous body of material addressing the transgendering of children and adolescents published online over the past two to three years. I recommend readers research this issue thoroughly and inform themselves of all perspectives.

The first two articles appearing in this publication concern parental rights - parents/carers have been largely excluded when decisions are made about transitioning their children. The gender affirmation model of management dictates that the child's wishes should be followed, irrespective of the legitimate concerns of parents/carers. In fact, many parents/carers have been virtually blackmailed into accepting gender affirmation as the only viable course for their child. The word 'affirmation' has cultish connotations and, arguably, that is what the trans lobby has become, a quasi-religious cult or belief system that has no scientific foundation.

I commend the authors of the enclosed articles. They come from a variety of professional backgrounds, including paediatrics, psychiatry, psychology, the law, parenting, women's sports and sociology. This publication finishes with a poem by Dr. George Halasz that is an excruciating description of the anguish felt by a practising psychiatrist trying to come to terms with a fully transitioned child. Once you have read this publication, which is a first of its kind for Australia, I recommend the following books (in date of publication order):

- Michele Moore & Heather Brunskell-Evans, *Inventing Transgender Children and Young People*, Cambridge Scholars, 2019
- Heather Brunskell-Evans, *Transgender Body Politics*, Spinifex, 2020
- Kathleen Stock, *Material Girls: Why Reality Matters For Feminism*, Fleet, 2021
- Susan Evans & Marcus Evans, *Gender Dysphoria: A Therapeutic Model for Working with Children, Adolescents and Young Adults*, Phoenix, 2021.

[1] https://www.womensdeclaration.com/en/

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1457760/

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Section 2: PARENTAL RIGHTS

Transgender trauma: a parent's perspective on rapid onset gender dysphoria

- Judith Hunter

Our daughter (aged 17 at the time) came out as transgender in October 2018, after 3 years of poor mental health, including diagnoses of anxiety, depression & bipolar. This was completely out of the blue – she had never shown any masculine tendencies in her life.

The week she declared she was transgender, she claimed she was suicidal & ended up in the adolescent mental health ward of our local hospital - John Hunter Hospital in Newcastle, NSW, Australia. We later doubted that she was actually suicidal, as the staff at the John Hunter Hospital did not seem concerned and sent her home on day release the day after she was admitted (she was sent home on a Saturday as many of the staff were not rostered on over the weekend). The hospital staff immediately affirmed her transgender identity upon her admission, without question or curiosity. We came in to see her on the first day she was in the hospital (a Friday) & there was a male name above her bed. We told the staff that was not her name, but they bullied us and ridiculed us for not pretending she was a boy. They said to us "Would you rather have a live son or a dead daughter?" and told us we should use her "new" name or else she would kill herself.

The hospital staff then told us that they were referring her to the hospital paediatric endocrinologist (Dr Prudence Lopez) for testosterone. She was 17. We told them we did not agree to the referral and that we were going back to her private General Practitioner and Psychiatrist. I explained that we had a 13 year old son at home and we were most certainly not allowing our mentally unwell daughter to take testosterone in front of her 13 year old brother. We were told we should "teach our son to be inclusive". Our daughter spent 5 nights in hospital and then was discharged. From that point on she started to verbally abuse us on a daily basis, screaming at us and calling us (among other insults) - terrible parents, pathetic people, transphobic bigots etc etc.

This went on daily for six months. It was like living in a war zone. It was also like she had rehearsed a script – it did not sound like the daughter we knew at all. Our 13 year old son became anorexic with the stress/distress that he was living through. He would curl up in a ball on the floor, sobbing and crying out "tell her to stop Mum". She would not stop the daily abuse.

We looked at her computer browser history and found a trail of transgender websites including YouTube videos of girls taking testosterone and saying how fabulous it was, as well as group chats with other transgender identifying people. We found messages on her phone from a transgender individual, Nevo Zisin, who had written a book "Finding Nevo". The messages were encouraging her to get rid of her family.

Our daughter turned 18 a month after the hospital admission and went to see the endocrinologist against our wishes, who put her on testosterone at the second appointment, in March 2019. We later found out that the hospital falsified her discharge summary and wrote up that we did agree to the referral for hormones. We did not.

We moved her out of our home in March 2019 into student accommodation nearby, after she called the police on us and accused us of assault. This was not true (it was she who was being abusive towards us), but the police believed her without even speaking to us and served a DVO on my husband without even giving us the chance to defend ourselves or explain her erratic & violent behaviour towards us. She had the police ring me many times, accusing us of not allowing her access to her belongings (completely untrue, she came home many times to get her things). She has pretty much spent 2 years in bed - dropped out of school, does not work and does not study. Late last year (October 2020) we found out that she was seeing a plastic surgeon, Dr Gary Avery (in Newcastle NSW) to have her breasts cut off. She has since been diagnosed with Complex PTSD (from childhood bullying) and Autism spectrum as well as ADHD. We wrote to the plastic surgeon and sent him a copy of Abigail Shrier's book - Irreversible Damage. We also spoke to him. I asked him was he cutting the breasts off young women 10 years ago and he sheepishly said "No". He advertises on

his website for "Top Surgery". Our daughter has now cut us off and will not speak to us because we removed her from our health fund as we did not want to finance having her breasts cut off under our health fund.

In 2019 we complained to the Health Care Complaints Commission about the John Hunter Hospital's treatment of us and the fact that they referred our daughter for hormones without examining her long and complex mental health history. Our complaint was dismissed. We then made a second complaint to the Health Care Complaints Commission about the John Hunter Hospital falsifying our daughter's discharge summary, by writing that we agreed to the referral to the endocrinologist. That complaint was also dismissed. We phoned the Health Care Complaints Commission and asked for clarification as to why that complaint was dismissed. We were told that they had investigated our complaint and that there was "an apparent agreement" to the referral to the endocrinologist. My husband said "That is nonsense, there either was an agreement or there was not an agreement, and we did not agree to the referral". The case officer told my husband that "This case is closed" and hung up on him.

In early 2020 we found out that our daughter was going to appear on an ABC 4 corners program about transgender youth. We were horrified. I contacted the executive producer, Sally Neighbour, and asked her if she would like to interview parents who were sceptical about transitioning young people. She refused. I told her about the trauma our family had been through and that it would be devastating to our son if his sister appeared on this program. Sally pulled our daughter's section from the show. The show was aired in February 2020 and it was called ""Not a Boy Not a Girl"". It showcases (among others) 2 transgender girls from Newcastle, both who our daughter met at a drama group in Newcastle. We believe that this drama group is where our daughter became first exposed to transgenderism.

Over a two year period we have written countless letters – to The Prime Minister, to the NSW Premier, to The State and Federal Health Ministers, to the Australian Medical Association, to the John Hunter Hospital – and we have been "fobbed off" every time. We have had responses insinuating we have a problem. The AMA told us to ""support our transgender child".

Our daughter's life has fallen apart since she became transgender. She has cut us off. Our family has been to hell and back. We experience PTSD ourselves from the horror we have lived through. We simply cannot understand how any health practitioners cannot see the damage they are doing to young people who have been sucked into the cult of transgenderism. Families are being decimated and torn apart. We are in contact with parents from all over the world who have had very similar experiences to ours. The similarity of our experiences lends so much evidence to the cult like tendencies of the transgender movement.

In defence of mothers

- Janet Fraser

I often speak up in defence of parents because for many people, the only option they're offered is to medically sterilise their child with the made up suicide threats held over them. I think a lot of people have no conception of how there is no other path if your child comes to the attention of juvenile transition clinics.

I don't know about "most" people being silently gender critical given the perpetual propaganda manufacturing everyone's consent. Mothers are particularly vulnerable to calls that we're Bad Mothers since mothers are also always wrong. Mothers *know* that going against medical opinion (and it is mainstream medical opinion) is risky and we are constantly massaged to be compliant consumers in the healthcare systems from the moment we're pregnant. Mothers also know that anything that happens to their child will be laid at their door. The suicide threats are very compelling. And then there are the groups I've observed who embrace gender because they'd rather have a straight son than a lesbian daughter. And the groups who want to go along with it because they've been trained and educated to it via their education. Genderism has been taught as fact for a few decades in universities now. Blame is always sheeted to mothers and that's very obvious in online conversations where mothers cop the fallout in the eyes of GC people who haven't thought through a. the pressure and b. their own socialised misogyny to mother-blame.

So absolutely, parents cannot all be blamed for the children being sterilised given that a multi billion dollar machine is set up to promote this

idea both to the kids and to the parents and to the medical system. I'm sure there were parents who embraced lobotomy too given it was also a "cure" for homosexuality. The power of medical lobbies is immense in Australia. There's no way to have open discourse about different ways to manage medical treatments about most things but many people coming to the genderist issue are also accepting medical opinion on a lot of things without questioning it. They're just going with the pack there too except with social approval so it's invisible to them.

In terms of altering public opinion, I've never held that it's really possible for groups where media blackout exists and particularly not when the lobby groups involved are so incredibly powerful. Pharmaceutical companies are already untouchable in Australia and the same groups are making the drugs and financing the campaigns to sterilise kids and harm them for life while making profitable customers from them.

I think challenging the notion that parents are all somehow nuts or mothers have Munchausen by proxy needs to be done whenever we see it. I'm particularly sensitive to MBP accusations because it's very fashionable in the family court right now as a way to punish mothers when children have genuine health issues. We are seeing the children with trauma from DV being used by unscrupulous parents in the courts too. The recent case Re Imogen, the father who was illegally buying hormones from overseas is pushing the boy's transition and is also the perpetrator of significant violence against the boy, his mum and sister.

There are complex issues at play here and writing people off as dopes is really not tackling the problems. I've been writing about and working in spaces with mothers for nearly 20 years now and I see so many of that same old prejudices coming through the new genderist lens.

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Section 3: EDUCATION SYSTEMS

Education Legislation Amendment (Parental Rights) Bill 2020 submission

- Katherine Deves,
Save Women's Sport Australasia

This submission is in response to deep concern caused by the proliferation of gender identity ideology that is being taught in NSW schools, to date, this has occurred without parliamentary oversight, parental knowledge or consent, public awareness or media scrutiny.

Gender identity ideology is already influencing policy and practice in NSW schools via Education Bulletin 55 – Transgender Students in Schools.

Critical analysis:

NSW Department of Education Bulletin 55 – Transgender Students in Schools

Bulletin 55 Transgender Students in Schools ("the document") is the official policy of the NSW Department of Education in relation to trans-identified ("transgender") students. It was conveniently published in December 2014 just before the holiday break, and it is in keeping with the International Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Youth & Student Organisation (IGYLO) strategies designed by global law firm Denton's for the regulatory and institutional capture by gender identity ideology lobbyists. The timing was likely purposeful in order to avoid any media scrutiny or public debate in implementing such policy and legislation. This tactic was favourable to the efforts of these ideologists, as it is likely the proposal would be rejected or criticised by the vast majority of the general public had they been aware of its intentions.

The document contains a number of discriminatory and alarming policies:

- It deliberately conflates 'sex' with 'gender', and omits to refer to the single-sex exceptions contained in the *Sex Discrimination Act 1984* (Cth) in relation to schools and other areas;
- It continually prioritises one protected characteristic ('gender identity') over others, contrary to Commonwealth sex discrimination legislation;
- It fails to satisfy Australia's international treaty obligations under CEDAW Art.10 in relation to education and sport;
- It ignores and fails to meet basic safeguarding requirements by promoting mixed-sex changing rooms and residential accommodation;
- It treats concerned parents as a safeguarding risk;
- It disregards the rights of all pupils to safety, privacy and dignity in single sex spaces;
- It disregards the rights of teenage girls to compete in sports on a level playing field as per *Sex Discrimination Act 1984* (Cth) s 42, *Anti-Discrimination Act 1977* NSW s38 and CEDAW Art. 10(g).

Reliance on Erroneous and Ideologically Informed Language

The policy begins by upholding the ideological stance that sex is "assigned" at birth. This is factually untrue as sex is observed and recorded at birth. Sex is determined at fertilisation with the absence or presence of the Y chromosome, specifically the SRY gene, with observation in utero possible from the beginning of the second trimester, and via genetic testing from 7 weeks via a blood test of the mother. The word "assigned" has been co-opted by gender ideologists from the now outdated practice of "assigning" a sex to an infant born with ambiguous genitalia due to a Disorder or Variation of Sex Development. The current protocol for such a situation is that scans and a blood test are conducted in order to ascertain the sex of the infant, as Disorders of Sex Development conditions (colloquially known as "intersex") are conditions that arise from either one sex or the other.

In relation to birth certificates, the document erroneously refers to "gender", because it is "sex" (not "gender") that is recorded on the document, and this opens up the broader implications of

people being able to retrospectively alter a core identity document to reflect a factually untrue status.

The document repeatedly refers to "gender", "gender identity" or "gender expression", without including a definition within the document. "Gender identity" has been defined in federal legislation and is based on a definition promulgated in the Yogyakarta Principles. The concept of "gender identity" is unable to be defined without resorting to circular reasoning and relies on offensive and restrictive gender stereotypes (i.e. a little boy likes "Frozen" and wants to grow his hair therefore IS a girl, instead of just being a child who may be gender non-conforming, or is simply exploring his personality as a normal part of child development). This is contrary to the Sex Discrimination Act (Schedule) and CEDAW Art.5(a) where sex-based stereotypes are specifically rejected in order to eliminate prejudice against women.

Toilets and Change Rooms

"The need for the student to be safe is a paramount concern in these circumstances. Students should not be required to use the toilets and change rooms used by persons of the sex they were assigned at birth if they identify as a different gender."

This statement privileges the needs of the trans-identified student over the rest of the student body. This is particularly problematic in the situation of a male student identifying as female and then using the girl's facilities. Girls are entitled to privacy, dignity and safety, particularly during puberty with the additional burden of managing menstruation (or pregnancy), without having to deal with a male-bodied person in this space.

There is ample evidence of girls being adversely affected at school via rebranding of female toilets as "gender neutral" or allowing biological males access to this space. There are reports of girls electing to self-exclude, being subjected to period-shaming, and refraining from eating and drinking (with a commensurate rise in UTIs).

In QLD there was a huge public outcry when a new school in Brisbane was promoted as having "gender neutral" toilets, which forced Premier Palasczuk to step in and revert the policy to single sex provision.

Sanctions for Objecting to Overriding of Boundaries

"If other students indicate discomfort with sharing single-sex facilities (toilets, change rooms, dormitories or overnight accommodation for example) with a student who identifies as transgender, this should be addressed through the school learning and support team."

Our society takes great pains and invests significant time, energy and resources to educate our children about safeguarding from a very young age (particularly for girls), and we encourage them to speak up if they feel uncomfortable, intimidated or frightened, particularly by the presence of a male in a space where they are vulnerable. Yet the document completely dismisses this basic safeguarding tenet by telling children that if they raise concerns or assert their boundaries, the child who is rightfully expressing their fear or discomfort with an opposite sex child being in a confined and private space with them, it will be the complainant student who will be removed, reprimanded and re-educated to acquiesce to gender ideology because the trans-identifying student's needs have been given priority. It also promulgates a false narrative that the male student is actually "female" and has every right to be in that space. We are asking to children to ignore the reality of their own senses and to accommodate a falsehood despite their own distress or discomfort.

It is particularly egregious and concerning to presume that a male student should be allowed to share sleeping quarters with female students - this is a significant safeguarding issue, and completely disregards the rights of girls to safety, privacy and dignity in spaces where they may be in a state of undress or asleep.

School Sport

"Most students will be able to continue to participate in competitive sport in their identified gender after they have turned 12."

This section of the document completely misrepresents the protection for sex-segregated sport under *Sex Discrimination Act 1984* (Cth) s42 where sports can be segregated by sex after the age of 12 years if "strength, physique and stamina" are relevant. These factors are relevant to all sports, particularly as most children have begun puberty by age 12, which is when the biological advantage

of males over females is arguably apparent. Under the Commonwealth legislation, a person over the age of 12 years old can be excluded from participation in any sporting activity on the basis of their sex if "stamina, strength or physique" are relevant. It could be determined that stamina, strength or physique are relevant for every sport, and that every sport is "competitive". Bulletin 55 fails to sufficiently explain that the purpose of this statute is to acknowledge the biological differences between men and women, and that it is lawful for males to be excluded from female sports.

Furthermore, *Anti-Discrimination Act 1977* (NSW) s 38P specifically protects women's sports and enables a transgender person to be lawfully excluded in any sporting activity for members of the sex with which the transgender person identifies. This means that a biological male who is a transgender person and identifies with the female sex can be lawfully excluded from female sports. Bulletin 55 fails to mention this exclusion in NSW legislation whatsoever. Bulletin 55 appears to be relying on the *Sex Discrimination Act 1984* (1984) s 42 where the implication is that there is a presumption that the needs of the trans-identified student will again take precedence, without any due consideration for safety and fairness of the girls, and the trans-identified student's needs take priority without any application of the legislative exemptions that allow for a player to be excluded solely on the basis of sex in NSW, and upon consideration of the factors of "strength, physique and stamina" under Commonwealth legislation. The prioritisation of persons with a trans-identity is a feature of much policy that concerns gender identity, along with failure to consider the needs and rights of girls and women, interpretation of the legislation as promulgated by Bulletin 55 is simply another example of this.

"It may be lawful to exclude students aged 12 and over from competing in certain sports at the elite level in certain circumstances."

The legislation does not differentiate between elite or community or social sports, in fact the legislation is entirely silent on distinguishing the differing levels of sport. The safety, privacy, dignity and fairness for girls in sports, fought for by women over many decades of activism to ensure equal participation in sport have been completely disregarded. Investment, resource allocation and media coverage of women's sports remains woefully inequitable and has only been further adversely impacted by COVID-19.

A high-profile case is currently being brought by three young girls in the US in relation to Title IX violations where the state of Connecticut has allowed males to compete against females (Selina Soule v Connecticut Association of Schools). One of President Biden's first acts was to sign an executive order that destroyed the purpose Title IX as protection for women and girls with the inclusion of "gender identity" as a protected characteristic under the legislation. This effectively means that any male can compete in any female sport as long as he declares a trans and/or gender identity where he claims to "identify as a woman". There have been a number of states that have successfully brought in legislation to specifically protect women's sports, such as Idaho and Montana, and other states such as Alabama and Mississippi are considering the same.

Enrolment in a single sex school

"If the student is seeking enrolment at a single-sex school, a decision about their eligibility to enrol should be made on the basis of his or her identified gender. If the student is already attending school advice should be sought from Legal Services."

The guidelines wilfully misrepresent the legislative rights of educational institutions by remaining silent on their rights under the relevant statutes and promoting the erroneous idea that a student must be accepted on the basis of "gender", as distinct from sex.

The guidelines assert a position contrary to an exclusion in the Commonwealth legislation *Sex Discrimination Act 1984* (Cth) s 21(3) as the statute expressly states that a student may be excluded from an educational institution on the basis of their sex.

The state legislation is silent on the point of exclusion on the basis of sex, but it expresses that a private educational authority is not discriminating against a student if they are excluded from the educational institution on transgender grounds (*Anti-Discrimination Act 1997* (NSW) s 38K(3).

Both statutes allow for an educational institution, single sex under commonwealth compared to private under state, to exclude a student on the basis of either sex if they are of the sex other than that for which the educational institution is conducted (commonwealth), or on transgender

grounds (state). Essentially and significantly, schools are under no obligation to accept the student on the basis of gender despite what is asserted in the Guidelines.

It is highly unlikely that the vast majority of parents electing to send their children to a single sex school would be accepting of a policy that enabled students of the opposite sex to attend.

Teaching Gender Identity in the Curriculum

"Gender identity may be discussed in many curriculum areas."

This is deeply concerning due to the highly contentious nature of the topic, and it is arguing that NSW school children should be taught factually untrue and ideological concepts such as human beings can "change sex", or "boys can be girls, or have periods" and some "girls have penises."

A recent example of this is the "genderbread person" - a transgender propaganda tool that managed to find its way into NSW classrooms, despite gender identity being explicitly excluded from the formal curriculum.

There is a case currently pending in Canada where a 6 year old girl was deeply distressed at being told girls aren't real.

"Teachers should treat the topic in a manner that is respectful, inclusive and positive".

Based on the current methods of silencing or shaming critics of the ideology, it is unlikely that the opinion of any student criticising the dogma would be welcomed. It is more likely the student would be reprimanded for failure to unquestioningly accept the ideology should they dare to critique it. Furthermore, "inclusion" in this instance excludes girls, as by accepting this ideology they are being compelled to subsume their needs to those of biological male students.

Undermining of Family Integrity and Parental Authority

The most alarming part of the document is found in Support for the extended family of the student and Reporting Requirements. If the parents of the trans-identified child do not "affirm" the child and refuse to provide "consent" to the school to facilitate the transition ("to help with decision making, planning, assessment or service provision"), the school is informed that they can rely on the Children and Young Persons (Care and Protection) Act 1998 to circumvent the parents' rights and authority, and they are encouraged to report the parents to Community Services for this "harm".

There is a growing group of concerned parents who have suffered already due to this policy - ordinary, caring, diligent parents whose children have come to believe "transitioning" is a solution to their problems. Many children "diagnosed" with "gender dysphoria" have pre-existing mental health issues; are on the autism spectrum; or are simply gender non-conforming and would likely grow up to be gay or Lesbian if they are left alone.

In Queensland, the state removed a young girl from the care of her parents because they wished for her to undertake a therapeutic pathway rather than the irreversible and risky medical treatment of injecting testosterone. This raises the issue of the medicalisation of minor children which has become a global scandal with the Keira Bell-v-Tavistock decision of the UK High Court in December 2020. A panel of three High Court judges decided that children under the age of 16 do not have the capacity to consent to gender affirming medical intervention (puberty blockers and cross-sex hormones), and it is highly unlikely that children between the ages of 16 and 18 have capacity, therefore consent of the court must be sought, but highly unlikely to be granted. As a result, the Tavistock-Portsmouth GIDS clinic that provided "gender affirming" medical interventions for children has ceased doing so. It must be noted that the Australian mainstream press, including SBS and ABC, have failed to report on this decision despite the fact it made headlines around the world. At this stage, no Australian federal or state legislation or policy has taken into consideration this landmark decision.

Managing Risk of Harm

"Schools have a legal duty to protect students from foreseeable risk of harm and to do what is reasonably practicable to ensure their safety."

It is clear from the document that the concerns and rights of girls and any non-trans identifying students have been completely disregarded and dismissed, if they were even considered at all. The

only student whose safety and risk of harm has been acknowledged is the student who identifies as trans. Most egregiously, the document asserts that other students must prioritise this as well, even if it is to their own detriment.

"The welfare and educational needs of the student are of primary importance and should be the focus of all actions taken by the school."

It is remarkable that the needs of the trans-identified student take priority over the needs of the rest of the entire student body, particularly in relation to the needs of female students failing to be given any consideration whatsoever.

A school's exposure to liability may be increased if biologically male students are entitled to access spaces that have been set aside for female-only use when the girls may be vulnerable, asleep or in a state of undress. Additionally, it appears no consideration has been given to the known and foreseeable increased risk of injury and concussion to girls playing sports should they have to compete against a biological male.

These questions demand answers:

- Who were the advisers to the Department of Education in relation to this Bulletin?
- Why has there been an obvious failure to consider the needs of the overall student body against those of a single or very small group of students?
- Why were the needs of female students ignored?
- Why has this policy and regulatory capture occurred with no media scrutiny or public debate, except for coverage that is unilaterally in favour of gender ideology?
- Why were students, particularly female students, and parents, not consulted?

Recently in the UK, school districts and the CPS implementing similar guidelines were threatened with judicial review and legal action and the guidelines have now been withdrawn. It will only be a matter of time before similar legal action occurs here in NSW, should these issues not be addressed.

Bulletin 55 is an egregious example of policy capture by transgender ideologists. It is deeply concerning that such guidelines are being implemented in our schools with little oversight or public scrutiny when it has such a significant material impact on the student body, particularly girls.

The entrenchment of gender identity ideology into our curriculum will further enable policies and guidelines such as Bulletin 55, which come at significant detriment to female students and male students who are not trans-identifying.

This has gone far enough, our children, especially our daughters, deserve better.

Opposing the Teaching of Gender Fluidity Ideology: The Education Legislation Amendment (Parental Rights) Bill 2020

- Professor Dianna Kenny PhD MAPsS MAPA

(Formerly) Professor of Psychology,
The University of Sydney Society for
Evidence-based Gender Medicine

Preamble

In 2020, Mark Latham, a member of the Legislative Council of the NSW State Parliament, proposed the Education Legislation Amendment (Parental Rights) Bill 2020 proposing to cease all forms of instruction in what he termed gender fluidity ideology. I offered this submission in support of the proposed Bill.

The current situation is that in various ways gender fluidity ideology (and gender ideology in general) is leaking into school classrooms across the state from numerous sources. For example, in some cases it is occurring through specific curriculum content. In other cases, it is being brought about by politically active teachers on their own initiative in classes such as PDHPE, placing unvetted information and materials before children and adolescents. Parents are not informed about the content of teaching on gender ideology in public school classrooms.

There is a growing awareness and concern in the community regarding the nature of the information and materials pertaining to gender development being taught without sufficient oversight of the NSW Department of Education. Growing numbers of parents want to challenge gender curricula; hence, the lobbying that took place to press for the development of the Bill and its introduction into the Legislative Council.

This submission critiqued the content of gender fluidity ideology teaching currently occurring in NSW government schools, in particular, how it departs from the established science of human social and cognitive development and human sexuality.

Specifically, gender ideology is based on an erroneous account of human nature and contains no scientific foundation, unsubstantiated assertions, generalisations, inconsistencies, and internal contradictions. Given that gender ideology has the same degree of scientific merit as creationism, flat earth theory, and anti-vaxxer ideology, I argued that it is an inappropriate subject to be peddled to children and adolescents in schools as a matter of scientific fact.

I hoped to contribute to the debate on this Bill by exposing and explaining the errors in gender fluidity ideology, thereby making a prima facie case that it should not be taught in government schools.

The biology of sex and the ??---ology of gender identity

Consider this "definition" of gender identity by America's peak body for psychologists:

"Gender identity" [is defined] as "a person's internal sense of being male, female, or something else [author's italics] (American Psychological Association, 2011).

"Something else?" There has been no definition or operationalization of the phrase "something else" anywhere in gender ideology and yet, on the basis of the faulty belief that sex is no longer binary, thousands of children around the world are declaring themselves, not to be this "something else," but to be of the gender opposite from their natal sex, that is, transgender. Thus, the concept of transgender is fundamentally binary – girls wanting to be boys and boys wanting to be girls, but this basic binary characteristic of transgenderism is never adequately acknowledged or addressed in gender fluidity ideology.

The American Psychological Association and the National Association of School Psychologists (https://www.apa.org/about/policy/orientation-diversity) persist with the myth that there are shades of gender between the poles of male and female. They

…affirm that diverse gender expressions, regardless of gender identity, and diverse gender identities, beyond a binary classification, are normal and positive variations of the human experience.

Sex and gender are linked, but they are often conflated into a single concept. Sex describes the biological differences between males and females, namely, the internal and external genitalia and the dominant gonadal tissue, ovaries or testes. The

male sex is the phenotype that produces smaller gametes (i.e., sperm), and the female sex is the phenotype that produces the larger gametes (i.e., ova). Almost all (99.98%) births are unambiguously male or female. Intersex conditions, known as Disorders of Sexual Development (DSD), comprise 0.02% of births which the transgender lobby uses to destabilize the foundation of binary biological sex by asserting the existence of the concept of "in between" male and female or "something else" other than male or female. Intersex is a biological disorder of sexual development, not a gender choice available to those who wish to identify as both male and female simultaneously (i.e., gender fluid, gender queer, nonbinary, demigirl, demiboy).

Gender is a sex-based behavioural phenomenon that describes behaviours, interests, and social roles associated with one's sex which are expressed in masculine and feminine traits. These traits can be influenced by biology but are based in culturally defined stereotypes of how males and females should behave. Societal expectations of how men and women should act are socially constructed. Thus, gender is both descriptive and normative and influenced by both biology and environment (nature/nurture). For example, boys tend to be more interested than girls in toys that move. This gender difference has both biological and sociocultural components. Biologically, prenatal androgens play a role in the hyper-development of the brain's visuospatial system. Since boys are often exposed to much more prenatal androgen than girls, more boys show an interest in moving objects.

When gender, not sex, becomes one's immutable trait, gender expression becomes the indicator of your "true" sex. Current gender ideology denies the existence of the male and female binary, claims it is socially constructed and ignores the evolutionary mechanisms that have unified all males and females across species for thousands of years.

Because gender stereotypes constrain individual behaviour, parents, teachers and those responsible for the care and education of children are advised to avoid them. Even though more boys than girls play with trucks, not all boys play with trucks and some girls play with trucks. These observations should not be used to define gender in these children. It would be tantamount to saying that girls who play with trucks are boys and boys who do not play with trucks are girls. This defines the sex of a child by using gender stereotypes of how boys and girls should act and behave.

Society used to describe a girl who played with male-typical toys as a "tomboy" and more recently as gender incongruent or gender non-conforming. Now, the transgender lobby assert that she is a boy, or that she should become a boy. Ironically, if you are a girl who likes playing with dolls, your interests are viewed as a product of socialization, but, if you are a girl who likes playing with trucks, then suddenly, you become a boy trapped in a girl's body.

Each of us has a mix of masculine and feminine traits. But this diversity does not transform us into the opposite sex or expand the categories of sex beyond the binary: "feminine" boys are still boys, and "masculine" girls are still girls. As long as our society keeps conflating sex and gender, and as long as we believe that boys and girls who do not conform to gender stereotypes were "born in the wrong body", then the liberty we desire from the constraints of gender roles will never be achieved. In the meantime, young people are suffering serious harm, including irreparable damage to their bodies, when they are convinced by those in authority, such as teachers, that it is normative to be transgender.

How is gender being taught in NSW government schools?

The curriculum of the NSW Department of Education on sex education - Sexuality and sexual health education in NSW government schools (2016) does not explicitly contain teaching on transgenderism. However, in the further information section of this document, there is a reference to Legal Issues, Bulletin 55, specifically covering the legal rights of transgender students in schools.

In 2016, a review of sex and gender education in English-speaking countries was commissioned by the NSW Department of Education to determine whether its policies and curricula in the area of sex and gender education aligned with international best practice. It compares the Curriculum of the US National Sexuality Education Standards (Table 1) that explicitly cover a transgender agenda throughout.

TABLE 1

US National Sexuality Education Standards: content and skills, identity strand, by phase of schooling

End of Phase	Content and skills
K - Grade 2	• Describe differences and similarities in how boys and girls may be expected to act. • Provide examples of how friends, family, media , society and culture influence the ways in which boys and girls think they should act.
Grade 3 - 5	• Define sexual orientation as romantic attraction to an individual of the same gender or of a different gender. • Identify parents or other trusted adults to whom they can ask questions about sexual orientation. • Demonstrate ways to treat others with dignity and respect. • Demonstrate ways students can work together to promote dignity and respect for all people.
Grade 6 - 8	• Differentiate between gender identity, gender expression and sexual orientation. • Explain the range of gender roles. • Analyse external influences that have an impact on one's attitudes about gender orientation and gender identity. • Access accurate information on gender expression and sexual orientation. • Communicate respectfully with and about people of all gender identities, gender expressions and sexual orientations. • Develop a plan to promote dignity and respect for people in the school community.
Grade 9 - 12	• Differentiate between biological sex, sexual orientation, and gender identity and expression. • Distinguish between sexual orientation, sexual behavior and sexual identity. • Explain how to promote safety, respect, awareness and acceptance. • Advocate for school policies and programs that promote dignity and respect for all. • Analyse the influence of peers, media, family, society, religion and culture on the expression of gender, sexual orientation and identity.

The Department of Education's 2015 statutory guidance for RSE (Relationships and Sex Education) in primary schools provides a list of resources that teachers may consult but reminds schools that they are responsible for selecting and quality assurance of teaching and learning resources, indicating that teachers have a lot of discretion in choosing topics and resources.

It is clear from their curriculum materials that the NSW Department of Education has built their curricula on the faulty ideology of the transgender lobby, as indicated in its two main curriculum packages - Teacher Toolkit and Crossroads. Both packages should be amended to comply with biological and medical science.

Many resources are available to assist teachers with their lessons in sex and gender[3], often with questionable science underpinning the content. Perusal of teaching materials on gender that are readily available on the internet generally reveals that human anatomy and biologically-based sexual dimorphism have been abandoned in favour of concepts like gender identity, gender expression, natal sex, sexual attraction and romantic attraction all falling along a spectrum and all being expressed in different parts of one's body (i.e., gender identity in the brain, sexual and romantic attraction in the heart, biological sex in the pelvis and gender expression, "everywhere"), evincing ignorance of human anatomy and brain-mind connections. These materials offer a tortured and incomprehensible definition of gender identity:

"how you, in your head, define your gender, based on how much you align (or don't align) with what you understand to be the options for gender."

Children are taught that there are "infinite" possibilities for gender identity but only four are specified: "woman-ness," "man-ness," "two-spirit," or "genderqueer." Children are taught that biological sex "isn't something we're actually born with, it's something that doctors or our parents assign us at birth." Figure 1 shows a graphic of the basic "philosophy" underpinning gender education. It was initially embedded in the "the genderbread person" infographic below.

No definition is given for the endpoints at the opposite end of each concept. This is problematic for dimensional scales but incomprehensible when applied to concepts like anatomical sex. How can anatomical sex be dimensional? How can you be anatomically fractionally female or fractionally male? Note that "sex assigned at birth" has been identified as categorical as opposed to the other concepts – gender identity, gender expression, and anatomical sex – which have been identified as dimensional. The distinction between "sex assigned at birth" and "anatomical sex" is not explained, possibly because they are same. The categories have been identified are Female, Intersex, Male. The use of "Intersex" in this way is a perverse and dishonest attempt to obfuscate the binary nature of sex.

Another precept of this ideology is that one can be sexually and "romantically" attracted to different genders and purportedly different people simultaneously. The concept "romantic" is not defined, nor is it differentiated from "sexual" attraction. How one can conduct an intimate relationship with simultaneous attractions towards different people is not clarified.

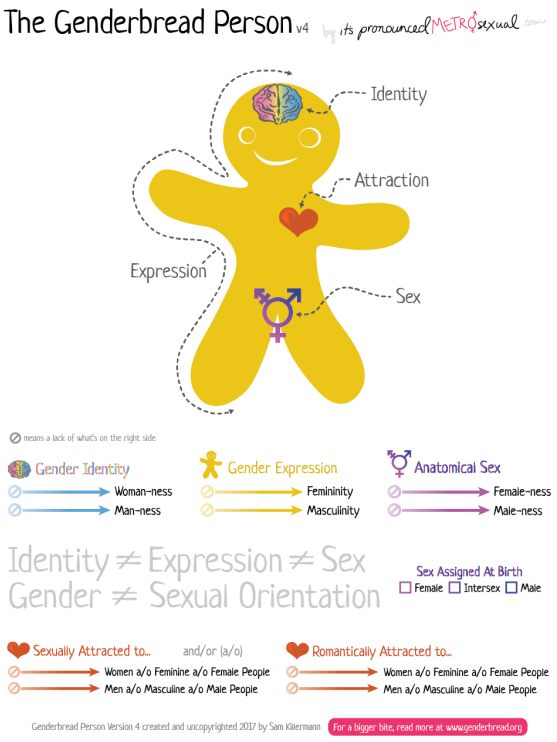

Figure 1. Genderbread person, Source: https://www.genderbread.org/resource/genderbread-person-v4-0

https://www.rainbowsinschools.org/resources
https://www.welcomingschools.org/resources/lesson-plans/transgender-youth/transgender-with-books/
http://www.teachingtransgender.org/

[3] https://www.nidirect.gov.uk/information-and-services/young-people/health-safety-and-relationships
https://www.nswtf.org.au/files/twenty10_trans_at_school.docx__0.pdf

http://www.stonewall.org.uk/ 48
http://the-classroom.org.uk/
http://www.schools-out.org.uk/
http://www.rainbow-project.org/
http://www.transgenderni.com/
https://www.aare.edu.au/blog/?p=1661

Interestingly, discontent arose within transgender ranks that the genderbread person appeared overly male and a breakaway group (Trans Student Education Resources) developed its own graphic – the Gender Unicorn (Figure 2) – that eliminates reference to male and female bodies. The underlying philosophy is mostly unchanged. It uses a body shape that doesn't appear either male or female, and instead of "biological sex" it has "sex assigned at birth." It also changes sexual and romantic attraction to physical and emotional attraction.

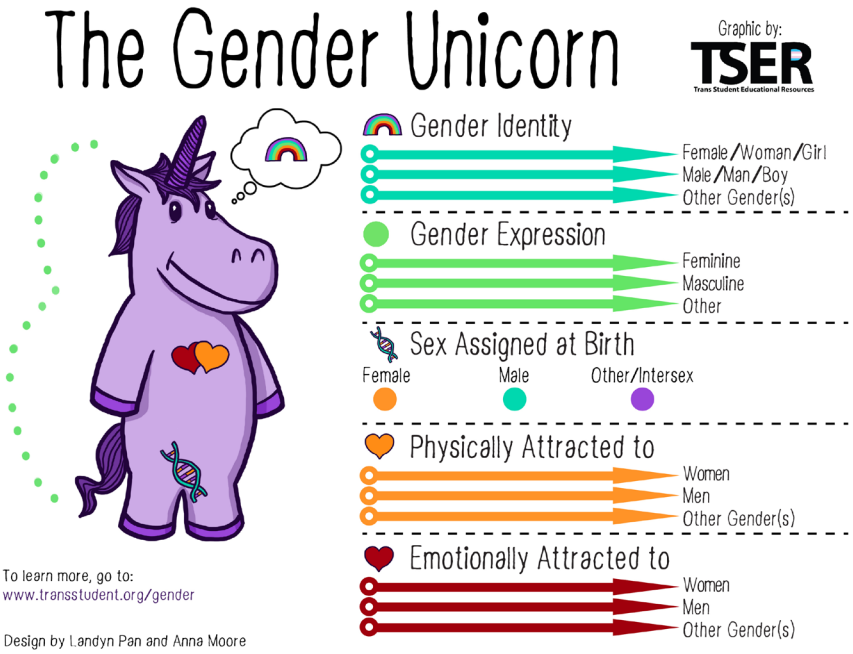

Figure 2. The Gender Unicorn, no longer human

Gender fluidity ideology

The incoherence of transgender ideology is breath-taking and almost too muddled to explicate and clarify. Proponents use and discard or change concepts opportunistically. One example is gender dysphoria. In their attempts to convince us that transgender identification is not a psychiatric disorder, but a normal variant of human gender expression, they eschew the concept of gender dysphoria; however, they coach young people to declare that their gender dysphoria is so bad that it is making them suicidal and they must have "treatment" to save their lives. They abjure biological sex and sexual dimorphism and yet are rigidly binary in their understanding of transgender, as boys trapped in girls' bodies, and vice versa. In each of their five categories in the genderbread person and the gender unicorn, they specify "male" "female" and "other" without expanding what "other" denotes. How can young children understand "other" when they have known only boys, girls, mothers, fathers, brothers, sisters? It is interesting that these graphics (curricula) specify female/woman/girl and male/man/boy and feminine/masculine yet want to assert a gender spectrum. They erroneously include other/intersex as a third or infinite category of "sex assigned at birth."

Further, if gender identity be innate and immutable, how can young people also feel gender fluid, nonbinary or queer? It is unclear whether gender identity can be experienced independently of biological sex. Without biological sex, how can transgender individuals have a gender "identity" since the current conception of transgender is an identity misaligned or opposed to their biological sex (or sex assigned at birth). It is staggering that these errors in basic logic have been embraced by Education Departments around the world. Many have accepted the ideology and prescribed it as compulsory curriculum for children without oversight or scrutiny. Similarly, seemingly intelligent practitioners in medicine, psychology, psychiatry and sport have all drunk from the same bottle of gender fluidity ideology cool aid (i.e., have succumbed to social contagion).

Education of all teaching staff in correct anatomy, physiology, and biochemistry pertaining to sexuality, sexual dimorphism, the meaning of gender, and the dangers (long- and short-term consequences) of attempting gender transition in adolescence is needed to redress the current errors in the gender curriculum.

With the arrival of COVID-19, the World Health Organization (WHO) warned that there would be an "infodemic" of misinformation spawned by social contagion. This has in fact occurred, but the false beliefs have not taken centre stage and swept all science before it in the manner of transgender ideology. Transgenderism is a cult and must be curtailed forthwith. As Anderson (2018) concluded:

> The [transgender] movement has to keep patching and shoring up its beliefs, policing the faithful, coercing the heretics, and punishing apostates, because as soon as its furious efforts flag for a moment or someone successfully stands up to it, the whole charade is exposed. That's what happens when your dogmas are so contrary to obvious, basic, everyday truths. A transgender future is not the "right side of history," yet activists have convinced the most powerful sectors of our society to acquiesce to their demands. While the claims they make are manifestly false, it will take real work to prevent the spread of these harmful ideas.

Below is a summary of the fallacies, mistruths, and misconceptions contained in gender ideology which has found its way into school curricula. These need to be urgently corrected in all the peak bodies, including the NSW Department of Education, to stem the psychic epidemic that is destroying the lives of young people and their families.

a. Definition of gender in self-referential terms e.g., "Gender identity is understood to refer to each person's deeply felt internal and individual experiences of gender" (Yogyakarta Principles) results in the absence of definition, a shaky foundation upon which to build the edifice of the new ideological order. Point b. follows.

b. Inconsistent and internally contradictory use of the term "gender" stating that it is both a "social and psychological phenomenon" and "a deeply held internal and individual sense of [self]". Each characterization privileges either nurture or nature as the defining feature but one cannot invoke opposites to endorse a fixed position. It can only be either/or, not both/and in this instance. Further, admission that gender may be socially constructed opens the door to the possible influence of social contagion, a position that the trans lobby decry, hence their confused logic in their causal attribution of gender.

c. This ideology rejects sexual dimorphism and the unique anatomies pertaining to male and female bodies. Instead, it claims that biological sex is a social construct that has been cemented in society through binary language (man/woman; son/daughter; mother/father etc). Eradication of binary language will purportedly release humanity from the oppression of gender norms that privilege masculinity and heteronormativity and regulation of sexuality, gender and identity.

d. Conflation of intersex with sexual orientation and gender identity as a means of demonstrating that sex and gender are dimensional constructs. The term "diverse bodies," a term propagated by the Australian Psychological Society purportedly "represents clients with intersex variations… [of which] there are more than 40." The fact that 40 intersex variations (many extremely rare) have been identified is used to underpin the transgender belief that there are multiple (diverse) sexualities, genders and bodies. However, intersex variations do not appear on a spectrum; they are discrete categories based on chromosomal, gonadal and genital characteristics and sex hormones and cannot be used to "prove" a gender spectrum. Intersex Human Rights, Australia state that most all births (99.98%) are unambiguously male or female. Intersex conditions comprise the remaining 0.02% (1 in 5,000) to 0.07 (1 in 2,000) of births. The Intersex Society of North America also provide estimates. InterACT statistics offer frequencies for the many varieties of Intersex conditions. These do not destabilize the foundation of biological sex.

e. Recruitment of Intersex as a gender identity. Gender fluidity ideology conflates people with intersex variations with those of "diverse" sexual orientation and gender identity despite an Intersex peak body, Intersex Human Rights Australia making explicit that intersex is an

issue separate from sexual orientation and gender identity and that Intersex is not a gender identity.

f. Transgender advocacy campaigns for earlier and earlier hormonal treatment and sex re-assignment surgery for minors. Yet, other peak bodies such as InterACT deplore genital surgeries on intersex children. Such surgeries have been classified as torture by the United Nations. Advocates argue that a reduction of genital surgeries in children is justified because there is no demonstrated benefit to early intervention. The Human Rights Law Centre likewise deprecates early surgery for young intersex people, stating that the decision should be delayed until the young person is old enough to provide informed consent for any surgical procedure.

   Points (a), (b) and (c) remove Intersex as a bastion to shore up the fallacious assertions in gender fluidity ideology that sex occurs on a spectrum and should therefore be removed from all curricular materials.

g. Use of the scientifically incorrect phrase "sex assigned at birth." The dishonest use of the term "assigned" in this phrase implies that parents and doctors make a unilateral decision regarding the sex of their infant at birth. On the contrary, sex is determined at conception when the sperm contributed a Y chromosome, which creates a boy, or an X chromosome, which creates a girl. Sex becomes observable between seven and nine weeks after fertilization. Historically and currently, babies' "birth sex" was and continues to be noted at birth. The phrase "sex assigned at birth" is mandated in gender ideology because it opens the door to "gender identity" as the true basis of a person's sex. The scientific understanding that sex is a biological reality and gender is a social construct has been reversed in transgender ideology which claims that gender identity is destiny and biological sex is a social construct.

h. Gender ideologists exhort us to recognise that "diverse sexualities are one variant of human sexuality and are not indicative of psychological disturbance." How can diverse sexualities be one variant of human sexuality? They explain evidence that young LGBTQ people have worse psychosocial health outcomes in terms of minority stress, social stigma, and sex discrimination (homophobia/transphobia) in a heteronormative society. If all sexual acts were "normalized" and given equal value, these outcomes would be reversed. They ignore the evidence that serious mental health problems mostly predate declarations of sexual diversity and that sex reassignment surgery does not alleviate psychological distress/disturbance nor reduce suicide.

i. Expressing diversity or psychological difficulties? A collateral logical dilemma arises when gender ideologists want us to believe that young people identifying as transgender are not psychologically unwell. On the one hand, they are simply expressing their diversity, a natural variant of human sexuality; on the other, they need a diagnosis of gender dysphoria in order to attract services, including feigning suicidality to coerce their parents and health care providers into agreeing to hormonal treatments.

j. Gender ideology claims that the dysphoria paradigm perpetuates stigma and discrimination. If that be the case, one can only conclude that dysphoria cannot be a criterion for diagnosis even though most young people presenting for treatment claim a subjective experience of gender dysphoria. Hence, reliance on solipsistic assertions of "born in the wrong body" discourse will become the only arbiter of medical treatment decisions. Yet, how can one assert that one has been born in the wrong body without experiencing dysphoria? If there be no dysphoria, i.e., no disturbance in the mind, one can conclude that the condition does not exist and hence any medical or psychological intervention is unnecessary and stigmatising.

k. Advocacy for gender and sexual diversity and its introduction into school curricula has resulted in the early sexualization of children, confusion about the meaning of gender, sex and gender roles, including reproduction, and the nature of relationships that is inconsistent with "the child's best interests" and is hostile to parents.

Transgender policies in schools and the deprivation of parental rights

The NSW (Australia) Department of Education's Bulletin 55 deprives parents of any rights in the management of their transgender declaring child at school. Bulletin 20 even deprives parents of parental authority regarding the registered name of their child. It states,

> If either or both parents object to the change to the way the first name is recorded by the school, the principal needs to make a decision about what is in the child's best interests [author's italics]. This decision should have regard to the age, capability and maturity of the student and can be informed by advice from a health care professional about the potential impact on the student's wellbeing of declining to use and record the student's preferred first name.

These guidelines undermine parental authority in the child's eyes, setting a dangerous precedent allowing children to make decisions about their wellbeing for which they are not emotionally or cognitively ready.

Summary and conclusion

I have argued in this paper that gender ideology should not be taught in NSW government schools for the sole reason, although there are many others, that to continue to do so, we would be engaged in the egregious act of miseducating our children by propagating a fallacious, illogical, unscientific, and seriously damaging ideology. It is imperative that we desist forthwith from "dead-teaching" a generation of young minds who will have to unlearn and be re-socialised into the bodies into which they born. This will not happen until the adults and institutions responsible for their well-being reactivate the brains with which they were born and cease their mis-intellectualising about a rainbow spectrum of gender and exhortations that they can "choose" their gender.

The NSW Department of Education should convene a panel of researchers, medical scientists, endocrinologists, paediatricians, psychologists, psychiatrists, and educators to develop a guidance comprising evidence-based precepts about the development of sexuality and gender upon which new curricula can be developed.

4

Section 4: LEGAL & ETHICAL ISSUES

We can't protect women's rights by denying biology

- Katherine Deves (first published in *The Australian*, 7th April 2021)

Our headlines and social media have been awash with allegations about male sexual harassment and violence towards women. Angry and frustrated women are demanding action. Yet amid all this commentary, there is silence about a profound redefinition of what it means to be a woman. This change, with troubling implications for the rights and interests of women and girls, is being spread through society by lobby groups and bureaucrats without proper public debate or media scrutiny.

Most Australians are simply unaware. Most mainstream media has failed to look into this cultural and political shift with any curiosity or impartiality. What dominates is the narrative of the activists driving this fundamental change to how we understand humanity. One way society seeks to protect women and girls from assault is through single-sex spaces such as change rooms, toilets, dormitories, prisons and domestic violence shelters.

Australia ratified the UN Convention for the Elimination of All Forms of Discrimination Against Women and passed the federal *Sex Discrimination Act 1984*. These protections and rights were based on a woman's biology, her reproductive sex. After all, one of the most common forms of discrimination relates to pregnancy and child-bearing.

How many of the politicians and journalists talking about the problems facing women in our national capital realise that the words woman and man were removed from the Sex Discrimination Act? That the biological significance of these words was considered problematic, and a new definition was adopted in 2013 that allows anyone to identify as the opposite sex? This novel concept of a self-declared "gender identity" potentially at odds with biology has flowed through into legislation and institutions more generally. Change in gender becomes a mere statement, with no requirement for medical intervention, psychological oversight or a sustained period of living as the opposite sex.

Even the Australian Academy of Science defines a woman as "anyone who identifies as one" — and this in a document about advancing female careers in science. The ALP's redrafted 2021 national platform refers to the dilemma of "whether people choose to continue with pregnancy". The 2018 platform had no problem speaking to "pregnant and new mothers". What happened?

In our politics and media we have a debate about sexism without sex. The quiet substitution of gender identity for biology is not just a word game. It comes with potential conflicts and risks. Single-sex spaces are under threat.

Overseas, women's domestic violence shelters have lost funding because they were deemed not inclusive of people who were born male but identify as female.

In Australia, women who resist the gender identity push were excluded by organisers of the March 4 Justice last month. Women with a public profile who speak up for sex-based rights suffer abuse and threats, and only a handful of commentators call out this unacceptable behaviour.

Following the rape allegation made by Brittany Higgins, Sex Discrimination Commissioner Kate Jenkins was asked to lead an independent inquiry into parliament's workplace culture. Yet the Human Right Commission on which she serves champions the promotion of gender identity at the expense of biological sex.

Its 2019 transgender inclusion guideline urges sports to reorganise along the lines of self-declared gender wherever possible, thereby putting girls and women at risk of unfairness and injury if they must compete against male-bodied players who identify as female.

Usually when a potential conflict of human rights arises, there is broad debate. Yet the conflict of rights arising between females on the one hand and males who declare a transgender identity on the other is being ignored. "No debate", we are told.

What happens under federal discrimination law when both sex and gender identity can be the basis for a complaint? If a man makes a successful complaint he has been discriminated against

because of his gender identity, that may have a discriminatory effect on a female on the basis of her sex. What takes precedence — subjective feelings of a male-born person about his gender, or the material reality of living in a female-sexed body? This is territory with extraordinary implications, and it is a debate that everyone has an interest in.

Sex is determined at fertilisation, observed at birth, and immutable; it is not something a person can identify into or out of. Gender identity reflects sex-based stereotypes: name, dress, mannerisms, appearance.

The definition of gender identity as found in Australian legislation was drawn from a document called the Yogyakarta Principles. This is a pseudo-human rights document that purports to have enforceable authority, yet it is merely a template for activism bolting together ideas from queer theory and post-modernism.

We are witnessing an extraordinary display of cognitive dissonance by our political and media class — the promotion of little understood policies hostile to women's rights, while stories about male sexual harassment and violence loom large. At what point will politicians and journalists face up to this contradiction?

Katherine Deves is co-founder of Save Women's Sport Australasia.

Tavistock Judgement: implications for Australia

- Elisabeth Taylor

Link to judgement here:
https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf

Summary of the judgement

The court found that it is wrong to state that puberty blockers (PBs) are prescribed to "give the child time to consider their gender identity." PBs generate persistence of gender dysphoria (GD) and almost all children who start on PBs progress to cross-sex hormones (CSH). In consenting to PBs, the child is also consenting to CSH – these decisions are part of the same clinical pathway and should not be treated as separate. The purpose of PBs is therefore more accurately described as facilitating an anticipated life-long transition. This being so, PBs should not be prescribed except where persistence is certain.

The court found that no amount of information, however comprehensive and age-appropriate, would be sufficient to enable a child to properly consider questions (such as sexual functioning and fertility) which are outside the scope of a child to imagine. Since it is not possible for a child to achieve "Gillick competence" in such a matter, it is therefore impossible for a child to give informed consent to PB and CSH treatment.

It is also impossible for parents to give consent on behalf of their child. The clinic stated that it is not, nor would it ever be, the practice of GIDS to accept parental consent to transition on behalf of a child who could not make this decision for themselves. The court recommended that GIDS consult the court before setting a child on this pathway.

The scope of the question addressed by the court

Judgement was limited to the issue of consent. Gender Identity Development Service (GIDS) prescribes puberty blockers (PBs) for children as young as 10. Can such young children give "informed consent"?

s.6: The issue at the heart of this claim is whether informed consent in the legal sense can be given by such children and young persons.

s.7: "The claimants' case is that children and young persons under 18 are not competent to give consent to the administration of puberty blocking drugs. Further, they contend that the information given to those under 18 by the defendant is misleading and insufficient to ensure such children or young persons are able to give informed consent. They further contend that the absence of procedural safeguards, and the inadequacy of the information provided, results in an infringement of the rights of such children and young persons under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (the Convention)."

s.9: The court is not deciding on the benefits or disbenefits of treating children with GD with PBs, whether in the long or short term …That is not a matter for us. ***The sole legal issue in the case is the circumstances in which a child or young person may be competent to give valid consent to treatment in law and the process by which consent to the treatment is obtained.***

The court did not consider whether a parent could consent on their child's behalf in cases where the child is deemed to lack Gillick competence (the normal recourse in law) because GIDS made it very clear that such a practice is contrary to the policy of the clinic:

s.47 [GIDS affirmed]: Although the general law would permit parent(s) to consent on behalf of their child, GIDS has never administered, nor can it conceive of any situation where it would be appropriate to administer blockers on a patient without their consent. The Service Specification confirms that this is the case.

It follows that is not necessary for us to consider whether parents could consent to the treatment if the child cannot lawfully do so because this is not the policy or practice of the defendant and such a case could not currently arise on the facts.

s.89 The case of the second claimant, Mrs A. (who is the mother of a 15-year old girl with ASD) was deemed largely theoretical. Mrs A. is worried that her daughter will be referred to GIDS but ***GIDS has made it clear that they would not proceed with treatment against a parent's wishes.***

s.41: [Professor Butler's] clinic has never sought to apply to the Court under its inherent jurisdiction "against" parental opinions because he is concerned that would cause familial frictions.

The case does not draw conclusions about the nature of GD or what treatments are appropriate:

s.92: [T]he claimants were not calling into question that GD existed. Nor were they questioning that it could cause extreme distress or that PBs should never be given to people under 18 or that it was never in their best interests for it to be prescribed. The central issue was whether those under 18 could give informed consent.

Further, the claimants are not asserting that the GIDS was negligent or not adhering to correct procedure [see s. 86]:

s.13: The GIDS is commissioned by the NHS, which is tasked by order of the Secretary of State with arranging "for the provision of services including, pursuant to para 56 of Schedule 4, a gender identity development service specifically for children and adolescents in addition to gender dysphoria services more generally (para 57).

Puberty blocking drugs can in theory be, and have in practice been, prescribed for gender dysphoria through the services provided by the defendant to children as young as 10. It is the practice of the defendant, through GIDS, to require the informed consent of those children and young persons to whom such drugs are prescribed.

Significant findings

The decision to transition has profound, life-changing consequences:

s.148: The treatment involved is truly life changing, going as it does to the very heart of an individual's identity. (See also s.134).

s.149: The decisions in respect of PBs have lifelong and life-changing consequences for the children. Apart perhaps from life-saving treatment, there will be no more profound medical decisions for children than whether to start on this treatment pathway.

The role of the court to protect vulnerable children trumps respect for a child's personal autonomy:

s.149: In principle, a young person's autonomy should be protected and supported; however, it is the role of the court to protect children, and particularly a vulnerable child's best interests.

There are conflicting explanations about the purpose of prescribing PBs. In is inaccurate to state (as clinics often do) that PBs are prescribed in order to give a child "time to consider":

s.134: There is a lack of clarity over the purpose of the treatment: in particular, whether it provides a "pause to think" in a "hormone neutral" state or is a treatment to limit the effects of puberty, and thus the need for greater surgical and chemical intervention later, as referred to in the Health Research Authority report.

Literature often describes PBs as giving the young person time to think about their gender identity. [s.52-59]. This has been (wrongly) interpreted by some to mean that the puberty suppression was for use in any children presenting to the clinic, i.e. that the blockers would not effect a change in gender dysphoria and that the child could then choose either to progress to cross-sex hormone treatment or to stop treatment and allow the onset of puberty in the birth gender.

Evidence for the benefits of PBs is lacking:

s.94: Mr Hyam submitted that the evidence for benefits of using PBs is lacking. (GIDs fails to inform patients of this).

The court acknowledged the lack of evidence:

s.71: [T]he lack of a firm evidence base for their use is evident from the very limited published material as to the effectiveness of the treatment.

PBs are an "experimental treatment"; the consequences are uncertain and evidence for efficacy is limited but the changes wrought are fundamental to identity:

s.69: [C]laimants submit that the treatment of PBs for GD is properly described as (i)

experimental (ii) a treatment with a very limited evidence base, and (iii) as a highly controversial treatment. [See also s.94 on this subject].

s.70 The court declined to judge the weight of evidence submitted in support of this claim but noted [s.71] that support for the counter-claim (i.e. that use of PBs for GD is beneficial) is lacking. At s.74 they noted that the issue is relevant to the question of consent:

> *s.74: However the degree to which the treatment is experimental and has, as yet, an unknown impact, does go to the critical issue of whether a young person can have sufficient understanding of the risks and benefits to be able lawfully to consent to that treatment.*

s. 134: The administration of PBs to people going through puberty is a very unusual treatment for the following reasons. Firstly, there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment … Thirdly, the consequences of the treatment are highly complex and potentially lifelong and life changing in the most fundamental way imaginable. The treatment goes to the heart of an individual's identity, and is thus, quite possibly, unique as a medical treatment.

s. 135 The judges recognize that clinical interventions for GD differ from other clinical interventions because there are no physical manifestations of the disorder, on the other hand, there are profound physical consequences from the treatment:

> *"In other cases, medical treatment is used to remedy, or alleviate the symptoms of, a diagnosed physical or mental condition, and the effects of that treatment are direct and usually apparent. The position in relation to puberty blockers would not seem to reflect that description."*

s. 143: [T]he combination here of lifelong and life changing treatment being given to children, with very limited knowledge of the degree to which it will or will not benefit them, is one that gives significant grounds for concern.

GIDS admits that children are being asked to consent to unknown side effects of treatment:

s.39 Ms Morris emphasised that the process of ensuring that consent could validly be given was a discursive and iterative one that involved multiple discussions and answering any questions the young people or their parents might raise. Dr Carmichael said at para 35:

> *"The GIDS clinicians make it very clear to children and young people that there are both known and unknown risks associated with GnRHa treatment." Further, she said at para 41: "In my experience, those young people we see who are recommended for GnRHa treatment understand the implications and limitations of treatment with GnRHa treatment and are able to consent to this stage of treatment."*

It is recognized that some adolescents who transition will detransition:

The Service Specification (effectively the NHS's license for the GIDS to operate) notes concern that some adolescents who currently identify as transgender will not always identify in this way:

s.37: The current context of treatment decisions about cross sex hormones in adolescence is that there is limited scientific evidence for the long-term benefits versus the potential harms of the intervention. There are also concerns that it is uncertain whether or not a young person will continue to identify as transgender in the future, given that some subsequently identify in a different way.

It is inaccurate to describe PBs as "entirely reversible". (Among others, this claim was made by the NHS website until June 2020).

s.60: Both WPATH and the Endocrine Society in their documentation describe PBs as fully reversible … However, it is important to note that apart from the Amsterdam study, the history of the use of PBs relied upon in this context is from the treatment of precocious puberty which is a different condition from GD, and where PBs are used in a very different way.

s.61-62: Dr de Vries (appearing for the defence) qualified what is meant by "fully reversible" She said:

"Puberty blocking treatment is fully reversible (see for example section 2.0 of the Endocrine Society's Clinical Practice Guidelines…). By fully reversible I mean that the administration of puberty blockers in young people has no irreversible physical consequences, for example

for fertility, voice deepening or breast growth". [T]he administration of puberty blockers in young people has no irreversible physical consequences, for example for fertility, voice deepening or breast growth … [but] long-term physical consequences of puberty blocking on bone density, fertility, brain development [are less certain].

s.64-65: [T]he claimants assert that neurological and psychological changes occurring in puberty are less well understood than the physiological changes …the child or young person will have missed a period, however long, of normal biological, psychological and social experience through adolescence; and that missed development and experience, during adolescence, can never be truly be recovered or "reversed".

s.68: [C]ommencing PBs in practice puts a young person on a virtually inexorable path to taking CSH. CSH are to a very significant degree not reversible.

The use of PBs is not itself a neutral process by which time stands still for the child, whether physically or psychologically:

s.137: PBs prevent the child going through puberty in the normal biological process. As a minimum it seems to us that this means that the child is not undergoing the physical and consequential psychological changes which would contribute to the understanding of a person's identity.

PBs generate persistence of GD:

In practice, however, since "practically all" [s.56] children in the Tavistock study who start on PBs progress to CSH, it is more accurate to say that PBs generate persistence. See also:

s.77: The treatment may be supporting the persistence of GD in circumstances in which it is at least possible that without that treatment, the GD would resolve itself.

PBs are therefore a stepping-stone to CHS and should only be prescribed in cases where persistence is certain:

It follows that PBs should not be prescribed except in cases where children have already demonstrated persistent gender identity dysphoria, the purpose of the treatment being to facilitate transitioning (suppressing puberty allows the patient to initiate CSH while avoiding the need to surgically reverse or otherwise mask the effects of puberty in the birth gender). [s. 52].

s.136: [T]he consequences which flow from taking PBs for GD and which must be considered in the context of informed consent, fall into two (interlinking) categories. Those that are a direct result of taking the PBs themselves, and those that follow on from progression to Stage 2, that is taking cross-sex hormones. The defendant and the Trusts argue that Stage 1 and 2 are entirely separate; a child can stop taking PBs at any time and that Stage 1 is fully reversible. It is said therefore the child needs only to understand the implications of taking PBs alone to be Gillick competent. In our view this does not reflect the reality. The evidence shows that the vast majority of children who take PBs move on to take cross-sex hormones, that Stages 1 and 2 are two stages of one clinical pathway and once on that pathway it is extremely rare for a child to get off it.

s. 137: There is an argument that for some children at least, this may confirm the child's chosen gender identity at the time they begin the use of puberty blockers and to that extent, confirm their GD and increase the likelihood of some children moving on to cross-sex hormones. Indeed, the statistical correlation between the use of puberty blockers and cross-sex hormones supports the case that it is appropriate to view PBs as a stepping stone to cross-sex hormones.

To be able to give meaningful consent the child would need to understand the implications not just of PBs but also of CHS:

s. 138: It follows that to achieve Gillick competence the child or young person would have to understand not simply the implications of taking PBs but those of progressing to cross-sex hormones. ***The relevant information therefore that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows:*** *(i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.*

No amount of information will enable to child to evaluate implications of the transition decision:

The defence agreed on the importance of conveying correct information:

s. 43: He [Professor Butler] then said: "it is an absolute

requirement before starting any treatment that a young person can fully understand this effect on fertility and sexual functioning according to their age and level of maturation.

But the court accepted evidence for the complainant that lack of information was not the problem. However well presented, a child is simply unable to process the implications of such treatment:

s.150: The problem is not the information given, but the ability of the children and young people, to understand and most importantly weigh up that information. The approach of the defendant appears to have been to work on the assumption that if they give enough information and discuss it sufficiently often with the children, they will be able to achieve Gillick competency. As we have explained above, we do not think that this assumption is correct.

Professor Scott (Director of University College London's Institute of Cognitive Neuroscience) explained that teenagers have not yet achieved the brain development necessary to fully grasp the implications of puberty blocking treatment [s.*45-46*]:

s. 46: [G]iven the risk of puberty blocking treatment, and the fact that these will have irreversible effects, that have life-long consequences, it is my view that even if the risks are well explained, that in the light of the scientific literature, that it is very possible for an adolescent to be unable to fully grasp the implications of puberty-blocking treatment. All the evidence we have suggests that the complex, emotionally charged decisions required to engage with this treatment are not yet acquired as a skill at this age, both in terms of brain maturation and in terms of behaviour.

Currently, it seems to be highly unusual for a child to be refused PBs or CHS on the grounds that they were not competent to give consent:

s. 44: The court asked for statistical material on the number, if any, of young people who had been assessed to be suitable for PBs but who were not prescribed them because the young person was considered not to be Gillick competent to make the decision, whether at GIDS or the Trusts… Ms Morris could not produce any statistics on whether this situation had ever arisen … The court gained the strong impression from the evidence and from those submissions that it was extremely unusual for either GIDS or the Trusts to refuse to give PBs on the ground that the young person was not competent to give consent. The approach adopted appears to be to continue giving the child more information and to have more discussions until s/he is considered Gillick competent or is discharged.

NB. In similar vein, Benjamin Law (Moral Panic 101) asked Elizabeth Riley if she ever recommends against social transitioning for children and records her answer as affirmative. The reader is given the impression that, as the expert, Riley just "knows" which children really are transgender. Law appeals to the reader's assumption that transgenderism is innate and immutable – an understanding of transgenderism which is entirely at odds with that promoted in Riley's doctoral thesis, where she is explicit about the importance of supporting gender non-conformity and gender fluidity.

Implications of this decision for Australia

1. GPs should not be prescribing PBs "off label" for GD patients.

s. 60: Both WPATH and the Endocrine Society in their documentation describe PBs as fully reversible … However, it is important to note that apart from the Amsterdam study, the history of the use of PBs relied upon in this context is from the treatment of precocious puberty which is a different condition from GD, and where PBs are used in a very different way.

s.70: In the USA the treatment of GD is not an FDA approved use and as such PBs can only be used "off-label". That does not prevent clinicians, whether in the USA or the United Kingdom, from using PBs for this purpose, as long as their use falls within the clinician's professional expertise.

The UK High Court regards the PBs (Stage 1) and CSH (Stage 2) as part of the same clinical pathway [s.136-138]. Gillick competence must cover not just the capacity to consent to PBs but to CSH as well. The court has ruled that children under the age of 16 are unlikely to have such competence.

Safeguards for children need to be implemented before they enter Stage 1.

2. Safeguards for vulnerable children are inadequate (or comprehensively missing) from Australian policy.

In several states, current Education Department policy recommends the social transitioning of children in schools, even without parental knowledge permission or consent. Australian GPs are free to prescribe PBs off-label. Activist-led workshops encourage GPs in the belief that PBs are "safe and entirely reversible" and work as a neutral "pause" button. From 15-years old, children can

apply for their own Medicare card. In Victoria, the "Doctors in Schools" program further reduces parents' visibility of their children's interactions with the medical profession.

3. Proposed anti-conversion therapy legislation imposes in law the inverse order of prioritization for the competing claims of a) respecting a child's personal autonomy versus b) protecting vulnerable children, to that recommended by the UK High Court.

Transition involves significant (and unknown) risks for children such that the UK High Court found:

a. Under the age of 16, a child's competence to give informed consent is compromised:

   s. 145: The conclusion we have reached is that it is highly unlikely that a child aged 13 or under would ever be Gillick competent to give consent to being treated with PBs. In respect of children aged 14 and 15, we are also very doubtful that a child of this age could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent.

b. It is not the practice of clinics do not proceed with PBs for children under 16 in the absence of parental consent. [s.47].

c. "Where the decision is significant and life changing [which transition is: s.134] then there is a greater onus to ensure that the child understands and is able to weigh the information."

d. Clinicians are now advised to seek court approval for puberty blockers, even perhaps for children aged 17-18. [s.147].

Anti-conversion therapy laws would criminally punish those who set their responsibility to protect vulnerable children above the need to respect a child's personal autonomy. The UK Court found that – speaking for the role of the court – the responsibility to protect vulnerable children was the superior responsibility.

4. Evidence for the benefits of transition is lacking. On the other hand, the profound and irreversible effects of PBs and CHS are certain. The Trans20 study currently under way in RMCH Gender Clinic will need to be reviewed.

Academic investigation is almost always dominated by activists who are ideologically pre-convinced of the benefits and necessity of transitioning. Studies into the effectiveness of trans medicine in children are designed to affirm pre-established conclusions, rather than to test the primary questions of efficacy and necessity. These studies have poor design in common; they are shaped to provide evidentiary support for desired outcomes and do not offer a control group against which outcomes could meaningfully be measured.

The study protocol for Trans20 (currently involving 600 children) is available here:

- Michelle Tollit, Carmen Pace, Michelle Telfer, Janet Bryson, Nicholas Fulkoski, Charlie Cooper, Ken Pang, "What are the health outcomes of trans and gender diverse young people in Australia? Study protocol for the Trans20 longitudinal cohort study", BMJ Open, 2019. doi: 10.1136/bmjopen-2019-032151 (https://bmjopen.bmj.com/content/9/11/e032151).

5. The Health Minister needs to ensure consistent and comprehensive data collection on patients from clinics in all states in a manner which enables information to be collated and analyzed, including for changes over time.

The UK High Court noted surprising gaps in the data analysis carried out by GID, noting in particular:

- **Lack of information about the age distribution of patients on PBs:**

  s.27: The court asked for statistics on the number or proportion of young people referred by GIDS for PBs who had a diagnosis of ASD. Ms Morris said that such data was not available, although it would have been recorded on individual patient records. We therefore do not know the proportion of those who were found by GIDS to be Gillick competent who had ASD, or indeed a mental health diagnosis…

  s.28: Again, we have found this lack of data analysis – and the apparent lack of investigation of this issue – surprising.

- **Lack of information about mental comorbidities of patients:**

  s.34: The court asked for statistics on the number or proportion of young people referred by GIDS for PBs who had a diagnosis of ASD. Ms Morris said that such data was not available, although it would have been

recorded on individual patient records. We therefore do not know the proportion of those who were found by GIDS to be Gillick competent who had ASD, or indeed a mental health diagnosis.

s.35. Again, we have found this lack of data analysis – and the apparent lack of investigation of this issue – surprising.

- **Lack of information about the proportion of patients on PBs who progress to CSH:**

  s.59: We find it surprising that GIDS did not obtain full data showing the figures and the proportion of those on puberty blockers who remain within GIDS and move on to cross-sex hormones.

6. Government-appointed gatekeepers of child safety who ought to be questioning and scrutinizing the "affirmation only" approach to transition for children are, instead, endorsing it. These officers appear to have signed up to an ideology-driven approach which, according to the UK High Court, leaves vulnerable children exposed.

State Commissioners for Children and Young People

On 20th November 2019 (the 30th Anniversary of the United Nations Declaration on the Rights of the Child (UNROC), Dr Geoff Holloway wrote to all Children's Commissioners and Guardians across Australia, including the National Children's Commissioner, requesting support for a national inquiry into gender dysphoria and gender transitioning.

In private correspondence, the Children's Commissioners for Western Australia and Victoria replied that they do not support the request for a national inquiry. A typical response was as follows:

"The Commissioner has noted your concerns, however will not be providing support for your submission to the Federal Government for a national inquiry into gender dysphoria and transitioning among children and adolescents."

No jurisdictions responded to Dr Holloway in detail with the exception of the Children's Commissioner in Tasmania, who answered as follows:

"I wish to make it very clear that I do not support the call, as you have described it, for the establishment of a national inquiry into gender dysphoria and transitioning among children and adolescents. I am in favour of legislative and other reform processes which would promote the best interests and wellbeing of children and young people who seek assistance with affirming their gender identity, including through access to medical treatment.' Leanne McLean, Commissioner for Children & Young People (Tas)."

NB: Michelle Telfer is named in Re: Jamie and Re: Kelvin. Since 2012, Dr Michelle Telfer has been Director of the Royal Children's Hospital Gender Service, responsible for ***"development and expansion"***.[4] She is described as *"a strong advocate for legal change and improved access to medical and mental health care for transgender and gender diverse children and adolescents in Australia."* In 2017 Michelle Telfer also won the "Straight Ally of the Year" Award at the GLOBE Community Awards for her work in supporting the LGBTI community.

Through her role in the Human Rights Law Centre at La Trobe University, ***Anna Brown*** was involved in promoting the *Preventing Harm, Promoting Justice study.* In her role as CEO of Equality Australia, she is now promoting the introduction of laws to prevent "conversion therapy".

The 2018 Family Court decision to pull out of supervision for Stage 2 treatments (CHS and surgery) was made in response to concerted activism. It is an abrogation of their responsibility to protect vulnerable children.

[4] See Telfer Bio: https://joy.org.au/familymatters/2018/07/19/michelle-telfer-australian-standards-of-treatment-care-for-trans-children-adolescents/

The Yogyakarta Principles: the false convention

– Geoff Holloway

The founding of the Yogyakarta Principles (YP) is a horror story, that is the only way to describe it – involving several key people, legalistic strategies and well-organised public relations[i] events, all designed to replace the term sex with gender.

The site of the first meeting, Yogyakarta in Indonesia in November 2006, was deliberately chosen because it is "south of the equator, in a Muslim majority country and in a jurisdiction ruled by a Sultan"[ii] at Gadjah Mada University (world university ranking 1,001+[iii]). The co-chairs of this meeting were from Thailand and Brazil and representation was carefully selected from outside of the West and Latin America - with people from Botswana, China, India, Indonesia, Kenya, Nepal, Pakistan, South Africa, Thailand and Turkey. The participants came from (only) 25 countries.

According to Sanders (2008), the key organisers included the International Service for Human Rights and the International Commission of Jurists with Chris Sidoti, Philip Dayle and Michael O'Flaherty (who was a major author of the YP). ARC International were also involved (as noted in my previous paper) and the only trans-supporting NGO to have an office in Geneva at that time[iv].

As Emeritus Professor Douglas Sanders, from British Columbia but now retired in Bangkok, acknowledges,

The meeting in Yogyakarta in November 2006, brought these groups together - academics, judges, UN experts and representatives of NGOs. But was this a UN meeting? No. Was it an academic meeting? No. Was it an NGO meeting? No.[v]

However, there were at least four other persons of note:

- Martine Rothblatt, CEO of United Therapies and former CEO of SiriusXM, the top earning CEO in the biopharmaceutical industry. Rothblatt identifies as a transsexual and transhumanist.

  He has created a robot replica of his wife, Bina, with the intention of installing Bina's consciousness into this robot so that they can live in cyber space indefinitely. He fully believes robots are people without skin – hence the transcendence from 'fleshism'.

  After a meeting with Ray Kurzweil of Google and being enamored with Kurzweil's Singularity theory, Rothblatt created a religious organization, Teresem Movement to promote the geoethical (world ethical) use of nanotechnology through educational programs, scientific research and development in the areas of cryogenics, biotechnology, and cyber consciousness.[vi]

- Phyllis Frye, another transsexual lawyer, from Texas.

  As a member of the International Conference on Transgender Law and Employment Policy (ICTLEP) since 1992, Rothblatt authored the first draft of the Transexual and Transgender Health Law Reports[vii]*, after meeting Phyllis Frye, another transsexual lawyer, in Texas. This small meeting of men with a penchant for wearing women's undergarments was the launch pad for an international project to drive transsexualism globally and deconstruct human sexual dimorphism. The document Rothblatt drafted would later be referred to as the International Bill of Gender Rights (IBGR). Phyllis Frye has been referred to as the 'grandmother of the transgender movement'.*[viii]

- Stephen Whittle, a transsexual identifying female in the UK, was contacted by Phyllis Fry following the above-mentioned conference. Whittle is, or was, a professor of Equalities Law at Manchester Metropolitan University and president of the World Professional Association for Transgender Health (WPATH). Whittle was part of the team that elaborated on the Yogyakarta Principles at the meeting in November 2006. At this meeting SOGU (Sexual Orientation Gender Identity) principles were added to the YP, known as Plus 10. Used as legal guidelines, they are not actually law but are treated as such by NGOs fronting for the trans medical industrial complex.[ix]

- The fourth person in this group of trans musketeers was another male, transsexual lawyer, Christine Burns, who advanced the UK Interdepartmental Working Group on Transexual People in 1999.[x]

These four lawyers, all transsexuals, have been the main generators of the project to deconstruct sex within the law on a global scale and to have it replaced with the subjective, ambiguous idea

of how people feel about their bodies (felt gender identity). Martine Rothblatt has been the key player in this deconstruction process.

The significant role of ARC International has also played a key-coordinating role in all of this, as has been covered in the previous paper on the YP.[xi]

In conclusion, as Jennifer Bilek writes, quoted here in full -

It's been less than thirty years since Rothblatt authored that first document to create a legal fiction of disembodiment and just over ten years since he wrote about re-conceptualizing our species boundaries. We are now facing the normalization of that disembodiment in the emerging industry of "gender identity." Shouldn't we be considering if this is what we want for ourselves? Are we ready to allow for the deconstruction of the very thing that makes us human, our biological roots in sex? Because if we are not, now is the time to act. The normalization of disembodiment has already been institutionalized and deeply imbedded in the marketplace. Children are being used in experiments both psychological and medical, which are dissociating them from their bodies. Their schools have become indoctrination farms, the largest *international law firm* in the world has been recruited to help with legal construction of the "transgender child" and more than *fifty clinics* have arisen in the US alone in the past ten years to manipulate their puberty and hormones, setting them down a life-long path of medicalization at a time when we have never been more set apart from each other by our machines.

The jig is up on this purported "human rights movement." If we want to hold fast to our humanity, there is no time to waste. We are in the eleventh hour and must end this tech-driven, hubristic flight from flesh, mortality and nature.[xii]

Why have the Yogyakarta Principles been so influential?

The reasons for the rapid conquest by transgender activists of the media, universities, government departments and woke corporations are mysterious. Is it cultural? Psychological? Philosophical? Legal?

Without being a complete explanation, one reason is widespread acceptance of the Yogyakarta Principles. Amnesty USA describes them as "a universal guide to applying international human rights law" to LGBT issues. A leading German NGO, the Heinrich Böll Stiftung, describes them as "a groundbreaking document, extensively used since by human rights mechanisms and advocates" and Human Rights Watch has praised them as "a milestone for Lesbian, Gay, Bisexual, and Transgender rights".

America's leading LGBT think tank, the Williams Institute at UCLA, says that "The Yogyakarta Principles are the primary document defining the application of international human rights law with respect to sexual orientation and gender identity." Despite scholarly journals often quoting these principles they are not recognised in international human rights law.

The Yogyakarta Principles, promulgated in 2006, addressed lesbian, gay and bisexual rights. In 2017, nine more principles to accommodate transgender rights. These are called the Yogyakarta Principles + 10.

You may have never heard of either document. But trans activists have turned them into powerful propaganda tools for transforming transgender rights into human rights. As an example, a recent submission by Amnesty Australia to a federal government inquiry into religious freedom quote the Yogyakarta Principles over and over again.

The trouble is, they are not worth the paper they are written on.

The back story

The genesis of the Yogyakarta Principles (YP) is a horror story involving several key people, legal strategies and well-organised public relations events around the world, all designed to replace the term 'sex' with 'gender'.

The site of the first meeting in November 2006, Yogyakarta in Indonesia, was chosen because it was "south of the equator, in a Muslim majority country and in a jurisdiction ruled by a Sultan"[xiii]. The co-chairs of the meeting were from Thailand and Brazil and representation was carefully selected from outside the West and Latin America, including individuals from Botswana, China, India, Indonesia, Kenya, Nepal, Pakistan, South Africa, Thailand and Turkey. The participants came from only 25 countries.

The original document became the Yogyakarta Principles Plus 10 in 2017. Its new principles included gender expression, sex characteristics, sexual orientation and 'gender identity'.

The 2017 document was signed by only 33 people[xiv].

Legally inconsequential

What is their legal status? They have none at all. They are just a Christmas shopping list for the transgender lobby.

The Principles have never been accepted by the United Nations. Attempts to make gender identity and sexual orientation new categories of non-discrimination have been repeatedly rejected by the General Assembly, the Human Rights Council and other UN bodies. In fact, the majority of members of the General Assembly opposed any reference to the Yogyakarta Principles as they are seen as being contradictory to the position of the UN Human Rights Council.[xv]

Despite its reputation in Australia, the Senate Legal and Constitutional Affairs Committee has acknowledged that the Yogyakarta Principles have no statutory power in Australia. They also have no binding effect in international human rights law.

Compare this to the legal support that the international community has given to women. The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) was adopted by the United Nations in 1979 and has been ratified by 189 states (the USA being one notable exception). Australia became a signatory of CEDAW in 1980, but the Convention was further empowered by our federal legislature when it was incorporated in its entirety into the Commonwealth legislation enacted to protect and further the rights of women, the Sex Discrimination Act of 1984.

Feminists betrayed

Do feminists support the Yogyakarta Principles? No.

In fact, the international feminist group called the Women's Human Rights Campaign (WHRC), including many well-known academics and feminist activists, is fiercely opposed to them. In their view, the principles are misogynistic and attempt "to make sex a defunct legal category." The Yogyakarta Principles document is designed to replace 'sex', which is a scientific, biological fact, with 'gender identity', which is a socially constructed fiction, based largely on postmodernist rhetoric and identity politics.

They claim that the popularity of the document is a sign that "we are moving towards a society where sex does not exist"[xvi], especially for women and girls. They fear that acceptance of the Yogyakarta Principles will destroy the enormous gains made in past decades by the feminist movement.

Nor has the Yogyakarta Principles project had much popular support. It is largely coordinated by Allied Rainbow Communities, or ARC International (ARC), an NGO based in Canada. In her analysis of the Yogyakarta Principles , feminist Anna Zobnina notes that ARC is basically a lobby group, not an internationally representative organisation.[xvii]

The WHRC Declaration on Women's Sex-Based Rights has been signed, as at September 9, by 11,772 individuals and 256 organisations from 119 countries. All supporters of the WHRC are listed on its Declaration page[xviii]. It is quite transparent.

The ARC website is not transparent. Its latest accounts date from 2016, when it received $407,000 from 'membership and donations' in 2016. It also received $275,000 from 'foundations' and $71,000 from the Norwegian Foreign Ministry.

The WHRC Facebook page has about 4,000 likes; the ARC page has about 2,500. The WHRC has representatives across at least 25 countries and was established only 18 months ago. The ARC was established 17 years ago.

What's wrong with the Yogyakarta Principles?

In the Yogyakarta Principles 'gender identity'[xix] is defined as –

Understanding 'gender identity' to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender. Including dress, speech and mannerisms.[xx]

As noted by Tina Minkowitz, "gender itself is not defined, but is situated in relation to 'sex assigned at birth', with which a person's internal experience of gender may or may not correspond" and the reference to 'sex' is only to indicate that it does not refer to personality traits. 'Sex' is not defined either.[xxi]

Alarmingly, for everyone, "*YP implicitly accepts a concept of gender as equivalent to stereotypes. When beliefs about mannerisms, dress and speech appropriate to one sex or the other are abstracted and made to serve*

as a ground for personal identity, they are shielded from challenge."[xxii]

This unravels decades of progress for feminists. The notion that an innate feeling can lead to a change in an individual's sex status at birth, with the corresponding legal entitlements and access to spaces and places reserved for girls and women (including their sports), is a violation of the protections established over decades for women, beginning with CEDAW.

As Minkowitz further notes, "It is not gender identity that is being protected, but the substitution of internal identity for recorded sex, upon the request of any person"[xxiii]. The legitimisation of this process is simply creating new forms of discrimination against girls and women and is in conflict with CEDAW.

This is not to say that transgender people should not be protected, but replacing 'sex' with 'gender identity' not only erases sex as a category and girls and women as a class distinct from that of boys and men, but also erases girls' and women's human rights.

A significant, currently relevant, example of the consequences of these changes is given by Minkowitz. She states that women have *"little reason to expect their rights will be protected, in (a) law and policy environment that treats their discussion of sex and gender as tantamount to hate speech"* [xxiv].

On the matter of 'sex' and 'gender', the CEDAW Committee's General Recommendation 28 emphasizes that changing one's gender does not change an individual's social positioning. Gender identity advocates are naïve to think this is possible; the ideological nature of their claims renders them as fictional as the postmodernist thinking upon which they are based[xxv].

Conclusion

In conclusion, there are six fundamental criticisms of the Yogyakarta Principles and its 'Plus 10' extensions -

1. They were constructed by a few unelected, unrepresentative civil groups and individuals;
2. They have never been adopted by the United Nations;
3. They have no legal force either internationally or within Australia and were rejected by the Commonwealth legislature and the United Nations;
4. The Yogyakarta Principles +10 principles were signed by just 33 people;
5. They are often quoted misleadingly by members of parliament and trans lobby groups as though they had been adopted by UN resolution; and
6. Their full implementation would effectively make 'sex' a defunct legal category, replacing it by the ambiguous category of 'gender'.

The Yogyakarta Principles & the Women's Human Rights Campaign

The Women's Sex-based Human Rights Campaign (WHRC) is a natural outcome from the use and misuse of the Yogyakarta Principles (YP) by the misogynistic, self-seeking supporters of the trans lobby - which is attempting "to make sex a defunct legal category … (as) we are moving towards a society where sex does not exist"[xxvi], especially for women and girls, and to destroy all the gains made previously over decades by feminist movements. The misuse of the YP is designed to replace sex, which a scientific, biological fact, with gender identity, which is a socially constructed fiction, based largely on postmodernist rhetoric and 'identity politics'.

The YP is largely coordinated by Allied Rainbow Communities, or ARC International (ARC), which is an NGO based in Canada. As Anna Zobnina points out, ARC is basically a lobby group, not an internationally representative organisation.[xxvii]

The WHRC Declaration has been signed, as of 18 February 2021, by 14,943 individuals and 310 organisations across 127 countries. Unlike ARC, the all supporters of the WHRC are listed on its Declaration page. ARC does not provide any membership details but says it received $407k from 'membership and donations' in 2016, the last of its audited reports shown on its website[xxviii]. It also received $275k from 'foundations' and $71k from the Norwegian Foreign Ministry in 2016[xxix].

The WHRC facebook site has 3,893 likes, whereas the ARC only has 2,416 likes. The WHRC has representatives across at least 25 countries and was established eighteen months ago - whereas ARC was established seventeen years ago.

ARC played a key role in establishing the YP. As it states on its website,

We initiated the project, convened a coalition of NGOs to implement it, facilitated meetings of the coalition,

worked closely on the preparations for and conduct of the experts' meeting, worked with partners to successfully launch the Principles, prepared backgrounders and advocacy materials to support regional launch initiatives, developed a website, track the ongoing use of the Principles, are participating in the development of an activists' guide, and conduct ongoing training and support for organizations using the Principles.

From the beginning it is very important to point out, as has Katherine Deves[xxx], that

The Principles were acknowledged by the HRAD Senate Standing Committee as having no statutory power in Australia, even though there were calls to include them as "relevant international instruments" by the Human Rights Law Centre:

[T]he Yogyakarta Principles have no legal force either internationally or within Australia. They were developed by a group of human rights experts, rather than being an agreement between States"[xxxi].

Unlike the YP, the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) was adopted by the United Nations (in 1979) and has been ratified by 189 states (the USA being one notable exception). The YP were published in November 2006 as the outcome of an international meeting of civil groups in Yogyakarta, Indonesia. The document created by this group, first published end of 2006, related to sexual orientation and gender identity[xxxii] (Anna Zobnina argues that gender identity was not in that original document - she also points out that, 'gender' does not exist as a concept in many cultures, only sex [xxxiii]).

The original Principles were supplemented in 2017 (Yogyakarta Principles plus 10). The Plus 10 principles added gender expression, sex characteristics[xxxiv], sexual orientation and 'gender identity'. However, the YP principles consider these issues at the expense of the rights of girls and women and, in effect, seek to supplant such rights. At the YP+10 meeting in 2017, only 33 people were signatories to the additional principles[xxxv].

The Principles have never been accepted by the United Nations and the attempt to make gender identity and sexual orientation new categories of non-discrimination has been repeatedly rejected by the General Assembly, the UN Human Rights Council and other UN bodies. In fact, the majority of members of United Nations General Assembly opposed any reference to the YP as they are seen as being in contradiction with UN Human Rights Council.[xxxvi]

All of this raises the question, why have the YP become so important? This is a classic case of 'regulatory capture' on a grand scale – but to explore this would take a separate and extensive paper, so it will not be covered here.

In the YP 'gender identity'[xxxvii] is defined as:

Understanding 'gender identity' to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender. Including dress, speech and mannerisms.[xxxviii]

As pointed out by Tina Minkowitz, "gender itself is not defined, but is situated in relation to 'sex assigned at birth', with which a person's internal experience of gender may or may not correspond" and the reference to 'sex' is only to indicate that it does not refer to personality traits. Sex is not defined either. [xxxix]

Also, by linking gender to personal expressions, dress, mannerisms and speech,

YP implicitly accepts a concept of gender as equivalent to stereotypes. When beliefs about mannerisms, dress and speech appropriate to one sex or the other are abstracted and made to serve as a ground for personal identity, they are shielded from challenge.[xl]

The notion that an innate feeling can lead one to changing one's sex status at birth, corresponding legal entitlement and access to spaces and places of girls and women (including their sports) is a violation of the protections that have been established over decades for girls and women, beginning with CEDAW. As Minkowitz points out, "It is not gender identity that is being protected, but the substitution of internal identity for recorded sex, upon the request of any person"[xli]. The legitimisation of this process is simply creating new forms of discrimination against girls and women and is in conflict with CEDAW. This is not to say that transgender people should not be protected but replacing sex with 'gender identity' not only erases sex as a category and girls and women as a class distinct from that of boys and men but also erases girls' and women's human rights.

Women should be understood as political actors whose self-determination as a fundamental rights and principle necessary for equality of the sexes pre-exists any recognition women have achieved in patriarchal legal systems.[xlii]

A significant, and currently relevant, example of the consequences of these changes is given by Minkowitz,

(women have) little reason to expect their rights will be protected, in law and policy environment that treats their discussion of sex and gender as tantamount to hate speech[xliii].

Not only is quashing (de-platforming) of freedom of speech, which I have discussed elsewhere as occurring in Tasmania[xliv], against human rights but also against Principle 26 of the YP, which argues for fostering dialogue and mutual respect between various cultural groups that hold different views on sexual orientation and gender identity[xlv].

One key point about CEDAW and its Committee's General Recommendation 28, is that it states that - *The term "sex" here refers to biological differences between men and women. The term "gender' refers to socially constructed identities, attributes and roles for women and men and society's social and cultural meaning for these biological differences resulting in hierarchical relationships between women and men in the distribution of rights favouring men and disadvantaging women.*

The hierarchical relationship and power inequality is emphasized in this Recommendation and "contrasts with a view that gender identity can reverse an individual's positionality by mere operation of self-declaration"[xlvi]. In other words, changing one's gender does not change social positioning within society. Gender identity advocates are kidding themselves if they think otherwise; the ideological nature of their claims renders their claims as fictional as the postmodernist thinking upon which they are based[xlvii] [xlviii].

The YP and YP + 10 are often misused in parliamentary debates. Here are a couple of examples, just within the Tasmanian context. In the House of Assembly on 20 November 2018 (page 103 of Hansard for that day), the Leader of the Greens, Cassy O'Connor, refers to the YP plus 10 has being "very clear about the application of the UN Human Rights Conventions to LGBTI people" – but the YP and its extension 'plus 10' is not a UN convention of any type. In the Tasmanian Legislative Council on 4 April 2019 (page 10 of Hansard for that day), Rob Valentine MLC, quotes a submission from the Australian Lawyers for Human Rights[xlix] as saying that the YP plus 10 as affirming "binding legal standards with which all states must comply" – which, as reiterated earlier, is not within the capacity of the YP as it is not a UN Convention. In fact, the attempt to make the YP part of UN protocols was soundly rejected[l].

In conclusion, there are five fundamental criticisms of the YP and '+ 10' extensions:

1. They were constructed by unelected, unrepresentative civil groups and individuals,
2. They have never been adopted by the United Nations,
3. They are often quoted misleadingly by members of parliament and trans lobby groups as though they had been adopted by UN resolution,
4. Their full implementation, both in law and within state organisations, would effectively make sex a defunct legal category, replacing it by the ambiguous category of 'gender',
5. Most importantly, these Yogyakarta principles are mentioned throughout the Tasmanian Law Reform Institute report, which is misleading as they have no legal status,
6. At the YP+10 meeting in 2017, only 33 people were signatories to the additional principles that form the basis of the claims by the trans lobby and their sycophants[li].

Key references:

Alston, A., 'Transgender Rights as Legal Rights', Canterbury Law Review 329, 1999,

http://www5.austlii.edu.au/au/journals/CanterLawRw/1999/6.html

Teaching Tolerance, 'International Bill of Gender Rights', https://www.tolerance.org /classroom-resources/texts/international-bill-of-gender-rights

Outright Action International, 'International: the Role of the Yogyakarta Principles'. This organisation is based in the USA and is funded by, among others, the Ford Foundation and Arcus Foundation (Jon Stryker, who is a billionaire stockholder of the medical supply company, Stryker

Corporation), https://outright international.org/content/international-role-yogyakarta-principles

Bilek, J., 'Martine Rothblatt: Founding Father of the Transgender Empire', 6 July 2020. Uncommon Ground, is based in the UK and states on its legal page that, "Uncommon Ground Media Limited makes every effort to ensure that its articles have no libellous material and no material which is factually incorrect."

https://uncommongroundmedia.com/martine-rothblatt-a-founding-father-of-the-transgender-empire/

The flawed logic & evidence with respect to `best interests' as applied to gender transitioning of children & adolescents

– Geoff Holloway

A request for support for a national inquiry into gender dysphoria and gender transitioning was sent out to all Children's Commissioners and Guardians across Australia, including the National Children's Commissioner, on the 30th Anniversary of the United Nations Declaration on the Rights of the Child (UNCROC), 20 November 2019.

One month later, two jurisdictions, Western Australia and Victoria, have declared that they do not support the request for a national inquiry. A typical response was as follows -

'The Commissioner has noted your concerns, however will not be providing support for your submission to the Federal Government for a national inquiry into gender dysphoria and transitioning among children and adolescents.'

No jurisdictions responded in detail, except for the Children's Commissioner in Tasmania -

'I wish to make it very clear that I do not support the call, as you have described it, for the establishment of a national inquiry into gender dysphoria and transitioning among children and adolescents. I am in favour of legislative and other reform processes which would promote the best interests and wellbeing of children and young people who seek assistance with affirming their gender identity, including through access to medical treatment.' Leanne McLean, Commissioner for Children & Young People (Tas).

While there is no consensus in either law or science as to what the expression 'best interests of the child' actually means1[1], in her submission to the Tasmania Law Reform Institute on 3 September 2019, the Tasmanian Children's Commissioner said,

'Decision-making is guided by what is in the best interests of the child which includes giving due consideration to the views of the child having regard to their age and maturity. I think it is important to note the below comment of the Committee on the Rights of the Child in relation to best interests –

> *22. The right of the child to have his or her best interests taken into account as a primary consideration is a substantive right, an interpretative legal principle and a rule of procedure, and it applies to children both as individuals and as a group. All measures of implementation of the Convention, including legislation, policies, economic and social planning, decision-making and budgetary decisions, should follow procedures that ensure that the best interests of the child, including adolescents, are taken as a primary consideration in all actions concerning them. In the light of its general comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration, the Committee stresses that, when determining best interests, the child's views should be taken into account, consistent with their evolving capacities and taking into consideration the child's characteristics. States parties need to ensure that appropriate weight is afforded to the views of adolescents as they acquire understanding and maturity.'*

There is a major problem with this argument, typical of many current 'best interests of the child' arguments, and it begins with the phrase 'the child's views should be taken into account, consistent with their evolving capacities and taking into consideration the child's characteristics'. The capacity of a child to contribute to decision-making about themselves is, in many jurisdictions including Australia, based on the common law test of 'Gillick competence' and the notion of the 'mature minor'.

The test, which is essentially subjective, is used by judges and health professionals to identify

children aged under 16 who can demonstrate sufficient maturity and intelligence to understand and appraise the nature and implications of any proposed treatment, including the risks and alternative courses of actions.

1. Gillick competence

'Gillick competence' is not determined by any psychometric tests. Most children and adolescents presenting with a desire to change gender suffer from a range of mental health issues (up to 96 per cent[21]), and high rates of autism spectrum disorder have been diagnosed in this cohort. It is hard to imagine how such children and young people can be routinely assessed as 'Gillick competent'.

A leading article in the *British Medical Journal* states that '(a)round 35% of referred young people present with moderate to severe autistic traits'. This is significant as only 1.1% of the UK population is estimated to be on the autistic spectrum.[lii]

In practice, individual clinicians determine a child's competence, so such judgments are inconsistent and not properly assessed by scientific criteria.

As Hansen & Ainsworth (2009, page 431) point out, while professional participants are specialists in their own areas they are not the child or adolescent's parents who look after the day-to-day, all day, every day needs of the child. 'Together or separately, all professional participants do not one good parent make' (Goldstein et al, 1996, page xix).

The two key problems here, while pursuing the child's right to be heard ('the voice of the child' as Children's Commissioners refer to it), are -

1. the matter of determining the child's *capability of forming views;* and

2. the *weighing* of such views of the child.[liii] [liv]

As Brunskell-Evans[lv] points out, a child or young person cannot truly give informed consent to therapeutic treatment because -

- *The medical consequences are extremely complex, and a child* (or young person) *will have little or no cognisance of a future in which he or she may come to regret lost fertility or the lack of organs for sexual pleasure*
- *In contrast to the staggeringly naïve proposition that the child (or young person) can give consent if he or she has been free from external pressures in the decision-making process, the competent 'consenting' child is an ontological figure, brought into being and continuously shaped and re-shaped by the fast-evolving social and political landscape of disputed biological truths, the hegemony of queer theory, trans affirmative lobbying and the trans activism.*

Brunskell-Evans simplifies this, following Laidlaw, by asking the question –

How can a child, adolescent or even parent provide genuine consent to such treatment? How can the physician ethically administer gender affirming therapy, knowing that a significant number of patients will be irreversably harmed?[lvi]

2. Transitioning and breaches of medical ethics

Transitioning is against several medical ethical principles, including –

a. 'The least intrusive intervention' is not followed, especially given that treatment is usually irreversible. Related to this, 'the least detrimental alternative' is not being followed;

b. Children and parents are not being fully advised of alternative interventions or the consequences of medical and surgical interventions. 'The risks and alternative courses of actions' are rarely presented by transgender clinics and certainly get no mention in the transgender 'treatment' manual produced by Telfer et al for the Royal Children's Hospital, Melbourne;

c. Sex is not acknowledged as a biological, immutable fact.

Further, the medical evidence **against** gender transitioning is being ignored – this is despite documentation of increasing numbers of adolescents and young adults who are attempting to de-transition.

Given that the human brain is not fully developed until age 25, the developmental capacity of the child or adolescent to make irreversible decisions with respect to their biology is being ignored. Also, recent evidence shows that transgender children have different levels of neurological functioning compared with the general population (see Gliske, *eNeuro*, 12 Dec. 2019).

3. Parental rights

Parental rights are clearly enunciated in UNCROC (see endnote[lvii]) but are being ignored or subverted in deference to the medical professionals. The professional advice is often phrased in terms of

the potential for the child to attempt suicide if the parents do not concede to their child transitioning. In effect, parents are being emotionally blackmailed into accepting the wishes of the child or adolescent.

4. Evidence base lacking

As Dr. Polly Carmichael, Director of the Tavistock Gender Identity Development Service (GIDS), concedes – *The reality is we still don't have the long-term outcome data … What's happening is our society is moving faster than the evidence base*[lviii]. However, as Michael Biggs points out, GIDS may have had such data if it had continued to monitor and record the patients from its 2010 experiment with puberty-blocking drugs.[lix]

In Australia, Professor George Patton would agree that 'our society is moving faster than the evidence base' as he has done much international research on the disjunction between physiological and emotional development of adolescents over the past few decades[lx].

The Royal College of Psychiatrists (UK) -

acknowledges the need for better evidence on the outcomes of pre-pubertal children who present as transgender or gender diverse, whether or not they enter treatment. Until that evidence is available, the College believes that a watch and wait policy, which does not place any pressure on children to live or behave in accordance with their sex assigned at birth or to move rapidly to gender transition, may be an appropriate course of action when young people first present.[lxi]

In conclusion, as Dr. Aoife Daly, Deputy Director, School of Law and Social Justice/European Children's Rights Unit, University of Liverpool, points out, if the answer to <u>all</u> of the following questions on 'best interests of the child' are not 'yes', then any actions in respect of a child should not proceed –

1. Is the outcome being determined in the child's best interests?
2. Does the child have a wish as to the outcome?
3. Does the child want this wish to prevail?
4. Is the best interest question free of legitimate obstacles to the child's best interests?
5. Is significant harm unlikely to result from following the wishes of the child?[lxii]

On the last question, in particular, transgender clinics and Children's Commissioners and Guardians fail significantly to fulfil their obligation to act in the best interests of children and young people!

Childhood gender dysphoria and the courts

- John Whitehall, (First published in Quadrant, May 2017)

Childhood gender dysphoria may be defined as distress due to conflict between the physical manifestations of gender in the body and their perception in the mind of a child or adolescent. The body reveals one sex, the mind feels the other.

This conflict between matter and mind can be as destructive as any other confusional state and deserves our compassion. Disturbingly, special clinics in capital cities in Australia are now reporting hundreds of new cases seeking attention each year. This contrasts, dramatically, with a straw poll I have undertaken of twenty-eight paediatricians with a cumulative experience of 931 years. This poll revealed only ten cases: eight associated with mental illness, two with sexual abuse. Protestations by a child that it belonged to the opposite sex used to be a warning sign of sexual abuse.

Given the increasing prevalence, the perturbation to family life as well as the mind of the child, and the possibility of prolonged therapy, the importance of gender dysphoria now rivals that of anorexia nervosa with its incongruity between bodily reality and mental perception (the body is thin but is imagined to be fat).

Fundamental differences exist, however, between the medical and societal managements of anorexia and gender dysphoria. In anorexia, management seeks to reduce the mindset, not substantiate it. No medical authority would augment weight loss with diet pills and a gastric band. No media would portray anorexia as heroic. No legislature would forbid therapies that did not affirm the delusion. No court would praise the courage of the child in refusing food, and no court would consider being relieved of a protective role. But, with regard to gender dysphoria, these are the kinds of things that are happening.

This article will consider three matters: First,

the treatment regime for childhood gender dysphoria; second, Family Court of Australia decisions regarding childhood gender dysphoria; third, research that indicates medical treatment for gender dysphoria may result in permanent changes in the brain.

Treatment of childhood gender dysphoria

International consensus declares that up to 90 per cent of children who question their sexual identity will orientate to their natal sex by puberty[1]. Particular difficulties, however, may occur when there are associated mental disorders such as autism spectrum and defiant disorders, and depression. Dr Kenneth Zucker of Canada would also warn of "environmental" factors including family influences, especially maternal, that predispose to gender dysphoria.

Given this likelihood of recovery, international opinion warns against "parental commitment" of the child to full "social transitioning". This is contrary to examples on television in which young children are renamed, re-clothed, re-declared and re-enrolled in schools as the opposite sex. This transitioning should be avoided because it will make it difficult for the child to return to its natal sex at puberty. Worse, the psychological imprinting of being raised as the opposite sex may lead to lasting confusion. Worse still, the child may progress to medical intervention from which there may be no return.

If the child is experiencing gender confusion, punitive measures should be avoided but kindly restrictions are in order as, for example, to where cross-sex clothing might be worn. The best approach would be "watchful waiting". The worst would be to allow the child to become a poster exhibit for the school and the media.

Childhood is the time of development of identity, and exploration is inherent. Puberty is the time of physical development for procreation; adolescence, for gaining maturity to raise offspring. The Bible explains, "When I was a child, I spake as a child, I understood as a child, I thought as a child: but when I became a man, I put away childish things." In that sense, puberty orientates the child towards the binary function of reproduction and rearing of the species.

Some therapists conclude that international reassurances do not pertain to the individual under their care and enter the child onto the pathway of medical therapy for gender dysphoria. This pathway is known as the "Dutch protocol" because it evolved from the Centre of Expertise on Gender Dysphoria in Amsterdam. The protocol became basic, in 2011, to one of the Standards of Care of the World Professional Association for Transgender Health.[2] It comprises:

Stage 1 therapy. Puberty is initiated by a biological clock deep in the brain and involves a cascade of chemical messengers that travel to the gonads to cause them to release hormones that evoke secondary sex characteristics and to prepare for procreation using organs laid down before birth. Not surprisingly, there are many checks and balances in this "multi-variant closed loop control system". Chaos from an inserted spanner could be expected.

In 1971 one of the chemical messengers was identified and then manufactured in a laboratory. As it stimulated the release of hormones from the pituitary gland that went on to stimulate the gonads, it was called gonadotrophin-releasing hormone (GnRH). Researchers found that GnRH was secreted onto the pituitary gland in pulses, every hour or so, as if the pituitary needed a period of rest before releasing its next burst of gonad-stimulating hormones.

Cleverly, scientists altered the structure of the GnRH molecule so it would stimulate the pituitary gland but would not "let go" of its docking receptor. This "agonist", or sustained stimulating effect, resulted in an immediate surge of pituitary hormones followed by inactivity for as long as the agonist lasted. Varieties of "GnRH agonists" were developed to last many weeks after injection and were employed to block release of sex hormones from the gonads in medical conditions in men and women.

It was also found that agonists would block the development of puberty if it was occurring too early. Subsequently, it seemed a good idea to employ blockers in cases of gender dysphoria, to give "more time" for the child to think about transitioning, and to postpone the appearance of secondary sex characteristics which might be upsetting. Such use was suggested to be delayed until the age of twelve or, at least, until the earliest stages of puberty had emerged.

The main side-effects were declared to be reduction in bone density, which would recover when sex

hormones were applied. The psychological effect of delaying puberty while peers were maturing was also considered and would become the basis for calls for giving sex hormones at increasingly younger ages.

In all Family Court considerations of blockers since 2004, only once was mentioned an effect on "cognitive ability and mood". Otherwise, blockers were declared "safe and entirely reversible" and, on that basis, their administration could be safely left to children, parents, guardians and therapists.

Stage 2 therapy involves administration of hormones of the opposite sex (testosterone and oestrogens) to evoke their external characteristics, advisably not before sixteen years of age. Such hormones would need to be continued for as long as the patient wanted to remain transgender, presumably for life. Side effects included metabolic, vascular, bone and emotional problems which would need sustained medical supervision. In some Family Court cases, the effects were declared to be "partially reversible", though how long it would take to result in chemical castration was unknown. An effect on the structure of the brain was never mentioned. Ironically, some deliberations listed psychological complications of depression, anger and instability, which the use of hormones was intended to reduce.

Stage 3 therapy would involve irreversible surgery, not usually performed under the age of eighteen.

Decisions of the Family Court of Australia on gender dysphoria

Review of Family Court decisions published online by the Australasian Legal Information Institute under the generic term "gender dysphoria" reveals almost seventy cases since 2004. Correcting for multiple appearances and removing cases of physical intersex now known as "disorders of sexual development" leaves fifty-six children with incongruity between natal sex and current feelings. Physical disorders should be removed because they are as irrelevant to psychological gender dysphoria as congenital abnormalities of the bowel are to anorexia nervosa.

Most of the fifty-six children went before the court for authorisation to consent to receive cross-sex hormones. In the earliest cases, some sought blockers. Five were authorised for bilateral mastectomy.

The review reveals a soaring incidence: from one case a year in 2004 and 2007, to two in 2010 and 2011, to five in 2013, then back to three in 2014, followed by eighteen in 2015 and twenty-two in 2016. So far there have been two in 2017. Natal females outnumber males thirty-four to twenty-two.

The summaries do not detail medical features, but many may be discerned. For example, in twenty-five of thirty-nine cases in which family arrangements can be discerned, dysphoric children live with single parents or in foster care[3] and only fourteen with both parents.

thirty-eight children are reported to have revealed gender dysphoria before the age of seven. Many are claimed to have demonstrated it from the earliest years. One parent declared an infant had identified with its opposite sex at the age of nine months, apparently not challenging the credulity of the court.

In twenty-eight of the fifty-six children, mental co-morbidities are emphasised. These include Autism Spectrum Disorder (six), major depression, incapacitating anxiety, oppositional defiance, attention deficit or hyperactivity, and intellectual delay. Though many of these major disorders were revealed in earliest years before or in parallel with gender dysphoria, therapists claimed gender dysphoria as the cause and its treatment as the primary solution.

In fifteen summaries, including the last one available in 2017, the safety and reversibility of blockers are emphasised. None refers to effects of cross-sex hormones on the structure of the brain.

In forty-one cases which reported on the competency of the child to understand the treatment to be received, eleven children were acknowledged to be incompetent, and authority to consent for treatment was extended to parents and guardians, as guided by therapists. Many of those with mental co-morbidities were considered to possess "Gillick competency", as discussed below. Such illnesses were apparently presumed not to affect understanding or motivation.

Of the five authorised to consent to mastectomy, the first was in 2009, involving a sixteen-year-old who had been on blockers for five years and cross-sex hormones for one year. The next was in 2015, a sixteen-year-old on cross-sex hormones for a year. Of those in 2016, one was fifteen and on blockers

for nearly two years and cross-sex hormones for eight months; one was seventeen and appears to have had no previous hormonal intervention; and one was fifteen and on blockers for almost one and a half years. The possibility that extended exposure of the brain to blockers and cross-sex hormones might reduce the capacity for informed consent was never discussed.

Gillick competency and re Marion

Fundamental to understanding the Family Court's summaries is the concept of Gillick competency, and the Australian case known as re Marion in which parents sought permission to consent on behalf of a retarded daughter for sterilisation to minimise the effects of menstruation and the possibility of pregnancy.

In considering whether Marion had the capacity to decide for herself, the Australian court accepted the precedent from the House of Lords regarding a Mrs Victoria Gillick who contested, unsuccessfully, that children under sixteen were not competent to consent for contraception therapy[4]. The English court decided that if a child possessed "sufficient understanding and intelligence to … understand fully what is imposed", the child could consent to medical treatment. This capacity became known as Gillick competency[5].

In 1992, in re Marion, the Australian court followed the House of Lords, declaring "This [Gillick] approach though lacking the certainty of a fixed age rule accords with experience and psychology" and "should be followed … as part of the common law"[6].

Accordingly, if the child was "Gillick competent", court authorisation would not be needed for medical interventions for conditions that involved "malfunction or disease" and were given "for the traditional medical purpose of preserving life".

If these traditional reasons for medical intervention were not obvious, and the child was Gillick incompetent, the authority of the court would be needed in "special cases" involving "invasive, irreversible and major [surgery]" where there was a significant risk of making a wrong decision and the effects of that decision were "grave". If the intended intervention was "non-therapeutic" and the child Gillick incompetent, neither parents, guardians or the court had the power to consent.

Re Marion emphasised the need for the protective role of the court, as averred in re Jane, that "the consequences of a finding that the court's consent is unnecessary are far reaching both for parents and for children. For example, such a principle might be used to justify parental consent to the surgical removal of a girl's clitoris for religious reasons."[7] Re Marion went further, warning against unqualified trust in the medical profession which, "Like all professions … has members who are not prepared to live up to its professional standards of ethics … Further, it is also possible that members of that profession may form sincere but misguided views about the appropriate steps to be taken."

The High Court considerations in re Marion have been like a stake in the ground to which subsequent courts have been tied with a short leash. As popular opinion demands the acceptance of gender dysphoria as part of rainbow normality and not a disorder, courts appear to be struggling to be free from the restrictions of such words as malfunction, disease, therapeutic, necessary, best interests, competency and responsibility. But what words in the English language can be used to define an entity as "normal" when it requires massive medical, and even surgical intervention, to confirm and maintain? And "necessary" when there is evidence the child will grow out of it?

In the end, the possibility of freedom for the court emerged: parliament could pass a law to extricate it from the whole business. Politicians could provide the bowl and the water for the washing of hands.

And, as the crowd encouraged Pontius Pilate, a petition launched in 2016 by Georgie Stone has garnered 15,659 signatures to "Remove Family Court of Australia from Medical Decisions for Trans Teens"[8]. Georgie is sixteen and began taking puberty blockers at ten years and nine months in transitioning to female. Georgie argues that "the courts follow medical advice in their decision making anyway, making the courts [sic] process unnecessary"[9].

That politicians are keen to involve themselves in childhood gender dysphoria is confirmed by six US states and one in Canada which have declared it illegal to practise "conversion" or "reparative" therapy on minors. These confusing terms mean the only therapy that can be extended to minors with gender dysphoria is one that "affirms" their condition, and does not seek to "convert" or "repair" them back to their natal state. In 2017, bills

to ban "conversion" therapy on minors have been filed in fourteen more US state legislatures.[10]

In Australia, the new Victorian Health Complaints Act has the potential for similar results. The Victorian Health Minister, Jill Hennessy, declared that the Act will "provide the means to deal with those who profit from the abhorrent practice of 'gay conversion' therapy … which inflicts significant emotional trauma and damages the mental health of young members of our community"[11]. She explained: "Any attempts to make people feel uncomfortable with their own sexuality is [sic] completely unacceptable."[12] Though the minister specified "gay people" and did not define age, the Act could apply to any therapist not affirming a child's gender considerations.

Overview of the cases reveals profound change in a short time, from dispassionate conviction for a protective role (supported by a submission from the Human Rights Commission), to passionate pleading in re Lucas[13] for laws to abolish the role of the court. Also, medical interventions have been performed at ages progressively younger than advised by international opinion. Blockers have been introduced at ten, not twelve; cross-sex hormones earlier than sixteen; irreversible surgery before eighteen.

Summaries also reveal a change in medical tone from traditional caution to a certitude that is rarely seen in other circumstances. Few doctors prophesy as fulsomely for the outcome of other problems as they do for the medicalisation of gender dysphoria. Rarely is such zeal indirectly proportional to evidence. Few doctors remain optimistic that chemical castration and surgical alteration of the genitals will ameliorate mental disturbance, though such therapies do exist in the distant history of psychiatry.

Along the way, the Family Court of Australia appears to have tired. Published judgments shrink from an average of twenty-eight pages in the first six cases from 2004, to seven and a half pages in recent cases (including three cases involving bilateral mastectomies). Does this reflect the influence of a small group of protagonists who argue that the court's almost exclusive reliance on its testimonies renders the court an unnecessary intrusion into its business?[14]

Looking more closely at some cases

In re Alex (2004), the Family Court considered whether authority to consent for hormonal treatment should be given to guardians of a thirteen-year-old natal female identifying as a male. The case was complicated by Alex's Gillick incompetence, depression, "perceptual disturbances" in which Alex "could hear his own voice or the voice of his father", and sense that, as Alex said, "somebody can read my mind and the thoughts in my mind".[15] The court was persuaded it was in Alex's best interests to start medicines that would suppress menstruation and to continue with "irreversible" hormonal treatment at age sixteen.

The judge wondered if gender dysphoria was a disorder or merely a point in a rainbow of normality, acknowledging that some might find it "offensive" to have their condition categorised as "disease or malfunction". He concluded, however, that the "current state of knowledge would not … enable a finding that the treatment would clearly be for 'malfunction' or 'disease'" and thus "therapeutic" in the considerations of re Marion. Nevertheless, authority was given and, whether normal or not, Alex progressed from blockers to cross-sex hormones to bilateral mastectomy.

Re Brodie (2008) concerned a thirteen-year-old natal girl adamant she was a boy. Brodie existed in such a "tremendous state of turmoil and anger" at "betrayal" by an abandoning father that she was so difficult to handle her mother "was nearly ready to ask the State to take responsibility". Arguing that puberty blockers would reduce the "hostility and anxiety", therapists assured the court their effects were "completely reversible", and their denial "would … endanger [Brodie's] life". The judge congratulated Brodie for being fortunate in having therapists who "continue to keep up with research" and who approached the matter with "sensitivity and reflection"[16].

In re Bernadette (2010), regarding a seventeen-year-old natal male identifying as female, the "Dutch protocol" appeared in Australian courts.[17] Philosophically, it was based on the ideology that sexual identity is determined by the mind and not the matter of "genitalia or other aspects of … physical appearance or presentation". Practically, it formalised therapy into the stages described above.

Three other features stand out in re Bernadette.

First, the judge was unable to be convinced that transsexualism was a "normally occurring factor of human development" which could be safely left to parental consent and, therefore, it was "in the best interests of every child" for the court to retain the authorising power. Second, for the first and last time in Family Court deliberations, concerns of "potential damage to the brain" by puberty blockers were raised.

In response, the judge declared he was "satisfied" the effect of Stage 1 therapy was reversible, despite the "British view … that brain development continues throughout adolescence" and blockage may incur "potential damage". The judge concluded that "this aspect" is dealt with by the Dutch professors who "comment on the need for a study on the brains of adolescent transsexuals to endeavour to detect functional effect and difficulties". He said "this potential aspect of the matter" would not cause him to deny treatment. Thus the judge appeared satisfied there would be no brain damage in the present on the basis of research to be pursued in the future.

Third, the judge declared, "so far as stage 2 is concerned, I am satisfied that it would be possible to reverse that treatment". It appears attention was not drawn to research already reporting effects of cross-sex hormones on brains, as discussed below. [18]

Re Jamie (2011) was a saga that continued into the Full Court in 2012, 2013 and 2015. It concerned a natal twin boy of ten years identifying as a girl. In 2011, Jamie was declared Gillick competent to consent to puberty blockers despite the fact it was "difficult to ensure" he understood "the full and extensive ramifications of such decisions, especially in the long term", and that the blocker would be administered at an age less than researched and, therefore recommended, in Holland.[19] Declaring blockers "safe and entirely reversible", the court decided there was no need for its protective role, and their administration could be left to therapists.

The court decided, however, that the "nature … of Stage 2" was such that authorisation would still be needed for parental consent to the child's treatment, unless the child demonstrated "Gillick competence", in which case the court could authorise the child to consent. If not, the court would decide what was in the "child's best interests". Thus, the role of the court was to establish Gillick competence. If that was established, the court would have no further role.

In 2015, the court heard that, after almost four years of blockers, Jamie was approaching fifteen with the appearance of a "pre-pubescent girl … [who] does not resemble her female peers, particularly in terms of development of breasts". Deducing psychological stress, the court pronounced Gillick competence, authorising oestrogens.

There was a major turn in the reasoning of the court in Jamie's saga. The need to protect the "best interests" of the child was subsumed to the concept that it could consent to irreversible, possibly grave, intervention as long as it could convince the court it knew what it was doing. The court was now dependent on therapists. Without their opinions, how could it evaluate competence?

It is ironic that Jamie's parents appealed to the Full Court with the argument that gender dysphoria was, in fact, a mental disorder which warranted psychiatric medication for "a malfunction or disease". This argument contradicted the popular claim that transgender orientation was merely a point in rainbow normality.

In 2013, in re Sam and Terry, Sam was a natal boy identifying as a girl, and Terry, a girl identifying as a boy. Both were Gillick incompetent. Sam suffered severe mental co-morbidities of anxiety, depression, eating disorder and social phobia and was, essentially, housebound. Terry suffered from Asperger's syndrome. Approval was sought and received by parents for administration of Stage 2 therapy.

The court reaffirmed its need to be the "decision maker" in the best interests of the child, revisiting reasons from re Jane[20], including the need to protect from removal of a "girl's clitoris for religious or quasi-cultural reasons or the sterilisation of a perfectly healthy girl for misguided, albeit sincere, reasons". A psychiatrist opined that gender dysphoria "does not require psychiatric treatment. The treatment it requires is gender transition which is a medical and surgical process." The irony seems unappreciated that such treatment for a rainbow culture could lead to both clitorectomy and sterilisation[21].

Disagreeing with the psychiatrist by declaring gender dysphoria was, indeed, within the ambit of a "psychiatric disorder", the judge seemed unaware of the status being conferred upon gender dysphoria: the only psychiatric illness still treated by surgery on the genitals.

By 2015, attitude had swung towards the concept

of transgender being normal, though no particular reason emerges from cases in 2014. "Pleasingly", the judge declared in re Cameron[22], gender dysphoria is "not now generally considered a mental illness". And, though the natal girl "did not have full understanding", the court "wishes him well, acknowledging the maturity and courage he has shown", while authorising cross-sex hormones.

By 2016, certitude in testimonies before the court had become almost evangelical. In re Celeste[23], new life was prophesied for a natal male transitioning to female: cross-sex hormones "would maintain … self esteem, retain her congruence of self as a young woman and facilitate her normative psychological, social and sexual development". These prophecies were, however, difficult to reconcile with other testimony that at four years of age the child had been diagnosed with Asperger's syndrome, attention deficit/hyperactivity disorder and language disorder, whose ongoing effects had reduced his capacity to attend and concentrate at school. In summary, it was admitted that "she" does not "understand everything that is said to her".

In re Gabrielle,[24] which involved another natal male identifying as female, the court found that oestrogens were necessary for the child to "continue living happily" and their denial "would result in a loss of recognition and validity of her sense of self … depression and anxiety [will] increase … and [she] will be at greater risk of self harm and death from suicide". Paradoxically, it was also asserted that if Gabrielle ever wanted to revert to being a male after all that positive experience as a female, "she has the thoughtfulness and creativity to be able to manage … de-transition comfortably". In fifty-one years of medicine, I have never heard medical "happiness" prophesied.

The certitude of 2016 was extended to three bilateral mastectomies. International guidelines for irreversible surgery were interpreted as merely advice, and minimised with the argument that it would be limited to the breasts and not involve the reproductive organs (as described in my previous Quadrant article, "The Fashion in Child Surgical Abuse", December 2016).[25]

Questioned about possible after-effects of the operation, one teenager replied that "he" would just have to "stay on the couch and watch Netflix for some weeks" and might have to "miss the formal". Was this nonchalance, or incomprehension of life-long implications?[26]

Another seeking mastectomy was declared to be "not very knowledgeable about … side effects and complications of the surgery" but this "did not strike me [the doctor] as being out of keeping with his stage of development". On advice, the judge declared Lincoln[27] competent to consent but, equivocating, he added, "if I am wrong … I accept the submission of all parties … that the proposed treatment is in the best interests of Lincoln". One way or another, Lincoln was going to lose her breasts. She had been on blockers for almost two years and cross-sex hormones for six months, but this was not considered to have affected the structure of her brain and, thus, cognition.

In re Lincoln, the judge set the stage for future loss of breasts and even genitalia by declaring he could not understand how a child could consent for Stage 2 therapy and not Stage 3 because both involved irreversible effects. Because of doubt as to whether Lincoln was Gillick competent, the judge also set the precedent for others to make decisions on behalf of the breasts of minors.

Deliberation over the fate of Lincoln[28] has probably set yet another precedent. One therapist argued that the age of administration of sex hormones should be lowered from sixteen to soon after the start of puberty (which normally occurs around nine in girls and ten in boys). He declared: "lagging behind their peers in pubertal development" creates its own "psychological stress". Therefore, Stage 2 should be started at a lower age if the "diagnosis is clear cut". The therapist did admit but did not specify a cognitive effect of blockers.

Facilitating entry to Stage 2, in re Darryl[29], the court rejected the assertion by an expert witness that the natal female who was prone to depression and self-harming did not have "the competency to consent to irreversible treatment". Uniquely, that witness had continued, "given the grave consequences, I am not persuaded that most minors would be in the position to fully understand the implications of irreversible hormone treatment over the entire lifespan".

The judge disagreed, declaring "there can be no doubt" about Darryl's competence. In any case, the judge concluded he did "not accept that the words 'understand fully' require a child to have achieved the maximum understanding which later years may give them when their brain and personality are

fully developed". The judge appeared convinced that full development would not bring recognition of a grave mistake in disturbed adolescence.

The 2016 cases ended with a call in re Lucas[30] for abolition of the role of the court in gender dysphoria. Regarding a seventeen-year-old natal girl seeking authority for testosterone, the judge declared an "urgent need for statutory intervention … to undo the consequences of re Jamie". Rejecting the declaration of the Australian Human Rights Commission in Jamie, the judge pleaded for the abolition of the need for the court to authorise Stage 2 therapy, implying the child should be left in the hands of therapists. Confirming his view that biology should be moulded to the mind, he asked, "What other section of our youth is required to endure such an ordeal to attain the corporeal manifestation of their [sic] identity?"

The cerebral effects of blockers and cross-sex hormones

It was first thought that the action of GnRH was specific to the pituitary gland but, as early as 1981, a role in other parts of the brain was being revealed[31]. By 1987, it was established that many of the nerve cells that produced that hormone were connected to other neurons in widespread parts of the brain, such as the limbic system, which is fundamental to executive, behavioural and emotional control[32]. These findings were confirmed[33] [34] [35], showing receptors for GnRH were expressed in numerous areas in the brain not involved with reproduction. They raised questions of what might result if the actions were blocked[36], especially in puberty, the "critical window for neuronal development and programming"[37].

By 2004, it was known that surgical castration of male animals can lead to "profound loss of synaptic density in the hippocampus and changes in learning and memory"[38] [39] due to absence of testosterone. Synapses are the junctions between cells through which information is shared by tiny electrical impulses or chemical transmitters. Their reduction implies reduced or altered activity of that region of the brain. GnRH blockers are a means of chemical as opposed to surgical castration, therefore, the effect of reduction of testosterone by blocking the pituitary needed to be elucidated.

By 2007, as animal and behavioural studies suggested blockers "may have significant effects on memory" their effects were examined in humans. Interference in memory and executive function[40], and abnormal cerebral function was found in women receiving blockers for gynaecological reasons.[41]

In 2008, review of the effect of testosterone deprivation due to blockers in men receiving them for prostate cancer raised the "strong argument" that blockers, alone, caused "subtle but significant cognitive declines".[42] Other studies confirmed "higher rates … of cognitive impairment" compared to controls[43], but were denied by some.[44] Laboratory studies were needed.

In 2009, scientists in universities in Glasgow and Oslo had begun collaborative research on the effect of blockers on the behaviour and brains of sheep. These foundational studies revealed that exposure of the pre-pubertal lamb to blockers led to an observable increase in the size of the amygdala[45], that the activities of a large number of genes in the amygdala and hippocampus were altered by the blockers[46] [47] and, not surprisingly, that some aspects of brain function were disturbed [48][49]. Female sheep had less emotional control and were more anxious. Males were more prone to "risk taking" and alterations in emotional reactivity. Males suffered reduction in spatial memory that persisted after treatment.[50]

These results suggest that blockers may alter the shape of the brain and the capacity of cells to communicate with each other at a molecular level[51] [52]. This could be due to a direct effect of the loss of GnRH or, alternatively, a reduction in GnRH-dependent production of local neurosteroids involved in the formation of synaptic connections when the brain is developing.[53] [54]

Contrary to the laboratory studies, a recent study by the Dutch group[55] on its own human patients asserted that no difference could be found in executive function between mid-teens on blockers and controls. Little reassurance can be gained from this conclusion, however, because close reading of the results reveals that males on blockers transgendering to females did have "significantly lower accuracy scores than the control groups". However, the authors declared that "it is possible that this is just a chance finding due to the small size of the subgroup (of eight adolescents)". Alternatively, it could have confirmed what had been revealed in sheep; but, indeed, the numbers were small.

Other psychological studies have suggested

positive outcome in humans on hormonal therapy but all are weakened by small numbers and their reliance on observations by involved therapists. [56] Reviews stress lack of evidence[57]. It should be emphasised that, unlike older men with cancer whose brains are deteriorating with age, children are being given blockers at a time of great brain development. Moreover, compared to the men whose treatment lasted only months, many children receive blockers for years.

Cross-sex hormones

Courts have repeated the testimony of experts that the effects of cross-sex hormones are "partially reversible". However, in none of the summaries does it appear that attention has been directed to the possibility of structural change on the brain, despite occasional warnings about mood swings, depression and anger.

Animal studies mentioned above on the effects of androgen deprivation should have raised concerns about similar effects of puberty blockers on the brains of natal boys. The added effect of oestrogen should have been considered because by 2006 it was described in medical literature.

Three studies have compared the effects of cross-sex hormones on the brain before and after treatment. One, in which oestrogen and an added anti-testosterone drug were given to transgendering males, found a reduction in brain "ten times the average annual decrease in healthy adults" after only four months. After a similar time, the brain volume increased in females receiving testosterone.

Other studies[58] confirm that shrinkage of male brains on oestrogen is associated with reduction in the size of grey matter after only six months. Increased size of grey matter in females on testosterone is associated with altered microstructure of neurons[59].

Oestrogen may reduce grey matter in males by inducing apoptosis, or death of neuronal and supporting cells. Testosterone may increase the size of female grey matter by an anabolic effect on molecular components of cells. As brains are chromosomally programmed before birth to respond to specific stimulation of appropriate sex hormones in puberty, there should be no surprise at disruption when the hormone they were expecting has been substituted by one they were not.

As with blockers, the above studies were conducted on adult brains exposed to cross-sex hormones for only several months. What can be expected from exposure in childhood that continues for decades? No one knows. A 2016 review concludes that "long term clinical studies are yet to be published … risks may become more apparent as the duration of hormone exposure increases"[60].

Conclusion

Blockers and cross-sex hormones cause structural alterations in the brain. No one knows the long-term effects. Their use in treating childhood gender dysphoria is utterly experimental. There is no reliable evidence of long-term benefit to recipient children. Most will grow out of gender dysphoria by puberty. So why medicalise the confusion?

Children and parents caught up in the transgender phenomenon deserve our compassion. The children are in great danger of psychological imprinting by a Gnostic ideology whose enlightened leadership declares mind is truly over matter: feelings trump chromosomes, and gender is fluid. The danger increases exponentially when children enter the pathway of medical experimentation. Who can protect them from this current fad, fuelled by the media and instructed by websites?

Lamentably, Australian courts seem to be tiring of the protective role declared necessary in Marion's case. At least one judge is calling for the abolition of the role for the courts in gender dysphoria and would leave treatment entirely in the hands of therapists.

There are, however, at least two problems in such unauthorised therapy. The first is that of human nature, to which Marion's case alludes. The medical profession is not alone in having sincere but misguided practitioners and the consequences of mistakes regarding childhood gender dysphoria are, indeed, irreversible and grave. Family courts have praised therapists for their knowledge but while those experts have been propounding the cerebral safety of hormonal treatment, international research has been proving otherwise.

The second problem is the new Victorian Health Complaints Act, which has the potential to restrict all therapists to affirmation of gender dysphoria.

Affirming therapists may face their own dangers. Patients may emerge with altered brains, asking why no one warned them about such things. The High Court in Rogers v Whittaker[61] declared that

"a medical practitioner has a duty to warn a patient of a material risk inherent in the procedure". In that case, an ophthalmologist did not think to warn a patient of the one-in-14,000 risk to the good eye when operating on the bad. Regarding the brain and hormonal treatment for gender dysphoria, reports of damage are established, and ignorance can be no defence.

[1] De Vries A, Cohen-Kettenis. J Homosexuality. Clinical management of Gender dysphoria in Children and Adolesecents: the Dutch Approach. 2012. 59 (3):301-316.

[2] World Professional Association for Transgender Health. Standards of Care. 2011 Accessed Feb 27, 2017,

[3] Information is available on 39 families. In 22 there are single parents, 3 are in foster care, and 14 in apparently double parented families.

[4] Gillick vs West Norfolk and Wisbech Area Health Authority. (Gillick's case) (1985)UKHL. 1986)AC 112.

[5] Re Marion, at 237-238.

[6] Re Marion at 237-238.

[7] Re Jane (1988). 94 FLR 1.

[8] https://www.transcendsupport.com.au

[9] Triple J Hack. Sarah McVeigh. Georgie Stone wins GLBTI person of the year: Globe Awards. October 23.2016

[10] https://en.wikipedia.org/wiki/List_of_U.S._jurisdictions_banning_conversion_therapy_for_minors

[11] Hennessy J. Health Complaints Bill 2016. Victoria Legislative Assembly. February 10, 2016. Second Reading. Hansard p98.

[12] Hennessj J, as reported in Zero tolerance: Andrews to crack down on gay "conversion" therapy. The Age. Jan 24, 2016

[13] Re Lucas (2016). FamCA.

[14] Telfer M, Tollit M, Feldman D. Transformation of health-care and legal systems for the transgender population: the need for change in Australia. JPCH.2015;51:1051-1053.

[15] Re Alex 68.

[16] Re Brodie. FamCA 776, (2007) and FamCA 334, 2008.

[17] Re Bernadette. 2010 FamCA 94.

[18] Hulshoff Pol, H. E., Cohen-Kettenis, P. T.,Van Haren, N. E., et al. Changing your sex

changes your brain: Influences of testosterone and estrogen on adult human brain structure. European Journal of Endocrinology,. (2006).: 155,:S107–S111.

[19] Re Jamie (2011). Fam CA 248.

[20] Re Jane (1989). FLC 92-007 (at 77, 256).

[21] Whitehall J. The fashion in child surgical abuse. Quadrant. December 2016.

[22] Re Cameron. (2015). FamCA 1113.

[23] Re Celeste. (2016) FamCA 503.

[24] Re Gabrielle (2016). Fam CA 470

[25] Whitehall J. The fashion in child surgical abuse. Quadrant. December 2016.

[26] Re Quinn. (2016) FamCA.

[27] Re Lincoln (2016) FamCA 1071.

[28] Re Lincoln 2016) FamCA 267.

[29] Re Darryl (2016) FamCA 720

[30] Re Lucas (2016). FamCA.

[31] Eiden, L,. Brownstein M. Extrahypothalamic distributions and functions of hypothalamic peptide hormones. Fed. Proc. 1981 40: 2553-2559. Eskay

[32] Silverman A, Jhamandis J, Renauld L. Localisation of luteinising hormone releasing hormone (LNRH) neurons that project to the median eminence. J Neurosci 1987;72:312-2319

[33] Wilson A, Salamat M, Haasl R et al. Human neurons express type 1 GnRh receptor and respond to GnRH by increasing luteinizing hormone expression. J Endocrinol. 2006;191:651-663.

[34] Skinner D, Albertson A, Navratil A et al. Effects of gonado-trophin releasing hormone outside the hypothalamic-pituitary-reproductive axis. J Neuroendocrinol. 2009;21:282-292.

[35] Skinner D, Albertson A, Navratil A et al. Effects of GnRH outside the Hypothalamic-Pituitary-Reproductive Axis. J Neuroendocrinology. 2009:282-292.

[36] Carel J, Eugster E, Rogol A et al. Consensus statement on the use of GnRH analogs in children. Pediatrics 2009. 123. E752-762.

[37] Berenbaum S, Beltz A. Sexual differentiation of human behaviour:effects of prenatal and pubertal organisational hormones. Front. Neuroendocrinol 2011.32:183-200

[38] Leranth C, Prange-Kiel J, Frick K et al. Low CA1 spine synapse density is further reduced by castration in male non-human primates. Cerebral cortex. 2004;14:503-510.

[39]Bussiere J, Beer T, Neiss M et al , Androgen deprivation impairs memory in older men. Behavioral Neuroscience, Vol 119(6), Dec 2005, 1429-1437.

[40] Grigorova M, Sherwin B, Tulandi T.Effects of treatment with leuprolide acetate depot on working memory and executive functions in young premenopausal women. Psychneuroendocrinology. 2006:31:935-947.

[41] Craig MC et al. Gonadotropin hormone releasing hormone agonists alter prefrontal function during verbal encoding in young women. Psychoneuroendocrinology. 2007;8-10:116-117

[42] Nelson C, Lee J, Gamboa M et al Cognitive effects of hormone therapy in men with prostate cancer: a review.Cancer. 2008 Sep 1;113(5):1097-106.

[43] Jim H et al. Cognitive Impairment in Men Treated with Luteinizing Hormone-Releasing Hormone Agonists for Prostate Cancer: A Controlled Comparison. Support Care Cancer, 2010.18(1):21-7.

[44] Salminen E, Portin R, Korpela J, Backman H Androgen deprivation and cognition in prostate cancer.Br J Cancer. 2003;89(6):971-6

[45] Nuruddin S, Bruchhage M, Ropstad E et al. Effects of peri-pubertal gonado-tropin releasing hormone agonist on brain development in sheep…a magnetic resonance imaging study. Psychoneuroendocrinology. 2013;38;3115-3127.

[46] Nuruddin S, Wojniusz S, Ropstad E et al. peri-pubertal gonado-tropin releasing hormone agonist treatment affects hippocampus gene expression without changing spatial orientation in young sheep. Behav. Brain Res. 2013.;242:9-16.

[47] Nuruddin S, Krogenaes A, Brynildsrud) et al. Peri-pubertal gonadotropin-releasing hormone agonist treatment affects hippocampus gene expression without changing spatial orientation in young sheep. Behav Brain Res. 2013;242:9-16.

[48] Wojniusz S, Vogele C, Ropstad E et al. Prepubertal gonado-tropin-releasing hormone analog leads to exaggerated behavioural and emotional sex differences in sheep. Hormones and Behaviour. 2011;59:22-27.

[49] Evans N, Robinson J, Erhard H et al. Development of psycophysiological motoric reactivity is influenced by peripubertal pharmacological inhibition of GnRH action-results of an ovine model. Psychoneuroendocrinology. 2012; 37:1876-1884.

[50] Hough D, Bellingham M, Haraldsen I et al., 2017 Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. Psychoneuroendocrinology. 2017; 75:173-182.

[51] Hough D, Bellingham M, Haraldsen I et al., 2017 Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. Psychoneuroendocrinology. 2017; 75:173-182.

[52] Hough D, Bellingham M, Haraldsen I et al., A reduction in long-term spatial memory persists after discontinuation of peripubertal GnRH agonist treatment in sheep. Psychoneuroendocrinology. 2017; 77:1–8.

[53] Naftolin F, Ryan K, Petro Z. Aromatization of androstenedione by the diencephalon. J Clin Endocrinol Metab. 1971;33;368-370.

[54] Prange-Kiel J, Jarry H, Schoen M et al. Gonadotrophin releasing hormone regulates spine density via its regulatory role in hippocampal oestrogen synthesis. J Cell Biol. 2008;180:417-426.

[55] Staphorsius A, , Kreukels B, Cohen-Kettenis P et al. Puberty suppression and executive functioning: An fMRI-study in adolescents with gender dsyphoria. Psychoneuroendocrinology. 2015;56:190-199.

[56] De Vries A, McGuire J, Steensma T et al. Young adult psychological outcome after puberty suppression and gender reassignmnent. Pediatrics. 2014;134(4):

[57] Fuss J, Auer M, Briken P. Gender dysphoria in children and adolescents: a review of current research. Current opinion in psychiatry. 2015.

[58] Zubiaurre-Elorza, L., Junque, C., Gomez-Gil, E., & Guillamon, A. (2014).

Effects of cross-sex hormone treatment on cortical thickness in

transsexual individuals. Journal of Sexual Medicine, 11, 1248–1261.

[59] Rametti, G., Carrillo, B., Gomez-Gil, E., Junque, C., Zubiaurre-Elorza, L.,

Segovia,S.,…Guillamon,A. (2012).Effects of androgenisation on the

White matter microstructure of female-to-male trans-sexuals. Adiffusion

tensor imaging study. Psychoneuroendocrinology, 37, 1261–1269.

[60] Guillamon A, Junque C, Gomez-Gil E. A Review of the Status of Brain Structure Research n

Transsexualism. Arch Sex Behav (2016) 45:1615–1648

[61] Rogers vs Whittaker (1992) 175 CLR 479.

Bitterness in the Family Court

– John Whitehall (first published in Quadrant 18th September 2020)

In August, the Family Court of Australia considered the provision of cross-sex hormones to a 16 year old natal male seeking to transgender with the approval of the father but in opposition to the mother. An earlier Court had suggested the current Court might raise the question of whether such hormonal therapy was 'therapeutic', but this did not eventuate. Instead, the Court declared in favour of their continued administration in disregard of side effects.

A complication unvisited by the Court was that female hormones had been administered for almost a year before the Court met to consider its approval. They had been prescribed by an endocrinologist until he stopped doing so in anticipation of the legal proceedings. In response, the father began to import the same brand of sex hormones and to administer them in the same dose. Monitoring blood tests of this illegal procedure were performed by unnamed medical practitioners.

The original prescriber defended their administration by arguing they were not given as Stage 2 therapy, the evocation of external characteristics of the opposite sex in the process of transgendering. They were merely given to 'ameliorate' side effects of the hormone 'blockers' that had been started earlier in the year. A supporting psychiatrist declared the doses were too small to constitute Stage 2 therapy, and these protestations were accepted by the presiding Justice Watts.

There was, however, opinion contrary to and unsupportive of those protestations. The doses given were, in fact, those recommended by international literature for the purposes of transgendering of post-pubertal males. And, literature reveals no support for the argument that small doses may ameliorate side effects of blockers.

Thus, the proceedings of the Court were based on a history of illegal prescription and administration of sex hormones to an underage youth, for reasons that were not validated by international practice. It might be expected that such illegality would have been examined by the Court, but it was not. It was

passed over: stated reasons were accepted without question and the father was virtually commended for his vigilance.

The father, however, had a long history of domestic violence, and the poor youth, Imogen, and her sister, had existed in turmoil, descending into mental illness. The psychiatrist for the mother who opposed the administration of cross-sex hormones maintained gender confusion was but a symptom that had emerged from a panoply of prior psychiatric disease. He advocated a year of psychotherapy. Despite their being no childhood indications, the father's psychiatrist argued for the primacy of gender dysphoria. Justice Watts aligned with the argument for hormonal transgendering. In the process, his rejection of the ideas of the mother's psychiatrist became more *ad hominen*.

Strangely, it does not appear the Court wondered at the influence of the father over his natal son. Sigmund Freud might have wondered if conflict had been avoided by the natal son's adoption of the opposite sex. The possibility that psychotherapy that might have explored and ameliorated such tensions has, however, been precluded by Justice Watt's preference for hormonal action.

The decision of the Court in *Re Imogen 6* will be influential. Its conduct will raise doubts about impartiality. Its decision will mean only the bravest and wealthiest of parents and medical practitioners, will be game to pursue alternative, psychotherapeutic options for gender confused offspring. It will be reasonable for parents to conclude there will be a twofold loss: the first being that of their child to hormones, the second being the loss of their own freedom, given current laws in the ACT and Queensland, and pending laws in Victoria and South Australia, hold the promise of gaol sentences for those who oppose hormonal therapy for gender confused children.

Imogen is now 16 years and 9 months old. For 15 years she was known as Thomas, having been born a boy. For much of her life, she has existed in turmoil. Her father has been violent. He would 'shout, swear and hit' her mother and younger sister, and herself, if she tried to intervene. Her (now estranged) mother returned from a six-week secondment with her employment in October 2016, to a 'war zone' in which the children and their father were 'screaming at each other'. The younger sister descended into mental illness.

So did Imogen, ultimately earning a list of psychiatric diagnoses from Major Depression, Social Anxiety with Panic attacks and Complex Post-Traumatic Stress Disorder to Parent-Child Relational Problem (due to her mother's untreated post-natal depression, according to the violent father's psychiatrist), and, as might be expected, addiction to the internet and school refusal.

Things worsened in 2018. The parents had separated in March 2017. School refusal increased, 'it was difficult to get her out of bed in the morning', she 'cried under the sheets and 'told her mother' she was 'lonely and depressed'.

Psychiatric medication was administered. Her relationship with her mother 'started to deteriorate'. She became 'aggressive and defiant'. And mother and two children underwent residential care.

The sister had regressed: by now 'hiding in boxes; becoming non-verbal; starting to behave like a cat; petrified by loud noises, having severe phobias… running away from home and regressing to baby behaviour'. Not surprisingly, a doctor reported that 'challenging family dynamics and (the sister's) presentation severely impacts upon (Imogen)'.

Then, from October 6-12, the children 'went on a holiday with the father and his then partner (who) was doing research on Gender minorities and their access to medical treatment'. On the very day of return, Imogen 'told her mother that she wanted to be a girl' and appeared to have 'shaved her body hair'.

On October 15, the father informed the mother 'Imogen has chosen a female name and prefers the female pronouns'. On October 25, Imogen went to live with the father. Psychological counselling continued.

In December 18, she was seen by a psychiatrist and a psychologist who did not diagnose Gender Dysphoria until February 2018. In the meantime, mother had remarried, and efforts to induce Imogen to schooling had stalled.

On March 21, the sister reported Imogen and her father 'had been fighting' and she (the sister) felt 'helpless' and had 'started to self-harm'.

Later that month, at around 15 years and 4 months, Imogen 'undertook sperm cryopreservation' and on April 16, entered Stage 1 of 'affirmation' therapy towards her elected gender identity, the administration of puberty blockers. On May 11, her

psychiatrist 'took a systemic history to determine if she met (diagnostic criteria) for Gender Dysphoria'. In Court, in August 2020, he declared she had.

On September 7, 2019, Imogen was prescribed a daily dose of 2 mg of Progynova (oestradiol valerate) which, according to the endocrinologist, was 'aimed at ameliorating a side effect of Stage 1 treatment, and was not the commencement of Stage 2 treatment (the administration of cross-sex hormones to evoke external characteristics of the opposite sex).

On October 12, the father informed the mother 'Imogen has commenced Stage 2 treatment'.

On November 5, an endocrinologist informed Imogen's mother that he had prescribed oestrogens. On November 7, he informed the mother he would no longer 'treat Imogen until the court made an order'.

On November 13, Imogen's mother received a letter from an involved psychiatrist stating 'the dose of oestrogen was not enough to be considered "phase 2" therapy'.

From December 2019, the father began to administer imported oestrogen 'each day for the purposes of dealing with the side effects of Stage 1 therapy', but according to the presiding Judge of the Family Court, 'the evidence from the father is that Imogen is not using the drug to attempt to commence Stage2 treatment'.

On March 24, 2020, the mother sought orders for the Court to instruct the doctors to 'cease providing hormone treatment (Stage 1 or 2)'. It would appear the mother did not learn of the imported doses until the hearing in August 2020.

On March 30, another psychiatrist was informed by Imogen and her father that oestrogen was being procured from overseas. That psychiatrist informed 'others' involved in Imogen's care. In May, Imogen was interviewed by psychiatrist Roberto D'Angelo, at mother's request, pursuant to orders of the Family Court (*Re Imogen 3*. 2020. FamCA 395.

Also in May 2020, in *Re Imogen 4*, when FCA considered who should be permitted to 'intervene' in its adjudication of Imogen's mother's opposition to Stage 2 therapy, and her insistence that Imogen was not capable of providing informed consent (Gillick competence), Justice Watts declared the proceedings 'could involve the reconsideration of whether or not Stage 2 treatment (and possibly Stage 1 treatment) is non-therapeutic'. This raised hopes that the 'Short March'[lxiii] of the Sexual Left through the FCA in pursuit of supremacy for the ideology of gender fluidity might have stalled: that some common sense remained.

On September 11, in *Re Imogen 6*, those hopes were dashed: Imogen was declared Gillick competent despite an acknowledged list of psychiatric conditions; the Court over-rule the mother's objections to hormonal therapy, and little consideration was undertaken as to whether hormones were 'therapeutic'. Most discussion of Gender Dysphoria focussed on theories of causation, and statistics of de-transitioning.

Physiology was totally ignored: whether chemical castration, chemical lobotomy and the evoking of breasts were appropriate interventions for this psychologically disturbed youth was not considered.

The bitter pills

Blockers have major effects on nerve tissue, from the brain to the periphery. They do not simply 'block puberty'. Their use has been associated with cognitive effects in adults suffering from diseases, such as prostate cancer, which are fuelled by the sex hormones they block. They have been shown to alter the structural development of human brain, and have been proven, in sheep, to inflict sustained damage on the limbic system which integrates emotion, memory, cognition and reward into a kind of 'inner world view'. Blocked sheep do not perform as well in mazes, are more emotionally labile, and have a demonstrable preference for the familiar, rather than the novel. In other words, they prefer the status quo and resist change, a proclivity relevant for someone who has become 'familiar' with the role of the opposite sex.

Blockers are alleged to provide more time for mature consideration of sexuality and procreation. However, they block the influences of both the primary centres for sexualisation near the midbrain, and the secondary centres, the gonads. How can a so-neutered youth ponder sexual identity and feelings with a damaged limbic system?

Blocking the testes blocks the formation of sperm, as well as the sexualising testosterone. Hence the collection of Imogen's sperm before their administration. How well this process of chemical castration (to be augmented in a few months with oestrogen) was explained and comprehended

is undocumented, merely assured by lawyers promoting their use.

Density of bone mass is increased during the process of puberty. Delaying puberty reduces that density, predisposing to later osteoporosis. There is no evidence that a small dose of oestrogen given to a 'blocked' natal male will reduce the propensity to bone thinning. As in The Monty, the dose needs to be Full.

The FCA judgement of *Re-Imogen* is but a summary of lengthy presentations and there is little comment on the lability of Imogen's emotions after starting blockers except the short declaration that 'tensions' escalated between her and the mother.

Oestrogens further suppress the production of sperm and testosterone. How long it takes for female hormones (and blockers) to suppress the testes beyond recovery is unknown. In the meantime, oestrogens will evoke facsimiles of the female sex, such as breasts but, of course, cannot alter the female chromosomal pattern.

Oestrogens have also been shown to alter the structure of adult brains. Sex specific parts of the brain are organised in the first weeks of foetal life and await activation and by appropriate sex-hormones in puberty. From then, they appear to need sustenance from those hormones. The brain of an adult male deprived of testosterone and bathed in oestrogen has been found to shrink at a rate ten times faster than ageing, after only four months. Imogen had been taking them for almost a year at the time of the hearing, during what should have been a period of great teenage brain growth.

It is this structural effect on the brain by both blockers and oestrogen in the pursuit of psychological advantage that justifies the term 'chemical lobotomy'. It hearkens back to the infamous period in which mainstream medicine colluded with the practice of surgical interruption of the forebrain for mental illness. Such was the uncritical adulation of the founder of this 'therapy' that he was awarded the Nobel Prize.

Imogen began to receive a daily dose of 2 mg of oestradiol valerate from September 7, 2019. As declared in *Re Imogen 4*, the 'rationale for moving quickly to prescribe the oestrogen' was 'the need to offset the harmful effects of stage 1 intervention on bone density'. The matter was raised again in *Re Imogen 6* when it was argued this dose was aimed at ameliorating an effect of Stage 1 therapy and was not the commencement of stage 2 treatment' which, of course, would have been illegal pending the approval of the Court.

In *Re Imogen 6*, it was reported the father told the mother 'Imogen has commenced Stage 2 treatment', but Judge Watts added 'The assertion that Stage 2 treatment had commenced was incorrect'.

A psychiatrist joined the defence, writing to the mother to declare 'the dose of oestrogen was not enough to be considered 'phase 2' treatment. And, later summarising the administration of imported oestrogen, Justice Watts declared, without clarification, 'The evidence from the father is that Imogen is not using the drug to attempt to commence stage 2 treatment'.

Despite protestations that 2 mg of Progynova a day does not comprise Stage 2 therapy[lxivlxv], international guidelines declare 1-2 mg to be inductive of puberty in post-pubertal males seeking to transgender to females. The dose may be increased to 6mg per day, according to effect.

Justice Watts was 'reassured' Imogen's father had taken 'responsibility for administering' her illegal medication and was 'limiting her to 2 mg a day' and that a hospital had not 'raised any red flag arising from Imogen's blood tests in relation to the level of oestrogen that Imogen is currently taking'. Regrettably, Justice Watts did not identify the nature of the blood tests, or their prescriber. The tests could have been assuring the absence of testosterone in the process of transgendering, as well as the level of administered oestrogen.

Identification of the requesting doctor (s) would have revealed something of the collusion between doctors and the father in the illegal administration of imported steroids to an under-aged and vulnerable youth. The lack of judicial interest in this underlying violation challenges respect for the Family Court.

It is strange that Justice Watts emphasised the importance of evidence in various parts of his judicial summary but apparently failed to seek it with regard to the claims for the use of oestrogen. A superficial Google search would have confirmed the transgendering dose of 2 mg a day. And, deeper searching would have failed to find any justification for the claim that a small dose would reduce the impact of blockers on density. It may be asked why various doctors arguing the dose was too small to transgender but sufficient to protects bones, failed to produce supporting literature. Doing so could have helped the reputation of FCA

The bitter fight

The psychiatrist for the mother, Roberto D'Angelo was outgunned in the Court, confronted by the father's barrister, the Australian Human Rights Commission and the Independent Children's Lawyer. Essentially, he argued gender dysphoria was a new symptom which had emerged from the panoply of established psychiatric disorder with help from social media.

One opponent argued hitherto unsuspected gender incongruity is emerging in increasing numbers due to 'developments in society and in medicine' which are 'leading to greater awareness and understanding'. On the face of it, these arguments appear similar: vulnerable teenagers are susceptible to societal influences, but the opponent was adamant that 'social contagion' was not relevant.

Much energy was then expended to discredit the conclusions of US researcher, Lisa Littman, that the rising phenomenon of 'rapid onset gender dysphoria' in vulnerable teenage girls was influenced by contagious social influences. Fulsomely, the opponent denied Littman's simple conclusion, declaring current changes 'in gender demands…increased knowledge, understanding and self-reflection and other factors more commonly play a part'.

Whatever that meant appears to have had greater appeal to Justice Watts who able to declare 'there is no actual evidence that Imogen has been infected by contagion as a result of involvement with the internet or social media'. Apparently the Judge found no relevance in all the testimony of fights over Imogen's addiction to her computer.

Also, accepting Imogen's mother was 'suspicious' of a link between the 'weekend' (more like a week if the Judge did the maths) Imogen spent with her father and his gender researching girlfriend, and her 'coming out' on the day of return, the judge propounded 'there is no evidence' the gender researcher 'said anything…that would have unduly influenced Imogen'.

Yet the Judge was quick to find 'evidence' of an alleged deficiency in Roberto D'Angelo's analysis of a major research publication from Sweden that had concluded there was a marked increase in suicidality in transgendered adults. From listening to the argument between D'Angelo and the father's barrister on interpretation of some statistical data in the article, the learned judge 'was satisfied Dr D'Angelo had not properly analysed the table in the report upon which he based his claim'.

The Judge's predisposition for accuracy was, however, challenged by his erroneous reference to the above paper in the Court summary. The paper was the one described below. Justice Watts referenced another, from Belgium. The question must be asked: did the Judge examine the papers himself, or merely relay rhetoric from the opposing lawyer?

The 'Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden' had involved 324 sex re-assigned persons from 1973 to 2003 and had concluded there was a 19 times increased 'hazard rate' for suicide compared with controls. It was authored by researchers from Karolinska Institute and Gothenburg University and had received no significant disagreement until that proffered by the lawyer from the Australian Human Rights Commission, supported by Justice Watts.

Similarly, in argument with the Human Rights lawyer over possible reasons for the loss of transgendered people to follow-up in another study[lxvi], Justice Watts declared 'I reject Dr D' Angelo's claim that the 30% loss to follow up may consist of people who regret their transition'. The judge produced no evidence to support his sweeping conclusion (how would anyone know the reason people refused to co-operate?). Nor did the Judge provide a reference to the paper.

Despite the hours of hearings and the need, therefore, to summarise succinctly, the Judge saw fit to emphasise the submission by the Independent Children's Lawyer that Dr D'Angelo displayed 'rigid unwillingness' to accept the new symptom of gender dysphoria as 'a driver' for her long standing anxiety.

In his conclusions, Justice Watts declared he had 'reservations about the basis and practicality' of Dr D'Angelo's recommendations for psychotherapy (rather than hormonal intervention)'. The Judge declared he did not accept the argument that Imogen does not have Gender Dysphoria. Nor did he not accept Dr D'Angelo's 'conclusions about how Imogen presented to him', declaring Dr D'Angelo 'presents as an advocate for an alternative approach to the treatment of adolescents with Gender Dysphoria'. Earlier, the Judge had asserted

his belief that the regime of 'affirmation therapy' had been accepted by the majority of the medical profession and represented the 'orthodox middle' of therapeutic options.

As to the impracticality of organising regular psychotherapy for one year, as suggested by Dr D'Angelo, Justice Watts appears to be unaware of the practical difficulties associated with a life-long dependence on medical supervision (often including mental issues) for those transgendering with hormones.

Without provision of any supporting evidence, and in contradiction to presentations of the father's violent nature and sustained family unhappiness, Justice Watts was able to pontificate 'Imogen has a robust relationship with her father in whom she has a great deal of trust and will continue to have a meaningful relationship with him' Someone with less prophetic zeal might have looked more closely at the relationship of the disturbed natal male with her father. It is surely not too Freudian to wonder at the power of the father over the natal son? Did Imogen find being a female resulted in less conflict? Did she find her father's toxic masculinity so unattractive she decided to join the other side? Was joining the other side the best way to ensure acceptance by the father/gender researcher dyad? Furthermore, it is surely not pedantic to acknowledge reports in international literature of the possibility of personality disorder in parents of children confused over gender identity?

One way or another, Justice Watts has banned the opportunity for psychotherapy that might have unravelled some of the tragedy, condemning her to hormones.

The bitter end

There may be a positive outcome from *Imogen 6*: the need for court authority for prescription of such drugs is emphasised if there is dispute between parents. Conversely, the failure of the Court to criticise the under-age prescription of oestrogen that had preceded its hearing by almost a year, indicates the Court does not really take such things seriously. Given the Australian Guidelines promulgated by the Melbourne Children's Hospital have expressed no age limits, the growing argument that children on blockers should be allowed to develop puberty at the same time as their peers, and the claim that forced delay of puberty to 16 years worsens psychological stress and predisposition to osteoporosis, it would appear only a matter of time before limitations are lifted.

Given recent legislation in the Australian Capital Territory that criminalises parental opposition to hormonal therapy for a gender confused child, and prescribes 12 months in gaol for miscreants, it is likely that opposition to 'affirmation' will decrease. Only the bravest of parents and doctors (and the wealthiest) are likely to commit themselves to the battle.

Finally, it was disappointing that Justice Watts went nowhere near questioning the therapeutic role of hormonal therapy. In corollary, it was painful to perceive an apparent intellectual and emotional abdication of the Court to 'affirmation therapy'. From the transcripts of many hours of discussion, Justice Watts selects excerpts that amount to *ad hominem* attack on Roberto D'Angelo for proposing an 'alternate' therapy for gender dysphoria: one based on psychotherapy rather than chemical castration and lobotomy. Sadly, there now threatens a fusion of powers: political, legal and medical to oblige that invasive experimentation.

5

Section 5: Social Contagion

The social contagion of gender dysphoria: a theoretical & empirical proposition

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Introduction

The term social contagion describes the "spread of phenomena (e.g., behaviours, beliefs and attitudes) across network ties" (Christakis & Fowler, 2013, p. 556). Using very large datasets (e.g., Framingham Heart Study) that have collected longitudinal data on original participants (Original cohort), as well as their children (Offspring cohort) and their children's children (Third generation cohort) and including their spouses, siblings, friends and neighbours, Christakis and Fowler have shown that social network effects, known as clustering, remain strong and can extend to those up to three degrees of separation from the original cohort. Such effects have been demonstrated across a large range of factors by different researchers using differing datasets. Examples include overweight/obesity, sleep patterns, smoking, alcohol abuse, alcohol abstention, marijuana use, loneliness, happiness, depression, cooperation, and divorce among others.

Social network analysis, the method applied to study contagions of all kinds, was first developed and used in public health as a way of determining the spread of diseases (e.g., influenza, HIV/AIDS) that resulted in pandemics. It was subsequently applied to the challenges of introducing changes and innovations in the health system (Blanchet, 2013). Its applications have since expanded with the advent of computers, the internet, mobile and smart phones, and social media. Members of a network play different roles in the dissemination of innovations. A small number will adopt early (i.e., early adopters). Some of these will become opinion leaders who are central to the network who contaminate their "peers" (homophily) who in turn will influence those others at different levels of the network.

There are three types of social networks; (i) egocentric (networks assessing a single individual); (ii) sociocentric (social networks in a well-defined social space, such as a hospital or a school); and (iii) open system networks (e.g., globalised markets, social media). Each network consists of nodes (members), ties (between nodes), and measures of centrality, density and periphery or distance between the nodes. Networks with high centrality are the most effective in disseminating information or innovation. A key example with respect to this discussion is the transactivist lobby that has achieved spectacular success in a short time in changing health care, educational practices and legislation related to transgender individuals. Other characteristics of networks include cohesion (number of connections within a network) and shape (distribution of ties within the network) (Otte & Rousseau, 2002).

In this article, I explore the influence of social contagion on the disquieting upsurge in the number of children and young people whose parents are presenting to gender clinics around the world for advice regarding social transition, puberty blocking agents, cross sex hormones, and ultimately surgery in an attempt to change their gender. First, I examine the concept of social contagion and the mechanisms by which it influences behaviour and attitudes. Then I review three key adolescent behaviours that have been shown to be subject to social contagion. Finally, I demonstrate that the same principles of social contagion apply to the increase of young people who believe that they are transgender and are consequently seeking irreversible medical remedies to assuage their gender dysphoria. Finally, I explore the social contagion (i.e., clustering) of medical practice with respect to treatment of gender dysphoria, the precipitous legislation appearing in its support, and changes to policy and practice in education and sport, despite our collective failure to date to fully understand the phenomenon of gender dysphoria and its rapid, epidemic-like spread in the Western world.

(i) Peer contagion

Peer contagion is a form of social contagion, defined as a process of reciprocal influence to engage in behaviours occurring in a peer dyad that may be life-enhancing (e.g., taking up a sport, studying for exams, health screening, resisting engaging in negative behaviours, altruism) or life-compromising (e.g., illegal substance use, truanting from school, aggression, bullying, obesity). Peer contagion has a powerful socializing effect on children beginning in the pre-school years. By early childhood, the time spent interacting with same-age playmates frequently exceeds time spent with parents (Ellis, Rogoff, & Cromer, 1981). Further, characteristics of peer interactions in schools (e.g., aggression, coercive behaviours, mocking peers) are carried over into the home environment (Patterson, Littman, & Bricker, 1967). By middle childhood, gender is the most important factor in the formation of peer associations, highlighting the significance of gender as the organizing principle of the norms and values associated with gender identity (Fagot & Rodgers, 1998).

(ii) Deviancy training as a mechanism of social contagion

Different mechanisms of transmission of peer influence have been identified. Deviancy training, in which deviant attitudes and behaviours are rewarded by the peer group have a significant effect on the development of antisocial attitudes and behaviours such as bullying, physical violence, weapon carrying, delinquency, juvenile offending, and substance abuse (Dishion, Nelson, Winter, & Bullock, 2004). Aggression in adolescence becomes more covert and deliberate and takes the form of exclusion, spreading rumours, and suborning relational damage among an adolescent's friendship network (Sijtsema, Veenstra, Lindenberg, & Salmivalli, 2009). Interestingly, adolescents associated with peers who engage in instrumental aggression became more instrumentally aggressive, while those associated with peers who engaged in relational aggression became more relationally aggressive, demonstrating the specificity of the effects of peer contagion via the deviancy training.

(iii) Co-rumination as a form of social contagion

Another form of peer contagion in adolescence is co-rumination, a process of repetitive discussion, rehearsal and speculation about a problematic issue within the peer dyad or peer group that underlies peer influence on internalizing problems such as depression, anxiety, self-harm, suicidal ideation and suicide (Schwartz-Mette & Rose, 2012). Co-rumination is more common among adolescent girls (Hankin, Stone, & Wright, 2010) although a similar phenomenon among boys has been observed. Being in a friendship that engages in perseverative discussions on deviant topics has been associated with increased problem behaviour over the course of adolescence. The longer these discussions, the greater the association with deviant behaviour in later adolescence (Dishion & Tipsord, 2011).

Peer contagion may undermine the effects of positive socializing forces such as schools, rehabilitation programs for young offenders, and treatment facilities for eating disorders among others. Collecting same-minded adolescents into group programs may be counter-productive because the peer influence impacts of a homogeneous peer group to maintain disordered behaviours may be greater than the program effects of the treatment facility (Dishion & Tipsord, 2011).

Young people are particularly vulnerable to peer contagion if they have experienced peer rejection, hostility and/or social isolation from the peer group (Light & Dishion, 2007). On the contrary, protective factors against peer contagion effects include secure attachment to parents, adequate adult supervision and oversight of the young person's activities, school attendance, and the capacity for self-regulation (T. W. Gardner, Dishion, & Connell, 2008).

(iv) Does social contagion have a causal effect on behaviour uptake?

Establishing a causal role for the effect of peer behaviour on adolescents is difficult because adolescents choose their peer networks; that is, they choose to associate with like-minded adolescents and those exhibiting similar attributes (homophily). This raises the question: Do adolescents choose their peers because they sanction and engage in similar behaviours or can peer social networks explain the uptake of (new) behaviours in individuals in the network? Sophisticated statistical models have been used to tease out the relative contributions of peer selection and peer influence. Correctly attributing the effects of these two factors has important policy implications since most interventions for reducing risky behaviour among adolescents are implemented at a school level (Ali & Dwyer, 2010).

(v) The special case of social contagion via social media

In the world of social media, social contagion takes on a new, less complex and narrower meaning:

"Unlike the broadcasts of traditional media, which are passively consumed, social media depends on users to deliberately propagate the information they receive to their social contacts. This process, called social contagion, can amplify the spread of information in a social network" (Nathan & Kristina, 2014, p. 1).

For example, the social network 'Instagram' is one of the most popular platforms for adolescents and young people, with 44% reporting Instagram to be an important part of their daily lives (Feierabend et al. 2015). Analysis of content shows that it is a major vehicle for the sharing of mental health issues, including depression, eating disorders, and non-suicidal self-injury (NSSI) (Fischer et al. 2015).

Systematic reviews have identified both potential risks and benefits of online activity. On the one hand, it reduces social isolation and offers encouragement, camaraderie, and reduction of self-harm impulses. On the other, it enables, enhances, or triggers potential risks of 'copycat' behaviours such as NSSI, suicide, and eating disorders through normalization of pathological behaviours, or vicarious and social reinforcement of these behaviours (Brown, et al., 2017).

Evidence for social contagion among adolescents

In this section, I review the evidence for social contagion among adolescents for three key psychopathologies that arise in adolescence (eating disorders, marijuana use and suicide) and compare the mechanisms of social contagion in these well documented areas with evidence for social contagion effects in gender dysphoria.

i. Anorexia nervosa

A number of researchers have identified the central role of social contagion in the development and propagation of anorexia nervosa in adolescent girls (Allison, Warin, & Bastiampillai, 2014). Adolescence is a time in which the focus on oneself becomes intense, and for some, critical and unrelenting. The developing female body constitutes one of the main objects of scrutiny. When this scrutiny is compounded by the collective inspection of all of one's body's flaws, the peer group becomes a powerful crucible for both the development and maintenance of disordered eating.

Intensification of peer influence in closed communities of like individuals, such as schools, inpatient wards, residential units (Huefner & Ringle, 2012), or therapy groups often results in the advocacy of the practices (e.g., self-starvation, compulsive exercise, deceitful practices around eating) associated with anorexia nervosa (Dishion & Tipsord, 2011).

If we add social media and online networks as further sources of influence, affected adolescents can effectively surround themselves exclusively with like minds, thereby normalising cognitive distortions around eating and body image and making recovery very difficult. These effects are further compounded by the high status of thinness in western culture, and an ubiquitous focus on nutrition and exercise. Originally thought to be caused by genetics and pathological family dynamics, this view was revised with the finding, using longitudinal study designs and social network analyses, that same-gender, mutual friends were most influential in the development of obesity in adulthood, with siblings and opposite-sex friends having no effect (Christakis & Fowler, 2007).

ii. Marijuana use among adolescents

Substance use amongst adolescents is a major public health issue (Fletcher, Bonell, & Hargreaves, 2008), with a population study conducted by the Center for Disease Control and Prevention showing that 10 percent of youths reported using illegal substances before the age of 13, with marijuana the most frequently used substance (Chen, Storr, & Anthony, 2009). Peer influence has long been suspected as a stimulus that amplifies risky behaviours in the social network (Clark & Loheac, 2007; Lundborg, 2006).

Using the National Longitudinal Study of Adolescent Health (Add Health) (n=20,745) representing a sample of adolescents from grades 7-12 in 132 middle and high schools in 80 communities across the USA examined the influence of peer networks in the uptake and continued use of marijuana. The peer group was identified by the nomination of close friends and classmates within a grade were used to identify the broader social network from which friends were chosen (Ali et al., 2011).

Results showed that for every increase in marijuana use of 10 percent in adolescents in a close friend network increased the likelihood of marijuana use by two percent. An increase of 10% in usage in grade peers was associated with a 4.4 percent increase in individual use. Reporting a good relationship with one's parents, living in a two-parent household and being religious were protective against marijuana uptake. When peer selection and environmental confounders were held constant, increases in close friend and classmate usage by 10 percent both resulted in a five percent increase in uptake in individuals within those networks

iii. Non suicidal self-injury (NSSI)

NSSI is defined as a deliberate self-inflicted attack on one's own body without suicidal intent. It excludes cultural practices such as ear piercing, tattooing, or circumcision, most of which are performed by others. NSSI is defined as socially contagious when at least two people in the same group inflict NSSI within a 24-hour time period. The social contagion of NSSI has been reported in a variety of 'closed' social networks such as in inpatient units, prisons, group homes, and special education schools, as well as in community samples of adolescents, young adults and college students (Jarvi, Jackson, Swenson, & Crawford, 2013).

Adolescence (onset between 12 and 14 years) and early adulthood are high-risk developmental periods for NSSI (Lloyd-Richardson, Perrine, Dierker et al., 2007). Between 14% and 21% of high-school aged adolescents report engaging in NSSI, with higher estimates (30%-40%) for adolescent psychiatric populations (Muehlenkamp, Hoff, Licht, Azure & Hasenzahl, 2008).

More recently, social media has been identified as an important conduit for social contagion of NSSI among young people. Platforms such as Instagram have high-frequency occurrences of pictures from adolescents who have self-harmed. When associations between characteristics of pictures (e.g., seriousness and type of the self-injury) and comments (e.g., supportive, empathic, negative, offers of help) and weekly and daily trends of posting were analyzed, patterns emerged suggesting social contagion. For example, the more serious injuries attracted more views and comments. Social reinforcement, imitation and modelling of NSSI through social media are the possible mechanisms whereby young people increase their risk of engaging in NSSI through digital means (Brown, Fischer, Goldwich, Keller, Young, & Plener, 2018; Fulcher, Dunbar, Orlando, Woodruff, & Santarossa, S., 2020).

iv. Suicide

Although social ties are generally protective against loneliness, depression and suicide, social ties can be toxic and can amplify the risk of psychopathology in members of a social network (Christakis & Fowler, 2008). Exposure to the suicidal ideation or suicide attempts of significant others increases the risk of suicidality in other network members (Abrutyn & Mueller, 2014). Experiencing self-harm or suicide at close quarters may erode the emotionally regulating effects of normative moral precepts against such behaviour (Mueller, Abrutyn, & Stockton, 2015). When vulnerable individuals share "ecologically bounded spaces" (p. 205) like schools or the family home, this may increase suicide contagion if social relationships within those spaces are psychopathological. Our emotional connections to members of our social networks is the mechanism through which social learning and the development of normative behaviours and attitudes are built. However, negative emotions are more "contagious" and thus exert a greater impact on members (Turner, 2007).

Celebrity suicides also trigger spikes in suicide rates, with the greater visibility of the celebrity and prolonged coverage of the suicide triggering higher spikes and longer duration of elevation of rates of suicide amongst fans (Fu & Chan, 2013; Stack, 2005). Similarly, Durkheim (1951) highlighted the phenomenon of suicide outbreaks or "point clusters" defined as "temporally and geographically bounded clusters" such as gaols, regiments, monasteries, psychiatric wards, and First Nations reservations (Mueller et al., 2015, p. 206). Individuals in such networks share a collective identity that appears to heighten subsequent suicides following the suicide of the first decedent (Niedzwiedz, Haw, Hawton, & Platt, 2014).

A well-documented example of a suicide "echo" cluster (an identical suicide cluster occurring within 10 years of a first cluster) occurred in two high schools in Palo Alto that, between them, had suicide rates four to five times higher than the national average. In 2009, three students committed suicide in a nine-month period by stepping in front of a commuter train. A fourth student committed suicide by hanging. In 2013

a mental health survey showed that 12 percent of students from these schools had seriously considered suicide in the previous 12 months. Thereafter, there was another spate of suicides, with three students taking their lives within three weeks of each other. A fourth committed suicide four months later by jumping off a tall building and a fifth followed shortly afterwards by walking in front of a train. Extreme perfectionism and pressure to excel at school, get into Stanford, make a lot of money, and be ostentatiously successful materially and intellectually were assessed to be far too great a burden for the more vulnerable students to withstand.

Using the same data set as the study examining marijuana use but following up four waves of these participants into adulthood, Wave IV assessed suicidality in young adults aged 24-32. This study showed that holding all other psychological risks constant, those young people having a role model who attempted suicide were more than twice as likely to report suicidal ideation in the following 12 months. Participants who had a friend or family member commit suicide were 3.5 times more likely to attempt suicide themselves compared with those who had no close associate attempt or commit suicide in the same 12-month timeframe. These effects were enduring. Young adults who reported an attempted suicide of a role model were more than twice as likely to report a suicide attempt six years after the role model's attempt compared with their otherwise similar peers. Attempting suicide in adolescence increased suicidal ideation and suicide attempts in young adulthood. Significant risk factors for this association included experiencing emotional abuse in childhood, a diagnosis of depression, and a significant other attempting suicide. Thus, suicide contagion appears to be a significant risk factor for suicide in young adulthood but contagion in this study did not require bounded social contexts.

v. Gender dysphoria

Commentators on the burgeoning incidence of young people claiming that they are transgender assert that peer contagion may underlie this ominous trend. However, it has rarely been systematically studied either theoretically or empirically. Given the strong evidence of peer contagion in suicide, substance abuse and eating disorders, especially among adolescents, the role of peer contagion in gender dysphoria demands urgent attention.

If we examine the gender dysphoria epidemic in social network terms, we see several features operating. It is an open-system network with nodes and ties expanding across the oceans to the US, UK, Asia, Europe, Scandinavia, and Australia. Most countries are reporting sharp increases in the number of people seeking services and treatment for gender dysphoria. Many are ramping up services and setting up new gender clinics to cope with demand. This network is highly centralised with only one voice – the transactivist lobby - being heard above the desperate whispers of terrified parents and horrified academics, doctors, psychologists and psychotherapists. Opinion leaders operating at the centre of these networks are very influential. The level of density in a network has two effects – firstly, it enhances the circulation of information between members and secondly, it blocks the introduction of dissenting ideas and evidence (Iyengar, Van den Bulte, & Valente, 2011).

The field is too young to have attracted researchers to undertake social network analyses to assess peer contagion effects in gender dysphoria. Hence, formal empirical studies have not yet been conducted. However, there is evidence from several sources that peer contagion may be a relevant factor in the sharp increases in young people presenting with gender dysphoria.

(i) Low gender typicality, peer victimization, ingroups and the trans-lobby

Low gender typicality (i.e., perceived lack of fit within one's binary gender) has a significant impact on social acceptance within one's peer group (Sentse, Scholte, Salmivalli, & Voeten, 2007). It is strongly associated with adjustment difficulties, behavioural problems, lower self-esteem, and increased internalizing disorders (e.g., anxiety, depression) (Smith & Juvonen, 2017). As children progress to adolescence, peer as opposed to parental acceptance becomes paramount. Peers therefore take over the role of gender socializing agents from parents (Blakemore & Mills, 2014). Adolescent peers tend to be critical of behaviours, dress, mannerisms and attitudes that are not gender typical as a way of policing and reinforcing gender norms and respond with criticism, ridicule, exclusion and even intimidation of non-conformers (Zosuls, Andrews, Martin, England, & Field, 2016). Research shows that the problems accruing to low gender typicality are mediated by peer victimization and that reducing peer victimization

may ameliorate these difficulties (Smith & Juvonen, 2017). Conversely, peer acceptance mediated the self-worth of gender non-conforming 12- to 17- year-olds (Roberts, Rosario, Slopen, Calzo, & Austin, 2013). Gender non-conformity and gender atypicality have also been associated with higher physical and emotional abuse by caregivers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Mental health is difficult to sustain in the face of caregiver abuse and peer bullying and victimization (Aspenlieder, Buchanan, McDougall, & Sippola, 2009). Indeed, gender non-conforming and gender atypical youth are at higher risk of depression, anxiety and suicidality in adulthood (Alanko et al., 2009).

It is tempting to speculate that these groups of young people, searching for homophily (i.e. like peers) started to exaggerate their points of difference from their gender-conforming peers rather than to hide and minimize them to avoid being bullied and excluded. In so doing, they left the "outgroup" of nonconformers and formed an ingroup of extreme gender-nonconformers, transcending the gender barrier altogether and declaring themselves transgender. Suddenly, the discomfort and fear of not being gender typical becomes a virtue and rather than fearing the disapprobation of their peers, their open revolt in declaring themselves transgender is valorised by a politically powerful transactivist lobby. One would expect that gender atypical children who feel both internal and external pressure to be gender conforming would experience greater discomfort (Carver, Yunger, & Perry, 2003) and therefore be more susceptible to the message of trans activism.

Ingroups behave in stereotypical ways with respect to outgroups – they favour ingroup characteristics, assigning more positive attributes to its members and derogating outgroups in order to enhance the status of their ingroup (Leyens et al., 2000). It is not surprising, then, that members of the transgender ingroup exaggerate the characteristics of the "trans" gender they take on – becoming more "feminine" or "masculine" than heteronormative groups of cismen and ciswomen. Transactivist groups have proliferated and consolidated in a short time frame by exploiting the characteristics of ingroups and outgroups. For example, social projection (i.e., the belief that other members of the group are similar to oneself) has been a powerful integrating process that simultaneously creates protection for its own members and distance from outgroup members, using the formula, "if you are not with us, you are against us" – those disagreeing with the ideology of the trans-lobby are labelled "transphobic" and publicly denounced.

(ii) Rapid onset gender dysphoria (ROGD) and the role of social media

The upsurge in rapid onset gender dysphoria (ROGD) tends to occur mostly in girls at around the age of 14 years, which is an age identified by developmental psychologists to be particularly susceptible to peer influence (Steinberg & Monahan, 2007). For example, a study of peer contagion for risky behaviours found that exposure to risk-taking peers doubled the amount of risky behaviour in middle adolescents, increased it by 50% in older adolescents and young adults, and had no impact on adults (M. Gardner & Steinberg, 2005). This group of young people were likely to belong to peer groups in which one or more of their friends had become gender dysphoric or transgender-identified. Their coming-out announcement to parents also tended to be preceded by recent increases in their daughters' social media and internet usage. It is only a small step to understanding the social contagion of ROGD in this age group.

Lisa Littman (2019) canvassed the perceptions of parents who had children who displayed ROGD during or just after puberty. There were 256 respondents, of whom 83% had daughters, with a mean age of 15.2 years when they declared themselves transgender,41% of whom had previously expressed a non-heterosexual sexual orientation, and 62.5% of whom had received a diagnosis for a mental health disorder (e.g., anxiety, depression) or a neurodevelopmental disability (e.g., autism spectrum disorder). Thirty-seven percent (37%) of these young people belonged to peer groups with other members identifying as transgender. Parents also reported a decline in their child's mental health (47%) and relationship with parents (57%) after declaring themselves transgender. Thereafter, they preferred transgender friends, websites, and information coming from the transgender lobby.

An indicative case study was written up in an article for *The Atlantic* by Jesse Singal (2018), in which a 14-year-old girl decided she must be trans because she was uncomfortable with her body even after she restricted her food intake, was finding puberty uncomfortable, had difficulty making

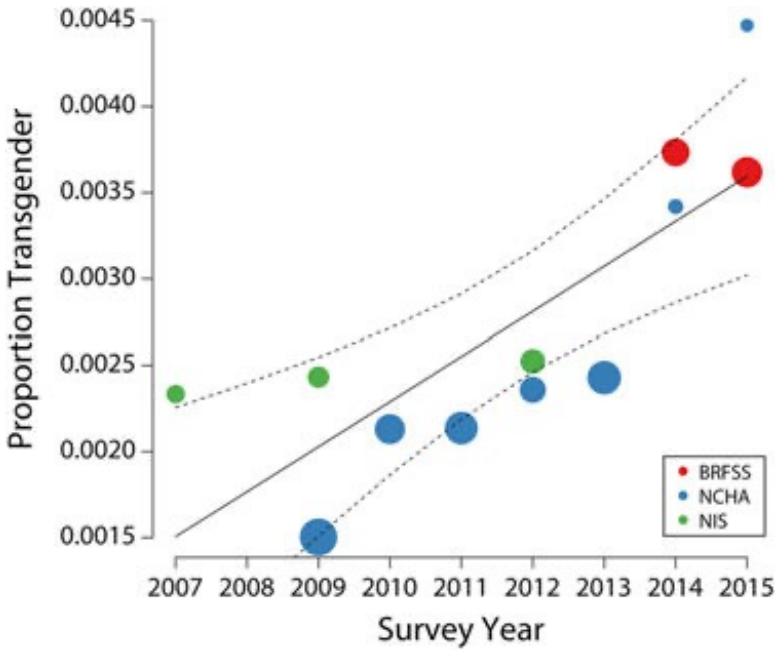
friends, was feeling depressed and was lacking in self-confidence. Against this backdrop of woes, she came across MilesChronicles, the website of an omnipotent and histrionic transboy, now a young transman. Watching this video resulted in Claire pouring all her sadness and unease about herself into the "realisation" that she was really a "guy." Miles made transitioning appear easy and simple, was effusive in his praise of his new self and supportive of others to follow suit. This is a very common scenario reported by parents of teenage girls with ROGD.

Such websites, all easily accessible to vulnerable adolescents, can have a very persuasive effect on viewers. Recent studies show that contagion is enhanced when the influencer is perceived to have high credibility and reduced when the influencer is perceived to have low credibility. A similar effect is observed if the influencer belongs to an out-group or an in-group (Andrews & Rapp, 2014). Miles is the quintessential trans pinup icon with a "You can be just like me if you transition!" message.

Following YouTube posts and social media with respect to the transgender debate over the past couple of years, I have noticed that posts that depict young people struggling with their gender identity or questioning their decision to take puberty blocking agents and cross-sex hormones, or to undergo what is euphemistically called sexual reassignment surgery are rapidly taken down so that only a homogenous message which matches the strident messaging of the transactivist lobby is on display in the ether.

Empirical evidence

There has been a sharp increase in the population estimates of those identifying as transgender. One study, a meta-regression of population-based probability samples provides compelling evidence of this trend, where estimates have more than doubled in the space of eight years from 2007 to 2015.



Source: Meerwijk, E. L., & Sevelius, J. M. (2017). Transgender population size in the United States: a meta-regression of population-based probability samples. American Journal of Public Health, 107(2), e1-e8. https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2016.303578

Figure 1: Similarly, upward trajectories of enrolments in GD clinics have been observed in the UK and Australia. Figure 2 summarizes the trends.

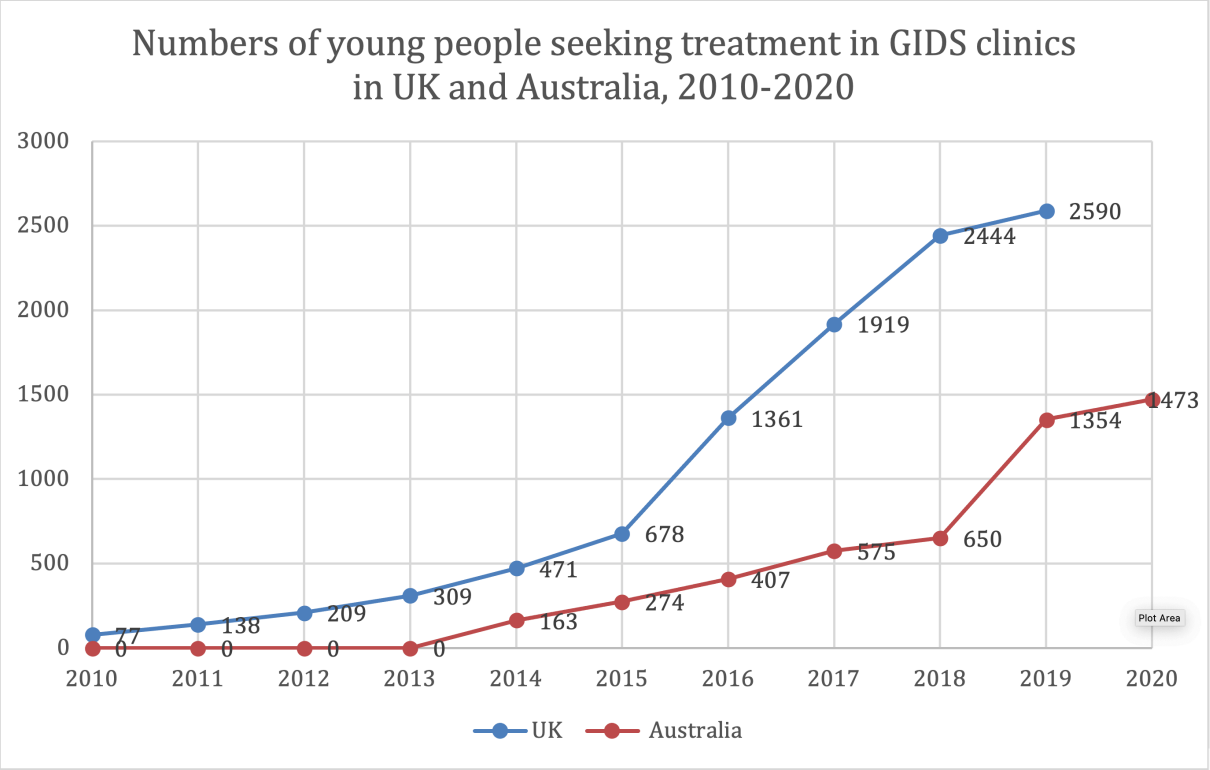


Figure 2 - Source: Kenny, D.T. (2021). Australian data provided by the gender clinics under freedom of information applications

Data from Australia (Figure 3) also show an upward trajectory in the number of children enrolled in gender clinics in the five states of Australia that offer a gender service over the period 2014-2020.

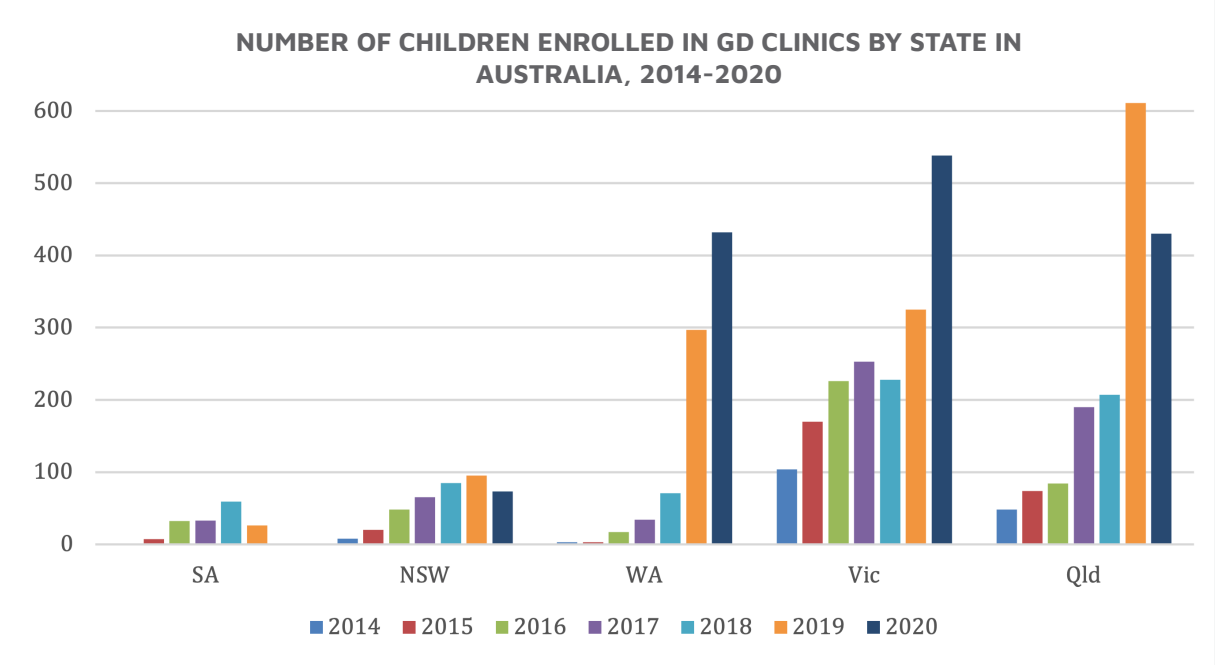


Figure 3 - Source: Kenny, D.T. (2021). Data provided by the gender clinics under freedom of information applications

The noteworthy feature of this graph is that three states (WA, Queensland and Victoria) show similar increases over the five-year study period (2014-2020), although Queensland showed a downturn in 2020. Although figures in NSW increased, the magnitude of absolute numbers was significantly lower than for the other states. Overall, Victoria had the largest numbers. It is also a state where the trans lobby has been particularly vocal, where the concept of the "safe schools" policy was conceived and implemented, and where the gender clinic at the Royal Children's Hospital, Melbourne has assumed the mantle of trailblazer in the gender transition enterprise.

Figure 4[5] shows the total number of young people taking puberty blockers and cross-sex hormones over the seven-year study period across Australia.

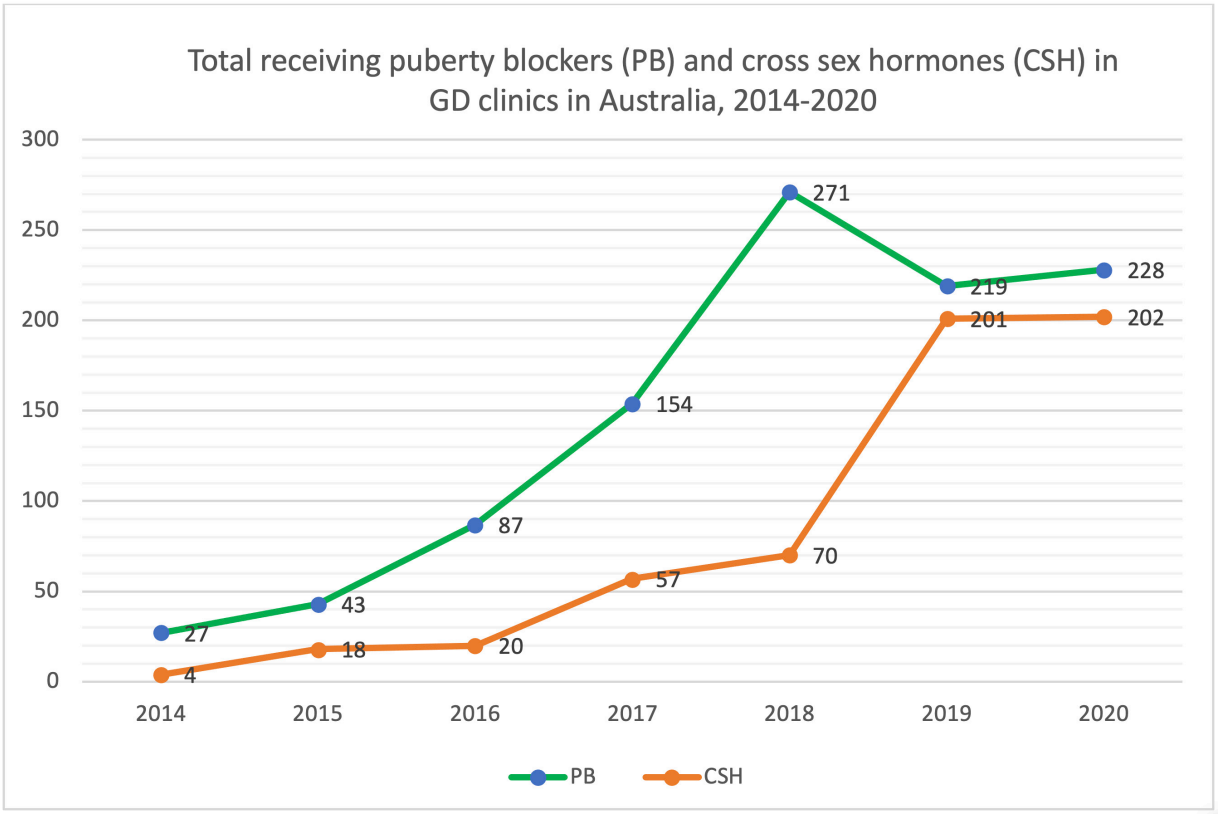


Figure 4 - Source: Kenny, D.T. (2021). Data provided by the gender clinics under freedom of information applications

Social contagion in treating practitioners, legislators, and educators

a. Treating medical practitioners

Iyengar, Van den Bulte, and Valente (2011) found contagion in the prescribing patterns of doctors after controlling for marketing outreach and systemic changes, such as the advent of new drugs and changes in the prevalence of diseases. Shared geographical proximity, shared group membership and self-identified ties between doctors were all factors in behavioural contagion, with self-identified ties the most compelling factor. A critical factor in marketing attempts to manipulate uptake of a new drug or medical treatment is the identification of those in the network who are influential and those

[5] NSW supplied "0" in each data cell for each of the seven years. A follow-up inquiry to Sydney Children's Hospital Network (Ref No: SCHN18/7854, 6/8/19) indicated "Sydney Children's Hospitals Network (SCHN) does not provide cross sex hormones at The Children's Hospital at Westmead. [O]ccasionally SCHN sees a patient in a crossover transition phase who has had stage two treatment initiated by an adult physician, as The Children's Hospital at Westmead pharmacy is still providing the patient's treatment in that crossover phase. However, their primary care at this stage is under the adult physician who prescribes the stage two therapy. The zero-response provided in the GIPA Notice of Decision is correct but that there may be instances in which children are receiving active stage 2 treatment elsewhere while still attending The Children's Hospital at Westmead clinic".

who are influenceable - without individual uptake, the marketing campaign will falter (Christakis & Fowler, 2011). Central figures in the network have a stronger tendency to adopt early. Of course, network contagion effects may be modified by product characteristics, for example, the perceived effectiveness and perceived safety of the new drug.

A few salient examples regarding government policy and legislation and changes in educational practice include the following:

b. Law and Legislation

Transgender activists in several countries have succeeded in persuading gender clinics to commence social transition in children as young as two and three years of age (e.g., Royal Children's Hospital, Melbourne, Australia), followed by the administration of puberty blockers at nine or 10 years of age. They have also been successful in lowering the age limit at which young people can access sex re-assignment surgery without parental consent. For example, in Oregon, USA the lower age limit for surgery has been removed with parental consent and lowered to 15 without parental consent (Medical Daily on parental consent). It is almost commonplace to read adolescent girls as young as 14 years undergoing double mastectomies (Rowe, 2016). Recently, a judge in Canada found a father potentially guilty of domestic violence if he continued to use his 14-year-old child's birth name and female pronouns. This child is petitioning the court to commence cross-sex hormones in the face of his father's strong objection (The Guardian on Canadian case). The lower court ruled that a minor is capable of giving consent to medical procedures. Accordingly, the child has commenced testosterone while the battle continues in the Court of Appeal.

Other legislative support for the transgender epidemic includes a bill allowing transgender people to change their birth certificates without undergoing sex-reassignment surgery (The Guardian on birth certificates). Titled the V*ictorian Births, Deaths and Marriages Registration Amendment Bill 2019*, (Victorian legislation). Under the legislation a person can self-nominate the sex listed as male, female or any other gender diverse or non-binary descriptor of their choice. Children can alter the sex on their birth certificate with parental support and a statement from a doctor or registered psychologist saying the decision is in the best interests of the child.

An article published by the Family Court of Australia (Family Court of Australia report) provides legal reasoning and argument regarding the disposition of gender dysphoria treatment for minors that outlines the limits of legal intervention in these cases, but which has been underpinned by current, often erroneous information about gender dysphoria. In r*e Kelvin*, the Royal Children's Hospital, Melbourne gave evidence that there was growing consensus regarding medical treatment of gender dysphoria and over-stating its positive outcomes but did not refer to the uncertainty and disagreement about treatment and outcomes outlined in the 2015 Dutch study.

Two *Amicus Briefs*, each supporting contrary arguments, were presented to the Supreme Court of the United States. They can be found at Amicus Brief 1 and Amicus Brief 2. The interested reader is invited to study both briefs and decide which of the two is more convincing.

c. Sport

The Australian Human Rights' Commission has provided guidelines about sports participation that clearly disadvantage natal females and which may well have a profound effect on female participation in sport (AHRC sport guidelines). It was written with the participation of peak sports' bodies including Coalition of Major Professional and Participation Sports (COMPS) and Sport Australia. The document purports a victory for "diversity and inclusion." The reality is that these guidelines neutralise the protections provided to females in the *Commonwealth Sex Discrimination Act*, 1984. A critique of the bill can be found at Critique of sport guidelines.

d. Education

The NSW Department of Education has issued a Bulletin (Bulletin 55 Transgender Students in Schools) that deprives parents of any rights in the management of their gender dysphoric child at school. Bulletin 20 even deprives parents of parental authority regarding the registered name of their child (Bulletin 20). It states,

If either or both parents object to the change to the way the first name is recorded by the school, the principal needs to make a decision about what is in the child's best interests. This decision should have regard to the age, capability and maturity of the student and can be informed by advice from a health care professional about the potential impact on the student's wellbeing of declining to use and record the student's preferred first name.

These guidelines undermine parental authority in the child's eyes, setting a dangerous precedent allowing children to make decisions about their wellbeing for which they are not prepared.

Conclusion

"All the world is queer save thee and me, and even thou art a little queer." When the Welsh reformer and philanthropist Robert Owen penned these words in 1771, the word "queer" meant "strange" or "different." The word "queer" is now an overarching term used to describe sexual and gender minorities. I wish to revert to the original meaning of this word in the context of this paper as it highlights yet another worrying psychic epidemic that has spread its tendrils into all corners of society – medical, social, legal, psychological, political, ideological and philosophical - with obscene haste. We still do not understand this phenomenon well. Parents are not exempt from these influences; there are numerous websites offering support to parents of transgender children (e.g. Transcend; Human Rights Campaign; Gender Centre; Gender Help for Parents).

By the time the proponents of gender dysphoria in children and adolescents realise the far-reaching damage they have caused by their unthinking political correctness in supporting gender affirmation, the courts will be clogged with lawsuits by transgender adults whose bodies and minds have been irreparably damaged by the zealous compliance with the strident voices of the trans lobby.

References

Abrutyn, S., & Mueller, A. S. (2014). Are suicidal behaviors contagious in adolescence? Using longitudinal data to examine suicide suggestion. American Sociological Review, 79(2), 211-227.

Alanko, K., Santtila, P., Witting, K., Varjonen, M., Jern, P., Johansson, A., . . . Kenneth Sandnabba, N. (2009). Psychiatric symptoms and same-sex sexual attraction and behavior in light of childhood gender atypical behavior and parental relationships. Journal of Sex Research, 46(5), 494-504.

Ali, M., Amialchuk, A., & Dwyer, D. (2011). The social contagion effect of marijuana use among adolescents. PloS one, 6(1), e16183. doi:10.1371/journal.pone.0016183

Ali, M., & Dwyer, D. (2010). Social network effects in alcohol consumption among adolescents. Addictive behaviors, 35(4), 337-342.

Allison, S., Warin, M., & Bastiampillai, T. (2014). Anorexia nervosa and social contagion: Clinical implications. Australian & New Zealand Journal of Psychiatry, 48(2), 116-120. doi:10.1177/0004867413502092

Andrews, J. J., & Rapp, D. N. (2014). Partner characteristics and social contagion: Does group composition matter? Applied Cognitive Psychology, 28(4), 505-517. doi:10.1002/acp.3024

Aspenlieder, L., Buchanan, C. M., McDougall, P., & Sippola, L. K. (2009). Gender nonconformity and peer victimization in pre-and early adolescence. International Journal of Developmental Science, 3(1), 3-16.

Blakemore, S.-J., & Mills, K. L. (2014). Is adolescence a sensitive period for sociocultural processing? Annual Review of Psychology, 65, 187-207.

Blanchet, K. (2013). How to facilitate social contagion? International Journal of Health Policy and Management, 1(3), 189-192. doi:10.15171/ijhpm.2013.35

Brown, R. C., Fischer, T., Goldwich, A. D., Keller, F., Young, R., & Plener, P. L. (2018). # cutting: Non-suicidal self-injury (NSSI) on Instagram. Psychological medicine, 48(2), 337-346.

Carver, P. R., Yunger, J. L., & Perry, D. G. (2003). Gender identity and adjustment in middle childhood. Sex Roles, 49(3), 95-109. doi:10.1023/a:1024423012063

Chen, C.-Y., Storr, C. L., & Anthony, J. C. (2009). Early-onset drug use and risk for drug dependence problems. Addictive behaviors, 34(3), 319-322.

Christakis, N., & Fowler, J. (2008). The collective dynamics of smoking in a large social network. New England journal of medicine, 358(21), 2249-2258.

Christakis, N., & Fowler, J. (2011). Contagion in prescribing behavior among networks of doctors. Marketing science, 30(2), 213-216.

Christakis, N., & Fowler, J. (2013). Social contagion theory: examining dynamic social networks and human behavior. Statistics In Medicine, 32(4), 556-577.

Clark, A. E., & Loheac, Y. (2007). "It wasn't me, it was them!" Social influence in risky behavior by adolescents. Journal of health economics, 26(4), 763-784.

Dishion, T. J., Nelson, S. E., Winter, C. E., & Bullock, B. M. (2004). Adolescent friendship as a dynamic system: Entropy and deviance in the etiology and course of male antisocial behavior. Journal of Abnormal Child Psychology, 32(6), 651-663.

Dishion, T. J., & Tipsord, J. M. (2011). Peer contagion in child and adolescent social and emotional development. Annual Review of Psychology, 62, 189-214.

Durkheim, E. (1951). Suicide: A study in sociology On Glencoe, IL: Free Press.(Original work published 1897).

Durkheim, E. (2005, 1897). Suicide: A study in sociology. London: Routledge.

Ellis, S., Rogoff, B., & Cromer, C. C. (1981). Age segregation in children's social interactions. Developmental Psychology, 17(4), 399.

Fagot, B., & Rodgers, C. (1998). Gender identity. Encyclopaedia of Mental Health, 2, 267-276.

Feierabend, S, Plankenhorn, T, Rathgeb, T (2015). Jim Studie (https://www.mpfs.de/fileadmin/files/Studien/JIM/2015/JIM_Studie_2015.pdf).

Fischer, T, Goldwich, AD, Haentzschel, O (2015). Instagram leaks. Neon 5, 16–21.

Fletcher, A., Bonell, C., & Hargreaves, J. (2008). School effects on young people's drug use: a systematic review of intervention and observational studies. Journal of Adolescent Health, 42(3), 209-220.

Fu, K.-w., & Chan, C. (2013). A study of the impact of thirteen celebrity suicides on subsequent suicide rates in South Korea from 2005 to 2009. PloS one, 8(1), e53870.

Fulcher, J. A., Dunbar, S., Orlando, E., Woodruff, S. J., & Santarossa, S. (2020). Selfharn on Instagram: understanding online communities surrounding non-suicidal self-injury through conversations and common properties among authors. Digital health, 6, 2055207620922389.

Gardner, M., & Steinberg, L. (2005). Peer influence on risk taking, risk preference, and risky decision making in adolescence and adulthood: An experimental study. Developmental Psychology, 41(4), 625.

Gardner, T. W., Dishion, T. J., & Connell, A. M. (2008). Adolescent self-regulation as resilience: Resistance to antisocial behavior within the deviant peer context. Journal of Abnormal Child Psychology, 36(2), 273-284.

Hankin, B. L., Stone, L., & Wright, P. A. (2010). Corumination, interpersonal stress generation, and internalizing symptoms: Accumulating effects and transactional influences in a multiwave study of adolescents. Development and Psychopathology, 22(1), 217-235.

Huefner, J., & Ringle, J. (2012). Examination of negative peer contagion in a residential care setting. Journal of child and family studies, 21(5), 807-815. doi:10.1007/s10826-011-9540-6

Iyengar, R., Van den Bulte, C., & Valente, T. W. (2011). Opinion leadership and social contagion in new product diffusion. Marketing Science, 30(2), 195-212.

Jarvi, S., Jackson, B., Swenson, L., & Crawford, H. (2013). The impact of social contagion on non-suicidal self-injury: A review of the literature. Archives of Suicide Research, 17(1), 1-19.

Leyens, J.-P., Paladino, P. M., Rodriguez-Torres, R., Vaes, J., Demoulin, S., Rodriguez-Perez, A., & Gaunt, R. (2000). The emotional side of prejudice: The attribution of secondary emotions to ingroups and outgroups. Personality and social psychology review, 4(2), 186-197.

Light, J. M., & Dishion, T. J. (2007). Early adolescent antisocial behavior and peer rejection: A dynamic test of a developmental process. New Directions for Child and Adolescent Development, 2007(118), 77-89.

Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs

Lloyd-Richardson, E. E., Perrine, N., Dierker, L., & Kelley, M. L. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. Psychological medicine, 37(8), 1183.of a rapid onset of gender dysphoria. PloS One, 14(3), e0214157.

Lundborg, P. (2006). Having the wrong friends? Peer effects in adolescent substance use. Journal of health economics, 25(2), 214-233.

Mackay, C. (2012). Extraordinary popular delusions and the madness of crowds, 1841: Simon and Schuster. http://www.econlib.org/library/Mackay/macEx1.html

Marchiano, L. (2017). Outbreak: On transgender teens and psychic epidemics. Psychological Perspectives, 60(3), 345-366. doi:10.1080/00332925.2017.1350804

Muehlenkamp, J. , Hoff , E. , Licht , J. , Azure , J. , & Hasenzahl , S. (2008). Rates of non-suicidal self-injury: A cross-sectional analysis of exposure. Current Psychology, 27, 234 – 241. doi: 10.1007/s12144-008-9036-8

Mueller, A. S., Abrutyn, S., & Stockton, C. (2015). Can social ties be harmful? Examining the spread of suicide in early adulthood. Sociological Perspectives, 58(2), 204-222. doi:10.1177/0731121414556544

Nathan, O. H., & Kristina, L. (2014). The simple rules of social contagion. Scientific Reports, 4. doi:10.1038/srep04343

Niedzwiedz, C., Haw, C., Hawton, K., & Platt, S. (2014). The definition and epidemiology of clusters of suicidal behavior: a systematic review. Suicide and Life Threatening Behavior, 44(5), 569-581.

Otte, E., & Rousseau, R. (2002). Social network analysis: a powerful strategy, also for the information sciences. Journal of information Science, 28(6), 441-453.

Patterson, G. R., Littman, R. A., & Bricker, W. (1967). Assertive behavior in children: A step toward a theory of aggression. Monographs of the Society for Research in Child Development, 32(5), iii-43.

Phillips, D. P. (1974). The influence of suggestion on suicide: Substantive and theoretical implications of the Werther effect. American Sociological Review, 39(3), 340-354.

Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., & Austin, S. B. (2012). Childhood gender nonconformity: A risk indicator for childhood abuse and posttraumatic stress in youth. Pediatrics, 129(3), 410.

Roberts, A. L., Rosario, M., Slopen, N., Calzo, J. P., & Austin, S. B. (2013). Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: an 11-year longitudinal study. Journal of the American Academy of Child & Adolescent Psychiatry, 52(2), 143-152.

Rowe, P. (2016, April 7). How a girl born at 2 pounds became a happy boy. San Diego Union Tribune. Retrieved from http://www.sandiegouniontribune.com/lifestyle/people/sdut-transgender-teensnew-life-2016apr07-story.html

Schwartz-Mette, R., & Rose, A. (2012). Co-rumination mediates contagion of internalizing symptoms within youths' friendships. Developmental Psychology, 48(5), 1355-1365. doi:10.1037/a0027484

Sentse, M., Scholte, R., Salmivalli, C., & Voeten, M. (2007). Person–group dissimilarity in involvement in bullying and its relation with social status. Journal of Abnormal Child Psychology, 35(6), 1009-1019.

Sijtsema, J. J., Veenstra, R., Lindenberg, S., & Salmivalli, C. (2009). Empirical test of bullies' status goals: Assessing direct goals, aggression, and prestige. Aggressive Behavior: Official Journal of the International Society for Research on Aggression, 35(1), 57-67.

Smith, D. S., & Juvonen, J. (2017). Do I fit in? Psychosocial ramifications of low gender typicality in early adolescence. Journal of Adolescence, 60, 161-170. doi:https://doi.org/10.1016/j.adolescence.2017.07.014

Stack, S. (2005). Suicide in the media: A quantitative review of studies based on nonfictional stories. Suicide and Life-Threatening Behavior, 35(2), 121-133.

Steinberg, L., & Monahan, K. C. (2007). Age differences in resistance to peer influence. Developmental Psychology, 43(6), 1531-1543. doi:10.1037/0012-1649.43.6.1531

Turner, J. H. (2007). Human emotions: A sociological theory. London: Routledge.

Zosuls, K. M., Andrews, N. C., Martin, C. L., England, D. E., & Field, R. D. (2016). Developmental changes in the link between gender typicality and peer victimization and exclusion. Sex Roles, 75(5-6), 243-256.

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Section 6: CALLS FOR A NATIONAL INQUIRY & OTHER SUBMISSIONS

Gender Transitioning and Responsible Responses

– Geoff Holloway (9th August 2019)

1. Introduction

Recently there have been big changes across the world with respect to the gender transitioning of children and adolescents. The American College of Paediatricians has declared that 'normalizing gender dysphoria is dangerous and unethical' – a view that is shared by the Association of American Physicians and Surgeons.[lxvii] [lxviii] In June this year the Royal College of General Practitioners in the UK pointed out that there is "a significant lack of evidence for treatments and interventions" and "a significant lack of robust, comprehensive evidence around the outcomes, side effects and unintended consequences of such treatments for people with gender dysphoria, particularly children and young people".[lxix]

Speaking out or daring to question the lack of robust, scientific evidence for transitioning regimes often comes at great personal cost for those who do so – they are frequently vilified and some have been removed from their employment.[lxx] [lxxi] [lxxii] This lack of debate is due to the physicians and mental health workers "bowing to pressure from 'highly politicised' transgender groups to affirm children's beliefs that they were born the wrong sex" according to Marcus Evans, a psychoanalyst and ex-governor of the Tavistock and Portman NHS Foundation Trust.[lxxiii]

It is as though evidence-based medicine has been suspended when it comes to gender dysphoria; objective criteria for diagnosis have been replaced by subjective declarations on the part of the patient as justification for a range of puberty blockers and hormonal interventions, which usually lead to surgical interventions. Gender affirming interventions are now commencing at a very young age (as young as four years of age). Surely this is a contravention of the primary ethos of medical practice – 'first, do no harm' - not to mention acting against 'the best interests of the child' (UN Convention on the Rights of the Child)?

There are four stages involved in transitioning: social transitioning, puberty blockers, hormone treatment and finally surgical intervention. Once social transitioning begins the pressure to continue 'all the way', i.e., medical intervention, slowly builds and dysphoria can become worse[lxxiv]. Those who transition have been shown to have rates of suicidal ideation up to 22 times higher than the general population according to a Canadian meta-study[lxxv].

There are a number of key elements to the issue of gender transition. They include -

a. lack of scientific diagnostic criteria for 'transgender' children and adolescents

b. the current trend to quickly diagnose and affirm children and adolescents as transgender, rather than following the 'wait and watch' approach – there is plenty of replicated research that shows 80-95% of children who experience cross-sex identification in childhood eventually desist and identify with their natal sex as adults[lxxvi]

c. similarly, the apparent dismissal of the fact that gender dysphoria for the majority of children and adolescents is resolved through the natural process of adolescent development

d. lack of evidence that transitioning resolves mental health and wellbeing issues in those who transition

e. the apparent adoption (if not promotion) of transgender ideology by prominent medical institutions such as the Royal Children's Hospital in Melbourne

f. lack of research into the long-term impacts of interventions; children undergoing transition interventions become medical patients for life, in the absence of any reliable long-term data

g. lack of research on children and adolescents who later de-transition (to the extent that it is possible); research shows that de-

transitioning typically occurs five years after transitioning[lxxvii]

h. lack of exploration of the social and cultural factors associated with gender dysphoria (e.g., gender dysphoria as a culture-bound syndrome)

i. contravention of children's rights - gender transitioning of children and adolescents is arguably a breach of children's rights under the UN Convention on the Rights of the Child

j. conflation of the terms 'sex' and 'gender' and obfuscation as to their meaning. Much of this can be traced back to post-modernist university 'gender studies', which are based on ideology, not science nor sociology

k. lack of recognition that no-one is born transgender – that it is not possible to be born into the 'wrong' body[lxxviii]. In other words, gender dysphoria is essentially a behavioral, socio-cultural construct with no scientific, biological foundation.

2. How is gender dysphoria diagnosed?

Correspondence published in *The Lancet*, Vol. 392, 8 December 2018, in response to an earlier *Lancet* editorial, noted that -

> *The health of transgender children is addressed with imprecise language and overplayed empirical evidence in new Australian guidelines (Royal Children's Hospital Melbourne. 'Australian standards of care and treatment guidelines for trans and gender diverse children and adolescents') and in an Editorial (June 30, p 2576). Sex has a biological basis, whereas gender is fundamentally a social expression. Thus, sex is not assigned—chromosomal sex is determined at conception and immutable. A newborn's phenotypic sex, established in utero, merely becomes apparent after birth, with intersex being a rare exception.*
>
> *Distress about gender identity must be taken seriously and support should be put in place for these children and young people, but the impacts of powerful, innovative interventions should be rigorously assessed. The evidence of medium-term benefit from hormonal treatment and puberty blockers is based on weak follow-up studies. The guideline does not consider longer-term effects, including the difficult issue of detransition. Patients need high quality research into the benefits and harms of all psychological, medical, and surgical treatments, as well as so-called wait-and-see strategies.*

How is gender dysphoria diagnosed? The recommended questions are as follows, according to the DSM-5 (American Psychiatric Association) -

In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months.*

1. *A strong desire to be of the other gender or an insistence that one is the other gender*
2. *A strong preference for wearing clothes typical of the opposite gender*
3. *A strong preference for cross-gender roles in make-believe play or fantasy play*
4. *A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender*
5. *A strong preference for playmates of the other gender*
6. *A strong rejection of toys, games and activities typical of one's assigned gender*
7. *A strong dislike of one's sexual anatomy*
8. *A strong desire for the physical sex characteristics that match one's experienced gender.*

** for adolescents just two criteria will suffice*

Surely no-one seriously considers these to be scientific diagnostic criteria? Well, yes, unfortunately they do, but there has been great uncertainty as to how to classify this ambiguous state of psycho-socio-cultural dis-ease. Until recently, gender dysphoria was classified as a mental illness, but now it has its own classification along with the unresolved ambiguity. In fact, gender dysphoria has all the characteristics of what is called a 'culture-bound syndrome'. The other factor to take into account with cases of 'gender dysphoria' is that they actually may be instances of the more general 'body dysphoria'[lxxix], and not gender related at all.

3. Gender dysphoria as a culture bound syndrome (GDS)

Gender Identity Dysphoria can be seen as a culture-bound syndrome. What usually constitutes a culture bound syndrome is a dis-ease that cannot be diagnosed by conventional Western medical

examinations because of its social, cultural and psychosomatic aspects – it is typically very difficult to reach a definitive diagnosis.

Examples of culture-bound syndromes include *susto*, anorexia nervosa, repetitive strain injury (RSI) and chronic fatigue syndrome (CFS). Rather than strictly medical issues, they can be seen as adaptive responses to normatively ambiguous social/cultural situations. I have conducted considerable research on *susto* and CFS. Medical anthropology and sociology, which I taught at Curtin University, are often relevant where there are ambiguities in health and illness diagnoses.

Gender Dysphoria Syndrome (GDS), as I prefer to call it, is a classic example of a culture-bound syndrome. Such syndromes defy the assignment of conventional explanations or meanings by both patients and physicians. There is a common misconception that such maladies are not related to social and cultural contexts, but their common element is anomie (Emile Durkheim) or alienation from the rest of society. It is not as though the afflicted person wants to be in their situation, but they feel they have no control or any other options (Holloway, 1994[lxxx]). In effect, they are de-normalized in a social sense, but to attempt to make their deviance from social norms somehow 'normal' would be a scientific deception.

> *The idea that trans identity is neurologically innate, set by laws of biology in utero, is one that can only come from a perspective that is blind to historical and anthropological realities. In some cultures, people who are outside the gender binary believe quite fully that they have chosen their gender path. In some, it's a choice made after the mid-point of one's life, while in others, puberty is when the issue is decided. What's more important is that in different cultures and times, the idea of gender identity and what it means to violate the gender binary and have a non-conforming identity is different.*
>
> *If the transgender identity phenomenon was, as many people have said (ad nauseam with arguments that sound way too much like people saying that men and women have different brains that explain their culturally-assigned differences), genetic/epigenetic and determined at/before birth, this would imply that the phenomenon of painful, debilitating dysphoria would manifest in this way throughout history and in many cultures. It doesn't. While there are gender non-conforming people throughout history, the near-obsessive, anxiety and depression provoking, dysphoric feeling that one's primary or secondary sex characteristics are "wrong" for one's brain is a phenomenon that isn't reflected in all history or cultures worldwide. It's culturally specific.*
>
> *A phenomenal amount of energy is devoted to telling people that their gender identity is brain-based and innate, and that there are "male and female brains".*[lxxxi]

What is much more likely to be the case is that sexual ambiguities/anxieties/ psychopathologies may be due to modernity and the disjuncture between faster physiological development compared with psychological/emotional development – as pointed out, through extensive research, by Professor George Patton -

> *Many brain changes take place during adolescence. Some precede and initiate puberty. Others continue for around a decade beyond. Yet gonadal hormones affect a wide range of neuronal processes: neurogenesis, dendritic growth, synapse formation and elimination, apoptosis, neuropeptide expression, and sensitivity of neurotransmitter receptors. Sex differences in brain development during puberty might reflect the different effects of male and female gonadal hormones.*[lxxxii]

Gender dysphoria and gender identity issues are due to a combination of factors, biological, social, cultural and economic, but to address these issues with medical acquiescence to any expressed desire by children or adolescents for gender change is at odds with what one has come to expect from the medical profession in terms of their duty of care.

Recent research shows that adolescents who experience rapid onset gender dysphoria are 83% female - 63% had been diagnosed with at least one pre-existing mental health disorder or neurodevelopmental disability and their parents reported further subjective declines in their teenager's mental health (47%) and parent-child relationships (57%) once they 'came out' as transgender. Transitioning is clearly not the answer to these problems.[lxxxiii]

4. How does the medical profession deal with GDS overseas?

Data from the UK show a massive and continuing increase in children seeking gender transition interventions - increasing among 13-year-olds by 30% in the year to April 2019 to 331, with 14-year-olds increasing 25% to 511, and 11-year-

olds by 28%, while the youngest patients were aged three[lxxxiv]. Also, there has been a continuing increase in numbers in Australia, as shown in Figure 1 below.

Meanwhile, in Sweden programs involving transitioning have come under ethical scrutiny by the Swedish National Council on Medical Ethics (SMER) -

> *According to the definition used by the National Council for Social Affairs [broadly speaking, the SE equivalent of NICE], gender dysphoria is a "condition of psychological suffering or reduced functional ability in everyday life that is caused by the perception that one's gender identity is not aligned with one's registered sex". In the past few years, the number of children and young people who turn to health care providers for assessment and treatment of gender dysphoria has increased dramatically. This increase is particularly large in girls. Similar developments can be seen in many high-income countries. Assessment and treatment of gender dysphoria in children and young people raises a number of difficult ethical questions. These concern the actual need, benefits, risks, agency, integrity and equitable access to healthcare, and how gaps in knowledge and understanding are addressed and managed.* (Professor Asplund, Chair of The National Council for Medical Ethics, 26 May 2019)

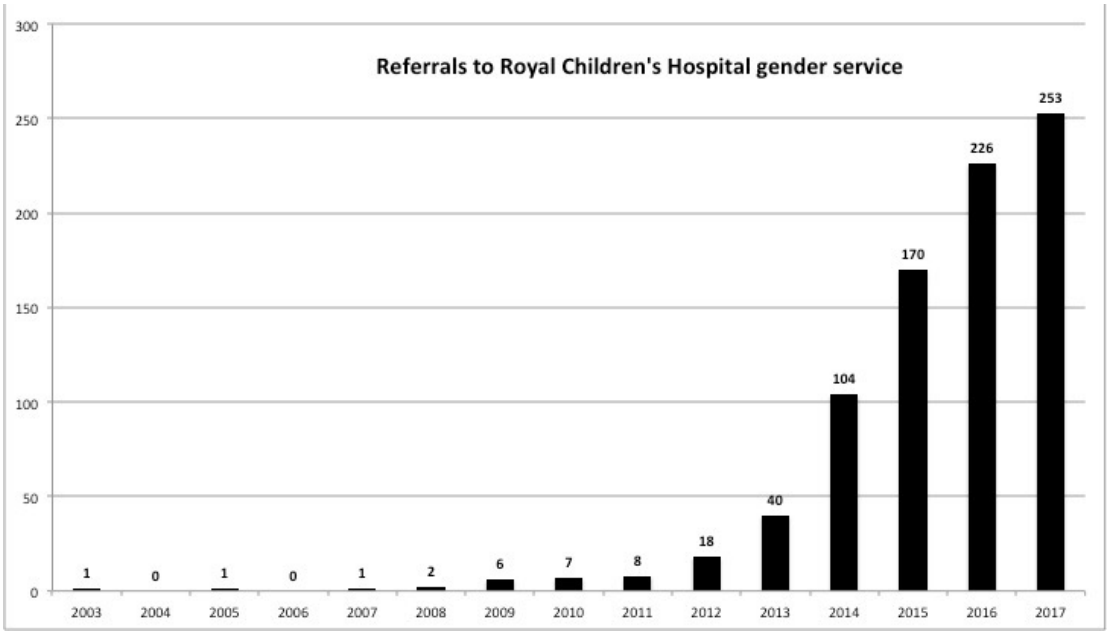
5. The impact of transgender ideology in Australia

Transgenderism is an ideology that has often been described as a cult, but perhaps it is better described as the result of social contagion, as follows -

> *The explosion of cases of gender dysphoria, previously an exceedingly rare condition, over the last few years has coincided with a meteoric increase in sympathetic attention to the topic in regular and social media—thus suggesting social contagion. Parents whose children "come out" as transgender when their friends do certainly agree with this explanation. (Robbins, 2019)*[lxxxv]

Gender dysphoria and sexual identity issues need to be dealt with using rigorous scientific evidence, not ideology. The RACP needs to thoroughly investigate these issues – otherwise, there could be an explosion of gender dysphoria across Australia, especially given recent legislative changes.

Figure 1. Referrals to Royal Children's Hospital Melbourne over time



Data source: ABC News - https://www.abc.net.au/news/2018-09-20/childhood-demand-for-biological-sex-change-surges-to-record/10240480

The increasing rate of transitioning among teenagers has been occurring in several developed countries, such as the UK, the USA and some European countries, and has been described as a 'psychic epidemic'[lxxxvi].

So, what does the Australian and New Zealand Professional Association for Transgender Health (ANZPATH) have to say about gender dysphoria? The Royal Children's Hospital in Melbourne has released a publication, the principal author of which is Dr. Michelle Telfer, the President of ANZPATH, titled *Australian Standards of Care and Treatment Guidelines For Trans and Gender Diverse Children and Adolescents*. These guidelines have many shortcomings, including -

a. The guidelines say, in relation to gender dysphoria, that "A study of the mental health of trans young people living in Australia found very high rates of ever being diagnosed with depression (74.6%), anxiety (72.2%), posttraumatic stress disorder (25.1%), a personality disorder (20.1%), psychosis (16.2%) or an eating disorder (22.7%). Furthermore 79.7% reported ever self-harming and 48.1% ever attempting suicide" - but the proposed treatment is 'psychological support' not assessment. Individuals who transition have higher rates of autism spectrum traits than the general population[lxxxvii] and more psychiatric co-morbidities[lxxxviii]. Further, and more importantly, people who proceed with gender transition also have high rates of depression, PTSD, suicidal thinking, et cetera. This is not mentioned in the Royal Children's Hospital document. There is also no mention of the increasing phenomenon of de-transitioning.

b. The bias inherent in the guidelines is clear in the statement - "Other psychiatric comorbidities such as depression, anxiety and psychosis may also increase the complexity associated with treatment and intervention decisions **but should not necessarily prevent medical transition in adolescents with gender dysphoria**" (emphasis added).

c. Surely the opposite would be required, that is, treat the psychological factors first, and then consider possible transition arrangements (if warranted). The assumption/premise implied in this document is that supporting transition is not only the best treatment but also the only treatment!

d. Australia's leading medical association, the Royal Australasian College of Physicians (RACP), which includes Australia's paediatricians, does not endorse it.

The RACP represents nearly 15,000 physicians and 6,530 trainee members across Australia and New Zealand. The RACP position is as follows -

> *The College does not have a formal position statement on gender dysphoria. However, the College supports access to best practice health care for individuals who identify as gender diverse or transgender, and improved access to publicly funded specialist outpatient health care in both paediatric and adult settings.* (received from the RACP, email 8 March 2019, responding to my email of 4 March 2019)

However, this leaves many unanswered questions, some of which I raised in my original email to the RACP (4 March 2019). They include the following -

1. Is there a policy that includes consideration of the 'best interests of the child' (as defined under the UN Convention on Rights of the Child)?
2. Does a child have to reach a certain age before gender change can be initiated by anyone in the medical profession?
3. Does the Australasian Chapter on Sexual Health Medicine (AChSHM) or the RACP treat gender dysphoria as a mental illness?
4. As standard policy, is there any psychiatric assessment of children wishing to undergo gender transition?
5. As standard policy, are there any social/psychological/cultural assessments of parents or carers who support or request the gender transition of any children under their care?
6. Is there any current research into gender dysphoria and its long-term psychological effects in Australia? Including children who later decide they would like to reverse the gender transition?

6. Is gender transitioning child abuse?

The impact of this ideologically driven practice on families is profound. Normalization of puberty blockers and hormone treatments to solve complex issues related to mental health and identity are

placing families, children and adolescents in difficult and painful situations without adequate guidance. The crises within families and the silencing of dissent ('no-platforming') are now being documented in Australia on the Women Speak Tasmania and the Trans Dissent Australia Facebook sites. Academics and others who dare to challenge the transgender orthodoxy are vilified.

The worst part of the unquestioning trend towards 'gender affirmation' along with the subjective wishes of patients, is that evidence-based medicine appears to have been suspended when it comes to treating a child or adolescent who presents as gender non-conforming.

7. Conclusions

Australia seems to be moving in the direction of accepting gender transitions without proper psychiatric evaluations under the guise of 'affirmation' responses, whereas overseas countries, such as England, are moving in the other direction due to –

a. a lack of scientific evaluation of the benefits of transitioning children and the long-term effects of the medications being used, and

b. gender affirmation of young children and adolescents with medical, hormonal and surgical interventions being seen as unethical and a form of child abuse (even though unintentional)[lxxxix].

While Australia hesitates to catch up with the rest of the world we recommend the following

1. Any physician or health-related staff involved in transitioning should be made accountable for the long-term consequences of their actions.
2. We need a much more in-depth and consultative process before continuing this social experiment of changing a child or adolescent's gender.
3. Gender dysphoria should be recognized as a real health and wellbeing issue and not passed off surreptitiously as having something to do with 'equality'.
4. No changes in gender should be supported, let alone promoted, before a child is at least 18 years of age. Below the age of 18 years the 'best interests of the child' should be the paramount consideration for medical practitioners.
5. Parents/carers should also be rigorously assessed when making decisions about the gender transition of children and adolescents.
6. The difference between sex and gender needs to be fully understood by medical practitioners and their patients. It should also be made clear to the general public, so that the obfuscation of these two concepts by the trans lobby is made apparent.
7. The Federal Government support for rebates on the medical interventions involved in gender transition should be suspended until scientific research has been conducted to resolve the issue of science versus ideology when it comes to the medicalization of gender dysphoria.
8. The Federal Government should initiate a scientific inquiry into the long-term consequences of gender transitioning through medical interventions.
9. The Federal Government should fully investigate the evidence base and current research associated with gender transitioning in order to protect any children and adolescents from further harm.

Letter to the Minister for Health

– John Whitehall

18th June 2020

Health Minister

Dear Minister,

We write to you in anticipation of what we understand will be discussion at the Australian Health Ministers' Advisory Council (AHMAC) meeting on 24th June on the significant matter of the treatment of children and adolescents experiencing gender dysphoria. We believe that it is not only appropriate, but necessary, indeed urgent that this matter be examined and considered by AHMAC. In terms of the key points that we wish to draw to your attention, we list them below as our Executive Summary:

1. We agree with some of the basic principles regarding the care of children and adolescents contained in the so-named document titled *Australian Standards of Care and Treatment Guidelines: For trans and gender diverse children and adolescents* (ASCTG) authored by The Royal Children's Hospital Gender Service, Melbourne including the need for 'respectful language' and especially, recognition of the Hippocratic Principle of 'First do no harm'.
2. However, we disagree over the management of children and adolescents experiencing gender dysphoria espoused by the so-named ASCTG.
3. We point to statistics that confirm that most gender confused children and adolescents will develop an identity congruent with chromosomes through puberty without the social and hormonal 'affirmation' described in the ASCTG.
4. We refer to past, international success with 'watchful waiting' management based on individual and family psychotherapy and psychiatry with consideration of associated mental co-morbidities and social disruption.
5. We deplore the condemnation of this non-invasive therapy as so-called 'conversion therapy' and object to what have been parliamentary initiatives to ban it, including criminalising it by legislative decree.
6. We are concerned about the lack of clinical evidence for the 'affirmation approach' and the existence of evidence of irreversible harm and damage that results from the use of puberty blockers, cross-sex hormones and surgery.
7. We deplore the interruption by hormonal therapy to the normal process of pubertal maturation, including socialisation and to its infliction of a lifetime of medical dependency.
8. We believe that major interventions with uncertain harms and damage on the basis of poor evidence and doubtful capacity regarding the provision of informed consent, amounts to medical experimentation.
9. We argue that 'informed consent' for lifetime intervention is not possible for children and adolescents, especially when deprived of knowledge regarding relevant complications.
10. We note the more cautious approach now being adopted by the UK Department of Health and Human Care. This follows litigation against the Tavistock Gender Identity Development Service that among other things is contesting the way in which the risks of harm were explained to patients (*R(ota) Mrs A, and Sue Evans v Tavistock and Portman NHS Foundation Trust*).
11. We warn that the experimental nature of 'affirmation therapy' with its withholding of publicised side effects renders Ministers of Health medico-legally vulnerable noting the High Court of Australia's ruling in *Rogers v Whitaker [1992] HCA 58*.
12. Therefore, we call for the establishment of an independent national inquiry into the management of child and adolescent gender dysphoria.
13. To this end, we have commenced developing new Australian Guidelines for the Management of Gender Dysphoric Children and Adolescents. We will be in a position to submit the new Australian Guidelines to an inquiry.

With respect to the treatment of children and adolescents experiencing gender dysphoria, we draw to your attention the alternative to 'affirmation therapy' which is now practiced by most gender clinics across Australia, based on the claim that gender identity is innate and immutable.

'Affirmation therapy' is based on the belief that a child or adolescent confused over their gender may best be served by the promotion of social identification with a gender incongruent with their chromosomes and by the application of hormone and surgical intervention in an attempt to align physical characteristics with mental concepts, all of which results in a lifelong dependency on medical care.

Although we would promote cautious and considered management that seeks to maintain accord between gender identity and chromosomes, we want you to know that we agree with some of the basic principles of caring for children and adolescents experiencing gender dysphoria that are enunciated in the so-named *Australian Standards of Care and Treatment Guidelines: For trans and gender diverse children and adolescents* authored by The Royal Children's Hospital Gender Service, Melbourne. However, we disagree over the management of children and adolescents experiencing gender dysphoria espoused by the so-named ASCTG.

We provide this letter to you to outline our concerns with respect to the current treatment programs being conducted in gender clinics across Australia for children and adolescents experiencing gender dyphoria. To this end, we have commenced developing new Australian Guidelines for the Management of Gender Dysphoric Children and Adolescents. We will be in a position to submit the new proposed Australian Guidelines to an inquiry.

Agreement with the *so-named Australian Standards of Care and Treatment Guidelines: For trans and gender diverse children and adolescents* authored by The Royal Children's Hospital Gender Service, Melbourne.

We agree with some of the basic principles regarding the care of children and adolescents contained in the so-named ASCTG. For example, we agree that 'Every child or adolescent who presents with concerns regarding their gender will have a unique clinical presentation and their own individual needs. The options for intervention that are appropriate for one person might not be helpful for another'.

We agree clinicians should use 'respectful' language and even more, extend compassionate and dedicated care to the affected children, adolescents and their families, in recognition of the distress being experienced by the patient.

We agree with the Hippocratic Principle to 'First do no harm' and with the emphasis by the so-named ASCTG that 'Avoiding harm is an important ethical consideration for health professionals when considering different options for medical and surgical intervention'.

We concur with the need to 'Consider socio-cultural factors' including recognition that 'Fear of experiencing stigma and discrimination by health professionals can be a barrier' and we are mindful of the need to 'Consider legal requirements' especially with regard to the growing phenomenon of 'detransitioners', some of whom have commenced litigation against institutions they believe did not offer and secure informed consent.

We agree with the so-named ASCTG for the need for 'Psychological support' because, if it is provided in 'a non-judgmental, safe and supportive environment for the child and their parents or caregivers (it) allows optimal outcomes from care provision'. Indeed, extension of psychological support is the basis of the new Australian Guidelines for the Management of Gender Dysphoric Children and Adolescents that we are developing.

We also agree with the recognition contained in the so-named ASCTG that 'Autism Spectrum Disorder (ASD) has been demonstrated to be associated with gender diversity' and that 'many children presenting to specialist gender services have co-existing ASD'.

We believe it is self-evident that 'When a child's medical, psychological and / or social circumstances are complicated by co-existing mental health difficulties, trauma, abuse, significantly impaired family functioning or learning or behavioural difficulties, a more intensive approach with input from a mental health clinician will be required. This form of psychological support should be undertaken by a skilled mental health clinician with expertise in child cognitive and emotional development as well as child psychopathology, and experience in working with children with gender diversity and gender dysphoria. This support requires an understanding of the child and their family through a comprehensive exploration of the child's developmental history, gender identity, emotional functioning, intellectual and educational functioning, peer and other

social relationships, family functioning as well as immediate and extended family support, in a safe and therapeutic environment'.

Thus in summary, we agree with the need for compassionate and skillful administration of psychological and social care to be extended to children and adolescents and their families caught up in the current explosion of gender confusion. We are all seriously concerned about this matter.

Disagreement with the so-named *Australian Standards of Care and Treatment Guidelines: For trans and gender diverse children and adolescents* authored by The Royal Children's Hospital Gender Service, Melbourne.

Fundamental to our disagreement is the ideology that maintains gender confusion in children and adolescents denotes an innate and immutable identification with a gender incongruent to chromosomes. We note that confusion is increasing in prevalence, perhaps reflecting amongst other factors the power of social media, but we are reassured by statistics that reveal the great majority of effected children and adolescents will mature, through puberty, to an identity congruent with their chromosomes.

In this sense we are much more optimistic than the authors of the so-named ASCTG. This optimism produces major disagreement with the management of childhood and adolescent gender dysphoria contained in the so-named ASCTG. We look to shorter periods of individual and family psychotherapy rather than a lifelong commitment to hormonal administration and medical dependency. We avoid all the side effects of hormonal and surgical intervention reported in the international literature, that we submit are not appropriately considered or explained in the so-named ASCTG.

Regarding more detailed information on disagreement with 'affirmative therapy', we refer to the two attached documents:

1. The submission to the Federal Minister for Health, the Hon. Greg Hunt MP by Dr John Whitehall titled *The lack of scientific basis for the medical pathway of treatment of childhood gender dysphoria*; and
2. An expert affidavit by Dr Stephen B. Levine, M.D. in a matter before the Circuit Court, State of Wisconsin, USA (Case No. 20-CV – 454).

In contrast to the now prevalent intervention with hormones and surgery and the attempt to align physical features with feelings, we point to the past success of what is termed 'watchful waiting' therapy. This is based on the compassionate and supportive care of needs explored in individual and family counselling, psychotherapy and psychiatry. This exploration extends from the particular problem of gender identity into the widespread association of gender confusion with mental co-morbidities and family disorder. It is not irrelevant that, in the history of paediatrics, insistence on association with a gender identity incongruent with chromosomes, may have been provoked by sexual abuse.

We note with dismay and concern that such 'non-affirming' therapy as 'watchful waiting' is now mistakenly condemned as 'conversion therapy' and as is being explored in Queensland with the *Health Legislation Amendments Bill 2019*, would be criminalised. The bill will criminalise failure to refer a gender confused child or adolescent to a clinic, other than one that offers 'affirmative therapy'. The proposed legislation contains penalties for up to 18 months imprisonment. The Victorian Government has publically announced that it intends to introduce into Parliament sometime this year similar draconian legislation.

With regard to management by 'watchful waiting', whereas there could be some latitude with temporary 'role play' with gender identity incongruent with chromosomes, full 'social affirmation' is considered dangerous because of its likelihood of leading to the next stages of affirmation, hormonal intervention and irreversible surgery.

We disagree with the assurance that the effect of puberty blockers is 'safe and reversible' and with the claim that blocking of the hormone Gonadotrophin Releasing Hormone (GnRH) will grant a confused child longer time for mature consideration of their gender identity. In particular:

1. We dispute that any child or even adolescent has the maturity to make such lifelong decisions.
2. We refer to long standing experimental research on animals that questions the argument that blockers can facilitate gender identity. They have been shown to damage the integrative limbic system and to block both central and peripheral centres for sexualisation. Reduction

in cognitive ability has been reported in association with blocking GnRH. Furthermore, a role for GnRH in the maintenance of neuronal integrity on the whole, has been strongly suggested. The side effects of blockers go far beyond their reported effect on bone density. Neutered by the blocking of the natural processes of sexualisation, held in the immaturity of early puberty, with impaired function of the integrative limbic system, used to the role of the opposite gender and under the sustained influence to maintain that role by authoritative figures and institutions, how can a child be expected to work out if they are a boy or a girl?

We disagree with the administration of cross-sex hormones to confused children and adolescents, noting the lack of supportive evidence and consideration of their effects on the brain, particularly the growing brain of adolescents. We note with alarm that the so-named ASCTG have no recommended age limits for this therapy, contrary to international guidelines and protocols. Therefore in Australia, cross-sex hormones can be initiated at the start of puberty when the brain, not only the body, is otherwise programmed for enormous change and development.

In accordance with the so-named ASCTG these cross-sex hormones may be initiated at puberty and continued for life, apparently with no reference to the international literature describing structural change to the exposed brain within a short period of time and no available research, whatsoever, on long term effects.

We disagree with the practice of mastectomies in confused female adolescents and are astonished by assertions (e.g. in Family Court of Australia judgements) that such surgery is justified because it is 'reversible'. We do not agree that the human breast can be reduced to a cosmetic appendage based on the shape of a silicon sac. We deplore such destruction of healthy human tissue.

We disagree with the claims that 'affirmation therapy' prevents self-harm. There is no evidence, per se, that gender dysphoria leads to suicide. We do acknowledge the need for the special care of gender confused children and adolescents. It is noted that associated mental and social disorders are known to be related to a higher risk of self-harm. Contrary to the prevention of suicide, we note reports that full affirmation in adults is associated with a much higher rate of suicide than in the general population.

Given contrary laboratory studies on animals, lack of physiological plausibility, lack of evidence for positive results of hormonal 'affirmation', the presence of serious and lasting but undeclared side effects on the brain and the statistical evidence that confused youth will mature without such intervention, we condemn hormonal and surgical affirmation as experimental. We refer you to the various Standards for Ethical Practice and Experimentation that were developed following World War 2 arising from the egregious examples of experimental abuse on humans. It is our view that 'affirmation therapy' does not meet those various Standards for Ethical Practice and Experimentation.

It is our view that the fundamental question is whether these experimental procedures are acceptable without providing recognition of any other established alternatives e.g. developed programs for psychotherapy which is the basis for the 'watchful waiting' approach. Furthermore, should governments effectively legislate for hormonal and surgical intervention, proscribing therapy based on the professions of psychology and psychiatry?

We believe there is an urgent need for an independent national inquiry into the management of child and adolescent gender dysphoria in Australia. In our view it should comprise of scientists capable of analyzing and interpreting data, veterinarians capable of interpreting physiological research on animals, physicians, ethicists and legal experts. To avoid conflicts of interest, individuals appointed to the inquiry committee should not themselves be involved in managing or working at any existing gender clinic.

In conclusion can we thank you for taking the time to read our letter. We wish you all well in your deliberations over this most important matter at the AHMAC meeting next Wednesday.

Yours sincerely,

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Tasmania's Gender Confused Parliament

– Patrick Parkinson (first published in Quadrant April 2021)

Probably few Tasmanian voters going to the polls on May 1st 2021 will be aware that their recently dissolved Parliament was responsible for some of the most radical (and incoherent) legislation in the world concerning gender issues. Remarkably, it was passed from opposition by Labor and Greens MPs in 2019. It was supported in the Legislative Assembly by the Speaker, Sue Hickey, a member of the Liberal Party at that time, who voted against the position of the Government. The changes were also supported in the Legislative Council by a sufficient number of independents.

The legislation incorporated certain unscientific ideas that have become fashionable amongst gender studies scholars in the United States and elsewhere, without thinking through all the legal consequences. The result is that the Tasmanian statute book now has a serious problem of inconsistency and incoherence when it comes to the meanings given to such basic terms as sex, gender and being male or female. The election of

a new Parliament will give an opportunity for the new Parliament to fix the problems and to restore coherence to the law.

Background

The legislation concerned was the *Justice and Related Legislation (Marriage and Gender Amendments) Act 2019* . It allows a person 16 years or older to register 'a gender' which has the effect of amending the birth register, and for parents to do so for a child under 16. The application must be accompanied by a "gender declaration". This is a statutory declaration in which the person declares that he or she identifies as being of the gender specified and lives, or seeks to live, as a person of that gender.

The choices of gender identification are not limited to male and female. The registered gender could be an 'indeterminate gender'; or 'non-binary'; or 'a word, or a phrase that is used to indicate a person's perception that they are neither entirely male nor female. The term used must bear some relationship to the idea that a person may consider themselves to be something other than male or female. The Registrar has a discretion to decline to record a term proposed. Subject to this limitation, an applicant may be as creative in their description of their gender identity as in their choice of name.

Similar legislation allowing for people to register their choice of gender identity was also passed in Victoria in 2019. It allows for changes to birth certificates on the basis of self-identification as another sex. Like in Tasmania, the choices are not confined to male and female. A person could use any sex descriptor that is not obscene, offensive, or that could not practically be established by repute or usage.

In both Tasmania and Victoria, it is possible to

change registered gender again after 12 months have elapsed. Gender, in these two states, is not just fluid. It can be transient. Notwithstanding this transience, the registration of a new gender identity displaces sex on the birth certificate.

The problem of sex reassignment surgery

In the parliamentary debate in Tasmania, the main stated goal of the amendments was to allow the very small number of Tasmanians who identify as transgender to record a change of gender without the necessity of going through sexual reassignment surgery. Prior to 2019, evidence of sexual reassignment surgery was needed for legal recognition. An application to register a change of sex had to be accompanied by a statutory declaration from two medical practitioners verifying that the person had undergone sexual reassignment surgery.

Sexual reassignment surgery is one option – but only one – for treating gender dysphoria, which is the suffering that arises from the incongruence between natal sex and gender identity. This distressing condition has long been known to the medical profession. There are those who have found relief and better health through medically-assisted transition to another gender presentation. That may involve a combination of cross-sex hormones (which must be taken for life) and surgeries. This is not necessarily an antidote to psychological distress. Suicide rates and mental health problems of transexuals after transition remain very high.

Sexual reassignment surgery can have significant complications.Giving transgender people a way of achieving a legally recognised status without having to undergo such major changes to their bodies was a laudable goal. No doubt for this reason, the amendments attracted sympathetic support from parliamentarians.

However, the legal changes brought about by the legislation went very far beyond this. They embedded in Tasmanian law beliefs that are held by only a small minority of people, albeit that the voices of those people exercise an influence disproportionate to their numbers in the media, universities and school education departments.

To illustrate how radical the changes to Tasmanian law were, a good starting place is to examine what happens now if a Tasmanian applies for a birth certificate. That ought to be a fairly straightforward issue. However, to understand the current law in Tasmania requires descending down a deep rabbit hole, guided by a dictionary to interpret the new meanings given to the terms 'sex' and 'gender'. Essentially, sex is a matter of anatomy and reproductive capacity, while gender is a state of mind.

Birth certificates in Tasmania

Registration of a birth in Tasmania is usually done by the hospital or a medical professional. Parents may also complete the registration by completing an online form which asks various questions. One of the questions is about the sex of the child. There are only two choices: male or female. All questions must be answered. The process is very simple.

By way of contrast, getting a birth certificate is the zenith of complexity. Applicants are offered a smorgasbord of options that must be bewildering to many people. The form helpfully lists them all. There is "birth certificate including all registered gender and name change details (if any)"; "birth certificate with current gender only"; "birth certificate with current gender and details of registered name changes (no gender history)"; "birth certificate with all registered gender details but no details of registered name changes"; "birth certificate without gender and no details of registered name changes"; and finally "birth certificate without gender with details of registered name changes". In the last two options, the words "without gender" are underlined for emphasis. There are also decorative options for commemorative birth certificates. Each of them has an option not to show the gender of the child.

Fortunately, the Government has made the choice between these options a little clearer by having "birth certificate including all registered gender and name change details (if any)" as the first option, and one which is recommended for evidence of identity. The remainder are given as alternative choices to that option.

Amongst the smorgasbord of choices with which the parent is presented, there is no option to indicate the child's sex, even though this was what the parent was asked about when registering the child. At the time of birth registration, the Government wants to know about biological sex; but when it comes to birth certificates, it only recognises something called 'gender'. This is curious because

the Government's birth certificate website states:

A birth certificate is an official, certified copy of the birth registration details held by Births, Deaths and Marriages.

Clearly it is not, for the applicant is not permitted to receive a birth certificate which has the same details as were registered, including sex. This would be a mere semantic quibble, if 'sex' and 'gender' were synonymous. However, as Tasmanian law now stands, they are not.

The Labor/Greens parliamentary coup

The legislation was embroiled in controversy in its passage through Parliament. In its original form it was the *Justice and Related Legislation (Marriage Amendments) Bill 2018*. It proposed a number of amendments to various Tasmanian Acts as a consequence of the federal legislation allowing same-sex marriage. These were minor and uncontroversial amendments to laws that removed inconsistencies between Tasmanian law and the Commonwealth law as it stood after the changes to the *Marriage Act*. One of the Acts to be amended was the *Births, Deaths and Marriages Registration Act*, which had provided that an applicant seeking to register a sex change could not be married (this, in law, creating in effect a same-sex marriage). The Bill proposed to delete that constraint.

The Labor and Green parties moved substantial amendments to the Bill to introduce wholesale changes to the part of the *Registration Act* concerned with registering sex changes. The Speaker voted with Labor and the Greens to allow debate on the amendments, notwithstanding that this almost certainly breached well-established rules for the conduct of Parliaments within the Westminster tradition. It is not open to members of Parliament to move any amendments to a Bill. Amendments must be within the scope and purpose of the Bill. It is very difficult to see how the Labor/Green amendments could have satisfied this test.

The extensive changes passed the Lower House and then went to the Legislative Council where some further amendments were made before the legislation passed.

How many people have registered a gender?

These provisions came into effect on September 5th 2019. Statistics obtained through freedom of information indicate that 95 people aged 16 years or over had registered a gender by April 16th 2021, that is, more than 18 months later. Seventeen children under 16 had a gender registered for them by a parent or parents. 31 people took, or were given, a male identity, 66 a female identity and 13 chose to describe themselves as non-binary (or were described as such by parents). Two chose a gender identity that was neither male, female nor non-binary.

The number of people over 16 who have registered a gender constitutes 0.0175% of the Tasmanian population. This is broadly consistent with expected prevalence of transgender identification internationally. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (5th ed, 2013) estimates rates of gender dysphoria for biological adult males at 0.005% to 0.014% of the population, and for biological females, from 0.002% to 0.003%, but there are differences in prevalence rates between countries. The DSM does not provide data on those who identify as non-binary, probably because this is such a novel concept.

The exclusion of gender from birth certificates

The smorgasbord of different options for what is included on a birth certificate in Tasmania is the consequence of s.46, which originally contained just 66 words. Illustrating the extraordinary capacity of the drafters of these amendments to make mountains out of molehills, the amended version of s.46 runs to ten subsections and contains a total of 1033 words.

The legislation discourages the inclusion of the category of gender on the birth certificate. Gender cannot be included unless the applicant specifically requests this. This prohibition may seem very odd. It is one thing to assist a very small number of transgender Tasmanians to register a different gender identity without having to go through surgery; it is quite another to dictate to all Tasmanians that sex at birth should not be included on a birth certificate unless they specifically request that. This was a change to the law affecting the 99.9% of the population who do not identify as intersex or transgender. The needs of the small minority could have been satisfied simply either by being able to request a birth certificate without a record of sex at birth or to have one with their recognised gender identity.

The belief system of the new transgenderism

The legislation is underpinned by a range of beliefs that are novel and in radical discontinuity with the previous consensus on how transgender identification should be understood. For the most part, these beliefs can neither be validated nor falsified by science.

The first of these beliefs (which is at least consistent with prior understandings of transgenderism) is that those who identify as transgender were born that way – hence a change of gender identification requires a change to the birth certificate. This widely-held belief is not, at this stage, well-supported by evidence. Some are confident of a biological cause, without being able to offer an explanation for it. However, research has thus far failed to identify a physiological basis for transgender identification. It may be that a genetic or hormonal explanation for some transgender identification will eventually be found, but so far it has eluded researchers.

There is, nonetheless, a lot of evidence that at least some of the young people now being referred to gender clinics are suffering from multiple mental health issues which cannot only be explained as being a consequence of discrimination or depression about their gender identity. These adolescents are many times more likely than young people in the general population to be on the autism spectrum. Gender dysphoria has been found to co-exist with attention deficit disorders and eating disorders. Adolescents identifying as transgender or gender diverse also report significantly higher rates of childhood sexual abuse. Recent new evidence from clinicians based at Westmead Children's Hospital indicates strong associations between gender dysphoria and disordered attachments to parents, as well as unresolved loss or other adverse childhood experiences, including abuse and neglect. There is also evidence that teenage girls in particular may identify as transgender as a result of peer and social media influences without any history of a divergent gender identity earlier in childhood.

Given the lack of clear scientific evidence for the idea that all those who identify as transgender were born with this condition, and the strong evidence that mental health issues and adverse childhood experiences play a part, it is unwise to pass legislation that assumes that the record of birth is in some way defective. Dealing with gender identity issues by making changes to birth certificates falsifies the historic record and embraces an unproven theory of causation. It also posits a single explanation for all transgender identification when there may be multiple causes.

The second belief is that gender identity is a matter of internal discovery, and rests entirely upon self-identification. Prior to someone being old enough to make such a self-identification, the designation of a child's sex as either male or female is believed to be provisional at best. In the academic literature, researchers often talk of sex being "assigned at birth", as if it represented a judgment call. An English charity, the Gender Identity Research & Education Society, seeks to communicate to young children the idea that gender has to be discovered through a penguin story. The penguin parent tells the infant: 'We can't always tell if you're a boy or a girl'. The parents encourages the infant penguin to tell them when the infant is ready. The idea that gender identity is something to be discerned within is something akin to the religious idea of a 'soul' that is somehow distinct from the body.

The third belief is that what really matters to a person is not their sex, but their gender identity, because that defines who they *really* are. It follows that they should be entitled to change their birth certificate and other official records to align those records with their gender identity. Because their gender is who they really are, trans females are really females and should be permitted to play in women's sports teams and competitions, and to use female changing rooms and other facilities, irrespective of whether they have had surgery to transition to a female physical presentation.

This is not necessarily a claim that transgender people make for themselves. In a large French study, researchers found that only 75% of those who had undergone sex reassignment surgery considered that they had made a complete transition across the binary divide to become a person of the identified gender. Furthermore, there is a degree of artificiality in this claim to be of the identified gender for all intents and purposes. Doctors, after all, need to treat their patients, where relevant, in accordance with their chromosomal and physiological sex, not their gender identity. Trans females will never need a hysterectomy, and trans males will never need a prostate exam.

The fourth belief is that self-identified gender represents the higher truth, displacing

chromosomes and reproductive capacity as definitional to what it means to be male or female. It follows that men can have babies. Thus, the Tasmanian legislation makes clear that any reference to the pregnancy of a female includes the pregnancy of a person of another gender and similarly clarifies that a person of another gender who carries a child in the "person's female reproductive tract", or who gave birth, is the mother, subject to the operation of surrogacy laws.

The fifth belief is that because gender identity is a matter of personal discovery, there is no need for medical diagnosis. Hitherto, transgender identification has been understood to be a medically diagnosable disorder. Prior to its most recent edition, the DSM, a primary reference source for psychiatrists, referred to the problem as a 'gender identity disorder'. A clear statement of the new ideology can be found in the Yogyakarta Principles, drawn up by some non-government human rights specialists in 2006. Principle 3 states that no-one should be forced to undergo medical procedures as a requirement for legal recognition of their gender identity - not even cross-hormone therapy. Principle 18 explains that a person's gender identity is not, per se, a medical condition that needs to be treated. This idea is embedded in the Tasmanian legislation. The Registrar for Births, Deaths and Marriages is forbidden from requiring "a medical certificate, or other medical document, in relation to the sex, sexual characteristics or gender of the person".

The sixth belief of this new transgenderism is that gender identity need be neither male nor female. Hitherto, those who identified as transsexual or transgender understood themselves within the context of the male-female gender divide. They identified as 'trans male', 'trans female', MtF, or FtM. Now, male and female are only two choices amongst many. People may be non-binary, or agender, or pangender, or genderqueer, amongst other descriptors that keep proliferating. None of these identities has an anatomical presentation, so this view of transgenderism is entirely disconnected from the notion that through sexual reassignment surgery, a person may be assisted to cross the binary divide from male to female or vice-versa.

This idea that there are multiple genders is reflected in the Tasmanian legislation, which gives people a large amount of choice about how to describe their gender. Just in case applicants need some ideas on what gender to call themselves, the relevant application form to register a gender offers the following as examples: Transgender, Transsexual, Bigender, and Agender.

The seventh belief is that because gender is something that can only be determined in the most provisional way at birth, it should not be on the birth certificate. Indeed, some argue that to do so is harmful to transgender and those with intersex conditions. There is a valid argument here in relation to those very rare cases where a child is born with a mixture of male and female reproductive organs or otherwise ambiguous genitalia. In the current Tasmanian law, there is no option to register a newborn as being intersex, nor to omit biological sex from the registration.

However, the argument made for omitting any reference to birth certificates is put on a much broader basis than just providing for those rare cases of what used to be called hermaphroditism. The Australian Feminist Law Journal, in 2019, published an article that argued that legally assigning a gender or sex after birth has "intrinsically violent" effects on bodies. The solution proposed was to avoid any public registration of gender or sex.

That position is supported by the non-government human rights experts who authored the Yogyakarta Principles Plus 10, drawn up in 2017. Principle 31 recommends that states take action to "end the registration of the sex and gender of the person in identity documents such as birth certificates, identification cards, passports and driver licences, and as part of their legal personality." The position has even been advanced in the pages of the prestigious *New England Journal of Medicine*.

The legal effect of a registered change of gender

One of the major problems with the Tasmanian legislation is that no-one seems to have thought through the impact of these changes on the rest of the statute book.

When the 2001 amendments were passed, allowing for a change of registered gender for those who had had sex reassignment surgery, the legislation provided:

Where a person's change of sex is registered under this Part, the person is, for the purposes of, but subject to, any law in force in this State, a person of

the sex as so changed.

Similar provisions exist in other jurisdictions. They have not caused controversy. They are an appropriate recognition of those who have gone through major changes in their bodies in order to pass as the opposite sex so far as possible.

The radical amendments to the legislation in 2019 left this section of the Act unchanged, except to substitute the word 'gender' for 'sex'. The effect is that if a person registers a gender as non-binary, then for the purposes of Tasmanian law, they are non-binary. Their sex, as recorded on their birth certificate, is no more. Theirs is an altered legal state.

The same is true in the Victorian legislation, except it uses the term 'acknowledgement of sex', for the process of registering a new gender identity; so a person who declares themselves non-binary has had, in law, a sex change.

The problem with the Tasmanian legislation is that it begins from the premise that sex and gender are different, and then concludes that gender is the same as sex once someone fills in a form which is accepted by the Registrar of Births, Deaths and Marriages. Through an application to an administrator without more, a person can, in essence, change their sex for legal purposes in Tasmanian law.

When does natal sex still apply?

This recognition of a new gender identity is subject to any laws to the contrary. The question arises when Tasmanian laws will have this effect. Most of the laws on the statute book, were of course, passed by the Parliament at a time when no-one had any concept that a person could be neither male nor female. Even those with atypical chromosomes or other disorders of sex development were classified, for legal purposes, as either male or female.

There is now no consistency in Tasmanian law on the meaning of 'gender'. One example where 'gender' clearly means biological sex is in the *Anti-Discrimination Act*. Ever since it was originally enacted in 1998, as the Tasmania Law Reform Institute notes, the Act has used the word 'gender' rather than 'sex' as the relevant attribute in relation to which discrimination is prohibited. Section 27 of the *Anti-Discrimination Act*, for example, creates various exemptions to the prohibition of gender discrimination, including allowing for single 'gender' schools. In this context, gender is clearly synonymous with biological sex. Consistently with this, the guidance provided by Tasmania's Equal Opportunity Commission uses the terms 'gender' and 'sex' interchangeably.

It follows that in the *Anti-Discrimination Act*, gender is binary in character (that is, either male or female). Gender identity is different. A single sex girls' school in Tasmania will not be in breach of anti-discrimination law in Tasmania if it rejects an application from a natal male who is registered as female by his parents. The school treats all natal males equally, irrespective of their gender identity, by not permitting any of them to enrol in the school. Similarly, the manager of the public swimming pool (subject to any relevant Council policies) would not be in breach of anti-discrimination law by refusing to allow a person with a male physique to use the female changing facilities. This is because the Anti-Discrimination Act allows discrimination on the basis of gender "in the provision or use of facilities, if those facilities are reasonably required for use by persons of one gender only." There is no obligation to include self-identified females aged 12 or over who are anatomically male in female competitive sports either, because such differentiation is lawful under s.29 of the Act.

The position in relation to other laws is far less clear, particularly for those who register their gender as non-binary. Numerous statutes are drafted with an understanding that sex may be either male or female. An illustration is the *Forensic Procedures Act* 2000 (Tas.), s.45 which refers to a police officer of the 'opposite sex'. The definition of relationship status in the *Surrogacy Act 2012* (Tas.), s.4 refers to "a sexual partner of another person of either sex". Section 30 of the *Misuse of Drugs Act 2001* (Tas.), concerning strip searches, contemplates that police officers may be either male or female. The *Environmental Management and Pollution Control Act* 1994, s.13A(2) requires that the Board of the Environment Protection Authority include at least one person of each sex. The *Education Act* 2016 (Tas.) ss. 229 and 241 refers to the desirability of certain Boards having representatives of 'both sexes'.

Inevitably, police officers, government administrators, lawyers and courts will be required to fall back on the biological categories of male and female in order to apply the law sensibly, notwithstanding the 2019 legislation which recognises different kinds of self-identified gender.

The Tasmania Law Reform Institute has proposed various changes to the statute book to bring it into conformity with the 2019 legislation, but glosses over the many difficulties that arise from the acceptance that self-identified gender can have legal effects other than for the purposes of an official gender recognition document. For example, it notes that the Tasmania Prison Service has a Standing Order on Transgender, Transsexual and Intersex Prisoners to the effect that prisoners will be managed according to the gender with which they identify. This is possible if sex and gender are understood as binary, but makes no sense once one accepts that legally, a person may be non-binary. It is hardly a good use of public money for Tasmania to develop new prisons, or wings of prisons, for the small number of prisoners who identify as neither male nor female. Common sense suggests that prison facilities be operated in accordance with anatomical sex, not gender, especially given the possibility that self-identified gender will be gamed in order to gain privileges. In the UK, reports indicate that one in 50 male prisoners now claims to be transgender.

The rights of others

Because self-identified gender identity has effects in relation to other Tasmanian laws, it may impact upon other people's rights. An example is s.22(4)(a) of the *Police Powers (Public Safety) Act* 2000, which requires that strip searches be carried out by a person of the same sex as the person being searched. This must now be read as inclusive of a person whose registered gender is the same as the sex of the person being searched. The person being searched has no right to object to a strip search by a person of the opposite biological sex who has changed gender on the basis of nothing more than self-identification. The same issues arise under a number of other statutes concerned with searches and forensic procedures, in which women may feel a particular concern for their bodily privacy and might want to object to a biological male conducting the search or procedure.

Law, policy and recognition of transgender status

The intentions of the Parliament to make it possible for transgender people to identify as another gender without sex reassignment surgery could have been fulfilled in a range of ways without embracing unscientific and highly controversial beliefs. People who self-identify as the opposite sex could have been given a gender recognition certificate for the purposes of indicating gender on driving licences or other such official documents. This does not impact upon the rights of anyone else. It may be that there are other contexts where recognition should be given to self-identified gender identity as well; but this has to be because the policy reasons that justify legislative differentiation between the sexes apply equally to those who self-identify as that gender.

There is no public policy case for allowing people to register an identity other than male or female, or for this to displace recorded sex. Law cannot change a person's anatomy. Self-declared gender identity does not displace, erase or irreversibly alter anyone's sex. Recognition of that gender identity needs to be in addition to, rather than a replacement of, a person's biological sex.

Of course, everyone is welcome to hold whatever beliefs they wish, and use whatever terms to describe their personality as they wish; but legislation must be founded on a consensus of known truth. Coherence could be restored to the law to some extent by repealing the provision that, for the purposes of Tasmanian law, a person is the gender as registered. A more limited provision could be put in its place. The entirety of the statute book does not need to be amended for the law to provide a respectful recognition of the gender identity of less than 100 adults. Still less should the Parliament deliberately erase differences between male and female.

There is a final question to be asked about this unfortunate episode in the Apple Isle's legal history. Is it so unreasonable for Tasmanians to want their birth certificates to be what they are meant to be – a record of their birth? If 99.98% of the Tasmanian population have no difficulty with their sex or gender, and have not sought to change official records, should policy be dictated by tiny minorities who would like to see sex at birth erased from public records?

The Tasmanian Parliament, recently dissolved, lost its way in a fog of ideological confusion and unscientific beliefs. The new Parliament needs to do better, and to take account of the beliefs of the large majority of people who do not have degrees in gender studies.

Section 7: CONVERSION THERAPY LEGISLATION

Banning alternatives to child gender experiments

- John Whitehall (first published in Quadrant, January-February 2020)

Victorian Labor to ban alternatives to gender experimentation on children.

The Labor government of Victoria is in the process of drafting legislation to ban so-called 'conversion therapy" which it defines as 'any practice or treatment that seeks to change, suppress or eliminate an individual's sexual orientation or gender identity'.

On the face of it, this would appear to be a good thing, given the effect of the so-called 'Safe Schools' programme, and other initiatives, which, under the camouflage of anti-bullying, have planted seeds of primordial confusion in the minds of many children with their doctrine of gender fluidity, which preaches there is no such binary entity as a boy or a girl. The ideology asserts everyone is somewhere on the intervening Rainbow, depending on feelings at the time.

The Victorian government could have been applauded had it decided its Education Department was no longer permitted to promote the ideology that has caused hundreds of Victorian children to be submitted to attempts by members of the Health Department to eliminate gender identity determined by chromosomes, and to change bodies to suit mental orientations.

But no: the Andrews government has no intention of stopping the evangelism and practices of the new ideology. To the contrary, with Orwellian Newspeak, it intends to ban any attempt to 'convert' or re-orientate, a confused child back to a gender identity congruent with its chromosomes.

Failure to comply with the ban will be punished by criminal or civil law, or both, whether committed by omission or commission. Omission will comprise failure of a therapist or teacher to refer a confused child to the Gender Service at the Royal Children's Hospital in Melbourne where it may undergo 'affirmation' of a new gender by means of hormones and surgery. Commission comprises attempts to 'make the child comfortable in the skin in which it was born' by means of family and individual psychotherapy: the former mode of therapy that was associated with success, but is now derided as 'abhorrent', and is to be banned as 'conversion therapy'.

Steps to the ban

The first step to the banning of 'conversion therapy' in Victoria is found in the Health Complaints Act 2017, whose provisions, according to former Victorian Health Minister, now Attorney General, Jill Hennessy, will 'provide the means to deal with those who profit from the abhorrent practice of gay conversion therapy…which inflicts significant emotional trauma and damages the mental health of young members of our community'.[xc] Moreover, according to Ms Hennessy, the crime of conversion therapy is so grave it demands 'reverse onus' in which 'the accused is required to prove matters to establish, or raise evidence to suggest, that he or she is not guilty of an offence.'

The second step was the release, in October 2018, of a report entitled 'Preventing Harm, Promoting Justice. Responding to LGBT conversion therapy in Australia'[xci] which was prepared by the Victorian Human Rights Law Centre and the Australian Research Centre in Sex, Health and Society at La Trobe University, with contributions from the Commissioners for Gender and Sexuality, Health Complaints, and Mental Health, and members of the Labor government's LGBTI task force[xcii]. It should be recalled that the Research Centre at La Trobe was largely responsible for the so-called Safe Schools Programme, mentioned above.

The report called for the Health Complaints Act to be strengthened and to become instructive for the rest of Australia: to consider 'legislative and regulatory options to restrict the promotion and provision of conversion therapies and similar practices, including by faith communities and organisations and both registered and unregistered health practitioners'[xciii]. It calls for legislation 'that

categorically outlaws (conversion therapy)'… that unequivocally prohibits (it) whether or not an individual complaint is made' and declares the need for a 'a legislator to intervene to protect children from conversion practices regardless of the setting or level of formality'

The report demands therapists of gender confused children undergo specific accreditation earned by special education that emphasises attempts to convert a confused child back to a gender identity congruent with chromosomes are 'not consistent with their professional obligations' and will invite 'disciplinary actions'. Schools must have similar accreditation. Infraction invites de-funding.

The report demands 'Public broadcasts' promoting 'conversion therapy' should also be banned. Given, therefore, this article argues against hormonal and surgical intervention in favour of traditional psychotherapy, it may be the last of its kind in Victoria!

The report coloured its arguments with declarations from 15 respondents recruited from 'various LGBTI, queer and ex-gay survival' and other networks, concluding it had found 'overwhelming evidence' of harm from 'conversion therapy' practiced as 'spiritual healing' in various religious institutions.

The respondents were aged from 18-59, nine identified as male and gay, two as transgender, one as female and bisexual, and one as non-binary. Thirteen were from Christian backgrounds, one Jewish and one Buddhist.

Therapy had included individual and group counselling, with theological discussion and prayer, but had failed to influence sexual orientation of the respondents. Worse, it was claimed to have increased misery through intensification of contradictions with traditional theological beliefs. Thus, conversion therapy is futile, harmful, deserves to be banned, and churches, especially Christian Protestant ones, should embrace differing sexual behaviours. Large graphics of crucifixes throughout the report maintain focus on Christianity.

The story of one of the fifteen, Jamie, requires special attention because, frankly, it beggars belief that such sexual torture could have occurred and not been revealed in these days of publicity of abuse within the church and psychiatric institutions. Abuses in the church are daily fare in the media, and the travesties of 'deep sleep' therapy in Chelmsford, and anarchy in Ward 10B in Townsville, must remain known within psychiatric circles: surely someone, somewhere, would have blown a whistle over Jamie.

Jamie's saga began when she was 17 years old, in the late 80's, after telling her parents she had 'fallen in love with a Christian woman'. In response, she was awakened one night and taken to a psychiatric institution where, for over two weeks, she was forced to 'sit in a bath full of ice cubes while Bible verses were read over her, to being handcuffed to her bed at night and deprived of sleep, to being interrogated and bated by a man in a dog collar' and to then having been 'restrained…having an electrode attached to my labia, and images projected onto the ceiling; a lot of pain from the electrodes and being left there for quite a long time afterwards; exposed and alone'.

The La Trobe report rightly condemns this story and needlessly refers to international obligations against torture. But, where is evidence the story is based on fact? If true, perpetrators should be in gaol. If sincerely believed by Jamie, but untrue (as in the 'repressed memory' debacle of psychiatry), she needs help. If the Andrews government is not concerned about its truth, the people of Victoria need help because it is part of the argument for major legislative change.

Apart from promoting a story of dubious veracity, there are other weaknesses in the La Trobe report. Given the Australian Human Rights Commission declares 11% of Australians to be 'Lesbian, Gay, Bisexual, Trans and Intersex people' [xciv], 15 complainants is not a convincing number, especially in the absence of a denominator: how many people have been helped with unwanted sexual pre-occupations by means of 'spiritual' counselling? How game would they have to be to go public? Do they and their therapists not have the human right to continue with such therapy if they both agree?

Also, self-selection from the established LGBTI community is not representative. Ironically, a review of experiences of American mothers of teenage daughters with Rapid Onset Gender Dysphoria[xcv], which concluded they were suffering from a 'social contagion' and not a biological disorder, was derided by gender activists, disowned by a university and pulled from website for its 'unscientific' recruitment from social media sites. Yet, based on similar methodology, the La

Trobe study is fundamental to major legislative change by the Labor Party.

Lastly, the study extrapolates from adults to children, and from homosexuality to transgendering. It ignores the widely reported assurance that, as they grow, almost all gender confused children will re-orientate to an identity that accords with natal sex without the help of hormones and surgery, but with the help of the compassionate counselling Labor is intent on banning.

The next step towards the ban occurred in November 2018 when the Victorian government referred the La Trobe report to the Health Care Complaints Commissioner (HCCC) who quickly concurred with the need for 'Introduction of legislation that clearly and unequivocally denounces conversion practices and prohibits conversion practices from occurring in Victoria'.

Then, in February 2019, the Andrews government publicly responded to the La Trobe study and the HCCC report with the announcement 'it will bring in laws to denounce and prohibit LGBTI conversion practices'.

Citizenry invited to Hail Caesar

Finally, in October, 2019, the Andrews government released a Discussion Paper entitled "Legislative Options to implement a ban of conversion practices' in order 'to seek the community's views on the best way/s to implement a ban of conversion practices'. The Paper is not interested in discussion as to whether conversion therapy should be banned: it merely seeks affirmation over something it has already decided to do. Most likely it seeks replies, such as Jamie's, which can be used for publicity purposes.

The Paper wonders if the public would like to banish conversion therapy by criminal or civil law, or both. It suggests criminalisation would 'send a clear message about the unacceptability of such behaviour' but warns 'criminal offences are investigated by police, (and) this approach is not as reliant as some civil schemes on individuals coming forward with complaints'. Citizens are invited to tick their reply in a drop down box.

In similar boxes, citizens are requested to advise who 'do you think should be banned from providing conversion practices? Specific professionals or persons? Or everyone who offers conversion practices?' Don't waste words, just tick the box.

And they are asked 'Who do you think should be protected (from conversion therapy)? Should protection be limited to children and people experiencing vulnerability? Should protection be available to all members of the community?'

Ominously, citizens are asked 'In what ways do you think the issue of consent is relevant to determining who should be protected?' This little question has major importance that might as yet be unappreciated: it concerns the power of the Orwellian State to be able to over-ride parental objections to the transgendering of children.

The greatest experiment since frontal lobotomies

In November, 2019, the Gender Service at the Melbourne Children's Hospital published the protocol of a study, named Trans20, which it has been undertaking since February 2017 on 'the health outcomes of trans and gender diverse young people'. The study will conclude in February 2020 by which date, it expects to have enrolled a massive 600 children.

Why was the study initiated? Because, according to its authors, 'specific healthcare for TGD (transgender and gender diverse) children and adolescents—including the use of medical interventions—is relatively new, having commenced only in the past two decades. Consequently, there is a need for more empirical data to inform best practice in important areas such as risk and protective factors and the long-term safety and outcomes of medical interventions'. The authors declare 'stronger evidence is required' regarding 'the natural history of gender diversity' because 'not all gender diverse children develop a transgender identity' with literature reporting that '45%–88% of children with gender concerns in childhood go on to identify with their birth-assigned sex in adolescence and adulthood… indicating that only some of these children report a transgender identity when older'.

The Gender Service had revealed details of its regime of medical intervention in Guidelines published in 2018, but summarised its stages in the Study. First, children are welcomed into the process of 'affirmation' towards a gender of their choice, contrary to natal sex. This begins with 'social transition' which may 'involve adoption of gender-affirming hairstyles, clothing, names and pronouns'.

Then, the child may progress to medical interventions: 'First, medications known as GnRH analogues ('puberty blockers') can help prevent the development of undesired physical changes during puberty, which can trigger and/or exacerbate GD. Second, gender affirming hormones, namely oestrogen and testosterone, can help promote physical changes congruent with the young person's gender identity. Thirdly, surgical procedures, such as chest reconstructive surgery for transmasculine individuals ('top surgery'), are performed on adolescents in some centres, while genital surgery is generally only advised after the age of majority'.

The article does not reveal which centres in Victoria are performing mastectomies on young people, and how many have occurred. But, before the Family Court of Australia abrogated its 'gate keeping' role in December 2017, five such procedures had been reported: 2 in natal girls aged 15, one at 16, and 2 at 17 years of age. Nor does the article clarify the word 'generally' with regard to genital surgery and its inherent castration.

The study will follow the outcome of children treated with hormones and surgery, but will provide no comparison with any alternate form of management. The authors claim it is 'not ethically possible to incorporate an untreated control group in the Trans20 study design', implying that no other form of therapy exists, and, no doubt (because it is an ubiquitous claim), failure to get on with medical intervention will invite self harm, including suicide.

Whereas few would insist on an 'untreated' cohort for comparison, review of international literature would insist on comparison with a cohort treated by compassionate, individual and family psychotherapy, as has been shown to be effective in many sites, including Australia, in the past[xcvi].

The study fascinates by its rejection of protocols for human experimentation which were hammered into various Human Rights documents following the travesties of 'research' in Germany in the Second World War. The Melbourne researchers confess most children will not need the therapy they are going to receive, the researchers must know that therapy is invasive, they admit they do not know whether it will work, or what side-effects may emerge, but, over the years, they think they can work it all out, without consideration of any alternatives which, in any case, will be banned by their supporting government. The question is, how did the prestigious Royal Children's Hospital in Melbourne come to approve of such experimentation? The machinations of its ethics committee should be made public. Who will be liable for litigation?

Normally, many conditions must be fulfilled before live experimentation is approved in Australia, even on rats, let alone children. There must be biological plausibility, an acceptable purpose, supporting review of literature, associated laboratory findings, supporting human experience, a pilot project, a control population, 'blinded' intervention, analysis by disinterested assessment, full disclosure of possible side effects resulting in informed consent, and the opportunity to withdraw at any time.

Trans20 offends at almost every point. The condition it is examining lacks biological plausibility. There is no blood test, Xray, genetic analysis etc to suggest a physical basis for the current epidemic of childhood gender dysphoria: the epidemic displays features of a contagious psychological problem to which mentally vulnerable children and some parents seem prone. Even the authors of the study admit 'Serious psychiatric disorders are very common, with rates of self-reported depression and anxiety diagnoses in transgender and gender diverse (TGD) young people in Australia as high as 75% and 72%, respectively, and 80% reporting ever self-harming and 48% ever attempting suicide'. The authors do not mention autism, which is a prominent co-morbidity in many international reviews, and is known for its distorted perceptions.

Proponents for hormonal intervention maintain the psychiatric co-morbidities result from societal bullying. They deny the more likely explanation, that gender confusion is a secondary symptom of an underlying disorder. Proponents also argue the need for medical intervention to prevent suicide but there is no evidence, per se, that gender dysphoria leads to suicide. Certainly gender confused children demand protection because all their associated psychiatric morbidities and family disruptions are associated with increased propensity to self-harm. Given the propensity of transgendered adults to commit suicide, as discussed below, the best way to reduce the rate of suicide in children might be to stop transgendering them.

Mental disturbances in parents include personality disorders and marital disruption. One prominent study in West Australia found a symbiotic

relationship of pathology between unhappy mothers and young boys. The mothers had been mistreated by men, found their little boy more appealing in a dress, who quickly learned that wearing it would bring a smile to his mother's face. These days, gender dysphoria appears more common in young, disturbed teenage girls whose parents are shocked by their daughter's unexpected psychological infection.

Hormonal and surgical management of a psychological problem lacks plausibility, and the study lacks acceptable purpose: the not dissimilar disorder of anorexia nervosa in which feelings are incongruent with bodily facts does not receive 'affirmation' therapy. The healthy body is not altered to fit the disturbed mind, nor should it be in children confused over gender.

Review of literature would have advised the researchers of the former rarity of the problem, of successful treatment by psychotherapy, of the widespread physiological role of the hormone they intend to 'block', of the side effects of that blocking, of the effects on the brain of cross sex hormones, of the lack of evidence for positive outcome as revealed by the growing number of 'detransitioners' and the high rate of suicide after transgendering in adults.

The rejection of a control arm to the study, and the associated evaluation of outcome by its 'un-blinded' authors, desirous of seeing good in their work, is an egregious example of 'observer bias'. That the authors attest they have no conflicts of interest in the study is challenged by the dependence of reputation, livelihood and medico-legal protection on a desired outcome.

Some details of blockers, cross sex hormones and surgery should be emphasised

It is important to look more closely at the effects of 'puberty blockers' and cross sex hormones because their use is fundamental to the medical intervention in childhood gender dysphoria but offends medical ethics, especially because proponents maintain the effects of blockers are 'safe and entirely reversible' when they are not, and are silent on the cerebral effects of cross-sex hormones.

Blockers

Puberty is initiated by Gonadotrophic Releasing Hormone (GnRH) released from the hypothalamus to cause the nearby pituitary gland to release Gonadotrophic Hormones into the blood stream to stimulate the maturation of the distant gonads and the release of their sex hormones, testosterone and oestrogen, which evoke secondary sex characteristics. Monthly injection of an analogue of GnRH blocks the pituitary from releasing Gonadotrophins, causing puberty to stall.

The analogues may be administered at the early signs of puberty: their earliest known administration in Australia was to a natal boy aged 10½. Proponents claim delaying puberty provides more time for a child to contemplate its gender identity and procreative future. They also claim it avoids 'unwanted' features of the rejected sex, and facilitates future surgery: a breast bud is easier to remove than the developed organ (but an undeveloped scrotum may offer insufficient skin for creation of an ersatz vagina, necessitating transplantation of a length of intestine to permit receptive intercourse).

The role of GnRH is not, however, limited to the vertical axis from hypothalamus to gonads. GnRH has 'horizontal' effects to other parts of the brain, and, perhaps, a widespread role in maintaining the integrity of nerve cells, even in the lining of the bowel.

Of particular importance to gender identity is the role of GnRH in the limbic system, and in sexualising centres in the middle of the brain. The limbic system coordinates emotions, cognition, memory and reward into a kind of internal world view, including identity, which is pursued by 'executive function' through ambition, behaviour and decisions.

Such cerebral function has been shown to be reduced in adults administered blockers to reduce pathological effects of sex hormones, for example, of testosterone in stimulating prostate cancer, or oestrogen stimulating endometriosis in women. Of course, confounders in assessment of the effect of blocking GnRH in those situations include age, disease and treatment, as well as interruption of the normal effects of sex hormones on the brain, but a specific effect of GnRH blockage cannot be excluded.

Such effect was proven in veterinary laboratories in Glasgow and molecular laboratories in Oslo. Given to immature sheep, blockers were found to result in sustained damage to the limbic system, associated with alteration of the function of many of its genes, resulting in sustained reduction of

ability in mazes and increase in emotional lability.

A specific role of GnRH in sexualising centres in the middle of the brain was shown by Pfaff et al[xcvii] in the 1970's. Stimulated, immature rats respond with sexualised behaviour: the immature female prepares to be mounted, and the male to oblige.

It may be wondered if any child of 10 ½ is capable of mature contemplation of gender identity, but more so when sexualisation has been neutered by interruption of primary centres in the midbrain, as well the secondary effects of sex hormones, combined with disruption of the integrating limbic system. It is not plausible to claim that such a child can make a mature decision of such magnitude. It is not right that someone could make that decision for it.

Other studies on the effect of blocking GnRH should be mentioned: blockers given to an immature natal boy interfered with normal growth of cerebral white matter and was associated with reduced function. Blockers given to women with endometriosis were associated with increased gastro-intestinal problems and a 50% reduction in intestinal nerve cells, suggesting a widespread role for GnRH in maintenance of neuronal health.

Traditional medical ethics demand full disclosure of possible side effects: so does the High Court of Australia, which, in Rogers vs Whittaker, ruled even possibilities of side-effects as remote as one chance in thousands must be declared to a patient considering treatment and, by inference, participation in research.

While proponents for the use of blockers in 'affirmation' refer to problems with bone growth, there is no evidence of discussion of effects on the central and peripheral nervous systems. There is only assurance of safety and reversibility.

Cross sex hormones

The use of these hormones to evoke sexual characteristics of the desired sex used be delayed until 16 years of age, but the Melbourne Guidelines have no such advice and the hormones now appear to be given much earlier, in accordance with a certain logic.

The development of the confused child is neutered by blockers while its peers are evolving socially and developing secondary sex characteristics. Thus, Jimmy believes he is a girl, a conviction fortified by authority figures, including the staff of the Gender Service. But his female peers are behaving as teenage girls and are developing breasts. It is cruel not to give oestrogen to help 'her' keep apace.

While proponents of affirmation publicise bone and cardio-vascular complications of cross sex hormones, there is no evidence they provide information on the effects of these hormones on the brain. But, Holshoff Pol et al[xcviii] have shown the male brain administered oestrogens shrinks at a rate ten times faster than ageing after only four months. The female brain on testosterone hypertrophies. Thus, the effect of cross sex hormones on a growing brain, organised before birth in a sex specific way to await activation by appropriate hormones in puberty, can only be contemplated as deleterious, especially when continued for life. It is implausible to imagine otherwise.

There is no evidence proponents for hormonal affirmation raise these issues with confused children and carers, but they should, perhaps especially in the context of the high rate of suicide in transgendered adults. Proponents argue that rate is due to ostracism, even though it is derived from epidemiological studies in the most accepting of European societies. It is not implausible to wonder if the rate reflects the absence of gold at the foot of the transgendered Rainbow, but also to wonder if the structural and functional effects of hormonal interruption of the cerebrum results in such disorder of mental processes that death is considered more preferable than life.

Surgery

It is not known how much detail of side effects of surgery are revealed to clients but known euphemisms suggest unrealistic assurance. For example, mastectomies are described as 'reversible' as if the function of the female breast can be reduced to a cosmetic appendage replaceable with a silicon implant. And, castration is described as 'reduced reproductive capacity' which may be avoided by preserving frozen biopsies of gonads or sperm: a process in which only expense is guaranteed, and in which there is an, apparently undiscussed, higher rate of foetal abnormality.

Wherein lies duty of care?

Faced with a confused child and parents, wherein lies the duty of care of a therapist or teacher? If the child is referred to a gender clinic which practices

hormonal and surgical intervention, there is vicarious participation in an experiment involving massive intervention in the minds and bodies of children: one that is biologically implausible, unnecessary, and associated with multiple side effects, according to international literature.

The excuse that emerged from Nazi Germany, that the 'government made me to do it', is not generally accepted as valid. Yet, that obligation is what the Andrews government appears determined to inflict upon its citizenry. On pain of civil and, probably, criminal sanctions, carers and teachers of confused children will be obliged to entrain them to 'affirmation'.

Given that most confused children will revert towards natal sex without medical 'affirmation', surely there is a greater 'Duty of Care' to avoid the experiment. Such a campaign is needed in Victoria.

National Association of Practising Psychiatrists (NAPP) Statement on Conversion Practices

- Philip Morris

Nov. 12, 2019 | Media Release, News

Conversion Practices

In 2019 the Victorian Government proposed that in 2020 legislation would be introduced to prohibit conversion therapy/practices. The government has asked for comment about the proposed legislation by 24 November 2019. The National Association of Practising Psychiatrists (NAPP) is making a submission to the Department of Justice and Community Safety. The submission is outlined below.

NAPP Statement on Conversion Practices

The definition of conversion therapy/practices in the Victorian Government proposal on this topic is as follows:

Conversion therapy/practices, often referred to as gay conversion therapy, is defined as any practice or treatment that seeks to change, suppress or eliminate an individual's sexual orientation or gender identity, including efforts to reduce or eliminate sexual and/or romantic attractions or feelings toward individuals of the same gender, or efforts to change gender expressions.

Contemporary forms of conversion therapy/practices can include counselling, psychology or psychotherapy, formal behaviour-change programs, support groups, prayer-based approaches and exorcisms. Providers of conversion therapy/practices may include unregulated health service providers.

We note that now conversion practices include 'an attempt to change a person's sexual orientation or gender identity'. Gender identity has been added to the previous definition of conversion practices that related to change of a person's sexual orientation. Sexual orientation and gender identity can involve different considerations in the clinical setting.

Unless conversion practices are narrowly and clearly defined in Victorian regulations, then doctors (including psychiatrists) using established approaches to assessing and treating patients with gender dysphoria may be in breach of the new Victorian legislation outlawing conversion practices.

Medical diagnosis requires a thoughtful, comprehensive and detailed assessment of the presenting clinical condition and the underlying possible alternative explanations and/or causes of those conditions.

With gender dysphoria this means exploring and understanding the reasons why an individual has come to the belief that their gender is different to the gender assigned at birth. Medical and psychiatric disorders identified in this process will need appropriate treatment (with consent) in order to enhance the well being of the patient.

These conventional and ethical actions of the physician must never be regarded as conversion practices under Victorian law. Any denial of patients presenting with gender dysphoria of the appropriate assessment and treatment of conditions leading to gender dysphoria or associated with it is an abjuration of the legitimate care of these individuals.

NAPP is concerned that the usual process of psychiatric assessment and treatment of psychiatric disorders could be misinterpreted as 'conversion therapy' in the clinical setting of gender dysphoria.

NAPP notes that psychotherapy is included in the Victorian Government definitions of conversion therapy. There are different types of psychotherapy and these include supportive, cognitive behaviour therapy, psychodynamic, psychoanalytic, and brief psychotherapy. Psychotherapy as practised by psychiatrists as a treatment modality is not conversion therapy.

The focus of both sexual orientation and/or gender identity can change over the course of psychiatric treatment. This is not conversion therapy. A patient may experience a change in the object of their sexual attraction during a course of psychiatric treatment. For example, a patient with a psychotic disorder, who has delusions and hallucinations about men, may lose these symptoms as a result of psychiatric treatment.

Further, as a result of the loss of an irrationally based fear during treatment, the patient may experience a sexual attraction to an individual of a gender opposite to the gender the patient was attracted to at the beginning of therapy. During the treatment and recovery from an episode of depressive illness or anxiety disorder a patient may experience a change in sexual attraction or gender identity.

Children and adolescents may temporarily have thoughts of being of a different gender to their gender assigned at birth due to the influences of social contagion, multiple psychosocial factors (including a history of sexual abuse), and the presence of psychiatric illness. Psychiatric assessment and treatment of children and adolescents, which is grounded on evidence-based practice, should not be labelled conversion therapy.

NAPP is concerned that there are dangers to patients if conventional psychiatric assessment and treatment is mislabelled as conversion practices. The danger is that psychiatrists and other doctors using conventional clinical methods will be at risk of criminal prosecution or deregistration when serving patients with sexual orientation or gender identity concerns. As a result, these patients will not be able to access psychiatric treatment in Victoria.

In order to avoid this undesirable consequence of prohibiting conversion practices in Victoria, NAPP recommends an amendment to the definition of conversion therapy/practices as follows:

That any therapy or practice deemed to be conversion practices must be practices that only and solely have as their purpose the change of sexual orientation or gender identity, and

That the definition of conversion practices exclude treatments and practices that explore and understand the underlying clinical influences on sexual orientation and gender identity, and provide empathic acknowledgment and evidence-based, support, and understanding for the facilitation of an individual's coping, social support, and identity exploration and development, and the treatment of any identified psychiatric comorbidity.

NAPP considers that the proposed legislation to provide protection from conversion practices should be primarily directed to children (up to age 18) and adults who do not have the capacity to provide informed consent.

People who have undergone medical and surgical transgender treatment and subsequently regret this treatment should be acknowledged and not be banned from stating their experience on public media. Discussion of these concerns and fears with their physicians is not conversion therapy and must not be mislabelled conversion therapy.

NAPP supports freedom of speech so that scientific matters can be debated and people can speak with their health care providers honestly, or if they chose, to tell others publicly of their experience without being prosecuted by the state.

National Association of Practising Psychiatrists

Managing Gender Dysphoria/ Incongruence in Young People: A Guide for Health Practitioners

Gender dysphoria/incongruence in young people is a contested area of medical practice. This approach avoids political, social, religious and ideological positions.

This approach to developing a guide for managing gender dysphoria [1] or gender incongruence [2] in children and adolescents aims to protect and

safeguard the health, safety and welfare of the child. This guide prioritises the best interests of the child in accordance with human rights obligations under the International Convention of the Rights of the Child [3].

Specifically,

> While respecting young people's views about their gender identity, this guide does so as part of the totality of their developmental and holistic clinical picture, and incorporates these into the clinical formulation. This approach requires that a comprehensive bio-psycho-social assessment be conducted before recommending specific treatment.
>
> It acknowledges that childhood and adolescence is a time of rapid physical and psycho-social growth and profound personal development, during which young people may question their identity, sexual orientation and gender. As the child matures and progresses through puberty this questioning usually resolves, and in the majority of cases the young person who has gender incongruence issues accepts his/her biological sex and adult body [4, 5].
>
> It is based upon an understanding that gender dysphoria/incongruence can be both a symptom and a syndrome. For a young person to have the syndrome of gender dysphoria/incongruence there must be a significant, established and prolonged pattern [2] of desire and behaviour that indicates the person insists they are a gender different to their natal (birth assigned) gender.
>
> It recognises that gender dysphoria/incongruence can often be a manifestation of complex pre-existing family, social, psychological or psychiatric conditions [6]. A holistic approach to assessment includes a comprehensive exploration for these potential conditions in order to more fully understand a child presenting with gender dysphoria/incongruence [7,8]. Where these conditions are presenting as gender dysphoria/incongruence, the treatment of the underlying condition is a priority.

Individualised psychosocial interventions (e.g., psychoeducation, individual therapy, school-home liaison, family therapy) should be first-line treatments for young people with gender dysphoria/incongruence. Exploratory psychotherapy should be offered to all gender questioning young people to identify the many potential sources of distress in their lives in addition to their gender concerns. Clinicians can provide a range of ethical psychological interventions (e.g., supportive psychotherapy, CBT, and dynamic psychotherapy) to assist the young person to clarify and resolve these contributory factors. Such approaches are consistent with established principles of comprehensive, systemic youth health care [7]. They should be undertaken before experimental puberty-blocking drugs [9] and other medical interventions (e.g., cross-sex hormones, sex reassignment surgery) are considered.

Medical interventions to block puberty and cross-hormone treatment to achieve feminisation and masculinisation according to the young person's perceived gender are not fully reversible and can cause significant adverse effects on physical, cognitive, reproductive and psychosexual development [9,10,11,12,13,14,15,16,17,18].

Currently, while some individuals report a successful transition, we are not aware of published long-term prospective outcome studies that have followed up adults who have undergone childhood or adolescent transition that show substantial benefit. As a consequence, there is no consensus that medical treatments such as the use of puberty-blocking drugs, cross-sex hormones or sexual reassignment surgery lead to better future psychosocial adjustment [17,18,19,20,21,22].

Increasing numbers of individuals who have undergone hormonal treatment and surgical interventions subsequently report experiencing regret and a wish to de-transition. They describe significant psychological and physical suffering, including loss of fertility and sexual function as a consequence of decisions made when younger [23,24,25,26,27,28,29].

Medico-legal considerations must be fully appreciated in this area of clinical practice. Health professionals are exposed to significant legal risk:

If a child or adolescent is found not to have been competent to give an informed consent,

If gender affirming treatment is not preceded by a comprehensive psycho-social assessment, that considers and excludes alternate diagnoses, or

If the patient was not informed of all the risks of puberty blockers and cross-hormone treatment including their experimental nature [9].

Clinicians should therefore reflect carefully before recommending treatments for gender dysphoria/incongruence.

The still unproven risks and benefits of gender reassignment interventions make it imperative that parents and children under 18 years and young people over 18 years are made aware of the current evidence of potential harm regarding gender transition and provide fully informed consent before potentially damaging and irreversible treatment is commenced.

This cautious approach is also mirrored in general clinical guidance by national advisory bodies in Finland [30] and the Karolinska Hospital in Sweden [31] that recommend treatment methods for gender dysphoria in minors.

In preparing this guide, advice was obtained from a number of senior medical specialists in child and adolescent psychiatry, adult psychiatry, forensic psychiatry, and clinical psychology and from physicians and other clinicians who have cared for young people experiencing gender dysphoria/incongruence, and legal practitioners who have experience in this field. Contributors to this guide include Dr Philip Morris, Dr Roberto D'Angelo, Dr George Halasz, Dr Cary Breakey, Prof Dianna Kenny, Dr Carlos D'Abrera, Dr Vivienne Elton, and Dr Ron Spielman.

References

1. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: Author.
2. World Health Organization. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en
3. UN Commission on Human Rights, Convention on the Rights of the Child., 7 March 1990, E/CN.4/RES/1990/74, available at: https://www.refworld.org/docid/3b00f03d30.html [accessed 3 November 2020]
4. Entwistle K. Debate: Reality check – Detransitioner's testimonies require us to rethink gender dysphoria. Child Adolesc Ment Health. 2020. doi:10.1111/camh.12380
5. Ristori J, Steensma T. Gender dysphoria in childhood. International Review of Psychiatry. 2016;28(1):13-20. doi:10.3109/09540261.2015.1115754
6. Kozlowska K, et al. Attachment patterns in children and adolescents with gender dyshoria. Frontiers in Psychology, 12 January 2021.
7. Kozlowska K, et al. Australian Children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments, 22 April 2021.
8. Kosky R. Gender-disordered children: does inpatient treatment help? Medical Journal of Australia 1987;146:565-69 (June 1, 1987). doi: 10.5694/j.1326-5377.1987.tb120415.x
9. https://www.judiciary.uk/wp-content/uploads/2020/12/Bell-v-Tavistock-Judgment.pdf
10. Vlot MC, Klink DT, den Heijer M, Blankenstein MA, Rotteveel J, Heijboer AC. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. Bone. 2017;95:11-19. doi: S8756-3282(16)30333-7 [pii].
11. Vlot MC, Wiepjes CM, de Jongh RT, T'Sjoen G, Heijboer AC, den Heijer M. Gender-affirming hormone treatment decreases bone turnover in transwomen and older transmen. J Bone Miner Res. 2019;34(10):1862-1872. doi: 10.1002/jbmr.3762 [doi].
12. Schneider M, Spritzer P, Soll B et al. Brain Maturation, Cognition and Voice Pattern in a Gender Dysphoria Case under Pubertal Suppression. Front Hum Neurosci. 2017;11. doi:10.3389/fnhum.2017.00528
13. Auer MK, Ebert T, Pietzner M, et al. Effects of sex hormone treatment on the metabolic syndrome in transgender individuals: Focus on metabolic cytokines. J Clin Endocrinol Metab. 2018;103(2):790-802. doi: 10.1210/jc.2017- 01559 [doi].
14. Alzahrani T, Nguyen T, Ryan A, et al. Cardiovascular disease risk factors and myocardial infarction in the transgender population. Circ Cardiovasc Qual Outcomes. 2019;12(4):e005597. doi: 10.1161/CIRCOUTCOMES.119.005597 [doi].
15. Nota NM, Wiepjes CM, de Blok, C. J. M., Gooren LJG, Kreukels BPC, den Heijer M. Occurrence of acute cardiovascular events in transgender individuals receiving hormone therapy.

Circulation. 2019;139(11):1461-1462. doi: 10.1161/CIRCULATIONAHA.118.038584 [doi].

16. Goodman M, Nash R. Examining health outcomes for people who are transgender. https://www.pcori.org/research-results/2013/examining-health-outcomes-people-who-are-transgender. Updated 2014. Accessed Nov 7, 2019.
17. https://www.evidence.nhs.uk/document?id=2334888&returnUrl=search%3ffrom%3d2020-01-01%26q%3dgender%2bdysphoria%26sp%3don%26to%3d2021-03-31
18. https://www.evidence.nhs.uk/search?q=Evidence+review%3A+Gender-affirming+hormones+for+children+and+adolescents+with+gender+dysphoria
19. [22] Dhejne C, Lichtenstein P, Boman M, Johansson AL, Langstrom N, Landen M. Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. PLoS One. 2011;6(2):e16885. doi: 10.1371/journal.pone.0016885 [doi].
20. Bränström, R., & Pachankis, Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. American Journal of Psychiatry. 2019;177(8), 727- 734. https://doi.org/10.1176/appi.ajp.2019.19010080
21. Correction to Bränström and Pachankis. American Journal Of Psychiatry. 2020;177(8), 734-734. https://doi.org/10.1176/appi.ajp.2020.1778correction
22. Kalin, N. Reassessing Mental Health Treatment Utilization Reduction in Transgender Individuals After Gender Affirming Surgeries: A Comment by the Editor on the Process. American Journal Of Psychiatry. 2020;177(8), 764- 764. https://doi.org/10.1176/appi.ajp.2020.20060803
23. Lesbian Strength 2019 - Charlie Evans. YouTube. https://www.youtube.com/watch?v=-JazgA3AdUE. Published 2019. Accessed November 1, 2019.
24. Female detransition and reidentification: Survey results and interpretation. archive Web site. https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey. Accessed Nov 7, 2019.
25. Pique resilience project. PIQUE RESILIENCE PROJECT Web site. https://www.piqueresproject.com/. Accessed Nov 7, 2019.
26. Subreddit survey update! : detrans. Reddit.com. https://www.reddit.com/r/detrans/comments/azj8xd/subreddit_survey_update/. Published 2019. Accessed November 1, 2019.
27. Reddit.com. Has anyone been to gender therapy? What was your experience?: detrans. [online]:https://www.reddit.com/r/detrans/comments/aeo5zd/has_anyone_been_to_gender_therapy_what_was_your/ Published 2019. Accessed November 1, 2019.
28. Tumblr: Guide on raging stars. Female detransition and reidentification survey. Available: https://tinyurl.com/female-detrans-survey. Published 2016. Accessed November 1, 2019.
29. Vandenbussche E. Detransition-related needs and support: A cross-sectional online survey. Journal of Homosexuality online, 30 April 2021.
30. Recommendation of the Council for Choices in Medical Treatment Methods for Dysphoria Related to Gender Variance In Minors. Health Care in Finland (PALKO / COHERE Finland), 11 June 2020.
31. https://segm.org/sites/default/files/Karolinska%20Policy%20Change%20K2021-3343%20March%202021%20%28English%2C%20unofficial%20translation%29.pdf

8

Section 8: GENERAL ARTICLE

Childhood Gender Dysphoria

– John Whitehall, (first published in Quadrant December 2016)

In recent years, the issue of transgender identity in children has leapt from the periphery of public consciousness to centre stage of a cultural drama played out in the media, courts, schools, hospitals, families, and in the minds and bodies of children. It is a kind of utopian religion with committed believers.

The drama is "gender dysphoria" and it is about children believing they belong to the opposite sex[xcix]. It is about parental anguish and commitment, court battles to instigate some therapies, laws to prevent others, cross-dressing, drugs that will block puberty, others that will transform an adolescent towards the opposite sex, pending feats of surgery that will castrate while turning a penis into an opening like a vagina, or producing a penis from a forearm in a foray into reproduction unrivalled since the days of eugenics. It is no wonder this drama is repeated on the media, especially as its players may be toddlers whose future is in the hands of the audience. Accept the pathways of "medicine", we are urged. Welcome transgender as but one hue in a natural rainbow. Or the children will kill themselves[c].

But is this massive intrusion into the minds and bodies of children necessary? What will happen if parents do nothing but "watch and wait" while their child muses on its gender? Can the child grow out of it?

The answer astonishes. While proponents argue for massive intervention, scientific studies prove that the vast majority of transgender children will grow out of it through puberty if parents do little more than gently watch and wait. Studies vary but from 70 to 97.8 per cent of gender-dysphoric male and 50 to 88 per cent of gender-dysphoric female children have been reported to "desist" prior to the onset of puberty. This likelihood of "growing out of it" is declared in no less than the current, official *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association[ci] (DSM-5), and is supported by a number of independent studies[ciiciii].

The Western medical profession boasts that it rests on "evidence-based medicine" but the tiny fraction involved with "affirmation" of gender identity in confused children is proceeding without supportive evidence for claims of high incidence, the need and safety of medical and surgical intervention, the avoidance of self-harm, and for the concept that the process will produce a happier human being in a happier society. Faith is needed for affirmation.

During a discussion on these matters, a leading endocrinologist declared to this writer, twice, that the issues of gender dysphoria are "utterly arbitrary ... utterly arbitrary", and that his greatest fear was that a mistake would be made by intervention. If most gender-dysphoric children desist without treatment, the "utterly arbitrary" medical pathways are also utterly unnecessary.

How common is childhood gender dysphoria?

No one really knows because there is "an absence of formal prevalence studies"[civcv] and estimates vary greatly. The leader of Toronto's Transgender Youth Clinic at the Hospital for Sick Children, Dr Joey Bonifacio, says estimates based on adult dysphoria clinics range from 0.005 to 0.014 per cent for men convinced they are women and 0.002 to 0.003 per cent for women convinced they are men, but believes they are "likely modest underestimates"[cvi]. Bonifacio's statistics are the same as those declared in the bible of psychiatry, DSM-5[cvii].

In Australia, prominence has been given to a cross-sectional questionnaire distributed to 8500 adolescents in New Zealand ("Youth 12") which reported 1.2 per cent answered "Yes" to the question, "Do you think you are transgender? This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl." 95 per cent denied being transgender, 2.5 per cent replied they were "unsure", and 1.7 per cent "did not understand" the question. The estimate of 1.2 per cent is promoted by leaders of the gender dysphoria service at Melbourne Children's Hospital[cviii], but the progenitors of the "Safe Schools" program appear to have inflated the figure to 4 per cent by adding the unsure 2.5 per cent.[cix]

Results of such tick-in-the-box questionnaires are unreliable. According to DSM-5, childhood gender dysphoria can only be diagnosed if there is "a marked incongruence" between natal and perceived gender lasting "at least six months", "manifested by at least six" features, including "a strong desire ... and insistence", together with a "strong preference" for the company, clothing and toys of the opposite sex and its role in fantasy play, and associated with rejection of the stereotypes of its natal sex, including anatomy. Also, to comply with "dysphoria", there should be "significant distress or impairment ... in functioning".

The unreliability of such questionnaires is emphasised in the *Journal of Homosexuality* in its consideration of the prevalence of suicide in sexual minorities[cx]. It warns that conclusions are limited because they are based on "retrospective" data, "do not effectively allow cause and effect relationships to be discerned" including "co-occurring mental disorders", are "restricted" in the number of questions they can ask to elucidate facts and are weakened by the possibility of incomprehension of the questions.

Is it any surprise that reliability of responses from adolescents has been questioned?[cxi] In the New Zealand survey deemed authoritative by some in Australia, 36.5 per cent of adolescents in this land of the All Blacks declared they did not understand the question: have you ever been "hit or physically harmed by another person?"

It is false to claim 1.2 per cent of the population is transgender on the basis of the survey. That would make its prevalence rival the 1 to 3 per cent of mental retardation. It is wrong to conflate the figure to 4 per cent for the "Safe Schools" program. That would mean one in twenty-five of all children would be transgender.

A straw poll of twenty-eight generalist paediatricians with a cumulative postgraduate experience of 931 years conducted for this article reveals eight children to have been observed with gender dysphoria. Four were remembered to have had severe associated mental disorder, one associated attention deficit/hyperactivity, one had been investigated for neurological disease on the basis of strange fidgetiness, and two had suffered sustained sexual abuse. In reality, childhood gender dysphoria is a rare condition whose prevalence is unknown.

How common are associated mental problems?

There are at least four reasons why a child with gender dysphoria might have associated mental disorder. The first is that transgender is but a symptom of a general disturbance. The second is that mental disorder could be caused by gender dysphoria. The third is it could be caused by external ostracism. The fourth would be a mixture of the above. Though studies reveal mental disorder, the cause remains elusive.

A study of Dutch children with dysphoria aged from four to eleven revealed associated psychiatric disease of at least one type in 52 per cent [cxii] with diagnoses including anxiety, phobias, mood disorders, depression, attention deficit and oppositional behaviour. A study by school teachers reported significant behavioural and emotional problems in about one third of 554 dysphoric Dutch and Canadian children under twelve[cxiii]. At the first presentation to a US gender clinic of ninety-seven children with mean age of 14.8 years, 44.3 per cent had a history of psychiatric diagnoses, 37.1 per cent were already on psychotropic medications and 21.6 per cent had a history of self-injurious behaviour[cxiv]. In an Australian study of thirty-nine dysphoric children of mean age ten, behavioural disorders were observed in a quarter, and Asperger syndrome in one in seven[cxv].

Proponents claim psychiatric problems are secondary to ostracism, but the American authors suggested gender dysphoria, itself, might be causal: "psychiatric symptoms might be secondary to a medical incongruence between mind and body", because the symptoms tended to abate with hormone therapy.

The frequency of autism spectrum disorder in children with gender dysphoria, and the known indifference of those children to the opinion of others, would argue transgender was a symptom of an underlying disorder and not a result of ostracism. Autism has been found in 7.8 per cent of transgender children in a Dutch clinic[cxvi], around 13 per cent in London[cxvii] and 14 per cent in Australia.

The answer to the question of whether dysphoria is primary or secondary is unknown and probably unknowable. This renders optimistic, if not delusional, the concept that massive intervention may secure happiness.

What is the risk of self-harm and suicide?

Risk of self-harm has been reported in gender-dysphoric children and is the argument for "treatment" and against inaction. Is self-harm another manifestation of an underlying disorder, or is it due to frustration from gender dysphoria alone, or due to ostracism? Proponents of affirmative treatment proclaim the latter and declare an "alarmingly high rate" of self-harm and suicide attempts, exemplified by highly publicised and tragic youth suicides in the US[cxviii].

As with most data related to gender dysphoria in children, studies are limited by lack of numbers and methodological bias, and the true rate of self-harm due to external ostracism is unknown. Other factors are very common and very important and seem neglected in the argument.

One London study retrospectively reviewed letters from referring doctors and its own notes regarding 218 gender-dysphoric children with mean age of fourteen. Of forty-one aged from five to eleven, it reported self harm in 14.6 per cent, suicidal ideation in 14.6 per cent and suicidal attempts in 2.4 per cent. Higher rates were reported in adolescents. A similar rate of ideation is reported from Canada[cxix], though associated with a lower rate of self-harm or attempted suicide (17 per cent as against 6.2 per cent). As in London, rates increased with age. Neither study revealed features of self-harm and attempted suicide.

The study reported high associated rates of psychiatric co-morbidity in children under eleven: autism spectrum disorder from 12.2 to 17.1 per cent, attention deficit hyperactivity in 14.6 per cent, anxiety in 17.1 per cent, depression in 7.3 per cent and psychosis in 2.4 per cent with, on the whole, rates increasing with age. It reports bullying and abuse in almost half to two thirds of all children but does not discuss whether it was provoked by transgender characteristics or those associated with autism, hyperactivity and psychosis.

Furthermore, though detailing living arrangements of the children, the authors do not comment on their influence, though the effect of family chaos on the mood of offspring is well known. The study found only 36.7 per cent were living with both biological parents, and 58.3 per cent "had parents who had separated". "Domestic violence was indicated" in 9.2 per cent, maternal depression in 19.3 per cent, paternal depression in 5 per cent; and parental alcohol or drug abuse in 7.3 per cent.

Nor does the study consider the significance of autism it found in 12.2 to 17.1 per cent of its children. Elsewhere, 14 per cent of children with autism aged from one to sixteen have been reported to experience suicidal ideation or attempts, suggesting a rate twenty-eight times greater than that for typical children (0.5 per cent)[cxx].

The New Zealand survey of adolescents ("Youth 12") deemed authoritative by some in Australia asked about "self-harm" in the previous year. Of non-transgenders 23.4 per cent replied "Yes", as did 45.5 per cent of "transgenders" but 23.7 per cent reckoned they did not understand the question. When asked about attempted suicide, 4.1 per cent of non-transgenders replied "Yes", as did 19.8 per cent of "transgenders", but 13.3 per cent declared incomprehension.

In other studies, between 19[cxxi] and 29 per cent [cxxii] of *all* adolescents are reported to have a history of suicidal ideation, and between 7 and 13 per cent to have attempted suicide; though what constitutes an attempt is not described in these studies, or in those above from London and New Zealand.

The question, then, is whether transitioning of transgender children will ultimately reduce self-harm. While Dutch experience concludes that "starting cross-sex hormones early ... followed by gender reassignment surgery ... can be effective and positive for general and mental functioning"[cxxiii], other centres report high rates of suicide in the years following reassignment.[cxxiv] [cxxv] To be fair, those reassigned in these studies did not have such a developed "pathway" for affirmation as in Holland. Nevertheless, suicide attempts after surgery have been reported to be more common than in the general population in Belgium (5.1 per cent as against 0.15 per cent)[cxxvi] and in Sweden[cxxvii].

Conversely, regarding suicide by adolescent members of sexual minorities, the *Journal of Homosexuality* concludes that "very few suicide decedents [*sic*]" have been identified as having "minority sexual orientation" in studies in North America: three of 120 adolescent suicides in New York, and four of fifty-five in Quebec; and warns conclusions based on "small numbers ... must be regarded as tentative".

The conclusion of the *Journal of Homosexuality* is valid. Numbers are small and data is obscure. No one knows how often real suicide attempts occur or their relationship with internal and external factors in gender dysphoria. When I raised the issue with

one experienced therapist, it was denounced as "bull****", merely a "weapon used by ideologues".

What are personality characteristics of parents bringing children to gender dysphoria clinics?

No studies are available on characteristics of parents despite numerous studies on their children. It is supposed that gender confusion in a child must deeply affect its parents, and the phrase common to those seen interviewed on television, "gut wrenching", is easy to accept. Perhaps, therefore, it is despair that is driving an increasing number of parents to start "social transition" of their child to the opposite gender before seeking medical help, under the guidance of websites and support groups and the encouragement of an enthusiastic media. Toronto's Dr Bonifacio says many have progressed far into transitioning before attending his clinic: parents are dressing and entertaining the child as the opposite sex, applying new pronouns and a new name. Such commitment, he explains, paves the way for further treatment.

A leading but nameless therapist agrees: about a third of children are already being "socialised". This therapist worries that they are at risk of being "conditioned" by parents who have become "enmeshed" to the degree of being "cheer leaders". This could lead to the child becoming "scripted" to repeat phrases that would convince therapists. One example is the declaration of a five-year-old that he was "transgender" when featuring with his mother in a recent documentary on childhood dysphoria by Louis Theroux shown on ABC television.

Becoming a "cheer leader" in therapy for a child is, of course, not uncommon. Many if not most parents become passionate for their children and are on the sidelines at soccer and in advocacy groups for advances in treatment of malignancy. But, unpleasant as it is to raise the matter, every paediatrician knows there is a tragic condition known as Munchausen syndrome in which symptoms are fabricated for some kind of benefit. In Munchausen's-by-proxy, the benefit accrues to the carer. I asked an experienced therapist whether this ever complicated gender dysphoria? Shoulders were shrugged: there are no studies. But, if mental illness affects 45.5 per cent of all Australians at some point in their lives and 20 per cent of those aged from sixteen to eighty-five will have experienced it in the previous year[cxxviii], the relevance of Munchausen's-by-proxy in carers needs to be considered.

What is the treatment for childhood gender dysphoria?

There are three categories. The first, known as "conversion" or "reparative therapy", is the attempt to make the child more comfortable in its natal sex and to lead it away from identification with the opposite gender. In the process, the reasons for the gender dysphoria are explored with the child and its parents. The second may be called "waiting and watching" while making the child comfortable in its natal sex until it grows out of it. The third is called "affirmative therapy" and involves supporting transition to the opposite gender.[cxxix]

"Conversion" or "reparative therapy", in which the child is orientated towards its natal sex, is anathema to transgender activists, and their political campaigns have caused it to be forbidden for minors in some states of North America. Evoking spectres of past brutal medical and societal treatment of transgender and homosexual adults, activists declare that anything less than affirmation in transgender children is inhumane, futile and may provoke suicide: transgender is fixed before and unchangeable after birth, and parents and society must accept the inevitable. The term "reparative therapy", therefore, has a pejorative, political ring to it. It is wielded more like a weapon than a description of a medical alternative.

The second involves keeping the child as happy as possible within its "own skin" or natal sex, in the expectation it will "grow out of it". It allows a child to dress and play with toys of the opposite gender but without encouragement and only in the home. It allows that a minority will "persist" into homosexuality but perceives life as a homosexual less complicated than that of transgender.

In practice, this middle option could swing towards dissuasion or affirmation. How much time should a child spend in his mother's clothes? How much effort into persuading a boy there are other interests than dolls? Depending on emphasis (or perceived emphasis as in the case of Dr Kenneth Zucker below) critics may decry "watchful waiting" as merely another form of "conversion" therapy, while others might fear too much affirmation amounts to "conditioning" towards a role from

which the child may find it difficult to escape.

The third option, "affirmation" excludes the first two and commits to a "pathway" that begins with "social transitioning" and progresses to blocking puberty with drugs (Stage 1). Stage 2 follows with stimulation of cross-sex features with administered hormones, in preparation for the possibility of later surgical intervention (Stage 3).

Problems are obvious. How might a child escape the "pathway" when gender re-orientation occurs with puberty? Complications with "second transitioning" after a life as the opposite gender are easily imagined[cxxx]. Worse, what if the child is so intimidated by the fear of coming out again that acceptance of the "pathway" seems the only possibility? Or, what if the child has been so mentally programmed it has no idea how to live as the "opposite" sex? Tragic mistakes are possible.

Stage 1: The blocking of puberty

The induction of puberty begins deep in the brain where it is started by a biological clock and involves a cascade of hormones with various checks and balances. Where and how it starts are unknown, but chemical messengers ultimately influence nerve cells in the hypothalamus to release hormones in pulsatile fashion to initiate a cascade of effects. They stimulate cells in the nearby pituitary gland to secrete other hormones that travel to stimulate the gonads to release yet other hormones that travel to evoke secondary sex characteristics.

The hormones that are secreted by the hypothalamus act on receptors on the surface of the cells in the pituitary. Their pulsatile secretion (every ninety minutes) allows time for the pituitary receptors to reset after they have fatigued themselves sending messages to the nuclei of their cells. If they are continuously stimulated the receptors become exhausted and puberty stalls. Drugs are now available that are similar to the hypothalamic hormones. If injected in slow-release form, these "puberty blockers" will exert a sustained effect, exhausting receptors and blocking puberty.

Since the 1980s these drugs have been used to block puberty when it has begun too early and, so far, no side-effects have been noted. It appears pituitary cells can recover from prolonged suppression and that hypothalamic and other upstream neurons are not damaged by their vain efforts. Activists declare that puberty blockage is "entirely reversible" (and Australian courts echo the conviction) but the international Endocrine Society is cautious, declaring passively that "prolonged pubertal suppression … should not prevent resumption" upon cessation[cxxxi]. The Society warns there are no data regarding how long it might take for active sperm and ova to appear after prolonged blockage.

Puberty is associated with psychological changes that reflect hormonal influences throughout the brain. Though used for an abnormal state since the 1980s, blockers have only been used in the presumably normal brain for gender dysphoria since the 1990s and, therefore, in neither case is the effect known in later years of life. The claim they are "completely reversible", is not yet based on evidence. The trial is too short, the numbers too small, the effect not blinded, and there are no controls.

Puberty is blocked to "give the child more time to consider future options" and, according to Dutch pioneers in treatment of childhood gender dysphoria, should not be initiated before breasts have begun to appear in a girl around ten to eleven years of age, and testes to increase in volume in a boy a year or so later. Distress at the appearance of early signs of puberty is reckoned to indicate likelihood of "persistence" with gender dysphoria, thus aiding diagnosis and the later decision to administer cross-sex hormones. Dysphoria through puberty is believed likely to persist.

There are problems in this process: the blocked child will be left behind by its developing peers and this, by itself, may provoke distress. For example, it will be shorter. More seriously, the blocked child will be asked to approve progression to Stage 2, as if it can comprehend its massive implications. Stage 2 may have irreversible effects on fertility in both sexes, and the ability to breast-feed in a female. Is a blocked and scripted child competent to see that far into the future? Do children ever think differently when their hormones have begun to flow? This competence to understand the implications of treatment is known as Gillick Competence after the decision of an English court[cxxxii]. As it appears most children who start Stage 1 continue to Stage 2, the stakes are high for presumed Gillick Competence.

Stage 2: The administration of cross-sex hormones

Cross-sex hormone therapy means giving enough hormones of the opposite sex to evoke and sustain

its characteristics. The hormones are given for life and must be monitored for side-effects including cardiovascular and thrombo-embolic disease, cancers of the opposite sex, and worsening of psychiatric disorder. By suppression of gonads, there is a slow process of chemical castration and the possibility of reproduction needs to be assisted by cryopreservation of ova and sperm.

According to international practice, cross-sex hormones may follow and then accompany blocking therapy, and be initiated around sixteen years of age. Some clinics, however, commence therapy as early as fourteen[cxxxiii].

This "earlier" trend obeys a certain logic: if the parents have already transitioned the child "socially" and, if the child might be distressed by the early signs of puberty and, if delaying puberty is likely to cause its own stress, why wait for early signs of natural puberty? Why not block that natural puberty before it appears and go straight to cross-sex hormones? Affirmation therapy is creeping earlier despite recommendations of the Endocrine Society: "Given the high rate of remission [of gender dysphoria] after the onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children."[cxxxiv]

Stage 3: Surgery

According to international guidelines, "sex realignment surgery" may be performed from eighteen years, though there are reports of it occurring earlier in private clinics[cxxxv]. Mastectomy, however, may be performed at a younger age if developing breasts increase dysphoria.

As the grandeur of realignment surgery may not be appreciated by a lay audience, it may be helpful to consider some details of the fate towards which children on affirmation therapy are headed. There are various components and not all patients progress to the final package, but the project will usually include relatively simple surgical procedures of castration, removal or augmentation of breast tissue, reduction in the size of the Adam's apple, and alteration of body hair.

Construction of alternate genitals is another matter. These surgeries are difficult, often multi-staged, fraught with complications, and limited in outcome.

Creating ersatz female genitals is easiest: an orifice is created in the perineum, lined with skin from a filleted penis and, sometimes, deepened by transplanted bowel. The scrotum forms labia. The glans is grafted above the orifice and the urethral tube is shortened.

Creating male genitals is harder. One surgeon declared that "the task assumes nearly Herculean dimensions"[cxxxvi] but this underestimates the ingenuity and range of objectives while exaggerating results. Hercules was always successful: creation of a penis is not. Some patients settle for a clitoris enlarged by male hormones. Others aspire to a penetrative organ, or at least one that can deliver urine when its owner is standing. In these cases, a shaft may be attempted from tissue grafted from thigh or even forearm and stiffened with a length of bone. Reversing the biblical account of the origin of females, bone from a woman's rib may now turn her into someone with a male phallus. A glans may be fashioned from a graft of inner-skin and the tube that delivers urine may be lined with mucous membranes from the mouth. The appearance of a scrotum may be achieved by creating a sac from the labia and inserting two artificial testicles.

Though techniques are improving with practice, complications are protean. Grafts may die, holes fill in, tubes obstruct, openings appear, bones protrude, bowels perforate and germs invade but, all in all, the result may be "aesthetically and functionally pleasing" to the recipient.

What does the law say in North America?

In California, in September 2012, a law was passed "to prohibit a mental health provider ... from engaging in sexual orientation change efforts ... with a patient under 18 years of age" which included "lesbian, gay, bisexual and transgender youth". Such efforts included "efforts to change behaviours or gender expressions" which were deemed "unprofessional conduct and shall subject the provider to discipline". The Bill cited various national organisations of paediatricians, psychologists and psychiatrists which described such activities as conversion or reparative therapies.[cxxxvii]

Similar laws have been enacted in New Jersey, Illinois, Oregon and Washington and, in 2015, in Ontario, Canada. Known as "anti-reparative" and "anti-conversion" laws, they oppose any attempts to re-orientate sexuality and to suppress gender

identity and expression in order "to save children's lives".

In effect, Barack Obama has joined the affirmation team. Responding to a petition for banning "dangerous ... conversion therapy" after a prominent suicide by a fifteen-year-old adolescent male who had sought to indentify as a female and allegedly underwent "conversion" therapy at his parents' church, the White House declared that the "Obama administration supports efforts" to ban conversion therapy for minors "because overwhelming evidence demonstrates" it "is neither medically nor ethically appropriate"[cxxxviii].

It is hard to gauge the effect of the laws. No charges have yet been laid but many therapists uncommitted to active affirmation are now reported to be unwilling to care for transgender children because they do not want the worry of the medico-legal risk. The result of their withdrawal in the face of increasing public demand is that children and their parents are funnelled towards those willing to continue or initiate the stages of transition.

One definite result of activists' pressure and the expectation of the law in Ontario was the ultimate sacking of an international leader in management of gender dysphoria, Dr Kenneth Zucker (as discussed below) and the closure of his long-standing clinic in Toronto for allegedly practising "conversion" therapy. In turn, this sacking has brought immeasurable weight to the intimidatory effect of the law.

Ontario Bill 77 or the "Affirming Sexual Orientation and Gender Identity Act, 2015" was passed unanimously and in a "miraculously" short time according to its promoter, parliamentarian the Reverend Cheri DiNovo, who explained, "Bills may take up to years to pass but this one succeeded in only two months". According to Wikipedia, DiNovo entered Parliament in March 2006, has been prominent in many issues including recognition of the Stalin-imposed famine on Ukraine as "genocide", has "passed most LGBTQ legislation in Canada", has conducted a weekly radio program, received literary awards, earned a masters degree in divinity and a doctorate in ministry from the University of Toronto, and has been a minister of the United Church since 1995. In 2001, she officiated over the first same-sex marriage in Canada[cxxxix]. Recitation of these educational achievements is relevant to some of the discussion we shared.

DiNovo is smart and at home in her conservative, stylish office in the Toronto parliament. Plainly, she could have been become the leader of her party had not ill-health intervened. Concisely, she declared the object of her law was not punitive but "instructional": to save children's lives, gender identity had to be affirmed. "Reparative or conversion" attempts should, therefore, be dissuaded and certainly not remunerated under the Health Insurance Act.

Moving to discussion of one of the clauses in the Act which declares the ban "does not apply if the person is capable with respect to the treatment and consents to the provision of the treatment", DiNovo was strangely unclear. I asked at what age a child would be deemed capable of consent to treatment. Up to what age would a child be incapable of consent and therefore at the mercy, as it were, of parents and affirmative therapists? DiNovo would not approximate, merely repeating, and now with many words, that the law was "instructional".

More disturbing was the response of this educated lady to my question as to why active, affirmative, transitioning therapy should be applied when most affected children were going to "grow out of it"? "I did not know that," she declared. I continued by presenting a book written by Dutch leaders in the field who attest to the majority desisting. She declared she had never heard of them! We went on to theological matters in which she declared her belief in the death and resurrection of Jesus Christ. I left perplexed. Could one so prominent not know most children would desist from transgender confusion? If she knew, could one so theological be so untruthful?

What does the law say in Australia?

In February 2017, a Health Complaints Act will become law in Victoria in which complaints may be raised against fraudulent and negligent practices which will include, according to Health Minister Jill Hennessy, "conversion" therapy. She explained that the Act will:

provide the means to deal with those who profit from the abhorrent practice of "gay conversion therapy" ... which inflicts significant emotional trauma and damages the mental health of young members of our community. This bill will enable the new Commissioner to investigate and crack down on anyone making dangerous and unproven claims that they can "convert" gay people.

Though she specified "gay people" and did not

define age, Hennessy's attributed declaration—"any attempts to make people uncomfortable with their own sexuality is completely unacceptable"[cxl]—suggests a broad intent for the law, in line with North American legislation.

More intimidating than the American laws, the Victorian Act will transfer the onus of proof to the accused, who will need "reasonable excuse" to avoid investigation after a complaint has been laid. In response to whether presumption of guilt would contravene human rights, Hennessy (tortuously) explained:

The reverse onus is required in relation to these offences as the "reasonable excuse" exception relates to matters which are particularly within an accused's knowledge and introduce additional facts from the subject matter of the offence, which would be unduly onerous for a prosecution to investigate and disprove at first instance. Once the accused has pointed to evidence of a reasonable excuse, which they should have access to if the excuse is applicable, the burden shifts back to the prosecution who must prove the essential elements of the offence to a legal standard. I am of the view that there is a negligible risk that these provisions would allow an innocent person to be convicted of any of these offences. Accordingly, I am of the view that these offence provisions are compatible with the charter[cxli].

More broadly than Ontario Bill 77 which focuses on therapists receiving National Insurance funding, the Victorian Act will embrace any person or organisation beyond the classical health care providers that offer "general health services" to "maintain or improve ... mental or psychological health or status". Given the antagonism of transgender and other minority sexualities to the Christian church it can be prophesied that, sooner rather than later, a church leader advising "watchful waiting" of a transgender child will be asked for a "reasonable excuse". The apparent suicide of seventeen-year-old Leelah Alcorn in Ohio in 2014 unleashed ferocity against the parents who had sought help in their Christian church, allegedly forcing their transgender son to undergo conversion therapy. There is the possibility of a similar backlash against pastors in Australia.

By passing these Acts, it is surprising that politicians should be aligning themselves, at least by default, with only one form of management of a medical problem. By banning "conversion/reparative therapy", they promote affirmative therapy as the single option, despite the fact children will "grow out of it".

Their punitive bias is not shared by the highest of international organisations. The international Endocrine Society acknowledges a middle path between "complete social role change and hormone treatment" on the "affirmative" end of the spectrum and punitive attempts to dissuade on the other. Implying that the large majority will desist if parents are patient, the Society recommends children should not "be entirely denied to show cross-gender behaviours or should be punished for exhibiting such behaviours". Given politicians cannot be expected to have full understanding of therapies (even DiNovo claims she has never heard the other side), their commitment must be credited to the lobbying of activists.

Success for activists in Ontario

Transgender activists have had great success in Ontario. After sustained pressure and with Bill 77 in sight, a review was initiated of the management of child and adolescent gender dysphoria by Dr Kenneth Zucker and his colleagues at the Centre for Addiction and Mental Health (CAMH) in Toronto, who have been at the forefront of this discipline for almost four decades. The review was commissioned in February 2015, the law enacted in September, and Zucker and the unit were stood down in December. They were alleged to be performing "conversion-reparative" therapy and were presumed guilty because no evidence could be found that they were *not* practising in that way. In reality, Zucker was toppled and his unit closed because they were not practising affirmative therapy.

Bill 77 could not have been associated with the toppling of a therapist with greater standing. A psychologist, Zucker is Professor in the Department of Psychiatry at the University of Toronto and is internationally prominent in research, publications, experience and recognition since he began at CAMH in 1975. He has been the editor of *Archives of Sexual Behavior* since 2002, was a member of the American Psychological Association Task Force on Gender Identity, Gender Variance and Intersex Conditions in 2007 and, in 2008, Chair of the American Psychiatric Association Sexual and Gender Identity Disorders Work Group that developed DSM-5 from DSM-4

(on whose committee he had also served). Zucker was also a member of the committee that revised the standards of care of the World Professional Association for Transgender Health[cxlii]. When he was dismissed, he had just been awarded a grant of close to a million dollars to study brain changes in gender-dysphoric adolescents receiving cross-sex hormones. Internationally, Zucker is almost unrivalled. Only the gender dysphoria clinic at the Vrije Universiteit Medical Center, in Amsterdam, has been as prominent as CAMH. Often, the two units have co-operated in research and publications.

For an Australian perspective on the dismissal of Zucker and his unit, consider a hypothetical sacking of the late cardiac surgeon Dr Victor Chang, and the closure of the Cardiac Unit at St Vincent's Hospital, Sydney.

Zucker was not available for discussion regarding how he and his clinic handled gender dysphoria but his concepts can be gleaned from his publications and statements attributed to him by his detractors. He described a Developmental, Biopsychosocial Model for treatment of gender dysphoria[cxliii] based on the concept that gender identity was not "fixed" before birth but was "malleable" under the influences of external factors of varying strengths at varying stages of development. Biological factors would include innate chromosomal direction and the effects of antenatal hormones. Psychosocial factors would include attitudes and behaviour of siblings, parents, care-givers and other close associates. All the factors would combine to have particular relevance at varying ages. For example, a four-year-old girl might conclude she was a boy if she wore boys' clothing and played their games, because until seven years of age gender identity may be confused by "surface expression of gender behaviour".

Zucker and his colleagues argued that "co-occurring psychopathology" in the child and "psychodynamic mechanisms" in its family influenced gender identity, with the latter sometimes exerting an unrecognised "transfer of unresolved conflict and trauma-related experiences from parent to child". Examples include "a girl observing her mother as bullied may self-identify as a male, while a boy observing his mother as depressed may self-identify as a female because subconsciously he wants to help his mother". Conversely, "a mother with unresolved hostility toward men may encourage effeminacy in her son"[cxliv].

Nevertheless, Zucker and his colleagues report that, despite external influences, most transgender children do not persist with that identity after puberty: only 12 per cent of transgender girls and 13.3 per cent of boys. They report:

It has been our experience that a sizable number of children and their families achieve a great deal of change. In these cases, the [gender dysphoria] resolves fully, and nothing in the children's behaviour or fantasy suggest that the gender identity issues remain problematic ... All things considered, we take the position that in such cases a clinician should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity.[cxlv]

Perhaps even more disturbing to transgender activists was Zucker's opinion that parents might be permitted to influence orientation of the child towards its natal gender. Declarations by Zucker that "if the parents are clear in their desire to have their child feel more comfortable in their own skin ... [and] would like to reduce their child's desire to be of the other gender, the therapeutic approach is organised around this goal"[cxlvi] became nails in his cross.

CAMH therapy included "open-ended play" to explore "underlying mechanisms" for which "surface behaviours" of gender dysphoria are symptoms, and "which can best be helped" if the reasons are understood. Limitations would be set on cross-sex play and dressing. For example, a boy might be permitted to wear at the home but persuaded against wearing them on trips to the mall. Same-sex "peer relationships" would be encouraged because they are "often the site of gender identity consolidation". If the boy in question did not like "rough and tumble" play, less physical peers might be sought.

Zucker's management of childhood dysphoria might be summarised as "minimise stress and maximise comfort" in natal sex, in the expectation most will grow out of it. He fears labelling a child is part of "conditioning" to transgender from which return is more difficult. He cautioned parents to: *resist too much accommodation from [a child's] teachers. Don't let the school make him a poster child ... don't let them parade him around for pink assemblies. This is his personal journey and we don't know where it is going to end up.*[cxlvii]

The latter advice is relevant for Australia. A spokesperson for the New South Wales Education Department has reported, "We have a four year old who is transitioning to kindergarten next year who has identified as transgender."[cxlviii]

Zucker and his colleagues report that a number of children who "persist" with transgender identity emerge from puberty as homosexuals. They insist, "We have never advocated for the prevention of homosexuality as a treatment goal for [gender dysphoria] in children" and explain to parents, "it will be their job and ours to support the child" whatever the future holds. Some children would desist from gender dysphoria to emerge as bisexual or homosexual. Some would persist with transgender identity and pursue the pathway of hormonal and surgical intervention, but Zucker concludes this to be the least favourable option because "growing up transsexual or transgender may augur a more complicated life".

Though not anti-gay, and involved in positive transitioning of adolescents to the opposite gender if transgender appeared inevitable, Zucker became Enemy Number One for transgender activists[cxlix]. Their pressure and Bill 77 resulted in Zucker and his unit being dismissed for not being "in step with the latest thinking".[cl] Over 500 colleagues expressed their dismay in a petition of protest which cited Zucker's contribution to science and medical care. The signatories warned "any clinical researcher who considers working at CAMH: in the event of a conflict with activists for a fashionable cause, CAMH might well sacrifice them [and their patients] for some real or imagined local political gain".

What do the courts say in Australia?

Decisions of Australian courts have kept pace with the exponential phenomenon of gender dysphoria. As recently as 1992, in Marion's case, the High Court declared that sterilisation of a fourteen-year-old mentally retarded girl, incompetent to decide for herself, needed the court's approval as a safeguard because there was a significant risk of making the wrong decision regarding an intervention that was "non-therapeutic, irreversible, invasive and associated with grave consequences"; sterilisation should only be performed "as a last resort"[cli]. This conservative attitude was confirmed by the Family Court in 2004 in *Re Alex*[clii] which determined that drug administration to effect transition to the opposite gender in the thirteen-year-old natal girl was a "special medical procedure" associated with "significant risks" of reversible and irreversible nature, and required the court's authorisation.

In 2013, in *Re Lucy* [cliii] , the court relinquished authority over Stage 1 therapy, determining it could be "appropriate" for "preventing, removing or ameliorating ... a psychiatric disorder" associated with gender dysphoria. Therefore, departmental guardians (and by inference, parents) could give consent to this therapy on behalf of the thirteen-year-old natal female who was competent to give informed consent with regard to transitioning to a male.

In that case, presiding Justice Murphy laid instructional ground by repeating with emphases the statement of an involved physician that:

It is important to state that the natural course of Gender Dysphoria, untreated, is that psychological stress increases over time, as the person becomes more and more disillusioned with their morphology which does not match their mindset of their assumed appropriate gender. Untreated Gender Dysphoria invariably progresses to immense disillusionment and then, to chronic depression which can often progress to major depression with significant suicidal risk.

In both *Re Lucy* and the following *Re Sam and Terry* [cliv] cases the courts, however, determined their authorisation was needed for implementation of Stage 2 therapy because of the permanence of effects. Deliberation in *Re Sam and Terry* emphasised the necessary protective authority of the court for two unrelated sixteen-year-olds who were both "Gillick incompetent".

In 2013, in *Re Jamie*[clv] the Full Court determined court authorisation would be needed for Stage 2 therapy if a child was Gillick incompetent but, if competent, a child could consent to Stage 2 therapy without the need for authorisation. The court declared, however, that a child's competence needed to be decided by the court "even where parents and treating doctors agree". These principles were confirmed in *Re Shane* later that year[clvi].

In July this year, in *Re Quinn* [clvii], the Family Court extended its permission beyond the drug components of Stage 2 into the irreversible surgical components of Grade 3 by approving bilateral mastectomies in a fifteen-year-old natal female committed to male gender. Even more significantly,

the court gave its authority despite the adolescent being Gillick incompetent because of associated Asperger syndrome.

Concerns with this symbiotic progress of courts and proponents of affirmation include:

The instructional declaration by Justice Murphy that untreated gender dysphoria *invariably* progresses to *immense* disillusion is not based on evidence.

Should courts be informed by only those committed to activist therapy?

Should courts rely on statements from a small group already involved with the transition of the patient? Is there no possibility of conflict of interest?

How can Gillick competence regarding future reproductive intent be assumed in an adolescent maintained in a pre-pubertal state? Do adolescents ever think differently when their own hormones flow?

How can irreversible, destructive surgery be permitted on an adolescent judged incompetent to understand the implications? Where is the line between transgender surgery and that for Body Identity Disorder in which the sufferer demands transformation of the physical state to satisfy the mental: for example, the removal of a normal leg in the false belief it is gangrenous?

The not-so-slow march of gender dysphoria through the judicial, medical and political institutions shows little evidence of obstruction. When will any authorisation by the court be declared unnecessary?

Obligation to consult the court rankles activists who consider it: "an expensive, time consuming and ultimately unnecessary intrusion into the complex decision making between the patient, their [*sic*] parents and the treating medical team [and] a form of institutional discrimination". The intervention of the court is considered unnecessary by leaders of the gender dysphoria clinic at the Royal Children's Hospital, Melbourne, because it "almost exclusively" relies on reports from the treating team regarding its client's competence[clviii]. They declare change is "urgently" needed given the "increasing acceptance of gender diversity being fuelled by social media and popular culture". They urge "equitable access" to all chemical blocking and cross-sex hormones and Medicare funding for "gender affirmation surgery".

Conclusion

The phenomenon of childhood gender dysphoria is exponential. Hundreds of children and their parents are reported to be consulting special clinics in Australia each year. How many undertake transitioning is unknown but the media provides regular confirmation, as do unofficial reports from schools. I attended Fort Street Boys' High, where at a recent reunion two current student leaders proclaimed the year's success to be the wearing of a dress to school by a boy, every day including graduation. A teacher from a school near my home reports five children to be undergoing transition.

Yet hardly any paediatricians recall any cases of gender dysphoria in almost 300 cumulative years of practice. Certainly, I have not seen one in fifty years of medicine. I accept cases must exist and consider them tragedies deserving as much compassion and medical care as the three cases of physical intersex I have encountered in my career.

What astonishes me is the lack of evidence to support massive medical intervention in the face of evidence that it is not necessary. I cannot help wonder how the intervention was approved by the various ethics committees in hospitals, health regions and universities when it took some students and me over a year to get approval for a study that merely asked mothers when they introduced solid foods to their children. Ultimately, I had to give my personal phone number to all respondents of the questionnaire lest someone suffer anxiety in the middle of the night.

It is less astonishing these days that laws should be passed to ensure compliance with activists' wishes. My generation has read the books of George Orwell, and observed the imposition of utopian ideas. Orwell would appreciate many aspects of the phenomenon of gender dysphoria. In *Nineteen Eighty-Four* obedience was ensured by the watchfulness of Big Brother, whose intimidation continues.

My motivation for writing an article is that of another physician, a leading endocrinologist, who declares evidence for intervention in gender dysphoria is "utterly arbitrary", and his great fear that mistakes would be made in consigning children to transition. I share those fears.

9

SECTION 9:

Westmead Hospital Report

– Janet Fraser

As the UK appears to be finally unpacking some of the assumptions and myths about medically altering children's bodies, Australia is still mired in just one dominant permitted view, promoted by corporations, the national broadcaster and government. The dominant view that 'transgender children' are a healthy phenomenon, with known historical antecedents, only opposed by those who seek to harm children and motivated by right wing or fundamentalist religious notions is everywhere. Parents of children who are medically altered without their consent are silenced by the courts and media. Their narrative does not fit the standard of brave knowing child who speaks a personal and unassailable truth from a place outside of any worldly concerns and without comorbidities or pressures from without. As we see on this panel let alone the groups set up around the country to support desperate parents, the reality is much less supportive of this set of stories.

Since I last spoke here about these issues, the landscape internationally has begun to shift in ways which would be major were they accurately reported in a media intent on pushing the profitable narrative of cute trans kids. Keira Bell, a genuinely brave detransitioned woman, spoke up with the support of academics, therapists, lawyers, women's groups and the ever growing ranks of desisters and detransitioners and the story finally broke in the UK that not all was rosy in the world of medical and surgical responses to psychological distress.

What should have broken with a deafening crash and tsunami of ripple effects in Australia, is the report by doctors at one of our major paediatric gender clinics, that of Westmead hospital in Sydney. The fact that only the Australian, in the form of the ever courageous and laudable, Bernard Lane, covered this story has done children and struggling families in this country a shocking disservice. This report is an appeal for nuance in a sector now overrun by activist physicians and corporatised government support to medicalise children on the flimsiest of excuses. It appears clear that the courageous doctors who authored the report are part of the worldwide phenomenon of people at ground zero where the drugs are dispensed trying to speak up in an effort to prevent potential harm to vulnerable teens. Tellingly, the authors have listened to detransitioners and seek to incorporate their experiences into their cautious holistic approach which treats each child as an individual with a story and an environment from which their discomfort and distress have flowed.

The authors make it clear they do not wish to attach themselves to the affirmation only model but seek to provide ethical, holistic care to what are significantly troubled children and very often families in crisis. As I've previously observed from my reading of the excellent work of John Whitehall, and my own reading of judgments made in the Family Court for teens seeking access to medical interventions, the issues of male violence and abuse are very much live and a consistent theme for many of these young people. The Westmead authors have observed this closely. As they note themselves, their study is small being 79 children however the Dutch study used as the justification for this medicalising model was only 70 people and the numbers of children embarking on this path as far as medicalisation does remain relatively small. The authors of the Dutch study have also recently drawn attention to their changed view but again, we don't hear about this in the Australian media. Of course we have no real way to measure this in Australia since private endocrinologists have a significant role to play and there is no way to capture their data via freedom of information requests.

Last time I spoke at one of the Brisbane Meanjin events, it was in the immediate wake of an Australian Story program on the ABC, about children who were being described as, 'nonbinary.' This time, since the propaganda is never ending, I'm speaking in the wake of a hagiography of one of our gender experts, the director of the Royal Children's Hospital gender clinic for adolescents in Melbourne. It is curious to me that the Westmead report and the doctor's reports of her patients, are so dissimilar. The Westmead report has much more in common with statements like this one made by

Dr Heather Brunskell-Evans in the Medical Law Review, in 2019. She wrote:

'Gender identity is the only condition for which a doctor prescribes treatment where there is no test and the diagnosis is self-report, and where the children and young people are physically healthy and phenotypically normal. A large percentage of young people referred for gender dysphoria have a substantial co-occurring history of psychosocial and psychological vulnerability, thus supporting the need for a comprehensive assessment that goes beyond an evaluation of gender dysphoria per se.'

It is curious how different the reports we have on ABC are from those we can read from around the world as self reported by those detransitioning but also by those doctors from Westmead. I've previously detailed the cases publicly available on legal databases which are the Family Court judgments and how the teenagers seem to be a population with high levels of anxiety, depression, male violence in the home, dysfunctional families of origin or the occasional child in foster care and thus the state is in loco parentis.

Another significant expert in the field, Dr Ken Zucker of Toronto, whose career was almost overturned by transactivists, made similar observations in his 2019 paper, Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues. Zucker also noted:

'Based on a variety of measurement approaches (e.g., standardised parent or self-report questionnaires, structured psychiatric diagnostic interview schedules, etc.), it has been found that adolescents referred for gender dysphoria have, on average, more behavioural and emotional problems than non-referred adolescents, but are more similar than different when compared to adolescents referred for other mental health concerns.'

It is important to note the care with which the Westmead report attempts to offer a holistic and honest view of the issues in children they see as well as the pressures and complications within the team playing a part in why this report has been produced. This is not a wholesale dismissal of children's pain or psychological issues, it is a careful survey of those who consented to form part of the study. Of the 108 children through the service during the time of the study, 79 agreed to be part of it. The majority of those, were girls (46 vs 33 boys), most were Caucasian at 86% and I think it important to note that Aboriginal children made up 5% of the total. Other groups were far smaller comprising 1-2% of the overall group. It seems clear from reports like this one, that trauma is one of the risk factors for an eventual diagnosis of gender dysphoria, going hand in hand as it also does with anxiety, depression and other mental health concerns. While our reporting is so poor, to me it is not insignificant that the largest single group, though far smaller, after white kids is Aboriginal kids. 5% of a population is an interesting statistic for a group which comprises maybe 3% of the Australian population and another aspect we need to look at more closely. Another statistic to note is that 3.8% of the children were living in foster care, another group with notable experiences of trauma. It also seems likely that the medical alteration of these children's bodies is being pursued while the parents are not the decision makers which brings to mind the concerns of Canadians who've noted a significant rise in foster children being medically transitioned. Canadian government policy is to, as we have seen in Australia, include the nebulous 'gender identity' in rafts of characteristics in need of legal protection and so foster children can only be placed with families who support the idea. As advocates I've spoken to have noted, fostered populations are a uniquely at risk group in need of trauma-informed care. This should give pause for thought to doctors seeing foster children without their parents' consent who are failing to offer a therapeutically holistic service to those children. The report does not make clear which children may also be Aboriginal and in foster care, a too common experience for Aboriginal children comprising the latest Stolen Generations.

38% of the children in the Westmead study are in two parent households, and 26% in the household of a single mother. 1.3% or one child was in a home with a single father. There are some concerning notes sounded in the report about a large proportion of the families being in crisis, often via domestic or family violence, some affected by immigration and a distinct group affected by adverse childhood events and bullying. Significantly, the families self report far differently from the clinical observations, which could be for a number of reasons including shame but also potentially a lack of insight into the stressors they manage on a daily basis. It also unsurprisingly indicates that children in this cohort are often managing significant familial stressors.

The case of Re A which was heard last year in the Queensland Supreme Court sheets home a number of these factors. A teenaged boy whose violent father has not been in touch with the mother and child since 2017 was exhibiting great distress about his male body and growth into an adult male. The doctors noted this child's comorbidities, particularly anxiety and depression, that he - whom they persist in calling she throughout, in the way of practitioners and courts which have accepted the idea of the trans child - is particularly distressed at the thought of his body changing and becoming more like that of an adult male. The judgment mentions the father perpetrator having committed significant violence within the home. Surely it isn't too much of a stretch to see a boy identifying that he shares his biology with a violent perpetrator and feeling that he absolutely does not want to grow into such a person? The court reports that the boy was indicating he wished to be perceived as a girl from around the age of four, that he chose stereotypically feminine clothing in preference to that of stereotypically masculine clothing. It is a curious phenomenon to me, as a mother of a boy and a girl, to consider that their choice in clothing, the colour of their clothing or their hobbies might indicate to me that they're something other than the sex indicated by their bodies? We also know that since we live in a world where heterosexuality is depicted on every street corner, that when a little boy says he wants to be the princess, not rescue the princess, he's synthesising what he sees around him in relational terms and transposing it with the only models available to him. Thus it isn't that he wants to be a girl, he wants a romantic relationship with the knight but we've failed to show him knights fall in love with knights too. Obviously we don't know about this child but given the international studies consistently show a large proportion of children indicating discomfort or confusion about their sexed bodies grow up to be lesbian, gay or bisexual, it is always worth considering and supporting your future gay child to be who they are without medicalisation.

Generally, unless there are significant issues at play, mothers want the best possible outcomes for their children. It discomforts me to see mothers automatically blamed for the medicalised children we see around us. 54% of the Westmead children first disclosed to their mother. 3.8% first disclosed to their father. A lot of what we see in terms of public views in families where a child is being medically transitioned, involves mothers because mothers are the frontal lobes for families, they organise the medical and dental appointments, they do the school canteen, they have the primary care and organising for children in the vast majority of heterosexual relationships. It thus falls to mothers to take children to appointments at the gender clinic. While there are complex relationships between transactivism and women, I do not think there is a new group of mothers with some form of Munchausen by proxy who are doing harm to their children for attention. I do think mothers know exactly how much punishment awaits them for being wrong and I think the suicide narrative exploited by transactivists bears some responsibility in this. It is worth noting Ken Zucker's comment on that in his 2019 paper, where he notes activist physicians, 'Karasic and Ehrensaft (2015) asserted that completed suicides are "alarmingly high"—a statement which, in my view, has no formal and systematic empirical basis. In fact, I would argue that the statement itself is alarming.'

The Westmead report raises some really major concerns. It is utterly shocking that the media barely noted its arrival. There are indications the team itself struggles along the fault lines well known to us all and the report is a tribute to professionalism. The authors report that there is a significant cohort of children who arrive at the clinic, well versed by other medical people, the Internet and activists to believe medical transition is their only and best option. The recent changes in law making medicalisation more accessible have led to increased pressure on doctors to immediately provide puberty suppressants and opposite sex hormones to younger kids than ever before.

'From the clinician perspective, we recognised the emergence of this "conveyor belt," or "tick the box," mentality—the medical model for treating gender dysphoria stripped bare of holistic (biopsychosocial) care—as being driven by the misguided belief that affirmation of gender dysphoria equates to a medical intervention pathway.'

The team note that their endeavours to explore belief systems and experiences are firmly rejected and also that they can see the children do not have the cognitive, psychological or emotional maturity to understand what they're really choosing. As they note, adolescents do not have the capacity

to fully understand the value, or otherwise, which fertility may hold for them in the future. This isn't a criticism of youth, it is a simple fact that there are some things which unfold for us all over time. Children struggling with complex mental health issues are not necessarily best placed to comprehend these adult endeavours. It is also deeply concerning that within the families themselves, the focus on the child and the trans identity of that child, is pursued to the exclusion of holistic therapeutic support of the whole family. As the authors put it:

'Not surprisingly, families tended to medicalise the child's distress, attributing it solely to gender dysphoria as an isolated phenomenon, with the consequence that the family identified the medical pathway as providing the only potential way forward. The motivation to engage in individual or family work to explore the broad range of difficulties and psychological, family, or loss/trauma issues contributing to the clinical picture was generally low.'

I find it all the more remarkable that ABC tv is able to present us with such a picture of functional families, loving supportive parents and children who only need doctors to provide the right body. I find it a curious statement that the subject of the show says of a girl, "I can help you have a boy's body" when there is only one way to have a boy's body and that is to be born a male. It would surprise me to learn that a demographic in the major city of Melbourne and the major city of Sydney would be so different. The report details deep concerns with autistic children, children with depression and children who've been victims of sexual abuse. As we have all been noting for some years now, this idea that any mental health issues are related to a lack of acceptance of trans identities and all is alleviated by altering the child's body is deeply entrenched. Families who are resistant to family therapies are also resistant to treating or managing those mental health issues so children's distress goes unmanaged even as the authors attempt to help them. A few of the children in the study were even psychotic and yet, as I've previously noted, children with psychosis have been given permission from the family court to access medical interventions.

The report makes a mention of the family agendas and dysfunction in terms which are familiar to those of us who've read the judgments of family court. There are some parents who both support the notion of gender identity and medicalisation. There are some who do not. As noted there is a high proportion of children from families where the threat or actuality of violence has manifested.

Which brings me back for a final word about A, the boy I mentioned at the start. A, whose doctors insist his perfectly understandable mental health issues coming from a place of terrible trauma will go away if they suppress his puberty with daily tablets because he has too great a fear of needles for the usual doses. Whose doctors are ignoring that this boy is so damaged he weeps over the thought of developing a normal male body and yet are prepared to deny him a future normal healthy adult relationship where he might enjoy comfort and love. Sensitive therapeutic support could make all the difference to children like A and we need more doctors like the brave Westmead authors speaking up on behalf of such vulnerable children.

Further reading:

Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service

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Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues https://pubmed.ncbi.nlm.nih.gov/31321594/

Bill 89 - gender ideology and foster children https://arpacanada.ca/news/2017/01/06/bill-89/

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Poem

– Dr George Halasz

This is based on my research in-depth interview with a late adolescent and his parents shortly after he had undergone 'top-surgery'. I was devastated at the time as their story unfolded, flooding me as it did with unspoken events, especially as I listened to the family history that included manifestation of severe problems never asked, now unmasked. Unlike before I heard between the lines the impact of a past unspoken suicide in the extended family. My writing the poem is one way to retrace my own vicarious trauma after clinical encounters like this harrowing experience. I simply found the poetry a more intimate way to share the unspoken anguish.

you (he/she/they) and I

we really did try
how I miss your simple presence
as I struggle in between
my familiar home

you and I

here, there, where I offered
solitary solace
mirrored self-same shame,
in safety, many weeks we did try

you and I

we remained mostly disconnected
much of the time, subjective islands
random reverberations
separated by oceanic isolation
barely aware, neither quite alone
nor securely together
in our ferociously buzzing minds

no longer paralysed by shame
you seized my imagination
how did we survive those turbulent times

you and I

I marshalled my scarce resources
from naive indifference
I refocused my concern
turn taking, as I struggled to tame
tainted pride to reframe frozen exposures
to historical shame, unspeakable crime

each visit we struggled more
almost, not quite attuned well-enough
to bear our traumatic triggers, on cue
we remained fatefully
misattuned, misgendered, misaligned

you (she/he/they) and I

between pleated warped time
our efforts redoubled
to make sense in real-time
our nurseries' veiled wounds
those wordless shameful crimes

one moment, through curiosity
we unravelled more reason
unveiled shadows, undefeated
yet suddenly you beat a retreat,
as we held our breaths
overwhelmed

either you (he/she/they) or I

imploded or exploded
truth be told
we disrupted or ruptured each other
much of the time
to make bearable another moment
witness passed suspended time
you revealed layer after layer
less than less care,
being overtaken as you ran
till you were caught and beaten
I exhaled, exhausted
I witnessed your survival

he/she/they and I

suddenly, once more,
beyond perception
I marshalled my scorched care
despite irresistible urges to run away
we managed to reach out
together, instantly reconnected

yet a heart-beat later
we disconnected, again
far, far out of your reach
deadened to your pleas
my masked and muted tears

adrift you (he/she/they) and I

afterwards, once more
dry-eyed I listened again
to register your faintest vibrations
I tried, best as I could
to proceed to decode
shame's sudden salience

was it you, she/he/they
who scarred both our troubled minds
as we forced each other to scrutinise
our sacred sonority of being
eulogised,

you (he/she/they) bonded with I

alone between our togetherness
fleeting complaints echoed each
heart-beat by beat
unsustainable subjectivity,
as we shredded our fragile identity
unshamed we cried

you and I

now our silence bypassed
we did survive
to possess fragments of each others entirety

you and I

in the end
awful power struggles precluded
gaining more foothold in our quest
for elusive tranquility between she/he/they

you and I

Appendix: Brief biographies of contributing authors

Judith Hunter: Judith is a parent of a young adult who declared a transgender identity over 2.5 years ago, aged 17. My scepticism (due to our daughters comorbid mental health issues) has led me to read extensively on this issue for 2.5 years. In that time I have connected with like minded people, people who see the immediate affirmation of a young person's claim to be transgender, as an unfolding medical scandal. Through Facebook, Twitter & other means I have connected with people globally, as this is a world wide issue. I am a member of various parents support groups, including Australian Parents Questioning Gender, Our Duty Australia & NZ, Genspect & Family & Friends of Transgenders & Detransitioners to name a few. Terrible harms are happening to so many young people. We need to stop the harm. I have a Bachelor of Commerce Degree & a Masters Degree in Business Administration. My husband & I run a commercial painting company with 45 employees. I would like to be able to devote more time to our business, however the importance of safeguarding young people has consumed my life in a manner I never envisaged. When I get to switch off from this scandal, I enjoy music, poetry, walking & spending time with friends & family.

Janet Fraser: Janet Fraser is a mother, poet, historian and has been National Convenor of the Australian homebirth network, Joyous Birth since 2004. She writes about feminism, history, human rights, birth and parenting. Janet is on the management committee of the Feminist Legal Clinic and Maternal Scholars Australia and cofounded the NSW Women's Guild in 2019. She was a winner of the Eva Bacon Award in 2021, given in honour of the Communist organiser Eva Bacon and awarded by IWD Brisbane Meanjin for her long commitment to women's liberation. Her book, "Born Still: a memoir of grief" was published in 2020 by the Australian publishers, Spinifex Press. She has been published in the Melbourne University journal, Hecate and has been published by the Hunter Writers Centre, Grieve collection and other journals. She also writes at Patreon, where she foments women's studies and revolution at Despatches from the Matriarchy. You can also catch her on Facebook and Twitter.

Katherine Deves: Katherine Deves is a practicing lawyer in NSW, cofounder and spokeswoman for Save Women's Sport Australasia, women's advocate, critic of gender identity ideology and mother of three daughters. Katherine writes and speaks on the impact of gender identity ideology on women and children in Australia, and its influence on policy and legislation more broadly.

Dianna Kenny: Dianna Kenny is a consultant child and adolescent psychologist, currently in private practice in Sydney, Australia. She completed her 31-year career at The University of Sydney with the title of Professor of Psychology. She has specialties in developmental psychology and developmental psychopathology. In these capacities she has provided exert reports to the Department of Public Prosecutions, the Joint Investigative Response Team in matters pertaining to the sexual assault of children, the Human Rights Law Alliance, and various legal practices. Her clinical practice includes a specialization in children, young people and their families presenting with gender dysphoria to whom she provides intensive psychotherapy and family therapy. In this field, she has made invited submissions to government inquiries, presented at parliamentary fora and advised politicians about proposed legislation affecting gender dysphoric children and young people. Dianna is the author of nine books, including one on gender dysphoria, 40 book chapters, and 200 peer reviewed journal articles. For details of publications and clinical services, see www.diannakenny.com.au

Elisabeth Taylor: Elisabeth Taylor is a Commonwealth Scholar with a PhD in Medieval Women's History from Cambridge University. As Director of Research for the Australian Christian Lobby (2016-2019) Elisabeth addressed contemporary political issues relating to gender and sexuality (such as LGBT activism, queer theory, transgenderism, comprehensive sexuality education, pornography, the Safe Schools program, prostitution, abortion, etc), focussing particularly on the ideological drivers of these issues (sexual

liberation, cultural Marxism, post-modernism) and their corrosive effect on children, the family and the Church. In her subsequent role as Senior Fellow of the Lachlan Macquarie Institute, she teaches on the history of feminism, the origins and consequences of the sexual revolution, as well as male/female complementarity and the expression of this in marriage.

Geoff Holloway: Sociologist, poet, author, ecocentric philosophy, sociology of social movements, medical sociology, tourism, gender critical feminism and fado fan. Current research interests include: domestic violence in Portugal, ecocentrism, Green politics, Nature's rights, transgender politics, gender dysphoria, sociology of tourism, fado and tourism. As in the past, he is again Secretary of the United Tasmania Group, the world's first Green party. See: https://hollowaygeoff.academia.edu/

John Whitehall: John Whitehall is Professor of Paediatrics in Sydney. His 50 year career began at Sydney University, continued through developing countries and western Sydney as a general paediatrician, then focussed on neonatology before focussing on academia. As an intensive care neonatologist he developed a special interest in neuroscience which drew him into considerations of physiology and the effect of hormonal and pharmaceutical interventions on the growing brain. For 15 years he was Director of Neonatal Intensive Care in Townsville, North Queensland, which included ante-natal diagnosis, resuscitation, management and transportation of premature, dysmorphic and sick neonates, many of whom were Indigenous. In Townsville, he was deeply involved in the establishment of the medical school at James Cook University and in the subsequent tuition of medical students, including embryology and genetics. He pursued a Masters in Public Health, while teaching its modules of 'Tropical Paediatrics' in various developing countries. Earlier in life he had secured a Bachelor of Arts with special interest in social and political theory.

His interest in neuroscience caused him to investigate the pathophysiology of 'puberty blockers' and cross sex hormones on the developing brain, through reviews of literature, and personal and electronic communication with international researchers. His interest in public health caused him to accept the evidence that almost all dysphoric children will orientate to natal gender given compassionate and adequate care of associated family and mental issues. His interest in social theory caused him to conclude the process of 'affirmation' to a gender incongruent with chromosomes was, though well meaning, essentially experimental, contravening many of the principles of human rights that were established after WW2.

Patrick Parkinson: Patrick Parkinson AM is a professor of law at the University of Queensland. He is an expert on family law and child protection. Professor Parkinson is a specialist in family law, child protection, law and religion and the law of equity and trusts. His books include Australian Family Law in Context (7th ed, 2019), Tradition and Change in Australian Law (5th ed, 2013), Family Law and the Indissolubility of Parenthood (2011), The Voice of a Child in Family Law Disputes (with Judy Cashmore, 2008), Child Sexual Abuse and the Churches (2nd ed, 2003) and Principles of Equity (editor, 2nd ed., 2003). Professor Parkinson served from 2004-2007 as Chairperson of the Family Law Council, an advisory body to the federal Attorney- General, and also chaired a review of the Child Support Scheme in 2004-05, which led to the enactment of major changes to the Child Support Scheme. He was President of the International Society of Family Law from 2011-14. Professor Parkinson is also well-known for his community work concerning child protection. He has been a member of the NSW Child Protection Council, and was Chairperson of a major review of the state law concerning child protection which led to the enactment of the Children and Young Persons (Care and Protection) Act 1998. He also works with churches on child protection and religious freedom issues.

Philip Morris: Prof Morris AM has medical qualifications MBBS (Hons), BSc(med) (Hons), and PhD. He is qualified in psychiatry and addiction medicine in Australia and is a Fellow of the Royal Australian and New Zealand College of Psychiatrists (FRANZCP) and a member of the Faculty of Forensic Psychiatry, the Faculty of Psychiatry of Old Age, and the Faculty of Adult Psychiatry. He is a Fellow of the Australasian Chapter of Addiction Medicine (FAChAM) (RACP). He is qualified in general adult psychiatry and geriatric psychiatry and addiction medicine in Australia, and in the USA is Board Certified by the American Board of Psychiatry and Neurology.

Dr Morris is President of the Australian and New Zealand Mental Health Association. He is President of the National Association of Practising Psychiatrists. He is a Distinguished Fellow, Treasurer and Board Director of the Pacific Rim College of Psychiatrists. He is a member of the Repatriation Pharmaceutical Reference Committee. He is a senior medical advisor to the Department of Veterans' Affairs. Prof Morris is visiting professor of psychiatry at Bond University. He has held professorial positions in psychiatry at the University of Melbourne and the University of Queensland. He teaches medical students and mentors doctors training in psychiatry.

George Halasz: George Halasz is a consultant child and adolescent psychiatrist and Adjunct Senior Lecturer at School of Psychology and Psychiatry, Faculty of Medicine, Nursing and Health Sciences, Monash University, in private psychiatry practice till 2020. From 1992–2005 he was a member of the Editorial Board of the Australian and New Zealand Journal of Psychiatry, and the Editorial Committee of Australasian Psychiatry (2005–current). He was consultant to chapters in Psychodynamic Diagnostic Manual (PDM)–2 (edited by V. Lingiardi & N. McWilliams, published by Guilford Press, 2017). His special areas of interests and publications include ADHD, Holocaust trauma and inter-generational trauma transmission, trauma informed care, child/adolescent psychotherapy and ethics, children of parents with mental illness (COPMI), and the interface between psychiatry and religion. Over the last twenty years he has lectured on trauma related themes in the UK, Israel, Poland, Hong Kong, US, NZ, and Australia. He was a regular panelist on Melbourne Radio Station RRR's "Radiotherapy" for close to twenty-five years. Email: george@halasz.com.au

Endnotes

[i] Including in Porto Alegre, Rio de Janeiro, Nova Igaucu and São Paulo in Brasil, Bangkok, Geneva and New York

[ii]https://outrightinternational.org/content/international-role-yogyakarta-principles The location was well planned - as co-chair Sonia Onufer Correa of Brazil said later at a launch in her country

[iii]https://www.timeshighereducation.com/world-university-rankings/universitas-gadjah-mada

[iv]https://arc-international.net/about/background/

[v]https://outrightinternational.org/content/international-role-yogyakarta-principles#one

[vi]https://uncommongroundmedia.com/martine-rothblatt-a-founding-father-of-the-transgender-empire/

[vii]For details on this meeting see http://www5.austlii.edu.au/au/journals/CanterLawRw/1999/6.html

[viii]https://uncommongroundmedia.com/martine-rothblatt-a-founding-father-of-the-transgender-empire/

[ix]https://uncommongroundmedia.com/martine-rothblatt-a-founding-father-of-the-transgender-empire/

[x]as above

[xi]https://www.academia.edu/43984852/_The_Yogyakarta_Principles_and_the_Womens_Human_Rights_Campaign

[xii]Jennifer Bilek, 6 July 2020, https://uncommongroundmedia.com/martine-rothblatt-a-founding-father-of-the-transgender-empire/

[xiii]https://outrightinternational.org/content/international-role-yogyakarta-principles The location was well planned - as co-chair Sonia Onufer Correa of Brazil said later at a launch in her country

[xiv]http://yogyakartaprinciples.org/signatories-yp10/

[xv]https://en.wikipedia.org/wiki/Yogyakarta_Principles - under subheading Reception.

[xvi]https://www.youtube.com/watch?v=jk0ga6PX2Kc - slide 21.21 seconds in, Anna Zobnina, webinar, 8 August 2020

[xvii]https://www.youtube.com/watch?v=jk0ga6PX2Kc Anna Zobnina, webinar, 8 August 2020

[xviii]https://www.womensdeclaration.com/en/

[xix]In the EU the European Commission uses the words 'gender' and 'gender identity' interchangeably - Anna Zobnina, webinar, 8 August 2020

[xx]Yogyakarta Principles, Preamble https://yogyakartaprinciples.org/preambule/

[xxi]Tina Minkowitz, Female Autonomy vs Gender Identity, University of Oslo, page 11, December 2016

[xxii] ibid, page 15

[xxiii] ibid. pages 20-21

[xxiv] ibid. page 25

[xxv]Much of this thinking is based on Michel Foucault, a self-confessed paedophile - https://www.conservapedia.com/Michel_Foucault

[xxvi]https://www.youtube.com/watch?v=jk0ga6PX2Kc - slide 21.21 seconds in, Anna Zobnina, webinar, 8 August 2020

[xxvii]https://www.youtube.com/watch?v=jk0ga6PX2Kc Anna Zobnina, webinar, 8 August 2020

[xxviii]I checked with a Canadian contact about the Incorporation rules in Canada – it is not necessary to publicize audited financial statements but it is necessary to provide a copy to all members of the corporate body. The ARC site does not show how one becomes a member.

[xxix]Not surprising as Norway has nominated men since then as representatives on women's-only groups in the EU.

[xxx]Katherine Deves, personal communication, 19 August 2020, and page 4 of https://www.academia.edu/43484191/Response_to_the_Tasmanian_Law_Reform_Institute_report_on_Legal_Recognition_of_Sex_and_Gender

[xxxi]Responses to questions on notice provided by the Attorney-General's Department on 21 May 2013, p. 8.

[xxxii] https://www.youtube.com/watch?v=-pHBnmtqpRc Tina Minkowitz, webinar, 8 August 2020

[xxxiii] https://www.youtube.com/watch?v=jk0ga6PX2Kc Anna Zobnina, webinar, 8 August 2020

[xxxiv] ibid.

[xxxv] http://yogyakartaprinciples.org/signatories-yp10/

[xxxvi] https://en.wikipedia.org/wiki/Yogyakarta_Principles - under subheading Reception.

[xxxvii] In the EU the European Commission uses the words 'gender' and 'gender identity' interchangeably - Anna Zobnina, webinar, 8 August 2020

[xxxviii] Yogyakarta Principles, Preamble https://yogyakartaprinciples.org/preambule/

[xxxix] Tina Minkowitz, Female Autonomy vs Gender Identity, University of Oslo, p. 11, December 2016

[xl] ibid, page 15

[xli] ibid. pages 20-21

[xlii] ibid, page 23

[xliii] ibid. page 25

[xliv]previous correspondence, AHMAC & Gender Transitioning among Children and Adolescents, page 2, 15 June 2020

[xlv]Minkowitz, page 25

[xlvi] ibid. page 35

[xlvii]Much of this thinking is based on Michel Foucault, a self-confessed pedaphile - https://www.conservapedia.com/Michel_Foucault

[xlviii]For a quick sketch on the nature of postmodernism see https://www.dailymotion.com/video/x2oh8ia?fbclid=IwAR0lVVwLUVreYuNEmRGTJYFwNv4Wc_Iq38sh3B48x6n4J4LLEKqMACOPHTU

[xlix] https://alhr.org.au/tasmanian-lgbti-law-reform/

[l] https://www.un.org/ga/search/view_doc.asp?symbol=A/C.3/65/SR.29

[li] http://yogyakartaprinciples.org/signatories-yp10/

[lii] Butler et al, British Medical Journal, July 2018, Vol 103, No 7

[liii] Committee on the Rights of the Child, 2009: paras 20-1

[liv] Daly, A., No weight for 'due weight'? A children's autonomy principle in Best Interest.

[lv] Brunskell-Evans, H. The Tavistock: Inventing 'The Transgender Child'. In *Inventing Transgender Children and Young People*, Ed. M. Moore & H. Brunskell-Evans, Cambridge, 2019, page 35.

[lvi] Ibid.

[lvii] UNCROC: Article 3, 2

States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

Article 5.

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

Article 14, 2

States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

Article 18, 1

States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

[lviii] *Children's Rights Impact Assessment*, Women and Girls in Scotland, 2019, page 25. Incidentally, the Children's Rights Impact Assessment tools was designed by Children's Commissioner Scotland.

[lix] Biggs, M. Britain's Experiment with Puberty Blockers. In *Inventing Transgender Children and Young People*, Ed. M. Moore & H. Brunskell-Evans, Cambridge, 2019, pages 40-55.

[lx] Patton, G. & R. Viner, Pubertal transitions in health, *Lancet*, 2007, Vol 369, March 31, 2007.

[lxi] Royal College of Psychiatrists, *Supporting transgender and gender-diverse people,* Position Statement, March 2018, page 4.

[lxii] Daly, A. op cit.

[lxiii] Whitehall J. The Short March of gender fluidity through the Family Court. Quadrant. August 2020.

[lxiv] Hembree et al Guidelines on Gender-Dysphoric/Gender-Incongruent Persons J Clin Endocrinol Metab, November 2017, 102(11):3869–3903.

[lxv] Smith KP et al. Gonadal Suppressive and Cross-Sex Hormone Therapy for Gender Dysphoria in Adolescents and Adults. Pharmacotherapy 2014;34(12):1282–1297) doi: 10.1002/phar.1487

[lxvi] D'Angelo R. Psychiatry's ethical involvement in gender-affirming care. Australasian Psychiatry. 2018:1-4. DOI:10.1177/1039856218775216..

[lxvii] American College of Pediatricians, press release, 3 August 2016.

[lxviii] Cretella, M. A., Gender Dysphoria in Children and Suppression of Debate, *Journal of American Physicians and Surgeons,* Volume 21, Number 2, Summer 2016.

[lxix] *The role of the GP in caring for gender-questioning and transgender patients, RCGP Position Statement*, June 2019.

[lxx] Vigo, J., "Evil Womxn": The Silencing Of Biological Reality And The Technology Of Obfuscation, *Forbes*, 26 October , 2018.

[lxxi] Entwhistle, K., An open letter to Dr Polly Carmichael from a former GIDS physcician, 18 July, 2019. https://medium.com/@kirstyentwistle/an-open-letter-to-dr-polly-carmichael-from-a-former-gids-clinician-53c541276b8d

[lxxii] MacGregor, I., Silencing and censorship in the trans rights debate, Tasmanian Times, 6 August 2018. https://tasmaniantimes.com/2018/08/silencing-and-censorship-in-the-trans-rights-debate1-d1/

[lxxiii] Doward, J., Politicised trans groups put children at risk, says expert, *The Observer*, 29 July 2019. https://www.theguardian.com/society/2019/jul/27/trans-lobby-pressure-pushing-young-people-to-transition?CMP=Share_iOSApp_Other&fbclid=IwAR28NMxBoNQJtI-r6Ke7yJFb_9rjk7sIB2Zn6_RIyXuaIlRchD1Zd0Ln-lo

[lxxiv] Marchiano, L., Outbreak: on Transgender Teens and Psychic Epidemics, *Psychological Perspectives*, 60:3, 345-366, DOI: 10.1080/00332925.2017.1350804, 2017.

[lxxv] Adams, N., Hitomi, M. & Moody, C. Varied Reports of Adult Transgender Suicidality: Synthesizing and Describing the Peer-Reviewed and Gray Literature. *Transgender Health*. 2017 Apr 1;2(1):60-75.

[lxxvi] Singal, J. What's missing from the conversation about transgender kids? https://www.thecut.com/2016/07/whats-missing-from-the-conversation-about-transgender-kids.html quoted in L. Marchiano (see above)

[lxxvii] Stella, Cari, Female detransition and reidentification: Survey results and interpretation, 3 September 2016. https://guideonragingstars.tumblr.com/post/149877706175/female-detransition-and-reidentification-survey

[lxxviii] Malone, W. J., *Gender Dysphoria Overview*, 18 June 2019. Institute of Medicine (US) Committee on Understanding the Biology of Sex and Gender Differences. "Every Cell Has a Sex." Exploring the Biological Contributions to Human Health: Does Sex Matter?, U.S. National Library of Medicine, 1 Jan. 1970, www.ncbi.nlm.nih.gov/books/ NBK222291/.

[lxxix] Vigo, J., "Evil Womxn": The Silencing Of Biological Reality And The Technology Of Obfuscation, *Forbes*, 26 October , 2018. https://www.forbes.com/sites/julianvigo/2018/10/26/evil-womxn-the-silencing-of-biological-reality-and-the-technology-of-obfuscation/?fbclid=IwAR1C8Ccuuuia NWy9amUTcb6iRVyd3V9wwjjxLoiC48Gu6xA3d4gP0a1wnU4#4c3522b718fd

[lxxx] Holloway, G., Susto and the Career Path of the Victim of an Industrial Accident: a Sociological Case Study. *Social Science and Medicine*, 38, 7, 1994.

[lxxxi] https://culturallyboundgender.wordpress.com/2013/03/03/the-concept-of-the-culture-bound-syndrome

[lxxxii] Patton, GC & Viner, R., Pubertal Transitions in Health, *The Lancet*, Vol. 369 March 31, 2007.

[lxxxiii] Littman, L. Parental reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria, *PLoS ONE* (2018) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0202330

[lxxxiv] Gilligan, A., Surge in girls switching gender, *The Times*, 30 June 2019, https://www.thetimes.co.uk/article/surge-in-girls-switching-gender-c69nl57vt

[lxxxv] Robbins, J. The Cracks in the Edifice of Transgender Totalitarianism, *Public Discourse*, 13 July 2019.

[lxxxvi] Marchiano, L., Outbreak: on Transgender Teens and Psychic Epidemics, *Psychological Perspectives*, 60:3, 345-366, DOI: 10.1080/00332925.2017.1350804, 2017.

[lxxxvii] Stagg SD, Vincent J., *European Psychiatry*. 2019 Jun 28; 61:17-22. doi: 10.1016/j.eurpsy.2019.06.003. Autistic traits in individuals self-defining as transgender or nonbinary.

[lxxxviii] Saad TC1, Blackshaw BP2, Rodger D. *Journal of Medical Ethics*. 2019 Jun 22. pii: medethics-2019-105611. doi: 10.1136/medethics-2019-105611. Hormone replacement therapy: informed consent without assessment?

[lxxxix] Brunskell Evans, H., Leeds Launch of The Declaration of Women's Sex-based Rights – Speech by Dr Heather Brunskell-Evans, 25 May 2019. http://www.heather-brunskell-evans.co.uk/body-politics/leeds-launch-of-the-declaration-of-womens-sex-based-rights-speech-by-dr-heather-brunskell-evans/?fbclid=IwAR1AyuJoxWtoC6pk_CDzo1kwBIEHYsUK06_viT2vL30inaZB wIcgu6q_RAI

[xc] Ms Hennessy. Health Complaints Bill Second Reading. Parliament of Victoria. Hansard. Feb 10, 2016.

[xci] Jones T, Brown A, Carnie L et al. Preventing Harm, Promoting Justice. Responding to LGBT conversion therapy in Australia. Melbourne: GLHV@ARCHS and Human Rights Law Centre, 2018.

[xcii] Ibid page 9.

[xciii] Ibid, p 3.

[xciv] https://www.humanrights.gov.au/sites/default/files/FTFLGBTI.pdf Accessed 20/11/2019

[xcv] Littman L. Rapid onset gender dysphoria in adolescents and young adults: A study of parental reports. PLoS ONE 13(8):e0202330. https://doi.org/10.1371/journal.pone.

[xcvi] A full review of the successes of non-hormonal therapy (with appropriate references) has appeared in Quadrant, March 2019, in an article entitled

[xcvii] Pfaff D, Luteinising hormone releasing factor potentiates lordosis behavior in hypophysectomised ovariectomised female rats. Science. 1973. 182:1148-1149.

[xcviii] Hulshoff Pol, H. E., Cohen-Kettenis, P. T.,Van Haren, N. E., et al. Changing your sex changes your brain: Influences of testosterone and estrogen on adult human brain structure. European Journal of Endocrinology. (2006). 155:S107–S111.

[xcix] Bonifacio HJ, Rosenthal SM. Gender variance and Dysphoria in Children and Adolescents. Pediatr Clin N Am. 2015. 62:1001-1016.

[c] Hiller L, Jones T, Monagle M et al. Writing themselves in 3: the third National Study on the sexual health and well being of Same Sex attracted and Gender Questioning Young People. Melbourne Australian Research Centre in Sex, Health and Society. La Trobe University. 2010 as quoted in Telfer M, Tollit M, Feldman D. Transformation of health-care and legal systems for the transgender population: The need for change. JPCH.2015. 51;1051-1053.

[ci] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Fifth Edn 2013:451-459.

[cii] Drummond KD, Bradley SJ, Peterson-Badali M and Zucker KJ. A follow up study of girls with gender identity disorder. Developmental Psychology. 2008;44:34-45.

[ciii] Wallien MS, Cohen-Kettenis PT. Psychosocial outcome of gender dysphoric children. J Am Acad Child Adolescent Psych. 2008; 47:1413-1423.

[civ] Ristori J, Steensma TD. Gender dysphoria in childhood. Int Rev Psych. 2016;28 (1):13-20.

[cv] Shumer D, Spack NP.Current management of gender identity disorder in childhood and adolescence: guidelines, barriers and areas of controversy. Current Opinion Endocrinology, diabetes and obesity. 2013;20(1):69-73.

[cvi] Bonifacio HJ, Rosenthal SM. Gender variance and Dysphoria in Children and Adolescents. Pediatr Clin N Am. 2015. 62:1001-1016.

[cvii] DSM-V. 2013:454.

[cviii] Telfer M, Tollit M, Feldman D. Transformation of health-care and legal systems for the transgender population: The need for change. JPCH.2015. 51;1051-1053.

[cix] All of Us: 8.

[cx] Haas A, Eliason M, Mays V et al. Suicide and Suicide Risk in Lesbian, Gay,

Bisexual, and Transgender Populations: Review and Recommendations. J Homosexual 2011;58:10-51.

[cxi] Fan X et al. An exploratory study about inaccuracy and invalidity in adolescent self-report surveys. Field Methods. Savon-Williams and Joyner. 2006;223: 33

[cxii] Wallien MS ,Swaab H, Cohen-Kettenis PT. Psychiatric comorbidity among children with gender identity disorder. J Am Acad Child Adol Psych. 2007;46:1307-1314.

[cxiii] Steensma TD, Zucker KJ, Kreukels BP et al. Behavioural and emotional problems on the Teacher's Report Form: a cross national, cross-clinic comparative analysis of gender dysphoric children and adolescents. J Abnorm child psycho 2014;42:635-647.

[cxiv] Children and adolescents with gender identity disorder referred to a pediatriic medical center. Spack NP, Edwards-Leeper L, Feldman HA et al. Pediatrics. 2012;129 (3):418-425.

[cxv] Hewitt Jk, Paul C, Kassiannan P et al. Hormone treatment of gender identity disorder in a cohort of children and adolescents. MJA. 2012;196(9):578-581.

[cxvi] De Vries AL, Noens IL, Cohen-Kettenis et al. Autism spectrum disorders in gender dysphoric children and adolescents. J Autiism Dev Dis. 2010;40:930-936.

[cxvii] Holt V, Skagerberg E, Dunsford M. Young people with features of gender dyshoria: demographics and associated difficulties. Clin Child Psychol Psychiatry. 2016;164:108-118.

[cxviii] Karasic D, Ehrensaft D. We must put an end to gender conversion therapy for kids. WIRED. 2015. Htp://www.wired.com/2015/07/must-out-an-end-gender-conversion-therapy-kids/ Accessed October 18, 2016.

[cxix] Aitken MA, VanderLaan DP, Wasserman MD et al. Self-harm and suicidality in children referred for Gender Dysphoria. J Am Acad Child Adol Psychiatry. 2016;55(6):513-520.

[cxx] Mayes SD, Gorman AA, Hillwig-Garcia J et al. Suicide ideation and attempts in children with autism. Res Autism Spec Dis. 2013;7(1):109-119.

[cxxi] Lewinsohn PM, Rohde P, Seeley JR. Adolescent suicidal ideation and attempts: risk factors and clinical

implications. Clin Psychol Sci Pract. 1996;3:25–46.

[cxxii] Faulkner AH, Cranston K. Correlates of same-sex sexual behavior in a random sample of Massachusetts

high school students. Am J Public Health. 1998;88:262–266.

[cxxiii] De Vries AL, Cohen-Kettenis PT. Clinical management of gender dsyphoria in children and adolescents: the Dutch approach. J Homosexuality. 2012; 59(3):301-320.

[cxxiv] Murad MH, Elamin MB, Garcia MZ, Mullan RJ, Murad A, et al. (2010)

Hormonal therapy and sex reassignment: a systematic review and meta-analysis

of quality of life and psychosocial outcomes. Clin Endocrinol (Oxf) 72: 214–231.

[cxxv] Dhejne C, Lichtenstein P, Boman M et al. Long-Term Follow-Up of Transsexual Persons

Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLOS 1. 2011;6(2):e16885.

[cxxvi] De Cuypere, Elaut E, Heylens G et al. Long term follow up: psychosexual outcome of Belgian transsexuals after sex reassignment surgery. Sexologies. 2006;15:126-133.

[cxxvii] Dhejene C, Lichtenstein P, Boman M et al. Long term follow-up of transsexual persons undergoing sex reassignment surgery:Cohort study in Sweden. PLOS. 2011. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0016885 Accessed. Nov 10, 16

[cxxviii] Department of Health, Australian Government. Prevalence of mental disorders in the Australian population. www. Health.gov.au/internet/publications/publishing.nsf

[cxxix] Ristori J, Steensma TD. Gender dysphoria in childhood. Int Rev Psych. 2016;28 (1):13-20.

[cxxx] Steensma TD, Cohen-Kettenis PT. Gender transitioning before puberty. Arch Sex Behav. 2011;40:649.

[cxxxi] Hembree WC, Cohen-Kettenis P, de Waal HA et al. Endocrine treatment of transsexual persons: an Endocrine Society Clinical Practice Guideline. 2009;94(9):3132-3154.

[cxxxii] Gillick v West Norfolk and Wisbech Area Health Authority (1986) AC 112.

[cxxxiii] Shumer DE, Nokoff NJ, Spack NP. Advances in care of transgender children and adolescents. Advances in Pediatrics. 2016;63:79-102.

[cxxxiv] Hembree WC et al 2009. ibid.

[cxxxv] Milrod C. How young is too young: Ethical concerns in genital surgery of the transgender MtF adolescent. J Sex Med. 2014;1:338-346.

[cxxxvi] Rashid M, Tamimy M. Phalloplasty: the dream and the reality. Ind J Plastic Surgery. 2013;46(3):283-293.

[cxxxvii] California Legislative Information. Senate Bill 1172. September, 2012. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120. Accessed October 18, 2016.

[cxxxviii] http://www.abc.net.au/news/2015-04-09/obama-calls-for-end-to-conversion-therapy-for-lgbt-youth/6380424. Accessed Nov3, 2016.

[cxxxix] https://en.wikipedia.org/wiki/Cheri_DiNovo Accessed October 19, 2016.

[cxl] Tomazin F. Zero tolerance:Andrews to crack down on gay "conversion" therapy. The Age Jan 24. 2016. http://.theage.com.au/action/printArrticle?id=1004994392. Accessed October 20, 2016.

[cxli] PARLIAMENTARY DEBATES (HANSARD)

LEGISLATIVE ASSEMBLY FIFTY-EIGHTH PARLIAMENT FIRST SESSION

Wednesday, 10 February 2016 page 94.

[cxlii] WPATH. Standards of Care. 7th version

[cxliii] Zucker K, Wood H, Singh D et al. Developmental, Biopsychosocial Model for treatment of children with gender identity disorder. J Homosexual . 2012;59:369-397.

[cxliv] Long term Toronto gender identity clinic shuttered in clampdown on "reparative therapy'. https://www.lifesitenews.com/news/homosexual-activists-slam-canadian-therapist Dec 22,2015. Accessed 28/9/2016.

[cxlv] The Bilerico Project. Daily experiments in LGBTQ. http://bilerico.lgbtqnation.com/2015/meet_the_last_respectable_reparative_therapist. Accessed 29/9/2016.

[cxlvi] Fix society Please Now. https://nowtoronto.com/news/leelah-alcorn-fix-society-not-trans-people/

[cxlvii] The Globe and Mail. Gender identity debate swirls over CAMH psychologist, transgender program. Feb 14, 2016. Http:licence.iccopyright.net/user. Accessed 28/9/2016.

[cxlviii] Greg Prior, Deputy Secretary of School Operations and Performance. Hansard, General Purpose Standing Committee No3 Legislative Council. 29 August 2016. P 13.

[cxlix] Dr Kenneth's war on transgenders. https://www.queerty.com/dr-kenneth-zuckers-war-on-transgenders. Accessed 29/9/2016

[cl] Anderssen A. Gender identity debate swirls over CAMH psychologist, transgender program. The Globe and Mail. February 14, 2016

[cli] Department of Health and Community Services (NT) v JWB (Marion's case) (1992) 175 CLR 218.

[clii] Re Alex (2004) 31 Fam LR503.

[cliii] Re Lucy [2013] FamCA 518.

[cliv] Re Sam and Terry [2013] FamCA 563.

[clv] Re Jamie. (2013) FamCACF 110. http://www.austlii.edu.au/au/cases/cth/FamCAFC/2013/110.html Accessed October 21/2016

[clvi] Re Shane [2013] FamCA 864

[clvii] Re Quinn (2016)FamCA617(29 July 2016)

[clviii] Telfer M, Tollit M, Feldman D. Transformation of health-care and legal systems for the transgender population: the need for change in Australia. JPCH.2015;51:1051-1053.