

Submission to the Queensland Inquiry into Outlawing Conversion Therapy

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Preamble

In the context of the *Health Legislation Amendment Bill 2019*, introduced into the Parliament on 28th November, the Queensland State Government proposes to render illegal what the proposed Bill describes as conversion therapy. The explanatory notes issued with the Bill state on page 4 that:

Conversion therapy is a term used to describe treatments and practices that attempt to change or suppress a person's sexual orientation or gender identity.

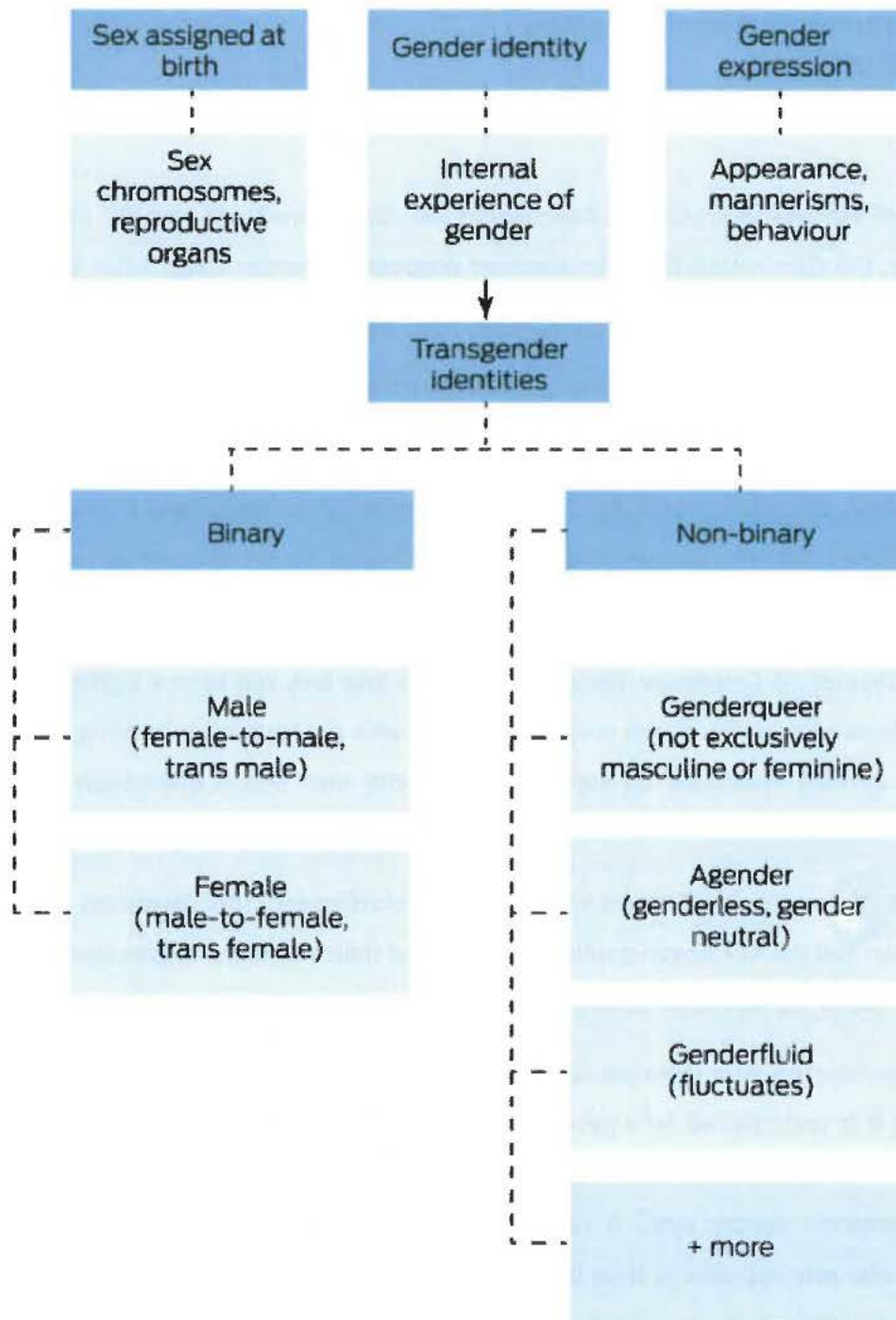
Under the proposal, the *Public Health Act 2005* will be amended to incorporate a new Chapter 5B Conversion therapies. The proposed wording for the new Chapter 5B can be found on pages 15-20 of the Bill introduced into the Parliament.

The proposed Chapter 5B Conversion therapies, if passed into law, will have a highly detrimental impact on health service providers and potentially others who are involved in treating, counselling, caring for and advising individuals on matters related with their sexual orientation and gender identity.

If passed by the Parliament, it will create an important precedent for other Australian jurisdictions. Both the Victorian and the ACT Governments have indicated their intentions to pass similar laws. It is expected that Victoria will have a Bill before its Parliament early in 2020.

No legislation founded on false premises can be justified or implemented. This legislation is fatally flawed because it is underpinned by a gender identity ideology that conflates 'gender' which is a social construct with 'sex' which is an unalterable biological fact. Gender identity is the performance of socially constructed gender roles. A person with transgender identity performs the socially constructed gender role opposite to their biological sex. A man may perform femininity, a woman may perform masculinity, but men cannot become female and women cannot become male. See the figure below for a schematic representation.

Even though the publication of this figure comes from a respected Australian medical journal, it persists with incorrect terminology and the implied incorrect theory underlying this terminology. Note the use of the phrase "sex assigned at birth." Sex is not assigned at birth; indeed, it is never "assigned" – it is a biological fact of the union of XY chromosomes at conception.



From [Medical Journal of Australia \(2019\)](#)

A second serious flaw underpinning the proposed legislation is the assertion that gender identity is fixed and immutable during the early part of the lifespan. Research in sexual orientation shows that same sex attraction during adolescence does not predict adult sexual orientation.¹ The proposed legislation does not consider the established fact that gender identity, like sexual orientation, is not fixed and immutable during childhood or adolescence.

Enacting the proposed legislation supports those attempting to establish a 'fixed' transgender identity in young people who are in the exploratory phase of their sexual and gender identity development. Thus, gender affirmation treatment meets the proposed legislation's own definition of conversion therapy and should be prohibited.

Issues with the proposed legislation

1. Definition of Conversion Therapy

The Bill, in the proposed sub-section 213F(1) of the *Public Health Act 2005* (QLD), defines 'conversion therapy' as:

...a treatment or other practice that attempts to change or suppress a person's sexual orientation or gender identity.

The conversion therapy section of the Bill originated in a round table in 2018 that was advertised as sexual orientation conversion therapy. There was no mention of gender identity. Inexplicably, the Bill now focuses on gender identity.

This section of the Bill is very poorly conceived and worded. It contains many inconsistencies and anomalies, is founded on incorrect assumptions, is not evidence-based and has no scientific merit. Nonetheless, on the basis of these additional chapters to the Bill, health practitioners found to be non-compliant with its provisions will face a maximum penalty of 18 months imprisonment and/or a fine of \$20,000 to \$30,000. The following problems have been identified in the current wording around the term "conversion therapy."

- (i) There is no evidence that the now discarded versions of "real" conversion therapy used to attempt to change an individual's sexual orientation from homosexual to heterosexual such as lobotomies (i.e., a surgery involving incision into the prefrontal lobe of the brain), chemical castration with hormonal treatment, aversion therapy i.e., emetic

¹ R. Savin-Williams & G. Ream, 'Prevalence and stability of sexual orientation components during adolescence and young adulthood'. (2007) 36 *Archives of Sexual Behavior*, 385, a report of the US National Longitudinal Study of Adolescent Health.

medications to induce nausea and vomiting, and electroconvulsive therapy involving application of electric shock to the hands and/or genitals, religiously-based intensive group therapies, 'ex-gay' camps, and exorcisms, have ever been systematically practised on those claiming to be transgender.

- (ii) In addition to aversion therapy, the definition of conversion therapy in the Bill includes psychoanalysis, hypnotherapy, "counselling" and "group activities," the precise nature of which have not been specified. Psychoanalysis is a non-directive therapy and has no fixed outcome. It is focused on process, not product (i.e., a pre-defined endpoint). It could under no circumstances be considered a "conversion" therapy which pre-empts the outcome at the commencement of the process. Similarly, "counselling" is a generic term that refers to a process of empathic listening. There are many forms of counselling and most of these provide unconditional positive regard and non-directive exploration of the material that the patient brings to the sessions with no preconceptions about the "desired" outcome of the process. Hypnotherapy is a minor form of therapy that is sometimes used to assist smokers to quit smoking, or people undergoing painful procedures to cope with the pain, among other applications. It is applicable only to certain patients who reach a threshold of suggestibility. Hypnotherapy does have a goal at the outset, but the goal is established by the patient and not the hypnotherapist e.g., I want to quit smoking. Group activities could include any team sport, cooperative games, psychodrama, group therapy, singing in choirs, book club etc. There is no specific therapy that falls under the generic heading of "group activities." This term is so vague as to be meaningless and has no place in legal documents.
- (iii) The Bill relies heavily on one report i.e., [Preventing harm, promoting justice: Responding to LGBT conversion therapy in Australia](#). The opening statement of this report defines its aim:

... [to] addresses the vexed problem of the **religious LGBT conversion therapy movement**... [which emerged in] Australian **conservative Christian communities** in the early 1970s and has been practised in these and other communities ever since (p. 2).

[C]onversion therapy teaching and practice remain pervasive in Australia's mainstream, conservative Protestant Christian communities, as well as in conservative Muslim, Jewish, Hindu and Buddhist communities (p. 11)

However, no specific reference is made to religiously-based conversion therapies in the proposed Bill, which has cast its net over the entire professions of psychology and psychiatry and redefined conversion therapy as practices that in most scientific circles

are considered effective and evidence-based and by their own admission, developed outside mainstream psychiatric or psychological treatment.

Religious conversion therapy, commonly referred to as the 'ex-gay movement', emerged in the early 1970s, *independently of mainstream medical, psychiatric and psychological practice* (p. 13) (Author's italics).

Secondly, this report seamlessly but dishonestly directs the reader to accept that conversion therapy was devised for both homosexual and transgender individuals. See for example, p. 11:

Conversion therapy is an umbrella term used to describe attempts to 'convert' people from *diverse sexual and gender identities to an exclusively heterosexual and cisgender identity* (Author's italics).

Conversion therapies originated in the 1970s. The issues facing the community currently regarding medical and psychological practices with respect to transgender individuals had not arisen in the 1970s and no mention is made of transgender conversion in scholarly articles from this time. Critically, there are no reports of attempts to convert young people (children and adolescents) from a possible homosexual orientation. Indeed, previous scholarship, based on Freud's (now obsolete) theory of psychosexual development accepted that pre-adolescent children occupied the latent stage of sexual development and were therefore 'sexless.'

Relying on this report as the basis of proof that conversion therapy is being practised outside religious orbits and on transgender individuals is disingenuous and unjustified.

This is a dishonest document that deliberately conflates

- (i) the concepts of sexual orientation and gender identity. They are not the same.
- (ii) LGB issues with issues concerning gender identity, in particular, a transgender identity.
- (iii) conversion therapy to change sexual orientation with a wide range of evidence-based practices such as psychoanalysis, psychotherapy and counselling and re-defining conversion therapy to include these approaches.

Participants (n=15) ranged in age from 18 to 59 years, with experiences of conversion therapy dating from the 1980s to the present. Nine participants identified as male and gay, two as female and lesbian, two as transgender, one as female and bisexual and one

as non-binary. Thirteen participants were from Christian backgrounds, one from a Jewish background and one from a Buddhist background.

- (iv) **Prima facie, the universal call from the trans lobby for the practice of gender affirmation therapy (GAT) to the exclusion of all other therapies meets the definition of a conversion therapy.** This therapy has a rigid course, and a pre-specified (impossible to achieve) outcome i.e., to change one's sex/gender. We hear from de-transitioners that they are excluded and vilified and told that they weren't really trans at all.

Although more data are needed regarding the spontaneous resolution of gender dysphoria, the available evidence indicates that there are no objective (laboratory, imaging etc) or psychological tests that can reliably diagnose a "true transgender child." By adulthood most children desist from a transgender identity.

Further high-quality longitudinal studies are required. While we await such studies, James Cantor has compiled a set of studies that address the question of desistance i.e., how many trans-identified young people desist by adulthood and accept their biological sex?

There is no way of predicting who will remain gender dysphoric. Therefore, many children will be irreversibly harmed by the universal application of gender affirmation therapy. In addition, puberty blocking agents (PBA) derail the path of natural desistance – once children are placed on PBA, most, as adolescents, progress to cross-sex hormones because of the physiologic and/or psychological effects of PBA. Hence, GAT can be defined as a conversion therapy and according to the Bill, should be outlawed with severe penalties for those continuing to practise in this way.

A [summary](#) of these studies is presented below, showing that between 50%–98% of trans-identified children and young people desist from a trans identity in adulthood.

In addition, see the article at [Is it a myth that the vast majority of gender dysphoric children desist?](#) by Paul Dirks

There is a table of desistance studies at the end of the document containing further detailed information.

Count	Group	Study
2/16	gay	Lebovitz, P. S. (1972). Feminine behavior in boys: Aspects of its outcome. <i>American Journal of Psychiatry</i> , 128, 1283–1289.
4/16	trans-/cross-dress	
10/16	straight/uncertain	
2/16	trans-	Zuger, B. (1978). Effeminate behavior present in boys from childhood: Ten additional years of follow-up. <i>Comprehensive Psychiatry</i> , 19, 363–369.
2/16	uncertain	
12/16	gay	
0/5	trans-	Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. <i>Journal of Pediatric Psychology</i> , 4, 29–41.
5/5	gay	
2/45	trans-/cross-dress	Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. <i>Journal of Nervous and Mental Disease</i> , 172, 90–97.
10/45	uncertain	
33/45	gay	
1/10	trans-	Davenport, C. W. (1986). A follow-up study of 10 feminine boys. <i>Archives of Sexual Behavior</i> , 15, 511–517.
2/10	gay	
3/10	uncertain	
4/10	straight	
1/44	trans-	Green, R. (1987). <i>The "sissy boy syndrome" and the development of homosexuality</i> . New Haven, CT: Yale University Press.
43/44	cis-	
0/8	trans-	Kosky, R. J. (1987). Gender-disordered children: Does inpatient treatment help? <i>Medical Journal of Australia</i> , 146, 565–569.
8/8	cis-	
21/54	trans-	Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. <i>Journal of the American Academy of Child and Adolescent Psychiatry</i> , 47, 1413–1423.
33/54	cis-	
3/25	trans-	Drummond, K. D., Bradley, S. J., Badali-Peterson, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. <i>Developmental Psychology</i> , 44, 34–45.
6/25	lesbian/bi-	
16/25	straight	

17/139 trans-
122/139 cis-

Singh, D. (2012). *A follow-up study of boys with gender identity disorder*. Unpublished doctoral dissertation, University of Toronto.

47/127 trans-
80/127 cis-

Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 582–590

2. Need for the Bill

- (i) What is the need for this Bill? Where are the data demonstrating the frequency with which “conversion therapies” are being practised on transgender identifying individuals? Who is the Bill purporting to protect? When questioned about the incidence of the use of conversion therapy on transgender identifying individuals in Queensland, Dr John Wakefield, Director General of Queensland Health was unable to provide figures.
- (ii) The best available figure, which is woefully inadequate, comes from the report, *Preventing harm, promoting justice* which states that “research suggests that up to 10% of LGBT Australians are still vulnerable to harmful conversion therapy practices (p. 3).” This statement fails to identify the precise target group, that is, those who have actually been subjected to conversion therapy. Further, it does not specify how the figure of 10% was derived to identify the “vulnerable” population of interest. The use of the qualifier “up to” before 10% renders the assertion meaningless. What is the exact proportion of individuals thought to be vulnerable to conversion therapy?
- (iii) The question arises as to whether the proposed legislation is warranted, given that there are no reliable data as to how many individuals would be protected, nor indeed, how many will be harmed by this Bill. I suggest that the latter would far outweigh the former.

3. Administration of the consequences of practising “conversion therapy”

A number of questions have not been addressed regarding the administration of this Bill. For example,

- (i) Who would decide whether the therapy practised meets the definition of “conversion therapy,” particularly in view of the vague, unsatisfactory and incorrect definitions of conversion therapy proposed in the Bill? Will a specially constituted body determine this? If so, how will “cases” come to their attention? Could this be done via a complaints

process to already established authorities like the Health Care Complaints Commission?
How would conflicts between these professional bodies and the legislation be resolved?

- (ii) Would this legislation to prosecute a psychologist or a psychiatrist for practising “conversion therapy” override the authority of professional bodies governing the ethical practice of these professions, such as the Australian Psychological Society, the National Association of Practising Psychiatrists, or the Australian Health Practitioners Registration Authority? How would conflicts between such bodies and those administering the legislation be resolved?
- (iii) The proposed Bill will legislate one form of therapy and criminalise all other forms of therapy for the distress associated with gender dysphoria. Because there are no prescriptions in the Bill regarding the population to whom this legislation will apply, questions arise as to whether adults seeking psychological or psychiatric therapies for gender dysphoria rather than gender affirmation treatment could not be treated because the practitioner approached for such therapy would be committing an offence.
- (iv) If, during the course of a non-directive therapy, the patient spontaneously changes their stance on their sexual orientation (unlikely) or gender identity (possible), would such a process be considered conversion therapy?
- (v) How does this legislation intersect with other laws regarding individual human rights? This legislation will silence dissenting thought, quash valid scientific endeavour to understand the condition better and remove freedom of choice regarding treatment options for both patients and health practitioners.

4. Patient group

- (i) A major oversight in this Bill is the failure to specify the relevant patient group. By far the largest growing subgroup in the transgender field are young people from early to late adolescence who present with Rapid Onset Gender Dysphoria. A second group are very young children who purportedly insist that they are the opposite sex from the preschool years. A third group are adults over the age of consent. Does the Bill apply to all of these groups?
- (ii) If this Bill pertains to children and young people below the age of consent, it removes parental authority to make decisions regarding treatment for the children in their best interest. Treatment for gender dysphoria will become a state mandated practice for parents, practitioners and patients. Knowing that most children desist by late adolescence means that this legislation is not in the best interests of the child because

they will be subjected to a potentially harmful and non-curative set of interventions that have as yet little long-term data attesting to their safety or efficacy. It will also inflict irrevocable harm on children who are not sufficiently mature to provide informed consent, thereby breaching the physician's oath to do no harm. Further, mandating only one type of therapy deprives parents of their parental authority to act in their child's best interest.

5. Timing of the Bill

Why is the Queensland government trying to pre-empt any national inquiry into the treatment of gender dysphoric children and young people that is urgently needed and which has been urgently called for?

The Position Statement from the Royal College of General Practitioners (June 2019) acknowledges the lack of research into different approaches in the clinical management of gender dysphoria in youth:

The promotion and funding of independent research into the effects of various forms of interventions (including 'wait and see' policies) for gender dysphoria is urgently needed, to ensure there is a robust evidence base which GPs and other healthcare professionals can rely upon when advising patients and their families. There are currently significant gaps in evidence for nearly all aspects of clinical management of gender dysphoria in youth. Urgent investment in research on the impacts of treatments for children and young people is needed.²

Federal Health Minister Greg Hunt initially called on the Royal Australian College of Physicians (RACP) to

urgently consider and advise on the clinical best practice for the treatment of gender dysphoria in children and adolescents. It is important that we have a nationally consistent standard of care that is evidence based and with appropriate safeguards to protect the interests of the patient. I look forward to receiving your advice in the coming months (21 August 2019).

The RACP has agreed to consult experts and committees.

² Position Statement (June 2019) Royal College of General Practitioners <https://www.rcgp.org.uk/policy/rcgp-policy-areas/transgender-care.aspx>

The Queensland Bill is being proposed at a time when a major aspect of it, i.e., the trans-gendering of children, is under consideration by the Federal Health Minister and should therefore wait until a review is completed.

6. The neglected concept of SOCIAL CONTAGION

The trans lobby has vehemently denied the role of social contagion in the spread of gender dysphoria in young people because it flies in the face of their flawed ideology that children are the “experts” regarding their gender identity, that it is an internal experience that cannot be altered by social factors.

A very large body of research that I will make available to the inquiry shows unequivocally that social contagion is a powerful force that influences the behaviour of individuals. Social contagion describes the “spread of behaviours, beliefs and attitudes across network ties” (Christakis & Fowler, 2013, p. 556).

Networks with high centrality are the most effective in disseminating information or innovation. A key example is the transactivist lobby that has achieved spectacular success in a short time in changing health care, educational practices and legislation related to transgender individuals.

Social contagion is a major factor in the disquieting upsurge in the number of children and young people presenting to gender clinics around the world. despite our collective failure to date to fully understand the phenomenon of gender dysphoria and its rapid, epidemic-like spread in the Western world.

Peer contagion

Peer contagion has a powerful socializing effect on children beginning in the pre-school years. Different mechanisms of transmission of peer influence include:

- (i) Deviancy training
- (ii) Co-rumination (a process of repetitive discussion, rehearsal and speculation about a problematic issue within the peer group)
- (iii) Social contagion affects uptake of new behaviours by individuals in the peer network

(iv) Social media

Evidence for social contagion among adolescents have been demonstrated in

- (i) Anorexia nervosa
- (ii) Marijuana use among adolescents
- (iii) Suicide

Social contagion in gender dysphoria

For full paper on social contagion, go to <https://www.diannakenny.com.au/k-blog.html>

Gender dysphoria meets all the criteria for a psychic epidemic.

This network is highly centralised with only one voice – the transactivist lobby - being heard above the desperate cries of terrified parents and horrified academics, doctors, psychologists and psychotherapists.

Relevant factors that may account for the sharp increases in young people presenting with gender dysphoria include:

(i) **Low gender typicality** (i.e., perceived lack of fit within one's binary gender), *peer victimization, formation of an ingroup of extreme gender-nonconformers, and support from the trans-lobby*. Gender atypical children who feel both internal and external pressure to be gender conforming experience greater discomfort and therefore are more susceptible to the message of transactivism.

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

Occurs mostly in girls at around the age of 14 years. This group of young people are likely to belong to peer groups in which one or more of their friends had become gender dysphoric or transgender-identified. This is coupled with an increase in their social media and internet usage.

(iii) Empirical evidence

There has been a sharp increase in the population estimates of those identifying as transgender. Data from Australia show an upward trajectory in the number of children enrolled in gender clinics in the four states of Australia that offer a gender service (See Figure 1).

NUMBER OF CHILDREN ENROLLED IN GD CLINICS BY STATE IN AUSTRALIA, 2014-2018



Figure 1

Source: Kenny, D.T. (2019). *Child and adolescent gender dysphoria in Australia – adopting the Zeitgeist but where are we going?* Invited paper to the NSW parliamentary forum, Parliament House, Sydney, Australia, 2 July.

Social contagion in treating practitioners, legislators, and educators

a. Treating medical practitioners

Iyengar, Van den Bulte, and Valente (2011) found contagion in the prescribing patterns of doctors after controlling for marketing outreach and systemic changes, such as the advent of new drugs and changes in the prevalence of diseases. Shared geographical proximity, shared group membership and self-identified ties between doctors were all factors in behavioural contagion, with self-identified ties the most compelling factor. We see such influences in gender clinics where one voice dominates and dissenters are silenced.

b. Law and Legislation

Transgender activists in several countries have persuaded gender clinics to lower the barrier age groups to social transition, puberty blockers, cross-sex hormones and now mutilating surgery, many without parental consent. Other changes include change of sex on birth certificates and change of name and pronouns.

c. Sport

The Australian Human Rights' Commission has provided guidelines about sports participation that clearly disadvantage natal females and which may well have a profound effect on female participation in sport ([AHRC sport guidelines](#)). These guidelines neutralise the protections provided to females in the *Commonwealth Sex Discrimination Act, 1984*. [see [Critique of sport guidelines](#)].

d. Education

The NSW Department of Education has issued a [Bulletin 55, NSW Department of Education](#) (Transgender Students in Schools) that deprives parents of their rights in the management of their gender dysphoric child at school. Bulletin 20 even deprives parents of parental authority regarding the registered name of their child ([Bulletin 20](#)). These guidelines undermine parental authority in the child's eyes, setting a dangerous precedent allowing children to make decisions about their wellbeing for which they are not prepared

Conclusion and recommendations

This Bill lacks a scientific basis, has not established the need, overrides the basic human rights of parents, children and adolescents, deprives practitioners of ethical, autonomous clinical judgment, and has the potential to inflict severe and irreversible harm on those receiving gender "affirming" therapy during childhood and adolescence given that most desist if not treated with GAT.

The Bill is fatally flawed by virtue of its illogical and ill-founded ideological base, its factual errors, and its failure to address issues in its implementation. It cannot be improved by amendments and should be abandoned. In short:

- (i) The Bill deceitfully conflates LGB issues with transgender issues.
- (ii) The Bill has not defined the term "conversion therapy" with any rigour or accuracy.
- (iii) The Bill does not specify the population to which it is directed.
- (iv) The need for the Bill has not been established. There are no reliable statistics on the number of practitioners practising conversion therapy nor the number of individuals being harmed by it.

- (v) The Bill does not specify how these proposed changes to clinical practice in transgender therapy will be administered. There are many professional bodies overseeing the work of health practitioners. The Bill does not specify how these bodies will interact with those administering the proposed legislation.
- (vi) There are several human rights violations implied in the proposed Bill, both for patients and therapists.
- (vii) The Queensland Bill is being proposed at a time when a major aspect of it, i.e., the trans-gendering of children, is under consideration by the Federal Health Minister and should therefore wait until a review is completed.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Dianna Kennedy', with a stylized flourish at the end.

Additional material from other submissions

Submission 40

A. Korte and others, 'Gender Identity Disorders in Childhood and Adolescence: Currently Debated Concepts and Treatment Strategies', (2008) 105 Deutsches Ärzteblatt International, 834 at 838.

All of the 21 patients who received a new diagnosis of GID in our clinic up to mid-2008 (aged 5 to 17; 12 boys, 9 girls) had psychopathological abnormalities that, in many cases, led to the diagnosis of additional psychiatric disorders. As a rule, there were also major psychopathological abnormalities in their parents. **The "motive for switching" among the 15 adolescents in the group was mainly a rejected (egodystonic) homosexual orientation, the development of which would have been arrested by puberty-blocking treatments.**

Submission 79

The abhorrent practices of the mid-20th century cannot, and are not, in any way supported. The use of **lobotomies, chemical castration with hormonal treatment, aversive treatments including the application of electric shock to the hands and/or genitals, and emetic medications to induce nausea and vomiting** as part of the treatment regimens once promoted by prominent (and generally not religious) mainstream medical and psychiatric practitioners is rightly condemned, more so if undertaken coercively.

There is no evidence that they remain in use within Australia. Indeed, during the Public Briefing held on 9 December both neither **Dr Wakefield or Mr Mahler from Queensland Health were, when questioned, see page 7 of the transcript, unable to provide any evidence of these or other conversion therapy' practices occurring within Queensland.** Even if evidence emerges to suggest that such practices are ongoing, existing regulation of medical and health services provides an appropriate mechanism to deal with these practices if they are occurring and not subject to existing criminal law.

The Bill, in the proposed **sub-section 213F(1)** of the Public Health Act 2005 (QLD), provides a definition of 'conversion therapy' as – *Conversion therapy is a treatment or other practice that attempts to change or suppress a person's sexual orientation or gender identity.*

The proposed sub-section **213F(2)** goes on to exclude 'gender affirming' practices and sub-section **213F(3)** introduces a **vague exclusion for practices that in the provider's reasonable professional judgment, is necessary to**

- provide a health service in a manner that is safe and appropriate; or
- comply with the provider's legal or professional obligations

Submission 84

Codifying ideological assertions about how medicine should be practised into the criminal code, without an adequate basis in clinical evidence, cannot be justified.

Submission 95

Part 5 Clause 28 establishes a controversial ideology, gender identity ideology, in law. It does this by linking gender identity ideology with a popular issue i.e., support for lesbian and gay rights. Generally, the **community does not support conversion therapy because conversion therapy**

weaponises therapeutic practices against lesbians and gays to ‘convert’ them away from their sexual orientation. It is likely that most people in our community would oppose conversion therapy.

Gender identity ideology however is a highly contentious ideology that does not enjoy community support. The two questions of lesbian and gay rights on the one hand and the imposition of gender identity ideology on the other, have nothing in common and to link them as an inseparable entity is misleading. It also hurts community support for lesbian and gay rights, which is strong. Lesbian and gay rights are about the legal and social acceptance of sexual orientation; gender identity has nothing to do with sexual orientation. In fact, Clause 28, Chapter 5B, Sections 213E, 213F, 213G, 213H and 213I establish and affirm the principle of conversion therapy for those with gender dysphoria while outlawing it for lesbians and gays. **Gender identity ideology IS conversion therapy for people with gender dysphoria.**

...opposition to gay conversion therapy and support for gender identity ideology must be broken.

Gender identity ideology, sometimes called transgender ideology, is a reflection of individualism attempting to replace the concerns of the collective. Individuals’ subjective, and supposedly innate, feelings about their gender, and depending on which theorist you read there may be scores of genders, **rely on replacing material reality** in theory, analysis, political goals. The **subjective experience of individual gender replaces the collective identity of biological sex.** The language of material reality understands the binary nature of biological sex amongst humans i.e., humans are **either female or male and this is immutable.** The exception (which proves the rule) is the condition of intersex which a small number of humans have where sex may be unclear and is often assigned at birth as a consequence. Gender identity ideology conflates gender and sex – the discussion often begins by recognising the differences but then conflating the two.

The rapid rise of transgender ideology is due to its enthusiastic embrace by the middle class left especially students and academics at universities, Big Pharma and the Medical Industry and neoliberal policy bodies.

Gender identity ideology conflates ‘gender’ which is a social construct, and ‘sex’ which is biology. Gender Identity is the way a person chooses to perform the opposite gender role. A man may perform femininity, or a woman may perform being masculinity. This has nothing to do with a person’s sex, or sexual orientation. Gender is simply the hierarchical and socially constructed performance of masculine or feminine.

The Bill also supports the **regressive notion that stereotypical gender roles are part of an official diagnosis for gender dysphoria.**

In Australia, literally **the only documented examples of conversion therapy have been conducted in a religious context**, and they are so rare that there is no evidence available of current practices. This is actually acknowledged in the Human Rights Law Centre/LaTrobe University Report used by the Health Department to justify the sections in this Bill which establish gender identity ideology in law. **The outlaw provisions are not even directed at religious personnel, they target health professionals.** Health professionals who try to practice conversion therapy are in violation of the ethics codes of their professions, such behaviour by health professionals is clandestine, fortunately rare, and should be outlawed.

“Homosexuality is same-sex attraction. Biological sex is real. Sex is binary, not a spectrum.”

In light of the need for further study and consideration of multiple areas of harm to lesbians and gays, and particularly children who may grow to be lesbians and gays, we have recommended that

the 'affirmative' model of gender transition under the incorrect guise of "banning conversion therapy" be removed as it relates to gender.

The Bill's Explanatory Notes insistently state the Bill outlaws "conversion therapy." This is misleading. **While the Bill does outlaw conversion therapy i.e., the 'conversion' of lesbians and gays away from their sexual orientation, it also obliges conversion therapy as the only option to be supported by health professionals for patients with gender dysphoria.** Any health professional who supports sufferers of gender dysphoria to work through the issues instead of immediately agreeing to conversion therapy risks criminalisation under this Bill. This is an extraordinary move, unsupported by data and evidence but supported strongly by a **regressive ideology**.

"A recent response published in The BMJ, titled Safeguarding adolescents from premature, permanent medicalisation, argues that when treating cases of gender dysphoria, "it remains legitimate to listen, assess, explore, wait, watch development, offer skilled support, deal with co-morbidities and prior traumas, and consider use of a variety of models of care. While respecting individuals' right to a different viewpoint, it is neither mandatory to affirm their beliefs nor automatic that transition is the goal, particularly when dealing with children, adolescents and young adults...With 85% desistance amongst referred transgender children and increasing awareness of detransitioning, unquestioning 'affirmation' as a pathway that leads gender dysphoric patients to irreversible interventions cannot be considered sole or best practice" [10].

Rapid onset gender dysphoria (ROGD), especially among teenage girls, and in particular among girls with backgrounds including autism, mental health issues and child sexual abuse, has been identified by some courageous professionals recently as a phenomenon requiring attention [5, 6, 7, 8].

In the UK there has been a surge in children who believe they are transgender (a 3,200% rise over the last ten years, 75% of whom are girls). For the first time, the majority of patients referred to the UK Tavistock clinic (54%) are aged 14 or under. Most are girls [13]. And yet efforts to question why there is currently such a developing discomfort with and hatred of their female bodies by teenage girls are closed down.

Tactic of linking a popular progressive issue (lesbian and gay rights) with a regressive and little known or understood area (gender identity ideology). Law firm, Dentons, recently provided advice to organisations wishing to establish gender identity ideology by law and this has been used as a template in a number of jurisdictions globally [18]. The Queensland Bill is an example of the template in action. James Kirkup has written succinctly of the template [20]. The Dentons' template includes: linking the gender identity ideological push to a more popular issue, minimising media coverage, minimising public scrutiny and minimising community consultation. This may produce outcomes desired by the trans lobby in some jurisdictions, it is not an example of the core values of democratic society which include, among other things, valuing community participation, public scrutiny and transparent decision making.

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For stories of detransitioned people regarding the pressure to transition see:

- <https://www.transgendertrend.com/current-evidence/>
- <https://www.genderhq.org/trans-youth-regret-rates-long-term-mental-health>
- https://twitter.com/charlie_sci
- <https://twitter.com/FlohrFritz>

Excerpts taken from TransgenderTrend

[Current evidence in the treatment of gender dysphoric children and young people](#)

A 2019 letter to the *Archives of Disease in Childhood* describes these treatments as ‘a momentous step in the dark’:

Butler provides evidence that intervention with a gonadotrophin-releasing hormone analogue (GnRHa) promotes a continued desire to identify with the non-birth sex — over 90% of young people attending endocrinology clinics for puberty-blocking intervention proceed to cross sex hormone therapy. In contrast, 73%–88% of prepubertal GD clinic attenders, who receive no intervention, eventually lose their desire to identify with the non-birth sex. Our concern is that the use of puberty blockers may prevent some young people with GD from finally becoming comfortable with the birth sex.³

Commissioned to review the evidence base for these interventions 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’:

The development of these interventions should, therefore, occur in the context of research, and treatments for under 18 gender dysphoric children and adolescents remain largely experimental. There are a large number of unanswered questions that include the age at start, reversibility; adverse events, long term effects on mental health, quality of life, bone mineral density, osteoporosis in later life and cognition. We wonder whether off label use is appropriate and justified for drugs such as spironolactone which can cause substantial harms and even death. We are also ignorant of the long-term safety profiles of the different GAH regimens. The current evidence base does not support informed decision making and safe practice in children.⁴

In their written submission to the government’s Health and Social Care for the LGBT Community consultation, a group of GPs, paediatricians and psychiatrists highlighted the need to differentiate between the ‘T’ and the ‘LGB’ in the treatment of children and young people, given that in the case of transgender identities ‘the issues are complex, the stakes high and the evidence very weak’:

It is important to acknowledge that gender questioning and feeling trans are influenced by a complex mix of cultural norms and personal predispositions (related e.g. to trauma and autism traits). This means parents, teachers, social workers etc must be careful to be both kind and neutral – ‘affirming a child as a child’ is not the same as ‘affirming’ another gender or actively discouraging children to believe they are not trans. ‘Wondering’ about identity and experimenting with roles is a normal part of growing up and most children desist from seeing themselves as trans with the passage of time and development.⁵

³ Richards C, Maxwell J, McCune N, Use of puberty blockers for gender dysphoria: a momentous step in the dark. *Archives of Disease in Childhood* Published Online First: 17 January 2019. https://www.transgendertrend.com/wp-content/uploads/2019/07/archdischild-2018-315881.full_.pdf

⁴ <https://blogs.bmi.com/bmiebmsspotlight/2019/02/25/gender-affirming-hormone-in-children-and-adolescents-evidence-review/>

⁵ Byng et al (2019) Written submission to Women and Equalities Select Committee <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/health-and-social-care-and-lgbt-communities/written/102806.html>

In Sweden, the Medical Ethics Council (SMER) is calling for caution in the medical treatment of gender dysphoria in young people.⁶ The Swedish Paediatric Society writes that:

Giving children the right to independently make life-changing decisions at an age when they cannot be expected to understand the consequences of those decisions, lacks scientific evidence and is contrary to established medical practice.⁷

⁶ <http://www.smer.se/publications/smer-calls-for-the-government-to-review-gender-dysphoria-in-childhood-and-adolescence/>

⁷ <http://www.barnlakarforeningen.se/2019/05/02/blf-staller-sig-bakom-smers-skrivelse-angaende-konsdysfori/>

Available studies on desistance

Year	Author	Sex	Sample Size	T0, Mean (Range)	Length T0-T1, Mean (Range)	T1, Mean (Range)	Des. M	Des. F	Des. Mixed	Sexual Orient. of Des. by Fantasy
1972	Lebovitz	Males	16			Adulthood	75%			62%
1978	Zuger	Males	16		14	22	93.75%			
1979	Money & Russo	Males	9		(8-10)	15-22 years	100%			
1986	Davenport	Males	8	9 (5-14)	11.1 (8-13)	15-27 years	87.75			
1987	Kosky	Males	8							
1987	Green	Males	44	7 (4-12)	~ 12 years	18.9 (14-24)	97.7%			80%
1995	Zucker & Bradley	Mixed	45	8.3 (3.1-14.3)	8.4 (2.8-14.9)	16.7 (13.1-23.5)	80%			24%
2008	Wallien & Cohen-Kettenis	Mixed	77	8.4 (5-12)	10.3 years	19.1 (16-28)	80%	50%	73%	54%
2008	Drummond	Females	25	8.88 (3-12)	~ 12 years	23 (15-36)		88%		40%
2012	Singh	Males	139	7.49 (3-13)	12.88 years	20.58 (13-39)	87.8%			61%
2013	Steensma Total	Mixed	127	8.7-9.83 (6-12)	(5.84-7.78)	15.92-16.32 (15-19)	71%	50%	63%	51%
	Steensma No Soc-Trans	Mixed	127	8.7-9.83 (6-12)	(5.84-7.78)	15.92-16.32 (15-19)	96%	54%	74%	

Note: Des = desistance

IS GENDER DYSPHORIA SOCIALLY CONTAGIOUS?

Dianna T Kenny PhD

Introduction

The earliest written record from the town of Hamelin in Lower Saxony is from 1384. It states simply, “It is 100 years since our children left.” Historical accounts indicate that sometime in the 13th century, many of the town’s children disappeared or perished, though the details of the event remain a mystery. “The Pied Piper of Hamelin” is...the only Grimm’s fairy tale that is based substantially on a historical event. Both the actual event and the Grimm’s tale suggest an archetypal situation in which adults have allowed children to be seduced away into peril. This tale is a disconcertingly apt metaphor for various social contagions that have overtaken collective life throughout the centuries (Marciano, 2019, p. 345).

Although it is tempting to blame the phenomenon of social contagion on the digital age, in which people, young and old, remain symbiotically tied to their social media devices, eagerly scanning their screens for the latest news, fashion, holiday location, rave party, or dating site to assuage their “fomo” (i.e., fear of missing out), social contagion predated the advent of the cyberage, thereby placing its origins squarely in the minds of humankind, assigning social media to its role as an efficient conduit of contagion.

In 1774, Johann von Goethe (1990) published a novel, *The sorrows of young Werther*, in which an idealistic young man finds his actual life too difficult to reconcile with his poetic fantasies, including his unrequited love for his friend’s fiancée. He eventually becomes so depressed and hopeless by the perceived emptiness of his life, he commits suicide. Goethe was able to capture the nameless dread and endless longing of the human condition so well that his novel spawned a number of suicides, committed in the same way that Werther had killed himself, by shooting (Phillips, 1974). Such was the alarm created by this phenomenon, the book was banned in several European cities.

Two hundred years later, in 1984, the suicide of a young Austrian businessman, who threw himself in front of a train, initiated a spate of similar suicides that

averaged five per week for nearly a year. Sociologists argued that this alarming occurrence was amplified by media coverage that glamorised suicide by providing graphic images of the suicidal act and details of the young man's life. When media exposure of the event was curtailed and then stopped completely, the suicide rate dropped by 80 percent almost immediately. Although the influence of suggestion and imitation on suicide rates was dismissed by Durkheim (2005, 1897), Phillips's (1974) work indicated that these factors do indeed play a significant role in the increase in suicides following a publicised suicide.

In 1841, a Scottish journalist, Charles Mackay (2012) wrote a book entitled *Extraordinary popular delusions and the madness of crowds*. In the preface to the first edition of the book, the aim of writing it is stated thus:

...to collect the most remarkable instances of those *moral epidemics* ... to show how easily the masses have been led astray, and how imitative and gregarious men are, even in their infatuations and crime (p. 1)...Popular delusions began so early, spread so widely, and have lasted so long, that instead of two or three volumes, fifty would scarcely suffice to detail their history... The present may be considered...a miscellany of delusions, a chapter only in the great and awful book of human folly (p. 3).

The preface to the second edition in 1852 continued this theme:

Nations,... like individuals, ...have their whims and their peculiarities; their seasons of excitement and recklessness... whole communities suddenly fix their minds upon one object and go mad in its pursuit; ...millions of people become simultaneously impressed with one delusion, and run after it, till their attention is caught by some new folly more captivating than the first. At an early age in the annals of Europe its population lost their wits about the sepulchre of Jesus and crowded in frenzied multitudes to the Holy Land; another age went mad for fear of the devil and offered up hundreds of thousands of victims to the delusion of witchcraft... the belief in omens and divination of the future... defy the progress of knowledge to eradicate them entirely from the popular mind... *Men... think in herds; ...they go mad in herds, while they only recover their senses slowly, and one by one* [Author's italics] (p. 7).

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

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

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

to transgender individuals. Other characteristics of networks include cohesion (number of connections within a network) and shape (distribution of ties within the network) (Otte & Rousseau, 2002).

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

Peer contagion

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

Deviancy training as a mechanism of social contagion

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

Co-rumination as a form of social contagion

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

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

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

Does social contagion have a causal effect on behaviour uptake?

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

Three possible causes of peer effects have been enumerated by Ali, Amialchuk, & Dwyer (2011):

i. *Endogenous effect.* This effect would occur in a situation in which "...an individual is more likely to use marijuana if there is a high rate of marijuana usage among the reference group because friends' engagement in such activities could develop a social norm which might compel an individual to use drugs in order to fit in with one's peer" (p. 2), a process described as induction (Christakis & Fowler, 2013), colloquially described as "birds of a feather flock together."

ii. *Exogenous or shared contextual effect.* This effect occurs when other social factors influence adolescent behaviour; for example, high substance abuse in a community population of adults, in which the adolescent's parents are also substance abusers. In such a scenario, adolescents whose parents abuse substances will be more likely to abuse, and contagion may occur in adolescents

as a result of peer influence even in those whose parents do not abuse substances.

iii. *Correlated effect*: These effects, known as environmental confounders, occur when adolescents in the same group behave in a similar way due to a third, perhaps unobserved factor, such as socioeconomic or demographic variables that cause their attributes to covary.

iv. The special case of social contagion via social media

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

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

Evidence for social contagion among adolescents

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

i. Anorexia nervosa

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

Intensification of peer influence in closed communities of like individuals, such as schools, inpatient wards, residential units (Huefner & Ringle, 2012), or

therapy groups often results in the advocacy of the practices (e.g., self-starvation, compulsive exercise, deceitful practices around eating) associated with anorexia nervosa (Dishion & Tipsord, 2011).

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

ii. Marijuana use among adolescents

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

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

Results showed that for every increase in marijuana use of 10 percent in adolescents in a close friend network increased the likelihood of marijuana use by two percent. An increase of 10% in usage in grade peers was associated with a 4.4 percent increase in individual use. Reporting a good relationship with one's parents, living in a two-parent household and being religious were protective

against marijuana uptake. When peer selection and environmental confounders were held constant, increases in close friend and classmate usage by 10 percent both resulted in a five percent increase in uptake in individuals within those networks.

iii. Suicide

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

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

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

committed suicide by hanging. In 2013 a mental health survey showed that 12 percent of students from these schools had seriously considered suicide in the previous 12 months. Thereafter, there was another spate of suicides, with three students taking their lives within three weeks of each other. A fourth committed suicide four months later by jumping off a tall building and a fifth followed shortly afterwards by walking in front of a train. Extreme perfectionism and pressure to excel at school, get into Stanford, make a lot of money, and be ostentatiously successful materially and intellectually were assessed to be far too great a burden for the more vulnerable students to withstand.

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

Gender dysphoria

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

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

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

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

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

acceptance mediated the self-worth of gender non-conforming 12- to 17- year-olds (Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Gender non-conformity and gender atypicality have also been associated with higher physical and emotional abuse by caregivers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Mental health is difficult to sustain in the face of caregiver abuse and peer bullying and victimization (Aspenlieder, Buchanan, McDougall, & Sippola, 2009). Indeed, gender non-conforming and gender atypical youth are at higher risk of depression, anxiety and suicidality in adulthood (Alanko et al., 2009).

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

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

the ideology of the trans-lobby are labelled “transphobic” and publicly denounced.

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

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

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

An indicative case study was written up in an article for *The Atlantic* by Jesse Singal (2018), in which Claire, a 14-year-old girl decided she must be trans because she was uncomfortable with her body even after she restricted her food intake, was finding puberty uncomfortable, had difficulty making friends, was feeling depressed and was lacking in self-confidence. Against this backdrop of

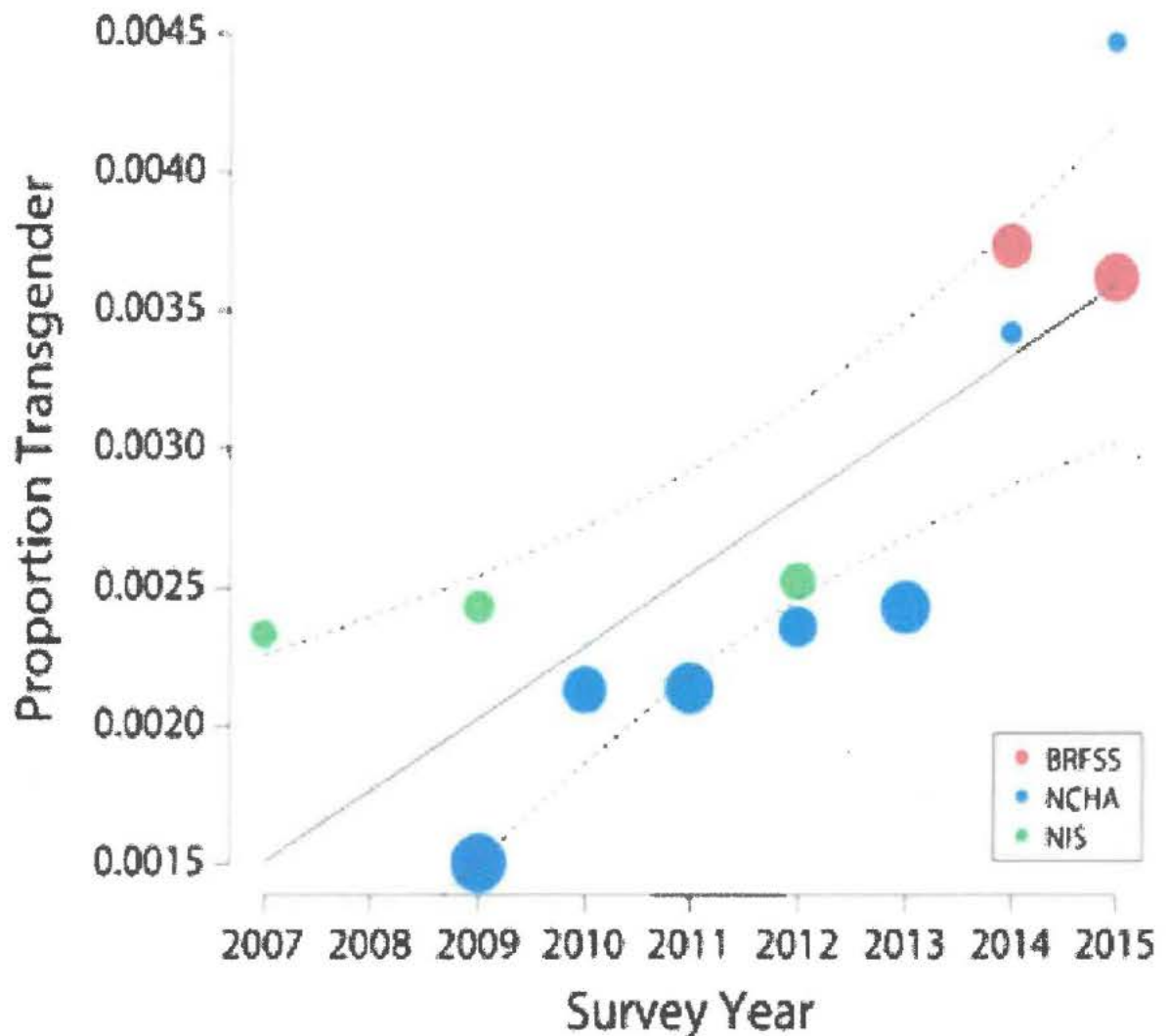
woes, she came across [MilesChronicles](#), the website of an omnipotent and histrionic transboy, now a young transman. Watching this video resulted in Claire pouring all her sadness and unease about herself into the “realisation” that she was really a “guy.” Miles made transitioning appear easy and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

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

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

(iii) Empirical evidence

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



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

Figure 1

Data from Australia also show an upward trajectory in the number of children enrolled in gender clinics in the four states of Australia that offer a gender service. The noteworthy feature of this graph (Figure 2) is that three of the four states (WA, Queensland and Victoria) show similar increases over the five-year study period (2014-2018). Although figures in NSW increased, the magnitude of

absolute numbers was significantly lower than for the other three states. Victoria had the largest numbers and the largest increases. It is also a state where the trans lobby has been particularly vocal and where the concept of the "[safe schools](#)" policy was conceived and implemented.

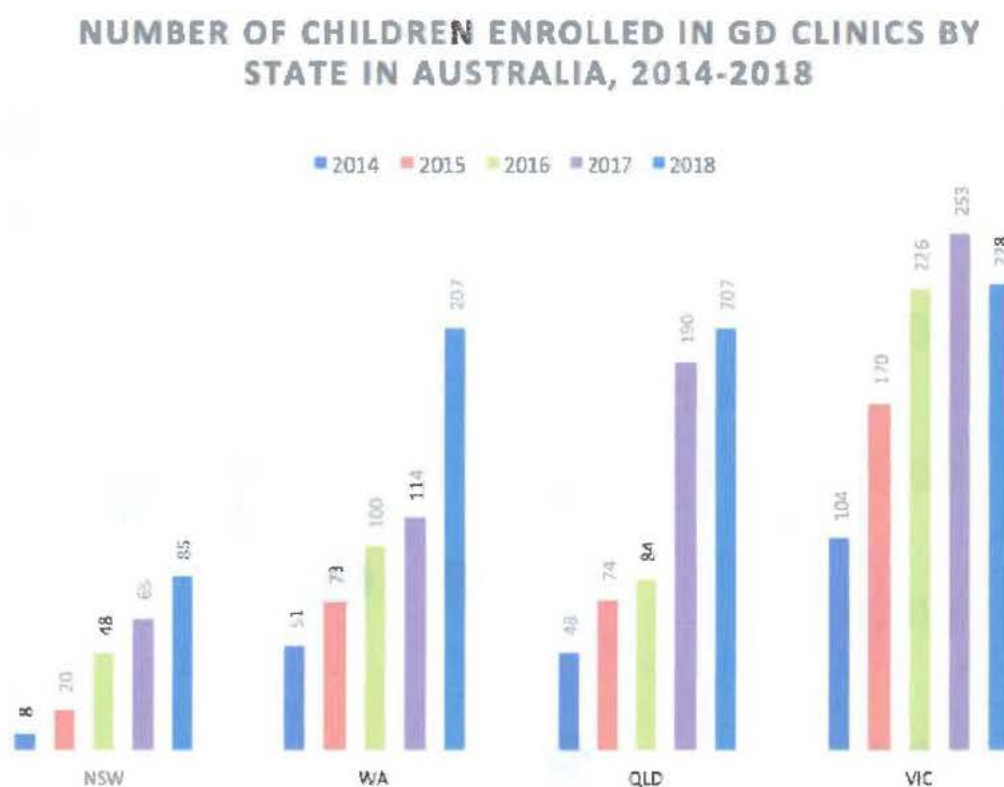


Figure 2

Source: Kenny, D.T. (2019). *Child and adolescent gender dysphoria in Australia – adopting the Zeitgeist but where are we going?* Invited paper to the NSW parliamentary forum, Parliament House, Sydney, Australia, 2 July.

Social contagion in treating practitioners, legislators, and educators

i. Treating medical practitioners

Iyengar, Van den Bulte, and Valente (2011) found contagion in the prescribing patterns of doctors after controlling for marketing outreach and systemic changes, such as the advent of new drugs and changes in the prevalence of diseases. Shared geographical proximity, shared group membership and self-identified ties between doctors were all factors in behavioural contagion, with self-identified ties the most compelling factor. A critical factor in marketing

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

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

ii. Law and legislation

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

Other legislative support e.g., *Victorian Births, Deaths and Marriages Registration Amendment Bill 2019* for the transgender epidemic includes a bill allowing transgender people to change their birth certificates without undergoing sex-reassignment surgery ([The Guardian on birth certificates](#)). Under the legislation a person can self-nominate their sex and list as male, female or any other gender diverse or non-binary descriptor of their choice. Children can alter the sex on their birth certificate with parental support and a

statement from a doctor or registered psychologist saying the decision is in the best interests of the child.

An article published by the Family Court of Australia ([Family Court of Australia report](#)) provides legal reasoning and argument regarding the disposition of gender dysphoria treatment for minors that outlines the limits of legal intervention in these cases. The reasoning in this report is underpinned by current, often erroneous information about gender dysphoria. In *re Kelvin*, the Royal Children's Hospital, Melbourne gave evidence that there was growing consensus regarding medical treatment of gender dysphoria. The RCH overstated its positive outcomes but did not refer to the uncertainty and disagreement about treatment and outcomes expressed by a growing number of researchers and clinicians.

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

iii. Sport

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

iv. Education

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

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

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

v. Parents

Parents are not exempt from these influences; there are numerous websites offering support to parents of transgender children (e.g., [Transcend](#); [Human Rights Campaign](#); [Gender Centre](#); [Gender Help for Parents](#)).

Conclusion

"All the world is queer save thee and me, and even thou art a little queer." When the Welsh reformer and philanthropist Robert Owen penned these words in 1771, the word "queer" meant "strange" or "different." The word "queer" is now an over-arching term used to describe sexual and gender minorities. I wish to revert to the original meaning of this word in the context of this paper as it highlights yet another worrying psychic epidemic that has spread its tendrils into all corners of society – medical, social, legal, psychological, political, ideological and philosophical. By the time the proponents of gender dysphoria in children and adolescents realise the far-reaching damage they have caused by their unthinking political correctness in supporting gender affirmation, the courts will be clogged with lawsuits brought by transgender adults whose bodies and minds have been irreparably damaged by the zealous compliance to the strident voices of the trans lobby shouting gender affirmation.

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