Births, Deaths and Marriages Registration Bill 2022

Submission No: 293

Submitted by: [redacted]

Publication: Making the submission public but withholding your name

See atatched:

SUBMISSION TO THE LEGAL AFFAIRS AND SAFETY COMMITTEE of QUEENSLAND PARLIAMENT

Comments on Births, Deaths and Marriages Registration Bill 2022

There are many problems in this Bill, that would lead to substantial disadvantage to women, present safeguarding concerns for children, and compromise data collection. Women need to be heard here. I must first deal with the way in which our concerns have already been dismissed.

Misrepresentation of critics of this Bill

In her speech to parliament, Attorney General Shannon Fentiman asserted "*We also know that some groups will try to cloak their transphobia in the guise of women's safety— making claims about trans women accessing women's spaces, including change rooms or even domestic violence shelters. I want to be clear: there is no evidence, domestically or internationally, to support these outrageous claims.*" I strenuously object to this characterisation of legitimate concerns as bigoted and "transphobic", which is a much over used term. This is also wrong. There is abundant evidence of the abuse of access to women's spaces. Below I will be able to provide only a small sampling of the many examples of loss of women's safety and comfort through loss of single-sex spaces, and I am happy to provide further examples on request.

In fact, a number of older transsexuals are alarmed at contemporary transgender activist demands, and appreciate the dangers of what is proposed. Debbie Hayton writes in the Guardian [1] regarding reforms to the Scottish Gender Recognition Act which is similar in aim, but not as radical as the Queensland Bill, *"As a transsexual, I am astonished and appalled that a bill purporting to extend trans rights compromises the rights of women and undermines the safeguarding of children. When distinguishing men from women, it is neither progressive nor practical to replace biological sex with self-identified feelings of gender – whatever gender might mean."*

Kristina Harrison, a post-operative transsexual writing in The Economist argues that "*moving away from a diagnostic system of legal gender recognition to one of self-declaration would fail some vulnerable youngsters, undermine women's sex-based protections and harm trans people themselves"* [2]. Regarding the consequences of self-declaration allowing change of "sex" being considered in the UK in 2018, she continues: "*That would enshrine a quite extreme gender ideology in law, and effectively amount to a comprehensive redefinition of what it is to be female, or male. These changes, after thousands of years of sex-based definitions, are happening with a minimum of political scrutiny. Public debate about them is deliberately impeded by a toxic and authoritarian atmosphere in which serious, repeated attempts have been made to silence and sideline dissenting voices, particularly those of women. This is despite huge implications for women and transsexuals, as well as for democratic politics and everyday cultural pressures*." It is still the case, that dissenting voices are being shouted down with accusations of "transphobia" and the threat of vilification and attacks on employment, and hence my own request for an anonymous submission. I believe there are ways to cater for the needs of transgender people and improve their lives, without impinging on women's rights, and this Bill needs substantial re-working.

Summary
In my submission below I detail the following problems with the Bill.

1. The words "sex", "male" and "female" are completely undefined and used in vague and novel ways that will create legislative confusion. The Bill confuses sex, that is biologically defined and unchangeable, and modern ideas of "gender identity" which is a poorly defined concept seemingly reliant on stereotypical gendered behaviour. The Bill seeks to allow people to change the sex marker on their birth certificate to an indicator of gender identity. If that is the aim, it should not be called "sex". The ability of males to become legally "female" according to this Bill, and vice versa, leaves us without language to accurately describe biological sex.

2. Women's safety and rights will be compromised by the inability to legally distinguish between biological males and females. This will result in the loss of single-sex spaces with associated safety concerns, fairness in women's sport will be destroyed, and women will lose grants, awards and scholarships that are designed to redress the disadvantage they face in society. The proposed *Births, Marriages and Deaths Act 2022* makes a change of sex descriptor extremely easy, with no requirement for anything other than a declared feeling regarding gender identity (that is mistaken for sex in the Bill). Combined with inclusion of changes to the *Anti-discrimination Act 1991* it will not be possible to maintain any biological-women-only services or spaces, and affects safety, amenity or information gathering in the following situations:

- prisons
- domestic violence shelters
- rape crisis counselling
- toilets
- change rooms
- gyms
- sporting events
- lesbian groups
- psychiatric wards
- selection of staff for strip searching
- medical services
- nursing home accommodation
- intimate care for disabled people
- awards, grants or scholarships
- quotas designed to redress women's disadvantage
- recording and reporting of male crimes as female

In asserting that there is a loss of safety for women and children, I am <u>not saying that</u> transgender women are inherently more dangerous to women than men are generally. But men are not normally in women's spaces whereas trans women seek to be. In addition, this Bill can be misused by people with nefarious purposes. Men are obviously stronger, more aggressive and frequently sexually motivated to access women. Sexual predators including voyeurs and pedophiles are highly motivated to seek out their prey. The idea that they will not abuse this system to get close to what they seek is naive. There have already been multiple examples of such abuse internationally. Furthermore, in some countries, facilities such as swimming pools, nightclubs and department stores have decided it is easier to just have mixed sex changing rooms. This has led to multiple instances of voyeurism and assault. Also - imagine these situations - prisons where women are locked up with sex offenders and pedophiles who have a

new-found female identity, vulnerable disabled women having to be washed and toileted by biological males, mixed accomodation in psychiatric wards including psychotic males claiming female status, domestic violence shelters housing biological males amongst traumatised women.

3. The lack of single-sex spaces will decrease participation in society by women of minority groups. Women from a number of cultures will lose important activities that need the privacy of single-sex spaces. For example, Muslim women are unlikely to use a gym if a trans woman might be present in the changing room. This leads to a substantial loss of freedom and quality of life for a significant proportion of our society.

4. Parental rights are undermined by allowing the Children's Court to approve name and sex change of children aged 12-16, without parental approval. The Bill would allow for a school guidance counsellor to support a 12-year-old child to change name and sex in the Children's Court, against the wishes of the parents. Adolescence can be a difficult and turbulent time and can involve conflict with parents. The judgements of children are by definition "immature" and may not stand the test of time. This proposal is a gross violation of the rights of parents to look after their children and guard them against trends which they may rightly see as transient or dangerous to health and mental health. This is over-reach by the state, into the family.

5. The Bill will encourage young people to make "concrete" their neo-identities that may otherwise be transient and exploratory. An extraordinary number of adolescents and young adults are coming to believe that they are "born in the wrong body" with a large role for social media in this trend. In Victoria, referrals to the gender service at the Royal Children's Hospital Melbourne went from only 1 in 2003, to 18 in 2012, to 821 referrals in 2021. This is a 46-fold increase in the past 9 years, and the trend in Queensland is similar. Activists claim that this is due to increased acceptance of being transgender, and ignore the obvious impact of social media and the contagion of ideas [3, 4]. An increasing number are now realising that they made a mistake and are "detransitioning" which is particularly traumatic if they have altered their body hormonally and surgically [5, 6]. It is also important to note that in the largest study to date of boys with gender dysphoria onset in early childhood, 87.8% end up desisting, with most going on to become homosexual adults [7]. A "social transition" is the first step along a path of medicalisation. A child of 16 is still a minor, too young to be taking the decision on legal change of name and sex, and a significant number will regret this decision. Indeed the Reddit chat site r/detrans (https://www.reddit.com/r/detrans/) has over 43,000 members, and distressing tales of regret and life-long medical harm are told. From reading entries on that site, the Qld government should be urging caution on transition, rather than encouraging it medically and legally, because in the end, it will cost the state, through medical and mental health costs.

6. The removal of an exemption for work involving the care or instruction of minors from the Anti-discrimination Act 1991 will compromise safeguarding of children. Given the huge number of historical sexual abuse scandals that society has had to cope with, great vigilance is needed in the selection of people working with children. Enforcing anti-discrimination legislation will remove the ability of employers to restrict employment when there is reasonable doubt about an individual's suitability.

7. Confusion between natal sex and legal sex would confound statistical and medical data and analysis of demographic trends. Collected data that fails to note both natal sex and transgender identification fails both the needs of society as a whole, and transgender people, as their

medical and welfare needs would remain unrecognised. The collection of crime statistics where trans women's crimes look to be committed by women will distort analysis of trends in criminal activity and the reasons behind it. It is also offensive to women that their sex class will see an increase in violent and sexual crimes, as it has been established that gender transition does not alter or reduce male-pattern criminality [8].

Misuse of change of gender/sex

I anticipate that proponents of this Bill argue that the chances of anyone bothering to misuse the provisions for change of sex, for anything other than a genuine transgender identity are negligible. However, a man in Ecuador recently changed legal sex because he thought it would improve his chances of success in a custody battle [9]. In Switzerland, a man changed his legal sex to obtain the pension one year earlier than he was permitted as a man [10]. It is completely naive to think that sexual predators will not do the same, especially if it involves no physical changes to the body.

Indeed, extremely concerning is a publication in *The Psychiatrist* journal, documenting 54 individuals in Oxfordshire referred for psychiatric assessment between 2004 and 2009, prior to treatment for gender dysphoria. It was noted that a "small group" of patients sought ***"gender reassignment to facilitate or normalise pedophilia. This latter small group described gender reassignment as a means by which to increase their intimate contact with children, which they viewed to be more socially acceptable in a female role."*** [11]. Thankfully they were not referred on for transition. And yet here the Queensland government seeks to introduce a Bill that will allow full legal recognition of anyone as female, just if they ask for it.

If males misuse provisions that allow them access to female spaces, how are we to distinguish them from legitimate trans women? Under the proposed changes, a man need do nothing other than assert a sense of "femaleness" to become legally female. How will we tell the difference between a man doing this for nefarious purposes and one profoundly convinced of their female status? In India, a man was recently convicted of rape, with the judge determining that he "pretended to be transgender" [12]. How are we to judge who is authentic and who is "pretending", and how do we challenge the pretenders? Another consideration is that a Swedish long-term study showed male-to-female transsexuals had the same rate of criminal offending as men, including violent crimes [7]. The only solution for women's safety in public spaces is to retain the ability to have truly single sex spaces where women do not have to fear assault.

Lack of definition of sex in the Bill.

The Bill proposes to let people freely change their "sex descriptor" on the birth certificate to male, female or anything acceptable to the registrar, and yet *sex is not defined*.

A biological definition of sex. Sex categories, male and female, provide the basis for sexual reproduction, whereby in vertebrates the large sessile female gamete (egg) is fertilised by a smaller mobile male gamete (sperm). Sex is biologically determined through the genetic code in every cell, and cannot be changed. There are only two sexes, defined by their reproductive role. Approximately 0.02% (2 in 10,000) of individuals have true disorders of sex development [13], commonly known as "intersex", for whom determination of sex at birth is more problematic although most can eventually be determined as male or female. However, these medical conditions, do not indicate that sex is a "spectrum" nor that other sexes exist. I can appreciate that some people with these conditions may not want to define their sex. However, this ambiguity does not negate the fact that sex is binary and unambiguous in the remaining 99.98% of the population

The proposed legislation allows people to choose what their birth certificate says for "sex". This then defies any rational and conventional definition of sex. To allow change of sex on the certificate is to allow falsification of an official document, because sex cannot actually be changed. If the government does not want to record the true sex on the birth certificate, the wording should be changed. The certificate could say "gender identity" or some other description that does not deny biological reality. Or better still, birth certificates should retain the correct sex marker, and there should be the option of recording gender identity on other identity documents.

Almost unrestricted choice of "sex"

The Bill allows for an unknown number of possibilities for sex descriptor. This would be impossible if the Bill included the accepted definition of sex. On page 140, the "sex descriptor" that can be put on the birth certificate can be male, female, or "any other descriptor of a sex. Examples- 'agender', 'genderqueer', 'non-binary'." However, these are not actually descriptors of sex, they relate to modern concepts of gender identity that have emerged only in recent decades. Apparently some descriptors will be prohibited if they are obscene or absurd, or cannot be established by repute or usage. However, there are a plethora of gender identities online that could be chosen from including hemigirl, illusoboy, gendermaverick, erotogender with fascinating definitions. Like "genderqueer" none of these have anything to do with "sex", and should be deemed "absurd". Choices for sex descriptor should be limited to male, female, and some accomodation for the rights of intersex people, as determined by discussion with patient advocacy groups. The desire to have anything else on a birth certificate would have to be labelled as something other than sex.

Effects of the proposed legislation on women in prison.

In a number of jurisdictions male-born people can now be housed in women's prisons if they profess to identify as women. Naturally there are attractions for doing so - life is less violent in women's prisons and they have prospects for sexual activity. The transfer of males into female prisons is contrary to the The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) [14] which state that:

The different categories of prisoners shall be kept in separate institutions or parts of institutions, taking account of their sex, age, criminal record, the legal reason for their detention and the necessities of their treatment; thus:

(a) Men and women shall so far as possible be detained in separate institutions; in an institution which receives both men and women, the whole of the premises allocated to women shall be entirely separate

It is likely that, like many inmates, trans women are unsafe in male prisons, but this problem has to be solved by providing appropriate units within the male prisons. It is completely inappropriate that female inmates are traumatised in order to provide safety for trans women. The Bill proposes that sex reassignment for inmates will require approval of the Chief Executive of Corrective Services. However, there are no indications of what criteria would be acceptable for approval, and this is a fallible system that relies on good judgement of the personnel involved. This also does not solve the problem of inmates who already identified as women at the time of conviction. In truth, no male bodied person should ever be housed in women's prison, in accordance with the Mandela Rules. To do so can constitute torture for female prisoners. A large proportion of women in prison are victims of sexual assault or domestic violence, and they do not deserve to be re-traumatised whilst in prison.

No doubt all jurisdictions who are transferring trans women prisoners to female prisons believe they have made judgement about their suitability. But in many cases this is going disasterously wrong, showing that no level of precaution is adequate. Some examples of reports of male-bodied people in womens prisons:

- A man who sexually assaulted a woman in Richmond, Melbourne and was previously jailed in Europe for a child sex offence now identifies as a woman and is housed in a women's prison in Victoria. Other inmates, many the victims of sexual assault, launched a petition that said “We feel threatened, unsafe, distressed and traumatised with this current situation. Accordingly, we demand that (the inmate) be immediately removed from the Murray unit.” [15].
- Evie Amati, a violent offender who attacked people with an Axe in a 7-Eleven store has been housed in the Mary Wade Women's Correctional Centre in NSW. There are reports of fights at the prison, because female inmates who no doubt find Evie's male-pattern violence intimidating, want her transferred to a male prison [16].
- Demi Minor, a transgender prisoner in New Jersey managed to impregnate two female inmates, proving conclusively that he is not female [17].
- Numerous prisoners have spoken out about the dangers and trauma of having males with working penises who are often violent criminals and sex offenders, transferred into their facilities [18].
- There is evidence that some prisoners are not genuine in their wish to transition, and are taking advantage of the opportunity to get into women's prisons. This can be seen from reports of prisoners returning to life as men upon release. An inmate interviewed in a study published in The British Journal of Criminology said "*The last one to get out, back living as a man. The one before that got out, back living as a man*." [19].

Effects of the proposed legislation on women's domestic violence shelters
There are alarming stories from North America, about predatory men exploiting their opportunities for access to women's shelters. For example:

- Christopher Hambrook claimed to identify as a woman in order to prey on women at shelters in Toronto. He has sexually assaulted 4 women and girls and is now jailed indefinitely as a dangerous offender [20].
- Serial sex offender Shane Green, 25 was arrested in Ontario for sexual assault in a women's shelter after fabricating an identity as a woman [21].

Other instances emphasising the importance of single-sex spaces for women's safety
There are numerous examples available of assaults of women in mixed sex toilets or change rooms, and a significant number of instances of assault or voyeur behaviour of men dressing as women to enter women's facilities. However, an area where women are particularly vulnerable is when disabled or under psychiatric treatment. In one troubling Australian case, a sexual abuse victim in St Vincent's hospital psychiatric unit in Melbourne was re-traumatised by her assault and rape by male patients, and later committed suicide [22].

Pedophile identification as women to gain access to children
The fact that this occurs has already been established by the published report referred to earlier, of pedophiles seeking transition who revealed in pychiatric assessment that their intention was to get better access to children as "females" [11]. Recent examples likely to fit this category:

- Australian Tiktok transgender personality Rachel Queen Burton is in custody in South Australia on child abuse charges [23].
- Sydney man presenting as a transgender woman Tiane Miller has been arrested for seeking sex with children [24].
- In the UK, a family trusted a 25-year-old to be alone with their 14-year-old daughter because he presented as a trans woman, resulting in the daughter's grooming and impregnation [25].

An uneven playing field - males in women's sport

There is no doubt that bodies that undergo male puberty gain superior strength, height and bone density over female bodies, providing advantage in the majority of sports. These effects are only partially mitigated by later blocking of testosterone, as the person's frame and muscle structure is largely preserved. This has been discussed at length in the literature, and I will not go through it here. This issue is not only important at the elite level. If school girls are routinely beaten in a competition they cannot possibly win, they may well be discouraged and drop out of sport. Concerns are not only about winning though, and serious injuries are documented in mixed sport because of the greater male bulk. It is commonly thought that this is only a minor problem because the numbers of trans women are small. It is an increasing problem, and it is infuriating, that for women and girls, their prizes, achievements, and participation is being taken away. Maintaining women's sport does not amount to "banning" trans women from sport, as they can be accomodated either within male or open competitions, or in social sport within mixed teams. The misogynistic disregard for women in the insistence that they should compete against male bodies, is palpable. This Bill will challenge the ability of sporting bodies to maintain fairness and safety in their sports, and also adhere to the *Anti-discrimination Act 1991*.

Risk to children's safeguarding of changes to the *Anti-discrimination Act 1991*

As per page 114 of the Bill, the *Anti-discrimination Act 1991* would be amended by omission of s 28 (work with children). It is proposed that it will no longer be lawful to discriminate on the basis of gender identity or lawful sexual activity in the context of work involving the care or instruction of minors. Here I just want to pose the question of what would be lawful under the proposed legislation, in the following situations which have occurred overseas.

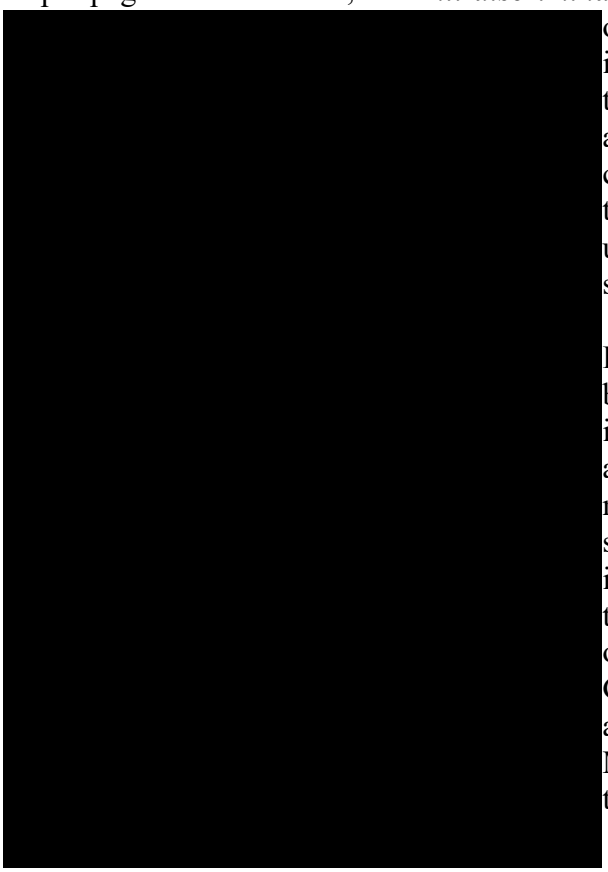


Figure 1: Monica Sulley, a trans woman, became a girl guide leader in the UK. This image posted publicly online by Sulley shows a BDSM interest - "Now behave yourselves or mistress will have to punish you". This suggests lawful sexual activity and gender identity. But many parents would be alarmed that their children might be supervised on overnight camps by this person. Should the Girl Guides Association be prosecuted under anti-discrimination legislation if they decided Monica was unsuitable as a guide leader after the online posts came to light? [26].

Figure 2: This teacher in Ontario Canada, comes to school wearing massive prosthetic breasts, and the school board has determined that the teacher is allowed to continue to do so [27]. Apparently the implementation of a dress code would "likely expose the board to considerable liability" and would be found to be discriminatory. It is unbelievable, that a teacher wearing fetish gear to school cannot be challenged because of anti-discrimination legislation protecting the right to "gender expression". This is not acceptable on any level. How would the proposed Queensland legislation deal with such a situation?

need for exemption from the *Anti-discrimination Act 1991* for work with children. It is quite unbelievable, given the rampant institutional child sexual abuse cases we have seen playing out in Australia in the last decade, that this Bill seeks to remove one of the protections for children.

Sensible legislative change

It is critical that women's rights to single-sex spaces, sports, awards, and rights of association be maintained. It is also important that the Queensland government recognises that the tide is turning on childhood gender transition, with a number of countries including Finland, Sweden and the UK realising that psychotherapy rather than 'gender affirmation' is more appropriate for children and adolescents, and legal change of sex and name should not be undertaken for those under 18. Regarding possible legislative change, I endorse the recommendations of UQ law professor, Patrick Parkinson, who is extremely knowledgeable in this particular field, has the professional competency, and who I understand has made a submission identifying major inconsistencies and problems presented by this Bill. It is illogical to allow changes to a birth certificate, that records sex, an immutable characteristic. For transgender individuals there should be some other route to alteration of driver's licence and other identity documents in order to record gender identity. Sex cannot change. Allowing a gender marker on other documents would go some way towards resolving conflict with women's rights, as transgender people would not need to legally change sex.

This Bill is not well thought through, having been driven by an activist agenda. Regarding how it would mesh with other laws, aspects become quite ludicrous. *The Corrective Services Act 2006* requires that strip searches should be conducted by two officers, and they must both be the same sex as the prisoner. This suggests that a trans woman who is anatomically male gets to be searched by two females who may understandably not be happy with this. However, what happens when the prisoner's sex is "gendermaverick"? The limited availability of gendermaverick prison officers could present a problem.

Closing Statement

In asserting that there are problems with this Bill, I am in good company. The UN Special Rapporteur on violence against women and girls, Reem Alsalem, has recently stated in an open letter [28] that similar proposed legislation in Scotland threatens the safety of women. She states that the proposal "*does not provide for any safeguarding measures to ensure that the*

procedure is not, as far as can be reasonably assured, abused by sexual predators and other perpetrators of violence...It is important to note that insistence on safeguarding and risk management protocols does not arise from the belief that transgender people represent a safeguarding threat. It is instead based on empirical evidence that demonstrates that the majority of sex offenders are male, and that persistent sex offenders will go to great lengths to gain access to those they wish to abuse. One way they can do this is by abusing the process to access single-sex spaces or to take up roles which are normally reserved to women for safeguarding reasons."

Various documents provided explaining the proposed Queensland legislation refer in deferential terms to the Yogyakarta Principles, that are in reality just a set of guidelines drawn up by activists. Robert Wintemute, Professor of Human Rights Law at King's College, London, was one of the original 29 signatories of the Yogyakarta Principles. He is now highly critical of aspects of the principles, in particular on self-definition of gender identity, as the conflict with women's rights was not discussed during the writing of the principles, and he had not considered the implications. He now says [29] "*With regard to change of legal sex, the Yogyakarta Principles are not a neutral document in human rights law but rather a radical advocacy document."* [30].

"Better protection of the human rights of a very small minority must not come at the expense of the human rights of the majority of the population... I would like to say that I have changed my mind with regard to certain transgender demands including access to women only spaces, after listening to women. Men are rarely if ever affected by transgender demands so it is easy to say yes. We must always try to imagine ourselves in the changing rooms, hospital wards, and prisons of lesbian, bisexual and heterosexual women."

Consequently, it is not only women you need to listen to, but sensible and informed men, like Robert Wintemute. The examples given in this submission firmly refute the assertion of the Attorney-General that there is no evidence of harm coming from allowing free access into women's spaces for anyone claiming womanhood. Finally, the timing of this consultation period has coincided with holiday period. There must be longer public consultation for any changes that are of such magnitude and affect at least half of our population.

References

1. Hayton D (2022) Nicola Sturgeon is revealing an appalling naivety over trans rights. *The Guardian*, 4 Dec 2022. https://www.theguardian.com/global/commentisfree/2022/dec/04/observer-letters-nicola-sturgeon-trans-rights
2. Harrison K (2018) A system of gender self-identification would put women at risk. *The Economist* Jul 3rd 2018. https://www.economist.com/open-future/2018/07/03/a-system-of-gender-self-identification-would-put-women-at-risk
3. Marchiano, L (2017) Outbreak: On transgender teens and psychic epidemics. *Psychological Perspectives* 60:345-366. DOI: 10.1080/00332925.2017.1350804;
4. Haltigan JD, Prinsheim TM, Rajkumar G (2023) Social media as an incubator of personality and behavioural psychopathology: Symptom and disorder authenticity or psychosomatic social contagion? Comprehensive Psychiatry 121: 152632 https://doi.org/10.1016/j.comppsych.2022.152362

5. Littman L (2021) Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behaviour* 50:3353-3369 https://doi.org/10.1007/s10508-021-02163-w;
6. Vandenbussche, E (2021) Detransition-Related Needs and Support: A Cross-Sectional Online Survey. *Journal of Homosexuality* 20. https://doi.org/10.1080/00918369.2021.1919479
7. Singh D, Bradley SJ, Zucker KJ (2021) A follow-up study of boys with gender identity disorder. *Frontiers in Psychiatry* 12:632784 doi: 10.3389/fpsyt.2021.632784
8. Dhejne, C et al. (2011) Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One* 6:e16885. doi:10.1371/journal.pone.0016885
9. Janowitz N (2023) Man legally changed gender to gain custody of his kids. Trans groups are concerned. *Vice World News*. Jan 5th 2023. https://www.vice.com/en/article/m7gdny/man-legally-changed-gender-to-gain-custody-of-his-kids-trans-groups-are-concerned
10. de Persigny G (2022) A man changed his gender to retire earlier. *The European Times* 11th Feb 2022. https://www.europeantimes.news/2022/02/a-man-changed-his-gender-to-retire-earlier/
11. Saunders K, Bass C (2011). Gender reassignment: 5 years of referrals in Oxfordshire. *The Psychiatrist* 35: 325-327. doi: 10.1192/pb.bp.110.032664
12. Samervel R (2023) Fake transperson gets 7 years jail for rape & black magic. *The Times of India* Jan 1st 2023. https://timesofindia.indiatimes.com/city/mumbai/fake-transperson-gets-7-years-jail-for-rape-black-magic-in-mumbai/articleshow/96654429.cms
13. Sax L (2002) How common is intersex? A response to Anne Fausto-Sterling. *Journal of Sex Research* 39: 174-178 https://doi.org/10.1080/00224490209552139
14. The United Nations Standard Minimum Rules for the Treatment of Prisoners. https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf
15. Women inmates demand removal of trans prisoner. *Herald Sun* 11th August 2022.
16. Sutton C (2019) 7-Eleven axe attacker Evie Amati involved in jail fight. *News.com.au* Jul 30th 2019. https://www.news.com.au/national/courts-law/7eleven-axe-attacker-evie-amati-involved-in-jail-fight/news-story/c7315afcb7805e6ec520cf7575fbf4a0
17. Transgender prisoner gets two inmates pregnant in women's prison. *Loop News* Jul 19th 2022. https://cayman.loopnews.com/content/transgender-prisoner-gets-two-inmates-pregnant-womens-prison
18. Keep Prisons Single Sex XX website. https://kpssinfo.org/women-in-prison-speak-out/
19. Maycock M (2022) Analysing the views of cis-women in custody about living with transgender women in the Scottish prison estate. *The British Journal of Criminology* 62: 1000-1018
20. Pazzano S (2014) Predator who claimed to be transgender declared dangerous offender. *Toronto Sun* Feb 26th 2014. https://torontosun.com/2014/02/26/predator-who-claimed-to-be-transgender-declared-dangerous-offender
21. Sieland J (2022) Sex Offender Identified as Woman to Access Women's Shelter, Allegedly Raped a Female Resident. *Reduxx* Oct 18th 2022. https://reduxx.info/male-sex-offender-identified-as-woman-to-access-womens-shelter-allegedly-raped-a-female-resident/
22. Tomazin F (2017) Sexual abuse in Victoria's mental health wards is bad and getting worse. *The Age* Dec 11th 2017. https://www.theage.com.au/national/victoria/sexual-abuse-in-victorias-mental-wards-is-bad-and-getting-worse-20171211-h02kcx.html

23. Sieland J (2022) Trans Tiktoker facing multiple child sexual abuse charges. *Reduxx* Oct 7th 2022. https://reduxx.info/aus-trans-tiktoker-facing-multiple-child-sexual-abuse-charges/
24. Lackey B (2022) Read woman's twisted messages to nine-year-old girl after she was caught trying to have sex with the child. *Daily Mail Australia* Dec 18th 2022. https://www.dailymail.co.uk/news/article-11549807/Tiane-Miller-jailed-five-years-arrest-child-exploitation-police-Sydney.html
25. Sales D (2022) Transgender paedophile, 25, who identified as a woman won family's trust to groom 14-year-old girl and got her pregnant *Daily Mail Australia* Nov 30th 2022. https://www.dailymail.co.uk/news/article-11482001/Transgender-paedophile-25-identified-woman-groom-14-year-old-girl-got-pregnant.html).
26. Slatz A (2021) Trans identified male now a senior leader at Girl Guides UK *4W* Nov 22nd 2021. https://4w.pub/trans-identified-male-now-a-senior-leader-at-girl-guides-uk/
27. Casaletto L (2022) Oakville teacher allowed to continue wearing large prosthetic breasts, school board says. *City News Everywhere*. Nov 11th 2022. https://toronto.citynews.ca/2022/11/11/oakville-teacher-prosthetic-breasts-ontario-school-board-dress-code/
28. Alsalem R (2022) Letter from the Special Rapporteur on violence against women and girls to the Scottish government. Nov 29th 2022. https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=27681
29. Robert Wintemute, LGB Alliance conference, UK Nov 2021 (recording from 10:50 : https://www.youtube.com/watch?v=8YdflWHcZQ0)
30. Singer R (2022) The man who suddenly heard women - and renounced the Yogyakarta Principles. *Gender Dissent* Dec 5th 2022. https://www.genderdissent.com/post/the-man-who-suddenly-heard-women-and-renounced-the-yogyarta-principles

A parent perspective on the Births, Deaths and Marriages Amendment Bill 2002

Introduction

I am the parent of a young adult Queenslander who identifies as transgender and is medicalising this identification. This can include hormonal treatment as well as operations, and this represents real medical harm being perpetrated on the youth of our state under the guidance of Qld Health. Parents who have doubts about "gender affirming care" as a useful or safe treatment for their child are silenced and told they are bigoted. Through my concern about what my child is undertaking and my fears for their future life, I have spent many years researching all aspects of gender ideology and the transgender trend. I take this opportunity to provide a parental perspective. ***This Bill, although well-intentioned, will actually exacerbate harm to our young people.***

The Births, Deaths and Marriages Amendment Bill 2022, in allowing for change of "sex" is a radical document that essentially eliminates the legal categories of biological male and female as sex classes. Although the intent is to improve the lives of transgender individuals, I think a number of the proposals are fundamentally against the best interests of people exploring gender. There are also profound threats to the rights of women and children from this bill, as expressed by many people, and seemingly dismissed and not considered by the government. From what I can see, the preparation of this bill has been driven by the lobbying of one interest group and fails to take into account broader implications and perspectives. A massive change such as this should not be undertaken in a rush, without widespread publicity and discussion. I call on the Queensland government to slow down this process and reconsider.

I hope you are aware of the ongoing controversy in Scotland over similar legislation. The Scottish legislation is not as radical as Queensland's, and it has been blocked from being enacted by the UK government. Although this would normally have caused a storm of nationalistic resentment in Scotland, in this case it has not, because the people do not broadly support the legislation. The Scottish government is now floundering to justify its case, with two scandals in one week about transfers of sex offenders into women's prisons. I ask you to consider whether the people of Queensland, if they truly had explained to them the effect of this Bill, would approve of it. Do you really think that Queenslanders will think it is OK for a school guidance counsellor to help a 12 year old child change their name and sex through the court system, against the wishes of parents? This is an outrage. This Bill needs light shone on it for the people of our state. I will first deal with the impact of the Bill itself and its problems, and then explain the background I have, as the parent of a child with gender confusion, that brings me to these conclusions. If we think about this properly and carefully, Queensland could lead the way with enlightened legislation that both meets the needs of transgender people, and protects existing rights of women and children.

SPECIFIC CONCERNS WITH THE BILL

1. There is no definition of sex, and the term is conflated with gender identity.

This has been pointed out by many others, and where this interacts with other legislation would be a point of great confusion. Sex has never needed a legal definition before, because it has never been misunderstood before. Sex is biological and cannot be changed by a piece of paper nor by hormones and operations. For the government to allow change of sex on a birth certificate, let alone the possibility of "genderqueer" as a "sex" is a nonsense, and promotes and validates magical thinking over reality.

Recommendation: As sex descriptor, a birth certificate should only allow male, female and some accommodation for the needs of medically-identified intersex people as discussed with them. Anything else is not a description of sex. Gender identity including non-binary status needs to be catered for separately. The certificate could in addition state a gender identification, or a separate gender ID certificate could do that. If added to the birth certificate, this is a field that should only be used upon application by an adult; since gender identity is an inner sense of self, this is not applicable to babies. Furthermore, not all people consider that they have a gender identity.

2. Promoting the idea that you can change sex is actually harmful to transgender individuals.

I have seen many detransitioners and transgender people talking about how stressful it is to try and live a life completely as the opposite sex, keeping transgender status secret. They live with two acute anxieties - firstly that they may not "pass" as the opposite sex and become obsessed with their appearance, in some case leading to multiple operations, and secondly that they may be exposed as transgender when they are trying to live in stealth. This can lead to attempts to erase all trace of their past life, and avoid past contacts. This constant state of anxiety no doubt contributes to the poor mental health of many transgender individuals. This is well expressed in an interview with Paris Lees a UK trans woman, published in *Vice News* (1):

> Passing may make public life easier, but the anxiety still remains, simply shifting from a fear of being visibly read as trans to a fear that people will find out. Passing wasn't too much of an issue for Paris when she was at university, but when one person did suspect she was trans, and brazenly called to confirm it, the panic set in.
>
> "I was absolutely gutted because people didn't know, but obviously this one person had picked up on it. It felt like a leak that I could stop, but I couldn't. I just thought, 'I can't do this anymore it's just too stressful,'" says Paris....
>
> After the call, hiding her trans history was no longer an option. As long as she was keeping it a secret, the internalized shame, stress of passing, and fear of being "uncovered" would persist. While she's now comfortable with her identity and relishes her high profile visibility, the day-to-day desire to pass persists.

Acceptance by the transgender individual of their own status, their own history and biological reality, is paramount for their mental health. We should be aiming for a society that acknowledges and does not discriminate against those undergoing gender transition, and a healthy acceptance of self, by transgender people.

Permitting change of sex on a birth certificate puts an official seal of approval on the magical thinking that they have indeed changed sex. It is ironic that in past years, most so called "transsexual" people were quite accepting of their biology and acknowledged that they had not changed sex, whereas now many "transgender" people truly believe they can change sex. Former Australian Army colonel Cate McGregor acknowledges her biology and said that she saw no necessity to change her birth certificate (2).

> Cate...isn't saying that she is a woman, either, only that she lives as one. "My experience of what it's like to be a woman is obviously different to that of a born-woman," she says, "but I express my gender as female."
>
> She holds a passport and driver's licence on which she is identified as female. She has not changed her birth certificate and says she may not because, "in a funny way, I feel my mum and dad thought they had a little boy and they called him Malcolm, and at this stage, I don't feel the need to unscramble that."

Good mental health relies on keeping a tether to reality, and this Bill helps to cut that tether. Also what is the meaning of LGBT "Pride" if people are hiding their personal reality?

Recommendation: Birth sex must not be changed on a birth certificate as that is falsification of historical and biological fact. As suggested above, the certificate could in addition state a gender identification, or a separate gender ID certificate could do that. There then needs to be further discussion on the legal status of both sex and gender and how these apply to other rights.

3. Change of "gender" with no medical opinion will allow people to change gender inappropriately.

Changing sex/gender on official documents will in a major way cement new identities for confused youths who may otherwise more easily come to realise that this was a mistake. Please see below for details on detransitioners. Social and legal transition then makes it much more likely that people will proceed to medicalise their new identity. As I will detail below, medicalisation has harmful health effects and is devastating for those who later realise it was an error. The recent Cass review of children's gender services in the UK (3) has reversed course completely from immediate "affirmation" of the chosen gender to exploration of gender ideas with the child. Her review makes it clear that social transition is not a neutral act and has profound psychological effects in promoting transition. Legal transition is the next step in cementing an identity. This change should not be undertaken lightly, and should not be as simple as a self-declaration with one supporting witness. It should involve psychiatric opinion stating the person has gender dysphoria, and should have a requirement for the person to have lived as their chosen gender. It should certainly not require harmful medicalisation such as hormones or operations.

Recommendation: Legal change of gender has serious psychosocial consequences and should only be undertaken on psychiatric recommendation and after the person has lived for at least one year in their chosen gender.

4. Change of "sex" or "gender" with no medical opinion presents a safeguarding risk

A quite separate concern about there being no medical requirement for legal gender transition is that there is no way to ensure that a person is legitimate in their wish when it only relies on a simple self-declaration. The fact that people are prepared to make such declarations can be seen in the misuse of such legislation by a gentleman in Switzerland who wished to get his pension a year earlier as a woman. Much more insidious is the misuse of such a process to gain better access to women and children as sexual "prey". This concern is in no way "transphobic", as it does not apply generally to transgender individuals, but only to those who seek to exploit the system. There is concrete evidence of this, published in the *Psychiatrist* journal (4). This article details the screening consultation with 54 individuals (39 males) between 2004 and 2009 in Oxford, before referral on to a specialist gender clinic. Some admitted to alarming motivation for seeking female status:

> Reasons for non-referral to a specialist centre included...seeking gender reassignment to facilitate or normalise paedophilia. This latter small group described gender reassignment as a means by which to increase their intimate contact with children, which they viewed to be more socially acceptable in a female role.

The "small group" described appear to be two individuals out of 39 males, who were identified as having a paraphilia. It is rare to have this danger so nicely spelled out by the potential offenders themselves. Under the proposed Bill which relies solely on self-identification, there would be no problem for these two paedophiles to gain all the documentation and rights of women. The evidence of safeguarding risks is coming thick and fast at the moment with self-

identification being adopted eagerly by exhibitionists. The latest example reported in a Canadian paper (5):

> Saskatoon parents are protesting after a man who identified as a female repeatedly walked around naked in the girls changing room during young children's swimming lesson times at the Shaw Centre. The man has walked repeatedly around the changing room with no towel or underwear. So, everything can be seen by little girls while they change for their swim classes. Parents have complained to the Shaw Centre about the man who identifies as transgender. The Shaw Centre staff told parents that anyone could use whatever change room aligns with their gender identity.

Once you install sex self-identification as a legal right together with the proposed changes to the anti-discrimination laws, it becomes impossible to police the access of exhibitionists and sex-pests to these spaces. This can be alleviated by allowing gender change that does not permit the same privileges that are accorded by sex, and including psychiatric approval in the gender assignment.

Recommendation: As before, I recommend that gender but not sex can be changed. Even in that circumstance, medical screening to ensure that applicants for gender change truly have gender dysphoria will further help avoid inappropriate applications and promote safeguarding. As in point 3, legal change of gender should only be undertaken on psychiatric recommendation and after the person has lived for at least one year in their chosen gender. Psychiatrists should be aware of possible ulterior motives for gender change. Furthermore, preventing change of sex but allowing change of gender will help to maintain safety, as sex-based spaces can still be legally maintained. In this case, more accomodation with extra gender-neutral facilities may be needed.

5. There should be no official change of sex/gender for minors

As stated above there will be profound effects of cementing what might otherwise be a changing identity in young impressionable people. This will have the effect of promoting many young people ultimately on a course of medical self-harm. Particularly, the proposal to allow children from age 12, in some cases without parental approval, to officially change sex, is irresponsible. These are children. Do we think that children are rational in all aspects of life? Why let them make such a massive decision as this? We need adults back in the room and in control on this one. Children may well insist that this is what they want, but they may also insist that they will only eat ice cream for dinner. The idea that this can be done against parental approval is a gross invasion of the state into the rights of responsible parents to protect their children from possible harm. It seems we now need to protect our children from the state. In Western Australia it is documented that the situation has gone much further, with a child being removed into state care in order to be medically transitioned against parental wishes. There are rumoured to be more similar cases but parents are gagged from speaking out and they have not been reported on. Those cases aside, it is over-reach to assert that others necessarily know what is better for a child than a parent who knows them intimately.

Recommendation: There should be no legal change of gender for any minor (under 18). Brain development is known to continue until well into the mid-20s, as is evidenced by adolescent risk taking behaviour. It would be preferable that legal transition did not happen until 25 when there is greater maturity.

6. Appropriate professional opinions on transition cannot be obtained under current Qld legislation regarding "conversion therapy".

My understanding is that current Qld legislation outlawing conversion therapy effectively prevents professionals interacting with children or adult patients/clients regarding gender identification from doing anything else other than affirming that chosen gender. Exploration of gender or questioning it may be construed as conversion therapy. The Bill requires a professional who is developmentally informed to present to the court arguments to justify a child's sex marker reassignment. Because they are bound by anti-conversion therapy legislation, there is no way for a professional to make a sound and frankly expressed judgement. They are bound to just support the child's asserted gender. This is ridiculous.

Recommendation: There should be no gender change for children. Adults should need a diagnosis of gender dysphoria as above. The legislation covering conversion therapy should be changed to allow reasonable exploration of gender ideas with patients, rather than a blanket acceptance of self-diagnosis.

7. Maintenance of sex-based rights and distinctions is essential

There are many situations where it is necessary to distinguish male and female biologically in order to ensure safety and fairness for women and children and the disabled. This has been the subject of many submissions to the enquiry and quite unfairly dismissed by proponents of the Bill. I am stunned that a government led by so many women, is putting forward such a proposal. The blanket rejection of all concerns as "transphobic" is unacceptable. I state categorically here again - expressing these concerns is NOT equivalent to stating that trans women are inherently dangerous. It is very frustrating to have these concerns miscast and misconstrued.

It is naive to assume that the ability of men to say they are women will not be misused, given that sexuality is such a powerful driver of behaviour and people with paraphilias are obsessional in their sex interest. See the examples in point 4. There is now abundant evidence of abuse of this capacity especially in prisons where we seem to have a worldwide rash of "prison onset gender dysphoria". I will not re-hash all the arguments of other submissions and all the situations where problems arise, but just ask the committee to consider for example, the violations inherent in allowing a person with a male body but claimed female gender identity to provide intimate care for disabled and elderly people. They may be non-verbal or intellectually handicapped or suffering from dementia. We have just had an enquiry and publicity about the abuse of disabled people in care. Similarly, governments are perennially hand-wringing about violence against women and child abuse. Let's not make the abuse easier.

Recommendation: If the Bill is changed to allow gender identity to be changed, but sex to never be changed, then distinction on the basis of sex can be easily maintained for situations which otherwise present a danger to children and women.

8. An exemption for work involving the care or instruction of minors must be maintained in the Anti-Discrimination Act 1991.

Given the proliferation of child sex abuse cases that have come to light recently, it is astounding to me that the government would reduce the capacity of employers to pick suitable employees to work with children.

Recommendation: Continue to allow exemption for organisations working with children so that they can exercise caution in the all-important issue of ensuring that adults working with children present no risk. Employers must not fear prosecution for exercising reasonable caution. Children's safety is paramount.

OVERALL: There will be solutions that allow mature adult transgender individuals to obtain documentation such as driver's licence in a form that suits their gender identity and satisfies their needs. A birth certificate is rarely used in normal life. But if, for those individuals who apply, it has both birth sex and gender identity listed, then this will allow for it to be used to justify listing of gender identity on other documents that are used more frequently. However, it would also maintain a correct birth sex which is important for a number of situations. These include identification within the medical system where correct sex is essential to know, and certain employment opportunities when discrimination on the basis of sex is essential. Examples being the care for vulnerable disabled people, or the house mistress of a girls' boarding school looking after them overnight. Overall, as described in point 2 above, under this approach, the mental health of transgender people will be improved if they accept that they cannot change sex, and are honest with themselves and other people about their history of transition. I do not understand the imperative to make legal change of gender so easy that it can be done by self-declaration. This is a major life-changing action and should be done only after careful consideration. Psychiatric approval should not be a major impediment for those who are genuine.

A PARENT'S PERSPECTIVE ON TRANSGENDER-IDENTIFIED CHILDREN

The parent's dilemma

As parents, our first and most basic instinct is to protect our children from harm. Transgender medicine is taking healthy young bodies, and turning them into medical patients for life. **I am here to call this out as a danger to our kids**. After they reach 18 of course we have no control, and we are watching, helpless, as our children are put on a conveyor belt of life-long medicalisation, possible surgery, and frequently worsening mental and physical health. All prescribed care of Queensland Health. We are not “transphobic” or “bigoted” or anything we are accused of. We are loving parents, programmed to defend our children from harm. We know our children, and we know harm when we see it. Medical practitioners are supposed to adhere to the principal of "first, do no harm", and yet this medical malpractice is promoted through our media, governments, and medical services. **This is an emerging medical scandal.**

Many many thousands of parents across Australia, are right now dealing with their teenage or young adult children who are professing that they are not the sex they were born. This is very common in some peer groups. For most of us, our children had no gender confusion in early life whatsoever. They are now demanding new names and pronouns, and frequently seeking hormones and breast removal, and in extreme cases removal of male genitals. In the majority of cases, psychologists will just affirm the child's gender, and there is no exploration of the underlying reasons for this declaration. If the child has other problems such as anxiety or depression or eating orders, gender dysphoria is promoted as the root cause of all these issues. They are said to be "born in the wrong body" and it is believed that transitioning will solve everything. This is ignorant malpractice.

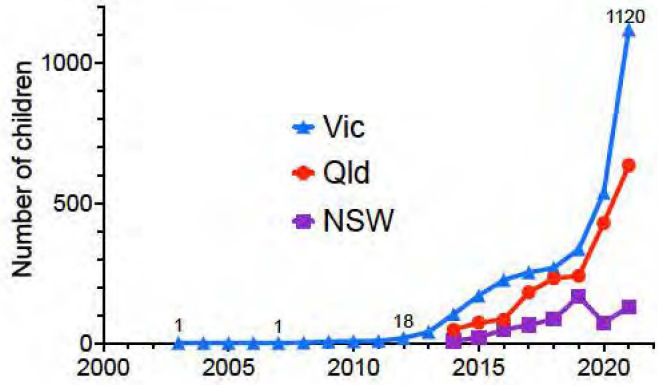
In a number of states, if the practitioner does anything other than affirm their new identity, it could result in prosecution under anti-conversion therapy laws. And in Victoria the laws seem to also restrict the rights of parents - failure to support a child's gender identity would likely be illegal. The exaggerated danger of suicide as promoted to them by health professionals, is key

to why many parents choose to go along with the child's identity. But this threat is not nearly so great as is presented, as discussed below.

Other parents, to whom this identity and the ideology make no sense, are joining a range of international or local groups that provide online support. Genspect, 4th Wave Now, Our Duty, Bayswater, Gender Dysphoria Support Network, Parents of ROGD kids. These organisations, and no doubt more, are engaged in counselling support for parents around the world or lobbying on their behalf to improve psychiatric care for gender dysphoric children, and to avoid medicalisation. Please note I have not fully referenced this document, but abundant information is available through sites such as Genspect, Society for Evidence-based Gender Medicine, Stats for Gender, and Transgender Trend (6-9).

Rapid rise in transgender identification

The number of children and young people identifying as transgender has been skyrocketing in recent years. The graph below shows the number of new referrals per year to public hospital gender clinics in three states. Furthermore, there will be many thousands more children visiting psychologists and other counsellors, who are not recorded here. A similar pattern has been seen in clinics all over the western world.



New referrals to public hospital children's gender clinics each year, in three states. Sources: Sydney Morning Herald, 2020 (10), Dianna Kenney, 2022 (11, sourced under GIPPA requests). NSW numbers do not include a non-hospital clinic in Newcastle.

Twenty years ago, gender dysphoria in children was rare and was generally seen in young boys in early childhood. Under a careful system of "watchful waiting" to support but not pre-empt development, most of these boys resolved their gender confusion by the end of puberty, with the majority being homosexual (12). Today, this careful approach has been replaced by "gender affirmative care", where children are automatically affirmed as their preferred gender with changes of names, pronouns, clothes etc. This is followed under this model of "care" by puberty blockers, cross-sex hormones, and quite likely surgery. In the quite common situation of gender confusion as a part of emerging homosexuality, many LGB people see this as conversion therapy for gay people and call it "transing the gay away". LGB Alliance is a prominent group trying to call attention to this problem (13).

In the meantime, we have seen a shift in the children presenting. The dominant class of kids with gender dysphoria is now teenage girls, although the number of teen-onset boys who believe they are girls is also significant. These are the cohorts that are driving the numbers in the graphs above. From informal observations there is also a similar increase in young adults presenting at adult gender clinics, although data is not available. The lack of curiosity by the medical profession about why this is happening, is very puzzling. They seem to be just treating it as a new business opportunity. Much of this movement is being driven be trends in the USA,

where transgender treatments and surgeries have developed into a major industry. Surgeons have been marketing operations such as mastectomy to children, over Tiktok and YouTube.

The transgender lobby tells us that numbers of children with gender dysphoria have not actually increased. They claim that all that has happened is that society is now more open to accepting transgender people, and so all the children who were previously repressed in their identification feel confident to come out into the open. If this were the case, we would expect people of all ages to be coming out as transgender, at a similar rate to these children. This is certainly not happening. But, many older women are saying they are really glad this was not a thing when they were young because they hated puberty and they would certainly have joined the cohort of girls transitioning.

The increase in numbers of gender dysphoric children parallels very closely the widespread uptake of smart phones and use of social media. Parents of children presenting with gender confusion almost universally report excessive social media, or time spent in online gaming groups. Other phenomenon such as self-harming behaviour, anorexia, and recently the development of Tourette's-mimicking ticks are well-accepted to be spread through social media influencers, with TikTok being a recent offender (14). There is no reason to doubt that social media has driven a large amount of the current transgender phenomenon. School peer groups and ostensibly well-meaning "information" delivered in school anti-bullying programs and LGBT support networks also likely play an important role in this increase. The trans-identified children all mouth the same mantras, and present the same dogma that they have learned from online sites. Parents report that they sound like they are reading a script. This is a social contagion spread by the internet, and fed by ideologues and the medical industry.

The regressive sexism inherent in gender ideology

If children were to just explore gender through considering that their own behaviour need not be limited by their sex, that would be a positive thing. We should encourage masculine girls and feminine boys to just be themselves. But gender ideology is a regressive and sexist ideology that reinforces stereotypes, and tells boys who are sensitive and like sewing but don't like football, that they must actually be girls. And girls who don't relate to the awful sexualised imagery of women that they are confronted with every day, and who like playing soccer, must actually be boys.

The sexist and regressive stereotypes inherent in this ideology stretch so far that historical figures are now having their genders reassigned. For example, a play recently put on in London presents that Joan of Arc was not really a woman and casts her as non-binary with they/them pronouns. This seems to be based on the idea that women are not strong, and they can't be leaders of armies, so therefore Joan was not a woman. Children are being presented with rigid stereotypical ideas of behaviour of the sexes, and also being told they can choose to change sex.

The children who are susceptible to these pressures

The children who are declaring trans identity generally have other challenges – autism spectrum, ADHD, depression, anxiety, self-harm, experience of sexual abuse, bullying, social isolation, obsessive-compulsive disorder. (see for example, 15). They are often very bright and creative children. Apart from social media, exposure to pornography can also play a role. Many of the children are also into fantasy, fanfiction, anime and cosplay, and a transgender identity may present another way to escape reality.

Manipulation by distorted and erroneous suicide "statistics"

Not surprisingly some parents believe the professionals who tell them that there are alarming rates of suicide and that their child is likely to commit suicide. Many parents report being asked by psychologists “Do you want a live son, or a dead daughter?” I have heard this so many times. This is highly manipulative. The statistics that are frequently quoted to scare parents are self-reported suicidal ideation and suicide attempts generally collected from online surveys with flawed methodology and analysis. Numbers are cited like 50% or 80% of transgender individuals have either attempted or thought about suicide in the past year. This is understandably terrifying for parents. The truth is that suicide by transgender-identified youth is rare, although of course every suicide is a tragedy. Michael Biggs analysed data from the UK children's gender clinic and found 4 suicides in 30,000 patient years, or 4 in 15,000 patients (16). This rate is somewhat higher than the general population but it is noted that the gender dysphoric youth also have depression, anxiety and autism, which have their own elevated risk of suicide. However, there is also no good evidence that suicide risk decreases with gender affirming treatment (17). Consequently there is no justification for embarking on risky treatment, and gender affirming "care" cannot be portrayed as "life-saving" as it so often is. Excellent analyses of suicide data are available on Transgender Trend and Stats for Gender websites. (17,18)

Lack of evidence for efficacy or safety of gender affirmative care

It is not possible to provide a thorough review here of medical literature on gender affirming care and health outcomes. There is good summary information available on the websites of Genspect, Society for Evidence-based Gender Medicine, Transgender Trend, and Stats for Gender (6-9). In summary, evidence for the efficacy and safety of gender affirming care has been repeatedly ranked as "low quality" in major reviews. Sweden, Finland, the UK and some individual states in the USA have assessed the procedures and determined that risks far outweigh the benefits for children, and they have now either seriously restricted or halted any treatments involving hormones and surgeries for children. The children with gender dysphoria are distressed, however, and need good quality care and psychotherapy to help explore the origins of their feelings. The same concerns about risk and benefit can be extended to the large number of young adults declaring transgender identity, but treatment continues unabated in adult gender clinics. Most studies claiming psychological benefits of treatment are poorly designed and don't have an untreated patient group. They are also generally short-term, during a honeymoon period and before regret might have set in.

There are no comprehensive studies on the long-term health risks of hormonal therapies. This is partly because the large-scale transgender phenomenon is very new. However, it is also likely because access to large amounts of data on transgender patients is restricted to those running gender clinics. Nevertheless, human male and female bodies have developed to function optimally with their respective sex hormones, and opposite sex hormones cannot be introduced without problems. It is well accepted that estrogen increases male risk of blood clots and testosterone leads to increased heart disease risk, vaginal and uterine atrophy in women. Women on testosterone generally need hysterectomies. It seems likely from reports that males taking estrogen are more susceptible to autoimmunity including multiple sclerosis. Liver damage is another major concern. Anecdotally, problems such as pelvic pain, joint pain, ovarian cancer and incontinence could be attributed to testosterone use. The puberty blockers that are being given to children in Australia, and in particularly high numbers in Queensland (11), can lead to dangerous loss of bone density and it is acknowledged that we have no understanding of their effect on brain development.

Risks can sometimes be taken if there are benefits. But I have seen multiple parents saying that their son's mental health declined after starting estrogen therapy. Testosterone on the other hand can make girls/women feel strong and empowered, and there is a honeymoon period for this drug. But this is a drug-induced mood change. There are many drugs we could recommend on that basis, and many of them are illegal. These drugs have not been approved for the purpose they are being used for, because there is not adequate data to say that they have a benefit. They are being used off-label, and pharmaceutical companies are not motivated to register them for gender dysphoria because performing proper controlled studies are unlikely to support their use, leading to loss of profits. The operations offered to transgender individuals carry their own risks and can have high rates of complication. These include mastectomy, frequently with removal of nipples, tracheal shave, facial feminisation surgery, vaginoplasty with removal of testes and inversion of the penis to make a "neo-vagina" sometimes also using colonic tissue, and the brutal phalloplasty where the forearm is stripped of flesh to make a mock-penis. The latter operation has an alarming complication rate.

This is medical systems causing real, long-term harm.

Detransitioners are proof that transgender identity is not innate

There are more than 43,000 members of an online Reddit site for detransitioners, r/detrans (19). It often takes 7-10 years for people to start to regret transition, and so we are nowhere near the peak of this. Detransitioners tell gut-wrenching stories of regret and pain, medical malpractice, life-long negative health effects. Sadly, in some cases, they are now suicidal because of their regrets over what they have done to their bodies. There are young men, who realise only after they have removed their genitals, that they are truly homosexual, and they were driven by their internalised homophobia. There are young women, mourning the loss of their breasts, their low voices, their loss of hair, and their inability to breast feed or in some cases have children. These are people who should have their lives ahead of them, who may now be unable to function in society due to psychological damage, or may be afflicted with lifelong health problems. A number of detransitioners have started legal action around the world. However, going public as a detransitioner exacts a heavy toll. Transgender activists sense that detransitioners ruin their story - gender identity is not actually innate, it is something chosen, and people make mistakes. There is a concerted effort to discredit and silence detransitioners, or claim they were never really transgender. In Australia we have had two detransitioners recently bravely tell their story publicly, one of whom is suing her psychiatrist (20-22). However, the onslaught of abuse that the receive for doing this discourages others from speaking. A third Australian detransitioner has made a series of YouTube videos describing her journey (23). A number of detransitioners told their powerful stories in an international forum for Detrans Awareness Day in 2022 (24).

Why don’t you hear from anguished parents in the media?

Why are we not in the papers publicly shouting about the dangers to our young people? Firstly, we are trying desperately to hold onto our kids and can’t be public. The movement they are part of tells them that if their parents don’t embrace this new identity and celebrate their transition, we are “transphobic” and hateful and that their home is “unsafe” for them. It tells them to estrange themselves from us. “We’ll be your family now” they say. I know some parents whose children now have no contact with them whatsoever. Loving parents whose only wish was to protect their children from harm. We operate as secretive online communities of parents supporting one another. Our meetings are full of tales of grief and pain, but we give one another strength. We are treading a fine line, trying to keep lines of communication open, but also trying to keep our children tethered to reality. Secondly, much of our mainstream media only provides good news transgender stories. ABC is signed up to the Pride in Diversity

scheme (as are many government departments) run by ACON that is an LGBTQ lobby now focussing on trans issues and it is likely that this influences programming (25). Detransitioners who regret everything, parents watching their children self-harming and descending into mental illness - these stories rarely feature in Australian media.

Furthermore, for anyone who speaks up about the harms of gender ideology there is swift and vicious retribution from transgender activists. They are not shy to attack people's livelihoods by going to employers and seeking to have them sacked for "wrongthink". In the most prominent case, Kathleen Stock, a professor of philosophy at Sussex University and author of *Material Girls*, resigned after enduring months of attacks and picketing activists (26). Her offence was principally to question the idea that men can become women, essentially the topic of this legislation.

Finally

There is no such thing as being “born in the wrong body”. I think it is being born in the wrong era that is the problem; the era of smart phones and social media in adolescence. This is a contagion, spread by social media and peer groups, encouraged by LGBTQ lobby groups like ACON, schools, psychologists, elements of the medical profession and pharmaceutical companies who are more than happy to sell drugs to people who don't need them. The distress of young people is real, but they need appropriate care and psychotherapy, and not generally drugs. People are being damaged physically and mentally, and this will be very costly for our society. I anticipate that our medical services will be the subject of legal action for the irresponsible treatments they are giving.

References used:

1. Vice News, 2015. Transgender men and women discuss the politics of "passing". https://www.vice.com/en/article/wd7enm/passing-when-youre-transgender
2. Women's Weekly 2015. "It's the secret I kept for 50 years": Transgender Australian Army Colonel Cate McGregor on transitioning from male to female. https://www.nowtolove.com.au/news/real-life/cate-mcgregor-talks-transitioning-from-male-to-female-10273
3. Cass Review, UK. Interim report. https://cass.independent-review.uk/publications/interim-report/
4. Saunders & Bass 2011. Gender reasignment: 5 years of referrals in Oxfordshire. The Psychiatrist 35, 325-327. doi: 10.1192/pb.bp.110.032664
5. Western Standard News, January 30th 2023. https://www.westernstandard.news/news/protests-launched-against-naked-man-in-the-little-girls-changing-room-in-saskatoon-pool/article_541d2066-a0d2-11ed-88cd-db9af5f25efc.html?utm_campaign=blox&utm_source=twitter&utm_medium=social
6. Genspect. https://genspect.org/
7. Society for Evidence-based Gender Medicine. https://segm.org/
8. Stats for Gender. https://statsforgender.org/
9. Transgender Trend. https://www.transgendertrend.com/
10. Sydney Morning Herald, April 19th 2020. https://www.smh.com.au/lifestyle/health-and-wellness/staying-on-her-feet-how-michelle-telfer-won-gender-clinic-battle-20200416-p54kjf.html

11. Kenney, 2022. Number of children enrolled, receiving puberty blockade and cross sex hormones in five gender clinics in Australia, 2014-2021. https://www.diannakenny.com.au/k-blog/item/20-number-of-children-enrolled-receiving-puberty-blockade-and-cross-sex-hormones-in-five-gender-clinics-in-australia-2014-2021.html
12. Singh, Bradley and Zucker, 2021. A follow-up study of boys with gender identity disorder. Frontiers in Psychiatry 12, 632784 doi: 10.3389/fpsyt.2021.632784
13. LGB Alliance. https://www.lgballiance.org.au/
14. Haltigan, Prinsheim and Rajkumar G. Social media as an incubator of personality and behavioural psychopathology: Symptom and disorder authenticity or psychosomatic social contagion? Comprehensive Psychiatry (2023) 121: 152632 https://doi.org/10.1016/j.comppsych.2022.152362
15. Kenney, 2002. Defining appropriate treatments for children with gender dysphoria (GD). Presentation to the forum on changes to the law proposed by the Tasmanian law reform institute (TLRI) on "conversion therapy". Parliament House, Tasmania, 23 Nov 2022.
16. Biggs, 2022. Suicide by clinic-referred transgender adolescents in the United Kingdom. Archives of Sexual Behaviour 51:685
17. Stats for Gender, analysis of suicide data. https://statsforgender.org/suicide/
18. Transgender Trend, Suicide Facts and Myths fact sheet. https://www.transgendertrend.com/the-suicide-myth/
19. Detransitioner support network. https://www.reddit.com/r/detrans/
20. Sydney Morning Herald, August 24, 2022. 'Absolutely devastating': woman sues psychiatrist over gender transition. https://www.smh.com.au/national/absolutely-devastating-woman-sues-psychiatrist-over-gender-transition-20220823-p5bbyr.html
21. The Australian, August 2022. Gender change agents: when the pressure wins out.
22. YouTube, You must be some kind of therapist. Episode 22: Healing through detransition. https://www.youtube.com/watch?v=mOLG6Bgk8tc
23. Courtney Coulson, YouTube. https://www.youtube.com/c/CourtneyCoulson/videos?app=desktop
24. Genspect, Detrans Awareness Day Webinar, 2022. https://genspect.org/conferences/
25. Media Watch, 17 Oct 2022. ACON & the ABC. https://www.abc.net.au/mediawatch/episodes/acon/101544378
26. BBC News, 29 Oct 2021. Kathleen Stock: University of Sussex free speech row professor quits. https://www.bbc.com/news/uk-england-sussex-59084446

ORIGINAL PAPERS

Gender reassignment: 5 years of referrals in Oxfordshire

Kate Saunders,[1] Christopher Bass[2]

The Psychiatrist (2011), **35**, 325 327, doi: 10.1192/pb.bp.110.032664

[1]Warneford Hospital, Oxford; [2]John Radcliffe Hospital, Oxford

Correspondence to Kate Saunders (kate.saunders@psych.ox.ac.uk)

First received 23 Sep 2010, final revision 23 Feb 2011, accepted 25 May 2011

Aims and method To evaluate the characteristics of individuals seeking gender reassignment, the frequency of subsequent referrals to a specialist centre, and funding approval. Cases were identified from a local referrals database and data were extracted from case notes.

Results Fifty-four individuals attended for assessment; 70% were biological males and 30% were biological females. Mean age at referral was significantly different between the two groups. Over half were taking hormone supplementation and three had already had surgery. Further, 24% had a current and 30% a past mental illness. The majority of individuals were referred to a specialist centre for gender reassignment but only two had funding for surgery approved. Paedophilia was a rare but concerning finding.

Clinical implications Psychiatric assessment plays an important role in confirming transsexualism and in identifying other relevant diagnoses.

Declaration of interest None.

Gender dysphoria is the personal experience of dissonance between actual and desired gender. When these feelings are persistent, the person is diagnosed with gender identity disorder.[1] It is a rare disorder, associated with significant psychological distress. Treatment involving hormones and gender-confirming surgery has been associated with excellent social, sexual and psychological outcomes.[2] In the UK the Gender Recognition Act 2004 allows individuals to obtain legal recognition of their post-transition gender. Lifetime psychiatric comorbidity is high in people with gender identity disorder,[3] with 71% reported to have a current and/or lifetime Axis I disorder.[1] The outcome of premorbid psychopathology following gender reassignment surgery is unclear. Mate-Kole *et al*[2] reported improvements in sexual functioning and neurotic symptoms, whereas Udeze *et al*[4] reported no significant effect on psychological functioning 6 months post-surgery. Following a successful appeal against a local health authority in 1999,[5] a blanket ban on funding of medical treatment for gender reassignment was deemed illegal and those diagnosed with gender identity disorder are entitled to appropriate treatment in the National Health Service (NHS). The courts have deemed genital surgery to be an appropriate treatment in this context. However, there are ongoing difficulties in accessing NHS-funded surgical procedures and geographical variation is wide.[6]

In Oxfordshire, treatment funding for core gender reassignment surgery is provided on an individual basis. The person must fulfil the current World Professional Association for Transgender Health criteria[7] and be recommended as suitable for surgery by a specialist NHS gender identity clinic. Cosmetic surgery and other procedures, such as breast surgery, larynx reshaping, rhinoplasty, hair removal, jaw reduction and waist liposuction, are considered 'low priority' and not a core part of gender reassignment surgery. These are not normally funded unless in exceptional circumstances, although the local primary care trust does not define 'exceptional' in this context.

All individuals who request treatment for gender dysphoria in Oxfordshire are referred to a single clinician (C.B.) for psychiatric assessment and subsequent referral to a specialist centre. There is currently no provision locally for ongoing specialist follow-up for those awaiting surgery. Referrals are received directly from primary care and from local psychiatric teams. We wanted to review the characteristics of individuals referred for assessment as well as the frequency of subsequent requests for surgery and funding approval.

Method

Individuals referred to C.B. between 2004 and 2009 were identified from a referral database kept by the Department of Psychological Medicine at the John Radcliffe Hospital in Oxford. Case notes were reviewed by C.B. and K.S. Data were extracted from the initial assessment notes and recorded on a form. Comparative analyses were then conducted using the student *t*-test for dimensional variables and the χ^2-analysis for categorical variables was performed using the statistical package SPSS version 17.0 on Windows 7.

Table 1 Axis I and II morbidity

	Male to female (*N*=38)	Female to male (*N*=16)	Total (*N*=54)
Age, years: mean (s.d.)	35.1 (14.2)	26.9 (9.6)*	32.2 (13.4)
Axis I disorder, *n* (%)			
Current	8 (28)	5 (33)	13 (24)
Past	9 (24)	7 (43)	16 (30)

*$P = 0.018$.

Results

Fifty-four individuals from a total of 56 referrals received attended for assessment. There were significantly more individuals seeking male-to-female transition (70%, $n = 39$) than those seeking female-to-male transition (30%, $n = 15$). The biological females were significantly younger than their male counterparts at referral (Table 1).

The majority (51%, $n = 29$) were referred for initial assessment as opposed to follow-up or re-evaluation of their eligibility for specialist referral. Eleven males (29%) and six females (40%) were taking hormone supplementation: eight males (21%) were taking oestrogens, one was taking oestrogens and antiandrogen, one was taking a gonadotropin-releasing hormone (GnRH) analogue, and one a 5-alpha reductase inhibitor; of females, five (27%) were taking testosterone (four depot and 1 gel) and one was taking a GnRH agonist. Two males (3%) had a penectomy, orchidectomy and vaginoplasty; two females (13%) had already had a mastectomy and one a phalloplasty.

Over half of individuals taking hormone supplementation had purchased it on the internet and were not receiving any form of physical monitoring for adverse effects. Of the whole sample, 24% ($n = 13$) had a current Axis I disorder and 30% ($n = 16$) had a history of mental illness. No significant differences in past or current mental illness were found between the biological males and biological females. Depression was the most common current and past diagnosis (Fig. 1).

The majority of individuals (80%, $n = 45$) were referred to a specialist centre for gender reassignment (Fig. 2), although only two (4%) have had funding for surgery approved at the time of the study. Three of the sample had or were planning to have surgery abroad, on the basis that services there were more easily accessible and less expensive than in the UK. Reasons for non-referral to a specialist centre included being deemed not ready for transitioning (either determined by the individual or because the person was not currently living in the desired gender role), being homosexual but not having gender identity disorder, having an autism-spectrum disorder with a significant degree of impairment such that the real-life experience criterion was not met, and seeking gender reassignment to facilitate or normalise paedophilia. This latter small group described gender reassignment as a means by which to increase their intimate contact with children, which they viewed to be more socially acceptable in a female role.

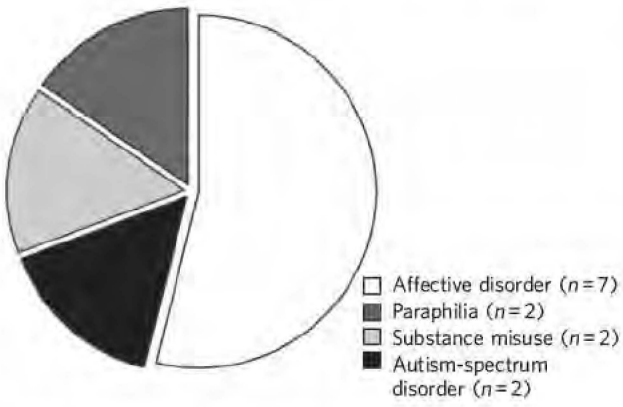


Fig 1 Current Axis I disorders in the sample.

Discussion

The results of our study are broadly consistent with the current literature. The younger age of those seeking female-to-male transition has been described in a number of studies.[8,9] Levels of psychiatric comorbidity appear to be lower than those described by Hepp and colleagues.[3] The relationship between autism-spectrum disorders and gender dysphoria has been described by a number of authors.[10–12] It poses a significant challenge given the social and communication difficulties associated with this diagnosis. This becomes a particular issue as living and functioning in

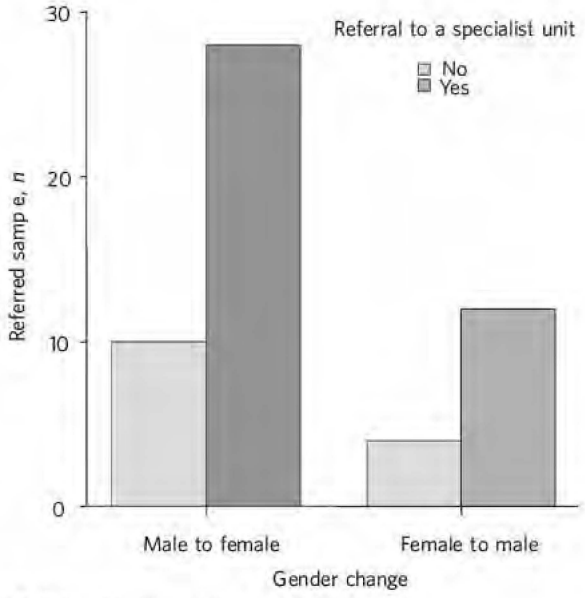


Fig 2 Referral to a specialist centre.

role are usually prerequisites for referral for surgery. There are also issues of capacity to consent to treatment, particularly if the presence of an autism-spectrum disorder is associated with intellectual disabilities, where it is advised that psychological and social treatments be pursued.[11] W have been unable to identify a previous literature describing individuals seeking gender reassignment as a means of normalising their paedophilia, but this is clearly a concerning finding.

Another worrying finding is that the internet has provided a new means by which to acquire drug treatments without seeing a doctor. Although this allows greater privacy and ease of access to hormone treatment, the chemical composition of medications acquired on the internet is often uncertain and any contraindications, interactions or side-effects may go unchecked.

The barriers faced by individuals seeking gender reassignment are considerable. There is widespread variability in the services funded by local primary care trusts,[7] and the proposed changes to NHS commissioning in England are likely to complicate this issue further. The lengthy process is often cited as a contributory factor in the development of comorbid psychiatric problems, and untreated gender dysphoria can be associated with significant psychological distress and is a risk factor for suicide.[2] The costs of treatment need to be weighed up against the ongoing costs of supporting the mental healthcare needs of those awaiting genital surgery.

Limitations

This study is retrospective in nature and its primary objective was not to establish psychiatric diagnoses. None of the individuals seen by the service had a formal diagnostic interview so it is likely that Axis II comorbidity in this sample is underreported. Oxfordshire has a high student population, with two universities in the city, which may have introduced some bias.

Future direction of services

Psychiatric comorbidity in the Oxfordshire cohort was lower than that described in other samples, but despite many individuals meeting the appropriate criteria, funding for surgery was rare. In view of this there is a case for ongoing psychological support to be provided for individuals awaiting surgery. Doctors should routinely enquire about where hormones are being bought from, advise against online purchasing and ensure appropriate physical health monitoring.

About the authors

Kate Saunders, MRCPsych, is OHSRC Junior Fellow, University Department of Psychiatry, Warneford Hospital, Oxford, and **Christopher Bass**, MD, FRCPsych, is Consultant Liaison Psychiatrist, John Radcliffe Hospital, Oxford.

References

1 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (4th edn, text revision) (DSM IV TR)*. APA, 2000.

2 Mate Kole C, Freschi M, Robin A. A controlled study of psychological and social change after surgical gender reassignment in selected male transsexuals. *Br J Psychiatry* 1990; **157**: 261 4.

3 Hepp U, Kraemer B, Schnyder U, Miller N, Delsignore A. Psychiatric comorbidity in gender identity disorder. *J Psychosom Res* 2005; **58**: 259 61.

4 Udeze B, Abdelmawla D, Khoosal D, Terry T. Psychological functions in male to female transsexual people before and after surgery. *Sexual Relationship Therapy* 2008; **23**: 141 5.

5 *Appeals Court judgement of North West Lancashire Health Authority v A, D and G* (QBC 1999/0226/4; 0228/4; 0230/4).

6 Murjan S, Shepherd M, Ferguson BG. What services are available for the treatment of transsexuals in Great Britain? *Psychiatr Bull* 2002; **26**: 210 2.

7 Meyer W, Bockting WO, Cohen Kettenis P, Coleman E, DiCeglie D, Devor H, et al. *The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version*. World Professional Association for Transgender Health, 2001.

8 Dixen JM, Maddever H, Van Maasdam J, Edwards PW. Psychosocial characteristics of applicants evaluated for surgical gender reassignment. *Arch Sex Behav* 1984; **13**: 269 76.

9 Blanchard R, Clemmensen LH, Steiner BW. Heterosexual and homosexual gender dysphoria. *Arch Sex Behav* 1987; **16**: 139 52.

10 de Vries ALC, Noens ILJ, Cohen Kettenis PT, van Berckelaer Onnes IA, Doreleijers TA. Autism spectrum disorders in gender dysphoric children and adolescents. *J Autism Development Disord* 2010; **40**: 930 3.

11 Parkes G, Hall I. Gender dysphoria and cross dressing in people with intellectual disability: a literature review. *Ment Retard* 2006; **44**: 260 71.

12 Landén M, Rasmussen P. Gender identity disorder in a girl with autism a case report. *Eur Child Adolesc Psychiatry* 1997; **6**: 170 3.

From: [redacted]
Sent: Tuesday, 21 February 2023 9:44 AM
To: Legal Affairs and Safety Committee
Subject: FW: Births, Deaths Marriages Registration Bill 2022
Attachments: mastectomy regret- Australia.pdf

FURTHER INFORMATION FOR THE ENQUIRY INTO BIRTHS, DEATHS & MARRIAGES REGISTRATION BILL 2022

I am writing with updated concerns to the Legal Affairs and Safety Committee regarding the Births, Deaths and Marriages Registration Bill 2022, as relevant issues are mounting up weekly. I have personal experience of the impact of transgender ideology on our Queensland youths and families. Internationally and locally, issues associated with youth gender transition are now being more widely discussed; the situation is changing rapidly and there is increasing concern. There are a few updates I would like to make sure you are aware of in writing your report.

1. **Scottish gender legislation causes political meltdown and resignation of the First Minister.** I am sure that you are aware that the similar Scottish legislation aimed at allowing gender self-identification has been blocked by the UK parliament. The passage of this bill in Scotland was followed in quick succession by **two** scandals involving transfer of a rapist and a violent offender into women's prisons (1,2). Once the public knew about this, there was understandable outrage. Adding to the public disquiet, soon afterwards a trans woman was arrested on charges of abduction and rape of an 11 year old girl (3), who may well have been destined for a women's prison. Support for the Scottish government has slumped dramatically, and the Scottish First Minister has now resigned (4). Although she claims this was not due to short term pressure, a party insider is reported as saying "We need to get back on track by pursuing things that matter to the people of Scotland, not pushing stuff that the public is vehemently opposed to. I expect the gender reforms to be parked somewhere as quickly as possible" (4). The Queensland Bill is more radical than Scotland's legislation. Once people understand the implications, it will not be popular and could be a political graveyard similar to the Scottish situation. There are ways to allow adult transgender individuals to have driver's licences and other day-to-day ID that suit their needs, without changing sex on the birth certificate.

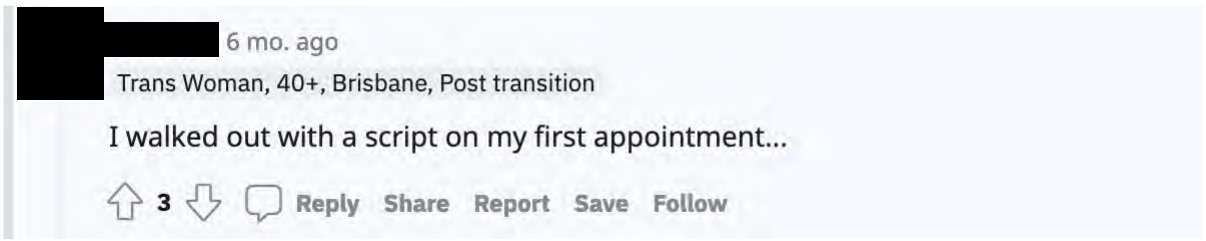
2. **Australian detransition tragedy**. The committee was interested in reports of Australian detransitioners, and I earlier informed you of two who have been public. By word of mouth, there are many, just as in other countries, but very few are prepared to be public as they get vilified by activists. However in the last fortnight a paper has been published that details a detransitioned Australian woman who had a mastectomy at age 20, and is now distressed to be unable to breastfeed her child (5) (attached). This is a very sad account of the impact of decisions made too young. The surgery was brutal: *"Elizabeth describes her right nipple graft chronically leaking a watery fluid, while voids in her scarred left nipple graft accumulated a smelly paste that had to be regularly squeezed out. Two years later, she underwent surgery to reduce scars; leaving her chest sunken and nipple-less while scarring and nerve pain remained."* At aged 24, she detransitioned, and considered the medicalisation a *"terrible mistake"*. When she later had a newborn she noted that when *"they put him on my stomach, he crawled up, he was looking for my breasts, and he couldn't find them. And he tried to suck on my chin. And he spent so much time in his early life trying to find my breasts."* This is what our medical system is permitting and indeed promoting. This Bill normalises the false idea that you can literally change sex, and will encourage people to formalise a new identity. This official stamp of approval, and the feeling of commitment through changing documents will increase the likelihood of progression to medicalisation.

3. **The tide is turning on transgender medicalisation.** A book has just been published about the closure of the children's gender clinic in London, the GIDS (Tavistock), detailing interviews with many former workers and whistle-blowers (6, 7). They followed the same model of care as Australian clinics. This book details that most of the children were either autistic or had other developmental or psychological issues, that staff were concerned that they were transitioning kids who had internalised homophobia, and that some of the kids also believed they were trans-racial, particular taking on east-Asian identification. Dramatically, in the past week another whistle-blower, Megan Reed, has come forward from a university hospital clinic in St Louis, Missouri, telling shocking tales of the inappropriate transition of vulnerable children by ideologically captured doctors

(8). This story is all the more powerful, because Megan Reed is herself married to a trans man, and she knows that what is going on in transitioning children and young people is wrong. It would be naïve to assume that these are all overseas problems and Queensland has excellent practice. This is a problem with similar features and medical treatments across the western world.

4. **Easy access to cross-sex hormones in Queensland.** I cannot emphasise enough that the medical landscape for transition is complete cowboy country. People who are not informed would assume that there is comprehensive psychological assessment before medical transition. Nothing is further from the truth. These comments come from an *online discussion on how to get cross-sex hormones in Queensland* on the Reddit platform (9). Note that the "informed consent" model specifically means that there is no psychological assessment, all that is required is patient consent for the treatment:

> I also see a Dr at [redacted] it's great and only took me 2 appointments to get HRT less than 2 weeks
>
> I see [redacted] who is amazing. [redacted] is at both [redacted] and at the [redacted]. I saw [redacted] twice to get started in T (using informed consent model, visit one was to discuss, get copies of consent and patient info and get path form) then second visit checked blood results and gave me the script! [redacted] then referred me to see [redacted] at [redacted] so that [redacted] could get me on PBS scripts for it (only specialists can do PBS). If you can get your usual GP to refer you to [redacted] [redacted] can also just start you off as well using informed consent
>
> So I got on estrogen within a week. One appointment with my gp to discuss and do a blood test. And a second with the same gp to get my script. The trick is you need to find a doctor who is familiar with trans health care. If a gp is willing to do informed consent they can prescribe the medication themselves. That being said I don't know what doctors are like near you. I would look into informed consent, and being it up with a friendly gp



So a person can start medical transition within a week or two of a decision to do so, and under this Bill, easily and rapidly change their identity. I ask you to consider whther such major decisions should be so easy.

5. **Media coverage has started changing**. The influential New York Times, bastion of liberalism that was previously a cheerleader for childhood transition has been transitioning themselves, to publishing more balanced articles. These now reflect the growing unease of the public about the health and mental health consequences of these treatments for children.

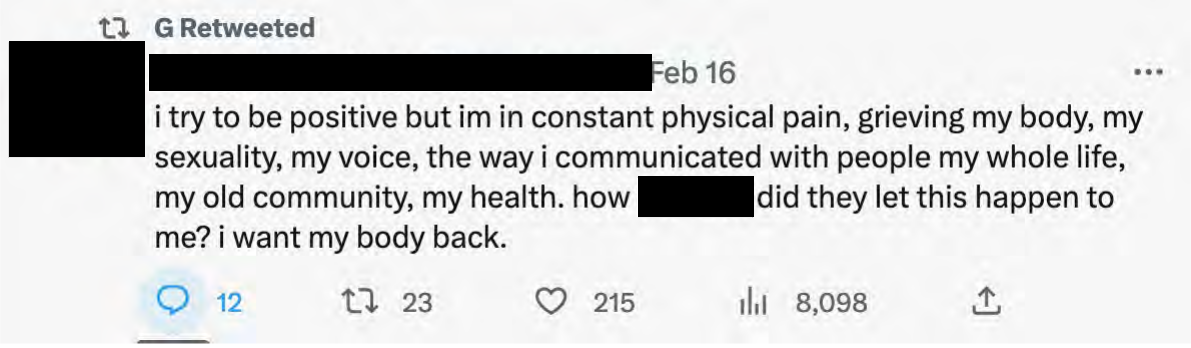
6. **Weekly new alarming stories on men in women's prisons**. International stories of trans women transfers into women's prisons, and the resulting assaults, intimidation and trauma continue. One of the latest reports is of a baby rapist moved into a prison with a mother-baby unit in Canada (10). There are many dozens of reliably sourced stories of trauma and rapes related to men in women's prison on the Reduxx website. These are happening in countries that would all claim they have adequate safeguards to prevent problems.

7. **Frequent reports of abuse of gender self-ID by voyeurs and sex offenders.** There are more and more stories about abuses encouraged by such legislation as this Bill. Canada has gone far down this route, and has regular scandals involving voyeurs in women's facilities. The latest involves another man claiming to be a woman loitering in the women's change rooms to watch

people undress (11). The comment from the local Pride group about this event was "We simply can't know right now whether this alleged offender is trans in the early stages of transition, or a cisgender man looking for loopholes…" This is *precisely* the problem that many people are warning your committee about, here nicely admitted by a transgender advocacy group. There is no way to tell "authenticity", and there are many male sexual predators prepared to pretend to be women.

Reliance on opinion of Victor Madrigal-Borloz. The Departmental response to submissions to your committee was very dismissive of women's concerns and overly reliant on the opinion of one man, Victor Madrigal-Borloz, whose title is UN Independent Expert on Sexual Orientation and Gender Identity. The LGB Alliance has written a letter of complaint (12) to the UN Human Rights Council, about the activities of Mr Madrigal-Borloz, as he campaigns almost solely on transgender rights and works against the interests of LGB people and women. This letter was signed by a wide range of LGB groups. The Yogyakarta Principles document that Mr Madrigal-Borloz promotes is just an activist manifesto, and as discussed by a number of the submissions to your committee, has been repudiated by one of its original authors Robert Wintemute. Mr Wintemute is a human rights lawyer who now realises that it took no account of infringements on the rights of women. Furthermore, Mr Madrigal-Borloz has been directly contradicted in his promotion of gender self-ID by two other UN appointees. The UN Special Rapporteur on the Rights of Women and Children, Reem Alsalem (13), and The Special Rapporteur on Torture, Dr Alice Edwards (14), have both condemned the Scottish gender self-identification legislation for its effect on women, particularly those in jail. In addition, putting male bodied people in women's prisons breaches the UN's own guidelines, the Mandela Rules, relating to conditions in prisons. So there seems to be an ongoing internal battle in the UN over this issue, and the opinion of this one man should not be taken as a UN stamp of approval. Lastly, Mr Madrigal-Borloz appears to be in receipt of funding from the Arcus Foundation (15), a transgender advocacy group, compromising his independence.

I will just finish with a Twitter post from one of many young detransitioners, to remind you of the pain that this Bill will encourage:



References

1. https://www.theguardian.com/uk-news/2023/jan/25/trans-woman-isla-bryson-guilty-raping-two-women-remanded-in-female-prison-scotland
2. https://www.bbc.com/news/uk-scotland-64438457
3. https://www.dailyrecord.co.uk/news/scottish-news/man-charged-rape-abduction-after-29241537
4. https://archive.md/2023.02.15-220721/https://www.telegraph.co.uk/politics/2023/02/15/nicola-sturgeon-brought-trans-row-snp-prepares-rip-gender-bill/#selection-1451.18-1455.76
5. Gribble 2023 Frontiers in Global Women's Health 4:1073053,
6. https://archive.md/Mtwtd
7. https://archive.md/jvtsq
8. https://www.thefp.com/p/i-thought-i-was-saving-trans-kids
9. https://www.reddit.com/r/transgenderau/comments/112sroc/hrt_in_qld/
10. https://reduxx.info/category/news/
11. https://reduxx.info/canada-mother-threatened-with-arrest-after-confronting-male-watching-girls-undress-in-changing-room-at-nanaimo-swimming-pool/
12. https://lgballiance.org.uk/wp-content/uploads/2023/01/Formal-complaint-about-Victor-Madrigal-Borloz-Independent-Expert-on-Sexual-Orientation-and-Gender-Identity-10th-January-2023.pdf
13. https://spcommreports.ohchr.org/TMResultsBase/DownLoadPublicCommunicationFile?gId=27681
14. https://twitter.com/DrAliceJEdwards/status/1619579182245347330
15. https://twitter.com/RoisinMichaux/status/1619968041974132736?t=Y90REoq3vXixkDXS15k9zg&s=19

frontiers | Frontiers in Global Women's Health

TYPE Case Report
PUBLISHED 03 February 2023
DOI 10.3389/fgwh.2023.1073053

OPEN ACCESS

EDITED BY
Alison Spiro,
Brunel University London, United Kingdom

REVIEWED BY
Sarah Earle,
The Open University, United Kingdom
Lisa Marchiano,
Lisa Marchiano, LCSW, LLC, United States

*CORRESPONDENCE
Karleen D. Gribble
k.gribble@westernsydney.edu.au

SPECIALTY SECTION
This article was submitted to Maternal Health, a section of the journal Frontiers in Global Women's Health

RECEIVED 18 October 2022
ACCEPTED 10 January 2023
PUBLISHED 03 February 2023

CITATION
Gribble KD, Bewley S and Dahlen HG (2023) Breastfeeding grief after chest masculinisation mastectomy and detransition: A case report with lessons about unanticipated harm. Front. Glob. Womens Health 4:1073053. doi: 10.3389/fgwh.2023.1073053

Breastfeeding grief after chest masculinisation mastectomy and detransition: A case report with lessons about unanticipated harm

Karleen D. Gribble[1]*, Susan Bewley[2] and Hannah G. Dahlen[1]

[1]School of Nursing and Midwifery, Western Sydney University, Parramatta, NSW, Australia, [2]Department of Women and Children's Health, King's College London, London, United Kingdom

An increasing number of young females are undergoing chest masculinsation mastectomy to affirm a gender identity and/or to relieve gender dysphoria. Some desist in their transgender identification and/or become reconciled with their sex, and then revert (or detransition). To the best of our knowledge, this report presents the first published case of a woman who had chest masculinisation surgery to affirm a gender identity as a trans man, but who later detransitioned, became pregnant and grieved her inability to breastfeed. She described a lack of understanding by maternity health providers of her experience and the importance she placed on breastfeeding. Subsequent poor maternity care contributed to her distress. The absence of breast function as a consideration in transgender surgical literature is highlighted. That breastfeeding is missing in counselling and consent guidelines for chest masculinisation mastectomy is also described as is the poor quality of existing research on detransition rates and benefit or otherwise of chest masculinising mastectomy. Recommendations are made for improving maternity care for detransitioned women[1]. Increasing numbers of chest masculinsation mastectomies will likely be followed by more new mothers without functioning breasts who will require honest, knowledgeable, and compassionate support.

KEYWORDS

breastfeeding, case report, detransition, grief, mastectomy, milk banking, transgender

Introduction

Female individuals who experience a gender identity in conflict with their sex and/or who suffer from gender dysphoria may seek surgery to construct a male appearing chest (1). This surgery is usually a type of subcutaneous mastectomy variously called "chest masculinisation", "chest reconstruction", "chest contouring", or "top" surgery (2, 3). The surgical purpose is to affirm a gender identity as a trans man or non binary person and/or to relieve psychological distress (1). Some breast tissue may be retained, unlike mastectomy for breast cancer, as aesthetic outcome is the priority (4).

Most transgender guidelines do not include the impact of chest masculinising mastectomy on breastfeeding as a part of the surgical consent process. Notably, the World Professional Association for Transgender Health (WPATH) Standards of Care makes no recommendation for counselling

[1]In this paper, the words 'women,' "girls," and "mothers" are used in their sexed sense to mean adult females, minor females, and female parents respectively. The exception is in the term "trans woman" which is used in a gendered sense to mean a male person with a gender identity of 'woman.'

on breastfeeding before surgery (5) and nor do guidelines from Australia (AusPATH) (6) or New Zealand (PATHA) (7). Falck et al. (8) considered the experience of six transgender individuals who had chest masculinising surgery. They found the surgeon raised the impact on breastfeeding in just one case. This discussion occurred only because the patient had requested breast reduction (rather than chest masculinisation) and had not advised the surgeon of their transgender identification (8). This suggests a double standard may be at play in terms of warning patients about harms dependent on identity rather than procedure.

The impact of different surgical techniques for chest masculinisation on breastfeeding is absent from the literature. Research on ordinary breast reduction surgery shows that where the nipple, areola and breast tissue underneath the areola remain in place (so called "pedicle" techniques) some milk making and milk removal capacity may be retained (9). However, when the nipple areolar complex is separated from underlying glandular tissue, milk removal is impossible (9). The most common chest masculinisation technique involves separation of the nipple areola complex from underlying tissue and excision of the nipple and areola which are then grafted back onto the reduced breasts in what is called "free nipple grafting" (10). Nipple reduction is a common adjunct, for which variety of techniques are used (4, 11); many result in a modified nipple with no functional orifices for milk removal [e.g., (12)].

It has been falsely claimed it is not possible to predict breastfeeding outcomes after chest masculinisation surgery based on surgical technique (13). Where surgery removes and grafts the nipple areola complex, there is little to no possibility of milk removal from the nipple, even should glandular tissue remain. Where the nipple is kept in place but tissue underneath it removed and duct connections cut or nipple integrity forfeited, milk removal is also impossible. Furthermore, surgical complications such as necrosis can result in nipple loss (4, 14, 15) and surgery that removes the nipple and areola entirely may be chosen (16, 17). Considered together, these factors mean that many, if not most, individuals who have undergone chest masculinisation mastectomy, are unlikely to retain ability to both produce and extract milk. Proper discussion is required for the patient to choose and consent. Without recognising that the future will include pregnancy for at least some patients, surgeons cannot offer a conservative approach; either of deferring surgery or attempting to preserve some function.

The only breastfeeding focussed research including participants who underwent chest masculinisation surgery is unfortunately unclear on the lactation and breastfeeding outcomes of all study participants (1). However, two individuals produced some milk that exited *via* their nipples; it seems in these cases, their surgeries did not involve nipple grafts and it can be assumed that some underlying breast tissue was retained. A further case involved an individual who had nipple grafts, sought to breastfeed but was unable to produce milk (1).

Some people do not persist in a transgender identification, and/or become reconciled with their sex, and detransition (18). Social detransition may involve presenting in a way more typical for their sex, reverting a name change, using sex based pronouns, or overtly rejecting a transgender identification (19). Medical detransition usually involves stopping cross sex hormones and require sex hormone replacement therapy in cases of gonadectomy (19). The experiences of detransitioners have been little studied, but transition regret is commonly reported in existing research (18, 19). Young and childless detransitioners who had mastectomies have spoken specifically of regret about inability to breastfeed (20, 21).

Case reports are a timely way for increasing knowledge of unusual or new conditions or circumstances and so help inform healthcare (22). They place the "*care and treatment of the individual patient centre stage*" (23), can be valuable as an "*early warning signal*" and contribute to the health and wellbeing of others in the future (24). This paper presents a case report of a woman who identified as transgender and obtained a chest masculinisation mastectomy but later detransitioned. She experienced intense grief around her inability to breastfeed her infant. During a three hour interview with the first author (KG), the woman, whom we are calling Elizabeth, told her story of transition, detransition, pregnancy, birth, and new motherhood. She also provided the authors with documentary support for her account including pregnancy medical records, her referral to the milk bank which described her reasons for seeking banked donor milk, and photographs of her mastectomy scarring. KG with the assistance of the second author (SB) developed the case description based on the transcribed interview in consultation with Elizabeth, with a focus on her experiences and feelings regarding her breasts, mastectomy, and breastfeeding and the impact of this on her as a pregnant woman and new mother. Some details have been changed to preserve anonymity. Written consent for publication and approval of the finalised paper was obtained from Elizabeth. Ethical approval for publication was granted by the Human Research Ethics Committee of Western Sydney University (approval H14913). The detailed experience of detransitioned women who had chest masculinisation mastectomies and then became mothers has not, to our knowledge, previously been described. This case report provides guidance to assist health professionals to better support detransitioned women who become mothers.

Case description

Elizabeth is a detransitioned woman in her thirties. She first experienced discomfort in her female body as a 10 year old when she developed breasts. She described being teased by other children and "*getting sexually harassed by adult men*" as "*really negative experiences*" that led her to hate her breasts. At age 15 years, Elizabeth heard about the concept of gender identity and became persuaded that her bodily discomfort was because she was transgender. She started wearing a sports bra to flatten her breasts, represented herself as a boy, and changed her name legally. At age 18, Elizabeth sought treatment at an adult gender identity service, was formally diagnosed with gender identity disorder, and was prescribed testosterone. At age 19, she obtained referral for chest masculinisation mastectomy and at 20 years she had a double incision subcutaneous mastectomy with free nipple grafts (25). She recollects no discussion of the impact on breastfeeding in this process.

The surgical outcome was not what was expected. There was extensive hypertrophic scarring, particularly around and under the nipple grafts, which were painful and itchy to the extent that wearing clothing was uncomfortable. Elizabeth describes her right nipple graft chronically leaking a watery fluid, while voids in her

scarred left nipple graft accumulated a smelly paste that had to be regularly squeezed out. Two years later, she underwent surgery to reduce scars; leaving her chest sunken and nipple less while scarring and nerve pain remained. Elizabeth felt unsupported by her transgender friends; they saw her surgical outcome as reflecting badly on transition and told her not to tell others about her experience because, "*you're making trans surgery look bad.*" She describes how she, "*went from being a trans activist… to being persona non grata because I was complaining about these botched chest surgeries, and it was just really devastating.*" The failure of the surgery to fulfil its promise, concurrent with rejection by transgender friends and testosterone induced vaginal atrophy, resulted in a psychological crisis. Elizabeth abandoned gender identity as a useful framework for understanding herself and the idea that she was a man of any kind. At age 24, she detransitioned, stopping testosterone, disassociating from the transgender community, and considering her previous identification and medicalisation a "*terrible mistake*".

Although her surgeon did not discuss breastfeeding, Elizabeth believed that if he had she would not have welcomed the conversation, "*I don't think I would have been receptive, I would have felt insulted and I would have said it was triggering my gender dysphoria.*" However, Elizabeth explains that this response would have been an avoidance tactic, "*That wouldn't really have been true. It would have been because…maybe I did want children… but it's like this trump card, gender dysphoria, meaning you can't have any conversation.*" That is, mention of gender dysphoria stops health professionals from further exploration. She explains, *"I was conflicted about* [possible future motherhood]*… because part of me actually did want children. I was very confused about, could I be an OK mother? Or would I be a bad mother? And so to me, rather than having to deal with those questions, the easiest thing was to make it impossible… take the choice away."*

Over subsequent years, Elizabeth determined she really did want children and then worried about whether she would be fertile because of prior testosterone use. She was also concerned about her inability to breastfeed, "*It was clear to me that I wanted to give my child the best possible start in life. And I did all the research, I knew that breastfeeding was really important.*" She contemplated not having a child because she couldn't breastfeed. However, at age 30, after a year of trying to conceive, Elizabeth became pregnant. The pregnancy was complicated by gestational diabetes but otherwise unremarkable. During one antenatal appointment with her midwife, Elizabeth expressed a desire to obtain donor milk. Her midwife reacted negatively and dismissively, saying she should "*just formula feed.*" In seeking understanding, Elizabeth shared her distress at not being able to breastfeed, her concern that she would be an inadequate mother because of this and described the trauma of her breast surgeries. Elizabeth's assessment is that her midwife was shocked; it was clear she had no experience of women without breasts following chest masculinisation mastectomy. The midwife also did not understand Elizabeth's anguish about her breastfeeding inability which only increased her distress such that a referral was made to an obstetrician.

Seemingly, this obstetrician had received training on the care of transgender people but he did not understand Elizabeth had detransitioned. She describes how, "*[the] doctor decided he was going to straighten things out, because he thought that, well, 'this old midwife just doesn't understand that this is a trans man and I'm going to fix things by correctly gendering this birthing parent, and then, you know, he'll calm down and everything will be great.'* He persistently referred to Elizabeth as 'a man' which Elizabeth found confusing and frightening. She tried to explain that she was not transgender and was not male. She wondered whether the obstetrician thought she was a mentally ill trans woman who mistakenly believed she was pregnant and was just being humoured. Alternatively, she considered whether the doctor was incompetent, persuaded by ideology that it was possible for a male to become pregnant. Either possibility made Elizabeth fear she would receive poor maternity care. Elizabeth's distress and her health providers" confusion resulted in a child protection report. It was only with hindsight that Elizabeth realised that the doctor must have been trained to "affirm" transgender identification and to prioritise gender identity over sex.

Elizabeth's infant was placed skin to skin on her chest after a caesarean birth and he sought her breast. She describes how, "*it was really hard knowing that he wanted to breastfeed, and I couldn't give him that…And when, when they put him on my stomach, he crawled up, he was looking for my breasts, and he couldn't find them. And he tried to suck on my chin. And he spent so much time in his early life trying to find my breasts.*"

Elizabeth was successful in obtaining banked donor milk; the milk bank manager was sympathetic to her circumstances, and thanks to Elizabeth's gestational diabetes, her infant met the eligibility criteria. While grateful for the respect given at the milk bank and for the milk itself, and despite knowledge that sick infants were prioritised in the system, Elizabeth felt guilty about taking this milk. She said, *"I always had the feeling that even if I knew that the babies who really needed it more, were getting served first, I was worried that a baby who might have needed it was going to be deprived because of me."* Elizabeth also obtained breastmilk directly from other mothers *via* social media. The combination of banked donor milk and peer to peer shared milk meant her infant was exclusively breastmilk fed for two months and mixed fed breastmilk and infant formula for a further two months.

Elizabeth had hoped that providing her son with donor breastmilk would alleviate her guilt and grief. However, this didn't occur. Seeing her infant exhibiting feeding cues and having to get up to make a bottle, instead of offering the breast, was difficult, "*I'd be cuddling with him. And I could feel like this is the time he would want the breast. It was so obvious.*" She recognised a relational aspect to breastfeeding they both missed.

Elizabeth's adjustment to new motherhood was made more stressful due to the child protection report follow up. Shortly after birth she had to, "*see a social worker from the child protective services and then go to a psychiatrist to get a mental health evaluation to prove that I wasn't insane…it was honestly traumatising.*" While no mental health concerns were identified and her case was closed, it nevertheless impacted her negatively. She said, "*We got off to a kind of a difficult start because of the stress of that…I just felt very misunderstood and very vulnerable, and very judged and inadequate.*"

Seeing her infant search for her breast was challenging, but Elizabeth looks back at the time spent skin to skin with fondness

and gratitude. She says, "*I didn't avoid it because of* [baby hunting for the breast]… *I'm really glad that that we did cuddle a lot when he was a baby… I'm glad that I spent a lot of time with him on my chest even though I couldn't actually breastfeed.*" Elizabeth says she now has a good relationship with her son who calls her "mummy" and that both these things helped her greatly. She is often misidentified as a trans woman due to her deep voice and flat chest but this does not bother her as it used to. Learning about other detransitioners post pregnancy helped her, "*to have some closure, where, you know, I don't feel alone with the stuff anymore and I now have vocabulary so I can describe my experiences.*"

Elizabeth wants to raise awareness of the experiences of others like her, "*to help try to make things less uncomfortable for pregnant, or shortly after pregnancy, detransitioned women who are trying to feed their babies.*" She wants health providers to know that, "*you can't assume based on how someone looks that they believe in gender identity and that they are going to want to be interacted with as if they are transgender.*" She wants people to be aware of potential complications associated with lactation following chest masculinisation mastectomy: for example, some will have remaining breast tissue but no working nipple or connection to the nipple and may develop engorgement; others may seek to feed their infant at their breast using a breastfeeding supplementer. However, this may be prevented or complicated by lack of breast tissue for the infant to latch onto or nipple grafts that are at high risk of damage due to compromised blood circulation and poor or absent sensation. She notes that those who retain a transgender identity may be reluctant to speak about their challenges because of social pressure to put a positive face on transition. She also suggests that for some their distress may be expressed as gender dysphoria rather than as breastfeeding grief, "*gender dysphoria is something that can conceal more than it reveals and somebody who's distressed because they realise they can't breastfeed their baby, that distress* [may be] *interpreted and expressed as gender dysphoria, rather than the actual cause.*" Such mothers (or fathers as they may wish to be called) and infants, she says, will need sensitive support.

Elizabeth is keenly aware of how lucky she was to be able to have a baby. This, to some extent, was a saving grace. She describes how she felt when trying to get pregnant, "*I had this feeling, if I'm able to still become a mother, then this whole transition, and how that was a miserable failure and mistake will just be a footnote in my life… but if I'm not able to have a child, then I will spend the rest of my life and go to my grave, having this combined regret of the transition and the childlessness together.*" She remains concerned about the potential impact of prior testosterone, "*I'll never be able to forgive myself for whatever potential effects of testosterone that I took might have had on my eggs and affected my son including, epigenetic changes… who knows what that did?*"

Because of her own experience, Elizabeth is highly critical of the quality of medical care provided to people with gender dysphoria, "*I'm really sad that there's going to be so many women, many of whom are children today, who are not going to be able to have children of their own because they're being sterilised. And I'm very frustrated, that it's taboo to talk about that… I am speaking because I want to spare future mothers and babies what we went through if I can.*"

Discussion

This case report exposes issues related to the undervaluing of breastfeeding in transgender medicine and maternity care. Transgender guidance routinely makes no mention of a need to discuss the impact of chest masculinisation surgery on breastfeeding, so it is perhaps unsurprising that Elizabeth's surgeon seemingly did not discuss this. Literature on the pros and cons of surgical techniques for chest masculinisation do not discuss the impact on breastfeeding [e.g., (2, 26, 27)]. Several authors have stated wrongly that those who regret surgery can have a "reversal" of their mastectomy (28, 29), apparently failing to appreciate that mastectomy involves removal of an organ and permanent loss of function.

The midwife was dismissive and confused by Elizabeth's distress and did not understand why she sought donor breastmilk. However, an abundance of research shows that Elizabeth was not unusual in seeing breastfeeding as consequential [e.g., (30, 31 34)]. Her reasons for placing importance on breastfeeding align with those previously identified: breastfeeding is a biologically normal, instinctive behaviour, intrinsically linked with motherhood, is a way of being in relationship with one's infant, and is important to infant health (35). Women who want, but are unable, to breastfeed are at increased risk of postnatal depression (36, 37). Dismissing their breastfeeding grief merely increases distress and decreases trust in health providers.

The other major source of distress for Elizabeth was lack of understanding of her situation as a detransitioner. Her midwife appeared unaware of gender transition and her obstetrician was unaware of detransition. Elizabeth's fear that her obstetrician believed she was a pregnant male might seem far fetched, but there are examples of individuals and organisations becoming confused about or believing impossible biology. Recently, student midwives at one university were provided with teaching materials on how to catheterise someone with a penis and told they may be required to care, "*for a pregnant or birthing person who is transitioning from male to female and may still have external male genitalia*" (38). This particular error (which was quickly corrected) seems likely related to the increasingly common use of language suggesting that a person of either sex may give birth or overt claims that men may become pregnant (39). Incongruence between pregnancy as an exclusively female experience and language stating otherwise may result in mistakes, similar to the "Stroop Effect" where conflicting stimuli introduce errors (40).

Other examples of erroneous health care advice exist. For example, the Canadian Cancer Society indicates that trans women may need cervical cancer screening (41). The potential for incongruent language and ideological infiltration to cause confusion, compromise care, and undermine patient confidence needs to be better appreciated. Certainly, maternity care providers need to be aware that detransitioners exist; they may have medical needs related to previous hormone treatment or surgery and they may overtly reject the concept of gender identity. Continuity of midwifery care should reduce the chance that the care itself becomes a source of psychological distress for detransitioned women. Continuity of care is shown to optimise physical and psychological outcomes (42, 43) and is highly valued by women

(44). A key advantage is that women can share their story once with the lead care provider who then advocates for them across the childbearing continuum.

The responses of Elizabeth's midwife and obstetrician contrast with the individualised care at the milk bank. Research has demonstrated the psychological benefit of milk bank staff listening to women and validating their desire to provide their infants with breastmilk (45). However, Elizabeth's feelings of guilt are consistent with research showing that women who access banked donor milk, may feel concerned they are taking milk from other needy infants (45). This highlights the importance of emotional support for all mothers seeking donor milk.

Elizabeth's experience also highlights the need for better health support for detransitioners. What limited research exists, indicates detransitioners often have low trust in health providers (19, 46) and do not believe they were properly evaluated nor properly informed about treatment health implications or risks (18, 19). During detransition, many report finding health professionals lack knowledge or are dismissive of feelings of being harmed by transition and of their health care needs (19). However, detransitioners recognise they need health care, including psychological support, with the majority wanting assistance coping with transition regret (19). Assistance may be most critical during the acute detransition, but may also be needed when transition consequences are experienced, such as if facing fertility issues or being unable to breastfeed. As Elizabeth found, peer support from other detransitioners is valuable (46). It is noteworthy that over a third of female detransitioners in existing research had chest masculinising mastectomy (18, 19).

The information deficit and lack of consideration about breastfeeding for those contemplating chest masculinisation mastectomy must be addressed. Guidelines such as those from WPATH, AusPATH and PATHA should require discussion about the impact of chest masculinising surgery on breastfeeding; it is surely unethical (and arguably negligent) for surgeons to remove an organ without explaining the functional effect to patients. Furthermore, guidance for clinicians supporting new mothers needs to be clearer on the likely impact of chest masculinisation surgery and potential breastfeeding complications. Current publications skirt around the issue and are not clear that the most common chest masculinisation surgical technique almost certainly precludes breastfeeding in terms of providing milk to an infant. They do not mention foreseeable complications such as engorgement from remaining breast tissue with no patent nipple orifices or that poor blood flow and enervation to nipple grafts increase risk of nipple damage and infections (1, 47 51) and may make it inadvisable for an infant to suckle. Current guidance also neglects emotional support for breastfeeding inability while even those who retain their transgender identification may find their inability to breastfeed difficult. As an example, the prominent UK trans man Freddie McConnell expressed sadness about being unable to provide any milk for his infant and described wishing his surgeon had maintained nipple placement so that the possibility of "chestfeeding" was retained (52). As Butler and Hutchinson (53) describe, there is a "*pressing need for research and services for gender desisters/detransitioners*". Support must include assistance for women who are unable to breastfeed but also those who are infertile either because they never fully developed due to puberty blocking medication, or because they used testosterone or underwent hysterectomy.

There is widespread concern about the rise in numbers of children attending gender clinics: 13 , 14 , and 19 fold increases in Norway, the United Kingdom, and Sweden respectively 2011 2017 (54). The proportion of girls attending UK gender clinics rose from 50% to 75% female 2011 2019 (20). In many countries, chest masculinisation mastectomies are carried out on minors, with reports of surgical referral for 12 year olds (28) and surgery undertaken on 13 year olds (3). One clinic in the USA reported a 13 fold increase in minor females referred for mastectomy 2013 2020 (28). Discussion of future inability to breastfeed is also absent in publications relating to minors [e.g., (28, 55, 56)]. One authority was recorded saying that adolescents who "*want breasts at a later point… can go and get them*" (56) demonstrating startling ignorance of breast function. A small retrospective study of 14 adolescents (1 month to 3.6 year follow up), found one young adult stopped testosterone two months after chest masculinisation surgery and asked to revert her sex marker to female five months later (57). Another retrospective study with 68 adolescents and young adults (13 24 years at surgery and one to five year follow up) found one individual reported surgical regret "sometimes" (3).

Detransition and regret about hormone administration or transition surgery are frequently said to be rare or exceedingly rare with low detransition rates <3% (5, 58 61). The research upon which such claims are made suffers from a number of serious limitations: short follow up [e.g., (62)]; high [e.g., (63)] or unclear rates of loss to follow up [e.g., (4)]; reliance on individuals returning to secondary care clinics reporting transition regret or seeking reversal procedures [e.g., (64)]; reliance on reversion of legal sex absent knowledge of the experiences or views of those who have not sought legal reversion [e.g., (60, 65)]; errors and non replicability (4, 66 69). Research suggesting much higher rates of detransition [7% 30% (70, 71)] also has flaws, meaning that detransition rates may be under or over reported. Short follow up is particularly concerning as it is evident that transition regret may have long latency; in one large cohort study the average time to regret was 10 years (63). Thus, there has not been time for long term follow up of the newer cohort of younger women who have transitioned in the past decade.

Research specifically regarding chest masculinsation mastectomy for minors and young adults, is of poor quality and makes surprisingly confident statements of benefit. For example, Ascha et al. (72), considered the psychological impact of chest masculinisation mastectomy on 14 24 year olds but had only a three month follow up and 14% drop out. They argued that there is no evidence to support delaying chest masculinisation mastectomy based on age and claimed that their findings would, "*help dispel misconceptions that gender affirming treatment is experimental.*" This paper, published in the highly ranked journal JAMA Pediatrics, was accompanied by an editorial entitled, "*Top surgery in adolescents and young adult effective and medically necessary*" (61). Such claims cannot be substantiated and call into question whether there has been a failure of peer review and the editorial process. Children and young adults with gender dysphoria deserve a good research basis for their treatment and a critical consideration of the risks and

benefits of procedures like chest masculinisation mastectomy (73). The number of people currently undergoing chest masculinisation mastectomy is increasing (74). Given that many women have their first baby in their 30s, there may be a decade or two between surgery and pregnancy during which regret may surface. In the future, there may be many mothers without breasts, needing support around inability to breastfeed.

Strengths and limitations

Strengths of this case study include the rich detail Elizabeth could provide about her own experience of giving birth and feeding her infant and her perspective of the attending health professionals. Limitations are that it is unknown how representative this is of detransitioned women.

Recommendations for practice

- Health systems and organisations, including breastfeeding organisations, should advocate with gender identity services, surgical associations, and transgender guideline producers to appreciate the importance of breast function and breastfeeding. They should ensure their own publications about chest masculinisation mastectomy provide honest information about the barriers surgery poses to breastfeeding and the potential complications. Quality research on the long term benefits or otherwise of chest masculinisation mastectomy, particularly regarding adolescents, is urgently needed.
- Gender identity clinicians must provide patients with more information before undertaking chest masculinisation surgery, given that the future is not predictable and because they will otherwise be open to medico legal challenges. This must include implications for infant feeding, even if pregnancy is not immediately contemplated.
- Awareness needs to be raised about the existence of detransitioned women who may require maternity care. Sensitive, informative content on detransitioners should be embedded in undergraduate midwifery and medical curricula. Assumptions should not be made about the gender identity of any individual based on their appearance, or indeed whether individuals have a gender identity.
- Continuity of midwifery care should be provided as standard and personal preferences regarding how individuals are referred to should be adhered to. Alongside sex (75), hospital and practice intake forms should collect data on gender identity, including an option of "I do not have a gender identity" or "not applicable."
- Antenatally, women who have had chest masculinisation mastectomy should be provided with assistance to consider their options for infant feeding. This should include discussion of the type of surgery and the condition of their nipples and areolae. They should also be informed on what to expect postnatally concerning engorgement or likelihood of lack of milk production or extraction.
- Pregnant women and new mothers who have had chest masculinisation surgery should be advised about the importance of skin to skin for infants, especially if they are unable to breastfeed. Anticipatory guidance about their infant's instinctive breast seeking behaviour needs to be provided with emotional support available for any distress. Support around responsive bottle feeding should also be provided where an infant is not breastfed.
- After birth, skilled care should be provided to women who have had chest masculinising mastectomy and who wish to initiate breastfeeding. Where attachment at the breast is possible, particular attention should be paid to optimising latch, preventing nipple damage and infections, and ensuring the infant is drinking sufficient milk at the breast or otherwise.
- All women who express guilt, sadness, or regret about being unable to breastfeed their infants, regardless of the reasons, should have their experience and feelings respected and be provided with appropriate emotional support. Health providers should be aware that transgender individuals may find it difficult to verbalise their distress because of a felt need to present transition interventions positively.
- Milk banks should consider eligibility for donor human milk for women who have had mastectomies on the basis of supporting the infant's right to health (76).

Conclusions

Until recently, it would be extremely unusual for a new mother to have had a mastectomy. With increasing numbers of female adolescents and young adults obtaining chest masculinisation mastectomies, more new mothers will present without functioning breasts. Some will retain a transgender identification and others will have detransitioned. Each requires an individualised approach to provide them and their infants with honest, knowledgeable, and compassionate support.

Data availability statement

The original contributions presented in the study are included in the article, further inquiries can be directed to the corresponding author.

Ethics statement

The studies involving human participants were reviewed and approved by Western Sydney University Human Research Ethics Committee. The patients/participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

KG interviewed Elizabeth. KG and SB constructed the case description. KG, SB, and HD provided original content for the paper. All authors contributed to the article and approved the submitted version.

Acknowledgments

We would like to sincerely thank Elizabeth for allowing her experience to be shared in this paper and for her assistance throughout the development of the manuscript. We would also like to thank those who contributed their expertise regarding breast surgery, gave feedback on earlier drafts of the manuscript and the reviewers for their constructive comments to improve the manuscript.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Publisher's note

References

1. MacDonald T, Noel-Weiss J, West D, Walks M, Biener M, Kibbe A, et al. Transmasculine individuals' experiences with lactation, chestfeeding, and gender identity: a qualitative study. *BMC Pregnancy Childbirth*. (2016) 16(1):106. doi: 10.1186/s12884-016-0907-y

2. Cohen WA, Shah NR, Iwanicki M, Therattil PJ, Keith JD. Female-to-male transgender chest contouring: a systematic review of outcomes and knowledge gaps. *Ann Plast Surg*. (2019) 83(5):589–93. doi: 10.1097/sap.0000000000001896

3. Olson-Kennedy J, Warus J, Okonta V, Belzer M, Clark LF. Chest reconstruction and chest dysphoria in transmasculine minors and young adults: comparisons of nonsurgical and postsurgical cohorts. *JAMA Pediatr*. (2018) 172(5):431–6. doi: 10.1001/jamapediatrics.2017.5440

4. Bustos SS, Kuruoglu D, Yan M, Bustos VP, Forte AJ, Ciudad P, et al. Nipple-areola complex reconstruction in transgender patients undergoing mastectomy with free nipple grafts: a systematic review of techniques and outcomes. *Ann Transl Med*. (2021) 9(7):612. doi: 10.21037/atm-20-4522

5. Coleman E, Radix AE, Bouman WP, Brown GR, de Vries ALC, Deutsch MB, et al. Standards of care for the health of transgender and gender diverse people, version 8. *Int J Transgend Health*. (2022) 23(Supplementary 1):S1–259. doi: 10.1080/26895269.2022.2100644

6. AusPATH. *Australian Informed consent standards of care for gender affirming hormone therapy*. Australia: Australian Professional Association for Trans Health (2022).

7. Oliphant J, Veale J, Macdonald J, Carroll R, Johnson RD, Harte M, et al. *Guidelines for gender affirming healthcare for gender diverse and transgender children, young people and adults in aotearoa, New Zealand*. New Zealand: Transgender Health Research Lab, University of Waikato (2018).

8. Falck F, Frisén L, Dhejne C, Armuand G. Undergoing pregnancy and childbirth as trans masculine in Sweden: experiencing and dealing with structural discrimination, gender norms and microaggressions in antenatal care, delivery and gender clinics. *Int J Transgend Health*. (2021) 22(1–2):42–53. doi: 10.1080/26895269.2020.1845905

9. Kraut RY, Brown E, Korownyk C, Katz LS, Vandermeer B, Babenko O, et al. The impact of breast reduction surgery on breastfeeding: systematic review of observational studies. *PLoS One*. (2017) 12(10):e0186591. doi: 10.1371/journal.pone.0186591

10. Tolstrup A, Zetner D, Rosenberg J. Outcome measures in gender-confirming chest surgery: a systematic scoping review. *Aesthetic Plast Surg*. (2020) 44(1):219–28. doi: 10.1007/s00266-019-01523-1

11. Trøstrup H, Saltvig I, Matzen SH. Current surgical techniques for nipple reduction: a literature review. *JPRAS Open*. (2019) 21:48–55. doi: 10.1016/j.jpra.2019.06.002

12. Mosser S. Transgender & non-binary nipple reduction described by Dr Scott Mosser (2017). Available at: https://www.youtube.com/watch?v=iiX41imoRuA

13. Hoffkling A, Obedin-Maliver J, Sevelius J. From erasure to opportunity: a qualitative study of the experiences of transgender men around pregnancy and recommendations for providers. *BMC Pregnancy Childbirth*. (2017) 17(2):332. doi: 10.1186/s12884-017-1491-5

14. Kääriäinen M, Salonen K, Helminen M, Karhunen-Enckell U. Chest-wall contouring surgery in female-to-male transgender patients: a one-center retrospective analysis of applied surgical techniques and results. *Scand J Surg*. (2017) 106(1):74–9. doi: 10.1177/1457496916645964

15. Knox ADC, Ho AL, Leung L, Hynes S, Tashakkor AY, Park YS, et al. A review of 101 consecutive subcutaneous mastectomies and male chest contouring using the concentric circular and free nipple graft techniques in female-to-male transgender patients. *Plast Reconstr Surg*. (2017) 139(6):1260e–72e. doi: 10.1097/prs.0000000000003388

16. Mosser S. Top surgery with no nipple grafts. Available at: https://www.genderconfirmation.com/no-nipples/ (August 3 2022).

17. The ultimate primer on top surgery and nipples (2021). Available at: https://www.topsurgery.net/nipples.htm (August 3 2022).

18. Littman L. Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. *Arch Sex Behav*. (2021) 50(8):3353–69. doi: 10.1007/s10508-021-02163-w

19. Vandenbussche E. Detransition-related needs and support: a cross-sectional online survey. *J Homosex*. (2022) 69(9):1602–20. doi: 10.1080/00918369.2021.1919479

20. Quincey Bell and Mrs A vs. The Tavistock and Portman NHS Foundation Trust, (2020).

21. The Florida Channel. 7/8/22 Agency for Health Care Administration Hearing on General Medicaid Policy Rule (2022). Available at: https://thefloridachannel.org/videos/7-8-22-agency-for-health-care-administration-hearing-on-general-medicaid-policy-rule/

22. Ngene NC, Rees M. Case reports: advancing knowledge of rare or unusual medical conditions. *Case Rep Womens Health*. (2022) 33:e00381. doi: 10.1016/j.crwh.2022.e00381

23. Williams DD. In defence of the case report. *Br J Psychiatry*. (2004) 184:84. doi: 10.1192/bjp.184.1.84

24. Kidd MR, Saltman DC. Case reports at the vanguard of 21st century medicine. *J Med Case Rep*. (2012) 6:156. doi: 10.1186/1752-1947-6-156

25. Etemad SA, Furuyama WM, Winocour JS. Double incision mastectomy with free nipple graft for masculinizing chest wall surgery. *Plast Reconstr Surg Glob Open*. (2020) 8(11):e3184. doi: 10.1097/GOX.0000000000003184

26. Bluebond-Langner R, Berli JU, Sabino J, Chopra K, Singh D, Fischer B. Top surgery in transgender men: how far can you push the envelope? *Plast Reconstr Surg*. (2017) 139(4):873e–82e. doi: 10.1097/prs.0000000000003225

27. Kühn S, Keval S, Sader R, Küenzlen L, Kiehlmann M, Djedovic G, et al. Mastectomy in female-to-male transgender patients: a single-center 24-year retrospective analysis. *Arch Plast Surg*. (2019) 46(5):433–40. doi: 10.5999/aps.2018.01214

28. Tang A, Hojilla JC, Jackson JE, Rothenberg KA, Gologorsky RC, Stram DA, et al. Gender-affirming mastectomy trends and surgical outcomes in adolescents. *Ann Plast Surg*. (2022) 88(4):S326–S31. doi: 10.1097/SAP.0000000000003135

29. Narayan SK, Hontscharuk R, Danker S, Guerriero J, Carter A, Blasdel G, et al. Guiding the conversation-types of regret after gender-affirming surgery and their associated etiologies. *Ann Transl Med*. (2021) 9(7):605. doi: 10.21037/atm-20-6204

30. Brown A, Lee M. An exploration of the attitudes and experiences of mothers in the United Kingdom who chose to breastfeed exclusively for 6 months postpartum. *Breastfeed Med*. (2011) 6(4):197–204. doi: 10.1089/bfm.2010.0097

31. Manhire KM, Hagan AE, Floyd SA. A descriptive account of New Zealand mothers' responses to open-ended questions on their breast feeding experiences. *Midwifery*. (2007) 23(4):372–81. doi: 10.1016/j.midw.2006.01.002

32. Griswold MK, Pagano-Therrien J. Women living with HIV in high income countries and the deeper meaning of breastfeeding avoidance: a metasynthesis. *J Hum Lact*. (2020) 36(1):44–52. doi: 10.1177/0890334419886565

33. Chang CR, Denney DF, Cheah WI. Perceptions of exclusive breastfeeding among bidayuh mothers in sarawak, Malaysia: a qualitative study. *Malays J Nutr*. (2015) 21 (2):263–8.

34. Tariq S, Elford J, Tookey P, Anderson J, de Ruiter A, O'Connell R, et al. It pains me because as a woman you have to breastfeed your baby": decision-making about infant feeding among African women living with HIV in the UK. *Sex Transm Infect*. (2016) 92:331–6. doi: 10.1136/sextrans-2015-052224

35. Brown A. What do women lose if they are prevented from meeting their breastfeeding goals? *Clin Lact*. (2018) 9(4):200–7. doi: 10.1891/2158-0782.9.4.200

36. Borra C, Iacovou M, Sevilla A. New evidence on breastfeeding and postpartum depression: the importance of understanding women's intentions. *Matern Child Health J*. (2015) 19(4):897–907. doi: 10.1007/s10995-014-1591-z

37. Gregory EF, Butz AM, Ghazarian SR, Gross SM, Johnson SB. Are unmet breastfeeding expectations associated with maternal depressive symptoms? *Acad Pediatr*. (2015) 15(3):319–25. doi: 10.1016/j.acap.2014.12.003

38. Staff Reporter. Trans women can give birth, Edinburgh Napier University midwifery students told. London: Daily Mail (2022). Available at: https://www.holyrood.com/news/view,trans-women-can-give-birth-edinburgh-napier-university-midwifery-students-told

39. Gribble KD, Bewley S, Bartick MC, Mathisen R, Walker S, Gamble J, et al. Effective communication about pregnancy, birth, lactation, breastfeeding and newborn care: the importance of sexed language. *Front Glob Womens Health*. (2022) 3:3. doi: 10.3389/fgwh.2022.818856

40. Stroop JR. Studies of interference in serial verbal reactions. *J Exp Psychol*. (1935) 18 (6):643–62. doi: 10.1037/h0054651

41. Canadian Cancer Society. As a trans woman, do I need to get screened for cervical cancer? (n.d.). Available at: https://cancer.ca/en/cancer-information/find-cancer-early/screening-in-lgbtq-communities/as-a-trans-woman-do-i-need-to-get-screened-for-cervical-cancer

42. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev*. (2016) 4:Art. No:CD004667. doi: 10.1002/14651858.CD004667.pub5

43. Cummins A, Baird K, Melov SJ, Melhem L, Hilsabeck C, Hook M, et al. Does midwifery continuity of care make a difference to women with perinatal mental health conditions: a cohort study, from Australia. *Women Birth*. (2022). doi: 10.1016/j.wombi.2022.08.002

44. Hildingsson I, Karlström A, Larsson B. Childbirth experience in women participating in a continuity of midwifery care project. *Women Birth*. (2021) 34(3): e255–61. doi: 10.1016/j.wombi.2020.04.010

45. Brown A, Shenker N. Receiving screened donor human milk for their infant supports parental wellbeing: a mixed-methods study. *BMC Pregnancy Childbirth*. (2022) 22(1):455. doi: 10.1186/s12884-022-04789-7

46. MacKinnon KR, Kia H, Salway T, Ashley F, Lacombe-Duncan A, Abramovich A, et al. Health care experiences of patients continuing or reversing prior gender-affirming treatments. *JAMA Network Open*. (2022) 5(7):e2224717. doi: 10.1001/jamanetworkopen.2022.24717

47. Ferri RL, Rosen-Carole CB, Jackson J, Carreno-Rijo E, Greenberg KB. ABM Clinical protocol #33: lactation care for lesbian, gay, bisexual, transgender, queer, questioning, plus patients. *Breastfeed Med*. (2020) 15(5):284–93. doi: 10.1089/bfm.2020.29152.rlf

48. Perini J. Transgender health in pregnancy and the postpartum period. In: Barghouthi N, Perin J, editors. *Endocrine diseases in pregnancy and the postpartum period*. Boca Raton: CRC Press (2021). p. 160–2.

49. García-Acosta JM, San Juan-Valdivia RM, Fernández-Martínez AD, Lorenzo-Rocha ND, Castro-Peraza ME. Trans* pregnancy and lactation: a literature review from a nursing perspective. *Int J Environ Res Public Health*. (2020) 17(1):44. doi: 10.3390/ijerph17010044

50. MacDonald T. Lactation care for transgender and non-binary patients: empowering clients and avoiding aversives. *J Hum Lact*. (2019) 35(2):223–6. doi: 10.1177/0890334419830989

51. Obedin-Maliver J, Makadon HJ. Transgender men and pregnancy. *Obstet Med*. (2015) 9(1):4–8. doi: 10.1177/1753495X15612658

52. McConnell F. freddie.mcconnell Instagram (2022). Available at: https://www.instagram.com/p/CZMTMQ8jXYF/?fbclid=IwAR1qYN9sqddo4vap4h4WrG-tN-nmCJVvpQ3Ew04W1dKwzGv4tHt0NLYxetc

53. Butler C, Hutchinson A. Debate: the pressing need for research and services for gender desisters/detransitioners. *Child Adolesc Ment Health*. (2020) 25(1):45–7. doi: 10.1111/camh.12361

54. Kaltiala R, Bergman H, Carmichael P, de Graaf NM, Egebjerg Rischel K, Frisén L, et al. Time trends in referrals to child and adolescent gender identity services: a study in four nordic countries and in the UK. *Nord J Psychiatry*. (2020) 74(1):40–4. doi: 10.1080/08039488.2019.1667429

55. Sood R, Jordan SW, Chen D, Chappell AG, Gangopadhyay N, Corcoran JF. Mastectomy and chest masculinization in transmasculine minors: a case series and analysis by ethical principles. *Ann Plast Surg*. (2021) 86(2):142–5. doi: 10.1097/sap.0000000000002614

56. Olson-Kennedy J. Dr. Johanna Olson-Kennedy explains why mastectomies for healthy teen girls is no big deal (2018). Available at: https://www.youtube.com/watch?v=5Y6espcXPJk

57. Marinkovic M, Newfield RS. Chest reconstructive surgeries in transmasculine youth: experience from one pediatric center. *Int J Transgend*. (2017) 18(4):376–81. doi: 10.1080/15532739.2017.1349706

58. Mookerjee VG, Brower JP, Kwan D. Gender-affirming surgical care. In: M Forcier, G Van Schalkwyk, JL Turban, editors. *Pediatric gender identity: Gender-affirming care for transgender & gender diverse youth*. Cham: Springer International Publishing (2020). p. 219–29.

59. Wu CA, Keuroghlian AS. Moving beyond psychiatric gatekeeping for gender-affirming surgery. *JAMA Surg*. (2022. doi: 10.1001/jamasurg.2022.5828

60. Danker S, Narayan SK, Bluebond-Langner R, Schechter LS, Berli JU. A survey study of surgeons' experience with regret and/or reversal of gender-confirmation surgeries. *Plast Reconstr Surg Glob Open*. (2018) 6(8S):189. doi: 10.1097/01.GOX.0000547077.23299.00

61. Thadikonda KM, Gast KM. Top surgery in adolescents and young adults: effective and medically necessary. *JAMA Pediatr*. (2022) 176(11):1071–3. doi: 10.1001/jamapediatrics.2022.3421

62. van der Loos MATC, Hannema SE, Klink DT, den Heijer M, Wiepjes CM. Continuation of gender-affirming hormones in transgender people starting puberty suppression in adolescence: a cohort study in The Netherlands. *Lancet Child Adolesc Health*. (2022) 6(12):869–75. doi: 10.1016/S2352-4642(22)00254-1

63. Wiepjes CM, Nota NM, de Blok CJM, Klaver M, de Vries ALC, Wensing-Kruger SA, et al. The Amsterdam cohort of gender dysphoria study (1972-2015): trends in prevalence, treatment, and regrets. *J Sex Med*. (2018) 15(4):582–90. doi: 10.1016/j.jsxm.2018.01.016

64. Pazos Guerra M, Gómez Balaguer M, Gomes Porras M, Hurtado Murillo F, Solá Izquierdo E, Morillas Ariño C. Transsexuality: transitions, detransitions, and regrets in Spain. *Endocrinol Diabetes Nutr (Engl Ed)*. (2020) 67(9):562–7. doi: 10.1016/j.endien.2020.03.005

65. Dhejne C, Öberg K, Arver S, Landén M. An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: prevalence, incidence, and regrets. *Arch Sex Behav*. (2014) 43(8):1535–45. doi: 10.1007/s10508-014-0300-8

66. Expósito-Campos P, D'Angelo R. Letter to the editor: regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plast Reconstr Surg Glob Open*. (2021) 9(11):e3951. doi: 10.1097/gox.0000000000003951

67. Escandón JM, Bustos VP, Bustos SS, Mascaro A, Del Corral G, Ciudad P, et al. Reply: regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plast Reconstr Surg Glob Open*. (2021) 9(11):e3954. doi: 10.1097/gox.0000000000003954

68. Bewley S. Regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plast Reconstr Surg Glob Open*. (2022) 10(9):e4512. doi: 10.1097/gox.0000000000004512

69. Erratum: regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence-erratum. *Plast Reconstr Surg Glob Open*. (2022) 10(4):e4340. doi: 10.1097/gox.0000000000004340

70. Roberts CM, Klein DA, Adirim TA, Schvey NA, Hisle-Gorman E. Continuation of gender-affirming hormones among transgender adolescents and adults. *J Clin Endocrinol Metab*. (2022) 107(9):e3937–43. doi: 10.1210/clinem/dgac251

71. Hall R, Mitchell L, Sachdeva J. Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: retrospective case-note review. *BJPsych Open*. (2021) 7(6):e184. doi: 10.1192/bjo.2021.1022

72. Ascha M, Sasson DC, Sood R, Cornelius JW, Schauer JM, Runge A, et al. Top surgery and chest dysphoria among transmasculine and nonbinary adolescents and young adults. *JAMA Pediatr*. (2022) 176(11):1115–22. doi: 10.1001/jamapediatrics.2022.3424

73. Clayton A. The gender affirmative treatment model for youth with gender dysphoria: a medical advance or dangerous medicine? *Arch Sex Behav*. (2022) 51 (2):691–8. doi: 10.1007/s10508-021-02232-0

74. Chaya BF, Berman ZP, Boczar D, Trilles J, Siringo NV, Diep GK, et al. Gender affirmation surgery on the rise: analysis of trends and outcomes. *LGBT Health*. (2022) 9(8):582–8. doi: 10.1089/lgbt.2021.0224

75. Bewley S, McCartney M, Meads C, Rogers A. Sex, gender, and medical data. *Br Med J*. (2021) 372:n735. doi: 10.1136/bmj.n735

76. Gribble KD, Gallagher M. Rights of children in relation to breastfeeding in child protection cases. *Br J Soc Work*. (2014) 44(2):434–50. doi: 10.1093/bjsw/bcu004