

Gender Transitioning and Responsible Responses

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.^{1 2} 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".³

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.^{4 5 6} 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.⁷

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evidence-based medicine has been suspended when it comes to gender dysphoria; objective criteria for diagnosis have been replaced by subjective declarations on the part of the patient as justification for a range of puberty blockers and hormonal interventions, which usually lead to surgical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 worse⁸. 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-study⁹.

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 adults¹⁰
- 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 transitioning¹¹
- 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' body¹². 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'¹³, 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, 1994¹⁴). 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".¹⁵

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.¹⁶

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.¹⁷

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 three¹⁸. 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)

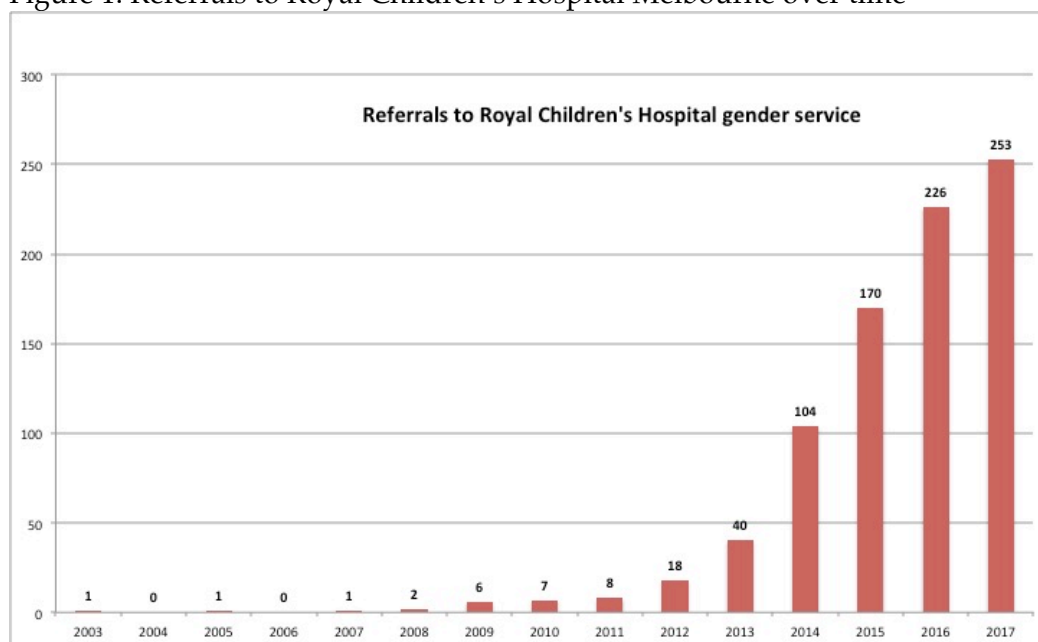
5. The impact of transgender ideology in Australia

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)¹⁹

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’²⁰.

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 population²¹ and more psychiatric co-morbidities²². 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).

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!

- c) 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)²³.

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.

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9 August 2019

Note:

This submission is endorsed by:

- Dr. Sue Packer AM, Senior Australian of the Year
- Women Speak Tasmania
- United Tasmania Group (UTG)

cc: Federal Minister for Health, the Hon Greg Hunt MP

¹ American College of Pediatricians, press release, 3 August 2016.

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³ *The role of the GP in caring for gender-questioning and transgender patients*, RCGP Position Statement, June 2019.

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