

Submission to Health, Communities, Disability Services
and Domestic and Family Violence Prevention Committee

Health Legislation Amendment Bill 2019, Chapter 5B
Conversion therapies

SUBMISSION BY

Coalition of Activist Lesbians (Australia) (1999)

COAL

Chapter 5B Conversion therapies

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Dr Waite is available to speak the Committee on behalf of COAL, in person on Feb 3rd.

ABOUT COAL

The **Coalition of Activist Lesbians Australia (Inc.) (COAL)** is a not for profit, national advocacy organisation formed in 1994 to work towards ending discrimination against lesbians . COAL is community based and operates with a human rights and women-centric framework to protect lesbian human rights, and to support lesbians across six state and two territory jurisdictions to participate in activities for positive social change.

It is the only lesbian NGO, holding accreditation with the United Nations Economic and Social Council (ECOSOC), as well as the Division for the Advancement of Women. COAL is Australia's only lesbian specific organisation that advocates on many issues to all levels of government.

Aims and Purposes

COAL aspires to be part of a society where respect for differences, the rule of law, the dignity of all humans and human rights practices are shared.

COAL aims to protect the rights and improve the lives of lesbians in Australia by:

- Monitoring Australian governments, and the public and private sectors to ensure implementation of principles inherent in international covenants, including freedom of speech and rights to association.
- Lobbying for legislative and policy changes to include the women-focused rights of lesbians.
- Promoting equitable inclusion of lesbians regardless of race and culture, socio-economic status, ability and health status, age, geographical location, and religion.
- Promoting participation and equity for lesbians in public, private and community sectors.
- Informing and educating people about lesbian human rights through training, lectures, conferences, workshops, fora, submissions and publications.

To achieve these aims and fulfill our United Nations accreditation, COAL networks internationally, nationally and locally, with other lesbian, women's, and a diversity of general community groups.

We work to identify and promote positive approaches in human rights, social inclusion, youth affairs, health, housing, workforce issues, ageing issues, education, anti-discrimination/equal opportunity and other areas. These core interests have been addressed through research papers, submissions to governments (11) and others, community publications, action research, personal narratives, art and other cultural works, conference presentations, seminar participation, community education and participation in consultative, advisory and management structures.

For many years before COAL was formed, some members of COAL were involved with researching, advocating on behalf of, and supporting lesbians experiencing discrimination and harassment. The current committee includes a University Professor, a lecturer in Social Work in a Rural Health School, a geneticist with PhD

in Biological Sciences, a retired Associate Professor of Sociology, a Senior Lecturer in Management and researcher with a PhD in Political Science

SUMMARY and RECOMMENDATIONS

COAL is an autonomous lesbian advocacy organisation and the only lesbian NGO with United Nations accreditation. It has insider and historical perspectives on conversion therapies and the need for precision in language and science as the basis of legislation.

The consequences of this Bill for lesbians is the focus of this submission, as in our experience, LGBTIQ+ conglomerates have been unable to adequately represent our views. Our position may be at odds with some of these groups and we respectfully request this submission be considered as part of our right to free speech and participation in the political process.

The scope of the Bill, intended to protect LGBT people from harmful practices, is far too narrow to achieve its objective. Its provisions only apply to health practitioners and not the main practitioners of conversion therapies.

We are concerned that sexual orientation and gender identity are combined into the same clauses of this Bill. This results in significant tension in the Bill because harsh medical treatments are outlawed for sexual orientation conversion, while extreme surgery and dangerous hormones are condoned and supported for children, in the case of gender identity.

Throughout the Bill the clauses in relation to gender identity treatment rely on medical consensus rather than science and evidence based medical practice. Many lesbians have lived through a time of medical treatments based on medical consensus and legal punishments to try to cure our same sex attraction and so are very sceptical of a non-scientific foundation for protections under this legislation.

The definition of sexual orientation speaking only of same gender attraction, and not same sex attraction, is disrespectful and unacceptable to lesbians. There is a crucial difference between sex and gender and they must not be conflated, ie treated as the same thing or used interchangeably. The definition excludes lesbian realities and the right to define ourselves.

The reliance on sex role stereotypes as part of the diagnosis of gender dysphoria in children, is disturbing because non conformity in behaviour and gender expression is being pathologized and in turn supported by this Bill.

The caution and warnings of harms in the reviews of the major children's gender services in the UK and Sweden, need to be fully considered in the re drafting of this Bill. In particular the consistent finding that, around 80% of children recover from their dysphoria if managed with watchful waiting. There is no way to tell which children fall into the 80% and which don't. This evidence alone ought to be sufficient for extreme caution by legislators in the area of gender identity and why health

professional ought to be free to practise treatment approaches that do not adopt the affirmation model.

This Bill currently is in danger of harming all those children and teenagers who recover with time and maturity. This may lead to future claims against the State and /or health services providers, due to the lack of evidence to support sections of this Bill.

RECOMMENDATIONS

1. Include religious groups and individuals of faith- based groups and organisations, including public health services provided by faith- based organisations, in the provisions of the Bill.
2. Restrict this Bill to cover sexual orientation and draft a different Bill to cover gender identity when there is robust evidence of a need and evidence based and appropriate treatments
3. Include a clause banning the advertising of conversion therapies by any person, on any communication channel.
4. Review the language and terminology used in the QCGS publications and resources about gender and sexually diverse children, to ensure it is scientifically accurate and consistent with the terminology of this Bill
5. Define the two concepts of Gender Identity and Gender Expression separately to be consistent with the meanings used in the National Care guidelines and The Queensland Children's Gender Service (QCGS)
6. Define sexual orientation as: sexual orientation of a person, means the person's capacity for emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different sex /gender, the same sex/gender or more than 1 sex/gender.
7. Remove gender identity and exemptions in relation to gender transition from the Bill.

INTRODUCTION and BACKGROUND

COAL welcomes the Queensland governments interest in and commitment to the health and wellbeing of people in LGBTI communities. The opportunity to make a submission to the Committee is much appreciated, especially as some of the content of the legislation is contested from both within and outside LGBTI communities.

COAL is in a unique position to offer this Committee a Lesbian-specific perspective on issues in and possible consequences of the Conversion Therapy Bill. Many lesbians in COAL lived through the times when the medical consensus insisted lesbians were mentally ill and dangerous. It was not until 1984 that the Australian Medical Association changed their official position and declared female and male homosexuality was not a mental illness. It took until 1990 before the World Health Organisation came to the same conclusion (ref)

This was way too late for the lesbian mothers summoned to court in custody cases after leaving heterosexual marriages in the 1960's, 70's and 80's. In the decade from 1974, there was an upsurge in the number of custody cases involving lesbians and resulting in deep trauma to lesbian mothers, their children and their partners. (12)

The State supported the medical consensus of health professionals- that women attracted to other women suffered from a serious mental illness (13)

This expert "evidence" placed before the court, meant many lesbian mothers lost custody of their children on the grounds they were either psychologically unfit to mother, too dangerous to be around children or endangered the heterosexual development of their children. (12) We know firsthand of the lifelong harms done when medical consensus about sexuality and gender, becomes codified and then uncritically adopted by States in legislation. (14)

The "mental illness" consensus was codified in professional diagnostic documents such as the DSM manual and through professional treatments and education in public and private health facilities. Homosexuality was listed as a mental illness in DSM-I until 1973 (16) The DSM – Diagnostic and Statistical Manual – is the American Psychiatry Association's standard classification of mental disorders, and is still the standard reference used in Australia.

Older lesbians harmed by these practices know that the concretisation of medical opinion being accepted into law, obscures critical facts and shuts down dissenting views. Our lives are the data on which we base these observations about the short comings of medical consensus as the basis for psychological and medical treatments

- diagnosis in psychiatry and psychology is a social act,
- the construct of an illness, such as lesbianism or gender dysphoria, has social and legal consequences
- shifts in the concept and nature of a disorder like gender dysphoria, always reflect wider social, political and economic forces more than scientific advancement

This submission primarily focusses on the 'L', or Lesbian, part of the LGBTIQAP+ acronym, rather attempting to be inclusive of every community in the generic acronym, because the rights of one groups can infringe on the rights of another group. It is the

position of COAL, that autonomous lesbian views should always be sought by governments in the development of legislation that both directly and indirectly affects their rights and wellbeing.

Their views and insider knowledge need to be respected and valued as much as those of generic and more politically powerful or government funded LGBTIQAP organisations. It is our experience that none of those organisations have demonstrated an ability to fully represent, adequately express lesbian views or protect our rights and culture. This inability to include and represent lesbians of all ages, was the original motivation for the formation of COAL as a standalone, autonomous lesbian organisation. Similarly in 2017, at the European Lesbian Conference, a recurring theme was the 'dilution' of the 'L' and of lesbian issues in the LGBTIQ movement. (18)

A number of generic LGBTI organisations and lobby groups have already been consulted and had input in the processes of framing of this Bill. However, COAL holds significantly different perspectives on a number of crucial aspects of the Bill. One of these is the issue of medical consensus, rather than scientific evidence, as the foundation for medical treatments for distress about sexual orientation and gender identity, especially in children. This is especially relevant to the clauses in the Bill in relation to gender identity, in particular Chapter 5B, 213F Clauses 2 and 3.

Due to our lesbian history of discriminatory and harmful treatments, COAL places a very high value on robust science and published evidence, in relation to medical interventions and legislation. When it comes to sexual orientation and gender identity, COAL is extremely sceptical of medical or health professional "consensus" because of the awful harms perpetrated on lesbians and gay men in our lifetime.

Throughout this submission reference will be made to the term *lesbian*. COAL's position is that the word lesbian, refers to females who have an enduring sexual, emotional and romantic attraction to other females. In short homosexual females. Just like others groups affected by this Bill, lesbians claim the right to name and define ourselves and our boundaries.

We recognise that some women call themselves gay, queer, camp or bent and that sometimes terminology such as sexual minority, LGBTI + or same-sex attracted is used. While this may be seen as inclusive, it actually places lesbians in a different social and political situation. We suggest that is more respectful to use *lesbian*, and this is what will be used for this submission.

The term *lesbian women* also underscores our approach as woman focused. Further it should be noted that language around sexuality and gender identity used in this Bill, is contested globally outside the confines of LGBTIQAP communities, as well as from within them. The first European Lesbian Conference of over 400 lesbians, in 2017, argued that *using the word "lesbian" is part of the political struggle for visibility, empowerment and representation* (18).

As lesbian women, our social and political position is mediated by **both** being born and raised female as well as our homosexual orientation. The term **lesbophobia** is used in this submission to accurately describe specific hostilities towards lesbians. It originates from two sources, being a female (sexism/ misogyny), PLUS being same

sex attracted (homophobia). The experiences of young lesbians in particular demonstrate how devastating it can be. (See Appendix for first hand stories)

The concept of lesbophobia has been in use since 1974 (17) and is currently used by the International Lesbian and Gay Association. (19) However, peak LGBTI bodies in Australia do not acknowledge the specific discriminations against lesbians and only include, transphobia, biphobia and homophobia in glossary of terms and resources about LGBTI communities. This in turn means government glossaries and materials are also silent about discriminations specific to lesbians (20). This issue is of major relevance to this Bill's terminology and language, as well as the gender transition clauses and will discussed below.

LGBTI politics and policies, have increasingly conflated the issues related to biological sex and with social stereotypes and social expectations (gender). The diversity of views and approaches that COAL brings, need to be acknowledged as a valid and complimentary contribution to free speech and participation in the political process, rather than antagonistic or hateful towards any other groups under the LGBTIQAP umbrella.

We cannot, and do not speak, for bisexual people, gay men, transgender persons or intersex persons and believe that organisations dedicated to each one of those groups are best placed to speak about their specific concerns. We maintain that it is of utmost importance to present lesbian-specific views rather than lesbians being subsumed into the conglomerate LGBTIQAP+ entity.

In fact, the increasingly common practice of legislators to consult with such conglomerates, had led to a number of problems in the framing of this Conversion Therapy Bill. Problems which are discussed in detail below. This submission will also address contextual and theoretical issues as well as practical aspects of the Bill. It is hoped that considerations of these will be given credence, just as one would when speaking with persons from diverse cultural or linguistic backgrounds

THE INTENT and SCOPE OF THE BILL

– to protect LGBTI Queenslanders from harmful conversion treatments

The intent of this Bill was announced by Health Minister Miles in parliament (23) *... strengthening our health system and protecting our LGBTIQ Queenslanders. We are leading the way in recognising the harms of conversion therapy ... This government is committed to serving the health needs of all Queenslanders. ...*

I am proud that Qld is leading the way to ensure the protection of our LGBTIQ community.

The Director General of Health, likewise stated that

Queensland will be and is the first jurisdiction to introduce legislation to protect LGBTIQ persons from these harmful and degrading practices. (9/12/2019 Public Hearing)

The Explanatory notes to the Bill also state

The objective of amendments to the Public Health Act prohibiting conversion therapy is to protect the Queensland LGBTIQ community from the harm caused by conversion therapy, and to send a strong message that being a LGBTIQ person is not a disorder that requires treatment or correction (24, p4)

The intent to provide Queenslanders with legal protection from unethical practices is clearly laudable. However, in its present form, this Bill cannot protect lesbians or gay men from conversion therapy or send a particularly strong message about its harms.

It is of concern that no autonomous lesbian group was part of the 2018 roundtable or the 2019 community consultation and the time for submission was short and over the Christmas New Year holiday period. Whilst it is noted one survivor was present at the roundtable, many lesbians are also survivors of conversion practices, but not members of any survivor advocacy group.

Similarly, it appears that no autonomous survivors' groups were consulted. The SOGICE group argues that survivors should be at the forefront of any conversation about the conversion movement, especially when drafting public policy. (25.P5)

Survivors must be equal partners in defining the movement. Attempts to define the movement led by non-survivors consistently result in definitions and interventions that inadequately address the scope, complexity, breadth, motivations and ideology behind the conversion movement.(25)

The available evidence (see below) shows that virtually all sexual orientation conversion therapies in Australia are practised by religious groups or in some kind of faith context. These are specifically EXCLUDED from the provisions of the Bill and so, it cannot possibly achieve its overall objective of protecting LGBTI people from harms.

This means it is very limited in its scope. There is important evidence by survivors not included in background to this Bill. Their statement called for Australia's elected representatives to intervene to curtail the ongoing and life-threatening practices employed by the ex- gay movement found in religious groups. The Statement was accompanied by an online petition that 62,000 people had signed by 19 October, 2019 (www.change.org/EndGayCures). The SOGICE Survivors Statement, emphasised that:

Instances of conversion practices being employed by psychologists and psychiatrists are therefore extremely rare and not the focus of survivor self-advocates. (25, p 3)

The position and wide experiences of this survivor group, raises very important questions.

Why is this Bill is being introduced with a sole focus on health professionals whilst excluding the main perpetrators of harmful practices?

Further the very narrow scope of this Bill certainly does not send a strong message to the community about the harms caused by conversion therapies.

The research by the Human Rights Law Centre, Gay and Lesbian Health Victoria, and La Trobe University, utilised in the framing of this Bill, also found conversion therapies are overwhelmingly practised by religious or faith- based groups or individuals (26) and which are exempted under the bill.

The report found conversion practices are not fading away, quite the reverse, they are entering the mainstream within particular Christian churches and they are being publicly advertised. The value of this research lies in it being the first of its kind on the topic and its findings really need to inform the content of this Bill.

RECOMMENDATION 1

Include religious groups and individuals of faith based groups and organisations, including public health services provided by faith based organisations, in the provisions of the Bill.

This bill is being presented by the government as primarily about harmful practices to change the sexual orientation of lesbians and gay men and protecting their health and wellbeing. In fact, *Sexual Orientation Conversion Therapy* was the advertised topic of the 2018 roundtable.

However, we note that issues about gender identity treatments have become a major addition to the scope of the Bill, since that 2018 roundtable. COAL considers it is problematic to treat sexual orientation and gender identity as the same in legislative clauses. It, is misleading for several reasons and a weakness in the Bill.

At one level, it is understandable that so many clauses in the Bill refer to gender identity and transition. The standard definition of conversion therapy to this date and

the scientific evidence of its harms have referred to attempts to change a person's same sex or bisexual orientation to a heterosexual one, using psychological methods, hormone and surgical treatments. The tensions between the understanding of conversion therapy as "gay" conversion, and current treatment for gender dysphoria are considerable, because the classes of treatments that are outlawed for sexual orientation are in fact being mandated for the treatment of gender dysphoria. This is why they need treatment in a separate Bill, rather being treated as exceptions to the provisions of the one Bill.

The tension also arises because, the dominant treatments for gender dysphoria can lead to a change in sexual orientation, especially in adolescents. Our health and legal systems now leave lesbians alone and do not intervene medically or psychologically in any way with the development of their sexuality during their adolescence or adulthood. Exactly what this Bill addresses.

However, it is the reverse case when the development of children diagnosed with gender dysphoria (some as young as 4) and adolescents is considered. Hormonal, medical and often surgical interventions are all deemed safe and appropriate treatments for children and adolescents by the clauses of this Bill.

No evidence is provided for the prevalence or incidence of conversion therapies on people identifying as a different gender to that associated with their birth sex in Queensland. It is essential to ensure all legislation has a robust evidence base. The evidence in relation to harms from sexual orientation conversion is extensive and has been accumulating for over 40 years.

Where is the equivalent evidence of widespread conversion practices in Queensland that merit treating gender identity the same as sexual orientation in this Bill?

How many health practitioners have been referred to their professional organisations, and/or to the Health Ombudsman in QLD for unethical conversion practices which contravene their professional standards?

There are very significant differences between the two categories of *sexual orientation and gender identity*. It is unfortunate they have been presented together and conflated in the clauses of the Bill. It compounds the common misconception that they are either the same thing or closely related. In fact, they are not connected at all, one relates to the behaviour of sexed bodies, the other describes internal feelings about social expectations and social roles.

Recommendation 2

Restrict this current Bill to cover sexual orientation and draft a different Bill to cover gender identity when there is robust evidence of a need and evidence based and appropriate treatments

Legislation in other Jurisdictions

This Bill follows the Malta legislation very closely. No other European country has yet adopted the Maltese legislative model. Germany plans to introduce legislation. (27)

The scope is limited to conversion therapy with people under 18. The rationale was that adults should be free to decide how they deal with discomfort about their same sex attraction or gender identity. Germany does not have any exemptions on the grounds of religion or faith. One of the strengths of the German Bill is the ban on any advertising of conversion therapies.

Adding a clause to the Queensland Bill banning advertising would certainly be a powerful addition to strengthen and reinforce the message that conversion therapies are unacceptable. This low cost symbolic action would be welcomed by COAL.

Recommendation3

Include a clause banning the advertising of conversion therapies by any one, on any communication channel.

In Australia the proposed Victorian legislation is suggesting civil, rather than criminal remedies. In addition, the Survivor statement (25) recommends civil rather than criminal penalties. It would worth reconsidering the implementation issues of criminalisation V civil provision, in the light of the wishes of Survivors and the research base of the Victorian proposals.

TERMINOLOGY AND DEFINITIONS

Before addressing specific language issues in the Bill it is important to clarify the meanings of two words. It has been noted frequently that the terminology in relation to sexuality, gender and transgender is constantly and rapidly changing (3,4).

This poses particular problems for legislators when creating laws with definitions and concepts that can be very variable, generalised and unstable over time and place. Therefore, the most commonly used definitions need to be the basis of legislation.

SEX : the biological characteristics of a person- external anatomy and internal physiology including chromosomes and reproductive organs. The words female and male refer to a person's sex.

The sex of a person **is biologically determined** at the moment of conception and not assigned at birth. Humans are either an XX (female) or XY (male). These chromosomes cannot be changed. A small minority of people have different chromosomal combinations (intersex variations) but are not a third sex.

Sex is binary because to create a human you must have 2 different gametes: one ova (female gamete) and one sperm (male gamete). This makes sex a binary.

Biological sex is central to how lesbians define and understand themselves and it has a profound effect on their health and well-being.

GENDER: those characteristics that are socially created (30) and which a culture associates with a person's biological sex (29). These characteristics include behaviours, attitudes and feelings, social norms and stereotypes. Words such as feminine or masculine, are terms which refer to a person's gender, but not their sex.

However, the terms **sex and gender** are incorrectly used interchangeably in scientific literature, health policy, and legislation, including this Bill. It conflates the two in the definition of sexual orientation where absolutely no mention is made of **sex** and only the word **gender** is used. This is a serious flaw in the definitional framework of this Bill.

It is essential that this Bill and the public health facilities funded for gender diverse children, be crystal clear about the differences between these 2 terms. The differences are crucial to a scientific understanding of gender diverse children and the basis of their treatment, which this Bill addresses.

For example , the Queensland Children's Gender Service (QCGS) fact sheet for parents confuses these 2 terms and uses them interchangeably.

*Gender and sexuality: The majority of children will have a strong inner sense of their **gender as male or female** and this matches the sex they are assigned at birth. Sex is determined by our chromosomes (genes), endocrine system (hormones) and body formation (reproductive organs).*

This explanation of *gender as male or female*, uses biological sex terms (male and female) to mean the same thing as gender. The language of gender ought to be feminine or masculine. Otherwise it should read, children have a strong inner sense of their sex as a male or female.

This example of the conflation of gender with sex by QCGS is disturbing in its explanations to parents of the nature of gender diversity in children when it states:

Gender is not something you can influence. (30,p1)

As gender is socially created, obviously it can be influenced. It is unfortunate misinformation is being used in health information in Queensland. Expressions of femininity and masculinity and attitudes about women and men, are constantly changing under the influence of the broader society. This totally inaccurate and a confused concept of gender ie *it can't be influenced*, is central to the treatment model of affirming gender diverse children. The merging of gender with sex leads to the unproven belief that gender identity is also fixed and biologically innate.

In the same fact sheet, when discussing diverse sexuality, it is states:

*Sexuality develops later, usually during puberty **but can evolve and change throughout a child's life. (30)***

So, here we have further confused theoretical foundations of the affirming treatment of gender diverse children in Queensland. Gender is stated as the unchangeable aspect of a child, but sexuality can change and evolve. However, a child's **sex** cannot be changed.

None of this reflects the science on sexual orientation. That science underpins this conversion therapy Bill. Instead the belief of QCGS is that gender identity is the unchangeable aspect of a child, but their sexuality is not very stable.

Recommendation 4

Review the language and terminology used in the QCGS publications and resources about gender and sexually diverse children, to ensure it is scientifically accurate and consistent with the terminology of this Bill.

Gender Identity

The very long definition, somewhat convoluted definition used in this Bill conflates two separate but related concepts. Gender identity and Gender expression generally refer to different things, one is internal, the other external. It needs to be noted that the term gender Identity has multiple definitions. Gender Identity is one of those terms which has seen rapid and frequent changes in meaning. It is suggested the Bill separate the terms as done by QCGS (2) and below.

Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents (1) use these two definitions as the basis of their treatment recommendation for children.

Gender identity A person's innermost concept of self as male, female, a blend of both or neither. One's gender identity can be the same or different from their birth sex.

Gender expression *The external presentation of one's gender, as expressed through one's name, clothing, behaviour, hairstyle or voice, and which may or may not conform to socially defined behaviours and characteristics typically associated with being either masculine or feminine. (1, p4)*

Recommendation 5

Define the two concepts of Gender Identity and Gender Expression separately to be consistent with the meanings used in the National Care guidelines and The Queensland Children's Gender Service (QCGS

Other important terms used in this submission.

Gender dysphoria A term that describes the distress experienced by a person due to incongruence between their gender identity and their birth sex.

Social transition The process by which a person changes their **gender expression** to better match their **gender identity** (1)

Being clear about treatments involving social transition is the reason why it is important to separately define gender expression and gender identity (an inner sense and feeling).

SEXUAL ORIENTATION

The Bill in section 213E, defines sexual orientation as

sexual orientation, of a person, means the person's capacity for emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a **different gender**, the same **gender** or more than 1 **gender**.

This implied definition of lesbians is disrespectful of the realities of lesbian sexuality and how lesbians define themselves. A lesbian is a homosexual female, ie a female who has an enduring physical, emotional and romantic attraction to other females. A lesbian is same sex attracted.

Same sex accurately describes our sexual orientation, same gender does not describe the same concept. For the purpose of the Bill it is essential that the definition clearly describes the people who are being protected by the Bill. As lesbians do not describe or experience their sexual orientations as same gender attracted, they are by default excluded from the Bill. A bill based on preventing the harms of conversion of same sex attracted people to become heterosexual, needs to include sex.

Problems with the existing definition

- has totally removed biology and actual sexed bodies, from the concept of sexual orientation- whether same sex or heterosexual

- gender is being used in its social sense of socially labelled characteristics and behaviour that either sex can adopt.
- in the case of lesbians, the words same **gender means** anyone, male or female who self- identifies as a woman.
- Lesbians have been re-defined by others, as same gender attracted
- The new definition is being imposed on lesbians by the State and originates from a political perspective hostile to the material reality of lesbians
- The word gender no doubt has been substituted to be “inclusive” of people born male, who then self- identify as women (transwoman) and then as lesbians
- Sexual orientation and gender are two distinct aspects of humanity and must be distinguished in this definition
- it puts this legislation at odds with Federal Laws such as Same Sex Laws re superannuation, where the terminology does not conflate gender and sex, an essential requirement in any legislation, ie does not treat sex and gender as the same thing.

COAL considers the conflation of sex with gender in the definition of sexual orientation as a serious flaw in legislation. It prioritises a gender identity belief system over the self determination of lesbian women.

There is evidence that lesbians’ sexual attractions, along with heterosexual females and males, are not based on the self- identified gender of potential partners.(32). For example, a study of the dating preferences of 1000 people stated (32):

- 87.5% of people said they **would not** consider dating a trans person, irrespective of their sexual preference
- only 1.8% of heterosexual women and 3.3% of heterosexual men chose a trans person of either gender
- most non-heterosexuals would not date a trans person either.
- 29% of the few lesbians who did include trans people in their dating preferences, included transmen (ie born female) rather than transwomen

However, the authors interpreted these results showing lesbian women and heterosexuals were unwilling to date trans women, as a sign of transphobia. Their discussion highlights the gender identity belief system, that sex can be ignored. In fact, the findings show the opposite- sex (not gender) really matters when it comes to sexual attraction. It is unlikely anyone would ask, do you want to have gender with me?

A UK study (33) investigating lesbian experiences of pressure from transwomen to be sexual partners, found:

- 98.8% of women defined themselves as **lesbians** with the others defining themselves as queer or bisexual
- 98.8% would not consider a transwoman as a sexual partner
- 50% reported they had been banned from their LGBTI groups for maintaining their same sex view about lesbian relationships

We look to this Bill to use definitions that respect the bodily autonomy and self definitions of lesbians born female. There is major pressure coming from some

transwomen to invalidate the realities of lesbian same sex attraction and relationships eg

- Zinnia Jonese talks about her 'girl dick'
- Riley Dennis suggesting it is 'cissexist' to be attracted to people with only one type of genital
- that your dating preferences are an act of hate,
- Roz Kaveney claiming that 'trans women's penises are not male penises. (34)

Language in legislation in this area needs much greater thought and precision. For example, a married heterosexual male

- transitions to identify as a woman
- has no wish to undergo any genital surgery
- has an entirely male body (around 70% do not opt for surgery (35))
- now identifies as a lesbian woman
- the formerly heterosexual female partner, now identifies as a lesbian.

In these circumstances, the word lesbian has lost any meaning.

Gender is a social term, sex is a biological term and same sex orientation accurately describes the biological realities of lesbians' sexual orientation. *Same gender attracted* does not. Transwomen may well feel same gender attracted and that is why the definition needs to include both groups of people

Recommendation 6

Define sexual orientation as:

, sexual orientation of a person, means the person's capacity for emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different sex /gender, the same sex/gender or more than 1 sex/gender.

This definition be used in the Queensland government in documents that relate to lesbians, eg in health departments, schools.

COMMENTS ON 5b Section 213F 1, 2 and 3 and 213G Gender Transition

The exclusion of gender transition treatments from conversion therapy definition with special reference to the protection of children

Many lesbians have always been gender non- conforming, even in childhood ie they reject sex roles stereotypes for females. For a start they are not heterosexual and have interests in a wide range of activities and occupations that have been stereotyped as more suitable for males and associated with masculinity. In addition, prior to the recent rise in the public profile of transwomen and transchildren, many heterosexual women were ‘tomboys’ and not subjected to pathologizing because of their behaviour and expression.(50)

Lesbians non conformity has been the basis for a great deal of discrimination and mental health issues related to being a despised minority. Despite this, lesbians reject conformity to feminine stereotypes and social norms of heterosexuality. Despite distress, and harassment, we do not have the need or desire to medically transition to another sex, even though medical transition has been an option for a few decades now. We could argue lesbians and gay men are, in some respects, pioneers of gender non- conformity.

Therefore, having lived our lives largely outside conventional femininity and having been pathologized for such a long time, we have very serious concerns about the recently developed and promoted treatment of gender non-conforming girls and teenagers. State sanctioned medical treatments after 37 years, once again pathologise and medically treat non conformity. These invasive treatments are specifically excluded under the provisions of this Bill.

The clauses in this Bill do not distinguish between children and adults. This is disturbing because the etiology of gender dysphoria in adults and children is quite different. This of course means treatments are different. What may be suitable for mature adults, is unlikely to be suitable for a developing 15year old. Adults are in a position to make fully informed decisions affecting the rest of their lives, children are not.

To highlight the extent to which non- conformity to sex role stereotypes, is embedded into the current diagnosis and treatment of children, below are the diagnostic criteria.(36) . This Bill is supporting this practice.

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

1. A strong desire to be of the other gender or an insistence that one is the other gender
2. A strong preference for wearing **clothes typical** of the opposite gender. In boys a strong preference for wearing or simulating female attire, and/or a **resistance to wearing traditional masculine** clothing. In girls, a strong

- preference for wearing typical masculine clothing, and/or a **resistance to wearing traditional feminine** clothing
3. A strong preference for **cross-gender roles in make-believe play** or fantasy play
 4. A strong preference for the **toys, games or activities stereotypically** used or engaged in by the other gender
 5. A strong preference for **playmates of the other gender**
 6. A strong **rejection of toys, games** and activities stereotypical of one's assigned gender
 7. A strong dislike of one's sexual anatomy
 8. A strong desire for the physical sex characteristics that match one's experienced gender

Five of the eight “diagnostic” criteria, are based on the child not conforming to traditional feminine or masculine stereotyped behaviour, appearance or activities. Note you only need 6 to be diagnosed as a gender dysphoric child. The emphasis on non conformity in these criteria, would have seen many of us who were children in the 1950 and 60's diagnosed with gender dysphoria, never being able to grow into our lesbian selves.

This philosophical and clinical position of pathologizing children who reject stereotypes, is definitely at odds with Federal and State Governments who are allocating resources for STEM programs across the country. The aim of these initiatives? To breakdown and challenge traditional stereotypes that activities involving science, technology, engineering, and maths are masculine, so that more girls and women explore and take up careers in these non traditional areas.(37).

Telling a child that she was born in the wrong body pathologizes “gender non-conforming” behaviour and makes gender dysphoria less likely to resolve during maturation. (41) It is also treating gender identity as a fixed innate characteristic when there is no evidence that this is true. It is our position no child is born in the wrong body. Rather, all adults need to expand their understanding of what male and female behaviour and preferences look like in a pluralist and secular society. In our society being female comes with a huge range of personalities, preferences, and possibilities.

The government would do well to examine to overseas debates and policies

*The College of Psychiatry acknowledges the need for better evidence on the outcomes of pre-pubertal children Until that evidence is available, the College **believes that a watch and wait policy**, which does not place any pressure on children to live or behave in accordance with their sex assigned at birth or to move rapidly to gender transition, may be an appropriate course of action .when young people first present.(42)*

Tavistock GIDS Consultant clinical psychologist Bernadette Wren has expressed the need for caution in her paper for the Journal of Clinical Child Psychology and Psychiatry (2019):

'It is my belief that we need to make creative opportunities for the open, accepting exploration of the gender experience and gender expression of these younger children; my fear is that to proceed to a full emphatic social transition may hamper their development'. (40)

How many false positives are there in gender dysphoria diagnosis?

We don't know because there has been no long term follow up of children and teenagers treated in gender clinics in Australia or the UK. There is no long term data collection or research which means a lack of robust scientific evidence about the accuracy of diagnosis or effectiveness of treatments.

Melbourne gender clinic has settled a number of claims by former patients for misdiagnosis of the condition. They all underwent genital surgery (39) as part of the medical protocol based on medical consensus about gender identity disorders and the need for surgical interventions. Unfortunately, 17year old young women are having double mastectomies as part of their gender transition treatment.

Detransitioners also provide growing evidence of false positive diagnoses and misdiagnosis of gender dysphoria.(42, and Appendix) These mostly young women in their 20's were all diagnosed with gender dysphoria in their teens, were put on puberty blockers and often cross sex hormones as well, as part of supporting their transition to transmen.(22)

The numbers are unknown, but there are hundreds seeking on line help from the women who have told their transition stories (42). They have only recently started to tell their stories and stand up to the abuse from some trans activists. (See Appendix 2, 3 for examples) These adolescent and young adult (AYA) children, mostly female, had no histories of childhood gender identity issues, when they experienced a perceived sudden or rapid onset of gender dysphoria. (40)

A study by Littman (40) with parents whose teenagers had rapid onset gender dysphoria, indicates the potential sources of false positives in diagnoses: 41% were not heterosexual before identifying as trans. We know changing a person sexual orientation is not really possible. Therefore, 41% of these teenagers may well detransition once their brains (frontal lobe cortex) had developed enough to reflect on what motivated their decision to transition.

- 82.8% were natal females with a mean age of 16.4 years
- The teens were 15.2 when they announced a transgender-identification.
- 41% of the AYAs had expressed a non-heterosexual sexual orientation before identifying as transgender
- 62.5% of the had been diagnosed with at least one mental health disorder or neurodevelopmental disability (autism) prior to the onset of their gender dysphoria
- 80.4% had zero indicators from the DSM-5 diagnostic criteria for childhood gender dysphoria(40)

This Bill, in legislating the affirmative model, appears to have taken no account of the growing evidence of the level of false positives among teenage girls, as evidenced by detransitioners (22). In addition, this Bill appears to ignore the facts from most long term practitioners in gender clinics - if children are not socially transitioned and not given puberty blockers around 75- 80% of children naturally recover from their dysphoria. (44, 45). Of those who recover the many will grow into lesbian, gay or bisexual adults (44).

At present, in the absence of robust evidence, there is no way of determining which child is in which group. At present it is not possible because much of the criteria are based on GENDER stereotypes, and or self diagnosis, and thereby must lead to numerous false positives.

Commissioned to review the evidence base for puberty blockers and cross sex hormones in 2019, Professor Carl Heneghan, director of the Oxford University Centre for Evidence Based Medicine, concluded that they are 'an unregulated live experiment on children':

*Children are not small adults; their changing body composition requires careful dosing; their physiology creates unique challenges that increase risks, and off-label use may lead to serious and life-threatening consequences. In my view, given **the paucity of evidence, the off-label use of drugs** that occurs in gender dysphoria **largely means an unregulated live experiment on children.***

The collection and evaluation of evidence, particularly when it comes to ensuring their safety, should therefore be a priority. It is not." (21)

Therefore, none of child or teenager should be getting hormone blockers and cross sex hormones It is very difficult to justify permanently damaging a child's body in order to satisfy the cosmetic preferences of others (46). This Bill must legislate in such a way as to protect children's health especially in relation to puberty blockers and hormones. (46).

There is no research on the long term (more than 24 months) effects on children of puberty suppression and hormones. (10)

Basic medical ethics recognises that treatments should seek to preserve the child's right to an open future. Blockers, and hormones are putting children on a track to permanent prepubescence and probably surgery at an age when they can't possibly appreciate what they are giving up, what health problems they are taking on and closing down future options of having biological children and full sexual sensation and enjoyment. The affirming pathway is unnecessarily turning healthy kids into lifelong medical patients.

The severely damaged bodies and lifelong harms done to the female athletes of former East Germany are evidence of the need for extreme caution by the government in relation to a Bill that condones testosterone for 16 year old females. These athletes were administered testosterone by government legislation, from as young as 10. Some have successfully sued the government and been compensated

(39) for the harms done by a government who legislated for their treatment to enhance performance (39).

One can ask, what would the liability of the Queensland government be, if young women who were made sterile because of the hormones, or were misdiagnosed, made a damages or negligence claim against the Government because of gender transition clauses of this Bill? A bill which indirectly restricts the treatment options available to health practitioners who want to use a watchful waiting approach.

The enormous ethical and scientific task of health professionals is to be able to distinguish with certainty between all those children who will recover from their gender dysphoria (the overwhelming majority) and those who won't, as well as identify those teens with rapid onset for whom their gender identity is a temporary problem and more related to other issues such as same sex attraction or autism (40). At present there is no scientific basis for practitioners to make these judgements.

The QCGS acknowledges this is the situation

We don't have clear answers as to why some children are transgender or gender expansive while others are not but we believe it is likely a complex interplay of factors.(2)

At this point there are many questions to be answered by rigorous scientific enquiry before this Bill can ethically include the exception clauses in relation to gender identity. Health Policy should not be just for the 10% who will be trans, but it must also protect from harm the 80% who are diagnosed as gender dysphoric but WILL NOT become trans and come to be happy with their body and gender identity. Many of these children and teenagers are likely to be lesbians. (40, 44)

Mental health and medical professionals, and LGBT organizations, have a professional and moral obligation to demonstrate scientifically that the medical consequences to young peoples' bodies (sterilization, possible loss of IQ points, possible eradication of sexual function, genital surgery, bone health issues, increased circulatory system risks) are worth relieving the youth's distress and anxiety about passing as their chosen gender.

Recommendation 7

Remove gender identity and exemptions in relation to gender transition from the Bill

Finally, it is important to remember some history about the medical and surgical cures for homosexuality. One of these was ice pick frontal lobe lobotomies. The doctor who popularised it, claimed it cured homosexuality in women and men, won a Nobel prize for his pioneering treatment. For a while, medical consensus and populism triumphed over rigorous science and systematic evaluation.(47) However more than 20,000 people were severely harmed by the practice, before it was outlawed.

Evidenced based medicine must be the basis of health policy and legislation in Queensland, in relation to sexual orientation and gender identity. not only for lesbians and women, affected by this Bill, but all Queenslanders.

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APPENDIX

First Hand Stories of young women who suffered from gender dysphoria

Sydney's Story - 2019

<https://www.dailysignal.com/2019/10/07/i-spent-a-year-as-a-trans-man-doctors-failed-me-at-every-turn/>

I can't wrap my head around all that I've done to myself in the last two years, much less the "help" that some health care professionals have done to me. Two years ago, I was a healthy, beautiful girl heading toward high school graduation. Before long, I turned into an overweight, pre-diabetic nightmare of a transgender man.

I won't place the full blame on health care providers, because I should have known better. But they sure helped me do a lot of harm to myself—and they made a hefty buck doing it.

Here's my story.

From my earliest years, I was always different from the other girls. I wore boy clothes, and I played with boy toys. I was a classic tomboy. As I got older, I became romantically interested in other girls. In fact, with the exception of one guy I dated in high school, I exclusively dated girls.

At the time, you wouldn't have been able to tell I was gay just from looking at me. I had long, blond hair, wore makeup, and carried myself rather femininely. But in my head, I knew I was gay—though I was more of a self-loathing gay.

The truth is, I didn't like gays, and didn't want to be associated with them. Yet there I was, dating only other girls. By the time I was 17, my parents had long divorced and I was living with my dad. That's when he found out I was dating girls. He promptly kicked me out of the house, saying it was his way or the highway.

With little choice, I moved in with my mom. Soon after that, I cut my hair—a decision that grieved both my parents. But what happened next grieved them far more.

At age 18, I started seeing a bunch of transgender men's "success stories" on Instagram. The trans men talked about how something had always "felt off" with them, and they said people couldn't tell they had been the opposite sex after their transition. Their stories all seemed to have a happy ending—and it made me rather jealous.

Here I was getting frowned upon for holding hands with my girlfriend in public, feeling like I'm constantly being judged by everyone, while transgenders could date their same-sex significant other while looking like the opposite sex. I resented that and began to envy the transgenders. I looked into it for myself.

Everything I read was in favor of transitioning.

They only mentioned how brave the transition would make you, and how good it would be for you.

Regrettably, I couldn't find any articles about transgender regret or the huge health issues that would come from making the transition. They only mentioned how brave the transition would make you, and how good it would be for you.

I tried my best to find books that discussed the issue critically and offered opposing views, but all I found were pro-transgender authors. That left me with the obvious conclusion: If all the "experts" were in favour of transition, why not do it?

Every passing day, I saw myself as this awful "dyke," this unnatural lesbian. I hated that image and would much rather have been a guy dating girls. So I Googled how to make the transition to male.

The first step was to find a therapist who would write me a letter to start me on male hormones. I soon found a therapist who said she would help me, and I told her I wanted to start the hormones on my 19th birthday, which was only five weeks off. She required only a one-hour appointment each week.

That's hardly enough time to get to know someone. Yet those five hours got me an official letter that unlocked the doors for me to get hormone therapy and become a "man." It also helped me change my "sex" on my driver's license from female to male. *Not once did she tap the brakes to keep me from gender transition.*

I now see a huge problem with how easy this was. If the therapist had gone slower and been more careful, she would have seen that I wasn't actually trans. But by this time, I'd seen the promotional videos. I was convinced that my gender is what was "off," and the therapist guided me along and made me feel like a sex change is what I needed.

By this point, my friends were also encouraging me to transition. "You're a hot girl," they said. "You'll be a hot guy, too!" Others were too afraid to say anything against it, because after all, it was 2017. I never got pushback from anyone. In reality, of course, I was not a boy, and hearing otherwise was the last thing I needed. I was simply insecure about being tomboyish and a lesbian in public.

My therapist never once tried to sit down with me and figure that out. Instead, she asked me questions like: "When did you start feeling this way?" "Why do you feel you're this way?" Not once did she tap the brakes to keep me from gender transition.

Once I got my letter, I went to a doctor in Atlanta in what turned out to be the worst treatment of my life. *I was not a boy, and hearing otherwise was the last thing I needed.*

The doctor came in and asked if I had any questions. I told him, "I'm just a little nervous." He asked, "Do you not want to do this?" I said, "I do," and he replied, "All right. Where's your letter?"

I gave him my letter, but he didn't open it—not even to check if it was real. He said, "I'll call in your prescription for testosterone." That surprised me—I thought he was going to administer it himself. I asked, "Are you not going to give me the shot yourself?" He then sarcastically suggested I could drive all the way back to Rome, Georgia, (four hours) to get my prescription, and then come back to his office to get the shot.

That wasn't realistic, and he knew it. "But I don't know how to give myself a shot," I said. He replied, "There's no wrong way to give it." He told me to go home and figure it out. He suggested watching a YouTube video. That honestly scared me. It should have been red flag No. 1 that the doctor didn't care, that this was just a money scam. His hands-off approach showed he was confident he wouldn't be held accountable for this treatment.

But at this point, I was still caught in the delusion. I thought gender transition could make me "normal." Unfortunately, that's not the reality that awaited me. The injections of male hormones started to have their effect, but not in the way I expected. I started gaining more and more weight. My skin started to get more and more puffy and discolored. My blood started to thicken.

The doctor's office was running bloodwork for me every three months, and it actually said I was now pre-diabetic—something that was totally new for me. My gender-transition doctor said not to worry, but I decided to see another doctor for a second opinion. He said my thickening blood put me at risk for a heart attack or stroke.

I did this to myself for almost a year. During that time, I gained 50 pounds and was miserable. None of my problems that I thought this would solve were being solved, and I came to have even less self-confidence than before.

I started feeling regret.

Unfortunately, I was stuck: I had already declared to everyone that this was who I was. I had changed my gender, and I had forced people to play along with it and call me by a new name: Jaxson. At work, men had to be OK with their former female co-worker now using the same restroom as them.

Everyone was walking on eggshells around me—and people fell in line for fear of what might happen if they objected. (Employers are already being sued over this kind of thing, after all.) Nobody could tell me what I was doing was wrong, or "Hey, wake up!" A few brave souls at work did quietly try to say, "Are you sure?" Or, "Why don't you think about it a little while?"

Meanwhile, my mom was crying daily about why I was doing this to myself, all the while blaming herself. Finally, one day, my grandfather sat me down to talk about it. He was, and will remain the only person whose opinion I will ever care about. With tears in his eyes, he asked me to stop.

Everything in me wanted to keep going—not even because I wanted it anymore, but because of pride. “What will people think?” I thought. I had made everyone play along. If I suddenly stopped, what would I tell people?

Those questions ate at me. And yet, there was my grandpa, the man I respect most, pleading with me through tears. I just couldn’t tell him no. That was a saving grace. I would have let this treatment kill me before admitting I’d screwed up. His intervention may have saved my life.

So I decided to quit—and I quit cold turkey without seeing my doctor again. Unfortunately, it wasn’t that simple.

Not even two weeks after stopping hormone treatment, the withdrawals kicked in with a vengeance. I was soon on the floor groaning, crying, throwing up, not able to keep anything down, and not able to eat at all.

Getting sick every single day was exhausting. I went to the emergency room three times and had to have two procedures to figure out what was happening to me. My hormone balance was way off, and I was miserable.

Before the ER gave me medicine to sedate me, I begged my mom to make them admit me to the hospital. “I will die if I go back home or leave here,” I said. She and I both sat crying before I passed out from all the sedatives they gave me. I thought I wasn’t going to make it.

I’m now more stable, but my body bears the scars of gender therapy. My voice is still deep, and I look very masculine. I’m now \$1,000 poorer due to the cost, though that’s a fraction of what insurance paid.

And, because of that doctor’s letter that said I’m irreversibly a male, my driver’s license is now stuck with a “male” label. I’ll have to appear in court to prove I’m a female again. Nevertheless, I’m just thankful to have gotten off this horrible path alive, and before I had any body parts mutilated.

It’s insane to me that our society is letting this to happen to young people. At age 18, I wasn’t even legal to buy alcohol, but I was old enough to go to a therapist and get hormones to change my gender.

This is happening to vulnerable kids much younger than I was, and the adults are AWOL. When you walk into these clinics, you won’t really see older people around. It’s boys and girls playing dress-up, brought there by clueless parents, waiting for the appointment that could likely ruin their lives.

I hope I’m not the only one who sees a major problem with this. Our culture has set up a fast-track to gender transition that will only result in scarred bodies and ruined lives—and the medical community is complicit. I met with these doctors in person and gave them my own cash. I can tell you they did not care.

At age 18, I wasn't even legal to buy alcohol, but I was old enough to go to a therapist and get hormones to change my gender.

This is a public health crisis that our media and politicians are completely ignoring. More young people are being deceived every day, being told that the solution to their insecurity and identity problems is to get a sex change.

That's just about the worst path you can put a young person on.

Until we do something, until the medical community puts up serious guardrails and begins to do its due diligence—and until politicians grow a spine and step in—expect to see more young people scarred for life.

If anything, I hope my story can serve as a warning bell and save some other young teenager the misery and grief I've been through.

CHARLIE EVANS · August 25 2019

Charlie says there were a series of epiphanies that led to her not so much coming out, but going back in. It was around the age of six that she convinced herself she was actually a boy. "I liked football, I liked trucks, I liked girls," she says, "therefore I was a boy."

"How could I remove my healthy breasts when I'd seen my mother lose one of hers to cancer?" asks Charlie Evans. Until recently, the science writer from Margate, England identified as transgender, convinced, along with increasing numbers of young women, that she had been born in the wrong body.

After undergoing a "social transition", for which she changed her name from Charlotte, as well as her pronouns, her passport and driving licence, she refused to go through with the gender reassignment operation that would give her the sexual characteristics she thought she wanted.

Earlier this year, at 28, she faced coming out for a third time in her life: having announced in her youth that she was a lesbian, then trans - now, finally, she is a "detransitioner". It's a phenomenon that's almost as new as transgenderism itself - but one that the movement rather you didn't talk about.

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1m 10s



Transgender teen vows to continue documenting her transition despite receiving death threats

Transgender YouTuber Hannah Phillips has bravely vowed to keep helping other people who are considering transitioning, by posting videos documenting her own experience - despite receiving daily death threats from trans-phobic internet trolls.

This was no mere childhood phase, one that would fade faster than an obsession with One Direction. Charlie now realises, after extensive therapy, that the feelings of gender dysphoria that developed were the result of what she is only willing to describe as "abuse" outside the family.

It began when she was eight and cemented within her a loathing of her female body. "The trauma exacerbated and accelerated feelings that were natural for a child who didn't conform, that I now see I would have outgrown," she says.

After appearing on television to talk about her experience of detransitioning, Charlie began to talk more generally about her gradual realisation that "you can't be born in the wrong body - it's our minds that need treatment, not our sex".

She has since been contacted by several hundred others who are undergoing a similar recalibration. They come from across the UK, as well as mainland Europe, Canada and Mexico, are generally under the age of 25 and conform to a transgender "trend" reported across several western countries.

It sees more adolescent girls than boys identifying as trans for the first time, and in ever-expanding numbers; over the past decade, the UK has experienced a 4,400 per cent increase in girls being referred for transitioning treatment.

Having identified since her teenage years as trans, Charlie, who is about to embark on a PhD at Newcastle, now lives as a bisexual woman. She decided to detransition this year after the scars left by her mother's mastectomy prompted her to question why she would want to have her own healthy body parts removed.....

And then someone said something that changed my life. "Could you be a boy born in the wrong body?"

Yes. Yes! This was it - it's exactly that. I have a boy brain! That's why I love science, and guns, and mud, and trucks, and mechanics, and cars, and girls. I am a boy.

That is why I hate my body! I was meant to be a boy. I had the answer. Everything fell into place, and I knew shaving my head, tightly binding my chest, and changing my pronouns was how I could find peace at last. I just needed to pass as the man I knew I was

This realisation was backed up by a trip to Ghana where insisting her pronouns were respected seemed like such a first world problem.

Key to her realisation was also undertaking long-term counselling with therapists who weren't gender specialists. "Unpicking what happened to me as a child was enough to take the edge off me feeling so uncomfortable with the body I wanted to be chopped apart," Charlie says. "I wouldn't have got that if I'd gone to a gender identity clinic, because they have to affirm your belief."

Others who have contacted her since she became the poster girl for this band of brothers, who are now sisters once more, have embarked on hormone treatment, leading to beard growth in females and permanent lowering of the voice. In males, there is a softening of features and breast growth.

"So many of these women describe a mental state where I do not believe they could have consented to these surgeries," Charlie says.

Most, according to Charlie, report remarkably similar characteristics and experiences: eating disorders, autism and social awkwardness, childhood trauma, sometimes as the result of sexual abuse, mental health problems. All, she claims, were "sold this idea that transitioning was magically going to solve their problems".

"I'm in communication with 19- and 20-year-olds who have had full gender reassignment surgery who wish they hadn't, and their dysphoria hasn't been relieved. They don't feel better for it."

While there is no doubt there are growing numbers of people suffering gender dysphoria, whose feelings of incongruence with their birth sex are improved by reassignment, according to those making contact with Charlie there are a significant number who have been left desperately disappointed, with nowhere to turn.

"I feel like a young woman who got lost along the way," says Keira, a 22-year-old from the south-east who contacted Charlie's newly formed charity, the Detransition Advocacy Network (Twitter: @DetransAdNet), having undergone a mastectomy in 2017. It was part of her search for an identity she now realises never existed.

3. Emma Dougherty

I'm a lesbian. I started realizing I liked girls when I was nearly done with middle school, and it triggered a crisis about my gender. I knew girls who liked girls existed, but I couldn't imagine that I was one.

I instantly jumped to "I like girls, I must be a boy." I couldn't comprehend being a lesbian and the idea that I was a straight guy rather than a lesbian was comforting. I'd never questioned my heterosexuality and the idea of being a straight guy seemed easier to me than just not being straight. I was so scared of being gay that being trans, as long I was still straight, seemed easier.

After months of questioning and trying out different labels, I realized I wasn't trans and after even more months I accepted the idea that I could like girls if I also liked

boys, identifying as bisexual, and nearly a year later came to terms with being a lesbian and came out to my friends and family.

I am so happy that I did not come out to my family as transgender because while I am so grateful they are accepting, it would have been so easy for me to get hormones and medically transition only to end up like these women. It's an unfortunate situation