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Surgical Abuse
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Gender Dysphoria and Surgical Abuse

What astonishes me is the lack of evidence to support massive medical intervention aimed at "changing" a child's sex when such procedures are simply not necessary. The enthusiasm of ethics committees in hospitals, health regions and universities for such procedures is an ongoing mystery

In recent years, the issue of transgender identity in children has leapt from the periphery of public consciousness to centre stage of a cultural drama played out in the media, courts, schools, hospitals, families, and in the minds and bodies of children. It is a kind of utopian religion with committed believers.

The drama is "gender dysphoria" and it is about children believing they belong to the opposite sex[1]. It is about parental anguish and commitment, court battles to instigate some therapies, laws to prevent others, cross-dressing, drugs that will block puberty, others that will transform an adolescent towards the opposite sex, pending feats of surgery that will castrate while turning a penis into an opening like a vagina, or producing a penis from a forearm in a foray into reproduction unrivalled since the days of eugenics. It is no wonder this drama is repeated on the media, especially as its players may be toddlers whose future is in the hands of the audience. Accept the pathways of "medicine", we are urged. Welcome transgender as but one hue in a natural rainbow. Or the children will kill themselves[2].

But is this massive intrusion into the minds and bodies of children necessary? What will happen if parents do nothing but "watch and wait" while their child muses on its gender? Can the child grow out of it?

The answer astonishes. While proponents argue for massive intervention, scientific studies prove that the vast majority of transgender children will grow out of it through puberty if parents do little more than gently watch and wait. Studies vary but from 70 to 97.8 per cent of gender-dysphoric male and 50 to 88 per cent of gender-dysphoric female children have been reported to "desist" prior to the onset of puberty. This likelihood of "growing out of it" is declared in no less than the current, official *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association[3] (DSM-5), and is supported by a number of independent studies[4][5].

The Western medical profession boasts that it rests on "evidence-based medicine" but the tiny fraction involved with "affirmation" of gender identity in confused children is proceeding without supportive evidence for claims of high incidence, the need and safety of medical and surgical intervention, the avoidance of self-harm, and for the concept that the process will produce a happier human being in a happier society. Faith is needed for affirmation.

During a discussion on these matters, a leading endocrinologist declared to this writer, twice, that the issues of gender dysphoria are "utterly arbitrary … utterly arbitrary", and that his greatest fear was that a mistake would be made by intervention. If most gender-dysphoric children desist without treatment, the "utterly arbitrary" medical pathways are also utterly unnecessary.

How common is childhood gender dysphoria?

No one really knows because there is "an absence of formal prevalence studies"[6][7] and estimates vary greatly. The leader of Toronto's Transgender Youth Clinic at the Hospital for Sick Children, Dr Joey Bonifacio, says estimates based on adult dysphoria clinics range from 0.005 to 0.014 per cent for men convinced they are women and 0.002 to 0.003 per cent for women convinced they are men, but believes they are "likely modest underestimates"[8]. Bonifacio's statistics are the same as those declared in the bible of psychiatry, DSM-5[9].

In Australia, prominence has been given to a cross-sectional questionnaire distributed to 8500 adolescents in New Zealand ("Youth 12") which reported 1.2 per cent answered "Yes" to the question, "Do you think you are transgender? This is a

girl who feels like she should have been a boy, or a boy who feels like he should have been a girl." 95 per cent denied being transgender, 2.5 per cent replied they were "unsure", and 1.7 per cent "did not understand" the question. The estimate of 1.2 per cent is promoted by leaders of the gender dysphoria service at Melbourne Children's Hospital[10], but the progenitors of the "Safe Schools" program appear to have inflated the figure to 4 per cent by adding the unsure 2.5 per cent.[11]

Results of such tick-in-the-box questionnaires are unreliable. According to DSM-5, childhood gender dysphoria can only be diagnosed if there is "a marked incongruence" between natal and perceived gender lasting "at least six months", "manifested by at least six" features, including "a strong desire … and insistence", together with a "strong preference" for the company, clothing and toys of the opposite sex and its role in fantasy play, and associated with rejection of the stereotypes of its natal sex, including anatomy. Also, to comply with "dysphoria", there should be "significant distress or impairment … in functioning".

The unreliability of such questionnaires is emphasised in the *Journal of Homosexuality* in its consideration of the prevalence of suicide in sexual minorities[12]. It warns that conclusions are limited because they are based on "retrospective" data, "do not effectively allow cause and effect relationships to be discerned" including "co-occurring mental disorders", are "restricted" in the number of questions they can ask to elucidate facts and are weakened by the possibility of incomprehension of the questions.

Is it any surprise that reliability of responses from adolescents has been questioned? [13] In the New Zealand survey deemed authoritative by some in Australia, 36.5 per cent of adolescents in this land of the All Blacks declared they did not understand the question: have you ever been "hit or physically harmed by another person?"

It is false to claim 1.2 per cent of the population is transgender on the basis of the survey. That would make its prevalence rival the 1 to 3 per cent of mental retardation. It is wrong to conflate the figure to 4 per cent for the "Safe Schools" program. That would mean one in twenty-five of all children would be transgender.

A straw poll of twenty-eight generalist paediatricians with a cumulative postgraduate experience of 931 years conducted for this article reveals eight children to have been

observed with gender dysphoria. Four were remembered to have had severe associated mental disorder, one associated attention deficit/hyperactivity, one had been investigated for neurological disease on the basis of strange fidgetiness, and two had suffered sustained sexual abuse. In reality, childhood gender dysphoria is a rare condition whose prevalence is unknown.

How common are associated mental problems?

There are at least four reasons why a child with gender dysphoria might have associated mental disorder. The first is that transgender is but a symptom of a general disturbance. The second is that mental disorder could be caused by gender dysphoria. The third is it could be caused by external ostracism. The fourth would be a mixture of the above. Though studies reveal mental disorder, the cause remains elusive.

A study of Dutch children with dysphoria aged from four to eleven revealed associated psychiatric disease of at least one type in 52 per cent [14] with diagnoses including anxiety, phobias, mood disorders, depression, attention deficit and oppositional behaviour. A study by school teachers reported significant behavioural and emotional problems in about one third of 554 dysphoric Dutch and Canadian children under twelve[15]. At the first presentation to a US gender clinic of ninety-seven children with mean age of 14.8 years, 44.3 per cent had a history of psychiatric diagnoses, 37.1 per cent were already on psychotropic medications and 21.6 per cent had a history of self-injurious behaviour[16]. In an Australian study of thirty-nine dysphoric children of mean age ten, behavioural disorders were observed in a quarter, and Asperger syndrome in one in seven[17].

Proponents claim psychiatric problems are secondary to ostracism, but the American authors suggested gender dysphoria, itself, might be causal: “psychiatric symptoms might be secondary to a medical incongruence between mind and body”, because the symptoms tended to abate with hormone therapy.

The frequency of autism spectrum disorder in children with gender dysphoria, and the known indifference of those children to the opinion of others, would argue transgender was a symptom of an underlying disorder and not a result of ostracism.

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Autism has been found in 7.8 per cent of transgender children in a Dutch clinic[18], around 13 per cent in London[19] and 14 per cent in Australia.

The answer to the question of whether dysphoria is primary or secondary is unknown and probably unknowable. This renders optimistic, if not delusional, the concept that massive intervention may secure happiness.

What is the risk of self-harm and suicide?

Risk of self-harm has been reported in gender-dysphoric children and is the argument for "treatment" and against inaction. Is self-harm another manifestation of an underlying disorder, or is it due to frustration from gender dysphoria alone, or due to ostracism? Proponents of affirmative treatment proclaim the latter and declare an "alarmingly high rate" of self-harm and suicide attempts, exemplified by highly publicised and tragic youth suicides in the US[20].

As with most data related to gender dysphoria in children, studies are limited by lack of numbers and methodological bias, and the true rate of self-harm due to external ostracism is unknown. Other factors are very common and very important and seem neglected in the argument.

One London study retrospectively reviewed letters from referring doctors and its own notes regarding 218 gender-dysphoric children with mean age of fourteen. Of forty-one aged from five to eleven, it reported self harm in 14.6 per cent, suicidal ideation in 14.6 per cent and suicidal attempts in 2.4 per cent. Higher rates were reported in adolescents. A similar rate of ideation is reported from Canada[21], though associated with a lower rate of self-harm or attempted suicide (17 per cent as against 6.2 per cent). As in London, rates increased with age. Neither study revealed features of self-harm and attempted suicide.

The study reported high associated rates of psychiatric co-morbidity in children under eleven: autism spectrum disorder from 12.2 to 17.1 per cent, attention deficit hyperactivity in 14.6 per cent, anxiety in 17.1 per cent, depression in 7.3 per cent and psychosis in 2.4 per cent with, on the whole, rates increasing with age. It reports bullying and abuse in almost half to two thirds of all children but does not discuss

whether it was provoked by transgender characteristics or those associated with autism, hyperactivity and psychosis.

Furthermore, though detailing living arrangements of the children, the authors do not comment on their influence, though the effect of family chaos on the mood of offspring is well known. The study found only 36.7 per cent were living with both biological parents, and 58.3 per cent “had parents who had separated”. “Domestic violence was indicated” in 9.2 per cent, maternal depression in 19.3 per cent, paternal depression in 5 per cent; and parental alcohol or drug abuse in 7.3 per cent.

Nor does the study consider the significance of autism it found in 12.2 to 17.1 per cent of its children. Elsewhere, 14 per cent of children with autism aged from one to sixteen have been reported to experience suicidal ideation or attempts, suggesting a rate twenty-eight times greater than that for typical children (0.5 per cent)[22].

The New Zealand survey of adolescents (“Youth 12”) deemed authoritative by some in Australia asked about “self-harm” in the previous year. Of non-transgenders 23.4 per cent replied “Yes”, as did 45.5 per cent of “transgenders” but 23.7 per cent reckoned they did not understand the question. When asked about attempted suicide, 4.1 per cent of non-transgenders replied “Yes”, as did 19.8 per cent of “transgenders”, but 13.3 per cent declared incomprehension.

In other studies, between 19[23] and 29 per cent [24] of *all* adolescents are reported to have a history of suicidal ideation, and between 7 and 13 per cent to have attempted suicide; though what constitutes an attempt is not described in these studies, or in those above from London and New Zealand.

The question, then, is whether transitioning of transgender children will ultimately reduce self-harm. While Dutch experience concludes that “starting cross-sex hormones early … followed by gender reassignment surgery … can be effective and positive for general and mental functioning”[25], other centres report high rates of suicide in the years following reassignment.[26] [27] To be fair, those reassigned in these studies did not have such a developed “pathway” for affirmation as in Holland. Nevertheless, suicide attempts after surgery have been reported to be more common than in the general population in Belgium (5.1 per cent as against 0.15 per cent)[28] and in Sweden[29].

Conversely, regarding suicide by adolescent members of sexual minorities, the *Journal of Homosexuality* concludes that "very few suicide decedents [*sic*]" have been identified as having "minority sexual orientation" in studies in North America: three of 120 adolescent suicides in New York, and four of fifty-five in Quebec; and warns conclusions based on "small numbers … must be regarded as tentative".

The conclusion of the *Journal of Homosexuality* is valid. Numbers are small and data is obscure. No one knows how often real suicide attempts occur or their relationship with internal and external factors in gender dysphoria. When I raised the issue with one experienced therapist, it was denounced as "bull****", merely a "weapon used by ideologues".

What are personality characteristics of parents bringing children to gender dysphoria clinics?

No studies are available on characteristics of parents despite numerous studies on their children. It is supposed that gender confusion in a child must deeply affect its parents, and the phrase common to those seen interviewed on television, "gut wrenching", is easy to accept. Perhaps, therefore, it is despair that is driving an increasing number of parents to start "social transition" of their child to the opposite gender before seeking medical help, under the guidance of websites and support groups and the encouragement of an enthusiastic media. Toronto's Dr Bonifacio says many have progressed far into transitioning before attending his clinic: parents are dressing and entertaining the child as the opposite sex, applying new pronouns and a new name. Such commitment, he explains, paves the way for further treatment.

A leading but nameless therapist agrees: about a third of children are already being "socialised". This therapist worries that they are at risk of being "conditioned" by parents who have become "enmeshed" to the degree of being "cheer leaders". This could lead to the child becoming "scripted" to repeat phrases that would convince therapists. One example is the declaration of a five-year-old that he was "transgender" when featuring with his mother in a recent documentary on childhood dysphoria by Louis Theroux shown on ABC television.

Becoming a "cheer leader" in therapy for a child is, of course, not uncommon. Many if not most parents become passionate for their children and are on the sidelines at

soccer and in advocacy groups for advances in treatment of malignancy. But, unpleasant as it is to raise the matter, every paediatrician knows there is a tragic condition known as Munchausen syndrome in which symptoms are fabricated for some kind of benefit. In Munchausen's-by-proxy, the benefit accrues to the carer. I asked an experienced therapist whether this ever complicated gender dysphoria? Shoulders were shrugged: there are no studies. But, if mental illness affects 45.5 per cent of all Australians at some point in their lives and 20 per cent of those aged from sixteen to eighty-five will have experienced it in the previous year[30], the relevance of Munchausen's-by-proxy in carers needs to be considered.

What is the treatment for childhood gender dysphoria?

There are three categories. The first, known as "conversion" or "reparative therapy", is the attempt to make the child more comfortable in its natal sex and to lead it away from identification with the opposite gender. In the process, the reasons for the gender dysphoria are explored with the child and its parents. The second may be called "waiting and watching" while making the child comfortable in its natal sex until it grows out of it. The third is called "affirmative therapy" and involves supporting transition to the opposite gender.[31]

"Conversion" or "reparative therapy", in which the child is orientated towards its natal sex, is anathema to transgender activists, and their political campaigns have caused it to be forbidden for minors in some states of North America. Evoking spectres of past brutal medical and societal treatment of transgender and homosexual adults, activists declare that anything less than affirmation in transgender children is inhumane, futile and may provoke suicide: transgender is fixed before and unchangeable after birth, and parents and society must accept the inevitable. The term "reparative therapy", therefore, has a pejorative, political ring to it. It is wielded more like a weapon than a description of a medical alternative.

The second involves keeping the child as happy as possible within its "own skin" or natal sex, in the expectation it will "grow out of it". It allows a child to dress and play with toys of the opposite gender but without encouragement and only in the home. It allows that a minority will "persist" into homosexuality but perceives life as a homosexual less complicated than that of transgender.

In practice, this middle option could swing towards dissuasion or affirmation. How much time should a child spend in his mother's clothes? How much effort into persuading a boy there are other interests than dolls? Depending on emphasis (or perceived emphasis as in the case of Dr Kenneth Zucker below) critics may decry "watchful waiting" as merely another form of "conversion" therapy, while others might fear too much affirmation amounts to "conditioning" towards a role from which the child may find it difficult to escape.

The third option, "affirmation" excludes the first two and commits to a "pathway" that begins with "social transitioning" and progresses to blocking puberty with drugs (Stage 1). Stage 2 follows with stimulation of cross-sex features with administered hormones, in preparation for the possibility of later surgical intervention (Stage 3).

Problems are obvious. How might a child escape the "pathway" when gender re-orientation occurs with puberty? Complications with "second transitioning" after a life as the opposite gender are easily imagined[32]. Worse, what if the child is so intimidated by the fear of coming out again that acceptance of the "pathway" seems the only possibility? Or, what if the child has been so mentally programmed it has no idea how to live as the "opposite" sex? Tragic mistakes are possible.

Stage 1: The blocking of puberty

The induction of puberty begins deep in the brain where it is started by a biological clock and involves a cascade of hormones with various checks and balances. Where and how it starts are unknown, but chemical messengers ultimately influence nerve cells in the hypothalamus to release hormones in pulsatile fashion to initiate a cascade of effects. They stimulate cells in the nearby pituitary gland to secrete other hormones that travel to stimulate the gonads to release yet other hormones that travel to evoke secondary sex characteristics.

The hormones that are secreted by the hypothalamus act on receptors on the surface of the cells in the pituitary. Their pulsatile secretion (every ninety minutes) allows time for the pituitary receptors to reset after they have fatigued themselves sending messages to the nuclei of their cells. If they are continuously stimulated the receptors become exhausted and puberty stalls. Drugs are now available that are similar to the hypothalamic hormones. If injected in slow-release form, these

"puberty blockers" will exert a sustained effect, exhausting receptors and blocking puberty.

Since the 1980s these drugs have been used to block puberty when it has begun too early and, so far, no side-effects have been noted. It appears pituitary cells can recover from prolonged suppression and that hypothalamic and other upstream neurons are not damaged by their vain efforts. Activists declare that puberty blockage is "entirely reversible" (and Australian courts echo the conviction) but the international Endocrine Society is cautious, declaring passively that "prolonged pubertal suppression … should not prevent resumption" upon cessation[33]. The Society warns there are no data regarding how long it might take for active sperm and ova to appear after prolonged blockage.

Puberty is associated with psychological changes that reflect hormonal influences throughout the brain. Though used for an abnormal state since the 1980s, blockers have only been used in the presumably normal brain for gender dysphoria since the 1990s and, therefore, in neither case is the effect known in later years of life. The claim they are "completely reversible", is not yet based on evidence. The trial is too short, the numbers too small, the effect not blinded, and there are no controls.

Puberty is blocked to "give the child more time to consider future options" and, according to Dutch pioneers in treatment of childhood gender dysphoria, should not be initiated before breasts have begun to appear in a girl around ten to eleven years of age, and testes to increase in volume in a boy a year or so later. Distress at the appearance of early signs of puberty is reckoned to indicate likelihood of "persistence" with gender dysphoria, thus aiding diagnosis and the later decision to administer cross-sex hormones. Dysphoria through puberty is believed likely to persist.

There are problems in this process: the blocked child will be left behind by its developing peers and this, by itself, may provoke distress. For example, it will be shorter. More seriously, the blocked child will be asked to approve progression to Stage 2, as if it can comprehend its massive implications. Stage 2 may have irreversible effects on fertility in both sexes, and the ability to breast-feed in a female. Is a blocked and scripted child competent to see that far into the future? Do children ever think differently when their hormones have begun to flow? This

competence to understand the implications of treatment is known as Gillick Competence after the decision of an English court[34]. As it appears most children who start Stage 1 continue to Stage 2, the stakes are high for presumed Gillick Competence.

Stage 2: The administration of cross-sex hormones

Cross-sex hormone therapy means giving enough hormones of the opposite sex to evoke and sustain its characteristics. The hormones are given for life and must be monitored for side-effects including cardiovascular and thrombo-embolic disease, cancers of the opposite sex, and worsening of psychiatric disorder. By suppression of gonads, there is a slow process of chemical castration and the possibility of reproduction needs to be assisted by cryopreservation of ova and sperm.

According to international practice, cross-sex hormones may follow and then accompany blocking therapy, and be initiated around sixteen years of age. Some clinics, however, commence therapy as early as fourteen[35].

This "earlier" trend obeys a certain logic: if the parents have already transitioned the child "socially" and, if the child might be distressed by the early signs of puberty and, if delaying puberty is likely to cause its own stress, why wait for early signs of natural puberty? Why not block that natural puberty before it appears and go straight to cross-sex hormones? Affirmation therapy is creeping earlier despite recommendations of the Endocrine Society: "Given the high rate of remission [of gender dysphoria] after the onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children."[36]

Stage 3: Surgery

According to international guidelines, "sex realignment surgery" may be performed from eighteen years, though there are reports of it occurring earlier in private clinics[37]. Mastectomy, however, may be performed at a younger age if developing breasts increase dysphoria.

As the grandeur of realignment surgery may not be appreciated by a lay audience, it may be helpful to consider some details of the fate towards which children on

affirmation therapy are headed. There are various components and not all patients progress to the final package, but the project will usually include relatively simple surgical procedures of castration, removal or augmentation of breast tissue, reduction in the size of the Adam's apple, and alteration of body hair.

Construction of alternate genitals is another matter. These surgeries are difficult, often multi-staged, fraught with complications, and limited in outcome.

Creating ersatz female genitals is easiest: an orifice is created in the perineum, lined with skin from a filleted penis and, sometimes, deepened by transplanted bowel. The scrotum forms labia. The glans is grafted above the orifice and the urethral tube is shortened.

Creating male genitals is harder. One surgeon declared that "the task assumes nearly Herculean dimensions"[38] but this underestimates the ingenuity and range of objectives while exaggerating results. Hercules was always successful: creation of a penis is not. Some patients settle for a clitoris enlarged by male hormones. Others aspire to a penetrative organ, or at least one that can deliver urine when its owner is standing. In these cases, a shaft may be attempted from tissue grafted from thigh or even forearm and stiffened with a length of bone. Reversing the biblical account of the origin of females, bone from a woman's rib may now turn her into someone with a male phallus. A glans may be fashioned from a graft of inner-skin and the tube that delivers urine may be lined with mucous membranes from the mouth. The appearance of a scrotum may be achieved by creating a sac from the labia and inserting two artificial testicles.

Though techniques are improving with practice, complications are protean. Grafts may die, holes fill in, tubes obstruct, openings appear, bones protrude, bowels perforate and germs invade but, all in all, the result may be "aesthetically and functionally pleasing" to the recipient.

What does the law say in North America?

In California, in September 2012, a law was passed "to prohibit a mental health provider … from engaging in sexual orientation change efforts … with a patient under 18 years of age" which included "lesbian, gay, bisexual and transgender

youth". Such efforts included "efforts to change behaviours or gender expressions" which were deemed "unprofessional conduct and shall subject the provider to discipline". The Bill cited various national organisations of paediatricians, psychologists and psychiatrists which described such activities as conversion or reparative therapies.[39]

Similar laws have been enacted in New Jersey, Illinois, Oregon and Washington and, in 2015, in Ontario, Canada. Known as "anti-reparative" and "anti-conversion" laws, they oppose any attempts to re-orientate sexuality and to suppress gender identity and expression in order "to save children's lives".

In effect, Barack Obama has joined the affirmation team. Responding to a petition for banning "dangerous … conversion therapy" after a prominent suicide by a fifteen-year-old adolescent male who had sought to indentify as a female and allegedly underwent "conversion" therapy at his parents' church, the White House declared that the "Obama administration supports efforts" to ban conversion therapy for minors "because overwhelming evidence demonstrates" it "is neither medically nor ethically appropriate"[40].

It is hard to gauge the effect of the laws. No charges have yet been laid but many therapists uncommitted to active affirmation are now reported to be unwilling to care for transgender children because they do not want the worry of the medico-legal risk. The result of their withdrawal in the face of increasing public demand is that children and their parents are funnelled towards those willing to continue or initiate the stages of transition.

One definite result of activists' pressure and the expectation of the law in Ontario was the ultimate sacking of an international leader in management of gender dysphoria, Dr Kenneth Zucker (as discussed below) and the closure of his long-standing clinic in Toronto for allegedly practising "conversion" therapy. In turn, this sacking has brought immeasurable weight to the intimidatory effect of the law.

Ontario Bill 77 or the "Affirming Sexual Orientation and Gender Identity Act, 2015" was passed unanimously and in a "miraculously" short time according to its promoter, parliamentarian the Reverend Cheri DiNovo, who explained, "Bills may take up to years to pass but this one succeeded in only two months". According to

Wikipedia, DiNovo entered Parliament in March 2006, has been prominent in many issues including recognition of the Stalin-imposed famine on Ukraine as "genocide", has "passed most LGBTQ legislation in Canada", has conducted a weekly radio program, received literary awards, earned a masters degree in divinity and a doctorate in ministry from the University of Toronto, and has been a minister of the United Church since 1995. In 2001, she officiated over the first same-sex marriage in Canada[41]. Recitation of these educational achievements is relevant to some of the discussion we shared.

DiNovo is smart and at home in her conservative, stylish office in the Toronto parliament. Plainly, she could have been become the leader of her party had not ill-health intervened. Concisely, she declared the object of her law was not punitive but "instructional": to save children's lives, gender identity had to be affirmed. "Reparative or conversion" attempts should, therefore, be dissuaded and certainly not remunerated under the Health Insurance Act.

Moving to discussion of one of the clauses in the Act which declares the ban "does not apply if the person is capable with respect to the treatment and consents to the provision of the treatment", DiNovo was strangely unclear. I asked at what age a child would be deemed capable of consent to treatment. Up to what age would a child be incapable of consent and therefore at the mercy, as it were, of parents and affirmative therapists? DiNovo would not approximate, merely repeating, and now with many words, that the law was "instructional".

More disturbing was the response of this educated lady to my question as to why active, affirmative, transitioning therapy should be applied when most affected children were going to "grow out of it"? "I did not know that," she declared. I continued by presenting a book written by Dutch leaders in the field who attest to the majority desisting. She declared she had never heard of them! We went on to theological matters in which she declared her belief in the death and resurrection of Jesus Christ. I left perplexed. Could one so prominent not know most children would desist from transgender confusion? If she knew, could one so theological be so untruthful?

What does the law say in Australia?

In February 2017, a Health Complaints Act will become law in Victoria in which complaints may be raised against fraudulent and negligent practices which will include, according to Health Minister Jill Hennessy, "conversion" therapy. She explained that the Act will:

provide the means to deal with those who profit from the abhorrent practice of "gay conversion therapy" ... which inflicts significant emotional trauma and damages the mental health of young members of our community. This bill will enable the new Commissioner to investigate and crack down on anyone making dangerous and unproven claims that they can "convert" gay people.

Though she specified "gay people" and did not define age, Hennessy's attributed declaration—"any attempts to make people uncomfortable with their own sexuality is completely unacceptable"[42]—suggests a broad intent for the law, in line with North American legislation.

More intimidating than the American laws, the Victorian Act will transfer the onus of proof to the accused, who will need "reasonable excuse" to avoid investigation after a complaint has been laid. In response to whether presumption of guilt would contravene human rights, Hennessy (tortuously) explained:

The reverse onus is required in relation to these offences as the "reasonable excuse" exception relates to matters which are particularly within an accused's knowledge and introduce additional facts from the subject matter of the offence, which would be unduly onerous for a prosecution to investigate and disprove at first instance. Once the accused has pointed to evidence of a reasonable excuse, which they should have access to if the excuse is applicable, the burden shifts back to the prosecution who must prove the essential elements of the offence to a legal standard. I am of the view that there is a negligible risk that these provisions would allow an innocent person to be convicted of any of these offences. Accordingly, I am of the view that these offence provisions are compatible with the charter[43].

More broadly than Ontario Bill 77 which focuses on therapists receiving National Insurance funding, the Victorian Act will embrace any person or organisation beyond the classical health care providers that offer "general health services" to "maintain or improve … mental or psychological health or status". Given the

antagonism of transgender and other minority sexualities to the Christian church it can be prophesied that, sooner rather than later, a church leader advising "watchful waiting" of a transgender child will be asked for a "reasonable excuse". The apparent suicide of seventeen-year-old Leelah Alcorn in Ohio in 2014 unleashed ferocity against the parents who had sought help in their Christian church, allegedly forcing their transgender son to undergo conversion therapy. There is the possibility of a similar backlash against pastors in Australia.

By passing these Acts, it is surprising that politicians should be aligning themselves, at least by default, with only one form of management of a medical problem. By banning "conversion/reparative therapy", they promote affirmative therapy as the single option, despite the fact children will "grow out of it".

Their punitive bias is not shared by the highest of international organisations. The international Endocrine Society acknowledges a middle path between "complete social role change and hormone treatment" on the "affirmative" end of the spectrum and punitive attempts to dissuade on the other. Implying that the large majority will desist if parents are patient, the Society recommends children should not "be entirely denied to show cross-gender behaviours or should be punished for exhibiting such behaviours". Given politicians cannot be expected to have full understanding of therapies (even DiNovo claims she has never heard the other side), their commitment must be credited to the lobbying of activists.

Success for activists in Ontario

Transgender activists have had great success in Ontario. After sustained pressure and with Bill 77 in sight, a review was initiated of the management of child and adolescent gender dysphoria by Dr Kenneth Zucker and his colleagues at the Centre for Addiction and Mental Health (CAMH) in Toronto, who have been at the forefront of this discipline for almost four decades. The review was commissioned in February 2015, the law enacted in September, and Zucker and the unit were stood down in December. They were alleged to be performing "conversion-reparative" therapy and were presumed guilty because no evidence could be found that they were *not* practising in that way. In reality, Zucker was toppled and his unit closed because they were not practising affirmative therapy.

Bill 77 could not have been associated with the toppling of a therapist with greater standing. A psychologist, Zucker is Professor in the Department of Psychiatry at the University of Toronto and is internationally prominent in research, publications, experience and recognition since he began at CAMH in 1975. He has been the editor of *Archives of Sexual Behavior* since 2002, was a member of the American Psychological Association Task Force on Gender Identity, Gender Variance and Intersex Conditions in 2007 and, in 2008, Chair of the American Psychiatric Association Sexual and Gender Identity Disorders Work Group that developed DSM-5 from DSM-4 (on whose committee he had also served). Zucker was also a member of the committee that revised the standards of care of the World Professional Association for Transgender Health[44]. When he was dismissed, he had just been awarded a grant of close to a million dollars to study brain changes in gender-dysphoric adolescents receiving cross-sex hormones. Internationally, Zucker is almost unrivalled. Only the gender dysphoria clinic at the Vrije Universiteit Medical Center, in Amsterdam, has been as prominent as CAMH. Often, the two units have co-operated in research and publications.

For an Australian perspective on the dismissal of Zucker and his unit, consider a hypothetical sacking of the late cardiac surgeon Dr Victor Chang, and the closure of the Cardiac Unit at St Vincent's Hospital, Sydney.

Zucker was not available for discussion regarding how he and his clinic handled gender dysphoria but his concepts can be gleaned from his publications and statements attributed to him by his detractors. He described a Developmental, Biopsychosocial Model for treatment of gender dysphoria[45] based on the concept that gender identity was not "fixed" before birth but was "malleable" under the influences of external factors of varying strengths at varying stages of development. Biological factors would include innate chromosomal direction and the effects of antenatal hormones. Psychosocial factors would include attitudes and behaviour of siblings, parents, care-givers and other close associates. All the factors would combine to have particular relevance at varying ages. For example, a four-year-old girl might conclude she was a boy if she wore boys' clothing and played their games, because until seven years of age gender identity may be confused by "surface expression of gender behaviour".

Zucker and his colleagues argued that "co-occurring psychopathology" in the child and "psychodynamic mechanisms" in its family influenced gender identity, with the latter sometimes exerting an unrecognised "transfer of unresolved conflict and trauma-related experiences from parent to child". Examples include "a girl observing her mother as bullied may self-identify as a male, while a boy observing his mother as depressed may self-identify as a female because subconsciously he wants to help his mother". Conversely, "a mother with unresolved hostility toward men may encourage effeminacy in her son"[46].

Nevertheless, Zucker and his colleagues report that, despite external influences, most transgender children do not persist with that identity after puberty: only 12 per cent of transgender girls and 13.3 per cent of boys. They report:

It has been our experience that a sizable number of children and their families achieve a great deal of change. In these cases, the [gender dysphoria] resolves fully, and nothing in the children's behaviour or fantasy suggest that the gender identity issues remain problematic … All things considered, we take the position that in such cases a clinician should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity.[47]

Perhaps even more disturbing to transgender activists was Zucker's opinion that parents might be permitted to influence orientation of the child towards its natal gender. Declarations by Zucker that "if the parents are clear in their desire to have their child feel more comfortable in their own skin … [and] would like to reduce their child's desire to be of the other gender, the therapeutic approach is organised around this goal"[48] became nails in his cross.

CAMH therapy included "open-ended play" to explore "underlying mechanisms" for which "surface behaviours" of gender dysphoria are symptoms, and "which can best be helped" if the reasons are understood. Limitations would be set on cross-sex play and dressing. For example, a boy might be permitted to wear at the home but persuaded against wearing them on trips to the mall. Same-sex "peer relationships" would be encouraged because they are "often the site of gender identity consolidation". If the boy in question did not like "rough and tumble" play, less physical peers might be sought.

Zucker's management of childhood dysphoria might be summarised as "minimise stress and maximise comfort" in natal sex, in the expectation most will grow out of it. He fears labelling a child is part of "conditioning" to transgender from which return is more difficult. He cautioned parents to:

resist too much accommodation from [a child's] teachers. Don't let the school make him a poster child … don't let them parade him around for pink assemblies. This is his personal journey and we don't know where it is going to end up.[49]

The latter advice is relevant for Australia. A spokesperson for the New South Wales Education Department has reported, "We have a four year old who is transitioning to kindergarten next year who has identified as transgender."[50]

Zucker and his colleagues report that a number of children who "persist" with transgender identity emerge from puberty as homosexuals. They insist, "We have never advocated for the prevention of homosexuality as a treatment goal for [gender dysphoria] in children" and explain to parents, "it will be their job and ours to support the child" whatever the future holds. Some children would desist from gender dysphoria to emerge as bisexual or homosexual. Some would persist with transgender identity and pursue the pathway of hormonal and surgical intervention, but Zucker concludes this to be the least favourable option because "growing up transsexual or transgender may augur a more complicated life".

Though not anti-gay, and involved in positive transitioning of adolescents to the opposite gender if transgender appeared inevitable, Zucker became Enemy Number One for transgender activists[51]. Their pressure and Bill 77 resulted in Zucker and his unit being dismissed for not being "in step with the latest thinking".[52] Over 500 colleagues expressed their dismay in a petition of protest which cited Zucker's contribution to science and medical care. The signatories warned "any clinical researcher who considers working at CAMH: in the event of a conflict with activists for a fashionable cause, CAMH might well sacrifice them [and their patients] for some real or imagined local political gain".

What do the courts say in Australia?

Decisions of Australian courts have kept pace with the exponential phenomenon of gender dysphoria. As recently as 1992, in Marion's case, the High Court declared that sterilisation of a fourteen-year-old mentally retarded girl, incompetent to decide for herself, needed the court's approval as a safeguard because there was a significant risk of making the wrong decision regarding an intervention that was "non-therapeutic, irreversible, invasive and associated with grave consequences"; sterilisation should only be performed "as a last resort"[53]. This conservative attitude was confirmed by the Family Court in 2004 in *Re Alex*[54] which determined that drug administration to effect transition to the opposite gender in the thirteen-year-old natal girl was a "special medical procedure" associated with "significant risks" of reversible and irreversible nature, and required the court's authorisation.

In 2013, in *Re Lucy* [55] , the court relinquished authority over Stage 1 therapy, determining it could be "appropriate" for "preventing, removing or ameliorating … a psychiatric disorder" associated with gender dysphoria. Therefore, departmental guardians (and by inference, parents) could give consent to this therapy on behalf of the thirteen-year-old natal female who was competent to give informed consent with regard to transitioning to a male.

In that case, presiding Justice Murphy laid instructional ground by repeating with emphases the statement of an involved physician that:

It is important to state that the natural course of Gender Dysphoria, untreated, is that psychological stress increases over time, as the person becomes more and more disillusioned with their morphology which does not match their mindset of their assumed appropriate gender. Untreated Gender Dysphoria invariably progresses to immense disillusionment and then, to chronic depression which can often progress to major depression with significant suicidal risk.

In both *Re Lucy* and the following *Re Sam and Terry* [56] cases the courts, however, determined their authorisation was needed for implementation of Stage 2 therapy because of the permanence of effects. Deliberation in *Re Sam and Terry* emphasised the necessary protective authority of the court for two unrelated sixteen-year-olds who were both "Gillick incompetent".

In 2013, in *Re Jamie*[57] the Full Court determined court authorisation would be needed for Stage 2 therapy if a child was Gillick incompetent but, if competent, a child could consent to Stage 2 therapy without the need for authorisation. The court declared, however, that a child's competence needed to be decided by the court "even where parents and treating doctors agree". These principles were confirmed in *Re Shane* later that year[58].

In July this year, in *Re Quinn* [59], the Family Court extended its permission beyond the drug components of Stage 2 into the irreversible surgical components of Grade 3 by approving bilateral mastectomies in a fifteen-year-old natal female committed to male gender. Even more significantly, the court gave its authority despite the adolescent being Gillick incompetent because of associated Asperger syndrome.

Concerns with this symbiotic progress of courts and proponents of affirmation include:

The instructional declaration by Justice Murphy that untreated gender dysphoria *invariably* progresses to *immense* disillusion is not based on evidence.

Should courts be informed by only those committed to activist therapy?

Should courts rely on statements from a small group already involved with the transition of the patient? Is there no possibility of conflict of interest?

How can Gillick competence regarding future reproductive intent be assumed in an adolescent maintained in a pre-pubertal state? Do adolescents ever think differently when their own hormones flow?

How can irreversible, destructive surgery be permitted on an adolescent judged incompetent to understand the implications? Where is the line between transgender surgery and that for Body Identity Disorder in which the sufferer demands transformation of the physical state to satisfy the mental: for example, the removal of a normal leg in the false belief it is gangrenous?

The not-so-slow march of gender dysphoria through the judicial, medical and political institutions shows little evidence of obstruction. When will any authorisation by the court be declared unnecessary?

Obligation to consult the court rankles activists who consider it: “an expensive, time consuming and ultimately unnecessary intrusion into the complex decision making between the patient, their [*sic*] parents and the treating medical team [and] a form of institutional discrimination”. The intervention of the court is considered unnecessary by leaders of the gender dysphoria clinic at the Royal Children’s Hospital, Melbourne, because it “almost exclusively” relies on reports from the treating team regarding its client’s competence[60]. They declare change is “urgently” needed given the “increasing acceptance of gender diversity being fuelled by social media and popular culture”. They urge “equitable access” to all chemical blocking and cross-sex hormones and Medicare funding for “gender affirmation surgery”.

Conclusion

The phenomenon of childhood gender dysphoria is exponential. Hundreds of children and their parents are reported to be consulting special clinics in Australia each year. How many undertake transitioning is unknown but the media provides regular confirmation, as do unofficial reports from schools. I attended Fort Street Boys’ High, where at a recent reunion two current student leaders proclaimed the year’s success to be the wearing of a dress to school by a boy, every day including graduation. A teacher from a school near my home reports five children to be undergoing transition.

Yet hardly any paediatricians recall any cases of gender dysphoria in almost 300 cumulative years of practice. Certainly, I have not seen one in fifty years of medicine. I accept cases must exist and consider them tragedies deserving as much compassion and medical care as the three cases of physical intersex I have encountered in my career.

What astonishes me is the lack of evidence to support massive medical intervention in the face of evidence that it is not necessary. I cannot help wonder how the intervention was approved by the various ethics committees in hospitals, health regions and universities when it took some students and me over a year to get approval for a study that merely asked mothers when they introduced solid foods to their children. Ultimately, I had to give my personal phone number to all respondents of the questionnaire lest someone suffer anxiety in the middle of the night.

It is less astonishing these days that laws should be passed to ensure compliance with activists' wishes. My generation has read the books of George Orwell, and observed the imposition of utopian ideas. Orwell would appreciate many aspects of the phenomenon of gender dysphoria. In *Nineteen Eighty-Four* obedience was ensured by the watchfulness of Big Brother, whose intimidation continues.

In fifty years of medicine, I have not witnessed such reluctance to express an opinion among my colleagues. For this article, I conducted a straw poll of paediatricians whom I know. Many advised me to be very careful, to appear neutral, and not to quote them despite their strong concerns about the current "fad", hence my reference to anonymous therapists. One warned I should be prepared for him to "deny me thrice". When I reminded him that Peter went on to become a martyred follower of Jesus, there was no reply.

My motivation for writing an article is that of another physician, a leading endocrinologist, who declares evidence for intervention in gender dysphoria is "utterly arbitrary", and his great fear that mistakes would be made in consigning children to transition. I share those fears.

Lastly, I confess a family conundrum. I have a four-year-old grand-daughter who insistently, persistently and consistently declares she is a shark. Worse, she declares her name is "Bruce the Shark". Reference to DSM-5 dismays: she plays with model sharks, dresses in shark motifs, wears a shark headdress, will take herself to the corner to await fish, loves to sit before the shark ponds in aquaria and thrills to caress their tails in special ponds for children at SeaWorld in California. Not above deriving some benefit from the tragedy, her father coaxes her to finish her meals by suggesting she "eat her fish". But, dejected, he seeks my private advice: "When should we deliver her to the aquarium?"

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