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Submission to Qld Parliament re pending Health Legislation Amendment Bill 2019

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Dear Committee Secretary

Members of the Christian Medical and Dental Fellowship of Australia empathise with the Parliament of Queensland in its concerns for children with gender dysphoria, and with their families. We understand the anguish involved with this problem and sympathise with the suffers. As doctors and dentists we are committed to reducing suffering in all our patients: gender dysphoria is no different; we are alarmed at its rising incidence and its implications, especially the concept of life long medical dependence and incidence of suicide in adult transgendered folk.

We appreciate the government would want to do all it can to reduce the suffering and that it has sought advice from various sources. But, in the spirit of cooperation we would like to share some 'good news' that may have been overlooked.

The first good news is that all respected sources assure that the great majority of children confused over gender will re-orientate to an identity in accordance their chromosomes, through puberty, with traditional support of individual and family psychotherapy. Please note the very optimistic report by psychiatrist Robert Kosky who was chief paediatric and adolescent psychiatrist of Western Australia, and other optimistic reports contained in the article ... published in Quadrant March 2019, with references supplied.

Sadly, the success of a 'wait and see' policy with psychotherapeutic support appears to have been overlooked in preference to a current vogue of hormonal therapy with the prospect of reproductive surgery.

Worse, such traditional psychotherapy is now derided as 'conversion therapy' and is to be banned in the state of Queensland, and punished as a criminal offence.

Another advantage of psychotherapeutic support is that the commonly associated mental disorders of autism, anxiety, depression and even psychosis may be dealt

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with in appropriate ways. We are aware proponents for hormonal and surgical intervention for the mental discordance between gender identity and chromosomes argue that such mental disorders are secondary to the gender dysphoria and or bullying by unsympathetic associates. But the evidence for that claim is weak: often eg with autism, the mental disorder clearly precedes what may be fairly described as the secondary symptom of gender confusion.

In corollary to the usefulness of standard psychotherapy, is its helpfulness in the tragic tendency for children with mental disorder to harm themselves. Proponents for hormonal intervention claim it will reduce such a tendency but sex hormones therapy is not recognised as a therapy for primary autism, anxiety and depression. And there is little scientific evidence that hormonal therapy renders gender confused children more stable. There are no blinded, cross-over trials, and in the single observation of children treated with hormones, there is the confounding effect of inherent psychological support provided by the affirmation and encouragement by the child's authority figures associated with the transgendering process...ranging from doctors, social workers, counsellors, parent, web sites, transgendering peers etc. Such concentrated love and attention might have been all the vulnerably child really needed in the first place.

The real issue of suicide is not with the vulnerable child as much as the vulnerable adult who has not found the process of transgendering as liberating as intended. It is on record that the suicide rate of such sufferers is some 20 times higher than that of the general population, even in the most accepting European countries.

Yet another problem with parliament's insistence on hormonal intervention by its intended banning of psychotherapy is that of the published side effects of the hormones, a reality that appears to be underestimated by proponents for hormonal therapy. Indeed, given the precedence of Whittaker vs Rogers in which the High Court of Australia declared there was an obligation to declare all side- effects, even rarities that might occur but once in several thousand cases.

These side effects, well published internationally relate, first, to the blocking of puberty, and then to the administration of cross sex hormones.

Attached supporting articles will refer more deeply to these effects but, essentially, the hormone blocked by 'puberty blockers' has been revealed to have a widespread role in maintenance of integrity of nerve cells, in and out of the brain.

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Within the brain, researchers at Glasgow and Oslo Universities, have demonstrated lasting deleterious effect of puberty blockers on the limbic system which integrates memory, emotion, cognition and reward and leads to a kind of 'internal identity' which is pursued by 'executive function'. On puberty blockers, the limbic systems of sheep are damaged: the functions of many genes are interrupted and, clinically, the sheep loses proficiency in mazes and is more emotionally unstable.

Adult humans, on blockers for various medical reasons, have also demonstrated reduction in 'executive function' but, of course, there are other effects on their brains, from drug therapy for cancer to ageing, that confound analysis. Nevertheless, the primary effect of puberty blockers on the brain cannot be excluded.

Recently, a young natal male administered blockers for gender confusion was found, on MRI examination, to have not undergone the expected growth in cerebral white matter, complicated by a reduction in cognitive ability.

Even nerve cells in the bowel appear to be affected by administration of puberty blockers: adult women receiving them for endometriosis demonstrated an unexpected increase in gastro-intestinal symptoms, associated, as revealed on biopsy by a marked reduction in enteric neurons.

Thus, it has been strongly hypothesised that the blocked hormone has a widespread role in maintenance of nerve cell integrity.

These demonstrated side effects should be acknowledged by proponents of hormonal therapy, instead of the repeated assertion that the effects of blockers are 'safe and entirely' reversible. That blockers may be administered to children as young as 10, when they are about to undergo the great cerebral development in adolescence, is of grave concern.

Blockers are given for several reasons, according to proponents. One reason is to afford the child more time to consider its gender identity and procreative future. But, if the sexualising effects of blocked hormones are denied to the brain, and if the limbic system is damaged, how is it biological plausible that blockers permit rational consideration of gender identity?

Cross sex hormones also have effects on the brain that appear not to be acknowledged by their proponents. For example, one study has revealed a male brain on oestrogens shrinks at a rate 10 time faster than ageing, after only four

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months. Yet the transgendering child and adolescent will be receiving them for life! Which raises the question of why transgendering adults are more likely to commit suicide? Proponents of hormones argue they do so because of ostracism by society, even though the high rates were recorded in the most accepting of countries. Unasked is the question of whether, ultimately, expected happiness did not eventuate after all that medical treatment. The psychological vulnerability of these folk is widely recognised.

Also unasked, but valid, is the question of whether the effect of the hormones on a brain organised before birth to anticipate and respond to hormones directed by chromosomes (and not gender clinics) might have so deranged neuronal connectivity that reality became distorted?

Many questions remain to be answered. Indeed, proponents of hormonal and surgical intervention are at the forefront of confessions of lack of evidence. Some programmes are now in place to 'see what happens', without any control 'arm' to the intervention which would, of course, involve not giving hormones, relying on psychotherapy.

Such is the depth and breadth of knowledge regarding any possible advantage of hormonal intervention, and such is the integrity of research revealing complications that the whole process can be fairly described as experimental.

Therefore, it is only fair to refer to the documents of human rights and experimentation that were hammered out at the end of WW2 in response to human experimentation.

Given all that is known (of side effects, including later suicide) and all that is not known of positive effects, it surprises that Queensland Government should identify with one arm of the experiment, and even threaten criminal sanctions against anyone utilising the, once standard and often effective, other arm of psychotherapy.

Why get involved in this medical matter? Why force a crisis of conscience on therapists aware of grave side effects and unconvinced of advantages of hormonal and surgical intervention in confused and vulnerable children, most of whom are known to revert to an identity in accordance with chromosomes with traditional support. Why ban psychotherapy? Why deride it as 'conversion therapy?' Does child and adolescent psychiatry have no role in allaying confusion and orientating the mind of vulnerable young people to physical realities?

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Given the excuse that 'the government made me do it' was renounced at the Nuremburg trials, why cause crises of conscience by forcing therapists to wonder wherein lies their greater duty of care? To obey the rulers and entrain the children to gender clinics that are prone to administer hormones and surgery? Or to disobey the government, rely on psychotherapy, and accept the consequences. Surely the Government of Queensland would prefer therapists who acted on traditional ethics?

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Please note attached relevant documents

Conversion Therapy and Review of Successful Psychotherapy

Conversion Therapy and Experimentation

Submission to the Federal Minister of Health

Conversion therapy, the ALP and gender dysphoric children.

It appeared a victory for common sense when the Federal Australian Labor Party retreated from its publicised aim of criminalising the practice of 'conversion and reparative therapies on LGBTIQ+ people' at its National Conference in Adelaide last December. Instead it was a victory of dialectical cunning: instead of wasting energies on pursuing criminal charges, abolition of so-called 'conversion therapy' would be more easily attained by advance along the easier route of civil proceedings with their less rigorous burdens of proof.

Louise Pratt, WA ALP Senator and leading Rainbow Labor figure, revealed the tactic was based on recommendations from a La Trobe University 'study', while reassuring 'the Party was more strongly committed against conversion therapy than ever'[1]. The study would have been 'Preventing Harm, Promoting Justice. Responding to LGBT conversion therapy in Australia'[2]. Released in 2018 from the Victorian Human Rights Law Centre and the Australian Research Centre in Sex, Health and Society at La Trobe it aims to reveal the 'truth' of these therapies, 'highlight' suffering they have caused, help religious and other organisations be more supportive, and 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'[3].

The Rights Centre promotes LGBTI rights. The Research Centre created the Safe Schools Programme with its ideology of gender fluidity. Recommendations were developed with the Victorian Commissioners for Gender and Sexuality, Health Complaints, and Mental Health, and with members of the Labor government's LGBTI Taskforce[4].

Under the rubric of 'Appropriate Sanctions and Penalties' for conversion therapists, the study recommended 'Civil penalty provisions rather than criminal offences' because they are 'more proportionate to prevent and respond to the harm'. That 'proportionate' most likely means 'effective' is revealed by the continued explanation: 'A criminal law would also require the elements (both the conduct and the mental element) of the offence to be defined with specificity and proven beyond a reasonable doubt. Such a burden of proof may be difficult to meet for these cases, particularly in circumstances where the only witnesses to the conduct are the victim and the perpetrator'.

Enforcement of civil laws would be increased by giving 'power' to a suitable 'office holder or statutory agency (whether the Health Complaints Commissioner or other body)' to 'enforce the provisions against both individuals and corporations'.[5]

What is 'conversion therapy'?

According to the study it is 'an umbrella term used to describe attempts to 'convert' people from diverse sexual and gender activities to an exclusively heterosexual and cisgender identity'[6]. In practice, with regards to gender dysphoric children, it has a simple meaning: anything which reduces their distress by helping to orientate their minds to their chromosomal gender, not their bodies to their minds.

Until recently, non-medical psychotherapies for gender confused children and their families were utilised, and are reported to have been effective, as discussed below, but advances in medical technologies in the 1970's led to medicalisation of treatment with drugs to block puberty, and hormones to promote features of the opposite sex. These would be associated with 'social affirmation' in a newly chosen gender, and often followed by 'cosmetic' surgery including

mastectomies, as well as uro-genital extravaganzas to mimic the genitalia and associated plumbing of the opposite sex, all under a life-time of medical dependency.

This medical pathway became known as the Dutch Protocol because it was launched in Holland, but it is now widely practiced in the Western world. It results in a superficial 'sex realignment' of the body to an image in the mind. Castration is inherent.

Such is the commitment to the Dutch Protocol that former psychotherapies are no longer considered, except to be condemned, without explanation, as 'conversion therapies. Indeed, they are to be forbidden if Labor's policies have their way.

The first legislative attempt at abolition is contained in the Victorian 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'.[7] In corollary, upon victory at Federal level, its abolition will be a personal priority for Labor Shadow Minister for Health, Catherine King[8].

Not only is it likely to become illegal even to delay referral of a child to a clinic practicing the Dutch Protocol, therapists in those clinics will be free, conversely, to direct that child towards any of the new genders promoted on the web, as often as the child feels like a change, as long as it is not re-oriented to the one in which it was born.

True, 'conversion therapy' has gained a bad name because attempts to 'convert' adult homosexuals to heterosexuality have been historically associated with instances of physical and mental brutality, as well as compassionate psychotherapies. The former has included torture, and such medical intrusions as hormones, lobotomies, and castration. But, regarding children, none of these things or any significant side effects of psychotherapeutic helping the child become comfortable in its natal sex have been reported in modern medicine. On the other hand, the experimental attempt by the Dutch Protocol to convert a child into a non-natal identity IS based on hormones, could be said to practice chemical lobotomy, and includes castration.

What evidence does the La Trobe study bring to the table?

The study claims there is 'overwhelming evidence' of harm from 'conversion therapy' as confirmed by the experiences it presents of 15 respondents recruited through social and LGBTI media and 'various LGBTI, queer and ex-gay survival networks'. Ranging from 18 to 59 years, 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.

All had participated in 'spiritual healing', including individual and group counselling, theological discussion and prayer, but this was reported to have failed to influence sexual orientation, while increasing misery through intensification of conflict with traditional theological beliefs. Accordingly, the study proclaims conversion therapy is futile, harmful, deserves to be banned, and churches, especially Christian Protestant ones, should be taught or forced to embrace differing sexual behaviours. Biblically: Saul's distress at 'kicking at the pricks' will be prevented by their removal.

One of the fifteen testimonies requires special mention because the torture she, Jamie, allegedly experienced is permitted if not encouraged to colour the whole discussion. At 17, in the late 80's, in Australia, after confessing she had 'fallen in love with a Christian woman', she alleges being awakened at night and taken to a psychiatric unit for two weeks where 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 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 study rightly condemns such treatment and needlessly refers to international obligations against torture. But, is this uncorroborated account convincing? Could such abuses remain in Australia after revelations of the 'deep sleep' scandals in Chelmsford Hospital, Sydney, in the 60's and 70's, or the Ward 10B abuses in Townsville in the 70's and early 80's, not to mention the sexual abuse in churches? Jamie's allegations demand official investigation before promotion in the interests of amending or creating legislation. Psychiatry was blighted by the vogue for releasing 'repressed (but spurious) memory'. In Jamie's case, we are in danger of adding the pathology of unrepressed credulity.

What is weak about the La Trobe study which is so influential for Labor? Jamie's case appears more propaganda than evidential. Fifteen recruits is a very low number. Self-selection is not representative. There is no mention of a denominator: how many people have been helped by 'spiritual counselling'? Recruitment after advertising in an established cohort is biased. Inconsistently, a review of experiences of American mothers of teenage daughters with Rapid Onset Gender Dysphoria which concluded they were suffering from 'social and peer contagion', a contagious psychological phenomenon, from which they might recover, and not a biological disorder, was derided by gender activists, disowned by a university and pulled from a website for its 'unscientific recruitment' from social media sites[9].

Perhaps, the most unscientific aspect of the La Trobe study is its extrapolation of adult experiences to children. While it is recognised it is difficult to alter adult orientation, it is also known that the large majority of confused children will naturally re-orientate to natal gender through puberty. The study compares apples with oranges. Yet it appears to have a defining influence on the Labor Party and its National Platform.

What does the La Trobe study recommend?

Given the study influenced a public retreat from the proclaimed Labor objective of criminalising conversion therapy, and that the retreat was accepted unanimously at the recent National Conference, further influence is likely: perhaps it is a blue print for action after electoral victory. Its recommendations should, therefore, be scrutinised: they are relevant for the medical, educational and theological professions, not overlooking gender confused children and their families.

The study calls for the Victorian Health Complaints Act (2017) to be strengthened, and to become instructive for the rest of Australia. It should be emphasised (because it still appears unnoticed) that the Act already possesses the power to reverse the traditional onus of proof in which innocence is presumed until guilt is proven. Ms Hennessy declared the need for '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 Minister sought to reassure, however, she was 'of the view that there is a negligible risk that these provisions would allow an innocent person' to be found guilty and declared them 'compatible' with the 'Charter of Human Rights and Responsibilities Act 2006'[10]. This 'reverse onus' may apply to anyone even reluctant to refer a confused child to a clinic practicing the Dutch Protocol: from medical doctors to psychologists, school counsellors, principals and pastors.

It could be argued the Complaints Act already possesses enough power to intimidate and punish but the study demands more. It wants to replace the unspecified intention to abolish conversion therapy with specific 'legislation that categorically outlaws (it) …that unequivocally prohibits conversion practices, whether or not an individual complaint is made'. And it wants to ensure action by obliging 'a legislator to intervene to protect children from conversion practices, regardless of the setting or level of formality'. Already, the Victorian Health Complaints Commissioner is 'investigating' conversion practices without prompting by complaints.

It demands thought control and obedience of all therapists of gender confused children by creation of a special registration (monopoly) whose membership will be 'subject to training requirements and professional codes', supplemented by 'relevant guidance materials' which emphasise 'conversion therapies' are 'not consistent with their professional obligations' and warn that 'disciplinary actions' will apply.

Obedience to the Party Line will be enhanced by delegation of policing powers and responsibilities to 'Associations of Health Professionals', such as Medical Boards, whose 'codes' should be 'strengthened' to 'specifically and explicitly prohibit conversion practices and ensure that enforcement action is available and actively pursued by the relevant professional body'. Relevantly, the Australian Health Practitioners' Registration Agency (AHPRA) is currently reviewing a new 'code of conduct' in which a doctor could be found 'unprofessional' by making public statements that challenge perceived beliefs, thus reducing community trust and causing some to feel 'culturally unsafe'. Penalties include deregistration.

The study demands school funding be dependent on prohibition of 'conversion therapies' by counsellors, provision of 'training' on their harms, and demonstrated awareness of obligations to report 'unlawful' behaviour to 'child protection services'. Such behaviour includes to submitting a child to a gender clinic.

It also demands government funding for sufferers from conversion therapies, and for research into these practices in 'faith-based organisations' especially 'Protestant Christian communities.

Finally, it demands restrictions of public broadcasts that promote 'conversion therapy' which, coupled with accusations of 'unprofessionalism' by AHPRA, would ensure immediate trouble for any practitioner inclined to speak favourably of psychotherapies, let alone question the experimental Dutch Protocol.

Looking back at past psycho-therapies: now to be outlawed as 'conversion therapies. Are they abhorrent?

Childhood gender dysphoria was rarely documented before the 1970's and, before the Dutch Protocol was developed in the late 80's, was managed by a variety of non-medicinal therapies. According to Zucker and Green, these included 'behaviour therapy, psychotherapy, parent counselling, family therapy and group therapy' with emphasis reflecting 'conceptual orientations' of the cause of gender dysphoria: was it a primary problem of the child, or secondary to issues in its family.

Most earlier therapists emphasised family influences, especially the interaction of boys and mothers which had developed into a 'symbiotic' relationship perpetuating the feminine identification of the boy. That emphasis, of course, confronts current ideology which insists gender identification arises within the child: irrelevant to chromosomes, there arises a kind of Gender Spirit which, sadly, may find itself in the wrong body.

In 1971, Spensley and Barter reviewed 18 adolescent boys with a mean age of 14.9, concluding 'all mothers and 77% of fathers played active and passive roles, respectively, in encouraging their sons' crossdressing'.

In 1975, Bates et al reviewed experience with 29 'gender-disturbed boys' and their families, during which they developed 'procedures that seem(s) to be effective' in improving a child's repertoire of masculine behaviours, social skills, and family relationships. They concluded 'the behavioural problems… are often formed and are almost always maintained as a function of family relationships. Eighteen months after treatment, 17 mothers had reported 'moderate increases in masculinity', and improvements in social skills and behaviour.

From the 70's Rekers and co-workers at the University of Florida reported regularly on their behavioural and psychotherapeutic management of gender dysphoria. Essentially, they rewarded masculine behaviour while ignoring feminine behaviour in dysphoric boys. Rekers maintained 'gender disturbed children who completed their therapies 'experienced significantly greater long-term improvement' which was observed to continue for at least four years[11]. Younger children were most responsive.

Rekers was criticised for allegedly promoting hyper masculine traits but responded by declaring 'the most adaptive psychological state appears to be the one in which the essential (biologically mandated and sexually defined) distinctions between the male and female roles are mastered by the child. Beyond that point, there should be sex role flexibility'[12].

Foreshadowing claims of current transgender activists, Rekers wondered if his critics believed 'transexualism' is 'deviant or undesirable only in the eyes of a skewed society with distorted and antiquated social standards'. He replied 'it is clearly deviant for a boy to state repeatedly that he can bear children, and to wear maternity clothes compulsively. It is pathological for a person to state his genitals are not rightfully his property, thereby requesting that they be surgically removed'. Even more controversially, Rekers reported one set of parents believed something more persuasive than rewards should be instituted and, consequently, delivered four 'swats' to the child for gender related behaviour during the treatment, plus two for general misbehaviour.

In 1974, Pauly summarised world literature on 80 cases of female transsexualism concluding: 'Parents ought to be more aware of the need to positively reinforce all infants for those gender characteristics which are consistent with their biological identity. I can think of very few worse fates than to be the life-long victim of the kind of family discord or ignorance with breeds gender identity problems'[13]. Re-enforcement of natal gender is, of course, anathema to the current belief in early affirmation of its opposite.

In 1976, Stoller stated 'simply …most feminine boys result from a mother who, whether with benign or malignant intent, is too protective, and a father who either is brutal or absent (literally or psychologically'[14]. He concluded, starting early, psychotherapy has 'regularly been able to diminish or remove' cross gender behaviour. Psychotherapy included 'uncovering, interpretation and the resolution of conflict by insight' plus the encouragement of 'masculinity' and discouragement of 'femininity' in the child. This therapy might result in a mother realising her dependency on a feminised son as 'the only good male in the world', and a distant father increasing 'commitment to his son, wife and family'.

In 1977, Davenport and Harrison reported a 14 ½ year old girl with marked gender dysphoria who 'convincingly presented herself as a boy in dress, voice, movement, interests, and orientation', while hiding her developing breasts. She insisted on sex change surgery (of which she understood little) but was admitted to a psychiatric hospital and underwent regular psychotherapy for some

twenty months. 'Geared specifically for adolescents', this included 'active intervention, therapeutic school, recreational and occupational therapy'. Gradually, she reorientated to her natal gender and two years after discharge 'appeared to have adopted a feminine identity.' 'Understanding the family constellation' had been important in the treatment.

In current Australia, such dysphoria with aversion of breasts and desire for surgery could have led to bilateral mastectomies, as experienced by five local girls under the age of 18: 2 at 15. Progress of puberty would have been blocked by drugs, and facial and body hair inspired by testosterone. She would have been given a new name and identity, and could have anticipated uro-genital rearrangement, sterility and a life-time of medical dependency.

In 1978, Zuger reported a 10 year follow up of dysphoric boys who had undergone psychological and psychiatric care. He noted 'a kind of 'decay' or burning out of these symptoms, completely in some, partially in others, and not at all in a few'[15].

In 1980, Lothstein reported a five year follow up of 27 cross dressing adolescents with mean age of nearly 17, identifying major 'stressors' associated with their request for sex realignment surgery. These included a recent change in a relationship, physical maturation, and stigmatized homosexuality. He reported 'urgent demands for surgery often decrease' with psychotherapy. He concluded 'gender dysphoria conflicts in adolescents have their roots in psychological conflicts' and, 'given the irreversibility of surgery and perhaps even some hormone effects', a trial of psychotherapy is the initial treatment of choice'. Lothstein warned 'surgery should only be considered towards the end of adolescence (age 21) after extensive psychological assessment, a lengthy evaluation and trial psychotherapy'[16].

Relevant for the current practice of 'affirmation' of a child's new gender identification by parents and other authorities, Lothstein observed 'an encouraging parent, or compassionate sibling, who supports the patient's cross dressing and wishes (for surgery), may make any psychotherapeutic intervention difficult'.

In current Australia, adolescents may undergo sex change surgery when 18, and mastectomies even earlier under the fatuous argument such surgery is reversible, given the availability of silicone sacs. Prior counselling is reported to be perfunctory: nothing remotely similar to the psychotherapy of Lothstein's day appears to exist. Indeed, in the Australian future, even broadcasting about it may become illegal.

Lest it be construed such psychotherapies were only practiced overseas, in 1987, surely their most dramatic account appeared in the Medical Journal of Australia, when Robert Kosky, Director of Psychiatric Services at the Perth Princess Margaret Hospital for Children, and WA State Director of Child and Adolescent Psychiatry Services, answered the question 'Gender-disordered children: does inpatient treatment help?'[17]

From experience with 8 primary aged children, seven boys and one girl, referred between 1975 and 1980, Kosky reported the problem of cross-gendering usually began 'around two years of age' when the parent had 'with delight, found that, when the child was dressed in clothes of the opposite sex, play together was fun'. Later, 'the child cross dressed on his or her own.'

Kosky observed 'unhappy (parents)…especially the parent of the opposite sex who seemed tied to the home, lonely and with few school contacts' but who claimed 'a close emotional bond' with the child. The parent of the same sex was usually 'absent'.

He concluded cross-dressing was 'not the only, or indeed the central problem…Unhappiness, anxiety, suicidal thoughts, aggressiveness and failure to learn adequately at school were features present in most. As were the cross-gender behaviours, these features appeared to be secondary to the pathological parent-child relationships. He found 'the essential disturbance in these cases was the inability of the parent of the opposite sex to accept the child, except on the conditional basis that the child met certain of their needs'. He explained that to overcome their own mental issues, the parents 'developed a fantasy about the child…(denying) the child's biological sex' and encouraging 'their notions of opposite sex behaviours in their child (such that) when the child adopted these behaviours, the parent changed from a cold mechanical interaction with the child to warmth and affection.' This 'symbiotic relationship' isolated the child from its peers: 'the mutually sustaining relationship precluded the development of ordinary social skills, reinforcing dyadic dependence'.

Treatment involved admission to a 'psychiatric unit' while attending the local school. In both places the child was encouraged to play with other children and to adopt 'age appropriate behaviours' but 'no conscious attempt was made by the staff members to encourage masculine or feminine behaviours. The only injunctions were that the children had to respect the privacy of others, and not steal 'underwear'. Parents visited regularly and were encouraged to join activities with their children.

What happened? 'Cross dressing ceased very quickly after admission…Many of the other behaviours, which had been present for years, vanished after several weeks. Improvement in 'general mood' was noted and 'school achievements and social behaviour improved steadily…' By the end of the average stay of 18 weeks, 'the children were functioning socially and educationally' at age appropriate levels.

Kosky reports, however, that 'such dramatic changes in the children's behaviour produced anxiety for all the parents. One mother had 'panic attacks' after which her 10-year-old son reverted to cross dressing. When she 'settled down', he 'ceased cross-dressing'. She then began 'sabotaging the treatment by bringing in female clothes… and isolating herself with him in his room'. Finally, she discharged the child against medical advice. He was never seen again.

Progress of the remaining children was reviewed one year after discharge but with continued psychiatric therapy. School, social progress and general maturation were judged reasonable. Cross dressing had resumed in one six-year-old in association with long periods of paternal absence, warranting re-admission for 2 weeks. He was last seen at 16 years when he identified as a male of heterosexual orientation without any cross-gender behaviour.

Eight years after discharge, but with continued psychiatric contact, one 17-year-old declared he was 'mixed up' about his sexuality, believing he had been 'programmed into homosexuality by his mother'. None of the others 'expressed homosexual feelings, was transvestite or transexual'.

Kosky declared 'an overemphasis on the biological model of gender dysphoria' may lead to 'therapeutic pessimism': some of the parents had been told there was 'no hope'. One was advised 'the child would have to go to New York for a sex change operation'. Kosky concluded 'the treatment of cross gender behaviour by means of inpatient therapy seems effective' and the 'emphasis on the familial and social context of the disorders…should counteract undue emphasis on the behaviours themselves…(which)…seemed relatively superficial manifestations of disordered personal interactions and an inadequate repertoire of social skills on the part of both parents and child.'

A most recent review of the role of psychotherapy in childhood gender dysphoria was published in the Journal of Homosexuality in 2012[18]. Written by Zucker and associates it describes management

of 590 children aged from 2-12 years referred to their clinic in Toronto since establishment in the 70s.

After a lengthy, introductory phone interview, if warranted, the child and family would be invited for assessment during 3-4 visits. If merited, according to the Diagnostic and Scientific Manual for Mental Health, the child and family would be invited to undergo psychotherapy which might continue for years with an intensity revealed by one 5-year-old who had his 112th therapeutic session when 9. The child would be encouraged to become 'comfortable in its own skin', that is, to return to natal gender. This would not only reduce individual and family stress but avoid the 'complexities of sex-reassignment surgery and its biomedical treatment'. If, however, 'a particular adolescent…is very much likely to persist down a pathway toward hormonal and sex-reassignment surgery', Zucker declared 'our therapeutic approach is one that supports this pathway'[19]. Zucker had reported a persistence rate of 12% of affected girls and 13.3% of boys but it is not clear how many continued to hormonal and surgical intervention, or whether it was helpful. [20]

Psychotherapy included '(a) weekly individual play psychotherapy for the child, (b) weekly parent counselling or psychotherapy, (c) parent guided interventions in the naturalistic environment (eg determining limitations for time and place of cross dressing) and (d) when required… psychotropic medication.' Biopsychosocial factors would be identified, explored and addressed: in a boy naturally disinclined to rough and tumble, self-esteem might be enhanced by introduction to boys with similar interests. Psychosocial factors might include the perpetuating influences of parental neutrality or actual encouragement of cross dressing. Social cognition might be limited: disinclination to rowdiness might make a boy think he is a girl. Co-occurring psychopathology such as autism might engender obsession with cross dressing activities. Psychodynamic factors might involve a transfer of unresolved conflict and trauma related experiences from parent to child.

The aim of the psychotherapy was not to establish 'right or wrong' but to help parents understand 'why their child feels the way': to explore and consider 'how best to help them and their child'. Therapy would aim to reduce the child's dysphoria, whether or not it turned out to be heterosexual or homosexual. Zucker emphasised 'our approach with parents is to make the point that the surface behaviours of (gender dysphoria) are, in effect, 'symptoms' and that symptoms can best be helped if the underlying mechanisms are better understood.'

Zucker's therapy was condemned as 'conversion therapy' by activists and this Professor who been leader of the Center for Addiction and Mental Health for decades in Toronto and international leader in the field, was stood down and his unit closed in 2015. Such is the power of the ideology of gender fluidity.

Summary.

Some earlier features of childhood gender dysphoria differ markedly from today. It was then rare: now it is not. Kosky reported 8 referrals over 5 years: now the equivalent hospital reports 2-3 referrals a week. None of Kosky's patients received hormones. Now, a few hundred Australian youths appear to be on regular therapy. Over 30 may have undergone irreparable surgery which many more are reported to be contemplating[21].

Once, confused boys predominated. Now, vulnerable teenage girls appear susceptible to a psychological phenomenon: a 'social and peer contagion'[22]. The psychological impact on gender identity of social media and the internet should be researched, and appropriate psychotherapy employed. Are girls recoiling from pornography?

No current sufferer appears to have been offered the once standard, non-medical treatment. Indeed, despite reports of therapeutic benefit, if a victorious Labor Party proceeds to legislate declarations in its newly minted National Platform, even positive discussion of psychotherapies will be illegal.

Does the great party of the working class really want the workers to know it no longer believes they produce boys and girls, merely loci on a flexible Rainbow? Does it really want them to know that if an offspring suffers gender confusion it will have legislated against discussion and practice of any alternatives to hormones and surgery?

Finally, given most dysphoric children re-orientate to natal gender, isn't the current 'transitioning' of a child to an alternate gender just the same as old fashioned 'converting' a homosexual with hormones and surgery, and ethical abhorrence?

Prof. John Whitehall

CMDFA National Chair

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Victorian Labour 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'.[1] 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'[2] 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[3]. 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'[4]. 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' [5], 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[6], 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[7].

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[8] 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[9] 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.

Prof. John Whitehall MB BS, BA, DCH, MPH and TM, MRCP (UK), FRACP.

Professor of Paediatrics and Child Health.

[1] Ms Hennessy. Health Complaints Bill Second Reading. Parliament of Victoria. Hansard. Feb 10, 2016.
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[3] Ibid page 9.
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Submission to the Federal Minister for Health, Mr G Hunt.

The lack of scientific basis for the medical pathway of treatment of childhood gender dysphoria.

Prof. John Whitehall MB BS, BA, DCH, MPH and TM, MRCP (UK), FRACP.

Professor of Paediatrics and Child Health.

Mr G Hunt

Dear Sir,

I write to thank you for your concern about the increasing number of Australian children reported to be suffering from gender dysphoria, a new phenomenon. I look back to the experience of Dr Robert Kosky when he was Director of Psychiatric Services at the Perth Princess Margaret Hospital for Children, and WA State Director of Child and Adolescent Psychiatry Services and reported his experience with only 8 confused children in the five years from 1979 to 1984[1]. Now almost 2-3 children are being presented to the Perth children's hospital every week.

I refer to my own discussions in 2016 with 28 of my paediatric colleagues in Australia from whose 931 cumulative years of practice only 12 cases could be recalled: 10 with associated mental disorder and 2 victims of prolonged sexual abuse. Indeed, when I was in general paediatrics, at the forefront of child abuse in Western Sydney, for a child to attest to be of the opposite sex was taken to be suggestive of abuse. Nevertheless, in my excess of 50 practice in paediatrics, no child was ever brought to me with concerns of confusion in gender identity. Nor was confusion over gender ever raised by a parent or carer in intimate discussions of sexual behaviours of their children.

Now, the numbers of children being brought to children's hospitals with gender confusion are increasing markedly. Across Australia, they may have arisen from 211 in 2014 to 727 in 2018, giving a total of 2415 children and adolescents who may currently be undergoing therapy. To permit perspective, about 960 children and adolescents develop cancer each year in Australia.[2]

In a survey conducted by WA Telethon, it is reported that of 602 transgendering correspondents aged from 14-25, 58.3% have transitioned socially, 4.7% are taking puberty blockers, 28.3% are taking cross sex hormones, 34% would like to start cross sex hormones, 6.3% have undergone gender confirming surgery and 20.9% intend to undergo it in the future. [3]

Given there are no plausible biological causes for what can be described as an epidemic, it is appropriate for health authorities to investigate the problem. In the UK, it is reported that the 'explosion in the number of children wanting to change sex has prompted an inquiry by ministers' with Penny Mordaunt, the Minister for Women and Equalities, declaring she wanted 'to understand the reasons behind a 4,400 per cent increase in girls being referred for transitioning treatment in the past decade'. The Minister is reported to have declared 'officials will look into the role of social media and the teaching of transgender issues in schools as part of their inquiries'[4].

Therefore, the Federal Minister for Health is requested to investigate the outbreak of gender dysphoria in Australia, especially because it appears to have an infectious characteristic. For example, in the same year in a high school in Western Sydney, several girls were reported to me to have 'suddenly' evinced concerns over their gender identity.

The relationship between gender confusion and co-incidental mental disorder has long been recognised.[5][6][7][8][9] Proponents of medicalisation declare the dysphoria may cause the mental disorder, but there are confirmations of it presenting after the onset of mental disease, as part of its manifestations[10]. Autism spectrum disease, presenting in early childhood is known to be associated with later gender dysphoria, perhaps related to fixation of ideas[11].

It is thus recognised that children expressing confusion over their gender are vulnerable children, suffering broadly, who deserve a considered approach to diagnosis and treatment. One symptom should not predominate but be seen to represent an underlying complexity. To give a medical analogy, just because children with pneumonia may vomit, their illness should not be ascribed to infection of the intestines rather than the lungs.

With this in mind, vulnerable children with a symptom of gender confusion should not be denied the benefits of extensive support from traditional psychological, psychiatric and family therapy. It should not be forgotten that such therapy is known to have been effective in the past for children with disordered appreciation of their gender identity[12131415161718] It is widely reported that most children with gender dysphoria will orientate to natal gender through puberty[19].

The Minister is requested to review the evidence for the positive effect of traditional psychological, psychiatric and family therapy

The question to the Minister is thus 'why are children rushed into a pathway of medicalisation when it has been proven that supportive 'wait and see' will suffice. I, personally, have heard the sad refrain from a number of parents that their confused children were submitted to a brief questionnaire followed by a short consultation, after which the diagnosis of 'being born in the wrong body' was made. The parents were then advised to 'say good bye to their former son/daughter and welcome their new daughter/son'. Almost universally, attempts at consolation for the parents were based on the argument 'it is better to have a live daughter/son than a dead son/daughter'. Almost universally, counselling was then offered: to the parent to accept the new reality, not for the child to resolve the former.

The Minister is requested to investigate the extent of psychological, psychiatric and family therapy which has been made available to children who are now receiving hormone therapy and who have received surgical intervention in the process of approximating the external features of the opposite sex. How many sessions were held? How long did the sessions last? Who supervised the sessions? On what basis was it deemed necessary to implement hormonal therapy?

At this stage, the issue of likelihood of suicide should be addressed. There is, in fact, little evidence on the association between gender dysphoria per se and childhood suicide[20]. Self-harm is reported in many children and adolescents[2122] and, certainly in the cohort with gender dysphoria. A large UK study wondered if the numbers threatening self-harm in their cohort of dysphoric children "simply reflect trends in the general population'[23]. An article in the Journal of Homosexuality concludes "very few suicide decedents (sic)" have been identified as having "minority sexual orientation" in studies in North America: 3 of 120 adolescent suicides in New York, and 4 of 55 in Quebec"; and warns conclusions based on "small numbers ... must be regarded as tentative"[24].

It should, however, be emphasised that gender dysphoria is associated with co-morbid mental disorders recognised for a propensity for self-harm[25]. The children are, in general, at risk, and should be supported by traditional psychiatric therapy.

Gender dysphoric children are also at risk because of their associated high rate of family disorder, whose stresses are known to affect all children[26].

It should, moreover, be emphasised that prevention of suicide may be more effectively implemented by helping the child become 'comfortable' in the skin in which it was born. The suicide rate in transgendered adults has been reported to be at least 20 times higher than in the ordinary population[272829]

The Minister is requested to investigate the role of gender dysphoria in suicides in Australia, noting that answering 'Yes' to a question to a child or adolescent as to whether they ever felt like harming themselves, though of deep concern, is not necessarily an expression of intent. The Minister should be aware of the powerful tool for manipulation that exists in an alleged threat of suicide.

In England, it was reported 'there are concerns among some MPs that drug treatment is being offered too readily to children - some of them as young as 10 - without fully understanding what lies behind their desire to change sex'.

The administration of gender drugs is usually preceded by 'social affirmation' of a child's protestation that it is born in the wrong body. There appears to have been a change in the epidemiology of this phenomenon which should be appreciated by authorities. In the era of the 1970's to 80's, most confusion, as reported by Robert Kosky, concerned young males who were found to be in a pathological relationship of symbiosis with their mothers. Typically, the single mother had been abandoned by an adult male and persuaded in her mind to feel more comfortable with the boy the more he aped the female persona. Others have pointed to a higher than expected prevalence of psychological problems of mothers[303132]. In Kosky's experience, when separated from the mother, the child reverted to natal identity.

In current experience, gender confusion is more prevalent in in young adolescent natal girls when it has a rapid onset and appears associated with social media[33].

In either case, there is a need for traditional psychiatric exploration and standard therapy before a superficial process of confirmation (described above) and subsequent progress to social affirmation in which all the authorities of the adolescent from medical personnel, to parents, to schools, to the media, affirm the choice of the child to attempt to identify a gender contrary to the direction of chromosomes.

The Minister is requested to investigate the association of gender dysphoria with social media, and the promotion of the ideology of gender fluidity in schools.

Social affirmation of a child's or adolescent's identification with the opposite sex is dangerous because it is likely to lead to hormonal therapy and even surgery, whose risks will be explained below. Given gender confused children are almost always suffering from mental disorder including autism, depression and anxiety, they will, of course, appreciate all the extra attention, rendering them all the more susceptible to the enthusiasm of adults for their change in identity. Are these vulnerable children capable of mustering the strength to deny the influence of the authority figures and to declare 'No, I realise I really am a boy/girl'. It is not surprising then that most children who have been socially affirmed progress to the next step, drug therapy, which may be administered at the earliest signs of puberty which typically appear from 9-11 years of age.

The Minister is requested to review laws which compel school and other authorities to take part in the social transition of a vulnerable child whose body identification is contrary to its chromosomes[34]. To be aware that participation in an experimental procedure that will lead to irretrievable intervention in a child is a challenge to many consciences. This is of special concern when it is widely publicised that most affected children will revert to natal gender without intervention.

From social affirmation, the next step is the introduction of 'puberty blockers'. These are analogues of natural hormones which were developed in the 70's and shown capable of blocking the cascade of hormones that began deep in the brain and progressed to the gonads, causing them to release testosterone and oestrogen. These sex hormones stimulate development of secondary characteristics, including cerebral sexualisation.

They were administered for pathological, early development of puberty which they blocked, and to adults suffering from diseases worsened by continued production of sex hormones, for example, prostate cancer in men and endometriosis in women.

They began to be employed in the medical treatment of childhood gender dysphoria in the 80's, in order, allegedly , to reduce distress caused by the appearance of unwanted sex characteristics, and to give the child more time to contemplate its sexual identity and procreative future. Repeatedly, and under oath in Family Court of Australia proceedings, proponents declared their effects to be 'safe and entirely reversible'.

Research on sheep has proven the above claim to be wrong. In universities in Glasgow and Oslo, the administration of blockers has resulted in demonstrative effect on the limbic system which has hypertrophied, and in which the action of many genes has been found to altered. In response, it has been demonstrated that the cognitive performance of the sheep has been reduced, and emotional lability increased[35363738394041].

Studies on executive function of adult humans on blockers has found an associated reduction in cognitive and psychological performance though confounders such as age, pathology and treatment could not be discounted[42434445].

Furthermore, research on intestinal disorders in women receiving blockers to reduce the effect of oestrogen in endometriosis, reveals an association with marked reduction of the number of intestinal neurons[46], raising the possibility of a widespread role for the hormone specifically blocked in the brain[4748].

Therefore, the claim of safety for the use of blockers in children is not substantiated by international research. It should not be overlooked that puberty is associated with a great development of cerebral anatomy, from organisation, to myelination, to apoptosis. Administration of any drug shown to affect neuronal tissue should be undertaken only with rigorous scientific basis.

The Minister is requested to investigate why international research is being ignored, and why blockers are being administered to children without scientific substantiation. Their uncontrolled use amounts to experimentation. Their use without full disclosure of known side effects is both unethical and medico-legally dangerous.

The Minister is pointed to the conclusions of the Rogers vs Whittaker legal case[49] in which was confirmed an obligation by a medical practitioner to reveal even a one in ten thousand possibility of material side effect of therapy. Given public hospitals are involved in the administration of a drug with undisclosed but proven side effects revealed in laboratory animals, and strongly suggested effects in humans, who will be responsible for compensation when these already vulnerable children claim handicaps are the result of un-informed treatment?

The effect of blockers on nerve cells is only part of the problem of their administration. It is claimed their use will permit time for contemplation of sexual identity but there are indications that the primary hormone blocked plays a central role in sexualisation, as well as a secondary role in stimulating testosterone and oestrogen.

The blocked hormone certainly plays a role in the limbic system which eventually integrates memory, emotions, and cognition into executive function, i.e. into the internal 'world view' of the brain and its associated ambitions, identities and decisions.

However, widespread that the blocked hormone plays a widespread role in the brain is suggested by the presence of its special receptors in the cerebrum and spinal cord[50]. It has been also shown to be associated with a 'sex centre' in the midbrain which was identified in the 70's. If the blocked hormone is injected into the midbrain of an immature animal, it provokes precocious sexualised behaviour: young female animals prepare for mounting and males to oblige[5152535455]. This sexualising effect is blocked by puberty blockers[56].

The sexualising effect of the brain was already initiated several weeks after conception through a male specific effect of a gene on the Y chromosome. This effect seems to be further activated in puberty through the added effect of the sex hormones, testosterone and oestrogen, as part of their overall effect on male/female characterisation.

A great deal is unknown about the genetic and hormonal bases of sexual maturation but sufficient is known to question the validity of the claim that blockers permit time to contemplate sexual identity and procreative future. How can that future be contemplated appropriately in a child who whose sexualising influences have been neutered by drugs? How can a child be expected to develop a 'world view' including identity when its limbic system has been affected?

The Minister is requested to investigate the claim that blocking of puberty will permit appropriate contemplation of gender identity in vulnerable children. This claim is being promoted in public hospitals and has no scientific basis.

Given the pressures of social affirmation and then the neutering effect of blockers, it is not surprising reports claim most children on blockers progress to the next stage, the administration of cross sex hormones to stimulate the desired external appearance.

Though proponents of cross sex therapy list many complications of such therapy, I could find no reference in eg Family Court proceedings or proclaimed Guidelines for management of gender dysphoria to any effects on the brain.

The research by Hulshoff et al which reveals a rate of shrinkage of the grey matter of the male brain on oestrogens at a rate 10 times that of ageing, after only four months of treatment[57]. Others have also demonstrated changes on adult brains[5859]. There are no reports available on the effect of cross sex hormones on the developing brains of children and adolescents.

Administration of cross sex hormones has a suppressing effect on the natural gonads. Just how long it takes for the suppression to become permanent is unknown, but chemical castration is the end result. Proponents of childhood transgendering confirm this by suggesting eggs of females and biopsies of testicles might be taken before undertaking cross sex hormones in order to procure artificial conceptions in the future.

International guidelines suggest cross sex hormones not be given to adolescents under the age of 16. The Guidelines of the Royal Melbourne Children's Hospital have no age limit.

The Minister is requested to investigate the experimental administration of cross sex hormones on children and adolescents. Why are they able to be given contrary to international suggestion, and why are they given without full explanation of possible effect. The Minister should be aware the hormones had a demonstrable effect on adult brains after only 4 months of treatment. Children are likely to be receiving them for life.

Surgery is the next step in the medical programme of transgendering therapy. International advice is that irreversible therapy should not be undertaken under the age of 18 years but, already in Australia, at least five natal girls have had bilateral mastectomies under that age. Two were aged fifteen one sixteen and two seventeen.

Proponents of transitioning argue the procedures are justified by the claim they are 'reversible'.

The Minister for Health is requested to dissociate from the sophistry that a female breast is merely a cosmetic appendage replaceable by silicon sacs.

Lest it be concluded I am a lone physician emphasising the lack of scientific bases for declarations of the experimental nature of medical intervention in childhood gender dysphoria, I refer to an article published in a recent, prestigious journal, 'Paediatrics', by clinicians at the Royal Hospital for Children in Melbourne: a hospital noted for its leadership in promotion of the medical pathway for dysphoria.

The authors conducted a literature search on hormonal treatment of young people from 1946 to 2017, finding only 13 publications of relevance. They declared this scarcity was 'problematic', concluding the studies 'neglected several key outcomes' including 'psychological symptoms', the impact on fertility, the possibility of

side effects on growth and cardiovascular function, and the manner of withdrawal from treatment, especially with regret[60].

The Melbourne authors are not the only ones to complain of lack of data. Others have complained of 'limited long term data'[61], 'small numbers from one clinic'[62], 'reliance on clinical impressions'[63], "lack of randomized controlled trials…thus best evidence available is characterised as 'expert opinion' which is influenced by prevailing cultural belief systems and theoretical orientations'[64], and 'lack of consensus regarding appropriate intervention or even appropriate goals of intervention'[65].

In a Special Review in the Journal of Homosexuality concerning "The treatment of gender dysphoric/gender variant children and adolescents" David Schwartz (2012)[66] a child psychiatrist from New York, emphasised the lack of scientific data regarding medical intervention and concluded with the reassurance that affected children would naturally desist. He declared

> the long term psychological and physiological consequences of ... (the medical pathway) ... are unknown and, as is the case with all self-selected populations, very difficult to assess owing to problems of (lack of experimental) control and limited sample numbers.

Schwartz highlighted concerns, including dependence on "clinical impression", "usage of anecdotal data", suspension of "natural scepticism" in "favor of literality" of children's and adolescents' claims, unquestioning "certitude", and lack of consideration of "potential disadvantages".

Yet another review of recent research by Fuss et. al. (2015) concluded that

> more longitudinal research ... is needed to compare different strategies of care and to see long term results especially in those minors with comorbid psychiatric disorders. The lack of evidence is even more pressing considering ... the dramatically increasing number of referrals to gender clinics ...[67].

The Minister is requested to review the lack of evidence for positive effect of the massive intervention into the minds and bodies of children. Lack of evidence for effect and denial of side effects renders the medical pathway of treatment of childhood gender dysphoria experimental.

I address my requests to the Federal and States Ministers for Health, and to governance of Children's Hospital because I am aware of no national precedent for such widespread unsubstantiated medical practice. In my opinion an ideology, gender fluidity, has been imposed on a section of the medical and broader community with the full force of manipulated law. Such experimental practice confronts all conventions of human rights for children that began with the Nuremberg Trials after World War 2.

I am aware a request for consideration has been delegated by the Federal Minister to the Royal Australasian College of Physicians (RACP) to which I belong, and there are benefits for at least, the acknowledgement of the need for investigation. However, the RACP is ill fitted, in my opinion, for an investigation of such gravity. It is after all, an organisation primarily dedicated to the education of physicians. Interpretation of ethical issues that transcend the activities of physicians and involve participatory social workers, psychologists, psychiatrists and surgeons are beyond its purview.

The issue really belongs to Ministries of Health and governance bodies of children's hospitals. After all, the latter provided ethical clearance for the procedures, and continue to support the practice with administrative staff, building space and the salaries of the participants.

I fully appreciate the sensitivity of the matter. I am aware of the pain and suffering of patients, and the commitment of staff of children's hospitals to the 'best interests' of children. I have no criticism of the commitment of staff in children's clinics. I have written a number of articles in various publications, especially Quadrant Magazine to which readers may go for further information, including references. This far, no objections have been raised to my interpretation of scientific references.

Finally, the Minister is referred to the unfortunate case of Finch vs Southern Health in which a young man who underwent sex change surgery in Monash Medical Centre. He subsequently alleged an underlying psychological condition had not been diagnosed by the hospital and that he had been inappropriately treated.[68] The Melbourne Age reported 'AUSTRALIA'S only sex-change clinic has been temporarily shut down and its controversial director forced to quit amid growing claims that patients with psychiatric problems have been wrongly diagnosed as transsexuals and encouraged to have radical gender reassignment surgery. *The Sunday Age* has been told at least eight former patients of the Gender Dysphoria Clinic at Melbourne's Monash Medical Centre believe they may have been misdiagnosed. Some have tried to commit suicide while struggling to live as the opposite sex after the irreversible operations'[69].

The Minister is requested to contemplate the number of children likely to allege their psychological problems had been minimised and their lives irretrievably altered after entering the medical pathway for treatment of the childhood confusion.

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