



THE GENDER FRAMEWORK

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Developing the Gender Framework

Position Statement

We believe that there are many routes that may lead to the development of distress over an individual's gender. Equally, there are just as many routes out of such distress.

We believe that gender and identity affect many people in different ways, and as such we need to listen and incorporate ideas and opinions from a wide range of disciplines. This means that we value the individual within a societal context. We do not privilege one ideological position above another, although the authors of each section had the autonomy to present criticism of ideological positions in their submissions.

We are informed by the latest knowledge in this field while acknowledging that we do not know what we do not know, and that political conflicts have shaped the research and discourse in this area.

Who is the Gender Framework for?

Lay people and professionals from every realm, including, but not limited to, teachers, parents, journalists, healthcare professionals, lawyers, policymakers, and anyone who has an interest in gender and identity issues.

This document has been conceived with settings in North America, Europe, and Australasia in mind. We hope the content will be helpful to those in other settings, but our author team has the most experience and expertise in these regions.

The journey so far

Following our conference held in Killarney, Ireland in April 2023, Genspect recognized the need to address the fact that the guidelines currently available for those thinking about gender and identity and gender-related distress were all rooted in a medical approach. We felt that the time had come to offer an entirely different conception of the challenges in this area. The Genspect leadership team recruited authors with expertise in a range of areas to draft the following sections: Contextual Background, The Psychology of Gender Dysphoria, Families and Education, Society, and Law and Policy. The authors submitted their initial drafts in August and September 2023. The authors and editorial team then engaged in a process of refining these drafts, including a process of fact-checking and review of references. Prior to publication at our Denver conference, a methodologist reviewed our plan of work and provided advice about methods going forward. Most, though not all, contributors and individuals accountable

for the final editorial decisions have been identified. We are actively working to ensure that every contributor submits a declaration of interests, and this information will soon be accessible on the Genspect website for public transparency.

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Introduction

Who we are

In 2021, Genspect was formed as a coalition of parent and professional groups, united in concern about the inappropriate social and medical transitioning of young people questioning their gender. These parents, and their allies, did not believe that their children’s complex social and mental health challenges would be resolved by social transition, hormones and surgeries—and that it was these complex challenges themselves which were causing kids to take flight from their authentic selves.

Genspect continues to give voice to this cohort of well-informed, engaged, compassionate parents and professionals, highlighting their concerns in the media and political spaces; yet we have also expanded during our short existence, garnering the support of detransitioned individuals who believe they received inadequate healthcare; transgender people who share our worries about over-medicalization and the influence of queer theory; teachers concerned about what they believe to be the rise of education policies and curricula that are underpinned by beliefs rather than facts; clinicians and researchers seeking to raise awareness of the low-quality evidence base for medical transition; gay rights and women’s rights campaigners; politicians and journalists; and, more broadly, members of the public who see a need for a radically different voice on this topic.

We have expanded our mission from being a voice for parents to offering a healthy approach to sex and gender. We unite left, center and right; religious, agnostic and atheist; male and female; straight, bi and gay; trans and detrans, and, as an international organization, represent members from dozens of countries across the world.

Why we created the Gender Framework—a vision for change

Genspect’s work with gender-distressed and gender-questioning individuals, their families, and professionals has led us to an understanding of gender that points away from medicalized approaches to gender distress and identity, and toward social, psychological and cultural solutions to the difficulties we are facing today. Our vision is to move beyond a medical understanding of gender identity and gender distress that typically leads to invasive medical interventions, and toward a deeper understanding of gender and identity. We recognize these are psychosocial and cultural phenomena, and that gender distress is often an individual’s response to biological, psychological and sociocultural factors. Hearing the rising tide of voices of detransitioners, desisters, disillusioned professionals, worried parents and many others around the world, it is clear

to us that a medicalized approach to identity and gender has produced significant harm, and continues to do so, both at the level of the individual and in wider society. We recognize and accept that some adults may choose to take a medicalized approach to dealing with their gender distress or identity, and we feel they should be free to do so. Our intention in this document is to lay out an alternative approach to the complex issues that gender presents, leaving aside the narrow, clinical model and opening out the discussion toward a holistic understanding of gender and identity.

Who is this document for?

This document is for anyone who is seeking a deeper understanding of gender and identity and looking for a new and different conceptual framework. It is for people questioning gender for themselves, parents, families, teachers, therapists, journalists, professionals in health and social care, policy makers, politicians, academics, and social commentators.

It is for anyone who has ever wondered whether there might be another way forward on gender.

Where did this document come from?

The Gender Framework was conceived and authored by the Genspect think tank, known as the Killarney Group. This team of authors, from diverse professional backgrounds, contributed their expertise to explore various aspects of gender identity, including the thorny and disputed questions that many communities face on these issues. Details about the authors and their declarations of interest can be found on the Genspect website. This preliminary version has been edited and fact-checked by our editorial team. It is a draft version that is subject to review and public consultation.

We wanted to move away from a medicalized approach, and therefore we have not used the structured methodology that might be found in clinical guidelines. This framework is not a guideline and does not set out to make recommendations on the use of (or withholding of) interventions. Instead, we are offering a different conceptual framework that we hope will be useful in many contexts.

The Gender Framework represents the opinions of our team of experts, drawing on their combined decades of experience in this area. We do not offer a systematic or structured review of the evidence on any question we cover. Rather, we have sought to substantiate our views and ideas using the best evidence we can find, in the knowledge that even the production and publication of good quality research in this area is highly contentious with many questions still unanswered.

Our journey together

This preliminary version is a starting point and an invitation to think differently. We are embarking on a process that will continue over the following year, with the aim of presenting a completed Version One of the Gender Framework at our conference in Lisbon in September 2024. This process will involve consultation with key stakeholders to revise and improve our work, and an external review of the document by independent experts. We intend Version One to be a completed policy document for use in multiple contexts.

Section One: Contextual Background

1.1 Sex and the body

Few topics command more human interest than sex. It is a subject of art, literature, comedy, and a major driving force behind human interactions. From an evolutionary perspective, this fascination and preoccupation is unsurprising. Organisms that were indifferent to sex, or actively shied away from it, would have left fewer descendants than those who pursued it with vigor. Therefore, it is no accident that a deep-rooted interest in sex is ingrained in our genes.

However, this obsession with sex is not unique to humans. The natural world teems with astonishing examples of physical traits and behaviors that animals and plants have evolved to optimize reproductive success. From intricate mating displays and perilous mass migrations to the vibrant hues and enticing scents of flowering plants, and even the fierce, sometimes lethal competition among males for females. These are just a few of the countless manifestations. In essence, nature's obsession with sex is clear and pervasive. From the tiniest insects to the largest mammals, from the most delicate flowers to the grandest trees, the drive to reproduce shapes behaviors, appearances, and entire ecosystems. It is a testament to reproduction's fundamental importance in life's grand tapestry.

Given the vital importance of sex in the natural world, it has been a primary focus of scientific inquiry from the start. Technological advancements, like the invention of the microscope, have revealed the core components of sexual reproduction. The discovery of genetic inheritance has further provided deep insight into the mechanisms and selection pressures that have favored sex and the evolution of males and females.

1.1.1 Sex basics

This discussion will primarily focus on humans, referencing other species only to clarify broader points. However, before delving deeper, clarifying some fundamental terms and concepts is crucial. These will form the foundation for this segment and the overarching Gender Framework. Specifically, what sex is, why sex is, and what sexes (i.e., males and females) are, will briefly be covered. After establishing these basics, we will address some widespread and influential misconceptions about the biology of sex, which, at best, lead to profound confusion and, at worst, cause considerable harm.

1.1.1.1 What is sex?

The term "sex" is often used as shorthand for the phenomenon of *sexual reproduction*: the process where two parents each contribute half of their genetic material—carried on *chromosomes*—to produce a new, genetically unique offspring (Bachtrog et al., 2014). The mixing of genetic material from each parent (and thus, the beginning of a

new individual) is achieved in a process called *fertilization*, which is the fusion of two specialized cells called *gametes*. Gametes are a unique cell type within sexually-reproducing species and the function of the gamete within any individual is singular; to affect sexual reproduction (Togashi & Cox, 2011).

1.1.1.2 Why is sex?

Sexual reproduction is biologically costly for individuals. For instance, seeking a mate requires energy, and leaving one's refuge risks exposure to predators. The act of mating itself also introduces the risk of contracting parasites and sexually transmitted diseases. Furthermore, perhaps the largest cost from an evolutionary perspective arises from the fact that half of one's offspring will be males who cannot themselves bear offspring (Maynard-Smith, 1978).

Considering these challenges, one might wonder why sexual reproduction prevails, especially when comparing it to the more direct and seemingly safer approach of asexual reproduction, where organisms create genetic clones of themselves. This prevalence of sexual reproduction in evolutionary biology is so puzzling that it has been dubbed the "queen of problems in evolutionary biology" (Bell, 1982). The fact that almost all complex species, even those with alternative reproduction methods, engage in sexual reproduction indicates a strong evolutionary benefit for mixing of genetic material in the next generation. These advantages include the accumulation of favorable genetic mutations and elimination of harmful ones, ensuring adaptability to changing environments (Fisher, 1930; Muller, 1932), keeping pace with co-evolving species (van Valen, 1973), and preventing harmful genetic mutations from accumulating within a population over many generations (Muller, 1964; Kondrashov, 1988).

The mechanisms that favor the evolution of sexual reproduction remain an area of ongoing research, but the near ubiquity of sexual reproduction among complex life indicates that the benefits of sexual reproduction far exceed its costs.

1.1.1.3 What are sexes?

As mentioned above, all sexually reproducing species produce offspring by combining gametes from two parents in a process called fertilization. However, sexually reproducing species come in two forms, and the distinction is rooted in the relative size of the gametes being fused (Togashi & Cox, 2011). Some species are **isogamous**, which means they reproduce by the fusion of two gametes that are of *equal size*. Other species are *anisogamous*, meaning sexual reproduction proceeds by the fusion of two *different sized* gametes. In anisogamous systems, the larger gamete is called an egg or ovum, and the smaller gamete is called a sperm or spermatozoon.

The sexes, male and female, represent these two distinct reproductive roles in anisogamous species. *Males* are defined as the sex that produces numerous small gametes, or sperm. *Females*, conversely, are defined as the sex that yields fewer but

larger gametes, or ova (Parker, 2011). Consequently, we categorize individuals as males and females based on the type of gamete (sperm or ova) they can or are expected to produce. Since there are only two types of sex cells in anisogamous systems—sperm and ovum—there are only two sexes. This binary division between sperm and ovum forms the crux of biologists' reference to sex as a "binary."

The modeling of evolutionary scenarios, as reviewed in Lehtonen and Parker (2014), indicates that a binary system of gametes is optimal; that is, large gametes and small gametes, with gamete fusion occurring only between one small and one large gamete (not small-small or large-large fusions). The female egg's larger volume provides the developing embryo with nutrition and all essential cellular components. In contrast, the male's sperm typically limits its contribution to offspring to providing chromosomes, and often becomes specialized for mobility to better reach female gametes. Sperm, given their low cost to create, are also produced in larger quantities than eggs to increase the likelihood of encountering a female gamete and to outnumber the sperm from rival males (Lehtonen & Parker, 2014).

1.1.2 Addressing common sex myths

Over the past decade, an influential movement has emerged that seeks to undermine our fundamental understanding of sex. Under the banner of "transgender rights," this movement alleges that the binary concept of sex is outdated and inherently oppressive and invalidating of transgender identities and experiences. This perspective has given rise to a genre of discourse—spread through social media and appearing in prominent news outlets and scientific journals—falsely asserting that a new scientific consensus on the biology of sex has been established.

Denials of male and female as concrete biological categories, however, is not entirely new. In her 1990 book, *Gender Trouble*, philosopher Judith Butler famously floated the idea that the distinctions of male and female lacked a solid biological foundation, asserting they were "as culturally constructed as gender" (Butler, 1990). Similarly, in 1993, sexologist Anne Fausto-Sterling authored a paper titled "The Five Sexes: Why Male and Female Are Not Enough" (Fausto-Sterling, 1993). Fausto-Sterling contended that the "two-party sexual system" in humans was "in defiance of nature," and that there were instead "at least five sex categories, and perhaps even more."

Contemporary political battles, however, have breathed new life into these old ideas. In 2018, Fausto-Sterling published an essay in the *New York Times* titled "Why Sex Is Not Binary," which argued that "Two sexes have never been enough to describe human variety." The once-respected popular science magazine *Scientific American* has also joined ranks in spreading disinformation about sex. In 2017, they featured an article by Amanda Montañez titled "Visualizing Sex as a Spectrum" with a misleading chart depicting "biological sex as a non-binary attribute" (Montañez, 2017). In 2023, an article by Princeton anthropologist Agustin Fuentes titled "Here's Why Human Sex Is Not

Binary” argued that the idea that “human sex rests on a biological binary of making either sperm or ova” is “bad science,” and that “the production of gametes does not sufficiently describe sex biology in animals” (Fuentes, 2023).

Regrettably, even scientific journals have been unable to avoid publishing sex pseudoscience. In 2015, *Nature*, considered by many to be the most prestigious scientific journal in the world, published an article titled “Sex Redefined” (Ainsworth, 2015). Its subtitle read, “The idea of two sexes is simplistic. Biologists now think there is a wider spectrum than that.” The author, Claire Ainsworth, rejected the sex binary and claimed that biologists “have been building a more nuanced view of sex, but society has yet to catch up.” Another *Nature* editorial in 2018 made the shocking claim that attempts to classify an individual’s sex using any combination of anatomy and genetics “has no basis in science” and that “the research and medical community now sees sex as more complex than male and female” (Editorial, 2018).

These examples are but a small sample of the sex denialism being published in popular newspapers and respected science journals. More are published every week. All the arguments presented in these papers that aim to debunk the sex binary demonstrate a deep misunderstanding of the fundamental property shared by all males and all females across the plant and animal kingdoms: the type of gamete they have the function of producing.

The arguments that activists employ to undermine the sex binary are numerous, but essentially fall into two categories: those that aim to increase the number of recognized sexes beyond two, and those that seek to eliminate sex categories altogether in favor of viewing sex as varying degrees of maleness and femaleness on a continuous spectrum.

1.1.2.1 Are there more than two sexes?

When biologists speak of the sex binary, they are referring to the clear distinction between sperm and ova—the universal differentiators between males and females (Parker, 2011). However, some activists and their scientific allies misconstrue, whether intentionally or due to misunderstanding, the sex binary as a distinction based solely on having either XX or XY sex chromosomes.

This misconception harks back to basic biology lessons from grade school, where many were taught that chromosomes determine sex: XX denotes female, and XY signifies male. This perspective is straightforward and appears binary. After establishing this false foundation, activists will then proceed to debunk this framework by referencing what are called *sex-chromosome aneuploidies*. These are cases where an individual might have an extra or missing X or Y chromosome, as seen in conditions like Klinefelter (XXY) and Turner (X0) syndrome, among others. They then question, how can sex be strictly binary and based solely on chromosomes if combinations beyond XX and XY exist. They may further underscore their argument with instances

of XX males or females with Y chromosomes, as proof that chromosomes do not determine an individual's sex.

However, chromosomal combinations beyond the common XX and XY do not denote additional sexes beyond male and female. Instead, they signify chromosomal variations *within* the two sexes. Moreover, the argument that the existence of XX males and females with a Y chromosome disproves the idea that chromosomes determine sex misunderstands the distinction between how sex is *determined* and how it is *defined* for an individual.

In developmental biology, "sex determination" is a precise term that describes the process by which specific genes initiate and guide sex development (Bachtrog et al., 2014). Mammals, including humans, exhibit *chromosomal sex determination*. Here, certain genes on chromosomes direct the development of males and females. The Y chromosome is deemed "sex determining" because it typically contains the *SRY* gene that initiates male development (Goodfellow & Lovell-Badge, 1993). Without it, a female develops. However, in very rare cases, an *SRY* gene can migrate to an X chromosome, leading to an XX male (Ergun-Longmire et al., 2005).

This mechanism differs from sex-determining methods in other organisms that do not depend on chromosomes. An example is the *temperature-dependent sex determination* found in many reptiles (Crews et al., 1994). Here, an egg's incubation temperature dictates male or female development. For the alligator species *A. mississippiensis*, eggs incubated at higher temperatures (>34°C) yield males, while those at lower temperatures (<30°C) result in females (Lang & Andrews, 1994).

Other mechanisms for determining sex include environmental and social influences. For instance, the green spoon worm (*Bonellia viridis*) begins its life sexually undifferentiated. It will develop into a male if the larva encounters female chemical cues; otherwise, it becomes a female (Berec et al., 2005). Clownfish, on the other hand, initially emerge as males but undergo an irreversible change to females once they ascend to the pinnacle of their dominance hierarchy to gain access to an anemone (Casas et al., 2016).

These examples illustrate that sex determination mechanisms are incredibly varied. However, it is crucial to note that although an individual's sex across a diverse array of species can be mechanistically *determined* in numerous ways through development, it is always *defined* the same way: by the type of gamete he or she has the function of producing.

This should be self-evident when we consider the foundational role of gametes in sex identification. Without a prior understanding that males produce sperm and females produce ova, we would not have been able to associate characteristics like Y chromosomes in mammals or high incubation temperatures in reptiles with being male.

Similarly, associations of XX chromosomes in mammals, ZW chromosomes in birds, and low incubation temperatures in reptiles with being female would have been impossible to discern. Our understanding of the universal roles of males and females *necessarily* preceded the discovery of the various mechanisms that produce them across species.

Another argument we will briefly address asserting the existence of more than two sexes pertains to the distinction between “mating types” and “sexes.” Understanding the difference is critical, as confusing the two can lead to misinformed articles like the one in *Discover Magazine* in 2018 titled, “Why This Fungus Has Over 20,000 Sexes” (Scharping, 2018), or the 2016 *Forbes* piece about a cellular slime mold dubbed “The Blob” that purportedly “has almost 720 sexes” (GrrlScientist, 2019).

The core mistake in these headlines is equating “mating types” with “sexes” when they represent different concepts in distinct systems. As discussed earlier, sexually reproducing species fall into two primary categories: isogamous and anisogamous. Isogamous species reproduce by merging gametes of the same size, while anisogamous species do so by joining gametes of varying sizes. However, even though isogamous species produce same-sized gametes, not all these gametes can pair up for reproduction. These varying isogamous gametes, based on compatibility, are termed “mating types” (Geng et al., 2014). Conversely, the term “sexes” refers to the differently-sized gametes in anisogamous species. Simply put, isogamous species can have mating types, often denoted by numbers, letters, or plus (+) and minus (-) signs. Anisogamous species have sexes, termed male and female based on the gamete’s size—small or large, respectively.

Given this distinction, the species of fungi (*Schizophyllum commune*) mentioned in the *Discover Magazine* article is isogamous; thus, the 20,000 so-called “sexes” are, in fact, mating types. The same applies to the 720 “sexes” of “The Blob” slime mold (*Physarum polycephalum*) highlighted in *Forbes*.

This error is simple to identify as there are only two sexes: male and female. Therefore, when one encounters articles claiming certain fungi, slime molds, or other microorganisms have a staggering number of sexes, they are invariably discussing mating types, not sexes.

While there are more arguments claiming there are more than two sexes, the two covered above concerning sex chromosomes and confusion over the distinction between sexes and mating types are by far the most common.

1.1.2.2 Is sex a spectrum?

While claims of there being “more than two sexes” (see section 1.1.2.1) are not uncommon, the assertion most frequently encountered against the binary nature of sex is that “sex is a spectrum.” According to this perspective, “male” and “female” are not

distinct biological categories. Instead, they represent two extremes that people can only ever statistically approximate. Advocates of the sex spectrum model tend to describe people in terms of varying degrees of maleness and femaleness, rather than strictly as males or females.

Two primary arguments are often forwarded to support the idea that sex is a non-binary attribute existing on a spectrum. The first revolves around the existence of disorders/differences in sex development (DSDs), also known as intersex, where individuals possess primary sexual anatomy that appears neither typically male nor female. This argument posits that there cannot be only two sexes if some people have genitals that do not clearly align with typical males or females. This perspective is often reinforced with visuals that plot intersex conditions along a continuum ranging from “typical female” to “typical male,” such as the one in the 2017 *Scientific American* article titled “Visualizing Sex as a Spectrum” (Montañez, 2017).

The second argument in defense of the sex-spectrum model focuses on secondary sex characteristics, which are the sex-related anatomies that differentiate during puberty. Since these traits exhibit some overlap between males and females, it is argued that we view biological sex as a continuum. We will examine these two arguments sequentially, beginning with the perspective on intersex conditions.

Those who mention intersex conditions as proof that sex is a spectrum insist that the existence of a tiny percentage of people with these conditions means that everyone is *somewhat* ambiguous. The science historian Alice Dreger makes this claim explicitly in her 2000 book *Hermaphrodites and the Medical Invention of Sex* (Dreger, 2000). Dreger, who refers to intersex people as “hermaphrodites,” says (emphasis added):

Hermaphroditism causes a great deal of confusion, more than one might at first appreciate, because—as we will see again and again—the discovery of a “hermaphroditic” body raises doubts not just about the particular body in question, but about all bodies. The questioned body forces us to ask what exactly it is—if anything—that makes the rest of us unquestionable. (p.6)

This desire to extrapolate a small blur at a boundary to the entire picture is rooted in the postmodern impulse to “queer,” thereby eliminating natural categories. In the queer-theory worldview, categories are themselves oppressive, and human liberation requires the “troubling” of categories (to borrow Judith Butler’s term), including those of sex. Yet Dreger’s account does not accurately describe biological reality. The existence of “questionable” cases with respect to sex classification does not automatically cast a degree of doubt onto everyone’s sex. For most people, their sex is clear.

The existence of intersex conditions has no bearing whatsoever on the binary nature of sex. This is because the binary nature of sex does not entail that every human

throughout history can be unambiguously categorized as male or female. Rather, it refers to the fact that considering the presence of only two gamete types (sperm and ova), there are only two sexes. Sexual ambiguity is not a third or intermediate sex because people with intersex conditions do not have anatomy that can or would produce a new or intermediate type of gamete.

The second argument typically offered in defense of the sex-spectrum model centers around secondary sex characteristics. As mentioned earlier, these refer to the sex-related anatomies that differentiate during puberty such as enlarged breasts and wider hips in females, and facial hair, deeper voices, more musculature, and broader shoulders in males. Given that the distribution of these secondary sex characteristics can overlap between males and females, it is argued we should, therefore, view biological sex as a continuum.

The primary flaw in defining a person's sex in reference to their secondary sex characteristics is that it confuses cause and effect. These traits—while plain to the eye, and inseparable from the way most laypeople think about men and women—do not actually define one's biological sex. Rather, these traits typically develop because of one's sex, via differences in the hormonal milieu produced during puberty by either male testes or female ovaries.

This portrayal of sex is not only scientifically inaccurate but also socially regressive. This is because it relies on sexist ideals and stereotypes to define males and females. If sex is a spectrum defined in relation to secondary sex characteristics, it follows that tall males with thick beards, deep voices, and large penises are “more” male than short males who answer to the opposite description. Likewise, females with larger breasts, a more “feminine” waist-to-hip ratio, and less body hair would be considered “more” female than small-breasted, less curvy, hairier females.

The mere fact that these *sex-related traits* exhibit some overlap between the sexes does not mean that *sex itself* exhibits overlap. Regardless of the degree of overlap in these secondary sex traits, there are still only males and females.

1.1.2.3 Is sex a ‘multivariate’ trait occurring at different ‘levels’?

An argument gaining popularity among activists that has managed to find refuge in several scientific journals seeks to redefine sex as a trait that exists as a spectrum operating at multiple “levels,” including sex chromosomes, internal sexual anatomy, genitals, secondary sexual characteristics, hormone profiles, behavior, and even a person's “gender identity” or “brain sex.” In this view, rather than classifying people in binary terms as being either male or female, we are asked to specify which trait or “level” of sex we are referring to.

This view of sex was made explicit in a 2023 paper in *Integrative & Comparative Biology*, a journal owned by Oxford University Press. The paper, titled “Multivariate Models of

Animal Sex: Breaking Binaries Leads to a Better Understanding of Ecology and Evolution,” argues that sex is best viewed as “a constructed category operating at multiple biological levels” rather than bimodal or binary (McLaughlin et al., 2023).

As a categorical term, “sex” is often semantically flattened into a binary, univariate model, for which individuals are classified as either “female” or “male” in gonochoristic species (i.e., an individual produces one type of gamete throughout its lifespan). A more expansive definition of sex is bimodal—with most individuals falling within one of two peaks of a trait distribution. However, even a bimodal, univariate model is an oversimplification, since “sex” comprises multiple genetic and phenotypic traits, with variable distributions. Individuals may possess different combinations of chromosome type, gamete size, hormone level, morphology, and behavioral roles, which do not always align or persist across an organism’s lifespan. Reliance on strict binary categories of sex fails to accurately capture the diverse and nuanced nature of sex (McLaughlin et al., 2023, p.892).

The paper dedicates four sections to each of the four alleged “levels” of biological sex: genetic, endocrine, morphological, and behavioral. However, there is a conspicuous absence of a section on gametes, the true universal trait that defines and distinguishes males and females in all anisogamous species.

Like many of the other arguments attempting to undermine the binary nature of sex, the multivariate model fails to differentiate between the causes and consequences of sex with sex itself. Genetics, for instance, guide an embryo’s development into becoming male or female, but genes are not equivalent to sex. Likewise, while hormones, morphology, and behavior are *influenced* by an individual’s sex, they do not define it.

Furthermore, the multivariate model of sex is self-refuting because it necessarily presupposes the primacy of gametes in defining an individual’s sex. For instance, we could only associate XX and XY chromosome profiles with females and males, respectively, if we had prior knowledge of what males and females were to identify the correlation. We could not link testosterone with males, or estrogen with females, without a prior understanding of what constitutes males and females apart from these hormones. Additionally, we could not determine which behaviors correspond to males or females, or identify fascinating exceptions to the rule, without first anchoring sex to a trait distinct from these behaviors—namely, gametes.

Despite the authors’ aim to downplay the centrality of gametes as the defining characteristic of sexes in favor of a multi-level or “multivariate” model, the paper’s dependence on gametes to make sense of their correlations refutes its foundational premise and conclusions.

This confused notion of sex is championed by proponents of “gender-affirming care.” This is based on the idea that different “levels” of an individual’s sex might be misaligned and could, in theory, be reconciled through various interventions. For example, the belief that a person who identifies as transgender has a physical sex that differs from their “brain sex” (i.e., their “gender identity”). The aim of gender-affirming care is thus to hormonally or surgically modify a person’s sex-related anatomy to align their physical sex with their brain sex.

This, however, is futile because a person’s sex cannot be changed. Furthermore, there is nothing misaligned or requiring “correction” in people with sex-atypical bodies or behavior. Such variations are completely natural and should neither be pathologized nor medicalized.

1.1.3 ‘Gender’ is a spectrum

Few topics have generated as much confusion in recent years as the distinction between the terms ‘sex’ and ‘gender.’ While many people use these terms interchangeably, the field of gender studies differentiates between them. Here, ‘gender’ describes the *set of expected social roles, behaviors, and expressions traditionally linked to one’s sex.*

The World Professional Association for Transgender Health (WPATH) defines ‘transgender’ or ‘trans’ as “umbrella terms used to describe people whose gender identities or gender expressions are not what is typically expected for the sex to which they were assigned at birth” (Coleman et al., 2022). WPATH further clarifies that ‘gender expression’ encompasses aspects of one’s physical appearance, such as “dress, hairstyle, accessories, cosmetics, hormonal and surgical interventions as well as mannerisms, speech, behavioral patterns, and names.” By this logic, individuals who are not transgender must therefore identify or express themselves in line with the traditional expectations of their sex. Thus, females exhibiting traits traditionally seen as masculine or males exhibiting traits seen as feminine might be perceived as deviating from their ‘assigned gender.’

Within the medical field, what is often termed as a person’s ‘gender’ can be viewed as a rough classification based on their self-assessment of how closely their personality, preferences, and behavioral traits align with conventional definitions of masculinity and femininity. However, this notion of ‘gender’ does not just stop there; it further asserts that these traditional notions of masculinity and femininity are the definitive benchmarks for being a man or woman, respectively. Should an individual not identify with the stereotypical attributes of their sex, they might be perceived as having a misalignment between their physical sex and ‘gender identity.’ This discrepancy is increasingly interpreted as indicative of a ‘brain sex.’

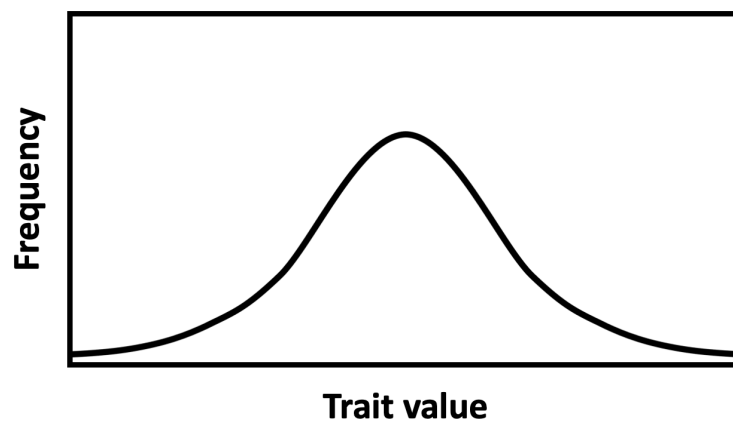
However, it is essential to recognize that sex differences in personality, preferences, and behaviors in humans are well-documented and widely accepted. While there are group-

level differences between males and females, there is significant variability within each sex (Del Giudice et al., 2012).

1.1.3.1 The normal distribution

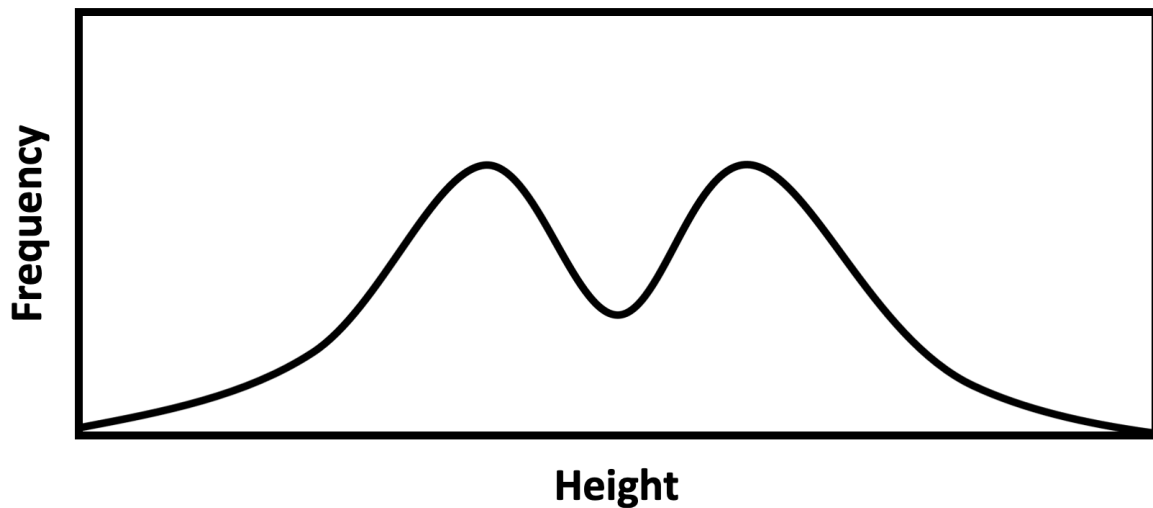
While it is true that the distinction between male and female is based on a binary classification of gametes (sperm versus ova), it is crucial to emphasize that this does not necessarily translate to a binary distribution for other sex-related traits.

When discussing sex differences, it is important to think in terms of the *normal distribution*. A normal distribution resembles a bell-shaped curve where most of the data clusters around the middle and tapers off near the edges. It is a common way data is spread in many natural phenomena.

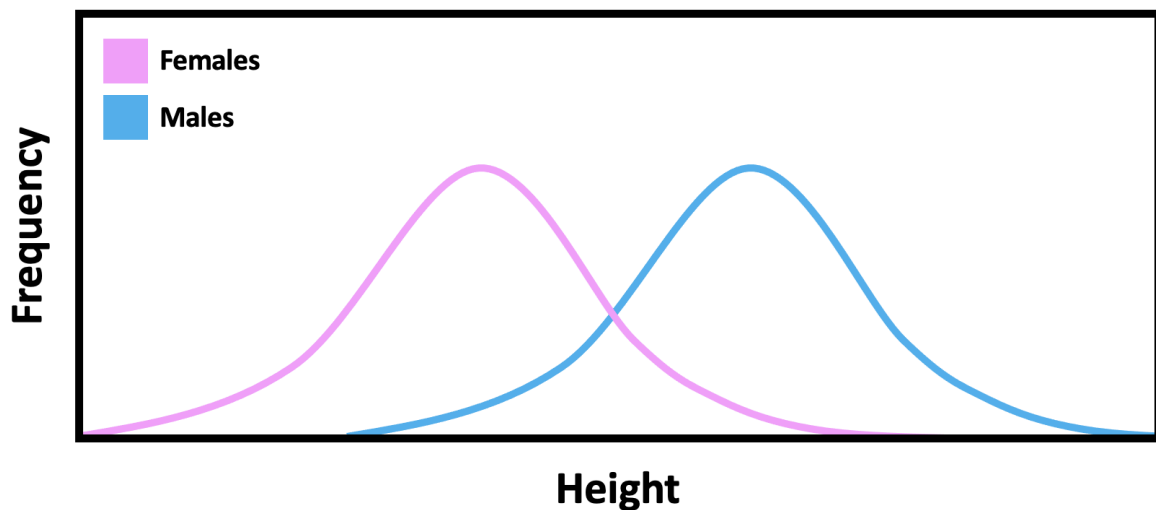


The figure above could illustrate many traits; for our purposes, let us say it represents the height of men in the United States. The bell curve's peak, or center, corresponds to the average male height, approximately 5 feet 9.5 inches, or 177cm (Fryar et al., 2021). However, most men do not measure exactly 5 feet 9.5 inches in height. In reality, about half of the men are taller than this, and the other half are shorter. As one moves further from the center of the bell curve, the number of men at each height diminishes, indicating that extremely short and tall men are less common.

Humans are a *sexually dimorphic* species, meaning that males and females as groups exhibit anatomical, physiological, and behavioral differences related to their sex (Frayar & Wolpoff, 1985). If we incorporated data on female height into our figure above, the resulting distribution would resemble the figure below.



This figure displays a **bimodal distribution**. While similar to a normal distribution, it has two pronounced peaks, or modes, representing values that appear most frequently in the data set. Such distributions emerge when a data set contains two groups with notably different average values for a given trait. In this case, the two groups are human males and females, each exhibiting their own normal distribution concerning height, as depicted more clearly below.



This figure underscores that, although males and females differ in average height, the typical distributions of males and females exhibit considerable overlap. This should

mirror everyday experiences: while most men are taller than most women, some men are shorter than most women, and some women are taller than most men.

The principle of distinct yet overlapping bell curves for males and females extends beyond physical attributes like height, body mass, voice pitch, breast size, and body hair, encompassing psychological traits and behaviors as well.

1.1.3.2 Multivariate traits

While the normal distribution described in the previous section provides a useful perspective on variation between the sexes for individual morphological or psychological traits, it often does not capture the more profound differences. Many significant differences between males and females emerge not from single variables but from how multiple traits correlate with one another (Del Giudice, 2009).

Consider the distinctions between men's and women's faces. Although studies show that people excel at identifying male and female faces, no single facial feature exclusively denotes male or female. Neurogeneticist Kevin Mitchell explained this concept succinctly (Mitchell, 2017).

Male and female faces differ on a wide range of parameters – size of the jaw, prominence of the ridge over the eyebrows, fullness of the lips, size of the bridge of the nose, and others. For each of these parameters, there is not a male form and a female form – there is a distribution, which is shifted one way in males and the other way in females. None of these markers by itself provides the means to accurately classify faces as either male or female. But taking all of them together certainly does (para.15)

Thus, male and female-typical faces are considered *multivariate traits*. Yet, just as some females are taller than many or most males, it is also the case that some females have more masculine faces than many or most males, and vice versa.

Psychological and behavioral traits are like facial features in this regard. What we perceive as male or female-typical personalities, preferences, and behaviors correspond to clusters of correlated traits. Personality, for example, is often categorized into the "Big Five" or OCEAN axes: openness to experience, conscientiousness, extraversion, agreeableness, and neuroticism. Generally, females score higher on neuroticism, agreeableness, and extraversion (Schmitt et al., 2008).

The Big Five model is broad and inclusive yet underscores some general patterns of sex differences. However, such broad categories necessarily obscure some important nuances and the overall magnitude of the sex difference. More detailed models reveal that when considering the correlational structure across 15 axes of personality, the sex difference in overall personality is quite large, displaying only a 10% overlap between

males and females (Del Giudice et al., 2012). Yet, despite these large sex differences, it is nevertheless true that some males and females will exhibit personality profiles more typical of the opposite sex.

Women and men also tend to differ in their inherent propensity towards empathizing (understanding and responding to the emotions of others) and systemizing (understanding and analyzing systems), respectively (Baron-Cohen, 2002). Occupational preferences also display clear sex differences, with men often favoring object-oriented jobs, and women leaning toward people-centric work (Kuhn & Wolter, 2022). Generally, men exhibit more aggression than women (Bettencourt & Miller, 1996). Moreover, stark differences emerge in toy preferences between boys and girls, particularly their affinity for vehicles and dolls, respectively (Davis & Hines, 2020).

Sexual orientation is another key area of differentiation, often overlooked. Typically, males show a strong and more exclusive attraction to females, while females display a strong yet marginally less exclusive attraction to males (Kinnish et al., 2005). Intriguingly, same-sex attraction correlates with opposite-sex personality traits (Lippa, 2008), occupational interests (Ellis et al., 2012), childhood toy preferences (Hines, 2011), and childhood gender variance (Steensma et al., 2013).

All these psychological traits, whether viewed individually or as correlated clusters, exhibit overlap between males and females. This overlap is paramount. It underscores that no single or composite psychological trait is exclusive to one sex. While organizations such as WPATH insist that “people whose gender identities or gender expressions are not what is typically expected” for their sex have a mind and body that do not “match,” natural science refutes such notions.

Sex differences at the group level are undeniable, but no personality, preference, behavior, or form of expression is incompatible with being a boy, man, girl, or woman. It is impossible to have a body that does not match one’s psychology.

1.1.4 Brain sex: can someone be born in the wrong body?

In the preceding section, we discussed how no psychological traits, either individually or in combination, are incompatible with being male or female. While there are average differences in personality, preferences, and behaviors, considerable and overlapping variation exists in these traits. The same is true for physical traits, apart from the primary sex organs. This includes attributes like height, body mass, muscle mass, hand size and grip strength, breast size, body and facial hair, voice pitch, facial features, and more.

The brain is just like any other organ or appendage in this regard. Although the brains of males and females exhibit small average differences in both size and structure, there is nevertheless considerable overlap between the sexes. The idea that someone could possess a brain that does not align with their sex makes no biological sense. If a

magnetic resonance image (MRI) were to indicate that an individual had brain structures more akin to those typical of the opposite sex, it would not imply that they literally have an 'opposite-sex brain.' By the same logic, a female with larger, hairier hands would not be deemed to literally have 'male hands.'

Nevertheless, many activists—and disappointingly, some scientists—endorse the notion that a person's brain can have its own sex independent of their body. The concept of 'brain sex' is of special interest to gender activists and medical professionals who seek to root 'gender identity' in something immutable and innate that allows them to draw upon existing legal precedents and civil rights laws.

The evidence frequently marshaled in favor of brain sex comes from a handful of studies that purport to have discovered that the brains of people with gender dysphoria have brain structures that are shifted toward those more typical of the opposite sex.

One study frequently cited to support the 'brain sex' hypothesis is by Kurth et al. (2022). The researchers recruited 72 participants (24 males, 24 females, and 24 transgender women) who all underwent magnetic resonance imaging (MRI). The images were then subjected to a multivariate machine-learning algorithm designed to predict sex, which it did reasonably accurately. From the machine-learning data, a 'brain sex index' (BSI) was created, with a BSI of zero being standardized to represent a totally female brain and a BSI of one representing a totally male brain. When applied to the transgender women, the BSI indicated a shift of 25 percent toward the female end (though still remaining much closer to typical male brains).

However, six out of the 24 transgender participants were attracted to members of the same sex. Why would this be important? As it turns out, several lines of evidence suggest that homosexual individuals have less sexually dimorphic brains than heterosexuals (or even a tendency for a reversed sex pattern, on average) (Folkierska-Żukowska et al., 2020; LeVay, 1991; Manzouri & Savic, 2018). Whether these differences are causal to homosexuality or not is irrelevant. What is important is that sex-atypicality within the brain is associated with sexual orientation.

To show exactly how sexual orientation can affect research on gender dysphoria, one study (Savic & Arver, 2011) scanned the brains of 24 heterosexual male-to-female transsexuals (i.e., males, identifying as women, who are attracted to females; also known as 'gynephilic') and compared them with male and female heterosexuals. When it came to the former group, the authors found no signs of brain 'feminization,' but instead found (in relation to both males and females) larger gray matter volume in the temporoparietal junction, an area involved in body perception and recognition (Savic & Arver, 2011), and out-of-body experiences (Blanke & Arzy, 2005).

Studies claiming that the brains of transgender-identifying individuals are shifted toward the opposite sex routinely do not control for homosexuality. Moreover, when

they do, they fail to demonstrate any such shift. Consider two studies that assess regional gray matter differences between transsexuals and controls. The first, by Simon et al. (2013), concluded that transsexuals have brains resembling that of the opposite sex. However, the second, by Luders et al. (2009), found no difference between male-to-female transsexuals and control males.

What caused these dramatically different findings? The transsexual participants in Simon et al. (2013) were all homosexual, whereas only one-quarter of the transsexual participants from the Luders study were homosexual. Across all studies, the percentage of homosexuality in the transgender cohort appears to correlate with the degree of sex-atypicality within the brain. The Kurth et al. (2022) study is consistent with this trend, as the BSI cross-sex shift and the percentage of homosexuality match perfectly (25 percent).

However, if it were demonstrated that gender identity is associated with sex-atypicality in the brain, this would provide only correlational evidence regarding a potential mechanism for feelings of gender dysphoria. It would not in any way demonstrate that someone can be born in the wrong body. Concluding otherwise conflates what is typical of one sex with what is essential to that sex.

1.1.5 Differences of sex development (DSDs)

Discussions about the biology of sex frequently become stuck on the issue of differences of sexual development conditions and how they relate to the question of whether sex is binary or a spectrum. In these conversations, it is common to hear the claim that intersex people make up 1-2 percent of the population, a prevalence often described as ‘as common as red hair.’

There seem to be two primary motivations behind this claim—one laudable, the other more radical. The laudable goal is to normalize the existence of people with intersex conditions. By doing so, we promote societal acceptance for a marginalized group that often experiences social ostracism, and who have been subjected to medically unnecessary ‘corrective’ cosmetic surgeries during infancy. The more radical objective seeks to challenge our collective understanding of biological sex, insinuating that the categories ‘male’ and ‘female’ are social constructs or perhaps exist on a ‘spectrum.’

However, the claim that 1-2% of the population is intersex vastly overstates reality, exceeding the actual figure by nearly 100 times. This statistic originated from Anne Fausto-Sterling in *Sexing The Body* (Fausto-Sterling, 2000), and was reiterated in an article titled “How sexually dimorphic are we?” (Blackless et al., 2000). Fausto-Sterling and colleagues reached their 1-2% estimation by applying an arbitrary and excessively broad definition of ‘intersex’ as “an individual who deviates from the Platonic ideal of physical dimorphism at the chromosomal, genital, gonadal, or hormonal levels.” By these loose standards, approximately 1.7% of individuals could be classified as intersex.

The authors even suggest that this figure could be as high as 2.27% if the definitions were expanded further.

Defining an individual as intersex for deviating from their sex's 'Platonic ideal' for any trait stands is extreme. In a 2002 paper titled "How Common is Intersex? A Response to Anne Fausto-Sterling," Leonard Sax pointed out a flaw in Fausto-Sterling's 1.7% statistic; namely, that the majority of the people categorized as intersex exhibited no sexual ambiguity whatsoever and could not be considered intersex in any clinically relevant sense (Sax, 2002). According to Sax:

Many reviewers are not aware that this [1.7%] figure includes conditions which most clinicians do not recognize as intersex, such as Klinefelter syndrome, Turner syndrome, and late-onset adrenal hyperplasia. If the term intersex is to retain any meaning, the term should be restricted to those conditions in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female. [emphasis added] (p. 174)

Conditions in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female, occur in 0.018% of the population (Sax, 2002). Fausto-Sterling's central error was to equate any differences of sex development (DSDs) with intersex. However, while all intersex conditions are DSDs, not all DSDs can be meaningfully categorized as an intersex condition. In fact, as Sax (2002) points out, conditions in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female, occur in 0.018% of the population. Nonetheless, since sex ambiguity does not constitute a third sex category, the prevalence of DSDs or intersex conditions is irrelevant to the discussion of whether sex is binary or a spectrum. Because there are only two gamete types—sperm and ova—there can be, and are, only two sexes.

1.2 Theories of gender

Emerging from a linguistic context, the word gender was originally used to categorize male or female. In recent years, however, it has come to be used interchangeably with the word sex to mean male or female. The word gender is becoming increasingly controversial these days as some people think gender is more important than our biological sex, while others say that gender is a social construct that does not exist in material life and can be used to impose restrictions on people (Stock, 2021). As a rule of thumb, it can be helpful to view sex as male or female and gender as masculine or feminine. While some may currently believe that gender is socially constructed, it is important to consider evolutionary pressures are likely responsible for at least some of the differences between sexes that we tend to think of as gender norms. Thus, gender

can be thought of as both the product of biology (as a result of evolution) as well as society (Soh, 2020).

The following theories about gender and related issues are not exhaustive; rather they are a general summary of some primary viewpoints that have recently gained traction in the discourse. However, to contextualize the more contemporary theories, it is necessary to begin with a very brief account of some well-known theories about sex and gender.

1.2.1 A very brief history of sex and gender theory

Sex has been conceptualized in a variety of ways throughout history. In ancient Greece, the physician and philosopher, Galen, subscribed to a 'one-sex model,' suggesting that men and women were similar, except that women were an inferior version with "exactly the same organs but in exactly the wrong places" (Joyce, 2021). Anatomical knowledge steadily progressed, and the 'two-sex model' suggested that male and female came to be universally understood as separate categories (Laqueur, 1990). Charles Darwin further added to our knowledge in the 19th century with his study of evolution, and the significance of the two sexes.

Notwithstanding Darwin and evolutionary theory, the German physician, Dr. Magnus Hirschfeld, put forth a different conceptualization of sexuality and biological sex in the early twentieth century, with a 'three-sex model' that viewed homosexuals as the 'third sex' (Joyce, 2021). Hirschfeld came to readjust his theory, however, proposing that sex was on a spectrum, that male and female were "abstractions, invented extremes," and posited that there were a range of naturally occurring sexual intermediaries within the human population such as "hermaphroditism, homosexuality, and transvestitism" (Joyce, 2021). Thus, the beginning of a distinction between sex and gender, and subsequent theories about gender began to be conceptualized and eventually became more mainstream.

Medical transition was incredibly rare until the middle of the twentieth century. Although advances in medical technology have made this option safer, it remains an intervention that is fraught with complications (Coleman et al., 2022). In the early 1930s, the first sex-reassignment surgeries were documented in Germany. Then, in 1952, Christine Jorgensen gained recognition as the first American to be known publicly as a 'transsexual,' which was the prevailing term of that era (Jorgenson, 2000). In 1961, the story of transwoman April Ashley was published in *The Sunday People* in the UK (Thompson, 2023). During the 1960s and 1970s there was a rise in the number of transition surgeries, arguably because of the promotion of gender identity theory and the work of the endocrinologist and sexologist, Dr. Harry Benjamin and others who sought to improve what is now known as transgender healthcare (Fritz & Mulkey, 2021).

In 1966, Dr. Benjamin published the landmark book, *The Transsexual Phenomenon*, establishing himself as an authority figure in the world of gender. Some years later, in

1979, the Harry Benjamin International Gender Dysphoria Association (HBIGDA) published its first standards of care for transsexuals, and in 2007, this organization was renamed as the World Professional Association for Transgender Health (WPATH) (WPATH, 2023). At the time, HBIGDA/WPATH's position on transgender healthcare was unchallenged—arguably because there were very few people working in this field and very few individuals identifying as the opposite sex. In recent years, however, there has been a sharp rise in the number of people identifying as transgender, and an equally sharp rise in challenges to WPATH, as well as a proliferation of theories about sex, gender and the drive to transition (Joyce, 2021).

1.2.2 Gender identity theory

In the 1950s and 1960s, clinicians such as John Money and Robert Stoller developed a theory that is now known as gender identity theory based on their work with people with DSDs (sometimes informally known as intersex) (Mak, 2022). Gender identity theory essentially posits that biological sex and gender roles develop independently (Morrow, 2006). The premise of their theory was based on the flawed notion that some people with certain DSDs were 'between the sexes' and such children could be raised as either gender. Physicians such as Money and Stoller believed that children could be socialized to be either a boy or a girl and some parents of infants with DSDs were advised to raise their children as the opposite sex based on the appearance of genitalia alone (Colapinto, 2000). Doctors in those days routinely performed genital surgery on children with DSDs to make the genitalia appear more typical (Calkin, 2023). However, these surgeries have sometimes had tragic outcomes and such invasive interventions have since come to be viewed as unethical, with the work of John Money being singled out as especially unethical and abusive (Colapinto, 2000). Today, Clinicians no longer offer this advice; parents of infants with DSDs are typically provided with information about the child's condition and a recommendation that they are raised according to their biological sex.

Dr. Harry Benjamin also promoted a version of gender identity theory in 1954, at a symposium sponsored by the *American Journal of Psychotherapy*, where Benjamin argued that humans are made up of a "mixture of male and female components" and that male "transsexualists" had a "constitutional femininity, perhaps due to a chromosomal sex disturbance" (Joyce, 2021, p. 20). In recent years there has been renewed interest in gender identity theory. Today, however, it is no longer focused upon discredited theories about people with DSDs and instead gender identity theory appears to underpin many people's understanding of transgender people. The presence of DSDs, however, enter the discussion regarding the sex binary and is used by some to support gender identity.

Morrow (2006) explained how gender identity theory is based upon a belief that everyone has a personal, subjective, and unfalsifiable gender identity. There is no scientific evidence to support this theory. This identity "refers to an individual's personal sense of identity as masculine or feminine, or some combination thereof." (Morrow,

2006, p.8). Similar in concept to the religious notion of a soul, the belief in the invisible gendered identity is often the cornerstone of disagreements between believers of gender identity theory and non-believers.

Gender identity theory has recently evolved and expanded to encompass the idea that a person's gender identity can change over time—and so a person might initially identify as a transman, then as non-binary and then as trans-masculine, and all identities are equally valid. Griffin et al. (2021) assert that “As a pure subjective experience, it may be overwhelming and powerful but is also unverifiable and unfalsifiable.” (p.129). Nonetheless, despite the absence of conclusive scientific data to support the theory of an innate gender identity, this theory continues to grip the public mind, perhaps due to society's unease with gender diversity, particularly in relation to feminine boys and masculine women.

1.2.3 Queer theory

Even though gender identity theory underpins many people's views, on the other hand, professionals working in the field have noted that a good deal of the current thinking associated with gender and transgender issues increasingly relies upon queer theory. Queer theory is aligned with postmodernism as objective reality is rejected in favor of a more subjective, individualistic experience (Jagose, 1996). This theory emerged in the late 1980s and early 1990s from feminist theory, women's studies and gay and lesbian studies, and is primarily supported by the work of writers such as Michel Foucault and Jacques Derrida. Judith Butler, a key figure in queer theory, tells us that gender is 'performative,' i.e., a person's gender comes about as a result of how they act (Butler, 1990). Other writers such as Gayle Rubin, Sandy Stone, Susan Stryker, and Eve Kosofsky Sedgwick offer further core concepts in queer theory. For example, that gender can be understood as a flexible, free-floating state that is not influenced by other factors. Within this framework of understanding, the links between sex and gender are liberated from each other and so there is no accepted understanding of boy, girl, male or female—rather these are subjective concepts that are personal to the individual (Jagose, 1996). It is important to note that if what it means to be male or female is subjective and individualistic, then the categories of male and female break down.

The astronomer Carl Sagan popularized the aphorism that “extraordinary claims require extraordinary evidence” and queer theory is currently unsupported by any evidence. Instead, subjectivity and fluidity are prioritized over epistemological knowledge. Thus, transwomen are accepted as women. Many countries have enacted self-ID laws which subvert societal norms based on biological sex such as same sex spaces – bathrooms, locker rooms, prisons, women's shelters and sports teams. In certain jurisdictions data for various purposes (health records, criminal records) may be collected or recorded based on gender, rather than sex (Joyce, 2021); Section Four discusses how doing so has implications for society.

Historically, the word queer was understood to mean 'odd.' It was also used as a slur to describe gay, lesbian, bisexual and transexual people. Now, based on queer theory, the word 'queer' is used to subvert oppressive systems of power with regards to sex and gender and the word queer can be applied to anyone whose beliefs align with queer theory (Gamson, 1995). This postmodern concept can be applied to almost everything, and hence, queer history, queer time, and queer death. Queer death, for example, suggests that our traditional view of death is embedded within the constrained beliefs that are underpinned by conventional religious or scientific mind and body dualisms. Equally, the concept of 'queer time' offers an alternative framing to concepts such as age and stage development (Jaffe, 2018).

Throughout history, young people have often sought to subvert the status quo. Today, youth movements base their rebellion on the idea that there is no universally accepted scientific or historical truth. Some people find queer theory academic, self-referential and destabilizing while others find it interesting, thought-provoking and liberating (Ayad et al., 2023). Initially, queer theory remained among the ivory towers of academia. Today, the cultural movements of social justice activism, critical theory and identity politics are pervasive and based largely upon queer theory, although most people are unaware of the underlying principles or its motives.

1.2.4 Gender identity ideology

Gender identity ideology is a system of beliefs that appears to encompass aspects of both gender identity theory and queer theory (Ion et al., 2023). This belief system promotes the idea that gender identity is innate, a subjective state that is fluid and can only be identified by the individual (Ion et al., 202). It is arguably impossible to fully encapsulate the wide range of often arcane beliefs that constitute gender identity ideology, such as what innate mechanism might cause gender identity to change. However, it is possible to outline some of the foundational principles encompassing gender identity ideology (further discussion is also offered in Section 4).

One of the ideas that underpin gender identity ideology is the belief that sex in humans is neither binary nor immutable, and the biological categories of male and female are not mutually exclusive but instead exist on a spectrum. According to gender identity ideology, gender identity is sometimes characterized as being synonymous with biological sex, other times it is conceptualized similar to how religious people might describe a person's soul. Essentially, gender identity ideology promulgates the concept of being "born in the wrong body" as a material reality rather than a metaphor: that it is literally possible to be born in the wrong body and to change our biological sex through hormones and surgeries. Within this concept, our bodies are not necessarily relevant to our existence as a male or a female; our subjective, inner sense of gender identity is more important in determining whether we are male or female (or some other identity such as non-binary or gender-fluid) (Jaffe, 2018).

Although gender identity theory and queer theory often contradict one another, current gender identity ideology encompasses both gender identity theory and queer theory. Some queer theorists suggest that gender is a social construct fabricated by members of a socio-cultural group. Proponents of queer theory do not necessarily acknowledge inherent differences between males and females; maleness and femaleness are based on how individuals perceive themselves. According to queer theory, having a gender identity that does not align with one's biological sex is neither a necessary nor sufficient criterion for identifying as transgender. Any individual can self-identify as transgender. Thus, arguably, being transgender signifies an alignment with a sociocultural movement whose goal is to prioritize gender identity over biological sex. This is reflected in DSM5-TR, in which gender dysphoria is categorized as a clinical condition, but transgender is presented as a normal variant. The influence of queer theory is also evident in the ICD-11 classification of gender incongruence, which downplays the experience of gender dysphoria. There is also a movement away from treatment intending to relieve psychological distress to treatment intending to achieve embodiment goals (Ashley et al., 2021), and hence the contemporary drive to dabble in microdosing hormones to suit the person's sense of identity (Rowan, 2023). A puzzling aspect of gender identity ideology is the question why, if gender is just a social construct, would one want to change the body so dramatically given the many known and unknown risks to the body.

Unlike queer theorists, proponents of gender identity theory believe that treatments such as testosterone or estrogen are medically necessary to resolve the distress of gender dysphoria. The hope is that the individual's distress will be alleviated once they change their external appearance so that it corresponds with their inner sense of identity. Further complexity is added however as this inner sense of identity is based upon stereotypes of what is considered masculine or feminine; the same stereotypes that queer theory aims to subvert. Although these theories differ fundamentally, both queer theory and gender identity theory reach the same general conclusion; that everybody's identity should be affirmed, regardless of age (Keo-Meier & Ehrensaft, 2018).

Gender identity ideology is promoted in various contexts (Ion et al., 2023). For example, according to this belief system, the current practice of observing and recording an infant's sex at birth based on genitals is a flawed system, hence sex in the Diagnostic and Statistical Manual of Mental Disorders (DSM) is described as "assigned male at birth" or "assigned female at birth." Thus, gender can only be determined by each individual rather than by an external third party, and an infant's sex may be easily miscategorized. Gender identity ideology is arguably evident within the medical world when pregnant women are described as "pregnant people" and women are described as "people with a uterus" (Gribble et al., 2022). Equally, in schools across the Western world children are taught concepts such as "Gender Identity is how we think of ourselves as a boy, a girl, neither or both" (Health Service Executive [HSE], 2020). This

arguably creates confusion among young children who have not yet developed sufficiently to understand these complex concepts; others believe it liberates children to identify into roles that make them feel comfortable. The inclusion of transwomen in a sports competition, in women's spaces such as rape crisis centers and prisons, the decision to record crimes, including sexual offenses, by gender rather than biological sex in some countries, and the censorship of topics relating to sex and gender (Suissa & Sullivan, 2021), suggests that gender identity ideology is widely accepted within certain contexts— i.e., transwomen are believed to be women rather than males who identify as women. Some people believe this brings about more inclusivity while others believe that boundaries are necessary for civilized society (see more about inclusivity and exclusivity in Section Four).

1.2.5 A biological model of understanding

Although the World Health Organization tells us that “Gender identity refers to a person's deeply felt, internal and individual experience of gender, which may or may not correspond to the person's physiology or designated sex at birth” (World Health Organization [WHO], 2023), yet the earliest historical records show that humans have consistently viewed themselves in terms of the sex binary, i.e., male or female. As the concept of gender, separate and distinguishable from sex, has only very recently evolved and taken hold within society, it is necessary for a deeper understanding of these concepts before we can be fully confident about our knowledge in this area.

Many people have unknowingly assimilated aspects of gender identity ideology into their understanding of sex and gender and often assume that ‘being trans’ is an innate condition affecting a small number of people. Often, a biological reasoning for deviations from gender norms is favored by the public. It has been suggested, for example, that feminine boys or masculine girls may have been exposed to too much testosterone or estrogen when they were a fetus in their mother's womb, but to date there is no robust evidence to support this hypothesis. The biological model disregards the significant differences between, for example, the levels of testosterone in a male or female (Severson, 2019) and appears to be rooted in the consequence of two errors of conflation:

- the conflation of same-sex attraction with gender diversity
- the conflation of DSDs with gender-related distress

Although same-sex attraction and gender diversity are experientially different, they are often considered the same. Same-sex attraction is physically driven and refers to our physical and emotional response to other people; it is the enduring pattern of romantic or sexual attraction to other people. This is a physical response, evident in the animal kingdom and empirical. Gender identity on the other hand refers to our relationship with ourselves. This is psychologically driven as it seems to develop within our minds; there is no equivalence with gender dysphoria for people who are same sex attracted.

Gender-related distress is strongly associated with neurodevelopmental conditions such as Autism Spectrum Disorder, Attention-Deficit Hyperactivity Disorder, Obsessive-Compulsive Disorder, and mental health comorbidities such as eating disorders, borderline personality disorder and anxiety (Becerra-Culqui et al.; Lipson et al., 2019). No such relationship is evident among same-sex attraction. Thus, it is important that same-sex attraction and gender identity are understood as fundamentally different experiences that require a distinct set of responses.

History shows us that some people, regardless of their environment, do not conform to stereotypical gender roles. Research shows that many gender-nonconforming children experience distress about their gender and that most of them turn out to be gay, lesbian or bisexual when they become adults (Kaltiala-Heino et al., 2018). It is perhaps for this reason that many people conflate same-sex attraction with gender diversity; they are two distinct experiences that often occur to the same individual. It must be noted, however, that this situation will become subverted if the uptick in the numbers of children (who could perhaps be described as 'pre-gay'), are socially and then medically transitioned and thereby rendered 'trans and straight' rather than 'cis and gay.'

Although a biological model of understanding might be attractive as an easy explanation for many people who are trying to figure out why some girls are masculine and some boys are feminine, as we have seen in earlier in this section, it is not scientifically accurate to categorize humans as anything other than male or female, and medical conditions such as DSDs do not alter this point. Furthermore, it is not helpful to make leaps of logic that discount psychological, sociological and other factors in order to presume that gender-related distress is somehow a consequence of biology. As research already shows, many factors can contribute to gender dysphoria and trans-identification (Littman, 2021).

1.2.6 A developmental model of understanding

It was not until the development of psychology as a science that human development came to be examined through a psychological lens. The works of certain key psychologists such as Freud, Watson, Skinner and Stanley Hall shaped our understanding of human development (Hagan, 2016). Psychologists such as Piaget, Vygotsky, Bandura, Kohlberg, Erikson, and Bowlby also advanced theories that promoted further specialization into developmental psychology in terms of cognitive, social and emotional development (Hagan, 2016).

The developmental approach to gender-related distress suggests that every person undergoes certain stages of development as they grow and mature and, within this model of understanding, gender dysphoria can evolve as a result of difficulty at a stage of development. The individual might, for example, feel a heavy weight of expectation because of the imposition of gender roles that do not suit their disposition. Some people more than others seek approval from society and so may feel a profound sense

of distress as they do not enjoy the gender roles typically associated with their biological sex and they could then feel alienated from their biological sex as a consequence. This could happen roughly between the ages of three and six, when the child's perception of what it is to be a boy or girl may become more concrete. For example, some individuals seek approval more than others seek approval from society and so may feel a profound sense of distress as they do not enjoy the gender roles typically associated with expected from their biological sex and they could then feel distressed and even alienated from their biological sex as a consequence.

1.2.6.1 Theories of child and adolescent development

According to theories of development, aspects of human development are continuous and quantitative such as height, while other aspects are discontinuous and qualitative such as emotional maturity. Continuous development versus stage development is often subject to debate. Yet, regardless of whether one perceives development as continuous or in stages, a child's physical, social, emotional and cognitive development from infancy to adulthood is arguably easy to perceive (Hayslip et al., 2006).

In 1966, the psychologist Lawrence Kohlberg introduced the theory of sex constancy, which stands as a key theory in developmental psychology with the potential to influence a child's perception of their gender identity (Kohlberg, 1966). According to Kohlberg, children go through stages as they complexify their understanding of sex and gender. Very young children learn to label people as 'boys' or 'girls' based on physical characteristics and societal cues. The child's understanding of what it means to be a boy or a girl develops between the ages of roughly five and eight and they begin to realize, for example, that a boy does not become a girl simply by changing his hairstyle or his clothing. They also begin to understand that a person's sex remains stable, no matter what happens or how masculine or feminine they appear to be. In this context, a child will then recognize that a girl is still a girl even if she dresses like a boy and uses he/him pronouns.

Gaining a more comprehensive grasp of their biological sex and expected gender roles can pose challenges for gender nonconforming children as they may feel burdened by societal expectations. This can be a difficult experience for some children as they may feel oppressed by these expectations. Some little girls do not like playing with dolls and want to climb trees; some little boys want to wear dresses and other pretty garments. If society dictates that only girls can play with dolls and wear fairy dresses, and only boys can engage in rough play, some stereotypically feminine boys and stereotypically masculine girls may feel profoundly uncomfortable with these gender norms and develop gender-related distress as a consequence.

Piaget's theory of cognitive development holds that children actively construct their understanding of the world through a series of distinct stages; abstract thought, a complex cognitive process, emerges as children advance through these stages and is

only achieved after prior stages have been traversed (Piaget, 1970). During the Preoperational Stage (2 to 7 years), children begin to use symbols and language to represent objects and ideas, but their thinking is limited to concrete experiences. In the Concrete Operational Stage (7 to 11 years), they develop the ability to think logically about concrete objects and perform basic operations, but their thinking is still tied to the present. Only during the Formal Operational Stage (11 years and beyond) does true abstract thought begin to emerge. At this stage, it is possible to engage in deductive reasoning, think about possibilities and outcomes, and consider abstract concepts such as a hypothetical gender identity that may differ from one's sexed body.

Common experiences can impact a child or young person's understanding of sex and gender identity. For example, children can go through a stage of magical thinking during their early development, typically in the early years. According to Piaget, magical thinking is most prominent in children between ages two and seven (Piaget, 1999; Piaget & Inhelder, 2014). During this stage, children can be egocentric and have difficulty understanding other people's perspectives. Consequently, a child who socially transitions (See section 2) at an early age, will not fully understand the limitations of life as their proclivity towards magical thinking will impact their sense of self. Children during this stage can attribute thoughts and ideas onto whomever or whatever they choose and can often turn to the supernatural as a way of making sense of the world (Piaget, 1999; Piaget & Inhelder, 2014). They are prone to believing that their thoughts or actions have a direct influence on external events. A little girl, for example, might believe that if she presents as a boy then everyone will believe that she is a boy. While it is developmentally appropriate for children to engage in magical thinking, it is also appropriate to outgrow this stage and develop a more complex understanding of life, typically from the age of seven onwards, when they begin to confront the reality of life.

Piaget's theory of cognitive development provided a foundational framework that has had considerable influence on contemporary understanding of human development. Piaget (1947, as cited in Muss, 1975) suggests that formal thought reaches its fruition during adolescence and considered adolescence as a "decisive turning point ... at which the individual rejects, or at least revises his estimate of everything that has been inculcated in him and acquires a personal point of view and a personal place in life." (p.192)

Adolescents often feel uneasy about their sexual development, and this is an increasingly common time for an individual to feel alienated from their body and experience gender-related distress (Littman, 2018; Littman, 2021). For example, a stereotypically masculine girl who realizes during adolescence that she is same-sex attracted can develop gender-related distress as she would prefer to present as the more culturally acceptable boy who is attracted to girls rather than a butch lesbian. Equally, a stereotypically feminine boy who is having difficulty coming to terms with his sexuality may also experience gender-related distress. It is believed that if the young

person can build awareness of society's rules vis-à-vis gender roles, and an acknowledgment of how this might impact them, they can then begin to liberate themselves from such societal expectations.

1.2.6.2 Erikson's theories of development

The psychologist and psychoanalyst Erik Erikson became well-known for his theories on psychosocial development. In Erikson's model, each stage is characterized by a specific psychosocial crisis or challenge that individuals must successfully navigate if they are to develop a healthy sense of self and adapt to their environment (Erikson, 1959). According to Erikson, identity is not bestowed upon the adolescent—rather it must be searched for during the maturation process and will be acquired through sustained efforts (Erikson, 1950). The individual who is unwilling to seek their identity can fall prey to role diffusion, which can result in alienation, and a sense of isolation and confusion. This is why Erikson identified fidelity as a core virtue during this process, as fidelity will aid the individual to uphold the values that contribute to a stable identity. The core conceptual theory is the acquisition of an ego-identity and, according to Erikson, the identity crisis is the essential defining trait of adolescence (Erikson, 1950). The adolescent requires meaningful recognition of their achievements and accomplishments if they are to acquire a strong and healthy ego-identity. Although our individual identity is formed within a cultural context, the accomplishment of the developmental task of forming an identity has common elements across a range of diverse cultures (Erikson, 1950).

The past, present and future are interlinked during the process of a meaningful self-concept and the task of identity formation is made more difficult if the past is unstable, within the context of the family or the community. Accordingly, within Erikson's theory, older generations cannot provide adequate role models for younger generations during a period of social change and adolescents can reject potential role models in this context as they perceive them as inappropriate.

Many adolescents identify with their glamorized heroes and seldom identify with their parents—indeed, often rebelling against their dominance, their value system and their apparent need to intrude into their private life which is in direct conflict with the adolescent's need to separate from their family and achieve autonomy (Erikson, 1959). Erikson emphasizes the importance of the peer group as role models in the twentieth century where it often became more important to find the answer to the question "Who am I?"

As Erikson notes, adolescents:

Are sometimes morbidly, often curiously, preoccupied with what they appear to be in the eyes of others as compared with what they feel they are and with the question of how to connect to earlier cultivated roles and skills with the ideal prototypes of the day. (Erikson, 1959, p.89)

The adolescent, according to Erikson, feels compelled to answer questions such as: “Who am I?” “Where am I going?” and “Who am I to become?” and requires a system of values—for example, religious beliefs, vocational goals, a philosophy for life and an acceptance of their sexuality. If the adolescent can accept their past and establish continuity with their personal experiences, then a positive outcome is likely to arise from the identity crisis. Adult maturity comes about, along with sexual and affectionate love and deep friendships when the adolescent has sufficiently worked through these questions.

Once the person’s identity is established, then they can move on to find intimacy (or isolation) in interpersonal relationships (Erikson, 1959). However, if the adolescent fails in their search for an identity, they will experience self-doubt, role diffusion and role confusion and are more likely to indulge in self-destructive behavior, with a morbid preoccupation about what others might think of them or, in contrast, a withdrawal from the peer group and from seeking approval from themselves or others. This leads to ego diffusion and personality confusion and is evident in people who become psychotic or delinquent, or even, at its most severe, who suicide or make suicide attempts.

1.2.6.3 Identity status and identity crisis

The development psychologist James Marcia further extended our understanding of child and adolescent development through his exploration of “identity status.” Marcia defines identity as “an internal, self-constructed, dynamic organization of drives, abilities, beliefs and individual history” and asserts that the criteria for the attainment of a mature identity are based on two variables: crisis and commitment. According to Marcia (1967), “*Crisis* refers to times during adolescence when the individual seems to be actively involved in choosing among alternative occupations and beliefs. *Commitment* refers to the degree of personal investment the individual expresses in an occupation or belief.” (p. 119)

Marcia interviewed students aged between 18 to 22 years about central aspects of identity such as their occupational choices, religious beliefs, political beliefs, and values, and classified them into four categories of identity status based on: 1) whether they had gone through an “identity crisis” as described by Erikson (1959), and 2) the degree to which they were now committed to a set of values and beliefs and an occupational choice. The four categories of identity statuses were defined by Marcia as:

- **Identity diffused or identity confused:** These individuals have not yet experienced an identity crisis, nor have they made any commitment to a vocation or set of beliefs.
- **Identity Foreclosure:** These individuals have not experienced crisis, but have made commitments, generally because of others—frequently parents or teachers or a peer group—and not because of their own searching and exploring.

- **Identity Moratorium:** These individuals are in an acute state of crisis. They are struggling to find their identity and often actively exploring and searching for alternatives but have only developed temporary kinds of commitment or else not yet made any commitment.
- **Identity Achieved:** When individuals have experienced crises but have resolved them on their own terms, and as a result of the resolution of the crisis have made a personal commitment to an occupation, a religious belief, or a personal value system and have resolved their attitude toward sexuality.

The young person's struggle to attain an identity and achieve adult status can be an arduous and frustrating experience. Thus, according to Muuss (1975), we can better understand adolescents if we view them as the "marginal man who stands in a psychological no-man's land without clear understanding of what is expected of him, struggling to attain adult status". Although neither Muuss, Erikson nor Marcia mention gender identity, nonetheless we can extrapolate the concept of a developing identity and apply it within the context of a developing gender identity.

Erikson (1968) introduced the concept of a psychosocial moratorium as part of his theory of psychosocial development. This refers to the crucial period of exploration and experimentation that takes place during adolescence and young adulthood and offers individuals the opportunity to try out different roles, values, and experiences without feeling obliged to fully commit to anything. A psychosocial moratorium ensures the young person does not end up "in a 'social pocket' from which there is no return" (Erikson, 1968, p.156), thus avoiding premature foreclosure on identity exploration. According to Erikson, individuals could experience their 'identity crises' during this psychosocial moratorium, helping the young people deepen their understanding of who they are, their values, and what roles they want to assume in society. A psychosocial moratorium would allow young people the freedom to form a more solid and coherent sense of self before they make any decisions that have far-reaching consequences.

1.2.6.4 Criticism of theories of development

Although theories on child and adolescent development offer different perspectives, they typically accept the universality of developmental norms in relation to child development. In our postmodern era, however, post-developmental theorists have started to criticize this stance as prescriptive and narrow minded (Al-Kassimi, 2018). The very nature of stage theory has been called into question by certain leading thinkers; the stages that have been identified might be inaccurate and can underestimate or overestimate childhood and adolescent development (Weiten, 1992). Also, the nature of the individual means that children and adolescents of varying ages can vary widely across the stages and in many ways these broad variations call into question the very attempt to differentiate between stages (Weiten, 1992).

With the arrival of the postmodern era, a more contemporary perspective came to view childhood as both a social construct and as a biological phenomenon (Kellett, 2013). Thus, with the advent of a new conceptualization of childhood, shaped by post-modernist thinking, children moved from being viewed as 'becoming' to 'being' in their own right: human 'beings' rather than human 'becomings' (Wiegerová & Gavora, 2015). Prior to this new sociological perspective on childhood, the traditional view of children was that they were individuals who were in the process of becoming and in so doing they make the transition from 'nature' to 'reason' and hold the promise of a better future (Mayall, 2002). This contemporary understanding of children heralds a new era whereby the approach seems to have moved from being 'child-centered' to 'child-led.' In the context of child and adolescent development this shift can be perceived as placing an inappropriate burden on children's shoulders. Nevertheless, in the context of pediatric gender transition, the advice to 'listen to the child' (and, implicitly, allow them to lead the way) currently holds more sway.

1.2.6.5 The trauma-informed model of understanding

A trauma-informed model is grounded in the understanding that exposure to trauma can impact an individual's neurological, biological, psychological and social development. Thus, for example, a person who has experienced a sexual assault could shut down their sexual development and seek to medically transition in a bid to move away from their experience. In fact, both transgender people and detransitioners have expressed that such trauma was integral to the development of gender dysphoria and the decision to transition (Churcher Clark & Spiliadis, 2019; Littman, 2021). The physical and emotional safety of the individual is prioritized within this model of care as the individual may not be able to recover and begin to grow without feeling a sense of safety. Depending on the clinician's perspective and the individual's experience, an individual's desire to socially or medically transition following a trauma could be viewed either as a healthy coping mechanism or an unhealthy defense mechanism.

1.2.7 The gender critical viewpoint

The gender-critical viewpoint picks up where second-wave feminism left off, the latter having been derailed by a third-wave feminism that replaced the goal of liberation for women with the goal of inclusion for anyone marginalized. Gender-critical feminism maintains that gender is a social construction built on top of biological sex, and that biological sex is an essential and immutable property of persons. According to gender-critical feminism, women have been oppressed for millennia as a result of ideas about femininity thrust upon the female sex (Lawford-Smith, 2022). For this reason, gender-critical feminists maintain that a complete rejection of gender -- which they refer to as 'gender abolitionism' -- is the more liberating way to approach women's oppression (and this will be good for gender diverse men too). Because nobody can change sex, anyone who undergoes medical or social transition may gain at most a new 'legal sex' or 'social sex' status (not a new biological sex). It is more appropriate to categorize this legal or

social status together with gender identity as part of the subjective way that people see themselves, while keeping biological sex distinct as a part of the way that people are objectively. For many, if not most, purposes, a person's biological sex will be just as important, or more important, than their gender identity.

The numbers of transsexuals were vanishingly small until the 1960s and 1970s. However, feminists were prompted to grapple with the issue of how to treat transwomen within the feminist movement earlier than most, probably because of their inclination towards women-only spaces. Radical feminism asserted that transwomen should not enter women-only spaces while liberal feminism tended to allow transwomen access (Stock, 2021). The term 'TERF,' trans-exclusionary radical feminist, seems to have first been coined to distinguish trans-inclusive feminists from trans-exclusive feminists (Smythe, 2018). This term is considered a slur and has now broadened to include anybody who believes that transwomen do not have an automatic right to women-only spaces. Today, however, the gender critical viewpoint has moved beyond radical feminism, and many others also recognize that gender is largely socially constructed and biological sex is immutable.

1.2.8 Rapid onset gender dysphoria (ROGD)

In 2018 the physician-scientist Dr. Lisa Littman undertook research in a bid to ascertain what was driving the sudden sharp rise in the number of adolescent girls identifying as various novel genders and seeking medical transition. In her study of 256 parental reports of adolescents experiencing gender dysphoria, Dr. Littman coined the term 'rapid onset gender dysphoria' (ROGD) to refer to trans identification in a young person that first occurred after puberty, 'out of the blue', and often after the young person had spent an extended period of time online or alongside peer(s) who identified as trans in real life. Littman pointed out that ROGD is "not a formal mental health diagnosis," notwithstanding this, the ROGD hypothesis arguably offers a viable explanation for the extraordinary rise in adolescents suddenly seeking medical transition and the similarity in presentation.

The journalist Abigail Shrier (2020) followed Littman's research with the publication of her book *Irreversible Damage: Teenage Girls and the Transgender Craze*. In her book, Shrier noted that until relatively recently, there were two main groups who sought transition—pre-pubescent boys and middle-aged men—then suddenly a new cohort, female adolescents, never been seen in the medical literature, began presenting at gender clinics; "Before 2012, in fact, there was no scientific literature on girls ages eleven to twenty-one ever having developed gender dysphoria at all... [now] they constitute the majority." (p. xxi).

ROGD appears to be a maladaptive coping mechanism for the individual, and Littman hypothesized in her research that social and peer influence is a factor in this phenomenon. As with all theories, time is needed to ascertain the long-term landscape,

and no substantive conclusions can be made about this cohort or this theory until we have a significant body of research.

1.2.8.1 Social contagion and the symptom pool

Social contagion is not a new phenomenon. Although the term 'behavioral contagion' was introduced into modern scholarship by Gustave Le Bon in his 1895 book *The Crowd: A Study of the Popular Mind*, it had already been accepted that *The Sorrows of Young Werther* first published in 1774 had created a social contagion of suicide (Goethe, 2012).

In 1897, Dr. Gould and Dr. Pyle played on the already established phrase 'fasting girls' to coin the phrase 'needle girls' which described a "peculiar type of self-mutilation ... sometimes seen in hysteric persons" of "piercing their flesh with numerous needles or pins" (Gould & Pyle, 1897). In his 1939 paper on collective behavior, the sociologist Herbert Blumer coined the phrase 'social contagion' with examples from history such as the dancing mania in the Middle Ages (Halas, 2012). Indeed, there have been many examples of social contagion throughout history (Chaney, 2019). Various typologies have been proposed by academics who have reported that the study of social contagion suffers from a lack of a widely accepted and precise definition. However, in a 1993 review, Levy and Nail suggest that social contagion should be defined as the spread of affect, attitude, or behavior "where the recipient does not perceive an intentional influence attempt on the part of the initiator." (Levy & Nail, 1993, p.266).

As humans, we possess an inherent vulnerability to being influenced by others, particularly by those with whom we share a sense of connection. It is notable, however, that social contagions happen more often among youth, especially females (Martinez et al., 2023). This is likely to be the consequence of certain traits that are more likely to be associated with female adolescents than other cohorts particularly at a vulnerable developmental stage. As described by O'Malley (2023):

- Co-rumination
- Excessive empathy
- Repetitive discussion of problems
- Excessive reassurance seeking
- Positive reinforcement of similarities
- Competitive friendship cliques

The term 'mass sociogenic illness' has been used to describe disease-like symptoms that are spread despite no infectious agents. Social media has already been shown to be able to spread contagion about weight gain, smoking, bulimia, politics, climate change, suicidality, depression, and any other number of other phenomena (Kravetz, 2018). With the advent of WiFi and social media platforms, social scientists today more

often focus on online social contagion, and the potential for mental health concerns to spread online. Online social contagion refers to the spread of ideas, behaviors, emotions and beliefs and the contemporary expression, 'going viral,' recognizes the capacity for rapid contagion.

The global lockdown between 2020 and 2022, due to the COVID-19 pandemic demonstrated a range of social contagions (Lu & Hong, 2022). One example was chronicled by German researchers, who noticed a rise in the number of young people, mostly teen girls (even though Tourette's typically affects young boys), presenting to clinics with similar presentations of Tourette's syndrome. It turned out that popular TikTok influencers exhibiting their tics on social media had created the social contagion.

The medical historian Edward Shorter introduced the term the 'symptom pool' to describe how people can manifest a variety of culturally recognized symptoms to communicate their distress to others in a manner that is easily understood. In *From Paralysis to Fatigue: A History of Psychosomatic Illness in the Modern Era* (1993), Shorter asserts that patients seek their doctor's approval, and so they draw from a culturally approved 'symptom pool' to elicit a positive response from clinicians. This results in a 'shared diagnosis' between patients and doctors; we do not want to be dismissed as hysterical and or hypochondriacal and so we tend to describe symptoms that we believe the doctor will recognize (Shorter, 1993). Anorexia arguably entered into the symptom pool following the death of Karen Carpenter in the 1980s. Following this social contagion, bulimia nervosa, often portrayed in popular TV programs at the time, became another condition newly recognized within the 'symptom pool.' Equally, self-harming behavior became a recognizable manifestation of distress. Today, gender dysphoria appears to be a new arrival into the symptom pool.

In *Rewriting the Soul: Multiple Personality and the Sciences of Memory*, the philosopher Ian Hacking introduced the term 'semantic contagion' to describe how assigning a name to a phenomenon can elevate its occurrence (Hacking, 1995). Individuals seek to understand themselves and their distress in culturally approved ways. In the 1980s and 1990s, conditions such as 'multiple personality disorder' and 'repressed memory' were often topics in the mainstream media and television talk shows and this, in turn, brought about an increase in the diagnosis of multiple personality disorder and repressed memories. Today, the advent and rise in the numbers of gender identities and the use of certain phrases such as being 'born in the wrong body' and the sharing of narratives about transgender individuals could likewise have increased the incidence of people who believed they were 'born in the wrong body.'

Hacking also described the concept of 'making up people,' and when we consider the new terms that are now often employed to describe certain people such as the 'trans kid' or a 'non-binary' person, we can arguably see semantic contagion at play (Hacking, 1995). Moreover, terminology used to describe the same phenomena changes over

time. Someone who may have been labeled a 'tomboy' as a child in the 1960-70s or a 'gender bender' as an adolescent or young adult in the 1980-90s may now be labeled as a 'trans kid'. Hacking points out that within the context of semantic contagion, the description can shape the narrative, and so terms such as 'genderfluid' or 'two spirit' have an influence on how people understand and label themselves. Equally, extensive discussion about 'detransition' and 'desistance' is likely to bring about more cases of detransition and desistance.

1.2.9 Biopsychosocial and spiritual perspectives

The biopsychosocial model, first conceptualized by the American psychiatrist George Engel in the 1970s, suggests that when we seek to understand a medical condition, we need to consider not only biological factors, but also psychological and social factors (Engel, 1980). Within this context, gender dysphoria could be described as a symptom of distress for what could be a range of biological, psychological or social reasons. Engel's biopsychosocial model offers a holistic view of the individual, acknowledging the many influencing factors that may shape our minds, bodies, and behavior.

The sociological aspect of gender-related distress could be influenced for example by the consumer-driven push that started to gain pace in the 1990s and continues today, categorizing children into 'blue' and 'pink' when marketing toys and clothing. Although many children do not care if their birthday cake is pink or blue, it appears to be distressing for a small section of children who rail against these categories. Teenagers today are also increasingly expected to present as stereotypically feminine, masculine or else some category pertaining to LGBTQ+ and the impact of this focus on narrow categories has yet to be fully understood. Marketing also influences contemporary thinking, and it is notable that up until the 1990s, transsexualism was based upon genital surgery. However, during the 1990s, testosterone and estrogen began to be promoted as symbols of femininity and masculinity. This shift, combined with several factors such as the numerous complications linked to genital surgery, may have contributed to the recent move from genital surgery to hormonal treatment for those who wish to medically transition (Ostertag, 2016).

There are a range of theories within the psychological realm that can account for gender-related distress (see Section Two). For example, the Swiss psychiatrist and psychoanalyst Carl Jung proposed a symbolic and archetypal view of masculinity and femininity. Jung posited that each of us has a necessary contra-sexual inner image—the woman has a male Animus figure to contend with while the man has the female Anima (Hillman, 1998). According to Jung, these archetypal figures can balance and complete our personalities. Other psychologists, already discussed in this section, offer a variety of perspectives on a psychological framing of sex and gender; further information is available in Section Two.

The biopsychosocial perspective is now often referred to as the biopsychosocial and spiritual perspective as this is more comprehensive and unlikely to omit any factor that impacts us. Many people experience a drive towards the spiritual. Although spirituality is unsupported by empirical science, the prolonged nature of its existence and many people's deep beliefs about their spirituality suggest that we dismiss it at our peril.

Although in recent years queer theory and gender identity have become more popular, leading more people to believe that gender is subjective to the individual, the developmental or biopsychosocial and spiritual understanding of gender-related distress suggests that a person's unconscious could be the primary driver underlying the desire to socially or medically transition. Thus, depending on the individual's beliefs about gender, transition can be viewed as a necessary medical treatment for a person who has been 'born in the wrong body,' while others may believe that a psychological approach is more appropriate as distress over one's sex is primarily a psychological issue. The biopsychosocial and spiritual perspective offers a catch-all approach until better research emerges in the field. It also offers varying approaches that may be tailored to the individual, considering the myriad of factors that may contribute to the distress.

1.3 Diagnosis of gender-related distress

As science and knowledge continue to advance, the renaming and redefining of conditions are reasonably common in the field of diagnostics and so it is unsurprising that gender-related distress has undergone the series of term changes that are outlined below. The more notable point, however, is that gender-related distress appears to follow the same trajectory as same-sex attraction, notwithstanding that these are experientially dissimilar. The recent surge in young people seeking medical treatment for their gender-related distress has been unexpected. Consequently, medical practitioners, professional groups, diagnostics, typology, research evidence and an understanding of this phenomenon are all lagging behind the culture. The following provides a broad outline of the main diagnostic categories that are currently applied and a brief synopsis of the changes that have brought upon these diagnostic categories.

1.3.1 The World Health Organization (WHO) and the International Classification of Diseases (ICD)

The WHO publishes the ICD, a diagnostic tool that is used for clinical purposes and revised on a regular basis. In 1990, the diagnosis of 'transsexualism' was incorporated into the ICD-10 and then in 1994 'transsexualism' was substituted with 'gender identity disorder'. The diagnostic category was changed again in 2018, and 'gender identity related health' was redefined respectively as 'gender incongruence of adolescence and adulthood' and 'gender incongruence of childhood' (WHO, 2022). This was a notable

change as it moved gender-related distress out of the chapter relating to 'Mental and behavioral disorders' and into another chapter entitled 'Conditions related to sexual health' and in so doing, changed the underlying assumptions around gender-related distress from a mental and behavioral issue to a sexual health issue. This suggests, as Dr. Lucy Griffin and Dr. Katie Clyde, in *World Psychiatry* pointed out, that children as young as three can be diagnosed with a 'sexual health problem.'

We note that ICD-11 has dropped gender dysphoria from its chapter on mental and behavioral disorders and moved it to the chapter on sexual health. What then, is the exact nature of this sexual health disorder? Are children necessarily prescribed puberty blockers and cross-sex hormones because they suffer from a sexual health issue? (Griffin & Clyde, 2019, Letter 3)

The impact of socialization, social contagion, psychological defense mechanisms and other factors are less likely to be contextualized with a diagnosis that is framed as a sexual health problem and not a mental health problem, and so the biopsychosocial perspective is discounted in this move. The WHO asserts that "trans-related and gender-diverse identities are not conditions of mental ill-health, and that classifying them as such can cause enormous stigma" (WHO, 2023). However, this is arguably in itself a stigmatizing statement as it stigmatizes mental health as somehow intrinsically problematic.

1.3.2 The American Psychiatric Association and the Diagnostic and Statistical Manual of Mental Disorders

Specialists have used a variety of terms over time to define and discuss the distress experienced by individuals who have a "persistent desire to become the opposite sex" (Zucker, 2010). The American Psychiatric Association (APA) publishes the Diagnostic and Statistical Manual (DSM), a manual that classifies mental disorders using a common language and standard criteria and which is also revised on a regular basis. As outlined below, the current American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) uses the term 'gender dysphoria' to refer to this distress with separate sets of criteria, one for adolescents and adults and another for children under the age of 12.

In 1980 the DSM-III first included 'transsexualism' and created the term 'gender identity disorder' (GID) in the context of the diagnoses of: 'GID/Children Transsexualism'; 'GID/Adolescent and Adult, Non-transsexual type' and 'GID/Not Otherwise Specified' (American Psychiatric Association [APA], 1980). The DSM-III-R (revised edition) was published in 1987 and retained the term 'transsexualism', placing it under 'Disorders Usually First Evident in Infancy, Childhood or Adolescence' (APA, 1987). The DSM-IV was published in 1994 and revised in 2000 (known as DSM-IV-TR) and replaced the term 'transsexualism' with 'Gender Identity Disorder in Adolescents and Adults.'

Then in 2013, the DSM-5 was published with the reclassification of 'Gender Identity Disorder' as 'Gender Dysphoria', thus moving the focus from an identity disorder to the distress associated with gender and sex. Until roughly 2013, gender-related distress was universally accepted as a psychological disorder and, within the clinical context, typically diagnosed as gender identity disorder. Then, with the arrival of the DSM 5, there came about a shift in the thinking, characterized by the renaming of gender identity disorder as gender dysphoria, and thus redefining this condition as relating only to the distress experienced; seeking to become and live as the opposite sex was no longer perceived as the result of a disordered mindset.

In 2022, the revised edition of the DSM-5, the DSM-5-TR, was published and 'was updated to use culturally-sensitive language' such as, replacing the term 'natal male' with 'individual assigned male at birth', replacing the term 'natal female' with 'individual assigned female at birth', and replacing 'cross-sex hormonal treatment' with 'gender-affirming hormonal treatment' (APA, 2022). The DSM-5-TR presents gender dysphoria as a diagnosable mental health condition that refers to the "distress that accompanies the incongruence between one's experienced and expressed gender and one's assigned or natal gender". This was then placed in the category of Sexual Disorders, along with a subcategory of gender identity disorders (APA, 2022).

The criteria used in the DSM-5 to diagnose Gender Dysphoria include a number of signs of discomfort with one's natal sex and vary somewhat depending on the age of the patient; but in all cases require "clinically significant distress or impairment in . . . important areas of functioning" such as in social, school, or occupational settings, with symptoms persisting for at least six months. The following section outlines how the DSM-5 categorizes the criteria for adolescents and adults together and then provides separate criteria for children.

1.3.2.1 Clinical diagnosis of childhood onset gender dysphoria

According to the DSM-5-TR, the criteria below are required to diagnose gender dysphoria in childhood. Evidently, these criteria heavily depend on sex stereotypes and some people do not agree with this position as they believe it to be regressive.

The DSM-5-TR defines gender dysphoria in children as a marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least six months, as manifested by at least six of the following (one of which must be the first criterion):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
- A strong preference for cross-gender roles in make-believe play or fantasy play
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
- A strong preference for playmates of the other gender
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
- A strong dislike of one's sexual anatomy
- A strong desire for the physical sex characteristics that match one's experienced gender.

As with the diagnostic criteria for adolescents and adults, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning (Turban, 2022).

1.3.2.2 Clinical diagnosis of adolescent and adult onset gender dysphoria

The DSM-5-TR utilizes identical criteria for both adolescents and adults. Perhaps the recent uptick in the numbers of young people presenting with adolescent onset gender dysphoria will hopefully prompt the development of more targeted criteria for adolescents in the future.

The DSM-5-TR defines gender dysphoria in adolescents and adults as a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least six months, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
- A strong desire for the primary or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

To meet the criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning (Turban, 2022).

1.3.3 Moves to towards self-diagnosis and informed consent

The "clinically significant distress" criteria used in DSM-5 to diagnose gender dysphoria indicates a heightened level of distress that rises beyond a threshold level of social awkwardness or discomfort with the changing body. Complicating matters, however, is the fact that there is no "clinically significant distress" requirement in the World Health Organization's (WHO) International Classification of Diseases, Version 11 (ICD-11) criteria for gender incongruence, WHO's equivalent to the DSM's diagnosis of gender dysphoria. The ICD-11 diagnosis of gender incongruence simply stipulates "a marked and persistent incongruence between an individual's experienced gender and the assigned sex" (WHO, 2023).

Therefore, there is significant disagreement between these two committee-based authorities as to what constitutes a gender condition justifying life-changing interventions. Some gender clinics and practitioners operate under the ICD-11 criteria rather than the APA's DSM-5 criteria, prescribing transition for children, hormonal interventions for older children, and different hormones for adolescents who assert a desire for a transgender identity whether or not they are exhibiting "clinically significant distress." Others adhere to the DSM-5 diagnostic standard.

Currently, the differences between the ICD and the DSM means that there is no consensus about an accepted term or category for gender-related distress, nor is there consensus about appropriate treatment paths. The recent emphasis in the discourse has been focused largely on 'informed consent' (Chiang & Bachmann, 2023). This consumer-driven model of healthcare positions the patient as a client who is in charge of their diagnosis and treatment. It is relatively easy to obtain a pseudo-diagnosis online and many young people are favoring online diagnoses as an important tool for their self-identity. Dr. David Bell, consultant psychiatrist, psychoanalyst and ex-governor of the Tavistock Clinic, expressed concern about this new trend to self-diagnose through online resources and 'the collapse of gender medicine into customership' (Genspect, 2021). If the informed consent model continues to gain traction, then any responsibility for misdiagnosis and mistreatment falls on vulnerable people who may not be fully cognizant of the risks. This shift from patient-care to customer-care could be very liberating for many people, however, perhaps it is those who need it most who will benefit least from this move. Other approaches such as the BRAN approach can help with more ethical decision-making (National Health Service [NHS], 2021). The BRAN approach ensures that each option is analyzed comprehensively under the following headings:

- Benefits
- Risks
- Alternatives
- Need time or do nothing

This approach helps structure decision making. Within the context of medical transition, the risks do not currently outweigh the benefits for many people, however, through the utilization of the BRAN approach doctors and patients can be provided with a comprehensive analysis of the patient's individual case and perhaps ascertain what is the best move for each person.

When considering the adult's drive to medically transition, the words of John Stuart Mill (1859) are brought to mind: "The only freedom which deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs or impede their efforts to obtain it." Adults are free to choose what they do with their bodies, if they are of sound mind to make that decision. However, civilized societies offer protection to the vulnerable and the young. As there is an insufficient evidence base for social or medical interventions for children and adolescents' gender identity, and as the potential adverse consequences of both social and medical transition may have significant negative consequences, it is arguable that no child can provide meaningful informed consent to such interventions.

1.4 Conclusion and suggestions

The ongoing debate surrounding biological sex and the multitude of conflicting theories on gender has brought to light the complexity of these issues. While biological sex is a fundamental aspect of human existence, the fluid and evolving nature of gender roles and identities has led to a variety of theories and perspectives. Recognizing and respecting diverse viewpoints, while also critically evaluating the implications of the diverse array of theories on gender is essential if we are to deepen our understanding of these issues. Better societal norms and policies will evolve through continued dialogue and examination of these multifaceted topics. Based on our examination of the literature on theories and supported evidence of sex and gender, we suggest the following:

- Recognize the well-established knowledge about biological sex
- Acknowledge that the distinct lack of knowledge about gender identity requires corresponding humility and caution from professionals working in the field
- Support quality research to study the relationship between sex and gender
- Encourage a holistic, mind-body approach to sex and gender with an emphasis on accuracy in language
- Advocate for a deeper understanding of gender-related distress in terms of the stages of development of children and adolescents
- Support more nuanced diagnoses for gender-related distress that move beyond stereotypes
- Support the establishment of a recognized nomenclature for gender-related distress
- Raise public awareness about the limitations of the informed consent model, especially in relation to children and vulnerable people
- Disseminate information about the various theories relating to gender identity so the public is better informed

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Section Two: The Psychology of Gender Dysphoria

2.1 Introduction

Historically, the rates of gender dysphoria (GD) or transgender identification were very low. In 2013, the DSM-5 estimated the incidence of gender dysphoria in adults to be at 2-14 per 100,000, or between 0.002% and 0.014% (APA, 2013). However, these numbers have recently increased dramatically, particularly in adolescent populations. Some surveys suggest that between 2-9% of high school students now self-identify as transgender or “gender nonconforming,” and there is a significant increase in adolescents claiming a “nonbinary” gender identity (Johns et al., 2019; Kidd et al., 2021). The Williams Institute estimates that 1 in 71 teenagers (1.4%) identify as transgender (Herman et al., 2022).

Consistent with these surveys, gender clinics around the world have seen the number of referrals increase rapidly in the last decade. The Gender Identity Development Service (GIDS) clinic at the Tavistock in London, for example, saw a 20-fold increase in the last decade (GIDS, 2021), with similar increases being observed in North America (Respaut & Terhune, 2022; Zucker, 2019a) and Europe (de Vries, 2020; Kaltiala-Heino et al., 2018) and Spain (Exposito, 2023). The rapid change in the number of individuals experiencing gender dysphoria, especially during the COVID-19 lockdowns, points to social and cultural, not biological, causes.

Further analysis of the data reveals some intriguing patterns; the age-range and sex ratio have also changed dramatically (GIDS, 2021; Respaud & Terhune, 2022). Consequently, much of the research prior to this uptick, based on individuals with childhood-onset gender dysphoria or gender dysphoria that began in middle age in natal males, is arguably not applicable to the current cohort of largely natal females with adolescent onset gender dysphoria. This section will provide a deeper analysis of the psychological roots of gender dysphoria, common risk factors and other pertinent issues. Insight into the value of a therapeutic process in relation to working with those with gender-related distress is also provided. In writing this section, we have consulted with clinicians who work with transgender people, detransitioners, trans-identified children, and parents and families impacted by gender dysphoria. The experiences and insights of mental health professionals (MHPs) are presented, alongside the latest research in the field, in the hope of generating further discourse and analysis to deepen our understanding of these complex issues.

2.2 Pathways to gender dysphoria

There is no single pathway to the development of a trans identity and no reasonably uniform short- or long-term outcome of medical treatment. As individuals grow physically, mature psychologically, and experience or fail to experience satisfying romantic relationships, their life course depends on their differing psychological, social, familial, and life experiences. Therefore, treating all trans-identified people in a particular manner is inappropriate. Doing so is problematic for two reasons: first, there is no systematic data on the impact of various treatment models. No reliable data is available comparing affirmative treatment to no treatment or to psychotherapy. Second, as with other psychiatric challenges, outcomes may vary based on a number of factors. As such, knowing the variables associated with these outcomes is important.

The marked shift in the demographics of people presenting with gender dysphoria or identifying as transgender is difficult to explain. Until approximately two decades ago, it was largely prepubescent boys who cross-sex identified, then a change in the demographics occurred (Littman, 2018). Beginning in the early 2000s, one researcher summarizing multiple recent samples documented a shift from 33% female to as high as 88% female (Zucker, 2019a). The GIDS, which arguably provides the most reliable data, saw a shift from 28% to 73% female within a decade (GIDS, 2019). Further recent research indicates that children are presenting for gender-related care at younger and younger ages (Sun et al., 2022).

This concerning pattern was highlighted in an editorial by Dr. Laura Edwards-Leeper and Dr. Erica Anderson (2021), who advocated for clinicians, researchers and the public to take note and ask questions as to why this might be the case. In addition, research has documented “clustering” of new presentations of gender dysphoria among natal females in specific friend groups (Littman, 2018), as well as sharp differences in rates of students who identify as trans in particular schools or school districts (Kidd et al., 2021). These dramatic changes in patient population and patterns suggest social factors may play a significant role, at least among adolescent females in recent years.

2.2.1 Typology and classification of gender dysphoria

Gender dysphoria has distinct characteristics depending on an individual's age of onset and sex. According to the DSM-5, there are at least five distinct subsets of gender dysphoria: early childhood onset; onset near or after puberty with no prior cross-gender patterns; onset after defining oneself as gay for several years and participating in homosexual activity; adult onset after years of heterosexual transvestism; and onset in later adulthood with few or no prior indications of cross-gender tendencies or identity (Levine, 2021).

The developmental and mental health patterns for each of these groups are sufficiently different that data collected from one of these subsets cannot be assumed to be applicable to the other subsets. Research shows, for example, that young children with cross-sex identification typically suffer fewer symptoms of concurrent mental distress

than older patients (Zucker, 2018). Equally, findings from gender dysphoric adult heterosexual males with cross-dressing tendencies, are not likely to generalize to those who begin to experience gender distress in early puberty. For this reason, three separate categories, child onset, adolescent onset and adult onset, are outlined here to distinguish and describe each group.

2.2.2 Childhood onset gender dysphoria

Children who identify as transgender are often unaware of a vast array of ways to live life as a man or a woman—possibilities that become increasingly apparent over time. A boy or a girl who expresses interest in pursuing a transgender identity often does so based on stereotypical notions of femaleness and maleness that reflect constrictive notions of what men and women can be (Levine, 2017).

A young child's—and often an adolescent's—understanding of what it means to be a man or woman is quite limited. When considering medical gender transition, they are not likely to grasp what it may mean for their future to be sterile or have limited sexual function, or even the impact medical transition will have on intimate relationships. These children often consider themselves to be relatively unique; they do not realize that discomfort with the body and societal gender roles is neither rare nor new to civilization. What is new is that such discomfort is now thought to indicate that they must be transgender.

2.2.2.1 Typical outcomes among early onset cohort

A critical finding in follow up studies of those with childhood-onset gender dysphoria is that in most cases, the gender distress resolves naturally without any intervention (Zucker, 2018). As outlined by Cantor (2019), each follow-up study of children diagnosed with gender dysphoria found that by puberty, most children with GD ceased to want to transition, aligning with their biological sex. While some have argued that these desistance findings are invalid because the patient population did not meet the current DSM criteria (Temple Newhook et al., 2018), careful analysis has reaffirmed the original findings (Zucker, 2018). Multiple studies have highlighted that without affirmative intervention, such as social transition or puberty blockers, gender dysphoria does *not* persist through puberty (Adelson et al., 2012; Cantor, 2019; Cohen-Kettenis, 2008; Zucker, 2018). The Endocrine Society guidelines recognize this important baseline fact (Hembree et al., 2017).

2.2.2.2 The Dutch Protocol and the early onset cohort

The Dutch Protocol is the current basis for what is often known as 'affirmative treatment' (i.e. medically transitioning children and adolescents) (de Vries & Cohen-Kettenis, 2012; de Vries et al., 2014). Prior to the Dutch Protocol, only mature adults were allowed to transition. Because those results were suboptimal, with persistent distress and mental illness despite their transition, the Dutch researchers hypothesized that through early intervention they could achieve better cosmetic outcomes—and hopefully, happier and better-functioning adults (Cohen-Kettenis & Van Goosen, 1997; Delemarre-van de Waal & Cohen-Kettenis, 2006; Gooren & Delemarre-van de Waal, 1996). What is known today as

the Dutch Protocol is based on the results of 55 of 70 patients selected from an original pool of 196 patients, 140 who were eligible for medical treatment and 111 who were prescribed puberty blockers (de Vries et al., 2011; de Vries et al., 2014).

The Dutch Protocol study (70 patients) required childhood-onset gender dysphoria, family involvement and extensive assessment. If a child met the criteria, they were prescribed puberty blockers (M = 14.8 years, SD = 1.8); followed by cross-sex hormones (M = 16.7 years, SD = 1.1); and gender reassignment surgeries (M = 19.2 years, SD = 0.9). Data were gathered one year after the surgeries. It should be noted that the Dutch researchers acknowledged the high desistance rate, discouraged social transition and advocated that their patients understood the biological reality of sex.

These researchers found that 55 of the 70 patients reported that their gender dysphoria improved, as did some aspects of their mental health. It should be noted, however, that a recent analysis of the gender dysphoria scales used to evaluate gender dysphoria, Utrecht Gender Dysphoria Scale (UGDS), calls into question the reported reduction in dysphoria, pointing out that the reduction may be due to an artifact resulting from switching the male and female version of the scales after surgery (Levine et al., 2022). The 15 patients who were excluded from the analysis included patients who did not complete questionnaires (no reasons provided), those who suffered significant negative complications (e.g., severe diabetes, obesity), those who were not yet one year post surgery, and one patient who died following complications from genital surgery. Thus, the research used to justify the Dutch pediatric gender transition protocol did not report on 20% of their selected participants and had a mortality rate of 1.43%. Further, when other countries adopted the Protocol, no long-term follow up of these patients had been conducted; nor has any study been able to replicate these results (Carmichael et al., 2021). Nevertheless, the Dutch Protocol continues to be considered the gold standard by many advocates of pediatric transition.

2.2.2.3 The impact of puberty blockers

The administration of puberty blockers during the formative years can significantly impact the outcome of a child's gender dysphoria. Ristori and Steensma (2016), reviewing the follow-up literature, for example, noted that the period between the ages of 10 and 13 years to be crucial. They found that changes in the patients' social environment, such as first experiences of romance, sexual attraction, and the actual and anticipated physical changes to their bodies during this period, contributed to an increase (for persisters) or a decrease (for desisters) in feelings of gender discomfort.

Many advocates of the gender affirmative approach speak of the use of puberty blockers as a 'pause button' to allow the child time and space to consider their options. This optimistic view is not based on science as puberty blockers disrupt critical aspects of human development during a period of significant growth and development of all organs. The bone, brain and cardiovascular health issues caused by puberty blockers are infrequently discussed. Puberty blockers are usually administered at Tanner stage 2 (typically 9-10 years old for girls and 11-13 years for boys). Puberty blockers administered

to boys during this period may result in so little penile tissue that subsequent genital surgeries become far riskier and more complex (Alzahrani et al., 2019; de Vries et al., 2014; Klink et al., 2015; Nota et al., 2018). Moreover, we have no data on the long-term health effects of these agents, or whether there may be differential effects for specific groups of individuals (e.g., neurodivergence, ethnicity, family medical history), or how those whose puberty has been blocked fit in with peers who are undergoing critical maturational gains, not only physically, but socially, psychologically and cognitively.

Thus, the administration of puberty blockers must consider the child as a whole and all factors, and the complex interactions of these factors, which are likely to be affected. Further, since almost all children (95-98%) prescribed puberty blockers go onto cross-sex hormones (Brik, 2020; Carmichael et al., 2021; de Vries et al., 2011; de Vries et al., 2020), the prescribing of puberty blockers virtually eliminates the possibility of desistance. Rather than a 'pause,' they appear to act as a psychosocial 'switch,' decisively shifting children to persist in a transgender identity. Therefore, as a practical and ethical matter, the decision to put a child on puberty blockers must be considered as the equivalent of a decision to put that child on cross-sex hormones, with all the considerations and informed consent obligations implicit in that decision.

2.2.2.4 Social transition in early childhood

Social transition is the term used to describe the process of changing a person's identity in the social context.

"This typically includes a change of name, a change of pronouns (for example, she/her, he/him or they/them) and a change of gender expression. Gender expression can include clothes, style, hair, grooming and even mannerisms that are believed to represent the gender grouping that the individual feels better matches their inner sense of self." (Ayad et al., 2023, p.69)

Children who socially transition utilize bathrooms, locker rooms and other facilities designed for the opposite sex. They participate in sports and other activities as if they are the opposite sex. Some children embark upon a 'stealth transition' and their biological sex remains a closely guarded secret as they present to the outer world as the opposite sex (see more on stealth transition later in this section), other children let everyone know about their transition.

Dr. Hilary Cass, lead of the NHS commissioned report on treatment for gender dysphoria in childhood, pointed out that social transition is an active intervention (Cass, 2022). This is a powerful psychosocial intervention with unknown consequences that MHPs are neither trained nor licensed to undertake. Although it may seem like an easy solution, interventions do not exist to make life simple for involved adults; sometimes a quick fix may cause long-term harm. Social transition in childhood strongly influences gender identity outcomes (Guss et al., 2015) to such an extent that a partial or complete gender social transition prior to puberty has been described as "a unique predictor of persistence"

(Singh et al., 2021, p.14). A comparison of recent and older studies suggests that when an 'affirming' methodology is used with children, a substantial proportion of children who would otherwise have desisted by adolescence persist in a transgender identity (Zucker, 2018). While under a watchful waiting approach in previous decades, 80-90% desisted by early adulthood, under the new affirmation model in which there was either partial or complete social transition before puberty far fewer desist (Steensma et al., 2013; Zucker, 2018). In a recent follow up study of children who were socially transitioned, only 2.5% desisted (Olson et al., 2022). Thus, the scientific literature shows that social transition is a psychotherapeutic intervention that dramatically changes outcomes and could be described as iatrogenic (Zucker, 2019a).

Social transition, like puberty blockers, cannot be thought of as a stand-alone treatment. Studies show that social transition can act as a mechanism that begins a cascade of interventions: social transition increases the likelihood of gender dysphoria persisting and the demand for puberty blockers and this, in turn, leads to cross-sex hormones (Carmichael et al., 2021; de Vries et al., 2014). As a result, there are arguably a number of important risks associated with social transition.

2.2.2.5 Impact on future sexual orientation

Sexuality is not independent of gender identity; the most likely long-term outcome for gender distressed youth is that they will grow up to be gay, lesbian or bisexual (Kaltiala-Heino et al., 2018). Sexual orientation variation is normal, and it may take time for young people to come to understand their sexuality. For these reasons, we suggest little or no radical interventions for childhood-onset gender dysphoria. Children in this cohort are best helped by being supported to develop their coping skills and, with psychoeducation, expand their notions about gender conformity and nonconformity, so they understand there are many ways to be male or female. As discussed in Section One, prepubescent children lack the cognitive ability required to understand the complex and theoretical gender identity belief system. Thus, exposing them to the concept of gender identity will sow confusion and inhibit their understanding of their own sexuality.

2.2.2.6 Sensitivity to high-risk minority groups

Given that a diagnosis of gender dysphoria typically leads to the disruption of the natural resolution of gender dysphoria and puts the young person on a medical pathway that potentially affects all aspects of life, the increasing rates of gender dysphoria diagnosis over the last two decades should be of serious concern to all practitioners (Cheng et al., 2019; Levine, 2018). The factors leading certain populations to be over-represented in gender distress experiences must be addressed by both researchers and clinicians. These factors include youth of color (Rider et al., 2018); those on the autistic spectrum (Shumer et al., 2017; van der Miesen et al., 2018); those with mental developmental disabilities (Reisner et al., 2015); Attention-Deficit Hyperactivity Disorder (ADHD) (Becerra-Culqui et al., 2018); a prior history of psychiatric illness (Edwards-Leeper et al., 2017; Kaltiala-Heino et al., 2015; Littman, 2018); children residing in foster care and adopted children (at a rate more than 3x the general population) (Shumer et al., 2017); victims of

childhood sexual or physical abuse or other *adverse childhood events* (Kozłowska et al., 2021; Newcomb et al., 2020; Thoma et al., 2021); and adolescent girls (Rider et al., 2018). These risk factors for the development of gender dysphoria, especially for those on the autism spectrum, will be discussed in greater detail later in this section.

2.2.3 Adolescent onset gender dysphoria

Adolescence is a pivotal life stage marked by intense physical, psychological, and emotional changes. As young people navigate the bridge between childhood and adulthood, they experience rapid growth and development, hormonal fluctuations, and ongoing brain maturation while they search for meaning and purpose. During adolescence, individuals are more prone to engaging in risky behaviors and tend to prioritize immediate rewards over long-term consequences. This is largely due to the ongoing structural and functional maturation of the brain, especially the prefrontal cortex, which governs executive function and impulse control, and continues to develop into the third decade of life (Katz & Webb, 2016; Lenroot & Giedd, 2006; Marquez-Ramos et al., 2023). The unique and prolonged development of the prefrontal cortex signifies that while adolescents are physically maturing into adulthood, their brains are still undergoing significant change; meanwhile, the surge of hormones during this period often amplifies emotional volatility (O'Malley, 2023).

Although many adolescents develop resilience during these tumultuous years, some have far more difficulty navigating the changes. They may develop unhealthy thought patterns and behaviors, lack coping skills, and become vulnerable to peer influence. Their challenges can be exacerbated when exposed to misleading online narratives that over-emphasize the role of mental illness in identity formation and encourage self-diagnosis. It is recommended that MHPs and other involved adults working with this cohort proceed with caution and compassion; the intense emotionality of the adolescent is not best served by corresponding emotionality from adults (Ayad et al., 2023).

2.2.3.1 Rapid onset gender dysphoria

Dr. Lisa Littman's description of 'rapid onset gender dysphoria' (ROGD) among adolescents lists a range of concerns that MHPs and other involved adults should consider when working with this cohort. The ROGD cohort are often very vulnerable; 62.5% of the parents in Dr. Littman's study reported that their children had one or more pre-existing neurodevelopmental or mental health issue; 43.1% had experienced a pattern of isolation from their peer group; 45% were engaging in self-injurious behavior prior to identifying as trans; 48.4% had encountered a traumatic or stressful event before the onset of ROGD, and 69.4% experienced social anxiety during their adolescent years (Littman, 2018). This cohort is also cerebral; Dr. Littman found that almost half of the young people described in her paper had been identified as academically gifted. MHPs and other involved adults need to be aware of the vulnerabilities and the strengths of the ROGD cohort. Clinicians working in the field note that these adolescents and young adults tend to be highly strung, sensitive, and emotionally volatile. This combination of traits can lead adults engaged in the care of these young people to feel like they are walking on

eggshells around them. It is valuable if adolescents meeting the ROGD descriptor are gently helped to confront the reality of life. Many ROGD youth are idealistic, spending excessive time online, often in online groups, creating a virtual persona far removed from their real life. It is valuable for MHPs to help expand the life of ROGD youth beyond the online world as they often use virtual reality to escape from their real life.

2.2.3.2 Online influences

Social media has come under significant scrutiny for its suspected contribution to rising mental health challenges among teenagers, particularly females, in the western world. Many experts suggest that there may be a connection between the surge in depression, anxiety, and suicidal ideation among teenagers and the advent of social media and smartphones (Haidt & Lukianoff, 2018; Haidt et al., ongoing 2023; Haltigan et al., 2023). Social media platforms have the capacity to simultaneously reduce the stigma associated with mental illness by facilitating open discussions, and yet, they unintentionally romanticize mental health conditions. The rise of mental health-related content gained prominence on platforms such as Tumblr during the 2000s, and more recently on platforms like Instagram and TikTok (Haltigan et al., 2023).

TikTok has rocketed to popularity among 13-17-year-olds, with approximately 67% of teens (n= 1,316) saying they use the short-form video sharing social network (Vogels et al., 2022). According to one report, there was a substantial surge in mentions of “mental health” on social media platforms, rising 80.53% between the years 2019 and 2020 (Captiv8, 2020). These platforms offer spaces where young people discuss mental health issues and find niche online communities, as evidenced by the numerous mental health-related hashtags amassing billions of views (Tik Tok Newsroom, 2022). Some researchers have used the term ‘sick-role subculture’ to describe the online subculture formed around the shared experience of perceived illness or identifying with a particular condition or set of symptoms (Harness & Getzen, 2022).

2.2.3.3 Self-diagnosis and identity

Dominant online narratives in the realm of disability rights often encourage self-diagnosis, viewing it as a valid substitute for a diagnosis by a qualified expert. These online communities often embrace self-diagnosed mental health conditions as an important part of one’s identity (Caron, 2022). However, researchers advise that overly identifying with a self-diagnosis can prevent personal growth by providing a convenient justification for behaviors without examining the underlying motivations which might be uncovered with professional help (Haidt & Lukianoff, 2018; Haltigan et al., 2023). Clinicians have noted that these self-diagnoses may also impede an adolescent’s identity formation by providing a ready-made identity.

While teenagers are developing more advanced reasoning skills, they may continue to struggle with abstract thinking and an inability to consider multiple perspectives. As a result, they might default to simpler, dichotomous explanations. Some teens can get

stuck in unhelpful beliefs or assumptions. They may become fixated on a single reason for their distress when the real cause is multifactorial. Without proper assessment by a trained professional, self-diagnosis can fail to accurately rule out other conditions with similar presentations, and thereby prevent differential diagnosis and the consideration of comorbidities.

Self-diagnosis often relies on comparing one's personal distress with the anecdotal experiences of others, by looking up symptoms, or even by taking online quizzes (Ayad et al., 2023). A largely unexplored factor is the way social media encourages users to become *influencers* and develop a *brand*, potentially solidifying their identities through the audiences they cultivate, by telling them what they want to hear and being rewarded for it. Mental health influencers mostly consist of untrained professionals; they are incentivized to create content that will attract and grow a social media following. One analysis found that only 9% of TikTokers offering mental health advice on the platform had a relevant qualification (Plushcare, 2022). This analysis found that 83.7% of the mental health videos being shared were misleading, and at least 14.2% were found to promote potentially harmful mental health misinformation.

Researchers have questioned whether social media algorithms are enabling the spread of self-diagnosed mental health conditions (Burton et al., 2021). These algorithms are designed to show users more of the content they engage with the most, creating a positive feedback loop. When most of the content a user sees on social media represents only a particular viewpoint, behavior, or lifestyle, it results in a distorted perception. A logical fallacy known as the *illusory truth effect* can also lead users to believe in false information through repeated exposure (Hassan & Barber, 2021). While these online spaces may offer valuable support, they also run the risk of reinforcing or even amplifying illness behaviors, especially if the community becomes an echo chamber without external perspectives. This may be why adolescents experience greater gender distress after coming out as transgender (Ayad et al., 2023).

2.2.3.4 Social contagion online

New research suggests that social contagion via extended social media use could account for why some teens, predominantly adolescent females, self-diagnose with rare mental illnesses and personality disorders (Haltigan et al., 2023; Heyman et al., 2021). The rise of 'TikTok tics' saw teenagers developing physical and verbal tics with no known biological cause after viewing TikTok influencers with Tourette's syndrome (Olvera et al., 2021). It is notable that, in new research from the University of Calgary, 43% of teens in their study (294 patients with FTLBs, 97% of whom were adolescents and young adults and 87% of whom were female) who presented with 'TikTok tics' also self-identified as transgender or nonbinary (Ghorayshi, 2023). Another trend involves the resurgence of the extremely rare condition of Dissociative Identity Disorder (DID)—where individuals believe they possess multiple personalities. Researchers believe the recent surge in self-diagnosed DID cases is also socially influenced rather than organic (Christensen, 2022; Haltigan et al., 2023). This trend of self-diagnosis on social media platforms appears to

extend to other conditions including bipolar disorder, borderline personality disorder (BPD), Obsessive-Compulsive Disorder (OCD), Autism Spectrum Disorder (ASD), Attention-Deficit Hyperactivity Disorder (ADHD) and Gender Dysphoria (GD) (Slay, 2021).

Transgender content online has exploded in popularity over the last decade and has gained increasing traction over the past few years (Herman et al., 2022). Clinicians report that the narratives in online transgender spaces can be particularly appealing to adolescents. Videos by trans influencers on TikTok and YouTube commonly describe 'coming out' as transgender in overwhelmingly positive terms. They present medical transition as a kind of magical remedy and describe experiencing "gender euphoria" from the effects of cross-sex hormones (Edwards, 2018). The increasing visibility of detransitioners and their testimony supports the social contagion hypothesis, shedding light on the ways that trans-identities are socially influenced. Detransitioners often describe being influenced by transgender narratives online that portray transitioning as a panacea (Littman, 2021).

Anecdotal video accounts from influencers who have become absorbed by a transgender identity often rely heavily on stereotypical portrayals of masculinity and femininity. For example, if a girl exhibits preferences and behaviors aligning more with stereotypical male traits, it is sometimes taken to indicate a male gender identity. As a result, adolescents might erroneously associate their own gender-nonconforming preferences and behaviors with symptoms of gender dysphoria. Furthermore, teens may be motivated to identify with marginalized groups (Haidt & Lukianoff, 2018).

In current cultural contexts, clinicians note that LGBTQ identities are celebrated, and adolescents who have adopted one of these identities often receive positive attention. A further incentive for adopting a trans-identity is gaining instant popularity and a sense of community among a constellation of new friends, which may be particularly attractive to those who have struggled to fit in socially (Ayad et al., 2023). In this context, clinicians are also concerned that detransitioners have often described the experience of being 'love-bombed' by the trans community when they initially came out as transgender. Love-bombing refers to a manipulative tactic often employed by cults to influence and control individual members (Huntington, 2022). It involves overwhelming a person with excessive affection, attention, and validation to create emotional dependency and foster a sense of loyalty and belonging within the group.

2.2.3.5 Social transition among adolescents

Social transition among adolescents (as in social transition in childhood) involves presenting as the gender they identify with, this is typically carried out through a name change, different pronouns, using different facilities and taking part as the opposite sex in sporting activities. However, the impact of testosterone on adolescent boys makes social transition a risky venture for a socially transitioned biological girl who presents as a transboy to play alongside boys in heavy contact sports. Equally, the sexual awakening that takes place in adolescence means that residential activities are fraught with sexual tension that could again create a dangerous situation for a vulnerable teen.

Many trans-identified young people use binders to bind their breasts. However, binding is a harmful and painful intervention that is not suggested. A survey of 76 trans-identified females who engaged in breast binding found that 68% were concerned about the health effects. The most common symptoms associated with binding were back pain (65%), shortness of breath (48.6%), bad posture (32%), chest pain (30%), and light-headedness (30%) (Poteat et al., 2018). Another study looked at 27 different negative health effects of binding and found that some harms do not show for years; this survey of 1,800 females who used breast binders reported a number of negative health effects some of which were felt immediately, while others took years to be fully seen (Peitzmeier et al., 2021).

Tucking is another do-it-yourself intervention that causes harm and is not recommended. Reported symptoms included itching (28%), rash (21%), testicular pain (17%), penile pain (14%), and skin infections (12%) (Poteat et al., 2018). Clinicians working with adolescents with gender dysphoria assert that the ceremonious aspect of binding and tucking, coupled with the dark glamor it exudes to teenagers, suggests that binding and tucking and other similar interventions may be experienced as an elaborate form of self-harm.

2.2.3.6 'Troubled teens'

Adolescents seeking services from gender clinics exhibit clinically significant psychopathology to a similar degree as those referred to mental health services for different reasons (de Vries et al., 2016; Zucker et al., 2012). Some trans-identified youth may fit the profile of a 'troubled teen,' which typically refers to an adolescent who is experiencing emotional, behavioral, or psychological challenges, including, but not limited to emotional and behavioral disorders, which might disrupt various areas of their life. Such challenges could encompass a wide range of issues including self-harming behavior, substance abuse, mental health disorders, family conflicts, academic struggles, involvement in risky behaviors, or difficulties with authority figures. Some situations can become so severe that 'troubled teens' require more intensive interventions, including inpatient psychiatric hospitalization. New research suggests that trans-identifying youth are overrepresented in inpatient psychiatric treatment (Alastanos, 2017; Stevens, 2023). Research also indicates that suicidal thoughts and behaviors among trans-identified youth might be linked to broader emotional and behavioral issues, potentially heightening their susceptibility to such tendencies (de Graaf et al., 2020). Among female trans-identified adolescents, the presence of suicidal ideation was correlated with challenges in peer relationships, along with a broader array of behavioral and emotional problems. Comparisons between the risk of suicidality in trans-identified adolescents and non-trans-identified counterparts who share similar mental health profiles revealed a relatively comparable level of risk. These findings draw into question the minority stress hypothesis (that mental issues are a result of stigmatization) as an explanation of mental health challenges in trans-identified youth.

2.2.3.7 Idealized beauty standards

In the contemporary digital realm, the challenges faced by teenagers are amplified by the pervasive impact of social media. Young girls are bombarded with images of idealized

beauty standards featuring heavily edited photos of celebrities and influencers, filtered to alter their facial features into idealized proportions (Damour, 2017; Twenge, 2018). For those who struggle to attain these perceived ideals, the effect on their self-esteem can be significant. Some might embrace a transgender or nonbinary identity as a way of rejecting what they mistakenly view as traditional womanhood. Internalized misogyny may further complicate matters (Herzog, 2017; Littman, 2021). For certain individuals, the allure of transitioning to a different gender might be viewed as a method to liberate themselves from the constraints of oppressive societal expectations.

2.2.3.8 Online 'grooming'

The term 'grooming' in the context of trans-identity is controversial. The term has expanded its meaning beyond acts that are sexual and predatory in nature. Within this context, 'grooming' entails a methodical process in which individuals are systematically manipulated, conditioned, and readied to embrace and conform to the ideology, rituals, and conduct of a specific group. Simultaneously, 'grooming' involves isolating potential candidates for the specific group from their offline relationships and connections, including family members.

TrevorChat (n.d), an initiative by the nonprofit organization The Trevor Project, illustrates this type of 'grooming;' it provides a platform for individuals aged 13 to 24 to engage in conversations, but concerns have been raised regarding inappropriate exchanges between adult users and minors, some of which include discussions of a sexual nature. There have also been instances of minors being advised to conceal their gender transition from their parents and being offered guidance on how to access transitioning resources without their parents' knowledge (Downey, 2022). TrevorChat, like many other similar platforms, offers a feature to swiftly exit conversations should a parent enter the child's room.

When individuals engage in these online communities to find understanding and express uncertainty about their own identity, other participants often respond by suggesting that the mere act of questioning a transgender identity is indicative of being transgender. This sentiment is encapsulated by the frequently used phrase, "if you think you might be trans, you are" (Transhub, n.d.).

Posts in online message boards devoted to transgender communities such as those on Reddit have been found to advise teenagers on how to manipulate parents and medical professionals to obtain hormone treatments. Encouraging secretive actions without parental knowledge is a recurrent feature of these communities; adolescents exchange advice on techniques like binding, packing, initiating testosterone use, or even undergoing double mastectomies without parental consent while residing at home (Littman, 2021; Reddit, n.d.(a); Reddit, n.d.(b)). The information communicated in these boards parallels that of Thinspiration, Pro-Ana and Pro-Mia groups that have been well-documented (Mento et al., 2022).

In some transgender online groups, if a teenager's parents are hesitant to embrace their newly arrived-at transgender identity, adults offer to function as surrogate family members, often referred to as "glitter families" (Shrier, 2020). The portrayal of parents as unsupportive or unloving is perpetuated by some individuals. Memes circulating on the internet, and even being posted as fliers by teachers, convey messages such as: "If your parents don't accept your identity, I'm your mom now" (Mondegreen, 2023). Research indicates that youth who identify as transgender devote a significant portion of their time online in curated social media communities where they can express their identities through personally chosen images and pronouns (Coyne et al., 2023). Digital spaces can be precarious for teens who are merely exploring their identities during the developmentally appropriate process of identity formation in adolescence and young adulthood. Excessive periods of time spent online can foster unhealthy thinking, promote dangerous behaviors, and even allow predators to operate (Ayad et al., 2023). MHPs and involved adults must be cognizant of the issues related to excessive periods of time spent online for gender dysphoric youth so that they can begin to help them expand their world beyond their bedroom and the internet.

2.2.3.9 Pornography

In recent years, clinicians report that exposure to pornography has provided a pathway to transgender identification among adolescent boys. The proliferation of smartphones offers unrestricted and unprecedented access to internet resources, including online pornography; the impact of this has yet to fully unfold (Rathod et al., 2022)

The well-known adult content platform, Pornhub, unveiled its 2022 data on the most frequently searched terms. This data revealed a significant surge in popularity for the term 'transgender,' which is now the United States' third most searched category. This rise reflects a 75% increase from the figures recorded in 2021 (Pornhub Insights, 2022). A distinct subcategory within transgender pornography known as "sissy porn" centers on a humiliation fetish where men partake in 'forced feminization,' encompassing activities such as dressing, applying makeup, and engaging in sexual submissiveness. Google Trends data highlights that searches for 'sissy porn' have experienced a tenfold surge in the United States since 2010 (GoogleTrends, 2023). An even more specific subset is referred to as "sissy hypno," an abbreviation for 'sissification hypnosis.' This entails a form of guided meditation that instructs men to visualize themselves as females (Gluck, 2020). This genre has been referred to as "pornography-induced dysphoria" (Gluck, 2020). While the rise of these new forms of pornography is suggestive, further research is needed to understand its role in promoting transgender identification among teenage boys.

Clinicians working with detransitioners have gained some further insight into the impact of pornography. For example, some male detransitioners have suggested that their initial identification as transgender was partly a response to societal expectations associated with traditional notions of masculinity, particularly as portrayed in certain aspects of the pornography industry (Boyce, 2022). For these individuals, identifying as transgender

represented a way to renounce what they perceived as "toxic masculinity." They believed that by transitioning, they could escape the pressure to conform to these stereotypes and expectations.

2.2.4 Adult onset gender dysphoria

The heavy burden of medical transition upon the body and mind is well-established for adults. These include, but are not limited to, impaired sexual functioning, sterility, incontinence, cardiovascular disease, impaired cognitive functioning, and increased risk of dementia, which are but some of the physical challenges that may confront the individual who medically transitions (Ayad et al., 2023; Cheng et al., 2019; Nota et al., 2018; Wierckx et al., 2012).

Nonetheless, some people may choose to take these risks based on their values and preferences. We believe that personal autonomy must be protected in a free society; prohibition does not work and typically drives activities into an underground system. Adults who are mentally competent to make these choices should be free to do so provided they have been sufficiently informed to give informed consent. However, vulnerable adults need protection. Doctors and MHPs are not shopkeepers; they are highly qualified professionals who are required to adhere to strict ethical standards. In this context, clinicians and doctors must abide by the ethical principle: Above all, do no harm.

2.2.4.1 Internalized homophobia

Although ROGD may account for a good deal of the rise in the numbers of adolescents and young adults seeking to medically transition, there have been many accounts of internalized homophobia as a reason for adults to seek transition (Ayad & O'Malley, 2021, 3:19; Genspect, 2022a). Butch lesbians speak about the difficulties of being masculine-presenting women in society (LGB Alliance, 2020). Clinicians report exhaustion among gender nonconforming gays and lesbians who feel embattled by too many questions inquiring whether they are men or women. The satisfaction wrought by presenting in a manner that suits their inner sensibilities can often be tarnished by a society that has yet to fully accept that women can wear suits, speak loudly, sit with their legs spread apart and behave in a stereotypically masculine manner; notwithstanding the many Pride marches and the current emphasis on LGBTQ issues. The rise in the number of drag acts including drag kings as well as drag queens might provide further recognition to the concept of masculine women and feminine men. However, some argue that drag is regressive and does not help gender nonconforming people in society. In any case, the anecdotal data about the number of butch lesbians seeking to transition suggests that there could be a societal issue at play that needs some further attention.

2.2.4.2 Autogynephilia

Ray Blanchard first introduced the term autogynephilia in the 1980s when he classified the males seeking to transition as either heterosexual autogynephilic males or homosexual males (Blanchard, 2005). The word autogynephilia is derived from the Greek

and means 'love of oneself as a woman' and describes a male's propensity to be sexually aroused by the thought of himself as a female (Lawrence, 2011). In fact, Blanchard posits that autogynephilia is a sexual orientation (Blanchard, 2005). This is an extremely under-researched and controversial paraphilia that can cause great shame in the sufferer and great harm to others. Many dispute that their gender identity is related to their sexual impulse. However, autogynephiles assert that Blanchard's typology resonates deeply with them (Ayad & O'Malley, 2021, 11:26). The term 'homosexual transsexual' has also been heavily disputed by critics of Blanchard's work, perhaps because it prioritizes the person's sexual motivation rather than their gender identity.

Blanchard identified four types of autogynephilic behavior (it must be noted that types often co-occur):

- **Transvestic autogynephilia:** the individual is aroused by the act or fantasy of wearing typically feminine clothing
- **Behavioral autogynephilia:** when the act or fantasy of behaving in a stereotypically feminine way causes arousal
- **Physiologic autogynephilia:** when acts or fantasies of body functions specific to women are arousing
- **Anatomic autogynephilia:** when the act or fantasy of having female body parts cause arousal

The exact nature of the relationship between autogynephilia and gender dysphoria is unclear; however, the drive to medically transition appears to often be a commonality. Blanchard's typology has attracted a good deal of criticism, yet many clinicians working in the field find it a helpful way to understand some males' extraordinary determination to transition.

2.2.4.3 Temperament

It can be valuable for MHPs to know that certain temperaments and personality traits can predispose individuals to trans-identification, particularly those who exhibit characteristics such as introversion, creativity, empathy, immaturity, insecurity, anxiety, emotional instability, sensitivity to criticism, social awkwardness, and a tendency to ruminate (Furento et al., 2023; Roberts et al., 1998). Clinicians report that these individuals might not actively participate in work or extracurricular activities and may feel disconnected from peers who share different interests. As a result, they might withdraw further and seek refuge in online communities, often preferring to lead a virtual life. This inward focus may drive the pursuit of an identity label, rather than engagement in activities and interactions that might enhance self-confidence and provide real identity exploration and development.

Currently, there is little quality research in this field. In this context we cannot offer definitive information, rather, in this section, we offer potential psychological motivations that could underlie an individual's desire to transition. It behooves the MHP and other

involved adults to ensure they view the person beyond a pathological viewpoint and instead in a holistic manner so that they can better offer appropriate support.

2.3 Common co-occurring challenges

Diagnostic overshadowing involves clinicians who neglect to consider concurrent conditions (comorbidities) that might have contributed to gender-related distress, or potentially provide an alternative explanation for mental health challenges other than gender dysphoria. This issue has emerged as a significant concern due to the growing prevalence of detransitioners (Cass, 2022; Littman, 2021). Based on two separate surveys, a notable majority of detransitioners (70%) opted to detransition after realizing that their gender dysphoria stemmed from other issues (Littman, 2021; Vandebussche, 2022). For this reason, we suggest that MHPs working with gender dysphoria take the time to explore the impact of co-occurring challenges and engage in differential diagnoses before radical interventions are considered. The following list is not exhaustive, rather it illustrates the wide range of challenges that can impact the gender dysphoric individual's sense of self and provides some insight into how this can be tackled.

2.3.1 Depression

MHPs working with young people with gender dysphoria note that for many, transitioning is initially viewed as a pathway to happiness, and a potential solution, especially for people who feel unhappy or depressed. Clinicians also report that some transgender people perceived their medical transition as an avenue of escape from emotional pain. Transitioning might also be perceived as an opportunity to reinvent oneself with a new identity for those who are dissatisfied with their current selves. Transgender identities then could be seen as symptomatic expressions of, rather than underlying causes for, feelings of depression and dissatisfaction. Individuals struggling with a range of psychological and emotional difficulties might gravitate toward medical transition instead of engaging in a demanding psychotherapeutic process and, for example, learn to challenge their negative thought patterns, destructive self-talk, and harmful behavior patterns. Opting for transition may offer what is perceived as an easier, more tangible solution.

Adolescents grappling with depression may find themselves particularly susceptible to transgender narratives. Studies on teenagers seeking treatment at specialized gender clinic services in Europe and North America reveal significant mental health issues in this cohort (Becerra-Culqui, 2018). The rate of mental health problems differs between countries, with the lowest being around one-third in the Netherlands and the highest being up to three-quarters in Finland and Canada (de Vries et al., 2011; Kaltiala-Heino et al., 2015; Zucker et al., 2012). Low self-esteem and depression are often closely interconnected (Orth & Robins, 2013). Individuals with low self-esteem tend to hold negative views about themselves, their abilities, and their worth. Research has shown

that, compared to age-matched controls, trans-identified children have lower self-perception in two domains: physical appearance and global self-worth (Alberse et al., 2019). Notably, detransitioners frequently recount experiencing depression and low self-esteem prior to adopting a transgender identity, often believing that transition would alleviate their distress.

2.3.2 Obsessive-Compulsive Disorder (OCD)

Numerous studies have found overlapping features between Obsessive-Compulsive Disorder (OCD) and gender dysphoria (VanderLaan et al., 2015b; Zucker et al., 2017). Some researchers suggest that the observed characteristics of gender dysphoria might actually represent manifestations of OCD (Perera et al., 2003). In this context, an individual might incorrectly attribute their distress to their biological sex and subsequently develop an obsessive desire to transition to the opposite sex.

MHPs report that children referred for gender dysphoria displayed heightened symptoms of obsessions and compulsions compared to their non-referred peers (VanderLaan et al., 2015b; Zucker et al., 2017). A case study of an OCD patient whose symptoms include the unwanted, intrusive obsessive thought that he was transgender, emphasizes the need to consider OCD as a potential diagnosis in patients who present with new-onset obsessions regarding gender identity (Safer, et al., 2016). Some clinicians have also attempted to distinguish between gender dysphoria and what they have termed Transgender OCD (TOCD) or Gender Identity OCD (GOCD), a subtype of OCD in which a person obsesses over their “gender identity” (Kaplan, 2020; Taylor, 2022). According to Kaplan (2020), TOCD involves intrusive thoughts that cause the person significant amounts of anxiety and uncertainty, as well as compulsive behaviors such as emotional checking, memory review, reassurance-seeking, and researching to relieve the distress.

2.3.3 Attention-Deficit Hyperactivity Disorder (ADHD)

The presence of ADHD as a comorbidity has become a notable prevalence among both trans-identified youth and detransitioners, shedding light on an important correlation. Within a sample of 174 adolescents referred to gender clinics, 23.3% carried a diagnosis of ADHD (Bauer et al., 2021). One metric focused on adolescent gender clinic referrals found that those with ADHD were 6.64 times more likely to express gender variance (Strang et al., 2014). Further, a survey of 237 male and female detransitioners found that nearly a quarter of them had been diagnosed with “Attention Deficit Disorder” (Vandenbussche, 2022). This recurrent connection between ADHD and gender-related experiences warrants further investigation to better understand its implications within these contexts.

2.3.4 Eating disorders and obesity

Clinicians report that trans-identified individuals grapple with significant challenges related to body image and self-perception. The utilization of gender-affirming hormone therapy can introduce changes in body weight, potentially leading to abnormal weight gain, increased body mass index, or even the exacerbation of disordered eating and

obesity-related complications (Williams et al., 2022). One survey of 14,804 college students revealed that those identifying as transgender exhibited a higher likelihood of either being underweight or obese when compared to their non-trans identifying counterparts (VanKim & Nelson, 2013). Multiple studies have found that disturbed eating patterns are prevalent among trans-identified youth (Avila et al., 2019; Watson et al., 2016), and a comprehensive review of the literature further highlights elevated rates of eating disorder symptoms within trans-identified youth in comparison to their non-trans-identified counterparts (Coelho et al., 2019). Further, a recent survey of 94 detransitioners and desisters found that 45.7% reported struggling with an eating disorder (Buttons & Rowley, 2023). One study revealed that trans-identifying youth were more inclined to perceive themselves as underweight, even when objective measurements indicated that they were overweight (Guss et al., 2016). A recent chart review study focusing on 277 trans-identified youth also unveiled striking figures: 20.2% may be classified as overweight and 30.3% as obese (Fornander et al., 2022).

2.3.5 Body Integrity Identity Disorder (BIID)

Body Integrity Identity Disorder (BIID), which is not listed in the current DSM-5 as an official disorder, is a rare psychological condition in which an individual experiences a profound and distressing desire to have a specific body part, typically a limb removed, or to become disabled. This desire does not seem to be rooted in physical discomfort or medical necessity but rather is rooted in a deep-seated psychological need to have their body align with their perceived sense of being disabled.

Lobby groups representing individuals with BIID draw parallels between their desire for amputation and the desire of transsexuals for surgical sex reassignment (Müller, 2009). Some psychologists have likened BIID to gender dysphoria (previously termed gender identity disorder), as both conditions involve discomfort with certain body parts conflicting with internal identity. Both conditions often originate in childhood, involve imitation of the desired identity and may evoke sexual arousal. Notably, a significant number of individuals expressing a desire for amputation are also male-to-female transsexuals (Berger et al., 2005; Braam et al., 2006; Dyer, 2000; First, 2004; Money et al., 1977).

Some research has indicated the co-occurrence of gender dysphoria and BIID in 19% of cases (First, 2004; Garcia-Falgueras, 2014; Lawrence, 2006), leading to the recommendation that BIID be categorized as an identity disorder in the DSM (First, 2004). To illustrate the undeniable parallel, researchers have even directly translated the definition of Gender Identity Disorder (GID) into the definition of BIID, replacing terms like 'male' with 'able-bodied' and 'female' with 'disabled' (Furth & Smith, 2002). Support groups for BIID utilize the term 'transabled' to draw an analogy with 'transgender,' highlighting the desire for amputation being similar to the desire for sex reassignment. Furthermore, a sexual aspect comparable to autogynephilia has been proposed as research has found that a desire for amputation and fetishism are correlated. One study, for example, with 52 participants, found that 87% of individuals with BIID were sexually attracted to

amputees, and about one-third exhibited additional paraphilias such as, transvestism, fetishism, masochism, and pedophilia (First, 2005).

2.3.6 Trauma

The process of internalizing trauma might lead individuals to reject their own bodies. For instance, a girl who experienced sexual assault might wish to distance herself from her gender and pursue procedures like a double mastectomy. Similarly, a young boy who endured abuse might opt for surgery to remove his genitals. In such cases, the act of transitioning could reinforce the idea that emotional pain resides within the body and can be alleviated by altering physical attributes (Marchiano, 2021). Instances of sexual abuse or assault frequently influence a desire to disassociate oneself from the gender associated with the traumatic experience (Littman, 2021; Respaut & Terhune, 2022, Respaut, 2023).

Research among detransitioners indicates that trauma plays a significant role in the emergence of a transgender identity and the subsequent pursuit of medical transition (Littman, 2021; Vandebussche, 2022). In Littman's study of 100 detransitioners (2021) 38.0% of detransitioners linked their gender dysphoria to specific triggers such as trauma, abuse, or mental health conditions. Another study showed that at least one-third of detransitioners experienced co-occurring post-traumatic stress disorder (PTSD) (Vandebussche, 2022). A recent study of detransitioners and desisters further underscores the impact of trauma, with a substantial 61.7% reporting either traumatic events or a PTSD diagnosis (Buttons & Rowley, 2023). Among participants in these investigations, internal factors were often cited as primary motivations for their decision to detransition, including a decline in mental well-being after transition or the realization that their gender dysphoria stemmed from an unfavorable response to trauma (Evans, 2023).

2.3.7 Internalized homophobia

Clinicians report a good deal of internalized homophobia in trans-identified clients, and many have achieved positive outcomes only when the individual acknowledged the resistance to their sexual orientation. Research on detransitioners has found that a significant portion of them attribute their initial transition to internalized homophobia, a factor they recognized only retrospectively. Among a study sample of 100 detransitioners, approximately 23.0% cited internalized homophobia, and difficulty accepting themselves as lesbian, gay, or bisexual, as motivations for their transition. Realization and acceptance of their sexuality was a significant factor in their subsequent detransition (Littman, 2021). In another study involving detransitioners and desisters—predominantly those who had previously undergone medical transition—52% expressed a psychological need to address and manage internalized homophobia (Vandebussche, 2022).

2.3.8 Borderline Personality Disorder

The clinical psychologist Dr. Lisa Duval has suggested that young people with traits of borderline personality disorder are “more vulnerable to ROGD, and how aspects of gender identity ideology inadvertently bring about dynamics in dysphoric kids that are reminiscent of borderline personality disorder” (Ayad et al., 2023, p.33). Individuals who exhibit borderline traits such as emotional instability, impulsive and destructive behavior, disturbed patterns of thinking or perception, anger outbursts, feelings of emptiness and intense but unstable relationships, can engage in frantic efforts to avoid real or imagined abandonment (Ayad & O’Malley, 2022, 6:24). Suicidal or self-harming behavior can often manifest. It can be beneficial for the individual with these traits to engage in a long-lasting, deep relationship with an MHP who understands this complex condition.

2.4 Gender and Autism Spectrum Disorder

As there is such a startling overlap between Autism Spectrum Disorder (ASD) and gender dysphoria, it is appropriate to provide a more in-depth analysis of co-occurrence. ASD is a neurodevelopmental condition based on significant challenges with social communication and a restricted, repetitive pattern of interests and behavior (APA, 2013). It affects approximately 1-2% of the worldwide population (Lai et al., 2013; Maenner et al., 2020). Children and adolescents on the autism spectrum are disproportionately represented among the new cohort of young people who self-identify as transgender, with a significant percentage of individuals referred to gender clinics being diagnosed with autism or exhibiting autistic traits. Multiple studies from gender clinics have reported high incidences of autism or autistic tendencies, as determined by various assessment tools. In a recent study of 68 youth seeking medical treatment at a pediatric gender clinic in the United States, 47% had an autism diagnosis (Cohen et al., 2023). Chart reviews of adolescents presenting to the Gender Identity Development Service (GIDS) in London, revealed that approximately 35% exhibited moderate to severe autistic traits (Butler et al., 2018). Different aspects involving the overlap between autism and trans-identification are outlined below.

2.4.1 Gender nonconformity

While there is significant overlap in masculine and feminine traits between the sexes, autistic individuals display heightened gender nonconformity compared to their neurotypical peers. Autistic women have been found to show more masculine physical traits, whereas autistic men often present with less masculine attributes (Bejerot et al., 2012). Studies have consistently found that autistic women identified as tomboys during their childhood (Bejerot & Eriksson, 2014; Ingudomnukul et al., 2007). Gender nonconformity is particularly pronounced in autistic females, with estimates ranging between 22%-33%, compared to 8%-22% in autistic males (Bejerot & Eriksson, 2014; Dewinter et al., 2017; George & Stokes, 2018). Autistic children are also significantly more likely to express gender variance than their neurotypical counterparts (Strang et al., 2014). Autistic females may struggle to identify with traditional definitions of femininity (Kanfiszzer et al., 2017). Overall, autistic individuals tend to identify less with, and hold

more negative views about, the gender group they belong to than neurotypicals (Cooper et al., 2018). Several hypotheses, such as elevated androgen levels in autistic women and differences in brain structure, attempt to explain the notable overlap between autism and gender nonconformity (Beacher et al., 2012; Knickmeyer et al., 2008).

2.4.2 Body incongruence and sensory sensitivity

Autistic individuals often face sensory processing challenges, manifesting as either hypersensitivity or hyposensitivity to stimuli such as sounds, lights, and textures (APA, 2013; Elwin et al., 2012; Tavasoli et al., 2014; Taylor et al., 2020). Furthermore, they encounter difficulties with interoception, making it hard to interpret internal body signals and alexithymia, the inability to understand and convey emotions (Brewer et al., 2016). Proprioception, or the sense of body positioning and movement, can also be problematic, causing coordination and balance issues (Fournier et al., 2010). Cooper et al. (2023) suggest a link between these sensory needs in autism and an increased risk of gender dysphoria. Sensory discomforts, like irritation from specific clothing or grooming activities, may push autistic individuals towards preferences typically associated with the opposite sex. For example, autistic girls might prefer boyish, looser clothing, and boys may prefer feminine attire, not necessarily because such clothing is stereotypically feminine or masculine, but because the individual prefers the sensory aspect of the particular clothing (Milner et al., 2019; Tateno et al., 2008).

The pressure to conform to societal clothing expectations can present significant challenges for autistic individuals, particularly for adolescent girls who may not want to adhere to the latest fashion trends, leaving them feeling excluded, and reinforcing their sense of otherness at a developmental period when their peers are absorbed by these topics. Adolescents with developing bodies that do not feel like they meet stereotypical ideals for their sex may reject their bodies, hyper focusing on their perceived flaws, leaving them at risk of body image disorders. Exposure to discussions on gender dysphoria, in educational settings and online, may particularly resonate with autistic individuals' experiences of bodily discomfort leading them to seek social and medical transitions as potential solutions to reconcile their discomfort.

2.4.3 Intense and restricted interests

Autism is characterized by intense and focused interests known as "special interests" (APA, 2013). Autistic males often gravitate towards objects and gaming, while autistic females are drawn to social content like people, animals, psychology, and even autism itself (Grove et al., 2018; McFayden et al., 2019). In a study by Grove et al. (2018), autism itself emerged as the most prevalent special interest among female participants and ranked third among males. The researchers proposed that this fascination with autism may be linked to a significant proportion of the participants being diagnosed later in life. They developed an interest in autism to enhance their understanding of themselves and found "comfort in autism as an identity" (Grove et al., 2018, p. 9). Similarly, when autistic individuals identify as transgender or receive a gender dysphoria diagnosis, they may also

perseverate on their diagnosis or what it means to be transgender, which may further cement a transgender identity.

Professionals diagnose gender dysphoria with "insistent, persistent, and consistent" assertion of a cross-sex identity (Hidalgo et al., 2013, p. 286). This pattern mirrors autistic engagement with special interests, which vary in duration and last for many years, complicating differentiation between the two conditions. Psychologist Dr. Zucker suggests that autistic fixation could drive the embracing of transgender concepts, potentially making some believe they are transgender (BBC, 2017). Some researchers propose that intense interest in opposite-sex-associated activities could lead to the formation of a cross-sex identity (VanderLaan et al., 2015a). Boys with ASD and gender dysphoria often favor stereotypically feminine interests (van der Miesen et al., 2018), potentially linked to sensory needs (Nabbijohn et al., 2019), and connecting gender dysphoria to ASD (Tateno et al., 2008).

Autistic individuals also exhibit a strong sense of fairness and justice (Kirchner et al., 2016), which may predispose them to engaging in contemporary social justice causes. In online autism communities, discourse centers around the 'neurodiversity movement.' It is notable that online autism and transgender communities frequently intersect. In a recent survey of detransitioners and desisters who had been diagnosed with autism or exhibited autistic traits (Buttons & Rowley, 2023), significant interest in social justice was reported by 95.6% of 94 participants. Further, 85.3% of participants reported that gender identity became an engrossing special interest.

2.4.4 Rigid thinking and cognitive style

Rigid thinking, a common trait in those with autism, (APA, 2013; D'Cruz et al., 2013; Petrolini et al., 2023), involves perceiving situations and ideas in absolute terms, latching on to one idea, and difficulty considering alternatives. Absolute thinking and confirmation bias may put autistic individuals at increased risk of mistakenly adopting a transgender identity. For example, gender nonconformity or social distress may be perceived as a sign of being transgender, which in turn will result in interpreting other inconsequential factors as being transgender further confirming their belief. This quality is believed by some to explain the overrepresentation of ASD among those with gender dysphoria (Strang et al., 2014; van der Miesen et al., 2017).

Rigid thinking in autism can also lead to challenges in understanding social norms. Gender-nonconforming autistic girls, for example, may struggle with comparisons with more feminine peers, potentially resulting in a rigid choice between fully embracing either traditional femininity or masculinity. Autistic individuals' tendency for black-and-white thinking may also lead them to oversimplify the cause of any psychological distress they feel as being due to being transgender. As a result, they may see transition as a panacea that will allow them to fit in better and feel more authentic or alleviate all their discomfort.

2.4.5 Preference for online communication

People with autism often struggle to comprehend social cues and norms, relying on explicit rules and mimicking behaviors to fit in. Research indicates that individuals with ASD often find online communication and socialization more comfortable than in-person interactions, as online environments offer control, reduced sensory overload, and extra processing time (Benford & Standen, 2009). Adolescents with ASD tend to spend more time engaging in internet activities than neurotypical peers (Mazurek et al., 2012). This preference for virtual interactions may stem from the more structured nature of online spaces and the ease of connecting over shared interests.

Although the influence of social media is not unique to those with autism, regular use of social media and exposure to certain content could lead individuals with autism to perceive certain atypical behaviors as 'normal' and to imitate them, while applying information in these platforms differently than their neurotypical peers due to their challenges with social cues and rigid thinking. Moreover, the 'illusory truth effect' which is likely intensified by social media algorithms could lead a minor to believe the contemporary narrative about gender and solidify a trans-identity.

2.4.6 Identity development in ASD

Decades of research consistently highlight a compromised sense of self as a key characteristic of ASD, indicating early challenges in self-development and in relating to others (Lyons & Fitzgerald, 2013). Expressing oneself effectively and forming a clear self-identity is especially complex for individuals with ASD, contributing to diminished self-awareness (Gopnik, 1993; Huang et al., 2017; Vogindroukas et al., 2022; Williams, 2010).

Many high-functioning autistic individuals, particularly those who do not have a diagnosis or an understanding of their diagnosis, have a deep longing to understand themselves and be understood by others. As conversations of gender take center stage in mainstream discourse, autistic individuals may tend to fixate on their own interpretation of what that word means. Recent research has highlighted this trend, particularly among youth who place an increased emphasis on gender identity (van Schalkwyk et al., 2015). In a recent study examining autistic adolescents and adults with gender dysphoria, it was established that gender is "an important identity, which needed to be discovered by the individual, their family and clinicians" (Cooper et al., 2023).

2.4.7 Naivety and gullibility

Naivety is another hallmark characteristic of autistic spectrum often linked to challenges in understanding social cues, hidden intentions, sarcasm, and deception (Gutstein & Whitney, 2002). This naivety could give rise to unrealistic expectations, particularly concerning social and medical transitions and the aspiration to be acknowledged as a member of the opposite sex. It is notable that clinicians remark on the surprising level of naivety evident among ROGD youth, and equally, this cohort is linked disproportionately with ASD. Naivety can lead to idealized expectations, and as a consequence, intense frustration and disappointment can arise when reality falls short of these expectations

(Strang et al., 2018). Naivety can also leave these individuals more susceptible to victimization (Nettelbeck & Wilson, 2002). This vulnerability is magnified in the context of the discourse around "gender-affirming care" in which media and public figures present an overly simplistic, often optimistic view of medical transition, downplaying risks and overstating evidence.

2.4.8 ASD as a 'phenomimic' of gender dysphoria

Some researchers have proposed that the overlap between ASD and gender dysphoria could be attributed to autism itself predisposing affected individuals to develop gender dysphoric features. In that case, gender dysphoria in people with autism would represent a 'phenomimic' of gender dysphoria. This view suggests that, while the outward presentation of gender dysphoria in individuals with autism might resemble typical cases, its underlying causation or origin could differ (Kallitsounaki et al., 2020). Notably, some high-functioning autistic females (particularly those who are undiagnosed or unfamiliar with how their autistic traits can manifest) may interpret their personal experiences through the lens of gender dysphoria, rather than through a lens of autism, leading them to adopt a transgender identity.

This theory is supported by research that identifies a considerable overlap between autistic traits and symptoms of gender dysphoria. Some of these shared traits include struggles with self-identity, rigid thinking patterns, intense and obsessive interests including gender, a natural inclination towards gender nonconformity, difficulties with social communication, and incongruity with one's physical body.

2.4.9 Autistic girls

Historically, autism was predominately diagnosed in males. As such, it was colloquially referred to as a "boy's disorder." However, current insights suggest that the prevalence of high-functioning autism, previously termed Asperger's Syndrome, might be underreported in females. Numerous studies consistently point to the underdiagnosis and misdiagnosis of high-functioning autism in girls and women (Bargiela et al., 2016; Fusar-Poli et al., 2022; Lai et al., 2015; Lockwood Estrin et al., 2021; Moseley et al., 2018; Zener, 2019). Studies show that females receive ASD diagnoses on average ten years later than males (Gesi et al., 2021), and boys are referred for assessments at a tenfold rate compared to girls (Attwood, 2007). The data indicate a substantial rise in pediatric gender clinic referrals, with the numbers increasing exponentially each year. This surge is particularly pronounced among adolescent females. Undiagnosed autism, particularly in girls, is a largely unexplored factor that could be contributing to this new trend (Bradley, 2022).

Revised ASD criteria, after the integration of Asperger's Syndrome into the ASD diagnosis in 2013, have raised questions regarding the utility of identifying high-functioning individuals who do not display language or intellectual impairments (Gesi et al., 2021; Hodges et al., 2020). Girls on the high-functioning end of the spectrum often display symptoms that diverge from the conventional male-centric diagnostic criteria (Kirkovski

et al., 2013; Lai et al., 2015; Mandy et al., 2012). A unique female autistic profile, combined with their capacity to 'camouflage' these symptoms, as well as the presence of comorbid conditions, often leads to a misdiagnosis for conditions with overlapping symptomatology (Attwood, 2007; Bargiela et al., 2016; Hull et al., 2020; Lai et al., 2017; Milner et al., 2019; Mosner et al., 2019 Tierney, 2016).

As a consequence, some studies estimate that up to 80% of autistic women might receive their diagnosis only in adulthood, which can have serious mental health consequences prior to diagnosis (McCrossin, 2022). A new report examining the connection between ASD and gender dysphoria suggests there may be a relationship between the delayed diagnosis in autistic females and the pronounced trend of adolescent and young adult females identifying as transgender (Buttons & Rowley, 2023).

2.4.10 Social communication deficits

Autism is characterized by challenges in social communication, making it difficult for individuals to understand and adhere to societal norms, including those related to gender (APA, 2013). These difficulties can hinder their ability to form and maintain friendships, especially for autistic females who often find it challenging to integrate into female cliques that demand a sophisticated style of communication. Many females with autism have expressed a preference for male company due to these challenges, perceiving male social circles as more forgiving (Bargiela et al., 2016; Cooper et al., 2018; Cridland et al., 2013).

These social difficulties may lead to internalized feelings of rejection, self-criticism, anxiety, and depression. Research has found that trans-identified females scored higher on the Autism Spectrum Quotient (AQ), suggesting their autistic traits could make integration into female peer groups challenging, hence drawing them towards male groups (Jones et al., 2012). Thus, one theory suggests that the alienation autistic females feel from their same-gender peers could contribute to feelings of gender dysphoria and the formation of a transgender identity.

2.4.11 How research on the connection between ASD and gender dysphoria has changed

The understanding and treatment of gender dysphoria in autistic individuals has evolved significantly over the years. Before 2016, the research landscape was one of caution and differentiation. For instance, researchers stressed the complexity of diagnosing gender dysphoria in autistic individuals, pointing to the challenges of differentiating feelings of being 'different' due to autism from genuine gender dysphoria (de Vries et al., 2010; van der Miesen et al., 2016). This earlier research also drew attention to the high occurrence of the resolution of gender dysphoria among youth. Some have suggested that autism-specific traits, such as social communication difficulties and intense interests, might influence a child's perception of their gender and have proposed psychological therapy to determine if these traits affected gender perception, (VanderLaan et al., 2015a) or

whether these features might lead some individuals to mistakenly believe that sex reassignment was their best course of action (Pasterski et al., 2014).

From 2016 onwards, however, the academic literature began to shift, integrating aspects of transgender activism with an emphasis on ensuring access to gender-affirming care for autistic patients who identify as transgender (Genovese et al., 2023; Warriar et al., 2020). This newer paradigm, represented by authors like Hadland et al. (2023), contends that an ASD diagnosis should not be a barrier to gender-affirming care and that these youth should be recognized for their 'authentic' transgender identities.

Engagement with activist organizations has also been more pronounced in recent research. References to statements and positions from organizations like the Autistic Self Advocacy Network (ASAN) are now more frequent. ASAN, for instance, collaborated with other transgender advocacy groups to call for less medical gatekeeping, emphasizing the potential harm in rejecting the gender identities of trans autistic individuals (ASAN joint statement, 2016).

2.4.12 Research on autistic detransitioners

A recent survey (Buttons & Rowley, 2023) delved into the experiences of 94 detransitioners and desisters, focusing on 69 participants (73%) with an autism diagnosis or autistic traits identified through screening tools. The results indicated a significant interplay between their perceived gender dysphoria and autistic characteristics. A noteworthy 57.5% of respondents diagnosed with ASD did not receive their diagnosis until adulthood, prompting many to report that it directly led to their decision to detransition. An overwhelming 80% believed that an early autism assessment during childhood would have been beneficial. Early detection of autism can pave the way for timely interventions and support, leading to improved outcomes and minimizing the risk of misdiagnoses.

One of the study's salient themes was the profound impact of exposure to transgender narratives. A staggering 95.6% of the participants reinterpreted their personal histories after encountering these narratives. Upon understanding that being transgender is associated with intense discomfort with one's physical self, 82.6% began relating their own bodily discomfort with a transgender identity. The study revealed that 89.7% of respondents exhibited rigid thought processes, perceiving transitioning as the only solution to their emotional turmoil. Once they aligned with a transgender identity, their rigid thinking made it challenging to consider alternative viewpoints. In their younger years, 66.7% considered themselves gender nonconforming, and 84.1% grappled with body image issues, feeling they could not meet the stereotypical ideals associated with their sex. For 85.3%, gender identity transformed into an obsessive 'special interest' that dominated their focus. Additionally, 89.9% favored online interactions, often coming across transgender narratives on digital platforms, which played a crucial role in shaping and cementing their transgender identities.

The survey also spotlighted the high incidence of other psychiatric disorders and comorbidities among the participants. These included depression, anxiety, eating

disorders, body image issues, self-harm tendencies, suicidal ideation, Obsessive-Compulsive Disorder (OCD), and Post-Traumatic Stress Disorder (PTSD). The urgent need for enhanced awareness among healthcare professionals was highlighted in this study, especially regarding the manifestation of high-functioning autism in females and the overlapping symptomology of ASD and gender dysphoria. Better education in these areas could lead to more precise early ASD diagnoses, potentially averting the distress and regret from irreversible medical procedures tied to trans-identification (Genspect, 2022b).

2.5 Three competing models of treatment

There is a paucity of quality clinical evidence in this field to support an evidence-based standard of care framework. Given the lack of scientific evidence, it is unsurprising that viewpoints are diverse among practitioners regarding the best therapeutic response for the child, adolescent, or young adult who suffers from gender dysphoria. There continues to be substantial disagreement among professionals about the etiology of trans identities, and because no randomized control studies have been conducted, there is vigorous debate on the best treatment paths. Biggs (2023) has pointed out that these current disagreements might have been minimized if those given gender-affirming treatment had been carefully followed up to determine long-term outcomes.

Reviewing the state of opinion and practice in 2021, the Royal Australian and New Zealand College of Psychiatrists observed that, “There are polarized views and mixed evidence regarding treatment options for people presenting with gender identity concerns, especially children and young people” (RANZCP, 2021). Similarly, a few years earlier prominent Dutch researchers noted that there was no consensus about the best approach to deal with gender dysphoric children (Ristori & Steensma, 2016). Although the following models of treatment are not exhaustive, they offer a summary of common approaches MHPs take when working with gender dysphoria. We look forward to other treatment models emerging in the future.

2.5.1 The ‘watchful waiting’ model

When a pre-adolescent child presents with gender dysphoria, a ‘watchful waiting’ approach seeks to allow for the fluid nature of gender identity in children to naturally evolve—that is, take its course from forces within and surrounding the child. As already mentioned, follow-up studies of gender dysphoric children illustrate that the large majority who present with gender dysphoria desist from desiring a transgender identity by the time they reach adulthood, if left untreated (Cantor, 2019; Zucker, 2018). Watchful waiting has two versions:

- A Treating any other psychological comorbidities—that is, other mental illnesses as defined by DSM-5 (Separation Anxiety Disorder, ADHD, Autism Spectrum Disorder, Obsessive-Compulsive Disorder, etc.), any subthreshold diagnoses, and

behavioral problems that the child may exhibit (school avoidance, bedwetting, inability to make friends, aggression/defiance) without a focus on gender; and

- B No treatment at all for anything but a regular follow-up appointment. This might be labeled a 'hands off' or 'low interventionist' approach.

Clinicians working in the field have noted that the watchful waiting approach was more appropriate before the current emphasis on LGBTQ issues in our contemporary culture. The environment in which the watchful waiting occurs can significantly affect the outcome. It is important to note that watchful waiting cannot take place if the child socially transitions as this intervention will subvert the process. Another issue is that a person experiencing gender dysphoria today will easily find an extensive online community that is often ideologically driven. These days, the level of online content promoting medical transition suggests that this approach disregards the cultural context in which gender dysphoria might become exacerbated. Nonetheless, watchful waiting has historically served as a valuable treatment model for gender nonconforming children.

2.5.2 The affirmation model

While it is widely agreed that the therapist should not directly challenge a claimed transgender identity in a child, some advocates and practitioners go much further, and promote and recommend that any expression of transgender identity should be accepted and automatically affirmed, whether the patient is a child, adolescent or adult. Although we suggest that MHPs might affirm the individual's thoughts, feelings and beliefs, we do not think it is appropriate to *confirm* them, as MHPs should be sensitive to their position of authority and responsibility and to confirm the patient's suspicion that they might have an unfalsifiable, unverifiable transgender identity could wield excessive influence on a vulnerable adult, child or adolescent. For example, if a person in therapy states that they intend to leave their job, a therapist might affirm that the patient believes this is the appropriate step to take and they clearly feel very strongly about this. However, the ethical therapist would respect and preserve the patient's autonomy; they would not confirm that this is definitely the correct decision and tell them to go ahead and leave as this would be overstepping their role as a therapist. Similarly, an MHP should not confirm an individual's self-diagnosis that the patient made based on online content, though they may empathize with their feelings.

Affirmation in childhood often consists of using certain clothing, toys, pronouns, etc. In the case of young children, prompt and thorough affirmation of a transgender identity, for example, with social transition, disregards the principles of child development and family dynamics and is not supported by science.

Affirmative clinicians are often child-led and argue that the child or adolescent should be encouraged to lead the way and, if they so wish, be comprehensively re-socialized in school in their aspired-to gender, no matter the age (Keo-Meier & Ehrensaft, 2018; Ehrensaft, 2015). Equally, the adult patient is also often immediately invited to socially transition, for example, when the MHP asks the patient's new name and which pronouns

they prefer to use, and medical options are introduced without engaging in any reflection or pressure-testing of either step.

Advocates of the affirmation model typically treat any question about the causes of a transgender identification as inappropriate and even harmful, thus disregarding the natural ambivalence of the human mind (Evans & Evans, 2021). Affirmative clinicians assume that any psychological comorbidities are unrelated to the patient's gender dysphoria, are a result of minority stress due to being marginalized, or will get better with transition, and therefore, they need not directly address these issues. The affirmative MHP sees their role as facilitating social or medical transition while providing supportive guidance concerning the individual's gender identity. Some advocates assert that the unquestioning affirmation of any claim of transgender identity is essential, and that the individual will otherwise face a high risk of suicide or severe psychological damage. However, as discussed below, these are unsubstantiated and damaging myths

2.5.3 The psychotherapy model

One of the foundational principles of psychotherapy is to work alongside a patient to help identify the root of their psychological distress and then tackle this as a way to alleviate the distress. Many clinicians in this field employ conventional psychotherapeutic methods for gender dysphoric patients to explore what factors might have contributed to their rejection of the biological sex (Levine, 2017; Levine, 2021). Psychotherapy typically helps alleviate distress for at least some patients, whether the patient's sense of discomfort or incongruence with his or her natal sex entirely disappears or not. Relieving accompanying psychological comorbidities liberates the patient to consider the advantages and disadvantages of transition more fully as their understanding of their psyche evolves.

In jurisdictions where medical transition is covered by insurance while psychotherapy remains an out-of-pocket expense, there is a risk that individuals may be discouraged from considering psychotherapy to address gender dysphoria. Ensuring comprehensive support for mental health aspects is crucial to allow individuals to explore non-invasive alternatives before opting for medical pathways.

The psychotherapist who is applying conventional methods of psychotherapy may help patients appreciate the wide range of emotional and behavioral patterns available to both males and females and the idea that there is no one way to be male or female. For example, the clinician may discuss with the patient that one does not have to be female to be gentle, sensitive, nurturing and emotional (Levine, 2017). The MHP could also focus on the patient's underlying internal, familial, and social issues.

Many trans-identifying males speak of their perceptions of femaleness as enabling them to behave in a more gentle and sensitive manner, whereas they perceive boys and men to be tough and aggressive. Men, of course, can be gentle and sensitive. The opposite can apply to girls and women. Thus gender roles can be valuable to discuss within the counseling context.

Minority and vulnerable groups who have reasons to feel isolated and have an uncomfortable sense of self are disproportionately represented among transgender people. In this context, a trans identity may be a hopeful attempt to redefine the self in a manner that increases comfort and decreases anxiety. The clinician who uses conventional psychotherapy may not focus on their gender identity, but instead work to help the individual address the actual sources of their discomfort. Success in this effort may remove or reduce the desire for a redefined identity.

When working with children, the MHP should take the time to explore the child's sense of gender roles within the family; the family dynamics; marital dynamics and other related issues. When working with adolescents and adults, MHPs can also offer a conventional therapeutic process to the gender dysphoric patient. The level of literature in this area is increasing and there are now a series of articles and at least one major book on the psychological treatment of adolescents (D'Angelo et al., 2021; Evans & Evans, 2021). The Gender Exploratory Therapy Association (GETA) has recently issued a highly recommended set of clinical guidelines for the practice of psychotherapy with those who suffer from gender dysphoria (GETA, 2022).

2.6 Commonalities arising within a conventional therapeutic process

Whether MHPs or involved adults favor gender identity theory, gender critical theory or any other belief about sex and gender, it is important to acknowledge that there is recognized value in a conventional, multifaceted, thought-provoking and ethical therapeutic process. While the benefits of the affirmative model are as yet undocumented because this is a new approach without any long-term analysis, the benefits of conventional psychotherapy are well-documented and should not be ignored.

The improved mental health that can come about because of effective therapy can help individuals manage and alleviate distressing symptoms and improve their coping skills. Whether or not this will help alleviate gender dysphoria, it will certainly help individuals to cope with their distress. The provision of a safe space within the therapeutic process provides the individual with the opportunity to discuss their innermost thoughts and feelings, and this can be transformative for some. Therapy can also promote an enhanced sense of well-being by helping individuals understand themselves better, build resilience, and improve their emotional and psychological health. Their relationships and friendships can improve, communication skills can develop and the ability to manage conflict can be enhanced.

Some people need therapy to recover from unresolved trauma, and until they do so, the unresolved conflict can have consequential effects on the person's life. As patients begin to realize their potential, this can generate increased self-esteem and bring about positive patterns of behavior. Additional benefits such as learning stress management and problem-solving skills can help bring about a more satisfying life. Of course, to

paraphrase Beckett, there is no cure for life, and psychotherapy is certainly not a panacea for all life's challenges; indeed, some people do not appear to benefit from it in any way. Nonetheless, when considering whether to embark on a course of life-long medical interventions that will significantly impede a person's physical health, it is more appropriate to first determine whether the less invasive option of psychotherapy should be prioritized.

Therapy can serve as a preventive measure that helps individuals address issues that have hitherto been avoided, and by doing so, these issues might not become entrenched. The specific value of therapy varies from person to person, and from context to context. Nonetheless, the evidence shows that therapy can have a powerful effect on the evolution of gender identity and whether gender dysphoria resolves. In practical terms, a clinician working with a patient who has gender dysphoria might:

- support development of self-awareness
- offer psychoeducation about gender identity, gender roles, social transition, medical transition, sexual development and sexual orientation,
- explore the complexities of gender and its implications
- explore the impact of internalized homophobia
- explore the impact of externalized homophobia
- support self-acceptance of the body and sexual self
- help visualize the future
- evaluate the individual's needs and wants
- consider the impact of comorbidities

This might, or might not, be different in content, but not so different in the approach of a clinician working with a patient who attended therapy for completely different reasons. For example, a clinician working with a patient who had internalized homophobia and sought help to come to terms with their sexual self might:

- support a developing self-awareness
- offer psychoeducation about sexual development and sexual orientation
- explore the impact of internalized homophobia
- explore the impact of externalized homophobia
- support self-acceptance of the body and sexual self
- help visualize the future
- evaluate the individual's needs and wants

The value of psychotherapy is difficult to quantify; just like it is hard to ascertain how art, literature or music might improve a person's life. People who have benefited from therapy might not be able to articulate exactly why it helped and yet they are sometimes very sure that it has been a positive experience. The psychoanalyst Carl Jung explains:

"one could say that while the patient is unconsciously and unswervingly seeking the solution to some ultimately insoluble problem, the art and technique of the doctor are doing their best to help him towards it. "Ars totum requirit hominem!" ["The art requires the whole person."] exclaims an old alchemist. It is just this homo totus [whole person] whom we seek. The labors of the doctor as well as the quest of the patient are directed towards that hidden and as yet unmanifest "whole" man, who is at once the greater and the future man. But the right way to wholeness is made up, unfortunately, of fateful detours and wrong turnings. It is the longissima via [longest path], not straight but snakelike, a path that unites the opposites in the manner of the guiding caduceus, a path whose labyrinthine twists and turns are not lacking in terrors. It is on this longissima via that we meet with those experiences which are said to be "inaccessible." Their inaccessibility really consists in the fact that they cost us an enormous amount of effort: they demand the very thing we most fear, namely the "wholeness" which we talk about so glibly and which lends itself to endless theorizing, though in actual life we give it the widest possible berth." (1968, p.6)

2.6.1 Cognitive dissonance in trans identities

Many transgender people are very focused on 'passing' as either male or female. Arguably, internalized transphobia is the root of this desire to pass, as the individual does not want to accept that they are trans and prefers to pretend to themselves and the world that they are actually a person who has been born as the opposite sex. While the transgender person may want to be perceived as trans, we operate within a social context, and some people who meet the transgender person may wish to know about the biological sex rather than the gender identity of the people in their vicinity; some for safety reasons, others for more complex reasons. Until very recently, medical technology was not able to sufficiently transition a person so that they passed in public. Now that technology has caught up, many transgender people can pass easily. This means that for the first time in history a person's biological sex is no longer automatically and publicly visible. These developments have brought about some unintended consequences.

The term 'stealth transition' typically refers to a transgender person who has transitioned, socially or medically, and chosen not to disclose their transgender status to others. This decision can give rise to an array of other issues that impact other people. Schools are often required to navigate this issue as the parents of the trans-identified child may insist on secrecy. However, the parents of other children in the same classroom may require knowledge about each child's biological sex, especially in the context of sports, locker rooms and residential activities.

Some young children are socially transitioned from as young as three or four and when they first attend school the other children may not know that they were born the opposite sex to their gender presentation. However, secrets can weigh heavily on young children's

shoulders, and the child often discloses their biological sex to their close friends. As time passes, a split can arise within the classroom, where some of the students and teachers know, but others are unaware. This lack of transparency can cause tension, resentment and polarization.

Cognitive dissonance may arise when a person holds conflicting beliefs, attitudes or values. In the context of stealth transition, cognitive dissonance can arise due to a sense of shame or discomfort about being transgender while at the same time, seeking to promote the rights of transgender people to live with dignity and pride. 'Going stealth' can inadvertently bring about cognitive dissonance within the transgender person as non-disclosure of their transgender status, especially to close friends, may generate feelings of dishonesty. Intimate friendships and relationships require honesty, and a growing sense of inner conflict can develop as the transgender person begins to experience and evaluate the long-term advantages and disadvantages of passing. The stealth transgender person can become distressed and conflicted by a fear of discovery. This can lead to photographs from the past being hidden and past experiences being fabricated. The transgender person's sense of privacy can become rigid, and this can create difficulty with intimacy. The incongruence between the person's inner sense of identity and their biological sex may remain unaddressed as the transgender person instead focuses on their outer presentation. They may grapple with feelings of shame, guilt or self-judgment, which can conflict with their self-acceptance and even their self-worth.

Debates around privacy and autonomy can become heated in the context of stealth transition as it is argued that it is up to the individual to decide when, how and to whom they disclose their transgender status. Notwithstanding this, honesty and transparency are already recognized as necessary elements of healthy relationships, so we suggest that individuals embrace their transgender status rather than 'go stealth.' Moreover, schools and other institutions should recognize that there can be legal implications with respect to purporting to offer sex-segregated spaces, especially within residential accommodation. Supporting a stealth identity can generate further issues as the individual may need to decide when, how, and to whom they should disclose their transgender status.

As honesty, transparency and authenticity are valuable traits and contribute to a better society, we suggest that being truthful about being trans is more helpful for the transgender person and for society. Internalized transphobia is perhaps better approached with open communication, honesty and authenticity. This can be a highly contentious area and opinions may vary widely. It is crucial to approach these issues with sensitivity and respect for diverse perspectives and experiences, keeping in mind the importance of supporting the wellbeing and rights of all.

2.6.2 Working alongside parents

It is well-established that MHPs and other involved adults working alongside parents lead to better outcomes than when the professionals exclude the parents (Doyle et al., 2022). When children or adolescents declare that they are transgender, many concerned and bewildered parents turn to online platforms for guidance, often seeking solace in private online groups designed to support parents of “transgender children.” However, these groups frequently consist of activists who exert emotional influence on distressed parents, urging them to suppress their inherent parental instincts by asserting that failure to immediately affirm a child’s new identity could lead to the child’s suicide. The relentless stream of messages claiming absolute certainty about what is best for these children can prove overwhelming for parents.

Dissenting perspectives within these groups are typically not tolerated, as questioning or challenging someone's gender identity contradicts the group's established rules. This dynamic results in an insular echo chamber, where anxious parents seeking guidance can easily be swayed onto a path of transitioning their child. Individuals deviating from the prevailing narrative often encounter forceful opposition from impassioned commentators and risk expulsion from the group (Joyce, 2021; Shrier, 2020). It is recommended that MHPs working with gender-distressed children include the parents in the process. Parents might take some time to adjust, and parents might not agree with their child’s analysis of the difficulty, however this does not mean that parents should be shunned, nor should their value as parents be diminished (Ayad et al., 2023).

2.6.3 Fluid gender identification

Advocates and some practitioners assert that gender identity is not binary but can span an almost endless range of gender identity labels, which a given individual may try on, inhabit, and often discard. A recent article identifies 72 “other genders” (Allarakha, 2022). No research exists to validate these various gender identities and no theory has been offered for how there is, or could be, a biological basis for gender identity as now expansively defined.

Attempts have been made to explain away the arrival of multiple gender identities, and corresponding pronouns. These include:

- these problems always existed, but people are now learning that there are effective treatments for their dilemma and are simply seeking them;
- historically people hid their trans identity and now that transgender people are recognized and accepted, they are presenting themselves in ever greater numbers;
- previously we were not aware of the range of gender identities; now that we are, it is important to support this.

All these explanations, however, are mere hypotheses unsupported by concrete evidence. Further, none of these provide any evidence and none of these hypotheses could even potentially explain the failure of science thus far to identify any predictive biological marker of transgender identification.

The core conditions of congruence, unconditional positive regard and empathy can be very valuable within the therapeutic process. Therefore, clinicians must provide a space where patients can speak about various novel gender identities and neo-pronouns without feeling patronized or belittled; this requires skill and careful consideration from the therapist.

2.6.4 The fear of conversion therapy

Conversion therapy is an inhumane, unscientific, and discredited practice that is not supported by any ethical therapeutic body in the world. In the early to mid-20th century, when homosexuality was either illegal or heavily stigmatized, psychiatry and psychology pathologized same-sex orientation. Many psychologists of previous generations viewed homosexuality as a mental disorder and explored a range of therapeutic interventions in an attempt to “cure” this. Cruel treatments such as aversion therapy and electroconvulsive treatments were utilized; which caused severe psychological, and even physical harm. Over the years, the medical and psychological communities developed a deeper understanding of same-sex attraction and eventually homosexuality was declassified as a mental disorder. Since then, conversion therapy has been almost universally condemned as inhumane, and ethical therapists do not offer this as a viable intervention. Today, it is only religious zealots and extremists who seek to change an individual's sexual orientation; everyone else has accepted it is a damaging practice.

In recent years, the concept of conversion therapy has undergone a revolution as it has expanded its definition from practices that seek to change a person's sexual orientation to include gender identity, and sometimes even gender expression. This post-modern version of conversion therapy offers quite a different proposal as it conflates sexual orientation with gender identity. Those who are same sex attracted do not seek heavy medical interventions to support the person's sexual orientation. For these reasons, we believe it is inappropriate to offer policies that frame sexual orientation as the same or similar to gender identity. Nonetheless, numerous countries and states ban conversion therapy practices without providing definitions about what is conversion therapy and what is allowable within the realms of conventional therapy. Indeed, some regions support bans that appear to limit the freedom for a clinician to carry out a conventional and ethical therapeutic process and instead favor a more narrow-minded affirmative-only approach. For this reason, we offer sample legislation that protects conventional psychotherapy from inappropriate governmental intrusions (see Appendix)

The practice of conversion therapy in the twentieth century seems to have cast a long shadow on the professions of psychiatry and psychology, which has yet to be fully resolved. Conventional and ethical psychotherapy must be protected from vague definitions and inaccurate language. In this context, therapist-patient discussions around sex and gender should be grounded in respect for individual autonomy and wellbeing, and work towards positive outcomes. Of course, this does not constitute conversion therapy, however, there appears to be a chilling effect on MHPs in this context, related mostly to a fear of being wrongly accused of conversion therapy. Consequently, few MHPs are

willing to work with gender-related distress and many vulnerable people cannot access quality therapy as a result.

2.7 Desistance and detransition

Desistance is the process of reversing a social transition, for example, reverting to a birth name and corresponding pronouns, and losing the drive to medically transition (Ayad et al., 2023). As already discussed, the high rate of resolution of gender dysphoria among those with childhood-onset gender dysphoria, as well as increasing (or at least increasingly vocal) numbers of individuals who first asserted a transgender identity during or after adolescence, who underwent substantial medical interventions to ‘affirm’ that trans-identity, and then ‘detransitioned’—reverting to a gender identity congruent with their sex—point to a social or psychological cause, rather than a biological one.

Desistance within a relatively brief period might be a common outcome for post-pubertal youths who are characterized as ROGD. However, because little follow-up and long-term research has been undertaken on this cohort, we have no precise data on the actual desistance rate.

Detransition is the process whereby an individual who underwent medical gender affirmation no longer identifies as transgender and seeks to stop or even reverse the medical alterations that have taken place. The visibility of individuals who have detransitioned is new and may be rapidly growing. A study of 100 adolescents and young adults who had transitioned and then detransitioned found that biological females transitioned at a younger age than their male counterparts and the average time to detransition was shorter for females (Littman, 2021). This study also reported that 60% of the participants reported that their decision to detransition was motivated, at least in part, by the fact that they had become more comfortable identifying as their biological sex, and 38% had concluded that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition. A significant majority (76%) did not inform the clinicians involved in their transition that they had detransitioned. Further, in a study of 237 desisters and detransitioners, the large majority of whom had transitioned in their teens or early twenties, found that 70% reported that a common reason for detransitioning was the realization that their gender dysphoria was related to other issues (Vandenbussche, 2022). These are notable findings that should not be ignored, especially considering the current cohort of trans-identifying youth, largely females, who are presenting at gender clinics at a younger age (Sun et al., 2022).

Prominent affirmative therapists, Dr. Edwards-Leeper and Dr. Anderson (2021), have drawn attention to the rising numbers of detransitioners that they and other clinicians are increasingly seeing in practice. They point out that many of these young detransitioners are typical of the young people currently presenting to gender clinics with other complex mental health issues. These young people report being immediately affirmed and rushed

to medicalize, but now regret their decisions. These detransitioners no longer trust doctors and therapists. They do not know where to turn and are forming online support groups. Other clinicians working with detransitioners have also noted this recent phenomenon (Marchiano, 2021). In 2019 the r/detrans subreddit group (ongoing), an online community for detransitioners, desisters and those questioning their transition had 1K members; currently it has 51K members.

A growing body of evidence suggests that for many teens and young adults, a post-pubertal onset of transgender identification can be a transient phase of identity exploration—just like it is for pre-pubertal children—rather than a permanent identity (Entwistle, 2020; Littman, 2021; Valeds & MacKinnon, 2022; Vandenbussche, 2022). Although the rate of detransition and regret has been reported to be very low, these estimates come from studies with significant methodological limitations and were likely undercounting true regret (D'Angelo, 2018). In any case, as many of these estimates came from studies before the implementation of the affirmation model, they may not generalize to the current cohort who are clinically different and treated using an affirmation approach with little conventional psychological evaluation.

A recent study of 175 case reports from a UK adult gender clinic observed that 6.9% of those treated with gender-affirmative interventions went on to detransition within 16 months, while an additional 3.4% showed patterns suggestive of detransition, yielding a probable rate of detransition in excess of 10%. In addition, 21.7% disengaged from clinic treatment, although some patients re-engaged with the gender service at a later date. Based on the pattern of patient engagement at their clinic, the authors concluded that the rates of detransition may be higher than previously reported (Hall et al., 2021). Another study of 68 patients identified as trans or gender minority from a UK clinic (Boyd et al., 2022), showed that 12.2% either detransitioned or documented regret, while 20% stopped hormonal treatments for a variety of reasons. Comparing these rates with the significantly lower rates reported in older studies suggests that, as the researchers noted, “the detransition rate found in this population is novel and questions may be raised about the phenomenon of overdiagnosis, overtreatment, or iatrogenic harm as found in other medical fields.” (Boyd et al., 2022 p.15)

Studies show that transition regret may take up to 8-11 years to materialize (Dhejne et al., 2014; Wiepjes et al., 2018), thus it is probable that there will be an increase in the number of people detransitioning (Irwig, 2022). There are large gaps in the knowledge about detransitioners. In the meantime, MHPs can take note that clinicians working with detransitioners point to the Littman (2021) and Vandenbussche (2022) studies as reflective of their clients' experiences. Both studies show that detransitioners from the recently transitioning cohorts feel they were rushed into medical gender-affirmative interventions without the benefits of a conventional therapeutic process.

2.8 The risk of suicide

Any discussion of suicide when considering younger children involves very long-range and very uncertain predictions. Suicide in pre-pubescent children is extremely rare, and the existing studies of gender identity issues in pre-pubescent children do not report significant incidents of suicide (McClanahan & Omar, 2012). Any suggestion otherwise is misinformed. Our focus for this topic, then, is on adolescents and adults. Every suicide is a tragedy, and evidence-based protocols that reduce suicide should always be adopted. If a medical or MHP believes that their patient presents a suicide risk, it is unethical for that professional merely to proceed with treatment for gender dysphoria and hope that it “solves the problem.” Rather, that professional has an obligation to provide or refer the patient for evidence-based therapies for addressing depression and suicidality (Levine, 2016).

This is especially so since there is, in fact, no reliable evidence that social or medical transition reduces the risk or incidence of actual suicide. In a study of suicide rates based on the GIDS data from 2010 to 2020, four patients were known or suspected to have died by suicide, two were on the waitlist (bigger sample) and two who were being treated (smaller sample). The suicide rate for this cohort was estimated to be 0.013% (Biggs, 2022). Bränström and Pachankis (2020a & 2020b), (after correction) also found no evidence that gender-affirming medical treatment reduced suicidal behavior.

Some authors have reported rates of suicidal thoughts and behaviors among trans-identifying teens and adults ranging from 25% to as high as 52%. These estimates are based on non-random self-reports from online surveys (Toomey et al., 2018). No quality research shows that affirmation reduces suicide, prevents suicidal ideation, or improves long-term outcomes, as compared to either a ‘watchful waiting’ or a psychotherapeutic model of response. Rhetorical references to figures such as 40% and other published studies confuse suicidal thoughts and actions that represent a cry for help, manipulation, or expression of rage with serious attempts to end life. Such statements or studies ignore a crucial and long-recognized distinction. Further, they fail to acknowledge that suicide is multifactorial, and rarely a single factor phenomenon. Suicide is a serious event; it is imperative that MHPs use reliable data in working with patients and carefully review the research. Many journalists and MHPs refer to research such as that done by Turban et al. (2020), demonstrating that puberty blockers reduce suicidality. The paper itself, however, does not make that claim. Further, the research design does not allow for causal attribution.

The assertion by clinicians such as Karasic and Ehrensaft (2015) that completed suicides among transgender youth are “alarmingly high” “has no formal and systematic empirical basis” (Zucker, 2019a). Thus, as the author of the Tavistock suicidality study highlights, it is unethical and irresponsible to exaggerate the prevalence of suicide (Biggs, 2022) as doing so may promote suicidality. Telling parents or allowing them to believe the false exaggerated narrative on suicidality in transgender youth is inaccurate and unethical. No clinician should be promoting the dangerous choice of “a live son or a dead daughter.”

Informed consent requires clinicians to tell the truth and ensure that their patients understand the truth; it should be explicit, never implied (Levine et al., 2022).

2.8.1 The post-transition suicide rate

As with mental health, the patient, parent, or clinician fearing the risk of suicide must consider not just the next month or year, but a life course perspective. There is some data on *completed suicide* among transgender individuals into adulthood. The results vary significantly but are uniformly concerning.

Dhejne reported a long-term follow-up study of 324 patients after sex-reassignment surgery (SRS). Across the multi-year study, those who had undergone surgical interventions died by suicide at 19.1 times the rate of population controls matched by age and sex. Male-to-female subjects died by suicide at 13.9 times the expected rate, and female-to-male subjects died by suicide at 40.0 times the expected rate (Dhejne et al., 2011).

A long-term follow-up of 1331 transsexual patients in the Netherlands' leading gender medicine clinic who started cross-sex hormones before July 1, 1997, examined death by suicide at a median follow-up period of 18.5 years. The mortality rate among male-to-female patients was 51% higher than among the age-matched general population (Asscheman et al., 2011). Importantly, Asscheman et al. found that no suicides occurred within the first two years of hormone treatment. However, after the 2-year mark, the rate of suicide increased. Similarly, Wiepjes et al. (2018) found that the median time between starting hormones and suicide was 6.1 years for natal males, and 6.9 years for natal females. This information is critical as much of the research on transgender patients treated medically involves short-term follow-up. Studies of insufficient follow-up time may therefore not provide accurate information regarding the effects of gender-affirming treatments on suicidality and may, in fact, underestimate the suicide rate. Short-term follow-up studies may reflect an initial period of optimism and may not capture the feelings of disillusionment and the increase in suicidality that follow in later years.

In a more recent nationwide cohort study of 6,657,456 individuals in Denmark, transgender individuals were found to have significantly higher rates of suicide attempts (adjusted incidence rate ratio [aIRR], 7.7), suicide mortality (aIRR, 3.5), suicide-unrelated mortality (aIRR, 1.9), and all-cause mortality (aIRR, 2.0) compared with nontransgender individuals (Erlangsen et al., 2023). Another cohort study of 139,484 individuals in England found that transgender individuals "had elevated overall mortality compared with cisgender people, specifically deaths from external causes (suicides, homicides, and accidental poisonings), endocrine disorders, and other ill-defined and unspecified causes" (Jackson et al., 2023).

These studies do not demonstrate that the hormonal or surgical intervention is a *causal factor in suicide*. The population that identifies as transgender suffers from a high incidence of mental health comorbidities that are, in themselves, correlated with suicide and there may be aspects of the transgender experience that leave one vulnerable to

suicide. What these studies do illustrate, however, is that hormonal or surgical treatments are not likely to resolve underlying issues. Those with mental health issues before transition continue to have these issues and need diligent psychological care (Kaltiala-Heino, 2018). Thus, claims that medical transition will reduce the risk of suicide for children, adolescents and young adults are not evidence-based. These claims are based on poor-quality survey data that conflate suicidal ideation with suicidal behaviors and actual suicides. While the claims of the high rates of suicide among the transgender population are used to make the claim that social and medical transition are lifesaving, this is simply false. At best they can aspire to be life-enhancing (Levine, 2016). It is imperative that MHPs and involved adults who seek to appropriately support transgender people fully understand the data on suicidality for this cohort.

2.9 The risk of affirmation and the medicalized pathway

As already highlighted, recent evidence demonstrates that pre-pubertal social transition increases the likelihood of using puberty blockers, which almost always leads to cross-sex hormones. For this reason, physicians bear the ethical responsibility for a thorough informed consent process for parents and patients that includes this fact and presents its full implications. Informed consent does not mean sharing with patients and families the doctor's values and beliefs; it means sharing what is known and what is not known about the intervention. So much of what doctors believe is based on mere trust in what they have been taught. Neither they themselves nor their teachers may be aware of the scientific limitations of what they are recommending. Practicing clinicians rely on a chain of trust, usually beginning at the profession's regulatory body, but as the information gets filtered down, details and nuance are lost, in place of certainty for treatments. It is the professional and ethical responsibility of practitioners involved in the care of young people with gender dysphoria seeking medical transition to continually update their knowledge, and to read the scientific literature carefully and critically.

No studies have meaningfully demonstrated that either puberty blockers or cross-sex hormones, as prescribed for gender dysphoria, are safe in the long term. No studies have attempted to determine whether puberty blockers' effects, as currently prescribed for gender dysphoria, are fully reversible. In fact, as already outlined, there are substantial reasons for concern that these hormonal interventions are not safe. Moreover, multiple researchers have expressed concern that the full range of possible harms has not yet been correctly conceptualized.

Recent systematic reviews performed by the British National Institute for Health and Care Excellence relating to the administration of puberty blockers for gender dysphoria in pediatric patients concluded that the quality of evidence across the board was very low and therefore provided only "very low certainty" of benefits (NICE, 2020a). In 2017, The Endocrine Society Guidelines called for more rigorous research on the effectiveness and

safety of delaying puberty in adolescents with hormonal treatments, including on the prolonged effects on bone development, gonadal function, and brain development and function (Hembree et al., 2017). Some years later, no such research has been published. Thus, MHPs should proceed slowly and with caution.

Some advocates appear to assume that puberty blockers are “safe” because they have been approved by the Food and Drug Administration (FDA) for the treatment of precocious puberty—a rare condition in which the puberty process may start at eight or younger. No such conclusion can be drawn. As the label for Lupron (one of the most widely prescribed puberty blockers) explains, the FDA approved the drug only *until* the “age was appropriate for entry into puberty” as the timing of discontinuation is critical for bone growth and normal development. However, for the treatment of gender dysphoria, blockers are prescribed precisely when the FDA and research (Eugster, 2019) suggests they should be discontinued for the treatment of precocious puberty.

No reliable information exists as to the safety or reversibility of blocking healthy, normally timed puberty development, and the cumulative effects of the length of time a child is treated with these agents. The cost-benefit analysis of puberty blockers for the treatment of precocious puberty has been established and favors treatment; such is not the case for the use of these agents to treat gender dysphoria. In fact, in the case of gender dysphoria, the risks of puberty blockers may outweigh the benefits. The following issues have already been highlighted regarding puberty blockers for gender-dysphoric youth, we do not yet, however, have comprehensive knowledge on this issue as there is no long-term research on this.

- **Fertility:** The Endocrine Society Guidelines indicate that research is needed into the effect of puberty blockade on gonadal function and sexual development. The core purpose and function of puberty blockers is to prevent the maturation of the ovaries or testes, the sources of female sex hormones and male sex hormones when stimulated by the pituitary gland. From this predictable process fertility is accomplished within a few years. Despite widespread assertions that puberty blockers are “fully reversible,” there has been no published research on the critical question of whether patients ever develop normal levels of fertility if puberty blockers are terminated after a “prolonged delay of puberty” with such puberty blockers (Hembree et al., 2017).
- **Bone strength:** Multiple studies have documented adverse effects of puberty blockers on bone density (Joseph et al., 2019; Klink et al., 2015; Vlot et al., 2017). One recent study, for example, found that after two years on puberty blockers, bone density measurements for a minority of the children had declined to clinically concerning levels. Density in the spines of some subjects fell to a level found in only 0.13% of the population (Biggs, 2022). While some studies have found fewer concerning effects on bone density, the available evidence remains limited and conflicting. Thus, it is impossible to conclude that the treatment is “safe.”

- **Brain development:** Important neurological growth and development in the brain occurs through puberty. The anatomic and functional effect of blocking brain development during natural puberty has not been well studied. A prominent Australian clinical team recently expressed concern that no data is available on whether delaying the exposure of the brain to a sex steroid affects psychosexual, cognitive, emotional, or other neuropsychological maturation (Kozłowska et al., 2021). Given the observed correlation between puberty and brain development, the default hypothesis must be that there *is likely to* be a negative impact.

A longitudinal study of one natal male child, assessed before, and at 20 months after commencement of puberty suppression found a reduction in global IQ and an anomalous absence of certain structural brain development expected during normal male puberty. The researchers hypothesized that the negative effect on cognitive function was a result of the disruption of the synchronic [appropriately timed] development of brain areas by pubertal suppression (Schneider et al., 2017). Although further research is necessary, parents and practitioners should be aware of such studies.

To protect patients, it is customary for the burden of proof to fall on the advocates of a new treatment to demonstrate its benefits as well as illustrate the cost benefit ratio that favors the use of the new treatment. This has not been the case with gender affirming medical treatment. Instead, advocates have begun using the legal and actuarial terms medically necessary to access these treatments.

Currently, given the paucity of adequate evidence, three questions remain unanswered:

1. Are there anatomic or functional brain impairments from blocking puberty when the commencement of puberty is not abnormally early as is the case with precocious puberty?
2. Are the documented changes reversed over time when puberty blockers are stopped and puberty commences naturally or cross-sex hormones are administered?
3. Will any of the effects of blocking puberty exogenously be dependent on sex, differentially affecting biological males and females?

With these questions unanswered, it is impossible to assert with certainty that the effects of this class of medications are “fully reversible.” Such an assertion is another example of ideas based on beliefs and hopes rather than scientific data.

- **Psychosocial harm:** Puberty is a time of stress, anxiety, bodily discomfort during physical development, and identity formation for *all* humans. No careful studies have been done of the long-term impact on the young person’s coping skills, interpersonal comfort, and intimate relationships as they remain suspended at the same stage of development while their peers undergo significant physical, and psychosocial transformations. Further, no research exists concerning the effects of these critical variables of undergoing an artificial puberty at an older age.

Pediatricians and mental health professionals are aware of the social awkwardness in those who naturally have a delayed onset of puberty. Individuals in whom puberty is delayed by multiple years through the use of puberty blockers are likely to experience subtle negative psychosocial effects as they stand on the sidelines witnessing their peers developing social relationships and the attendant social learning experiences that come with adolescence (Levine, 2018). Social anxiety and social avoidance are common findings in the evaluation of trans-identified children and teens. Is it credible that creating years of being further different from their peers has no lasting internal consequences? Do we ignore adolescent psychiatry's knowledge of the importance of peer groups among adolescents?

We simply do not know what all the psychological impacts of *not* grappling with puberty at the developmentally natural time may be, because it has not been studied. Furthermore, we have no information on whether that impact is "fully reversible." As already mentioned, since the overwhelming proportion of children who begin puberty blockers continue to cross-sex hormones, there is an important element of "psychological irreversibility." The question of to what extent the physical and developmental impacts of puberty blockers might be reversible is a hypothetical one if psychosocial realities mean that very few patients will ever be able to make that choice once they have started down the road of social transition and puberty blockers.

2.9.1 The risk related to cross-sex hormone treatments

As with puberty blockers, all evidence concerning the safety of extended use of cross-sex hormones is of very low quality. The UK NICE evidence review cautioned that "the safety profiles" of cross-sex hormone treatments are "largely unknown," and that several of the limited studies that do exist reported high numbers of subjects "lost to follow-up," without explanation—a worrying indicator (NICE, 2020b). A 2020 Cochrane Review reported finding insufficient evidence to determine the safety of hormonal treatment approaches for transgender women in transition (Haupt et al., 2020). The Endocrine Society acknowledged these risks and tagged all its recommendations for the administration of cross-sex hormones as based on "low quality evidence" (Hembree et al., 2017). The following points outline just some of the known risks associated with cross-sex hormones:

- **Sterilization:** It is undisputed that cross-sex hormones may sterilize the patient. This is evident in The Endocrine Society 2017 Guidelines which caution that prolonged use of estrogen has been associated with testicular damage and that in biological females, prolonged exposure to exogenous testosterone negatively impacts ovarian function (Hembree et al., 2017; Tishelman et al., 2015; Guss et al., 2015).

The Endocrine Society Guidelines go on to recommend that medical practitioners counsel the patient about the problematic and uncertain options available to collect and preserve

fertile sperm or ova before beginning cross-sex hormones. The life-long negative emotional impact of infertility on both men and women has been well studied. While this impact has not been studied specifically within the transgender population, the opportunity to be a parent is likely a human, emotional need, and should be an important consideration when considering medical transition for any patient.

- **Sexual response:** Puberty blockers are known to prevent maturation of sexual organs and response. Some, and perhaps many, transgender individuals who did not go through puberty consistent with their sex who are put on cross-sex hormones face significantly diminished sexual response as they enter adulthood and are unable ever to experience orgasm. In the case of males, the cross-sex administration of estrogen limits penile genital growth and function. In the case of females, prolonged exposure to exogenous testosterone impairs vaginal function and leads to vaginal atrophy within a few years of taking testosterone (Rubble of Empires, 2022). Much has been written about the negative psychological and relational consequences of anorgasmia among non-transgender individuals that must be considered for medicalized transgender persons (Levine, 2018). It must be noted that prolonged exposure of females to exogenous testosterone often increases sex drive to a distracting degree, but that sexual activity may be painful and cause tearing or bleeding. If parents and physicians are uncomfortable discussing aspects of genital sexual activity with patients, patients may not be fully aware of the consequences of the treatments they are considering.
- **Cardiovascular harm:** Several researchers have reported that cross-sex hormones increase the risk of various cardiovascular diseases, including strokes, blood clots, and other acute cardiovascular events (Asscheman et al., 2011; Getahun et al., 2018; Guss et al., 2015). Following a systematic review of the evidence, The Endocrine Society and the NICE Evidence reviews concluded that meaningfully assessing patient-important outcomes, such as death, stroke, myocardial infarction, or venous thromboembolism is not possible given the current research, and that further research is necessary to determine the potential harm (Hembree et al., 2017).

The question of whether cross-sex hormones are safe cannot be answered by analogies to hormone replacement therapy in menopausal women, because treatment in menopausal women is not a cross-sex usage. Further, in contrast to administration of hormone replacement therapy for menopausal women, hormone usage for trans-identifying individuals begins as early as adolescence and is likely to be administered for four to six decades. Considerable research has been done on the use of hormone replacement therapy for menopausal women examining the risks of cancer, cognitive decline, and cardiovascular disease. Careful studies have been conducted to determine the effects of dose, duration, and patient age, among other variables that may affect outcomes, to determine the cost-benefit analysis. The endocrine treatment of gender dysphoric youth has bypassed the careful long-term collection of data, in favor of short-

term studies or clinical impressions of efficacy and safety. The published evidence of adverse impact, coupled with the lack of data sufficient to reach a firm conclusion, makes it irresponsible to assert that cross-sex hormones are safe and effective.

- **Harm to family and friendship relationships:** Relationships are intrinsic to good mental health. Gender transition routinely disrupts relationships and leads to isolation from at least a significant portion of one's family in adulthood. In the case of a youth transition, this will be less dramatic while the child is young, but it commonly increases over time as siblings marry and have their own children. By adulthood, the friendships of transgender individuals tend to be confined to other transgender individuals (often virtual friends known only online) and a limited set of others who are comfortable interacting with transgender individuals (Levine, 2017).
- **Sexual-romantic harms associated with transition:** After adolescence, transgender individuals find the pool of individuals willing to develop a romantic and intimate relationship with them to be greatly diminished. Clinicians report that when a transgender person who passes well reveals his or her natal sex, many potential mates lose interest. When a trans person does not pass well, options are further diminished. Regardless of a person's appearance, these adults soon learn that many of their dates are looking for exotic sexual experiences rather than genuinely loving relationships (Levine, 2013).

2.9.2 The risks related to surgical interventions

Gender-affirmation surgery appears to be a growth industry. For example, in the United States, approximately 11,000 gender-based surgeries were performed in 2019, an increase of 10–15% over the previous year and the market is expected to further expand 14% per year, with most of that growth from female patients (Ayad et al., 2023). These surgeries, however, are fraught with complications. Also, the complications related to surgery can be irreversible and cause much distress.

Mastectomies can lead to skin issues, itching and unsightly presentation. It is usually impossible to have intercourse with metoidioplasty, and phalloplasty can be life-threatening with high rates of complications such as urethral fistulas and strictures, death of the transferred tissue, and bladder or rectal injury (Robinson et al., 2021). There may also be issues related to scarring, decreased sensation and pain (Bettochi, 2005). Phalloplasties usually lead to a hysterectomy (Ayad et al., 2023). Some transmen seek hysterectomies because of the increased risk of cancer that accompanies long-term use of testosterone. However, hysterectomies with or without oophorectomies, also increase the risk of dementia and Parkinson's disease (Ayad et al., 2023; Gong et al., 2022). There are also links between hysterectomies and an increased incidence of heart disease, certain kinds of cancer, metabolic conditions and stroke (Ibrahim, 2022). Vaginoplasties carry many risks, including sexual dysfunction and anorgasmia (Manrique et al., 2018). Incontinence is also a common complaint, as are fistulas, infections and suture line dehiscence (Nassiri et al., 2020).

The heavy medical burden of surgical interventions upon healthy bodies needs considerable further analysis, not to mention dissemination into public awareness so that MHPs and involved adults do not mindlessly encourage vulnerable people to make decisions that could cause a good deal of long-term damage.

2.9.3 The timing of harms

The multi-year delay between the start of hormones and completed suicide observed, as discussed earlier, warns us that the safety and benefits of these treatments cannot be judged based on short-term studies, especially those that do not continue into adulthood. Similarly, several of the harms discussed above would not be expected to manifest until the patient reaches at least middle age. For example, stroke or other serious cardiovascular events are complications that are unlikely to manifest during teen years. Regret over fertility or the inability to form a stable intimate relationship may occur sooner. The psychological challenges of being a transgender adult may manifest after the medical providers conclude routine follow-up care—or, in many cases, have lost contact with the patient altogether. Because few, if any, clinics are conducting systematic long-term follow-ups with their child and adolescent patients, the doctors who counsel, prescribe, or perform hormonal and surgical treatments are unlikely to ever become aware of the later life impacts, however severe, as noted by the findings that 76% of detransitioners did not inform their clinicians of their detransition (Littman, 2021).

The steps along the transition pathway, while potentially lessening gender dysphoria in the short term, may lead to additional sources of emotional and psychological pain. These longer-term consequences are rarely considered by advocates of social and medical transition and not considered at all by the trans-identifying young person or their parents whose focus is on the immediate (Levine, 2016). Clinicians must judiciously weigh the short- and long-term benefits and consequences and help the patient and parents understand these implications. A young patient may be unable to consider the future. They may downplay medical risks and may be incapable of understanding the health risks of medical transition on the body, as well as many other variables such as future relationships, intimacy and fertility.

Individual patients, particularly adolescents and young adults, often pin excessive hope on transition, believing that transition will solve what are, in fact, ordinary social stresses associated with maturation, or mental health comorbidities. In this way, transition can prevent them from mastering personal challenges at the appropriate time or directly addressing conditions that require attention. When the hoped-for vanishing of other mental health or social difficulties does not occur, disappointment, distress, and depression may ensue. It is noteworthy that half of the respondents to the larger detransitioner survey reported that their transition had not helped their gender dysphoria, and 70% concluded that their gender dysphoria was related to other issues (Vandenbussche, 2022).

Without monitoring clinical and psychosocial outcomes of these young patients as they age into adulthood, professionals involved in social and medical transition may experience no challenge to their affirmative beliefs. However, medical and mental health professionals who deliver trans-affirmative care, especially for those with previous and co-existing mental health problems, have an ethical obligation to inform themselves, and to inform patients and parents, that these dramatic treatments are not likely to be a panacea.

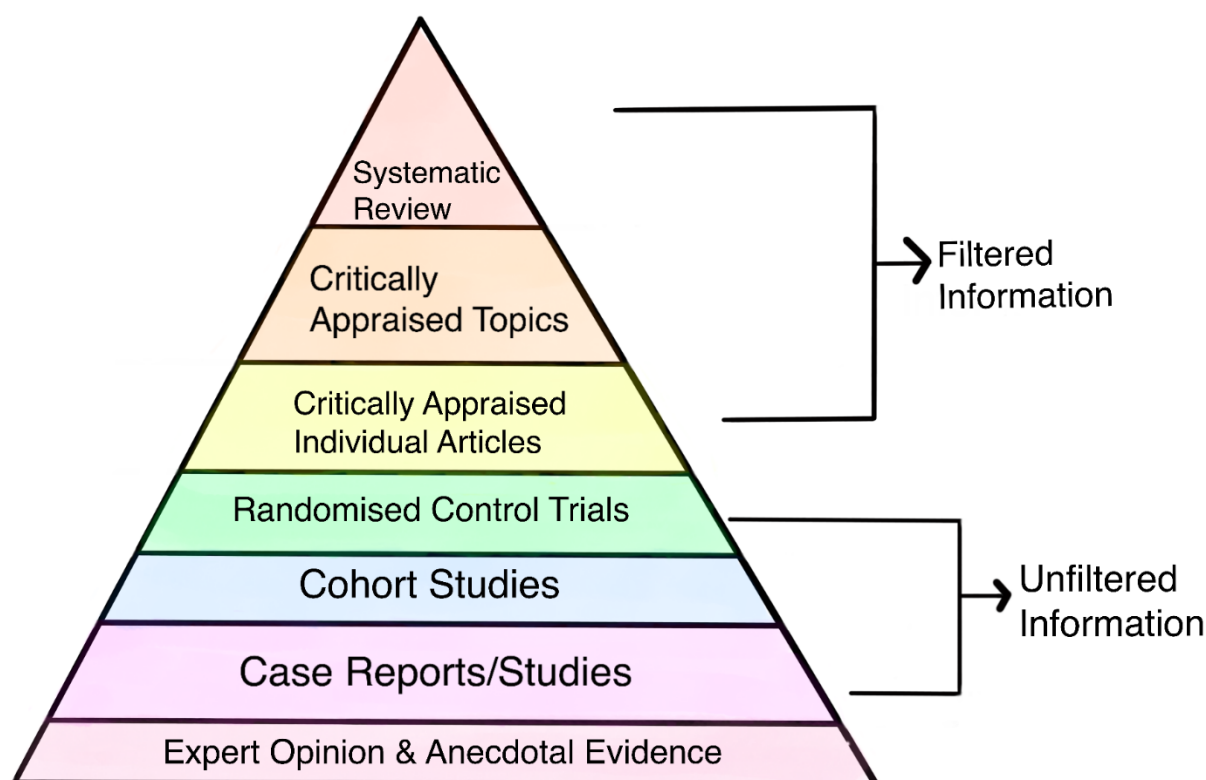
In sum, whether we consider physical or mental health, science does not permit us to say that either puberty blockers, cross-sex hormones or surgical interventions are “safe,” and the data concerning the mental health of patients before, during, and after such treatments strongly contradict the assertion that gender dysphoria is “easily managed.”

2.9.4 The “very low quality” knowledge base

When evaluating scientific research, it is axiomatic in science that no knowledge is absolute. The very nature of science is the constant evolution of knowledge. Unfortunately, opinion is too often confused with knowledge in this field, rather than acknowledging what is clearly known and unknown. To understand the validity, reliability, credibility and certainty of scientific claims, one must understand the quality of the research that is used to make that scientific claim or asserted knowledge. The best evidence comes from systematic reviews or well-constructed studies in which confounders are carefully controlled for (e.g., double-blind randomized control trial) to make high certainty conclusions. However, such studies may not always be possible for many reasons. The diagram below illustrates the hierarchy of the levels of evidence. It should be noted that many of the claims made about the positive utility of medical gender transition come from studies that fall into “unfiltered information,” which cannot be used for assessing causality.

Prominent voices in the field have emphasized the significant lack of quality research in this field. For example, the American Academy of Child and Adolescent Psychiatry has recognized the different clinical approaches to childhood gender discordance. They further acknowledge that there have been no randomized controlled trials for these various treatments and that the proposed benefits of treatment to eliminate gender discordance must undergo careful cost-benefit analyses (Adelson, 2012). Similarly, the American Psychological Association has stated that because the treatment protocols for working with gender dysphoria and gender nonconforming children have not been adequately empirically tested, no consensus exists regarding best practice (APA, 2015). As one expert in the field has pointed out, no randomized control trials have been conducted on treatment protocols for children with gender dysphoria (Zucker, 2018).

In recent years, several formal evidence reviews of hormonal interventions for gender dysphoria have been conducted. The British National Health Service (NHS) commissioned formal evidence reviews concerning the efficacy and safety of puberty blockers and cross-sex hormones as treatments for gender dysphoria in minors. These



evidence reviews were performed by the UK National Institute for Health and Care Excellence (NICE), applying the respected GRADE approach to evaluating the quality of evidence. Both reviews, published in 2020, found that *all* available evidence in support of using puberty blockers and cross-sex hormones in this population to be of “very low quality” (NICE, 2021a; NICE, 2021b). “Very low quality” according to GRADE means there is a high likelihood that the patient *will not experience* the hypothesized benefits of the treatment (Balshem et al., 2011).

Similarly, the highly respected Cochrane Library, the leading source of independent systematic evidence reviews in health care, commissioned an evidence review concerning the efficacy and safety of hormonal treatments for “transitioning transgender women” (i.e., testosterone suppression and estrogen administration to biological males). This review, also published in 2020, concluded that there is insufficient evidence to determine the efficacy or safety of hormonal treatment due to the poor quality of research in this area (Haupt et al., 2020). It must be understood that both the NICE and the Cochrane reviews considered *all* published scientific studies concerning these treatments. During the past few years, other systematic reviews (COHERE, 2020; SBU, 2022) and even overviews of systematic reviews (Brignardello-Peterson, et al., 2022) have come to similar conclusions. Countries such as Finland, Sweden and the UK that have done systematic reviews now reserve pediatric medical gender transition strictly to research settings. Denmark, too, now reserves pediatric medical gender care to clinical trials only based on these systematic reviews (Society for Evidence-based Gender Medicine, 2023).

2.9.5 Poor outcomes post-transition

While the systematic reviews (NICE, 2021a; NICE 2021b) concluded that the supporting evidence is of very low quality and therefore there is considerable uncertainty that the patient will experience the hypothesized benefits of the treatment, more recent evidence indicates that, on average, they do not experience those benefits.

An analysis of a study by Branström and Pachankis (2020) of the case histories of a set of individuals diagnosed with gender dysphoria in Sweden found no positive effect on mental health from hormonal treatment (Landén, 2020). The clinical outcomes of youth treated at the GIDS, reporting on measures of general psychological function and suicidality before commencement of puberty blockers, and then repeatedly after commencing puberty blockers for up to three years, found no evidence that psychological functioning improved (Carmichael et al., 2021). Recent reanalysis of this data using more sophisticated analysis tracking individual trajectories found that the outcomes were more variable: 34% of the children had reliably deteriorated, 29% had reliably improved and 37% showed no change. This analysis underscores the need for a better understanding of the patient populations seeking medical transition to determine who potentially may benefit and who will be harmed, and as mentioned earlier, long-term quality research is paramount.

No studies show that affirmation leads to long-term positive outcomes (mental, physical, social, or romantic) compared to 'watchful waiting' or psychotherapy. Much of the research in this field focuses on whether subjective feelings of gender dysphoria are alleviated. However, it is arguably more appropriate to consider the holistic perspective. For this reason, long-term data reporting both objective and subjective measures: physical health, life milestones, relationship status, bodily comfort and quality of life should be used to examine treatment effects.

2.10 Conclusion and Suggestions

The responsible MHP cannot focus narrowly on the short-term happiness of the patient but must instead consider their long-term health, well-being and safety. When we look at the available studies of individuals who continue to live as transgender people in adulthood, there are many unknowns and many potential outcomes. For these reasons, we believe that least-invasive-first treatments should be prioritized, and medical transition should only be available to adults who are of sound mind and able to understand the significant risks associated with these interventions.

The following suggestions are offered for MHPs and other involved adults who work with gender dysphoric individuals.

- MHPs should look at the patient as a whole person and within a holistic framework, rather than pathologizing gender diversity.
- Childhood is a special time for physical, cognitive, social and emotional growth and development. For this reason, we suggest little or no radical interventions for childhood-onset gender dysphoria.
- MHPs should be aware that social transition leads to puberty blockers and puberty blockers lead to cross-sex hormones, which in turn, often lead to surgical interventions.
- Given the probability that social transition increases the likelihood of medicalized pathways, social transition can bring about more problems than it resolves and is not recommended.
- Secrecy is seldom helpful, and it is suggested that MHPs encourage open communication, honesty and transparency and model this for their patients.
- Following a critical analysis of the literature, there is no quality evidence to support the use of puberty blockers for children.
- MHPs must be humble and aware of the unknowns concerning these interventions.
- When working with children, MHPs should involve parents so that they are part of the support network for the child currently and in the future.
- MHPs and others need to be well-informed about the implications of social contagion.

- The impact of online influences should not be discounted for childhood and adolescent onset gender dysphoria.
- Binding and tucking are not benign interventions. Their use has known risks and may represent an elaborate form of self-harm for some people.
- MHPs should be aware of complicated issues such as autogynephilia and the impact of pornography in this arena.
- MHPs should be aware that detransitioners report feeling like they were rushed into medical gender-affirmative interventions with irreversible effects, often without the benefit of conventional therapy. MHPs should consider the implications of detransitioners' experiences in relation to the care they received prior to medical transition.
- Patients with gender dysphoria have the right to the same quality of care as everyone else, including a broad approach to understanding distress and consideration of differential diagnoses.
- A slow, careful and cautious approach is the most appropriate pace for the MHP working with gender dysphoria.
- It is healthy to protect the need for an individual's personal autonomy; moreover, prohibition does not work and typically drives activities into an underground system. Adults who are mentally competent to make these choices should be free to do so, however, vulnerable adults need protection. Doctors and MHPs should abide by the ethical principle: Above all, do no harm.

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Section Three: Families and Education

3.1 Introduction

Section One provides a biological and conceptual framework for understanding sex and gender, while Section Two looks at the psychological roots and risk factors for gender dysphoria. This section expands beyond the individual to offer guidance to the families of loved ones who are trans-identified or experiencing gender related distress and how they may seek and achieve the best solutions in working with clinical and educational professionals. Directed primarily at mental health professionals and other involved adults, the first part of this section offers guidance on the provision of psychosocial support for families. Following this, gender identity ideology within schools today is discussed alongside advice to parents on how to challenge the district rules and policies that often enforce it.

An individualized approach is provided in this section that considers every dimension of the individual –past, present and future– and incorporates the latest evidence-based knowledge and well-established developmental theory. While safety remains the top priority, parental authority plays a vital role in all decisions related to the care of a child. Rather than viewing gender distress exclusively as an identity issue to be resolved by the individual child, the family system is placed at the heart of treatment plans. In particular, the risks of triangulation are highlighted, where clinicians, teachers and administrators may align with a gender-distressed child against parents and other family members, undermining the family unit and the long-term health and well-being of the individual experiencing distress.

3.2 Family

3.2.1 What is a family?

A family consists primarily of people with a shared genetic, social, and legal bond. Within medicine and professional realms, “Family is defined by the patient, or in the case of minors or those without decision-making capabilities, by their surrogates...they are individuals who provide support and with whom the patient has a significant relationship” (Davidson et al., 2016, p.105). Family, therefore, is defined by the patients when they are legally adults but should be defined by the patient’s surrogates when they are minors. In providing care for minors, special attention should also be paid to those individuals whom any courts have deemed to be the legal guardians.

A legal guardian can be different from those people with whom the minor patient might reside or with whom a patient might appear at an appointment. For any professional

relationship with a minor patient (client, student), it is crucial that the relationship with the presenting caregiver be defined by both legal custody and physical custody. This might require requesting and reviewing any legal custody agreements, guardianship agreements, and court documents.

Some families may include adults who struggle with mental health issues such as active substance abuse disorders or cognitive issues and are therefore prevented from serving as the legal guardian or decision maker. In some situations, the provider might have concerns regarding such issues that a child welfare agency needs to evaluate or consider. If such concerns arise, consulting with the local child welfare agency is advised.

3.2.2 Family structures

Families may be structured in different forms, such as the nuclear family, same-sex family, single-parent family, stepfamily, extended family, blended family and grandparent family (Davidson et al., 2016; Marsolini, 2006). Children benefit from a responsive, warm, and loving family regardless of the structure. Families optimally provide necessary and meaningful support, but family structures may also be weak and tenuous and, therefore, inadequate to weather some emotional challenges. Most family structures fall somewhere in between, and many families that might have strength facing certain kinds of challenges might demonstrate unexpected weaknesses with others.

Struggles with gender identity in children and adolescents are a particular challenge that might bring weaknesses or strengths to the forefront within the family structure. "The development of individuals within the family does not occur in isolation" (Etkin et al., 2014, p. 2). Similarly, a child or adolescent's understanding of gender develops within these family structures, and even within society at large.

3.3 Family-centered care

"Family-centered care is an approach to health care that is respectful of and responsive to individual families' needs and values" (Davidson et al., 2016). One criticism from many families seeking care for their child or adolescent with gender concerns is that the response has often been child-centered, not family-centered. The individual child is considered the authority, effectively removing that child from the family unit and its social parameters. As Ehrensaft (2017) explains, affirmative care, as practiced today "is defined as a method of therapeutic care that includes allowing children to speak for themselves about their self-experienced gender identity and expressions and providing support for them to evolve into their authentic gender selves, no matter at what age" (p.62). This is an unnatural system that places children at the head of the family, a responsibility they are not prepared to shoulder. Further, it contradicts well-accepted frameworks of child and adolescent development.

Systems (e.g., schools, mental and medical health clinics) that interact with children and adolescents struggling with gender identity concerns should focus on the family unit, foster communication, encourage the family to talk more, and spend more time listening to all family members. Communication is essential because it enables family members to understand what is happening to their loved one and the care they are receiving (Curtis, 2008). For providers working with children and adolescents experiencing gender identity issues, refocusing on the family will require a shift in practices and policies that currently place all focus on the individual child. Such a refocus is essential to provide quality, effective care.

3.3.1 How gender distress can impact the family

Parents consistently describe how having a child with gender distress impacts the entire family system and the relationships within the family structure (de Abreu et al., 2022). Childhood gender distress can follow many pathways, but nearly all of them will be influenced by relationships within the family. It is crucially important to understand the family to understand the evolution of a child's or adolescent's identity issues. Providers should also be cognizant that there are mixed findings on parental responses. While some have found mothers to be more open to a new gender identity and fathers taking longer to accept this (de Abreu et al., 2022), other researchers have highlighted that mothers expressed greater concern than fathers (Diaz & Bailey, 2023); arguably we can conclude that in relation to the new cohort of individuals who identify as transgender, typically mothers are more involved compared to fathers. Providers should take additional time to acknowledge and understand all family members' responses and values, and to be open to differing response presentations as consideration of multiple perspectives will enrich a provider's understanding of the child or adolescent's gender distress and its evolution.

Some pathways to gender dysphoria are highly specific and require additional specialized care responses. Children and adolescents in some form of out-of-home care, foster care, relative care, or guardianship care are overrepresented in populations struggling with gender issues (Matthews et al., 2019). These families are known to have high levels of historical trauma, abuse, neglect, poverty, and substance abuse. For this reason, multiple care systems may need to be engaged concurrently to address gender identity issues. This may require the gender identity issues, depending on the seriousness of the distress, to be placed lower on the triage assessment. A family currently in a high trauma situation which includes any abuse, neglect, substance abuse, or significant mental health concerns, should have these issues triaged to the top of the response tree. The same is true for the individual patient.

Acute and chronic stressors to family systems can result in many different outcomes. These outcomes often depend on the level of functioning within the family system prior to the stressor. For many families, there are acute stressors that coincide with the child or adolescent's gender issues. These can include, but are not limited to suicidal

ideation, suicide attempts, self-harm, eating disorders, physical aggression, hospitalization, and mental health crises. Such acute stressors can quickly become chronic.

Patterns of resilience may occur with acute or chronic stressors. Resilience may take the form of post-traumatic growth, minimal impact resilience, unaffected coping, recovery, avoidant behavior, hidden resilience, and maladaptive coping (Ungar, 2016). A family’s resilience will depend upon their available resources, how long the stressors occur, and their understanding of what it means to be resilient across cultures and contexts (Ungar, 2016). Therefore, the needs and behaviors of all family members and those of the gender-distressed child must be carefully considered.

In western cultures, families with distressed children, adolescents, and young adults face disparate cultural messaging without clear cues to help them understand what resilience looks like in these contexts (Haidt & Lukianoff, 2019). Moreover, their communities do not foster resilience as a way to cope with distress. Hence, a focus on family-centered care is crucial to help them contextualize their own goals for resilience.

3.3.2 Mapping the family unit

An important initial goal for professionals working with families is to collaborate on creating a map of the family system in which all key individuals are identified. Family structural mapping can be a tool to identify structural problems and to help focus on areas that need interventions and assistance. Such a family map does not focus on gender; instead, it helps the family to understand itself as a system.

Necessary elements of the Family Map:

Element	Identification	Placement
Membership	Members should be identified as: <ol style="list-style-type: none"> 1. Youth or child 2. Parents and caregivers 3. Siblings 4. Grandparents, Aunts, Uncles 5. Family Friends 6. Professional relationships 	Each member should trace their relationships and outline who provides support to whom
Boundaries	Once the members are identified, the boundaries between them should be explored.	Boundaries should be identified as weak, missing, rigid, conflicting, strong, clear, and flexible.
Roles	Roles should be explored.	Roles should be identified as unclear, unstable, inappropriate, conflicting, strong, stable, and appropriate.

3.3.2.1 Journey mapping

A visual method can be used to engage family members in tracking the evolution of the child or adolescent's gender struggle. As opposed to being *child-led*, this *child-centered* activity traces the timeline, involves all key members, and visually ties together different memories from key individuals. By using color coding along the timeline, each individual can identify when they felt most connected and when they felt disconnected or stressed. They should also identify which supports were positive and provided assistance, which supports were not helpful, and any supports that could have been helpful.

The journey map should focus on the interfamilial journey. An additional map should be made looking at external influences on the functioning of the child or adolescent. External influences may include, but are not limited to, peers, school, parasocial relationships and social media. This activity should provide clarity as to which internal and external influences have provided support and what might have been detrimental. An example of an external influence might be the introduction of a cell phone or a gaming console to a child's room, or a change in school or peer group.

The use of journey mapping should encompass helping the family identify future journey goals. These goals should focus on family connections and relationship hopes, not solely on one individual's personal concerns. The child or adolescent should be centered in this activity but should also be encouraged to consider the journeys of those within the family structure and, if age appropriate, to work on developing empathy and understanding for all members within the family structure.

3.3.3 The erosion of parental authority—issues related to triangulation

Throughout history, parents have been viewed as the natural authority figures within a family system. Parents' authority should be respected regarding their children's education, medical care, and social interactions. Particular care should be taken where legal guardians have been appointed by court order in the case of a custody agreement or guardianship decree; the authority of such legal guardians should be respected.

Parents have a duty to provide for their children, protect their children, and facilitate their children's growth toward adulthood. The length of time for children to become independent has become longer, often seeing the 'teenage years' extending well into an individual's early twenties (Haidt & Lukianoff, 2019).

Over time, legislative changes, legal challenges, and systematic pressures from school and medical clinics on children and adolescents experiencing gender issues have gradually eroded parental authority (Moore, 2023). Professional considerations should support parental authority and focus on the long-term health and well-being of the family system, which in turn will support the young person's long-term well-being. Professionals should also recognize that families and patients seek positive relationships and dynamics that do not require ongoing interventions from

professionals. It is better for the individual, family, and society that families themselves provide support for their own members. Thus, professionals should work towards family stability, fewer interventions over time, and helping families become less dependent on external support (Moore, 2023). This means assisting families to establish good boundaries, systems, rules, and values, and working to place and hold the parents in a position of authority. Practices that intentionally or unintentionally alienate family members should be avoided.

3.3.3.1 Triangulation

In discussing triangulation, Etkin et al. (2014) remind us that “triangulation is a family-wide process in which children are inappropriately involved in interparental conflict, placing them at heightened risk for adjustment problems.” (p. 1). Triangulation often occurs without intention by parents and can be an extension of patterns developed over years within a family system. Triangulation is a heightened concern in families with a child, adolescent, or young adult with gender identity issues. Many of these families have already experienced divorce, separation, or trauma—situations that leave families at risk of triangulation.

In divorced families and blended families, researchers have found that parents are more likely to pressure daughters to take sides in marital conflict, leaving them to feel caught in the middle, often harming the mother-daughter relationship (Etkin et al., 2014). In families with children, adolescents, and young adults facing gender issues, there has been no research to date exploring whether such mother-daughter alliances are also the most common. For parents seeking alternatives to affirmation or who have differing views, it is often the mother who navigates the emotional challenges and shoulders the burden (Diaz & Bailey, 2023). As Etkin et al. (2014) point out, parents must be cognizant of the dynamics that may develop in maintaining their relationships with their children experiencing gender distress; “In families characterized by alliances, warmth can often be partnered with elements of coercion or psychological control” (p. 10). Any professional working with these children and youth should complete an in-depth assessment of the family structure.

Triangulation may also inappropriately involve children in conflicts between their parents, families and external systems. Triangulation increasingly occurs as a result of the erosion of parental authority occurring throughout systems that interact with families. School, therapeutic and medical systems have increasingly been adopting policies regarding children and adolescents with gender struggles that displace the parents as the primary authority within a family and in regard to their own children.

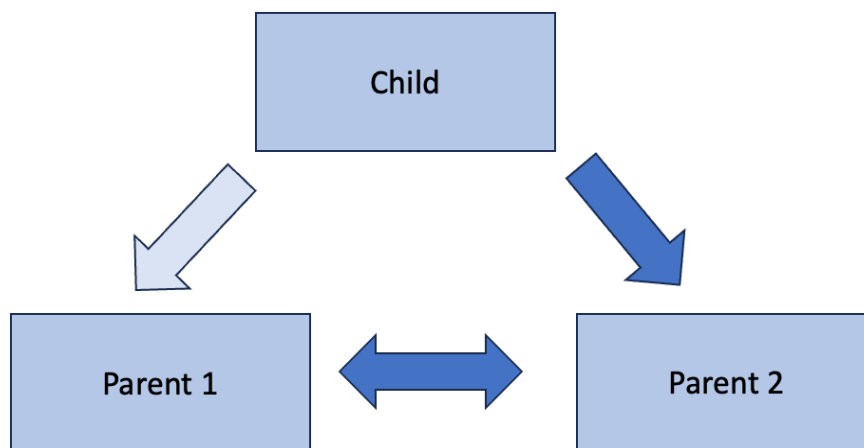
3.3.3.2 Evolving triangulation

Youth and adolescents often sense the triangulation in advance of ‘coming out’ as transgender and will intentionally choose one parent to disclose this information to. Some youth and adolescents might even attempt to enlist that parent to intentionally

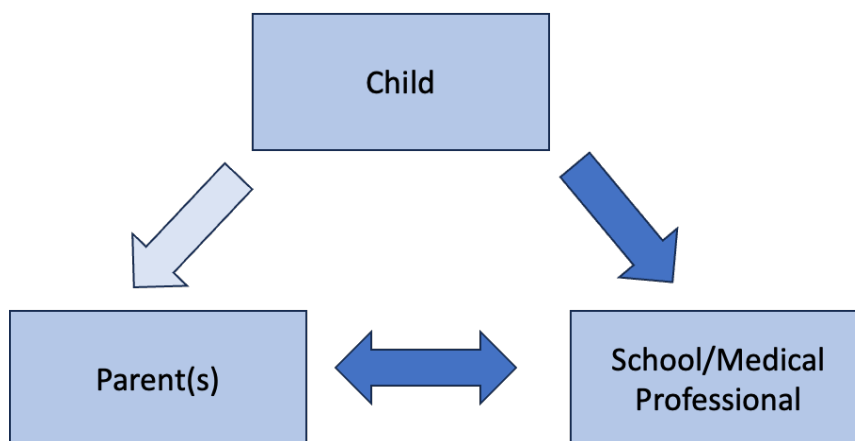
keep this information away from the other parent. Since adolescents have greater emotional and verbal competency necessary for building effective alliances, parents may be more inclined to triangulate adolescents, as opposed to younger children (Etkin et al., 2014).

Families with children experiencing gender identity issues are unique and may struggle with both weak boundaries and enmeshed relationships in addition to triangulation (Ayad et al., 2023). Boundaries are necessary as they support stable child development. When boundaries are weakened or broken down altogether, the child may become inappropriately involved in conflicts, such as in the marital dyad, potentially harming the child's relationships, growth, and development (Etkin et al., 2014).

This figure depicts the well-known triangulation process within a family:



Triangulation has shifted with newly identified paths, especially when the child, adolescent or young person experiences gender identity concerns. These may involve school staff and clinicians.



These shifts in triangulation increasingly result in children and adolescents being inappropriately included and directing decision-making discussions regarding gender identity concerns. It is important to note that considerable conflict can occur when separated/divorced parents disagree on the most appropriate treatment path. Extreme care and caution are required in this context (Ayad et al., 2023). Such triangulations create conflicts and add another dimension of potential risk for their adjustment problems.

As Curtis points out, professionals should remember that with parents, “shared decision making should be the default starting place, but this default should be modified based on the family’s preferences about their role in decision making, and by the prognosis and our certainty about the prognosis” (2008, p.482). The prognosis of persistent gender dysphoria is of very low certainty. This means that the parents’ or caregivers’ decision-making will be challenged; professionals should, therefore, use high levels of caution, work intentionally against triangulation, and avoid placing children and adolescents in the decision-making role.

There has also been a dearth of quality, unbiased information available to parents. Further, some professionals have stated, “With regards to informational support, ‘transgender’ adolescents temporarily become teachers of their own parents” (de Abreu et al., 2022, p. 11, Table 1, S20). Parents and professionals should be cautious about the assumptions underlying an adolescent’s assertions. It should not be assumed that the child or adolescent with gender identity concerns has access to or the level of knowledge to understand the material being presented and the maturity needed to process and analyze it.

Parents should be granted sufficient time and resources necessary for decision-making. This is often not the case. One study (de Abreu et al., 2022), for example, reported that “parents felt overwhelmed and lacked informational support, and after meeting their children’s demand, they [then] returned to the discovery phase to try to understand their situation and their role” (p. 8, Table 1, S13). Professionals should work to reverse this course. Parents should be guided through a discovery phase as soon as any child or adolescent expresses gender identity issues. Professionals should not encourage parents to meet their child’s demands, but rather assist them in assessing the child’s needs and wants, responding in ways that support a child’s or adolescent’s functioning while keeping long-term health and well-being in mind. Professionals should be cognizant of the fact that, in most cases, parents have far greater knowledge of their child than clinicians. Professionals should not support a system where demands are immediately met without allowing the parents time to adequately assess all relevant information and engage in meaningful discussion with their child.

3.4 Body image

One way for professionals who work with families with a child or adolescent experiencing gender concerns is to introduce them to the research on body image issues. Adolescents commonly experience issues with body image. During adolescence, the physical body undergoes unprecedented changes within a relatively short time. As Choukas-Bradley et al. point out, “the increase in body dissatisfaction in adolescence is likely caused by numerous developmental transitions, including biological, social and psychological changes; girls’ body image typically worsens during puberty when increases in body fat move them farther from the thin ideal” (2022, p. 683).

Parents are not powerless to help their children during this period. Choukas-Bradley et al.’s tripartite influence model of body image, developed prior to the advent of social media, may be a helpful framework for parents to support their children. The model “proposes that three sociocultural forces—peers, parents, and the media—influence girls’ and women’s body image through two primary mechanisms: (1) encouraging internalization of the thin ideal, and (2) fostering appearance comparisons.” (2022, p. 684). Parents can influence their children’s ideas of healthy bodies and model behaviors that de-emphasize the fostering of comparisons. Professionals can coach and guide parents in fostering an environment where negative media effects on adolescents’ self and body image are mediated by the family (de Vries et al., 2018).

In the context of gender identity issues, one must assess parental influences, the family’s functioning, and the social media environments in which the child or adolescent is immersed. Research has shown that individual factors, such as the tendency to engage in social comparison and level of media literacy, mediate body dissatisfaction and self-image (de Vries et al., 2018), leaving some more susceptible to the negative impact.

Research in this area has also shown that families play a vital role in a treatment modality’s success. Research using randomized control trials, for example, has shown that family-based approaches are effective in the treatment of body-image related issues (de Vries et al., 2018). It is, therefore, short-sighted *not* to focus interventions on family-based approaches.

3.5 Dynamics within the family

The coping strategies available to a family ultimately depend on other systems’ capacity to adapt and accommodate the family’s needs (Ungar, 2016). Many families in the current ‘affirmation only’ environment will find that nearly all systems are neither adapting to, nor accommodating of the family’s needs. Thus, the ability to exercise parental authority is central to the family units’ ability to gain the necessary support, which may require pushing back on the systems in place. This may be extremely

challenging when parental authority has been eroded by the current culture (Moore, 2023).

Parents will also find it challenging to find information and unbiased resources that provide neutral evidence-based research to help guide their decision making. This guide can assist professionals in providing parents with evidence-based data and resources.

3.5.1 Parental responsibility

At this time, parents may need to take full responsibility for many areas that were previously shared with clinical and community systems. Parents specifically need to pay attention to the following:

1. School systems
2. Medical and therapeutic systems
3. Social media/internet access
4. Extracurricular activities
5. Friend and peer group

This responsibility can be time-consuming, overwhelming, and resource draining. Parents should be encouraged to seek support from extended family members and members of their community whenever possible. However, parents may also need to be forewarned that the support they are seeking may not be forthcoming due to the politicization of gender issues. While they may have been able to rely on external support for other mental and physical health issues of their child, this may not be the case for their child experiencing gender distress. Parents might find that they need to physically attend school board meetings when, in the past, they might have only glanced at the minutes. Parents may need contact information for every teacher and school staff member with whom their child or adolescent interacts. Parents may also need support in communicating their child's and family's needs.

Within medical and therapeutic systems, this might mean spending more time evaluating a professional resource before engaging with caregivers. This might also mean requesting more involvement if the adolescent or young person engages in any care delivery without a parent being present.

3.5.2 Managing technology

From the time their children are young, parents should have a plan for managing social networking and internet access by potentially limiting access to smartphones, for example, or keeping all technology in a public space within the home. The use of smartphones is ubiquitous. As reported by Choukas-Bradley et al. (2022), in 2018, 95% of U.S. teens reported having access to a smartphone, with smartphone ownership nearly universal across gender, race, ethnicity, and socioeconomic background" (p. 681). Parents must take responsibility for limiting such access (Ayad et al., 2023).

Social media use does not affect everyone in the same manner, and there is evidence that there is a differential effect of social media for boys than girls. Parents raising girls should be particularly attuned to social media's impacts on them during adolescence. Given that girls tend to focus on physical appearance and personal image and are socialized to attune to peers, adolescence may be a stage in which social comparison may be particularly high, leaving them at high risk for body dissatisfaction and associated mental health concerns such as eating disorders (Choukas-Bradley et al., 2022). This developmental period also poses a high risk for social contagions to develop, and parents should be aware that these contagions now spread via social media whereas before, they used to primarily spread through real life social interactions (Ghorayshi, 2023; Haltigan et al., 2022).

Finally, parents should understand that it is not only online groups and social media, but also school lessons, extracurricular activities, after school groups, and even summer camps that may inappropriately or inaccurately discuss gender with children and adolescents. Seemingly innocuous rituals might be occurring that parents should be aware of. Summer camps, for example, may ask children daily to identify their pronouns or preferred names. After school clubs such as diversity clubs might be propagating queer theory in the context of social justice. Parents should have access to resources to exercise their right to opt their children out of such activities.

Professionals should assist parents in developing tools to assess resources, and, through role-playing activities help them to practice calmly advocating for their family's needs and values. Professionals should also assist families in demanding greater transparency in programming that includes children and adolescents to ensure that the advertised content adheres to programming.

Parents should routinely document their exchanges with various outside systems. For example, they might create a folder for each child with separate sections for school, medical, and therapeutic interactions. Parents should keep notes, save paperwork, and document phone calls and meetings, including the names and roles of all individuals interacting with their child. Email communication may be archived. Parents who are organized and educated as to the issues will be more effective advocates for their children. Professional social workers, case workers, and life coaches can assist families in developing these skills.

3.5.3 Sibling issues

Relationships with siblings are among the longest and most significant that a young person will have, and they will inevitably be impacted by any gender identity issues that arise. Many children and adolescents with gender identity issues will also have concurrent mental health disorders (Becerra-Culqui, et al., 2018). As such, they may face periods in which typical childhood activities are not possible. These children may also require acute or long-term medical attention. In such situations, parental attention

may be disproportionately directed at the child with the gender identity issues, with siblings feeling unattended to, ignored, or even neglected (Ayad et al., 2023; Long et al., 2021). Parents may also be unsure how to explain their gender-distressed child to their other children. Some families may decide not to notify the other siblings and to create systems that hide these issues. In other families, especially those with adolescents and children of similar ages, some siblings may collude in concealing identity issues from the parents.

Providers caring for these families should be cognizant of these factors. All these situations may be improved by strategies outlined previously, including family mapping and journey mapping. Professionals can also assist by promoting a view of the family as a unit. Long et al. (2021) also point to other interventions including the assessment of siblings' psychosocial needs, addressing their needs as a necessary part of a comprehensive family care plan. They also advocate for increasing siblings' inclusion in family sessions, centering parent-directed interventions and developing accessible referral pathways to community-based supports and interventions.

Siblings of children with significant and prolonged mental or physical health conditions may, themselves, have normative or non-normative emotional or behavioral issues (Ayad et al., 2023). They may also develop non-normative responses when parents are unable to adequately meet their needs. School systems should also be made aware if sibling issues are intensive in order to identify the context of the sibling's functioning and to provide additional services if applicable.

Professionals working with families with a child experiencing gender issues should not be surprised to find that there may be multiple siblings expressing similar gender issues (Ayad et al., 2023). Particular attention should be paid to these families when completing the journey mapping. Assessments of sibling relationships and influences need to be addressed, and individualized treatment plans and goals should be created for every sibling.

3.5.4 Children of transgender people

"A recent analysis of a national survey by Goldberg (2023) found that 1% of trans respondents were parents, with over half being transwomen, about one-third being nonbinary, and one-tenth being transmen" (p. 3). Professionals must be prepared to address multiple family structures where parents identify as transgender.

In the past, some transgender individuals would not publicly trans-identify at the time of their children's birth and early childhood, choosing to come out as transgender when their children were older. These cohorts have been included in some studies (Goldberg, 2023) where "young adults and adults with trans parents' navigated ambiguity and ambivalence in relation to their parents' changing roles and designations/titles" (p. 4). Most research on transgender parents, however, has focused predominantly on individuals who had children before disclosure and transition (Tornello & Bos, 2017).

Since cohorts are rapidly changing, professionals will encounter families that include individuals with medical transition histories well before children were born or adopted. Some will not have completed any medical interventions and identify as transgender or non-binary. In years to come, individuals with medical transition histories who subsequently detransition will likely become parents in increasing numbers. How families are being created will differ. The aspiration to become parents and how parenthood will be achieved will vary. Research suggests that transwomen are more likely to seek adoption (75%), whereas transmen are more likely to become parents through sexual intercourse and pregnancy (58.3%) (Tornello & Bos, 2017). Little research exists concerning the challenges to the family unit or to individuals, who have transitioned or detransitioned, and the potential solutions. Some research, however, highlights some of the challenges to detransitioned biological females (Gribble et al., 2023).

Professionals should be prepared and open to working with families that include transgender parents and those who have detransitioned, and not prejudge parenting skills or family functioning based on a parent's gender history. Transgender and detransitioned individuals will commonly have medical needs to be met, including those related to reproduction, conception, and birth. The aspiration to become parents, typically to two children, is held by most people, regardless of their gender identity (Tornello & Bos, 2017).

Some parents who are transgender or detransitioned require sensitive consideration from professionals and researchers. Professionals must address these families with sensitivity, compassion, and a willingness to consider that social contagion can also exist within family units.

3.6 Queer theory and the dismantling of the family

As outlined in Section One, queer theory may be thought of as a disruptive force that challenges the notions of the status quo, a force that can be used in regard to all cultural and social interactions, structures and paradigms (Jagose, 1997). Fundamentally, queer theory challenges social norms and those who maintain these norms, targeting many of them for disruption. The inherent goal of queer theory is to transgress all boundaries (Butler, 1990). Queer theory does not merely question sexuality or gender. The theory and its practices attempt to dismantle "the broader systems through which social power is granted or restricted" (Hrynyk et al., 2023, p. 959).

For families who are raising children, the traditional developmental goal promoted by society is to raise and nurture a child, slowly teaching and guiding them toward taking their place in society that gives them a larger part in social power. The limitation of the voting age being 18 or older in most countries recognizes the extended learning and socialization process necessary to be a responsible contributing member of society.

These limitations also protect children and adolescents from making poor decisions and exerting social power unwisely, in ways that may have long-term impacts on the individual, family, and society at large. Society can reject queer theory's goal of dismantling boundaries while acknowledging that the widening of some societal boundaries, including that of gender norms, is both acceptable and desirable.

One of the most significant boundaries in an individual's life delineates who falls within and outside of the family. Furthermore, it is this boundary that defines who has decision-making responsibility for a child. There are legitimate social norms that provide safety and structure for families and for the children and young people within them. These boundaries are especially important for youth with mental health challenges.

Queer theory is also being applied to fields such as medicine and science (Hrynyk et al., 2023). Statements such as "medicine privileges and reifies these masculine constructions of knowledge production and dissemination; examples of these masculinist ideals include, but are not limited to, 'objectivity, rationality, and outcome oriented measures of success, hierarchical relationships, power disparities, activity, and the endowment of authoritative status of those who conform to the discourse' (Hrynyk et al., 2023 p.958). Long-established principles in medicine and science such as objectivity, rationality and outcome-oriented measures of success, have historically positively influenced the overall health of humans.

Societal change and evolution do occur, but usually through a process where "families, schools, governments, and cultural groups react to one another [in] reciprocal processes of change that adapt over time" (Ungar, 2016, p 20). As the Western world is explicitly or implicitly adopting queer theory, with its rejection of the family as a protected institution, the usual shifts in social change that work to strengthen families are being eroded. This has created adversity between families and systems that used to be mutually supportive: "In contexts of adversity, a family's well-being depends on both how well the family as a system accesses the resources it needs to sustain itself and grow and how well other systems change to meet the needs of the families" (Ungar, 2016, p 20).

3.7 Working with families

All work with gender-questioning youth needs to place the family system at its center. Some key elements of working with families include valuing family statements, acknowledging emotions, listening, understanding the patient as a person, and eliciting questions during family conferences, as these elements facilitate clinician-family communication (Davidson et al., 2016).

Families and parents face intense internal and external pressure when a child, adolescent or young adult experiences gender concerns. This pressure can lead to

serious harm to the family and will require intensive support. Professionals working with these families should be attuned to such potential harm. Barriers to sound decision-making such as stress, emotion, the complexity of the clinical situation, uncertainty, poor communication quality, and lack of social support must be addressed (Davidson et al., 2016). Families should not make treatment decisions with lifelong consequences for their child or adolescent while their decision-making capacities are being challenged; nor should professionals pressurize families and parents with timelines for making decisions about their child's gender issues, especially not in front of the child. The goal of all family-professional interactions should be to maintain and support the individual experiencing gender-related distress within the context of the family unit.

Professionals should limit all discussions regarding potential interventions to those visits where the child or adolescent is not present. Professionals should also value each parent as an individual and be willing to discuss any issues with them one-on-one. Parents should be provided with multiple options for treatment, ranked from least invasive to most invasive. No interventions (including social transitions such as name or pronoun changes) should be rushed. Navigating and understanding gender distress takes time. Parents can be encouraged to provide caring support without having to accept interventions quickly or without thoughtful consideration. Wherever possible, parents should be provided with the best available evidence, in the form of unbiased systematic reviews. Due weight must be given to the many complex individual factors concerning all members of the family.

Professionals should review their ethical guidelines and view all interactions with these families through a strengths-based lens, acknowledging parents as the natural heads of the family at the top of the decision-making pyramid. Professionals working with families should support key healthy behaviors and place gender where it belongs, as a page in a family's book and not its title. This will allow for a holistic approach to the long-term health and well-being of the individual child, the family unit and all family members.

3.8 Education

3.8.1 Ethical responsibilities

Parents are the primary educators and guardians of their children's physical and emotional well-being. Parents typically know their child's personality and developmental history, whereas school personnel have, at best, incomplete knowledge about an individual child. Schools should be in a supportive role to parents, and not attempt to direct a students' psychological or medical care. Schools should never act against parents' wishes unless they have serious and substantiated concerns about

parents' fitness to support their child's well-being, which has been adjudicated via formal channels, such as Child Protective Services.

Schools' ethical responsibilities are outlined below:

- **Privacy** – Schools shall not disclose a child's gender dysphoria to anyone other than the school staff who reasonably need to know to support the child, and to the child's parents or guardians.
- **Transparency** – When presenting in a manner that prioritizes gender identity and hides biological sex, schools should request that children disclose their biological sex in an appropriate manner. Schools should not support children 'stealth transition' as it can create further distress for vulnerable people (see more in Section Two). The parents of a child experiencing gender dysphoria or who expresses concerns about their gender shall be informed when school staff become aware of the child's gender-related distress.
- **Medical/psychological evidence and ethics** – Gender dysphoria can present in different ways, at different ages, and with different root causes. Schools should work within an ethical framework in which students are matched with a therapeutic approach that is customized to the student's unique developmental and medical/psychological history. The appropriate and most effective approach requires collaboration with parents, and, in many cases, with family identified medical or psychological experts. Schools should not pursue a "one size fits all" approach in which any child identifying themselves with a gender contrary to their biological sex is, for example, automatically socially transitioned.
- **Supportive neutrality** – Schools can best respect their students' search for meaning and personal identity by creating space for uncertainty and exploration while remaining supportively neutral as to outcome or direction. Schools should regard variations in student interests and expression as normal and natural, not as signs that a student is transgender. Schools should provide the same provisions for students seeking transition and detransition.
- **Informed consent** – Parents shall have the right to play a determinate role in defining the school's approach to their child's needs. They have a right to be informed about their options prior to granting consent to the approach the school uses to support their child at school.
- **Non-stigmatization** – Schools shall offer a non-judgmental environment for students with gender non-conformity or dysphoria, making every effort to destigmatize it, show acceptance and comfort in dealing with gender issues, and create a safe environment for students.

3.8.2 Adolescence and identity formation

Dr. Erik Erikson identified eight psychological stages of human development from infancy through old age (McLeod, 2023). Each stage has a primary conflict or area of

concern. As outlined in Section One, for adolescents, their primary concern is identity formation, and it has always been common for teenagers to explore a wide variety of identities during this time. The identities students explore reflect the cultural conversation at the time of their adolescence, as many current parents who remember “goth,” “emo,” “jock,” “nerd,” “preppie” and other identities from their youth can attest. As schools have increased their instructional emphasis on sexuality and gender identity and the idea of a transgender minor has become a concept that adolescents are familiar with, this is now a possible identity that more students may consider. However, transgender identities open the possibility of major and life-altering medical, and surgical interventions which carry a much higher burden of responsibility, requiring parental and medical professional involvement. This higher standard extends beyond the ethical reach of school personnel and requires a consistent aligned response among family and caring adults in a child’s life.

Also, there are diverse cultural perspectives, traditions, religious beliefs and non-beliefs within our communities. School personnel must respect this diversity and create a welcoming and inclusive environment for all, without imposing their personal beliefs on students. As part of identity development, it is critical that students learn to respect others with different views and cultural beliefs. Learning to respect differences in beliefs and views is a fundamental part of adolescent development and preparation for adulthood.

3.8.3 Social contagion in school

At the time of this writing, the scientific understanding of gender dysphoria, especially adolescent-onset gender dysphoria—sometimes known as rapid onset gender dysphoria (ROGD)—is not settled. Sections One and Two outline how Dr. Littman, a physician and researcher with expertise in public health, coined the term rapid onset gender dysphoria in her 2018 seminal paper. Dr. Littman surveyed parents of transgender-identified adolescents who described that the onset of their children’s gender dysphoria occurred in the context of belonging to a peer group where one, multiple, or all of a child’s friend group became gender dysphoric and transgender-identified during the same time frame. In many cases, parents reported an increased use of social media/internet prior to disclosure of a transgender identity. These adolescents did not exhibit gender dysphoria as children, and many were not even gender non-conforming, but the majority struggled due to mental health or neurodevelopmental issues. This led Littman to hypothesize that transgender identification for some youth may be a result of maladaptive coping mechanisms to psychosocial stressors mediated by sociocultural factors. The idea that gender dysphoria may be socially mediated is an area of active research and debate (Littman, 2018).

A sampling of key findings to date is presented below; further information on these details is also offered in Section Two. Schools should recognize that this information may change as scientific research continues to emerge. In August 2023, the American

Academy of Pediatrics acknowledged that the US approach is discordant with several European countries on best practices and committed to conducting a systematic review of the evidence. This will, however, take one to two years to complete.

- ***Prevalence.*** From 2017-2022, the number of youths who identify as transgender in the United States has doubled, with youth between the ages of 13-17 identifying at a rate of 1.4%, all adults identifying at a rate of 0.5%, and adults aged 65 or older identifying at a rate of 0.3% (Herman et al. 2022). Historically, gender dysphoria was found in 0.01% of the United States population (mostly boys), and prior to 2012, there was little to no scientific literature about girls aged 11 to 21 ever having gender dysphoria (Shrier, 2020). Currently, most gender dysphoric youth are female at a ratio of approximately 2:1 (Aitken, 2015; Butler et al., 2018; Kyriakou et al., 2020). There is currently no consensus regarding the cause for the recent rapid rise in gender dysphoria or why females are now experiencing it at a much higher rate than males. These phenomena have also been observed in other Western countries (de Graaf et al., 2018).
- ***Persistence and desistance.*** Across 12 long-term studies done on gender dysphoria, prior to the newly adopted affirmation mode in which a watchful waiting approach was taken, the vast majority of children desisted by the end of puberty, with a range of desistance from 61-98% (Ristori, Steensma, 2016; Kaltiala-Heino, 2018a; Temple Newhook, et al., 2018; Singh et al., 2021). It is notable that even children with severe gender dysphoria can experience desistance (Soh, 2020). While most children's gender dysphoria desists before or through puberty, some children experience increased feelings of dysphoria as they undergo puberty (Kaltiala-Heino, 2018b). Currently, there is no accurate method to detect who will persist or who will desist. It should be noted, however, that in a recent study of 317 young people who had been socially transitioned, 97.5% retained a transgender identity after five years. Only 2.5% desisted (Olson et al., 2022).
- ***Identity outcomes.*** For those with childhood-onset gender dysphoria, in 2.5%-20% of cases, their gender dysphoria may be the initial manifestation of transgenderism and they may ultimately identify as transgender as adults (Korte, 2008). After undergoing puberty, for 61-98% of children who are not socially transitioned, their gender dysphoria will resolve, with most identifying as homosexual or bisexual (Wallien & Cohen-Kettenis, 2008). No long-term data is available for the newer cohort characterized as ROGD, for whom gender dysphoria emerged post puberty.
- ***Influence of schools' affirmation-only policy:*** Dr. Hilary Cass, who carried out a large-scale independent review of gender identity services in the United Kingdom, concluded that for social transition, "it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning" and "There are different views

on the benefits versus the harms of early social transition. Whatever position one takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes” (Cass, 2022).

Current research on the affirmation model suggests that affirming a person’s gender identity is associated with gender dysphoria persisting (de Vries & Cohen-Kettenis, 2012). Schools affirming a student’s gender identity or publicly celebrating a transgender student’s courage are not neutral actions and can unintentionally influence students’ identity formation (Zucker, 2020; Wren, 2019). Since schools have an ethical duty to remain neutral regarding identity outcomes as well as to collaborate with parents and align around an approach that reflects their values and professional advisors, an affirmation-only school policy is not recommended. Instead, schools should treat their students as individuals and recognize that there are multiple pathways into and out of gender dysphoria.

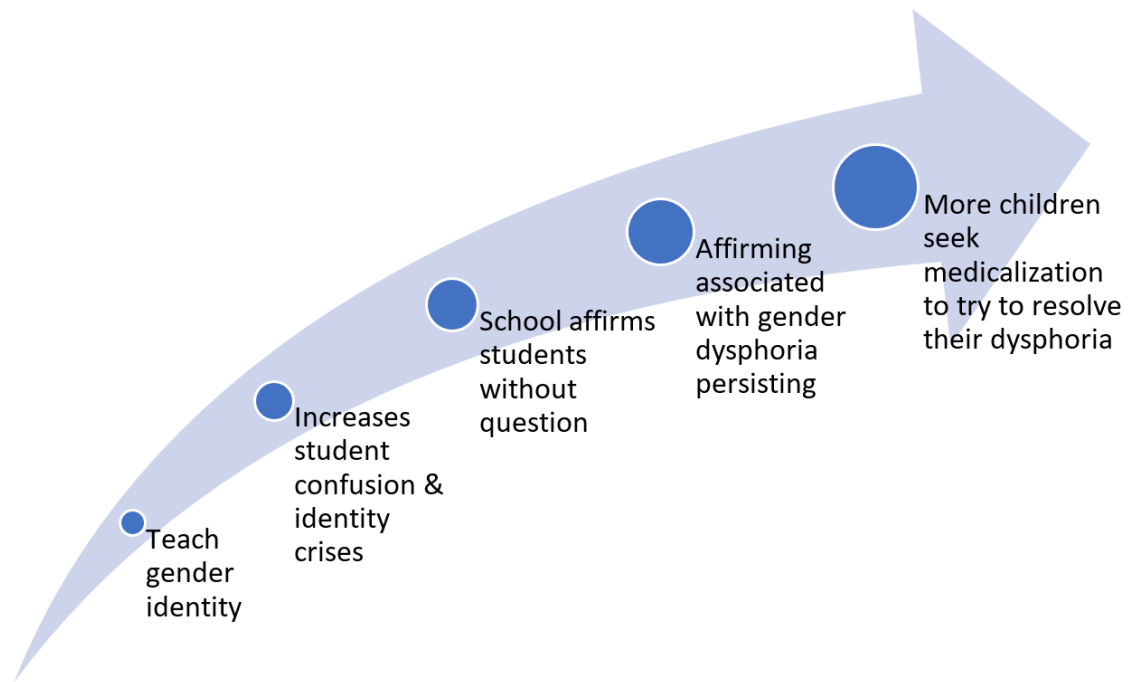
3.8.4 Possible instruction-to-transition pathway

Over roughly the last ten years, schools have increasingly taught the disputed concept of gender identity, often starting as young as kindergarten. Around the same time, there has been a substantial increase in students identifying as transgender. Historically, only 1 in 10,000 people experienced gender dysphoria, almost all young boys (Gupta et al., 2016), but this rate has shifted to 1 in 71 teenagers, mostly girls (Herman et al., 2022).

This correlation does not necessarily imply causation since other factors such as social media, greater social acceptance, and the availability of experimental medical treatments are also likely factors in students’ increased interest in transgender identities. However, schools need to consider that their well-intended efforts to destigmatize being transgender and support transgender-identified students, may play a role in this rapid and unprecedented rise in minors’ transgender identification.

Dr. Ken Zucker oversaw the writing of the gender dysphoria section of the Diagnostic and Statistical Manual 5th Edition (DSM5), the main manual used by psychiatrists and psychologists to determine accurate diagnoses. Dr. Zucker has argued that teaching about gender identity is likely to be iatrogenic—meaning causing harm—and will increase students’ confusion. He further argues that teaching gender theories leads to more youth wanting to transition socially and medically to live as a different gender, which comes with significant mental and physical health consequences (Zucker, 2020).

No matter their age, schools must consider that teaching novel cultural beliefs about gender may confuse students and contribute to their vulnerability and even identity crises. These risks are significant and may outweigh the potential benefits of teaching this material, especially when combined with an affirmation-only school policy. This potential instruction-to-transition pathway is illustrated below.



To minimize their potential role in influencing students' identity formation, schools may want to consider the curriculum guidelines outlined in the next section.

3.9 Instruction in schools

3.9.1 Sex education, gender identity theory and gender identity ideology

Despite concerns raised by clinicians such as Dr. Zucker (2020), schools are increasingly teaching gender identity theory and gender identity ideology as a part of their comprehensive sex education programs and incorporating these concepts into other subjects such as English and mathematics.

One fundamental rule for instruction is that schools have a duty to teach the most accurate information available and point out areas where scholars disagree, so that students can come to their own conclusions about controversial topics, preferably with family input, especially at younger ages. It is important to note that there is a difference between instruction that focuses on "gender identity" versus "gender dysphoria."

"Gender identity" is an academic concept that has been debated for a few decades but has now made its way into mainstream educational instruction. "Gender identity" is defined as a person's internal sense of maleness or femaleness, often based on stereotypes about what interests, emotional reactions, personality, or other traits are typical for males or females. Currently, many schools teach the concept of "gender

identity,” a controversial belief system, as if it is an undisputed fact. There is no way to scientifically test the concept of gender identity.

“Gender dysphoria” is distress about one’s biological sex; it is a diagnosable mental condition listed in the DSM-5 and is a topic of scientific research (American Psychiatric Association, 2022). People experiencing gender dysphoria often express a feeling that they “should” have been the opposite sex, or that they were “born into the wrong body.” Schools do not typically teach about “gender dysphoria” or reference the psychological definition provided in the DSM-5.

The differences between gender identity theory and the psychological theory are outlined in the table.

Area	Identity	Psychological Theory
Prevalence	Everyone has a gender identity, which may be different from their biological sex.	Gender identity is a theoretical concept from the 1960s meant to explain gender dysphoria, and not everyone has a sense that their identity is separate from their biology.
Permanence	“Gender identity” is innate.	“Gender identity” is socially imposed, especially as children mature. It may vary over a lifetime.
Experience	A person whose gender identity differs from their biological sex was “born into the wrong body.”	In 61-98% of cases, a person experiencing gender related distress will grow comfortable in their natal sex if they are allowed to undergo puberty.
Support	The only appropriate solution to a person’s gender distress is to immediately affirm their gender identity, including changing their names and pronouns, living as their gender identity, including opposite sex bathrooms, changing areas, overnight stays, and sports teams.	There are multiple pathways into and out of gender dysphoria, which warrants allowing a child to mature and providing support through open-ended psychological exploration before changing one’s name and pronouns or living as their gender identity.
Prejudice	Failure to affirm a minor’s stated gender identity is transphobic and unacceptable.	Allowing a minor to develop without affirming their current identity is not transphobic, but a prudent approach that recognizes they are still in the process of identity formation.

If schools decide to present these ideas, it is important to give a balanced treatment of the supporting evidence, and only include age-appropriate material. Just as it would be inappropriate to teach Shakespeare to very young children because they are not cognitively or emotionally developed enough to deal with the language or the complexity of his work, teaching about gender identity/gender dysphoria is equally inappropriate.

Similarly, it would be unwise for schools to teach young children about the rare possibility of childhood schizophrenia and hearing voices since children are impressionable and might believe they have these symptoms.

Given that the ideas of gender identity ideology are disputed and could affect some students negatively, it makes sense that parents should have the right to opt their children into instruction about gender identity. Families often have different values, beliefs, or knowledge of the child's development and history (such as having undergone a sexual assault) that schools do not. We strongly urge that schools teach gender identity beliefs as a theory (rather than fact) and in an age-appropriate manner. We suggest that parents work with the school staff to obtain more information about the content of their children's assignments and file a public information request if necessary so they can be fully informed. Once the facts of the curriculum are transparent, parents can explore their options for registering their objections to current curriculum content.

3.9.2 Instruction for children aged 5-10 years

For young students, the research literature on the concept of gender constancy must be considered. As outlined in Section One, sex constancy is the endpoint in the developmental process in which a child understands that their biological sex is fixed, and that clothing and other contextual factors do not change one's biological sex (Swanson, 1968). Research indicates that a more stable schema of sex begins at roughly age five, with sex constancy being achieved by the age of seven for most children (Ruble, 2007). Sex constancy delays have been observed in children with gender dysphoria (Zucker et al., 1999) and with Autism Spectrum Disorder (Furlong & Furlong, 2021).

Schools that teach gender identity based on the idea that students would otherwise not realize this was an option for them and might find relief if the topic were presented may misunderstand how gender dysphoria typically presents. Young children with gender dysphoria are "consistent, persistent, and insistent" to use the common psychological description. Gender dysphoria in prepubescent children usually develops organically out of their own internal sense of self, rather than needing to have it suggested to them by an adult.

We do not suggest schools teach this topic to younger children in school because it will not be relevant to most students, and many will be unable to understand it properly. Students with gender dysphoria can be supported on a case-by-case basis by working with parents to determine the best way to support the student at school, including customizing the information about gender dysphoria shared with the child (and the child's classmates if necessary) to ensure it is helpful to their particular ages and circumstances.

3.9.3 Instruction for children aged 11-18 years

In contrast to younger children, whose gender dysphoria appears to develop without external influences, tweens and teens are generally more susceptible to external influences, including peers and social media, and current research suggests that these influences play a role in this group's interest in transgender identification (Littman, 2018). Indeed, as already outlined in previous sections, this phenomenon of girls claiming to have rare conditions spreading via social media has been seen in the "TikTok Tics," where girls posted videos showing their sudden development of Tourette's Syndrome (Ghorayshi, 2023)—including suspiciously identical tics—and other videos where girls claimed they had multiple personality disorder (Harrison et al., 2021). Like gender dysphoria, both conditions have historically been rare.

Schools may want to include discussions of the dangers of social media use in their health and sex education curricula, including discussing the concept of social contagion and the idea that the availability of a diagnosis, label, or others with a physical or psychological condition can influence students to think they have the same condition (Watters, 2011). The most significant risks in this context appear to be from socially mediated mental health problems, which pose a risk to many youths (Haidt & Ludianoff, 2018; Watters, 2011).

Of particular concern for tweens and teens is the natural detaching from their parents that many experience as they undergo the natural process of identity development. This, coupled with instruction about gender identity along the lines of "only you can know your gender identity" and the idea that if others do not immediately embrace their new gender identity the student should regard their family as "unsafe", place the school into troubling territory where their influence coupled with normal teenage independence can damage family relationships at a point in their lives when vulnerable students most need family support. We suggest schools address this natural sense of detachment through their curricula and encourage students to develop open and healthy family relationships.

3.10 Transition in schools

3.10.1 Social transition evidence

Some studies find that children who socially transition experience relief from gender dysphoria and a reduction in suicidal ideation (Russell et al., 2018). Other studies have found that gender transition does little to relieve suicidality and mental health comorbidities or improve life functioning (Kaltiala et al., 2020). Further, there is speculation that "gender-affirming treatments" may be highly subject to the placebo effect (Clayton, 2022), which is consistent with detransitioner accounts that they initially experienced euphoria, only to return to a dysphoric state later (MacKinnon et al., 2022; Vandenbussche, 2021; Chantal et al., 2018). Social transition is reversible in the sense

that it involves temporary cosmetic and name changes, but the long-term psychological effects of social transition or desisting are not fully known (Ehrensaft et al., 2018; Sievert et al., 2021).

As highlighted in Section Two, it is important to consider that social transition is likely to impede the natural resolution of gender dysphoria as it is associated with higher rates of persistence; some have argued it is iatrogenic leading to medical transition (Ehrensaft et al, 2018; Sievert et al., 2021). Further, once a child has made the transition public, reverting back may be embarrassing and cause considerable stress and anxiety, making hormonal and surgical interventions more likely. For biological females, socially transitioning can involve binding their breasts, which poses considerable risks such as back, shoulder, chest and abdominal pain, rib and spine changes, shortness of breath, lightheadedness, and skin infections (Peitzmeier et al., 2021). Tucking (for males) lacks long-term studies, but one case study suggests that this can impact fertility by causing cryptozoospermia and testicular torsion (Debarbo, 2020; Trussler & Carrasquillo, 2020) (see more about binding and tucking in Section Two). Schools affirming a student's gender identity or publicly celebrating a trans-identifying student's courage are not neutral actions and can unintentionally influence students' identity formation (Zucker, 2020). There is currently no validated method to determine the likelihood of whether a person will or will not desist prior to socially transitioning; nor is there any long-term evidence in relation to this psychosocial intervention.

3.10.2 Social transition for young children

Social transition for young children deserves special consideration, since this group is particularly vulnerable. Sometimes a student will enter school living as a gender identity different from their biological sex, and within a few years, a significant portion of the class comes to understand that their biological sex differs from their gender identity. This can create significant distress for the socially transitioning child, who may struggle to maintain two different identities when interacting with peers. Other children can also be negatively impacted, especially those with certain religious beliefs or those with additional needs. Psychologists and therapists often remind us that "we are only as sick as our secrets." We suggest that school administrators focus on creating an environment of openness and transparency in staff dealings with students and parents and discourage students from keeping secrets inappropriately. These vulnerable individuals should have access to extra counseling support so that they can live with honesty and integrity, liberated from the pressure to live a secret life.

Neurodiverse children can feel very uneasy around socially transitioned children. These students will sometimes have a more literal understanding and may believe that if a girl uses he/him pronouns and the boys' facilities, then this girl has literally become a boy. These students can feel distressed if the girl reverts to a girl's presentation. Concerned

adults need to safeguard against this by ensuring that the concept of social transition is explained to each child with patience and integrity.

Children with certain religious beliefs may follow rules that limit their interaction with the opposite sex in some contexts. It is imperative that schools recognize any conflict of rights or conflict of interests that might occur in this context.

3.10.3 Medical transition evidence

As explained in Section Two, puberty blockers, which are used “off-label” for the treatment of gender dysphoria are typically prescribed at an early stage of development known as Tanner stage 2. Once thought of as a harmless “pause button,” this is no longer the case. A recent study shows that in 98% of cases, children put on puberty blockers move onto cross-sex hormones (Carmichael et al., 2021). The long-term physical and psychological effects of taking puberty blockers and delaying puberty are not fully understood (Giovanardi, 2017). Taking puberty blockers will delay brain development that typically occurs during puberty, a time in which significant brain development occurs, potentially impacting cognitive development (Latham, 2022). There is also evidence that puberty blockers may negatively impact bone density and cause bone and skeletal issues (Hembree et al., 2017). The impact of puberty blockers on sexual development and anorgasmia in adulthood is also of concern (Ley, 2021). Some research has found an association between puberty blockers, depression and other psychological issues (Biggs, 2019).

If a person has not undergone puberty before taking cross-sex hormones, they will be permanently infertile. For biological males who have taken puberty blockers to halt puberty, medical transition to female via vaginoplasty may prove challenging, since there may not be enough penile tissue available to perform the operation (Klink et al., 2015; Nota et al., 2018; Rubble of Empires, 2022; Ayad et al., 2023). Cross-sex hormones result in irreversible secondary sex characteristics. Surgical procedures, including facial reconstruction, double mastectomy, breast construction, gonadectomy, and phalloplasty, involve risks in terms of undesirable health outcomes (infertility, scarring, loss of sensation, and sepsis) and may result in less-than-desired cosmetic outcomes (Ayad et al., 2023). Maintaining a cross-sex appearance requires lifelong hormonal treatment, which carries risks including hypertension, vaginal atrophy, higher cancer risk, stroke, liver damage, and bone mineral loss (Fitzgibbons, 2015; Ayad et al., 2023). Since the affirmation model is relatively new, long-term research is needed to understand the full effects. Some people who medically transition have regret and detransition, while others are satisfied with the result. According to one study, approximately 25-35% of trans-identifying people pursue some form of medical transition (Nolan et al., 2019). There is currently no validated method to determine the likelihood of whether a person will or will not desist prior to medical transition, or who may regret medical transition. In sum, there are serious risks associated with medical transition and many unknowns.

3.10.4 Medical transition in school

Minors taking puberty blockers or cross-sex hormones in school warrant special consideration. If a child's puberty is blocked through puberty blockers, then this child will need certain protections, including designated toilet and dressing room facilities. This child will not develop in the same manner as their peers and this will need to be addressed within certain contexts, for example, on the sports field. Viable alternatives for competitive athletics may need to be made available for this child.

The school should have a freely available policy on medical transition. Integrity and transparency need to be front and center of any such policy, and the safeguarding of children undergoing transition and all other students in the school must be considered. Notifications to parents of the fact that a student is transitioning—with identifying information kept private—may be warranted, especially for parents of neurodiverse children who have a harder time understanding the meaning of transition.

Staff should be cognizant of the potential for significant emotional changes for students undergoing cross-sex hormone treatment. Male to female transitioners may experience greater emotional lability, more depression, and less aggressiveness (Ayad et al., 2023). Female to male transitioners may experience more stable moods, greater sexual drive, increased aggressiveness and less depression (Ayad et al., 2023). School staff should be prepared for these potential changes and make additional counseling support available after consultation and coordination with the students' parents.

3.10.5 Desistance and detransition evidence

There is currently limited data on the reasons people choose to detransition. Some studies found that trauma (including sexual trauma), difficulty accepting oneself as homosexual, dysphoria rooted in misogyny, peer influence, social media use and online communities influenced their development of a transgender identification and desire to transition (Littman, 2021; Vandebussche, 2021). Some reported health concerns and found alternative methods to deal with their dysphoria. External factors such as a lack of support, financial concerns, and discrimination also occurred, but were much less common. One study found that only around 24% of people who detransition report their detransition to the doctor who facilitated their transition (Littman, 2021). The rates of desistance and detransition have not been reliably established. One study of youth in the UK indicated that it may be as high as 10.3% within 12 months of seeking treatment (Hall et al., 2021). Another study of adolescents and adults found that as many as 30% discontinue gender-affirming hormonal treatment within four years (Roberts et al., 2022).

3.10.6 Desistance and detransition in school

Bullying is never acceptable for any reason, including for students who are gender-questioning, gender non-conforming or have a transgender identity. Schools must be cognizant of the fact that peer pressure can work in two directions—both influencing

students to identify as transgender and influencing them to not identify as transgender—and that staff should not underestimate this influence or assume it is always in one direction. Staff should also be aware that some students who socially transition desist and re-identify with their birth-assigned sex. These individuals are at considerable risk of bullying by members of their former social group. Studies have noted that trans-identified children are as likely to be perpetrators as they are to be targets of bullying (Heino et al., 2021).

3.11 Sports and changing areas in schools

3.11.1 Sports participation

There is usually little morphological difference between boys and girls before puberty, and they can often compete with one another safely and fairly. For older students, however, schools shall endeavor to maintain single sex sports, and shall create viable alternative options and activities for students who do not want to engage in single-sex sports. Schools should recognize that it is essential that girls and young women have opportunities to compete safely and that competing against biological males can be demoralizing and, in certain contexts, dangerous.

If allowing mixed-sex sports is required to comply with a legal mandate, a full risk and impact evaluation should be conducted and documented according to the relevant protocols, addressing the impact not just on the individual concerned but on the wider student population. The parents of all pupils shall be provided with this risk assessment (with student identifying information removed) and impact evaluation, and consent for all participating athletes must be obtained prior to participating in the sporting activity. Any injury or negative impact must be documented and used to inform and update risk assessments.

3.11.2 Facilities and dressing rooms and gender

Schools should provide an option for additional single-occupancy toilets and single-occupancy changing rooms, to ensure privacy for vulnerable students while also accommodating those with different viewpoints. For instance, this includes children from religious and cultural traditions that forbid sharing these spaces with students of a different biological sex. Single-sex spaces should be maintained, and a third space should be provided where single-occupancy toilets and changing rooms are available, allowing anyone who wishes to use a gender-neutral space to do so.

3.12 Politics in schools

School boards are understandably concerned about the political consequences of their policies and often find themselves in the middle of significant controversy due to individual parents and community groups with vastly different views about sex education and gender dysphoria. It is often difficult for school boards to find a suitable

policy that respects the rights of all parents and avoids the school board siding with one side or the other.

Proponents of affirmation-only policies often want these policies to be applied to all students, even without parental notification or consent. However, parents want to be notified if their child expresses gender confusion at school. We encourage school boards, parents, and the public to assume the best motives of each other and work together to pursue policies that follow the latest scientific evidence regarding gender care. School communities may want to consider the Comprehensive Sex and Gender Policies Genspect has developed for several countries that emphasize tolerance of different beliefs and the right of parents to choose how to support their gender questioning child (Genspect, n.d.).

3.13 Suggestions for policies

3.13.1 Pronoun guidance for teachers of minors

In the last ten years, schools have seen a rapid rise in students with gender dysphoria, a diagnosable mental condition listed in the DSM-5. Historically, prepubescent males presented with gender dysphoria, now, it is mostly tween and teen females (Gupta et al., 2016; Herman et al., 2022). This rapid shift in demographics has never been seen before.

Stated simply, gender dysphoria is feeling distress with one's biological sex. As a result of this distress, some students will request that schools use different names and pronouns to try to begin living as a different gender to relieve this distress. The following guidance represents the best scientific evidence to date to help staff handle these requests.

1. **School staff should immediately seek parental involvement before agreeing to pronoun and name changes.** No major medical associations recommend keeping a child's request a secret from parents. Parents know their children's history and are critical in determining if the child's interest in transitioning is fluid or is due to other psychological issues or social influences that may be presenting as concerns about gender. If serious and legitimate concerns exist about a student's parents' ability to handle their child's gender concerns, school staff shall involve Child Protective Services and follow formal proceedings before taking any action. Unless otherwise directed by Child Protective Services' proceedings, school staff must obtain written permission from the parents before referring to any student with a new name and pronouns. Neo-pronouns and rapidly changing pronouns are not recommended, as this can destabilize the school body.

2. **Recognize that socially transitioning a minor child to a new gender is a major psychosocial intervention that requires mental health assessment prior to conducting, and while the transition is occurring.** School staff are not qualified to practice gender medicine and should not assume liability for attempting to manage students' transitions. School staff should work with the child's parents and the medical and psychological professionals overseeing the child's case. School staff should be in a supportive role and neutral about identity outcomes.
3. **Recognize that social transition is not a neutral act and is associated with a child's gender dysphoria persisting.** Social transition can impede the natural resolution of gender dysphoria, solidifying a pathway to puberty blockers, cross-sex hormones, and eventual surgery. Since medical transition requires lifelong medication and psychological support, staff must recognize the serious consequences of this powerful psychosocial intervention and proceed cautiously. It should be noted that puberty blockers were once thought to be a harmless pause button. It is now believed that they lock in a trans-identity. Therefore, the intervention cannot be thought of in isolation but as the initial step in medical gender transition. Similarly, it has been recommended that social transition should also not be considered in isolation because of its potential effects.
4. **Avoid hyperbole or simplistic thinking regarding the importance of pronouns, especially regarding the risk of suicide.** Misleading statements such as "Respecting the pronouns young people use to identify themselves is not only polite—it can save lives" are not helpful. The best research to date shows that the risk of suicidal thoughts is about the same as depression and anxiety and lower than autism and eating disorders. More importantly, no reliable medical evidence shows that gender social transition improves adolescent mental health outcomes. Any consideration of social transition at school is a serious psychosocial intervention that should be undertaken only with in-depth family involvement and professional oversight. Moreover, it is imperative that any discussion about suicide is strictly accurate (see more about this in Section Two).
5. **Treat students as much more than their gender identities.** Ruminating about one's identity, especially a single aspect of one's identity, seldom improves mental health outcomes. Staff should encourage students to explore all their talents, personality, and character, and not engage in lessons or other discussions in which students are expected to place themselves in various "gender identity" boxes. School staff should welcome everyone, avoid gender stereotypes, and project the fact that there is no right or wrong way to be a boy or a girl.
6. **Acknowledge that taking a stealth approach to transition is inappropriate for the school body, especially for children with additional needs and challenges and**

children with certain beliefs. Hiding who you are can often signify some deeper issues (see Section Two) and the child may need further help and support.

3.13.2 Stealth transition at school

Some families seek help from the school to maintain the secret transition of a child. This is often known as “stealth transition,” and may involve failing to disclose that a child is staying overnight with or changing clothes alongside children of the opposite sex. In all situations, the consideration of the whole student body needs to be balanced with the needs of the child seeking stealth transition. A full discussion with the child and family, with health professional input, should be sought, and a risk and impact assessment should be carried out before any decisions are made.

Schools shall prize openness and transparency wherever it is possible to do so. Vulnerable individuals should have access to extra counseling support so that they can live with honesty and integrity, liberated from the pressure to live a secret life. Schools shall support these vulnerable students by nurturing a school community that is supportive of gender non-conforming behavior.

Schools shall encourage school administrators to focus on creating an environment of openness and transparency in staff dealings with students and parents and shall not compromise other members of the school community by keeping secrets inappropriately. Stealth transition is not recommended as it can be troubling for the school body; the child will inevitably tell someone, which can create conflict. Children with additional needs may not feel equipped to tackle these issues and other children may feel deceived; honesty is the best policy and schools should not recommend children accept stealth trans identification.

3.13.3 Triangulation and parent communication

As discussed earlier in this section, schools must recognize that young people can use triangulation as a communicative strategy. Triangulation occurs when a third party (the school) is used either as a substitute for direct communication with the subject of the communication (in this case, the parents), or used as a messenger to carry the communication. In this case, this expresses implicit dissatisfaction with the parents. The goal of triangulation is to divide, which often happens using exclusion or manipulation of a situation. School staff need to be aware of triangulation and endeavor to avoid allowing triangulation to occur between the student, parents, and school body (Jones, 2020). Schools shall not exclude parents from decisions or information exchange unless this takes place within a formal structure and involves social services. Schools shall not act against the parents’ will unless there are adjudicated concerns about the fitness of the parents involving formal proceedings with Child Protective Services.

Schools shall not encourage children to keep secrets from their families unless there is serious justification to do so. If there is good reason to believe that any student will become unsafe if their parents are made aware of their gender dysphoria or transgender identity, schools shall immediately follow the appropriate protocol, including contacting Child Protective Services. Unless otherwise warranted, schools shall assume the family unit is a safe and nurturing place. If parents have previously shown themselves to be reasonable, loving and engaged, the school should collaborate as far as possible with the family, and nurture healthy communication between students and parents.

Schools recognize that, historically, schoolteachers may have kept a student's secret because of a fear of serious repercussions from their family. We acknowledge that there is a significant difference between a conversation that is kept in confidence between a student and a teacher, and an open secret kept by the school staff and entire school community. The latter can be humiliating for the parents and damaging for the family's well-being and ultimately the child. In some cases, families could end up being the last to know, even though the entire school community was fully aware of the child's social transition. Schools should avoid creating these situations.

We acknowledge that needlessly keeping secrets from parents can inadvertently cause divisions between the school body and the parents, and damage the parent-child relationship, leading to triangulation and even alienation. A child may end up changing clothing, names, and pronouns halfway between home and the school to live a "double life." Our schools are mindful of how distressing and potentially damaging this could be for everyone, including the child. School staff shall help parents who feel distressed by their child's gender dysphoria by giving them information about family support groups. Schools shall aim to uphold the integrity of the family unit to ensure the student's long-term mental and physical health.

3.13.4 College affirmation and social transition policy

Many transgender organizations advise colleges and universities to "affirm" students' gender identities by using the names and pronouns students request, and letting students use the bathroom that matches their gender identity. This is known as social transition.

Influencing a student's gender identity can verge on positive encouragement, intervening during a critical period to push a young adult in one direction at the expense of another. Identity formation is a personal process and an important psychosocial stage of development for young people between the ages of 12 and 25.

In this formative period, it is not the function of colleges or universities to concretize an identity that is in transition, particularly not if this results in a young person being denied the opportunity to explore and develop different aspects of their sexual self, unimpeded by medical intervention. We also suggest that colleges and universities foster a tolerant

and caring approach with all students and ensure that everyone feels accepted, no matter what their beliefs.

3.14 References

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Section Four: Society

4.1 Introduction

Currently, there are conflicts of interest between multiple marginalized groups in our societies. The denial of these conflicts by many commentators makes discussion difficult, thereby hindering a possible resolution of those conflicting interests. Historically, it has been the role of well-functioning societies to balance the needs of competing groups, at times favoring the interests of some over others. To pretend the conflicts do not exist resolves nothing.

Over the past two decades a new ideology¹ has emerged, overturning many established ideas and concepts, and upending well-established protections for marginalized groups. New ideas are not necessarily bad; they often make the world a better place. However, not all new ideologies are beneficial to society. A new ideology must therefore be critically examined by identifying its foundational assumptions, asking what accepting it would change, and whether that change would be for the better, especially for marginalized groups that need ongoing protection.

This section will examine *gender identity ideology*: What is it? Through which major institutions is it transmitted? And what challenges emerge to society from adopting this ideology? Answering these three questions will demonstrate that important conflicts of interest do exist, and contrary to the dominant public discourse, no obvious resolution to such conflicts exists. Nonetheless, our extensive analysis of these issues offers some reasonably workable solutions and suggestions in this arena.

4.2 A new ideology: gender identity

Gender identity ideology is a set of beliefs, principles, and values. According to this theory, gender identity, first conceptualized by clinicians such as Robert Stoller, Ralph Greenson and John Money (Byrne, 2023; Janssen, 2023; Money, 1994), relates to an individual's internal sense of being male or female. This belief system contends that gender identity, the sense of maleness or femaleness (or some other sense of gender), is intrinsic to the person, innate and unchangeable. As a result, gender identity has become a protected attribute in many jurisdictions, giving transgender people the same

¹ WHILE THE WORD 'IDEOLOGY' HAS BOTH A NEUTRAL AND A PEJORATIVE SENSE, THIS SECTION USES IT EXCLUSIVELY IN ITS NEUTRAL SENSE, TO REFER TO A SYSTEM OF IDEAS: 'MOST INTERPRETERS READ MARX AS HOLDING THAT THESE ["IDEOLOGY" AND "PROPAGANDA"] ARE INEVITABLY NEGATIVE CONCEPTS, ASSOCIATED SPECIFICALLY WITH CAPITALIST IDEOLOGY AND PROPAGANDA. ON THE NEUTRAL CONCEPTION, BY CONTRAST, IDEOLOGY IS UNDERSTOOD AS A WORLDVIEW, A SYSTEM OF CORE BELIEFS SHARED BY A CERTAIN GROUP; IT CAN ALSO BE USED TO REFER TO COMPREHENSIVELY POLITICAL DOCTRINES, SUCH AS MARXISM ITSELF, OR FEMINISM' (DUTILH NOVAES, 2018).

rights as other minority groups based upon that protected attribute. Proponents of this ideology see the transgender rights movement as similar to the civil rights, feminist, and the gay rights movements.

Although not everyone who subscribes to the ideology agrees on all points, most subscribe to key tenets. Below is an attempt to articulate the commitments of the gender identity belief system.

Gender Identity Ideology

Theory

- Sex is not binary (there are more than two sexes)
- Intersex people prove that sex is not binary
- The sex binary is a social construction
- Sex is not an essential property of a person; it can be changed through surgical, medical, legal, or social intervention
- We learn to identify our sex/gender through introspection (as we do our sexual orientation)

Politics, morality & law

- Biological sex is not as relevant as gender identity (morally, socially, and politically). What matters most is a person's self-determined gender identity (or her/his 'legal sex' or 'social sex')
- Self-identification statutorily declared is sufficient to determine one's legal sex category
- Women-only spaces and services, previously thought to be for biological females only, should be accessible by anyone with a gender identity of 'woman' or a 'female' legal sex classification
- There is no conflict of interest between sex and gender identity; however, if there is a purported conflict of interests between sex and gender identity, gender identity takes precedence as it is more central to the individual
- Because we learn our sex/gender through introspection, each person is the ultimate authority on which sex/gender they are. We should, therefore, defer to their self-identifications

Concepts & language

- Gender means gender identity; no other relevant gender concept exists
- Sex means gender identity, or gender identity replaces sex
- The terms 'man' and 'woman' refer to gender identity
- The terms 'male' and 'female' refer to gender identity
- Therefore: transwomen are 'women' and 'female,' transmen are 'men' and 'male,' and nonbinary people belong to none of those categories ('woman'/'female'/'man'/'male')
- The terms 'boy' and 'girl' refer to gender identity
- The terms 'mother,' 'wife,' 'sister,' 'girlfriend,' 'lady,' 'lesbian,' etc., all refer to gender identity
- Terms like 'gay' and 'lesbian,' traditionally thought of as referring to sexual orientation, now refer to gender orientations. Therefore, males can be 'lesbians' and females can be 'gay men.'

Harm

- It is erasing a person's existence to notice their sex when they have a gender identity—e.g., to notice that a transwoman is a biological male or that a transman is female
- Because gender (as identity) is so important to transgender people, we should not be 'gender abolitionists'—that is, people who seek to eradicate enculturation into femininity on the basis of female sex, and enculturation into masculinity on the basis of male sex. Gender identity depends conceptually on gender, so to affirm gender identity we must retain gender.

Four ethical concepts have combined to buttress gender identity ideology. The first, *nothing about us without us*, holds that other groups should not work on or work for marginalized groups without the active involvement of members of the marginalized group itself. The engagement of people with lived experience ensures that their needs and interests are accurately considered. The second moral principle, known as *prioritarianism*, means that our efforts should be focused on improving the situation of those who are worst off. The third concept, *intersectionality*, holds that we must consider the multiple identity categories an individual belongs to and all the potential interactions between them. Identity categories and their interactions may make certain groups of individuals even more marginalized. The fourth and final concept is *inclusivity*; *inclusion* is always good, and *exclusion* is always bad, without exception.

These four concepts combined mean that:

1. Transgender people must have a voice in all contexts relating to transgender individuals and their community;
2. Transgender people who also belong to other marginalized identity groups are likely to be especially disadvantaged; when this makes them the worst-off social group, our social justice efforts should be dedicated to aiding them;
3. The exclusion of transgender people should not be tolerated in a democratic society.

While *'nothing about us without us'*, *prioritarianism*, *intersectionality*, and *inclusion* may seem like worthy goals in the abstract, as with all ideas, both good and bad, they can be taken to extremes. A sensible interpretation of *'nothing about us without us'* would invite marginalized people to give testimony regarding their experiences, desires and interests; it would not assume that marginalized people are *experts* in technical domains such as medicine and law simply by virtue of belonging to particular social groups. Appropriate input from marginalized groups would be sought for work being done on or for them, rather than requiring deference to them on all matters.

A workable interpretation of *prioritarianism* would recognize the fact that the group that needs our attention most will often change and sometimes rapidly. So rather than shifting attention to whichever group happens to occupy that position at any given time, a better approach would ensure that the progress made to advance the interests of one group does not set back the interests of another group. Groups should not be abandoned in the middle of an effort to improve their position just because another deserving group comes along.

To give a practical example, in the pursuit of equal marriage rights for gay and lesbian people, if it becomes evident midway through the campaign that people with disorders/differences of sexual development are even more in need, which does not mean that the equal marriage campaign should be abandoned. Once equal marriage rights for gay and lesbian people have been secured, efforts to help intersex people should be undertaken, but not in ways that might *undo* equal marriage rights for gay and lesbian people or worsen their position. The impulse behind prioritarianism is better respected when we strive to pull everyone up, not switch the relative positions of several disadvantaged social groups.

Intersectionality does not simply mean that the more marginalized identity groups that a person belongs to, the worse off their position in society. An individual may belong to several marginalized identity groups and yet thrive because they also belong to a dominant identity group that largely insulates them from the negative impacts of the other marginalized identity group. A person might have a disability and be gay, for example, and yet also be so wealthy that they can configure an environment that facilitates their movement; they can walk away from any employer or workplace that discriminates against them or is unable to physically accommodate their physical needs. Being trans, in addition to belonging to other marginalized identity categories, does not inevitably make a transgender person worse off, and so does not necessarily support a prioritarian claim.

Finally, inclusion is not always good, nor is exclusion always bad. Inclusion in *the public sphere* may be good without exception, because all humans have equal moral worth and equal human dignity. However, transwomen can be included in the public sphere without, at the same time, being included in all single-sex spaces for women. Exclusion may have beneficial effects depending on the interests it serves. Most countries' anti-discrimination and equal opportunity laws build in permanent exemptions, recognizing that offering goods and services to just one marginalized group can sometimes help to improve its situation. We can value inclusion without ignoring the benefits of *exclusion* where appropriate. The question, then, is whether transwomen's or transmen's exclusion—e.g., from a single-sex space or service, or from a single-sexual-orientation space or service—is sometimes appropriate.

The word *clusivity* in linguistics refers to a grammatical distinction between inclusivity and exclusivity in relation to first-person pronouns and verbal morphology. If we expand upon this word, society is continuously tackling clusivity in many different areas, for example, schools are inclusive to a tacitly agreed extent. Schools may include all children between the ages of five and twelve but exclude children under the age of five and over the age of twelve; also, within schools, certain children are excluded and included in certain class levels. Many schools are inclusive in the broader sense of the word too, as they provide equal access to all children between certain ages, no matter their religion, ethnicity, sex or abilities. Yet they remain exclusive to children within a

certain age range. Equally, a rape crisis center or a sexual reproductive health clinic may decide to be women-only or men-only in order to specialize in this arena.

The remainder of this chapter will explore how the relative balancing of these issues might play out, using problem cases unfolding within three major social institutions involved in the context of gender identity ideology. While these cases are hypothetical, the issues involved have in fact already arisen in real life situations where gender identity ideology comes into conflict with a pre-existing belief in the reality of biological sex.

4.2.1 Media

Media as a major social institution includes all print media (newspapers and magazines), online media, television, film, radio, podcasts, etc. Transmission of gender identity ideology occurs through choice of content (which issues are covered and which issues are conspicuously not covered) and the viewpoint of the author and choice of language (how the issues are framed, and whether the journalist includes both sides in an impartial way). Consider the following example.

Television programs about sex differences. A state-owned television network airs a program concerning differences between the sexes, with academic voices on either side of the debate over the effects of the ‘sex hormones,’ estrogen and testosterone. Throughout the program, interviewees associate testosterone with ‘men’ or ‘males,’ and estrogen with ‘women’ or ‘females’. The program presents a balanced range of views conveying the current major points of contention arising from research into sex differences. The following day, some of the television network’s younger staff members complain that they feel ‘unsafe’ at work because the program was ‘transphobic’. The network also receives angry emails from members of the public, complaining that the television show was ‘transphobic’ and ‘put transgender people at risk of violence.’

For those staff involved in writing, presenting, and producing the television program, this response is likely to be both surprise and confusion. If the content was (unintentionally) offensive, then the staff should be receptive to criticism and learn from their mistakes. However, it is also possible that the content was *not* offensive; sometimes people make complaints as part of a strategy for advancing political causes. Alternatively, the content might have been mildly offensive but not to the extent that staff should be reprimanded. A normal part of living in a democracy is that a range of different viewpoints can be expressed. The allegedly offensive viewpoints expressed in the program could have been easily avoided (for example, by choosing not to watch the

program). The bar for deciding that a viewpoint should not be expressed should be very high.²

According to the central beliefs of gender identity ideology set forth at the beginning of this section, 'male' and 'man', 'female' and 'woman' should not be used to refer to biological sex but only as gender identity terms; binary sex should be viewed as a social construction, not a condition based on biological fact. While the program did make clear that considering estrogen and testosterone as 'sex hormones' may be misleading because both sexes have some amount of each hormone, it did not deny the reality of biological sex. The complaints allege that the program should not have endorsed this view, nor used the words 'man' and 'male,' 'woman' and 'female' to refer to two biological sexes.

Which marginalized groups are stakeholders in the debate over how these complaints should be resolved? If the television network considers only the complainants' perspective in the way it responds, it might (unintentionally) alienate those who do believe in the biological reality of the sexes, particularly those who have historically, and even currently, faced discrimination due to these biological differences: women. The fact that the network received complaints does not automatically prove that the program was transphobic, and that some remedy proportionate to such an offense is warranted. Such a response may disadvantage women, who are also stakeholders to the resolution of the complaints because the program specifically addressed the extent to which estrogen and testosterone do or do not account for social inequality between the sexes.

To reach a decision about how to respond to the complaints, the network executives should: a) take into account all the affected stakeholders; b) consider whether the complaints are genuine, a result of misunderstanding, or possibly strategic; c) determine whether the complainants could easily have avoided viewing the content; and d) decide whether, upon reflection, the substance of the complaints is persuasive. This might mean deciding whether they agree with the tenets of gender identity ideology upon which the complaints are based. These considerations will help network executives to decide whether to dismiss the complaints, say that the offense is regrettable but on balance justified, or apologize for the offense and specify the changes they plan to make to avoid such offense in the future.

Media outlets that do not think carefully about these decisions are at risk of becoming propaganda outlets, wittingly or unwittingly. If most complaints are simply accepted as correct, then those willing to complain can succeed in excluding viewpoints they dislike; a major incentive for activists to complain. If restrictive language and viewpoints are accepted as reasonable, then the outlet will begin speaking the activists' language and

² FOR A DETAILED DISCUSSION OF BOTH 'OFFENSIVE NUISANCES' AND 'PROFOUND OFFENSE' IN RELATION TO THE POTENTIAL LIMITING OF SPEECH AND ACTION, SEE DISCUSSION IN (FEINBERG, 1985, ESP. CHAPTERS 1-3).

promoting their message. Avoiding this kind of bias is crucial for serious journalists to preserve their reputation as trustworthy and impartial.

4.2.2 Corporate DEI

Many companies and corporations have staff members (and sometimes entire departments) dedicated to implementing 'Diversity, Equity and Inclusion' (DEI) policies. This section will focus on those companies and corporations, but the same observations could be made, and the same issues raised, concerning nearly any governmental or third sector organization. Consider the following case.

LGBTQIA+ ally training module. Celine works in the head office of a large home electronics retailer, managing a team of about 50 people. An employee in the company's Human Resources (HR) department sends out an email during Pride Month, announcing that the company has introduced a mandatory 'LGBTQIA+ ally' training module, to be completed online during work hours. A member of Celine's team is an older gay man who conveys to Celine his unhappiness about the module. He says it contained 'alternative facts' about the history of gay liberation,³ that it homogenized differences between the groups named within the 'LGBTQIA+' initialism, and 'erased' same-sex attraction by redefining same-sex attraction as *attraction between gender identities and gender expressions*. The employee is bothered by the falsehoods contained in the module and by its disrespect for an aspect of his personhood (his homosexuality), which he feels has been erased by a training module that claims to advocate at least partly in his name.

Celine herself may already have taken the online training module and reacted differently because she has no stake in the issues it raises. She may also feel confident that the company genuinely intends to make the workplace more welcoming to LGBTQIA+ people. At the same time, she may feel disconcerted to hear that the training module affected a gay man so differently. She may feel even more confused if she hears from other LGBTQIA+ employees that they found the module's content to be well-crafted and accurate.

In our prior example, the interests of women advocating for a scientific and evidence-based approach to sex differences conflicted with the interests of activists promoting a belief in gender identity ideology. In the current example, the parties potentially come into conflict over competing definitions of keywords and concepts that advance their respective interests. The way we describe the parties will determine whether a conflict exists.

³ FOR EXAMPLE, CLAIMING THAT A TRANS PERSON THREW THE FIRST BRICK IN THE STONEWALL RIOTS. ON SOME OF THE 'ALTERNATIVE FACTS' PRESENTED BY GENDER IDENTITY ACTIVISTS ABOUT THE HISTORY OF THE GAY LIBERATION MOVEMENT, SEE THE LGB ALLIANCE'S INTERVIEW WITH FRED SARGEANT (LGB ALLIANCE, 2023).

4.2.2.1 Description #1

On the one side are lesbians, gays, and bisexuals (LGB) and on the other are trans-identified individuals (T). The 'LGB' contingent has an interest in the accurate recounting of the gay liberation movement's history (*their* group's history) and in defining the protected attribute and minority status they share—that is, same-sex attraction or sexual orientation. Coming to terms with this identity may have played a significant role in their individual life histories, coming out stories, and recovery from childhood bullying and victimization.

The 'T,' by contrast, may have an interest in securing uptake for gender identity ideology and promoting society-wide acceptance of trans identities. They too seek to come to terms with their identities and may have experienced bullying and victimization for being gender non-conforming. As this issue has become increasingly politicized, this goal may lead some people to make false claims about LGB history (or to exaggerate true claims) to benefit from the movement's popularity and success. Some people push for a definition of sexual orientation based upon gender identity (rather than biological sex) on the grounds that it includes transgender people. For the LGB contingent, the words 'gay' and 'lesbian' refer exclusively to same-sex attraction and therefore depend upon the biological sex of both partners: a transwoman attracted to women would be considered *heterosexual* (a biological male attracted to biological females) and a transman attracted to women would be considered a *lesbian* (a biological female attracted to other biological females).

The T contingent instead defines 'gay' and 'lesbian' in terms of same *gender* (identity) attraction: a trans-identified female who considers herself a 'man' would not fall into the 'lesbian' category, nor would a trans-identified male who considers himself a 'woman' merit the 'straight' label. The conflict of interests in this first description thus embodies a conceptual and linguistic dispute over defining *sexual orientation*, *sexual minority*, *gay*, and *lesbian*, and specifying what the words 'gay' and 'lesbian,' 'heterosexual' and 'homosexual,' should refer to.

4.2.2.2 Description #2

From a different perspective, the parties on one side are *some of the* lesbians, gay men, bisexuals, transgender people, people who call themselves 'queer', intersex people, and asexuals represented under the LGBTQIA+ initialism, and on the other are *some of the members of the same groups*: the conceptual and linguistic dispute set forth in Description #1 does not neatly cleave the LGBTQIA+ into clearly distinct and opposed parties. As viewed from this second perspective, not *all* or even most lesbian, gay and bisexual people believe biological sex is of crucial importance and reject most of gender identity ideology; not *all* or even most transgender people believe sex to be irrelevant and fully subscribe to gender identity ideology. Many LGB people support the definition of same-sex attraction as being between gender identities or gender expressions, while many of them reject it.

These two different ways of characterizing the parties make deciding whether a conflict of interests exists between marginalized groups more challenging. To determine if a conflict exists, we must establish that it is objectively in LGB people's interests to define sexual orientation in terms of biological sex, and objectively in the interests of transgender people to define it in terms of gender identity. Of course, something may not be in a group's interests, but the group may support it, especially when group members lack political awareness, or when ideological indoctrination has influenced group beliefs.

However, the case for a widespread absence of political awareness regarding gay and lesbian issues is not compelling, at least in regions such as North America, Europe, and Australasia. Nor is it clear that the social and legal pressures to accept gender identity ideology rise to a level of ideological *indoctrination*.

If the interests of marginalized groups do not clash, there can be no conflict of interests—it is instead a more straightforward disagreement or dispute: some people believe we should alter our definition of sexual orientation while others do not, and everyone is allowed to have an opinion on this issue. Those in favor of redefinition believe it would be more inclusive of transgender people; those opposed believe the historical framing is crucial to gay and lesbian people, their identities and self-worth.

Description #1 and Description #2 offer alternative ways of conceptualizing the issues that arise as a result of the team member's comments. This section does not come down in favor of either one; instead, the goal is to demonstrate the many ways that competing interests need to be balanced, and how efforts to resolve them often mean favoring some people's views while disadvantaging others' views.

Regardless of how the issues are framed, Celine should not simply dismiss her team member's comments. His feedback concerning the experience of completing the training module may help her to open a discussion with HR about that module, to ensure that the company understands that, to some employees, it appears to have taken a side in a contested social issue, and it should instead make sure to consider all perspectives. It may turn out that the company has not given much thought to the issues involved, perhaps because it bought the online training module from an outside organization without understanding it to be a political lobby group.⁴

If the company is genuinely committed to one side of that contested social issue, Celine should communicate that fact to her team members, along with information concerning their rights, responsibilities, and available remedies should they disagree. For example, employees may be expected to uphold the company's values while they are acting as

⁴ FOR EXAMPLE, BOTH STONEWALL IN THE UK, AND ACON IN AUSTRALIA, ARE NON-GOVERNMENTAL ORGANIZATIONS ADVOCATING FOR LGBTQ+ RIGHTS, AND WHICH PROVIDE TRAINING PROGRAMMES TO ORGANIZATIONS. SEE [HTTPS://WWW.STONEWALL.ORG.UK/WORKPLACE-TRAINING-EVENTS](https://www.stonewall.org.uk/workplace-training-events) AND [HTTPS://WWW.PRIDETRAINING.ORG.AU/](https://www.pridetraining.org.au/), AS WELL AS CRITICISM OF THE FORMER IN THE PODCAST SERIES NOLAN INVESTIGATES (BBC, 2021), AND THE LATTER IN (ABC, 2022) AND (MASTERS & HUME, 2023).

employees (i.e., within work hours, doing work tasks, and while wearing a work uniform or other company-branded items), and may be subject to disciplinary proceedings if they fail to do so. In some countries, such an expectation by the company may be illegal, because beliefs such as the one held by Celine’s team member count as philosophical beliefs (UK) or political beliefs (Victoria, Australia) and so would be protected from employment discrimination by law.⁵

In any event, Celine as a manager needs to come to a complete understanding of the issues involved, potential conflicts of interest, and the relevant company policies so she can provide information to her team members about how to avoid putting their employment at risk. Such an understanding will help her protect them from challenges by HR or senior management when they express legitimate disagreement with workplace policies and allow her to advocate for better policy regarding contested social issues.

4.2.3 Schools

Public education is a third major social institution involved in the transmission of gender identity ideology, a system comprising kindergartens, primary schools, high schools, and universities – any institution whose primary provision is education. Consider a third example.

School policy concerning trans-identifying students. Teachers at a high school in a small town are advised in a monthly staff meeting that the school will henceforth take an affirmative approach to gender identity. If a student declares that they are trans (or that they are the opposite sex/gender to their birth sex) then school staff must affirm that declaration by calling the student by a new name and pronouns and requiring other students to use the new name and pronouns. The school has elected *not* to tell parents about their child’s new identity without the student’s permission. If the student prefers that their parents should not know, then the school will facilitate the student’s social transition without the parents’ knowledge or consent. They will also offer the student the use of the opposite sex’s physical spaces, including bathrooms as well as the gymnasium and swimming pool changing rooms, without informing the parents of other students that this is occurring. One of the female students at the school tells her parents that ‘Ashley,’ previously ‘Andrew’ (the son of one of her mother’s colleagues), is now using the girls’ changing rooms, and that she feels uncomfortable because he has been staring at her while she undresses. The girl’s mother is certain that Andrew/Ashley’s mother is unaware of this development.

⁵ FOR ONE EXAMPLE OF A CASE LIKE THIS, INVOLVING AN EMPLOYEE EXPRESSING VIEWS ABOUT SEX SELF-IDENTIFICATION LAW THAT CONFLICTED WITH HER EMPLOYER’S POSITION, SEE *M FORSTATER V CGD EUROPE AND OTHERS*: 2200909/2019. [HTTPS://WWW.GOV.UK/EMPLOYMENT-TRIBUNAL-DECISIONS/MAYA-FORSTATER-V-CGD-EUROPE-AND-OTHERS-2200909-2019](https://www.gov.uk/employment-tribunal-decisions/maya-forstater-v-cgd-europe-and-others-2200909-2019)

Almost certainly those behind the school policy change have good intentions, although they have likely failed to consider the interests of all stakeholders. For example, they may have exclusively considered what is good for Andrew/Ashley and neglected what may be bad for the girls whose physical spaces at school will now be open to biological males; they may also have neglected what may be bad for students with additional needs. Many people believe that gender identity is analogous to sexual orientation, meaning that both are biological/innate and are not the result of sociocultural factors. They assume that being transgender is similar to being gay, in that people become aware of it through introspection, usually by noticing which category of people arouse sexual or romantic thoughts for them. If gender identity does work in the same way as sexual orientation, as proponents of gender identity ideology argue, then we can expect children and young adults to 'know who they are.' Accordingly, to avoid repeating the same mistakes that caused lasting shame and trauma to gay and lesbian people during a prolonged history of homophobia, we should *accept* who people say they are and *affirm* their identity. We must accept and accommodate a boy's claim to be a girl, a girl's claim to be a boy, or a boy or girl claiming another gender identity.

Proponents of gender identity ideology and the affirmative approach also argue that people with gender identities differing from their own biological sex are behaviorally more like the sex with which they identify and should be treated as such. When the affirmative approach goes hand-in-hand with inclusion into opposite sex spaces, it often fails to assess the risks involved for members of said opposite sex. In the present case, for example, teachers and administrators may fail to consider *why* girls and boys have historically been separated, or to evaluate the consequences of making exceptions to that separation. To them, it will appear no different from a new female joining the student body. In other words, they will believe that new student *Ashley* is now using the girls' changing rooms, as is standard policy, not that biological male *Andrew* is now using those facilities. They will neglect the potentially traumatic effect of that decision upon biological females or students with additional needs who may not have the capacity to fully understand the differences between biological sex and gender identity.

Andrew has not become a new person simply by changing his name and pronouns. Regardless of whether Andrew has always had a female gender identity, he has also grown up in a world that treats the sexes differently, and up until the time of his social transition, he has been treated as a male. Further, it should be acknowledged that he is likely to have a male physiological response. The extent to which that fact matters, and the ways it might affect Andrew's future behavior, should be part of the school's considerations in balancing the interests of *all* students and other stakeholders (including parents). Forming policy based solely on what they believe would be best for Andrew excludes other interests from consideration.

What are some of these other interests? To begin with, there is the interest of all students in their own privacy, especially in spaces such as bathrooms and changing

rooms where there is nudity or partial nudity, and where exposure of bodily functions may give rise to embarrassment. Single-sex bathrooms and changing rooms partly mitigate this embarrassment and facilitate privacy by grouping people based on shared body types and bodily functions. Girls need sanitary bins to dispose of menstrual products, for example, and sinks to rinse menstrual cups. Girls also have an interest in not being sexualized or objectified while changing, which can be facilitated by separating girls from boys, especially teenage boys going through puberty who may be preoccupied with sex.

Second, there is the interest of all students in freedom of thought and expression. Some students will have religious beliefs and families that share them. Some students will have scientific beliefs imparted to them by parents who consider them to be of fundamental importance. Protecting Andrew from bullying and discrimination at school is one thing but insisting that everyone else speaks and acts as though Andrew's beliefs about himself are factually true is another. Regarding other serious metaphysical disputes (such as disputes about the nature of reality or the existence of a god), liberal societies have required *mutual toleration* from their citizens. We do not have to accept another citizen's religion or lack thereof, but we must treat them with respect. As with other belief systems, students should simply be asked to respect those students and teachers who subscribe to gender identity ideology, while asking for the same respect in return.

Third, parents are interested in knowing whether their child has socially transitioned at school and whether their daughters are being compelled to share intimate spaces with boys or their sons are being compelled to share intimate spaces with girls. Parents with reasonable concerns about their children's safety and privacy should be able to advocate on behalf of those children. Being kept in ignorance about social transitions occurring at school prevents them from doing so. One frequent objection to this position is that a child may request that their parents not be informed of their social transition for fear that it will lead to parental rejection, and even violence within the home. While this may be a reasonable concern in certain limited cases, the specter of a violent parent must not be exploited by schools as a pretext for assuming authority over decisions that in nearly all cases should rest with the parents. If the child is at risk, the teacher should follow appropriate protocols as set down by the school.

Another objection is that some parents, once informed, would likely protest a policy allowing boys to use girls' bathrooms and changing rooms; as a result, their fear and outrage (rather than factual evidence and the requirements of anti-discrimination law) will influence school policy concerning marginalized students. However, this is a complicated matter since anti-discrimination law itself has been influenced by gender identity ideology,⁶ and those advocating for evidence-based policy tend to be selective

⁶ ,FOR AN EXAMPLE FROM AUSTRALIA CONCERNING INTERPRETATION OF THE FEDERAL SEX DISCRIMINATION ACT, SEE (LAWFORD-SMITH, 2023).

about *which* evidence they want considered. Often when it comes to the issue of bathrooms and trans inclusion/exclusion, the evidence presented is exclusively focused on the risk of violence *to transwomen* forced to use men's bathrooms and neglects the risk of violence *to women* when their bathrooms are opened to boys and men who claim a female gender identity.

Fourth, the more that schools adopt a diversity-and-inclusiveness approach to forcing acceptance of gender identity ideology onto students, the more pressure gender non-conforming or gender atypical students will feel to interpret their own differences through the lens of that ideology. That poses a risk to neurodiverse students, lesbian and gay students, tomboys and feminine boys, who may be persuaded to believe they are nonbinary or trans, rather than being helped to accept that there are many different ways to be a boy or a girl.

In short, once all stakeholders to the school's policy are considered, it becomes obvious that the affirmative approach to gender identity creates significant problems concerning privacy, freedom of thought and expression, parental rights, and the future health of gender non-conforming students. Schools must not exclude consideration of those issues and viewpoints when adopting policies to protect trans-identified youth.

4.3 Single-Sex Spaces

The effects of adopting gender identity ideology on nominally single-sex bathrooms and changing rooms in schools has already been discussed in this section, however many other physical spaces have also been impacted: rape and domestic violence shelters, prisons, hospital wards, sports, and gay and lesbian spaces. As in Section 4.2, this list is indicative rather than exhaustive. *Any* space, service, or provision that is nominally single-sex or restricted to a single sexual orientation may be affected by a belief system seeking to shift social and legal categorizations from sex to gender identity.

4.3.1 Rape & domestic violence shelters

A range of services offer support to women and girls who (1) have experienced trauma from rape, sexual assault, child abuse, incest, domestic violence and domestic abuse (including coercive control); (2) are battling or recovering from drug and alcohol addiction; and (3) are homeless or at risk of homelessness. Such spaces are all nominally single sex, meaning they are normally referred to as 'women's services.' Gender identity ideology's challenge to the definition of 'woman' entails contestation of who these spaces are for.⁷ Consider the following case.

⁷ AN EDINBURGH RAPE CRISIS CENTRE IS HEADED BY A TRANSWOMAN. SEE (GORDON, 2021).

Rape crisis center. Alina manages a rape crisis center in a major city. The center has received an exemption under the country's anti-discrimination laws allowing it to hire only female counsellors, to accept only female volunteers, and to offer support services to female clients only. The center provides staff to accompany women to police and court appointments and offers 1:1 counseling services as well as group counseling services. After operating for thirty-nine years without conflict (although with occasional requests for aid from gay men who have been referred to other support services), in the last month a transwoman lawyer has offered to contribute pro-bono legal services, and two transwomen have made applications to access the center's support services. Alina suspects that this is the beginning of a coordinated challenge to the center's single-sex status. She feels it is crucial to maintain the service as single sex, but also worries that the service will lose funding due to accusations of 'transphobia.'

Reactions to a case like this are likely to be mixed. On the one hand, it is a central commitment of our morality to protect the vulnerable, and survivors of rape are quintessentially vulnerable. How then can we turn away *anyone* in need from a rape crisis service, even if they are a gay man or a transwoman? In some cities and towns, such support services are scarce, and there may be no alternative resource to which we can refer them.

Nevertheless, it is easy to focus on the impacts on those refused access to the service and overlook the impacts on those currently accessing the service were its single-sex status to be altered. While female victims of abuse often feel triggered by the presence of male bodies even when those men are gay, gay men have no sexual interest in women and so are not likely to be a threat to women, and *some* gay men experience similar treatment to women in penetrative sex, being categorized as sexually submissive or as being *for* sexual use by (other) men. This might create enough of a sense of shared experience that including gay men in the service *may not* necessarily undermine its aims.

The same may not be true of transwomen. Most transwomen (biological males) have a heterosexual orientation with a sexual interest in women (Blanchard, 1985) - hence the rise of male 'lesbians'—see discussion in Section 4.2.2. They may be felt as a threat by women using the services. (Since these are women recently traumatized by rape or sexual assault, it is *particularly* important not to subject them to any unwanted sexual advances or otherwise sexualizing treatment.) Transwomen and women may have little in common beyond superficial matters like presentation.

If the rape crisis service accepts the transwoman lawyer's pro bono services, it puts women survivors in a difficult position. The service advertised itself as hiring female staff only, so a client will not expect to be presented with a lawyer who is a natal male, has a male voice and who presents as female. She may not agree with the gender

identity belief system and she may perceive the transwoman as a male but feel pressured to go along with the pretense that this is a woman/female; she may also believe that she would lose support from the service were she to ask for a different lawyer; or she may simply evade her difficult position by declining to make use of the service's provisions. Women who need rape crisis support may simply self-exclude from accessing the service if they know they will encounter male staff and be expected to pretend to believe they are women. They may view the service as putting the desire of men to have their identities as 'women' validated ahead of the interests of biological women who have survived rape and are in recovery. An additional problem with the inclusion of transwomen in women's crisis services is that funding for women's services is generally limited and, in many countries, fails to meet demand. If women's services like rape crisis centers would need to compete for limited funding, it might be better simply to offer services in a way that supports the largest group. There are obviously more women in need of rape crisis services than there are gay men or transwomen. Nonetheless, it is an empirical question of what proportion of those women would self-exclude from services offered to women understood as a gender identity rather than a sex.

This issue of whether to include transwomen may divide along ideological lines just as it did in the case of the LGBTQIA+ ally training module (see discussion in Section 4.2.2). If access to the rape crisis center is a matter of women's interests versus transwomen's interests, then it is a straightforward conflict between marginalized groups. However, suppose some women believe that transwomen are women and should be included in services for women, while other women believe that transwomen are men and should be excluded from those services. In that case, it appears to be a more standard type of disagreement rather than a true conflict of interests.

One resolution might entail having both types of services, one operating based on gender identity, or being open to anyone who has experienced rape and sexual assault/abuse (including men); the other operating on a female-only basis. Unfortunately, in an effort to protect against gender identity discrimination, many countries have passed laws that conflate sex and gender identity, thereby making it illegal to offer female-only services. The language in the laws need to be clarified to make clear that women's services *can* be offered on the basis of sex, regardless of gender identity.

4.3.2 Prisons

Prisons have historically been segregated by sex, but in several countries, male prisoners are being placed in female prisons on the basis of their claims to be transgender (Kay, 2021; see also Joyce, 2021). In some cases, they made a gender identity claim prior to committing the crime for which they were convicted; in other cases, they have made the claim *after* conviction, usually after having been incarcerated in a male prison and serving part of their sentence. Consider the following case.

Incarcerated male ‘comes out’ as transgender. Mateo is a prison guard at a high-security men’s prison. One of the prisoners, Bryce, is halfway through a 40-year sentence for second-degree murder. He killed his wife when she threatened to leave him. One day, Bryce tells Mateo that he is transgender, and requests a transfer to the women’s prison. Mateo has been working at the prison for about ten years and has never witnessed any signs that Bryce is transgender. Mateo wonders if Bryce is acting on advice from his brother, a state bureaucrat, who visits regularly. Recent news reports have described prisons receiving an increasing number of requests from male prisoners to move into the female estate, based on the grounds that they are transgender.

Government bureaucrats, prison officials, and human rights experts have been increasingly troubled by this issue in recent years (Joyce, 2021). Most people believe that gender identity works in roughly the same way as sexual orientation, and that we learn ‘who we are’ by introspection. In addition, people commonly believe that those with gender identities differing from their biological sex are behaviorally more like the sex with which they identify. According to these common beliefs, each individual is the sole authority on their gender identity, and classification into ‘male’ or ‘female’ must align with that authority. If a male criminal/prisoner states that he is a woman, then he *is* one; and if his gender identity is ‘woman’ then he is more like women than men. It therefore makes sense to incarcerate him along with women rather than with men.

Because transgender people are uncommon and perhaps incomprehensible to most people, they are in danger of mistreatment, especially in a men’s prison rampant with violence, including sexual violence, that targets men who are comparatively weak. Because femininity in men is equated with weakness, transwomen are especially likely to be targeted for violence, including sexual violence (Jenness & Fenstermaker, 2016; Jenness et al., 2019; Jenness, 2021). This might be an additional reason *not* to house transwomen in the male estate, especially if there are only two types of prison, one for each sex.

Of course, even if we accept that someone ‘knows who they are’ with regard to their gender identity, it does not follow that what they say about it will be truthful. What they say may depend upon the incentives for saying or not saying particular things. Gay people in homophobic societies, for example, are unlikely to acknowledge their sexual orientation publicly. In contexts where being trans earns special protections or benefits, transgender people are more likely to acknowledge it; but so too are *non-transgender people* who wish to benefit from those special protections. If we accept that each individual is the ultimate and indisputable authority on whether they are or are not trans, we create an incentive for people who have not previously identified as trans to claim trans status to access those special benefits and protections.

Public discourse on transgender people and prisons tends to focus almost exclusively on the vulnerability of transwomen and reflects a more general pattern in thinking about trans issues—a tendency to focus exclusively on the interests of transgender people rather than to consider the interests of everyone affected and balancing those interests in a fair and reasonable way. (As noted earlier, one explanation for this tendency is the commitment to prioritarianism, which directs us to focus our social justice energies on improving the situation of the least well-off). Who are the other stakeholders when it comes to policies allowing transwomen (biological males) to be housed in the female estate, and how are their interests affected?

The most obvious stakeholders are *female prisoners*. This is an extraordinarily vulnerable group: women tend to be incarcerated for less serious crimes than men, and tend to come from extremely marginalized backgrounds.⁸ According to some estimates, 85% of women prisoners ‘have experienced violence at some point in their lives’, with some studies putting it as high as 98% (Burns, 2021; Gleeson, 2019; Meyer, 2021). Women prisoners are already at risk of rape and sexual assault by male prison guards and prison wardens; adding (heterosexual) male prisoners to the ‘female’ prison population places them at further risk. The risk of pregnancy is an additional problem. It is also important to note that the pattern of criminal activity, including sexual assault for transwomen, parallels those of heterosexual men (Biggs, 2020; Freedman et al., 2021).

In addition to the risk of physical and sexual violence, there is also a violation of privacy in forcing women to share communal shower and bathroom facilities with males, as well as the psychological strain of living in close quarters with someone likely to be much stronger physically. As in the case of Bryce, that person may also be in prison precisely *because* he has perpetrated violence against women. Violent retaliation may result from any rejection of the male prisoner’s status as a ‘woman.’

Prison wardens and guards at female prisons represent another group of stakeholders. Their job is to manage the day-to-day operations of the prison, and (ideally) to prevent violence, a job made more difficult when men are added to the female prison population. Female prison officers are at particular risk when they need to subdue or restrain someone physically stronger and may, as a result, then become a target of sexual assault and harassment at work.

A final consideration: what does it do to crime rates and recidivism when male criminals know transgender identification will win them assignment to the female estate, thereby providing them with sexual access to women and a much less dangerous and difficult prison environment? It may reduce the deterrent effect of incarceration on crime or

⁸ FROM AN AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE REPORT ON WOMEN IN PRISONS: ‘WOMEN IN PRISON OFTEN COME FROM DISADVANTAGED BACKGROUNDS, WITH HISTORIES OF POVERTY, DOMESTIC VIOLENCE, SOCIAL DEPRIVATION AND CHILDHOOD TRAUMA’ (AIHW, 2020, p. 4).

raise the rates of reoffending. (This is not to suggest that it makes incarceration *appealing*, rather that it becomes significantly less *unappealing*, which may change some people's risk assessment about whether to engage in crime).

So, what should Mateo do? The prison may already have a policy in place regarding transgender prisoners, and so the decision about how seriously to take Bryce's claim will be out of his hands. That does not mean he cannot advocate for a change to that policy or become involved in advocacy for prison policy reform more generally. He can also speak to other staff at the prison and the prison warden to determine whether others share his concerns. Those who witness firsthand the impacts of bringing men into the women's prison (as well as those who witness firsthand the impacts of leaving transwomen in the men's prison) are in a key position to testify about those impacts – upon women, transwomen, and prison staff. Such testimony will likely prove helpful in devising a policy that can prioritize different stakeholder interests in terms of risk and develop a fair and practical solution that balances all of them.

4.3.3 Hospital wards

Patients can be incredibly vulnerable while in hospital, whether for psychological reasons (worrying about health problems and impending operations) or for physical reasons (being incapacitated and relying upon doctors and nurses for care). Some hospitals offer single-sex wards, enabling women to share multi-person hospital wards exclusively with other women. These tend to have shared bathroom and shower facilities as well. Consider the following case.

Single-sex wards & same-sex intimate care. A woman patient is scheduled for a hysterectomy, and requests accommodation on a female-only ward, as well as female-only aftercare. The hospital employs several transwomen as doctors and nurses and is committed to making sure they do not experience workplace discrimination. Hospital administrators are divided over whether respecting the patient's request (and thereby excluding transwomen from her care team) would be discriminatory and are awaiting advice from their legal counsel. In the meantime, in order to avoid inadvertently discriminating on the basis of gender identity, they decide to allocate work tasks to transwomen just as they would do for female doctors and nurses.

Again, we must identify the stakeholders involved. There are the doctors, nurses, and other hospital staff who interact with the patients and with one another. There are the female patients in the single-sex ward at any given time. There are the transwomen prospective patients who wish to be admitted to a female single-sex ward rather than a male single-sex ward or a mixed-sex ward. Finally, there are the transwomen doctors and nurses working at the hospital, who may or may not be assigned to the female single-sex ward.

Doctors, nurses, and other hospital staff (like administrators) typically interact with patients and colleagues of both sexes, so staffing considerations alone are unlikely to provide a strong reason to maintain wards as strictly single-sex versus nominally single-sex. Nevertheless, hospital administrators have a general duty to prevent harm, and to protect the hospital from exposure to severe negative publicity should crimes be committed there. A 2023 study from the UK reported 6,500 sexual assaults in hospitals during the prior four years, 1 in 7 of which occurred in hospital wards (Phoenix, 2023). Sexual assault is an overwhelmingly male crime,⁹ but it is unclear whether these assaults were perpetrated by hospital staff against patients, hospital patients against other patients, or members of the public entering the hospital and taking advantage of patients' vulnerability. One way to mitigate against further such assaults is to ensure that single-sex wards admit strictly no males, whether as patients or as staff.

Female patients have a privacy and dignity interest in sharing a ward with other female people, given that they will be sharing bathroom and shower facilities and receiving care and information within hearing distance of other patients. They also have a safety interest in sharing a ward exclusively with other female people, given that they will be especially vulnerable (e.g., when sleeping, medicated, or in recovery from surgery). At a time when people are already at a low point, they do not need the additional stress and pressure of worrying about their privacy and safety. This can all be avoided by maintaining single-sex wards as single-sex and providing same-sex care from a genuinely same-sex doctor or nurse (rather than an opposite-sex doctor or nurse with the 'same' gender identity). Power hierarchies between doctor and patient and nurse and patient mean that a patient's complaints carry little weight; so when hospitals claiming to offer single-sex wards and same-sex care then admit opposite-sex patients and provide opposite-sex doctors, they are disregarding that power asymmetry to enact a policy that potentially makes female patients uncomfortable and possibly unsafe.

On the other hand, transgender doctors have an interest in being able to do their jobs without facing discrimination, whether by their patients or by their colleagues. A hospital would likely *not* avoid sending a black doctor to assist a racist white patient, at least not at the patient's request (though they might decline to send in the doctor at her request, if that would make her working life more pleasant and less stressful). Advocates of transwomen's inclusion in female single-sex hospital wards will see the two cases as parallel in the sense that discriminatory or otherwise bigoted attitudes should not be allowed to affect a person's employment. From this perspective, transwomen doctors and nurses *should* be assigned to work in female single-sex wards, and in cases where women patients have requested female-only care.

⁹ ACCORDING TO THE AUSTRALIAN BUREAU OF STATISTICS IN 2021, FOR EXAMPLE, 6,090 MALES COMPARED TO 98 FEMALES WERE INCARCERATED FOR SEXUAL ASSAULT AND RELATED CRIMES, MAKING SEXUAL ASSAULT A 98.4% MALE-PERPETRATED CRIME IN THIS SAMPLE (ABS, 2021).

However, the strength of this argument depends on whether it is discriminatory to provide the transwoman doctor or nurse with work assignments in a way that takes sex into account. Sex and gender identity are distinct attributes. Depending on the country, it is legally permissible to discriminate based on sex in some cases. If the hospital can establish that it is discriminating because of sex *not* gender identity, and that it is doing so for reasons usually considered non-discriminatory, then its assignment of the transwomen doctors and nurses to tasks in accordance with their sex (whatever their gender identity) will not count as employment discrimination. There may still be a social cost if the trans staff feel their work assignments to be disrespectful, offensive, or a denial of ‘who they really are,’ which may create problems for the employment relationship and cohesion between colleagues in the workplace. The more strongly trans staff members believe gender identity should take precedence over sex in all cases (as gender identity ideology maintains), the more likely they are to resent and object to their work assignments.

4.3.4 Sport

Some sports are played or competed in by individuals or teams, at different levels (community, elite, etc.), and with more and less physical contact (e.g., badminton versus rugby). However, in many sports, at least, competitiveness depends on physical strength, speed, or agility; these all differ according to sex. Consider the following case.

Community rugby team. Not long ago, a high-school girls’ rugby team accepted their first transgirl player. Neither the girls on the team nor their parents had objections, and the team remains cohesive and moderately successful in competitions. However, a video clip from a recent game was shared on social media, and the high school has since been tagged in frequent social media posts, with many comments to the effect that the school does not care about the safety of the opposing teams’ players, has no regard for fairness in sport, and displays ‘institutional sexism’ because it ‘puts a boy’s feelings ahead of girls’ safety’. The school administrators are debating whether to issue a public statement in an effort to stop the negative commentary.

The school may have thought carefully about the different basic values central to team sport—e.g., safety, fairness, and inclusion (Pike, 2021)—and decided that inclusion should take precedence in this particular case. Whether that was the best choice would depend upon several factors. Suppose, for example, that the girls’ rugby team had never been particularly good, and so was not a likely pipeline for girls in the team to enter elite rugby later on. Suppose further that while the transgender player in question is visibly male, he is not *particularly* large or strong, so the school does not consider him to pose a serious risk of physical injury to the girls playing on opponent teams. Under such conditions, the school might very well decide that belonging to a team would benefit the

trans player, and—having consulted with the current players—would not cause any problems for the team.

However, variations to this scenario might raise very different considerations. It matters if the team is good, because when a female player loses a spot on the team to a trans player, she may miss further opportunities to play elite sport later on or be considered for an athletic scholarship at a university or college. Suppose the other players have strong beliefs about their sport remaining single sex. In that case, the trans player's inclusion will cause disharmony within the team (a team's harmony is usually central to its success.). If some or all the girls have concerns about privacy, given that teammates share changing rooms and bathrooms, and sleeping accommodations when traveling for tournaments, accepting the trans player creates a conflict with their interest in privacy. If the trans player is considerably bigger than the girls, it may lead to injuries for other players, whether on the same team or the opposite team.

If the school *does* decide to put out a statement, it might reassert its commitment to safety and fairness in sport. This will address the criticism that it is *ignoring* safety and fairness and advancing the interests of a trans player *at the expense of* the female players. The school could also explain that it is handling questions of inclusion/exclusion on a case-by-case basis; in this particular case, the balance of considerations came down on the side of inclusion, but that does not mean they would make the same decision next time.

4.3.5 Gay and lesbian events

Historically, a range of physical spaces have been offered exclusively to people of one minority sexual orientation. These include gay saunas, gay bars and nightclubs, lesbian bars and nightclubs, lesbian and bisexual women's sex clubs (Dumas, 2006), gay or lesbian speed dating events, and gay or lesbian cultural events like music festivals and gay liberation celebrations. Consider the following case.

Gay saunas. A gay men's sauna in a large city has typically allowed entry only to men. However, in the wake of an ongoing campaign by gender identity activists, it has begun to admit transmen as well. Some of the transmen present themselves in a way that makes them indistinguishable from (non-trans) women. Many of the regular users of the sauna have complained to management that transmen should not be admitted, that it is socially awkward negotiating sexual rejections with them in a way they will not consider 'transphobic' or exclusionary, and that they feel uncomfortable being watched by women. Some of the regular users have stopped attending.

What are the arguments on each side, for the *inclusion* versus the *exclusion* of transmen from gay saunas? The pro-inclusion side will assert, in accordance with gender identity

ideology, that 'transmen are men': 'man' is a gender identity, and transmen are female people with that gender identity. 'Gay man' is also a gender identity, referring to attractions between gender identities and gender expressions, not sexes. Thus, any venue designed for 'gay men' must admit transmen as well. To exclude transmen would be to make distinctions between types of men, no different from distinguishing men with disabilities from men without disabilities and excluding the former or distinguishing white men from black men and excluding the latter. According to this line of argument, to single out transmen for exclusion would be to discriminate based on transgender status: the transman is *trans* while the other men are not. This is illegal in states and countries with laws that protect against discrimination on the grounds of gender identity, gender expression or transgender status.

The pro-exclusion perspective would argue that the transman is also a biological female and might therefore be excluded on the basis of sex rather than *gender identity*. To make this distinction clear, we might ask whether transwomen would be refused entry to the gay sauna. If the sauna truly discriminates against *transgender people*, then it will admit *no transgender people*. By analogy, we would not allege that the gay sauna is 'racist' for excluding black people if it excludes only black *women* and not black *men*. Its policy is more likely designed to exclude *all* women regardless of their race. The same principle applies in this case. The gay sauna could choose to exclude all females (including transmen) and admit any males (including transwomen) who wish to enter.

Do gay men have an interest in saunas excluding transmen? Some of their reasons for favoring exclusion have been given already above: negotiating rejections is awkward, and the feeling of being watched by women is uncomfortable. However, a change of policy to admit transmen would also communicate disrespect to gay men. It redefines their protected attribute, same-sex attraction, to mean 'same gender (identity) attraction,' as though the sex of a partner is inconsequential and irrelevant. That does not reflect how most gay men feel about their sexuality. Such a policy change would also tell gay men that their interests are less important than those of transmen, for by accepting transmen into gay men's spaces, the sauna has adopted the meaning and policy position that transmen prefer – that being gay is characterized by same *gender* (identity) attractions.

Do those who run the saunas have an interest in being *permitted to* exclude transmen to remain profitable? Perhaps the latter depends on how many gay men are likely to stop frequenting the sauna due to its admission of transmen. Of course, those who support transmen's inclusion will frame this as a moral issue: no business should ever be allowed to discriminate against people, and whether they make a profit is irrelevant. However, as argued above, the mere fact that transmen are excluded does not prove that the sauna has, in fact, discriminated against them in an impermissible way. Discrimination based on sex is not always unlawful, and in several cases has been permitted through permanent exemptions to anti-discrimination laws. Suppose many

or most of the customers of gay saunas stop frequenting them once a certain proportion of female people are admitted. In that case, the inclusion policy will disrupt the culture of saunas for gay men, and if this culture has value to gay men, there is a legally permissible reason to exclude transmen.

This issue might also be resolved by having two different types of saunas, one admitting customers on the basis of their gender identity and one on the basis of their biological sex. In a city with both, the gay men who accepted that 'transmen are men' could attend the former and the gay men who do not believe that 'transmen are men' could attend the latter. However, at least in some countries, such a compromise could not be implemented, either because the law prevents exclusion on the basis of sex when there is also a gender identity, or because there is such tremendous social pressure against the exclusion of *any* trans person from *any* space that businesses will not run the risk of being targeted as the result of implementing a single-sex policy, even when it is technically lawful.

4.4 Conclusion and suggestions

In conclusion, contemporary society faces a range of multifaceted challenges when grappling with issues related to sex and gender, as well as in relation to sexual orientation and gender identity. It is evident that we must engage in thoughtful and open discourse that acknowledges the complexities surrounding gender identity and its impact on various aspects of society. While advocating for the rights and dignity of all individuals is crucial, we must also remain vigilant in safeguarding the interests and experiences of all stakeholders in any given context. Striking a balance between appropriate inclusivity and exclusivity is a daunting task, but one that we seek to address with nuance, respect for diverse perspectives, and a commitment to finding common ground for the betterment of society as a whole.

The following suggestions are offered in a bid to promote a balanced approach to addressing societal issues related to sex and gender. These suggestions aim to strike a balance between respecting diverse gender identities and acknowledging the concerns of those who are concerned about sex-based rights. If we can foster open and respectful dialogue, then we can work towards a society that values the rights and dignity of all its members, regardless of their identity or their viewpoint.

4.4.1 Stakeholders' rights, needs, interests and responsibilities

- Ensure every stakeholder's needs are considered before formulating policies and laws.
- Critically and comprehensively assess complaints or claims relating to marginalization of a social group or its members.

- Recognize the need to maintain sex-based protections, especially in areas like women's sports and safe spaces for vulnerable populations.
- Recognize the importance of preserving spaces for minority sexual orientations.
- Ensure access to physical and mental health services that are sensitive to the needs of all individuals, providing those who need it with appropriate care options.
- Ensure prisons and other previously sex-segregated spaces recognize the value of sex segregation in some contexts.
- Recognize that ethical scrutiny lifts the standards, and when confronted with an allegation of exclusion or marginalization concerning a group or individual, emphasize the need to clarify everybody's respective interests and balance them.
- Value parents as the primary authorities in children's lives and ensure they are fully informed about any decision that may impact their children's lives.
- To ensure fairness, provide choices when there are conflicts of interests.

4.4.2 Policies

- Promote comprehensive and unbiased policies that acknowledge the importance of biological sex, and review policies that prioritize gender identity over biological sex.
- Ensure safety and fairness are prioritized over the affirmation of identities.
- Support policy development that considers the impact of unfair prioritization of one group and ensures that everybody is treated fairly and can be assured of safety.
- Propose policies that encourage members of any institution (for example, a school or a corporate body) to show respect for those who subscribe to gender identity ideology, while asking for the same respect in return.
- Support policies that recognize different viewpoints, foster discussions to seek common ground and balance competing interests.
- Ensure that conflict of interest declarations are completed when making law or policy, to work through how personal beliefs may conflict with professional responsibilities.
- Facilitate third party scrutiny and ensure that whoever assesses any conflict of interest declaration is separate and independent from the stakeholder.
- Continuously adapt recommendations and policies as new data emerges.

4.4.3 Discourse

- Use accurate language with clearly defined terms.
- Seek responsible, fair and accurate reporting in the media.
- Advocate for a high threshold when deciding whether a viewpoint should be subject to censorship.

- Encourage open dialogue and civilized discourse to increase understanding and empathy.
- When presenting corporate values to employees, companies should be clear and transparent, and ensure that the right to dissent is clarified and upheld.
- Any reporting, training, or policy-making that is underpinned by gender identity theory needs to signpost clearly that it is taking this perspective.
- Journalists should be fully informed so that they are trustworthy, impartial and refrain from using biased language.

4.4.4 Data collection and research

- Ensure data collection methods preserve the integrity of sex-based data while also respecting diverse gender identities when required.
- Support ongoing research and dialogue on issues related to sex and gender, recognizing that societal understandings and needs evolve over time.

4.4.5 Legislation

- Review laws that allow self-identification of legal sex or prioritize gender identity over biological sex
- Uphold and strengthen legal protections against unfair discrimination.

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Section Five: Law and Policy

5.1 Gender identity and the rule of law

In 2006, a group of activists and international law scholars met in Yogyakarta, Indonesia, to endorse "the application of international human rights in relation to sexual orientation and gender identity." Endorsement of a declaration by a group of scholars does not create law. Scholars have no law-making authority within the international system, though they may contribute to the process of norm making and legal interpretation. Even if endorsed by multiple States, a declaration does not create universally binding norms of international law. Normally, these types of documents are endorsed to serve as a soft blueprint for domestic legislation, and to work their way into becoming recognized international norms through States' adoption and practice. They may also aid in the interpretation of existing norms. To be clear, the Yogyakarta Principles (YP) are not binding international law or an "authoritative statement of law", and its "supplement" YP+10 is not a reflection or "affirmation of existing international standards", as claimed by the introduction to YP+10.¹ Those claims misrepresent the state of international law and should bring into question the character of its endorsers and promoters.

The YP document is a declaration, an aspirational statement that the rights contained therein should be adopted as law. A declaration may influence the formulation of domestic laws, international treaties, or judicial interpretations, but its referent function is not conclusive. It is important to distinguish between legal and non-legal norms and their effect as binding or non-binding, thereby also distinguishing between the legal and the political. That is the distinction between the law *de lege lata* (existing law) and the law *de lege ferenda* (developing law). The YP are the latter, *de lege ferenda*, a declaration that aims to become law, but is not itself law. How and to what extent a declaration may come to be recognized as universally binding international law is nuanced and debatable, and thus beyond the scope of this section. In short, the YP is an aspirational document that can be used by advocates to politically influence interpretation of international and domestic laws as well as formulation of new laws, but States are not obligated to adopt it; they may reject it or modify it at their discretion without violating their obligations under international law.

The trouble with the use of the YP as a blueprint or guide for drafting national laws is that it is an activist document and lacks the most basic qualities required of a purported model law. A law is effective and valid if it satisfies the principles of "rule of law", which serve as safeguards against arbitrariness and abuse of power. The principle of legality

¹ YOGYAKARTA PRINCIPLES PLUS 10, INTRODUCTION, 2017. [HTTPS://YOGYAKARTAPRINCIPLES.ORG/INTRODUCTION-YP10/](https://yogyakartaprinciples.org/introduction-yp10/)

requires law to possess clarity, consistency, and certainty/predictability.² If those criteria are not met, the law may be deemed arbitrary, and thus invalid. Multiple provisions of the YP, including its core concepts of gender and gender identity, do not withstand the slightest scrutiny under the rule of law standards.

The YP purport to advance the application of human rights to people of diverse sexual orientation and gender identity. Yet, neither sex nor gender are defined, and sexual orientation is defined without any reference to sex, therefore creating confusion and potential for inconsistency and unpredictability.

Law predominantly operates through application to classes, which may be a class of persons or acts or circumstances. The YP underhandedly attempt to circumvent the class of sex by implicitly submerging it into a new and vague catch-all class: gender identity, defined as "each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth." By definition, feelings are not an observable phenomenon or otherwise verifiable. It is not possible to know what it feels like to be a man or a woman beyond a shared biological experience and its common social effects. Therefore, that feeling of being of another gender is highly subjective, self-defined, and informed by superficial qualities and regressive stereotypes. International human rights law has recognized the harmful effects of sex stereotyping, and it obliges States to combat stereotyping, yet gender, the core concept of the YP, has deep roots in stereotypes.

Using an elusive phenomenon such as feelings as the core element of a legal classification that also includes persons that are definable with clarity and certainty by reference to biology makes the application of law inconsistent and uncertain, and thus does not satisfy the rule of law principle of legality. Gender identity is fluid and diverse and as such, it is an unstable concept and thus unsuitable for integration into foundational law. Non-discrimination cases that protect gender identity rights do so on the basis of sex, and the prohibition on stereotyping.³

The most far-reaching objective of the YP is not the extension of human rights protections to LGBT people, but its *de facto* erosion of sex as a cognizable legal category and supplanting sex with gender. It is one thing for a person to identify as transgender, but another to identify as the opposite sex based on internal feelings, an extension that appears to be permitted by the YP by effectively conflating sex with gender.

² COUNCIL OF EUROPE, EUROPEAN COMMISSION FOR DEMOCRACY THROUGH LAW, RULE OF LAW CHECKLIST, ADOPTED BY THE VENICE COMMISSION AT ITS 106TH PLENARY SESSION (VENICE, 11-12 MARCH 2016).

³ SEE, E.G., *BOSTOCK V. CLAYTON COUNTY, GEORGIA*, 140 S. CT. 1731 (2020). CASE C-13/94, P. V. S. AND CORNWALL COUNTY COUNCIL, COURT OF JUSTICE OF THE EUROPEAN UNION, 30 APRIL 1996.

The legal class of sex, like other legal classifications, does not exist to validate or invalidate anyone's feelings. It is founded upon objectively verifiable characteristics, and it exists to identify sex-based rights and protections which include relational boundaries. Women's sex-based rights reflect historical conditions that had disadvantaged women in all spheres of life, and the legal efforts to ameliorate those conditions. Self-identification as a woman creates no common ground and in fact revives and reinforces the historical oppression that sex-based rights aimed to correct. The right to exclusive spaces is intended to protect women physically and psychologically. Sex-based data is intended to inform society and policy makers of changes in conditions and behaviors of women so that more suitable policies and laws can be promulgated. Sex segregation in competitive sports is intended to provide women a safe and equal opportunity to compete physically. Spaces for same sex attracted persons exist to facilitate the group's social life against the historical background of oppression and closeted identity. Distortion of those sex-based protections are harmful in effect and serve no legally cognizable legitimate purpose. Transgender individuals can enjoy protection from discrimination without violating the rights of others. No rational basis exists for allowing biological men to violate women's sex-based rights on the basis of their internal feelings.

Feelings and expressions are aspects of lifestyle, personality, and personal identity, all of which are protected by the right to privacy and the right to free development of personality. However, privacy rights and personality rights may encounter limitations in the public realm. The right to privacy and autonomy does not cover every public activity that may involve other human beings.⁴ The goal of personality rights is to ensure and respect the full integrity of the human person, physical and psychological. Therefore, a person's right to determine their own name and identity and be recognized as such is protected.⁵ However, the State has an obligation to delineate the boundaries of identities carefully when respecting a private choice of identity gives rise to a conflict of rights in the public arena.

Personality and lifestyle are not relevant to publicly used legal classification, but identity based on verifiable characteristics serves legitimate public purposes as it determines relations among identities as well as rights and protections. Therefore, the boundaries of each identity matter. The boundaries of an identity must be defined by the members of the group themselves; that is the right to self-determination. The State, much less a group of scholars, lacks legitimate authority to redefine the identity of any group or otherwise diminish any group's distinctive characteristics.

⁴ FRIENDS AND OTHERS V. THE UNITED KINGDOM, NO. 16072/06 27809/08, §§ 40-43, ECHR, 24 NOVEMBER 2009.

⁵ CHRISTINE GOODWIN V. THE UNITED KINGDOM [GC], NO. 28957/95, § 90, ECHR, 11 JULY 2002.

There is no legitimate basis for the State to unilaterally redraw any group's existing identity boundaries, in either the social or the legal sphere. To do so would violate the principles of self-determination, non-discrimination, and the right to identity. The right to self-identify as a group is a protective right and creates a negative State obligation, and thus no one may be compelled to be part of an identity.⁶ Expanding the boundaries of one group to include persons of another identity is compelling two groups to merge identities, thereby minimizing their distinctive characteristics and compelling membership into a new group, thus erasing the pre-existing identities. The State has no right to erase an identity.

The freedom to live according to one's own beliefs and views of life lies at the heart of liberty, however, that freedom does not bring into question the State's authority to regulate actions based on self-defined concepts. To legitimize an unfettered ability to act based on one's subjective feelings and beliefs and without consideration for the rights of others corrodes the rule of law. The State has an obligation to carefully craft laws with sufficient precision and clarity that define boundaries among classes while extending protections to all classes.

The YP do not reflect a mere expansion of human rights protections to include new classes of persons; rather they aim to alter human rights laws to reflect the tenets of transgender identity ideology, which denies the distinction between the sexes and between adults and children. The international human rights mechanism, however, must not be used to advance or endorse any ideology, particularly one that may in any manner be incompatible with the principles of human rights. While everyone has the right to enjoy the freedom of belief and expression, it is only the principles of human rights that are recognized as universal.

The scholars who thoughtlessly endorsed the YP did a disservice to their own reputations and to the role of scholars in the development of international law. It is apparent that the scholars who endorsed the YP did not consider the conflict the YP create with women's sex-based rights and, ironically, also with gay and lesbian rights and its far-reaching adverse effects on social life and healthcare. However, the scholars had an obligation to know. Furthermore, the YP comprehensively cover nearly all fundamental rights, without admitting any boundaries, which should have alarmed any legal reader, but it did not. The numerous human rights violations caused by the attempts to implement the YP bring into question the value and validity of such endorsements. Those scholars are ethically complicit in the harm that women and confused youth have sustained as a result of the attempts to implement the YP. It is now incumbent upon them to step forward and explain what they thought they were

⁶ SEE TASEV V. NORTH MACEDONIA, NO. 9825/13, § 33, ECHR, 16 MAY 2019.

endorsing. Professor Robert Wintemute, one of the co-authors of the YP has bravely done just that.⁷ It is time for the signatories to join him.

5.2 The intricacies of informed consent

5.2.1 Informed Consent in International Law

Historical analysis indicates that consent was adopted in the practice of medicine as early as the eighteenth century. The English case of *Slater v. Baker & Stapleton* in 1767 is the first case on record to have found a physician liable for failing to obtain consent before performing a procedure.⁸ In the nineteenth century, French physicians suffered professional condemnation for experimentation without consent. In Norway, a physician was found "guilty for failure to obtain consent", vaccine experiments carried out in an Indian prison were done with volunteer subjects, and there is evidence that an experiment in an infantry division of the Indian Army utilized a procedure of consent.⁹ At the inception of the twentieth century, Prussia adopted the Berlin Code that expressly prohibited experiments without consent.¹⁰ In the United States, failure to obtain consent was judicially recognized as a source of legal liability in two cases in 1905.¹¹ Consent to experimental medical intervention, i.e., an intervention that departs from established practice, was judicially recognized as a requirement in 1926 and again in 1935.¹²

What constitutes a medical experiment does not have a hard and fixed legal definition. It is a factual inquiry. It may refer to a formal and controlled experiment for the purpose of research, but it may also refer to a treatment that differs widely from generally accepted practice or is unsupported by empirical evidence, or one that is innovative and developed by the physician to treat a particular condition. While formal research experiments are subject to specific regulations, experimental treatment in the context of patient care falls within torts law.

It is an established norm of international law that medical experiments require the voluntary and informed consent of the subject. This principle extends to medical treatments, in general, because the same moral imperatives underlie both scenarios. History of the law of medical consent reveals that the State practice of requiring

7 JONATHAN KAY, A MOB STORMED A FEMINIST EVENT AT MCGILL LAW SCHOOL—IN DEFENCE OF GENDER JUSTICE, OF COURSE, QUILLETTE, 12 JANUARY 2023, AVAILABLE AT [HTTPS://QUILLETTE.COM/2023/01/12/FEMINISTS-TRIED-TO-MEET-AT-MCGILL-LAW-SCHOOL-FORTUNATELY/](https://quillette.com/2023/01/12/feminists-tried-to-meet-at-mcgill-law-school-fortunately/)

8 ROBERT D. MILLER, *SLATER V. BAKER AND STAPLETON* (C.B. 1767): UNPUBLISHED MONOGRAPHS BY ROBERT D. MILLER (BY AUTHOR 2019), AVAILABLE AT [HTTP://DIGITAL.LIBRARY.WISC.EDU/1793/80595](http://digital.library.wisc.edu/1793/80595)

9 LAUREL HATTIX, EXPANDING NOTIONS OF SELF-DETERMINATION: INTERNATIONAL CUSTOMS OF INFORMED CONSENT IN MEDICAL EXPERIMENTATION PRE-1945, 19:1 CHI. J. OF INT'L L., ARTICLE 5, 167-171 (2018).

10 *Id.* AT 172-173.

11 *PRATT V DAVIS*. 118 ILL APP 161 (1905). *MOHR V WILLIAMS*. 95 MINN 261, 104 NW 12 (1905).

12 *OWENS V. McCLEARY*, 313 Mo. 213, 223, 281 S.W. 682, 685 (1926). *FORTNER V. KOCH*, 272 MICH. 273, 282, 261 N.W. 762, 765 (1935).

consent has been constant and widespread since the eighteenth century, and that the practice was based on a legal obligation as indicated by evolving State policies.¹³ The requirement of informed consent did not originate with the Nuremberg Trials, although the Trials served to crystallize the requirement of informed consent as an international norm of human rights law.

Between 1946 and 1947, twenty-three Nazi physicians were charged with torture and murder in the context of medical experimentation on prisoners, in the Nuremberg Trials, and sixteen were convicted of crimes against humanity.¹⁴ The Trials produced the Nuremberg Code for regulation of medical experiments. The Code consists of ten principles, and the first principle states:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent: should be so situated as to be able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and their effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.¹⁵ (Emphasis added).

At least eighty-four countries have now enacted laws that explicitly prohibit non-consensual treatments and experiments, thus reaffirming the prohibition as a norm of customary international law.¹⁶

The right to informed consent was subsequently enshrined in the International Covenant on Civil and Political Rights (1966), art. 7, and the European Convention on Human Rights and Bioethics (1997), art. 5. The right to informed consent is a human

13 HATTIX, SUPRA NOTE 4. AT 186-187.

14 UNITED STATES V. BRANDT, 2 TRIALS OF WAR CRIMINALS BEFORE THE NUREMBERG MILITARY TRIBUNALS UNDER CONTROL COUNCIL No. 10, 181 (1949).

15 ID. AT 181-182. THE NUREMBERG CODE, REPRINTED IN BRANDEIS UNIVERSITY, HUMAN RESEARCH PROTECTION PROGRAM, AVAILABLE AT [HTTPS://WWW.BRANDEIS.EDU/ORA/HRPP/POLICIES/NUREMBERG-CODE.HTML](https://www.brandeis.edu/ora/hrpp/policies/nuremberg-code.html)

16 OFFICE OF HUMAN RESEARCH PROTECTION, DEP'T OF HEALTH HUMAN SERVS., INTERNATIONAL COMPILATION OF HUMAN SUBJECT RESEARCH PROTECTIONS (2008).

rights norm from which no derogation is permitted. States have an inter-State obligation to comply with customary international law and the treaties that they have signed by implementing those norms domestically.

The right to informed consent also implicates other rights, such as the right to bodily autonomy and the right to privacy.

5.2.2 The elements of informed consent

5.2.2.1 Foundation

Informed consent of the patient or the human experimental subject is both a legal obligation and an ethical imperative. The conceptual and philosophical roots of informed consent can be traced to Immanuel Kant's moral philosophy, the categorical imperative, which rests on four pillars: universality of reason, humanity as an end and not a means, freedom constrained by duty, and autonomy, the ability to self-govern through reason. The human capacity to self-govern through universal reason gives human beings their inherent worth and dignity, which gives rise to positive rights and prohibitions on conduct that violate dignity. These Kantian principles illuminate the analysis and application of informed consent.

Informed consent aims to promote two important values: "well-being and self-determination", which are enhanced through a process of joint physician-patient decision making.¹⁷ It is a process and cannot be replaced by a formalistic recitation of information. For consent to be valid, the patient must receive all material information relevant to the treatment, have functional capacity to understand the information, and consent freely and without manipulation. These elements together ensure respect for the patient's right to self-determination.

5.2.2.2 Disclosure

Kant's conception of self-determination differs from the popular notion of choosing as one sees fit without any qualification, and it does not translate into a patient's right to demand whatever medication or treatment they want analogous to consumer behavior. Rather, self-determination in medicine is respect for the patient to knowingly choose from medically accepted options.¹⁸

Respect for autonomy begins by disclosing all material information relevant for choosing a course of treatment. Withholding of *material* information would interfere with the patient's freedom to choose, because a choice without sufficient information cannot be well-reasoned. Furthermore, information and conditions can shift, therefore, disclosure, discussion, and consent are a continual process throughout the period

17 PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS, A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT- PRACTITIONER RELATIONSHIP, VOL. 1, AT 2, OCT. 3, 1982, AVAILABLE AT [HTTPS://REPOSITORY.LIBRARY.GEORGETOWN.EDU/BITSTREAM/HANDLE/10822/559354/MAKING_HEALTH_CARE_DECISIONS.PDF?SEQUENCE=1&SALLOWED=Y](https://repository.library.georgetown.edu/bitstream/handle/10822/559354/making_health_care_decisions.pdf?sequence=1&SALLOWED=Y)
18 ID. AT 43.

leading to and during treatment. The process needs to reflect the complexity of the treatment and the patient's capacity to appreciate the information.

What is material? The risks and benefits, alternative treatments, the evidence for and against a treatment, the range of outcomes, uncertainties, the physician's own skills and experience, any information that can affect the patient's decision. Different legal jurisdictions may apply different standards in determining materiality, such as the standard of disclosure among physicians, the "reasonable" patient's expectations, or by reference to the subjective patient's characteristics and circumstances.

Beyond the principle of autonomy, the imperative that humans be treated as an end and not a means further informs the quality of the disclosure process. A "ritual recitation" of risks and benefits turns the patient into a means to create a veil of legal protection for the physician. To treat the patient as an end, the physician has a duty not only to disclose all material information, but also to discuss the information with the patient and assess the patient's functional capacity to understand the information.

5.2.2.3 Capacity

Functional decision making in medicine is dependent on the nature of the particular decision and is not necessarily dependent on the patient's status characteristics, such as age. It is determined on the basis of the patient's cognitive and emotional state to deliberate his decision in light of his personal goals and values, to articulate reasons for his choice that exhibit an understanding of the disclosed information about risks/benefits, and a realistic view of potential outcomes. Choice must be a product of purpose and intentionality to be an expression of autonomy. Complex and uncertain treatments may require evaluating the patient's capacity to understand over a period of time. If a patient does not appear to possess a "stable framework of values" or is unable to articulate a reasoned understanding of risks, benefits, and outcomes, it may be justifiable to constrain that patient's choice, particularly if the choice does not advance his or her well-being. Under limited circumstances, a physician may treat a patient whose capacity to consent is impaired.

Patient capacity acts as a constraint on both the patient and the physician. It is an equipoise between freedom and duty. The balance between the patient's autonomy and the physician's duties depends on facts and circumstances and is an ongoing challenge in the field of bioethics.

5.2.2.4 Autonomy and voluntariness

Voluntariness is another reflection of autonomy. A voluntary decision is one that is free of external constraint and undue influence. The patient makes their own choice in the context of their own goals and values. To respect autonomy, the patient's decision should not be induced by threats or acts of duress, coercion, or manipulation. The quality and extent of the physician's influence is particularly important because patients

generally trust their doctors, and are vulnerable to manipulation if the physician abuses the disparities in knowledge when presenting information.

5.2.2.5 Children's capacity to consent

Generally, adults are presumed to have the capacity to give consent while children are presumed to lack such capacity. This difference reflects society's judgment that children lack the necessary experience and maturity to understand complex information and make sound decisions. However, the Convention on the Rights of the Child (1989) recognizes children's evolving maturity, which should be given concordant consideration in decisions that affect them. Determining a child's capacity is a nuanced and contextual task. The child's age, the person who is seeking treatment, the type of treatment, and the gravity of harm from a bad decision are factors that require evaluation.

Gender-affirming treatment includes social transition, hormonal treatment, and surgery. Who is seeking treatment for the child raises interesting and challenging questions in the context of gender-affirming care: School personnel? Parents? Clinicians? It cannot be assumed that any of these parties are always a neutral party who have no conflict of interest. It is highly doubtful that school staff are qualified to accurately diagnose or treat gender dysphoria. Although it is assumed that parents are a child's best protector, parents sometimes have their own issues that interfere with their ability to make the best decision for their child. Clinicians also have their own biases, professional peer pressures, and potential conflicts arising from economic and reputational interests. The complexity of these relationships with the child illuminates the need for caution and a long process of evaluation and discussion, and perhaps, involvement of an independent professional, such as a clinical psychologist or an attorney, to decipher the situation.

Whether adolescents understand the consequences of gender-affirming treatment to assent is highly doubtful. Adolescents do not have a fully formed identity and may be confused about their own sources of distress and motives.¹⁹ One study has shown that adolescents do not understand these treatments or appreciate their long-term consequences.²⁰

There are instances when an older child is deemed competent to consent independently to healthcare, such as obtaining contraceptives. However, that context is vastly different from gender-affirming care which causes harmful side effects, some of which are irreversible. Older children's ability to consent is highly task specific, and

19 LEVINE, S.B., & ABBRUZZESE, E. (2023). CURRENT CONCERNS ABOUT GENDER-AFFIRMING THERAPY IN ADOLESCENTS. *CURR SEX HEALTH REP* 15, 113–123. [HTTPS://DOI.ORG/10.1007/S11930-023-00358-X](https://doi.org/10.1007/s11930-023-00358-x)

20 VROUENRAETS, L.J.J.J., DE VRIES, A.L.C., ARNOLDUSSEN, M., ET AL. (2022). MEDICAL DECISION-MAKING COMPETENCE REGARDING PUBERTY SUPPRESSION: PERCEPTIONS OF TRANSGENDER ADOLESCENTS, THEIR PARENTS AND CLINICIANS. *EUR CHILD ADOLESC PSYCHIATRY*. [HTTPS://DOI.ORG/10.1007/S00787-022-02076-6](https://doi.org/10.1007/s00787-022-02076-6)

competence to consent to one treatment does not automatically translate to competence to consent to a much more complex treatment.

There is no single method to assess a child's competence, however the determination of competence must consider the complexity and the uncertainty of the proposed treatment. A review of various legal sources²¹ yields some common factors that are considered: (1) ability to understand facts related to the condition and the treatment options; (2) decision-making process that is rational, in other words, the conclusion or decision logically follows from the initial premise; (3) appreciation of the effects of the decision given one's own values and life circumstances, and ability to think of the future; and (4) the decision itself is sound and does not reflect mental illness. From a developmental perspective, it would be reasonable to consider adolescents' susceptibility to social and peer pressure and to assess whether the youths' decision is truly voluntary. The application of these factors and its outcomes are context specific and may be applied inconsistently among jurisdictions.

Many jurisdictions recognize an older child's competence to seek and consent to psychotherapy. This policy recognizes the highly personal nature of therapy and the fact that sometimes children seek therapy due to problems at home. Therefore, the child's privacy rights in seeking and receiving psychotherapy with confidentiality are protected. However, gender-affirming therapy should not fall into this general category of psychological care, because affirmative therapy is not a neutral act; it is the exercise of undue influence by a fiduciary that can lead to harmful medicalization with uncertain and sometimes irreversible consequences.

5.2.2.6 Informed consent and gender transition

"Gender-affirming care" often involves integration of psychotherapy with hormone therapy followed by surgery. In the case of young adolescents, it may include GnRH agonists. Each treatment is subject to its own consent requirements, although the requirement of informed consent for psychotherapy is often overlooked. Psychotherapy is subject to the same requirements of informed consent as other fields of medicine, even when not provided by a medical doctor.²²

Gender-affirming therapy raises numerous thorny questions about informed consent. Gender-related therapy is normally sought at a time when the patient is highly distressed about their feelings of incongruence, and thus vulnerable to influence. The therapist's affirmation, instead of exploration of the cause of the patient's distress, is an approval and affirmation of the patient's feelings. Affirmation without exploration and assessment may amount to the exercise of undue influence and negate the

21 SEE, E.G. PLANNED PARENTHOOD V DANFORTH, 428 U.S. 52 (1976). GILICK V WEST NORFOLK AND WISBECH AHA [1985] UKHL 7 (17 OCTOBER 1985). SEE LATHAM, A. (2022). PUBERTY BLOCKERS FOR CHILDREN: CAN THEY CONSENT? THE NEW BIOETHICS, 28(3), 268-291. DOI: 10.1080/20502877.2022.2088048 ALAN MEISEL, THE EXCEPTIONS TO THE INFORMED CONSENT DOCTRINE: STRIKING A BALANCE BETWEEN COMPETING VALUES IN MEDICAL DECISIONMAKING, 1979:2 WIS. L. REV. 413 (1979).

22 SEE, E.G., AMERICAN PSYCHOLOGICAL ASSOCIATION, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT, STANDARD 10.01 (2016), AVAILABLE AT [HTTPS://WWW.APA.ORG/ETHICS/CODE](https://www.apa.org/ethics/code)

voluntariness of the patient's consent to psychotherapy as well as the subsequent medical treatments.

"Hormone therapy" also presents troublesome questions about the patient's capacity and agency in giving consent. "Hormone therapy" has psychological and cognitive effects which are not well understood. For example, if suppression of testosterone causes mental fog and depression, does the patient continue to possess the requisite capacity to understand the consequences of his continued treatment when it is being dispensed with the expectation that "hormone therapy" will improve his well-being?

Affirmative therapy is essentially a one-size-fits-all model of care that assumes the patient already has knowledge of his or her condition, its cause, the risks and benefits of transition, and its potential consequences for her or his life, and further, it disregards evidence of negative outcomes or transition regret. It operates on the assumption that identity is fixed despite gender identity ideology's postulation that identity is fluid. The act of affirmation itself reifies and animates an idea in the patient's mind. This effect makes the assessment of the patient's capacity to consent to medical procedures more complex and challenging. The psychological effects of affirmation therapy make the practice even more troublesome when the patient is a minor or young adult whose sense of self is still developing.

Neuroscience has established that adolescents have trouble regulating emotions and controlling impulses. They are also more susceptible to social pressure, risk taking, and addictive behavior. The brain's executive function is not fully formed until a person is in their twenties.²³ Adolescents and young adults not only lack emotional maturity but also the intellectual capacity, life experience, and temporal perspective necessary to fully understand and critically examine complex information related to a medical intervention with irreversible life-long consequences.

It cannot be assumed that parents, due to age and life experience, necessarily have a greater capacity to consent to such highly complex and uncertain treatments. A recent study, applying the criteria of consent comprising of understanding, appreciation, communication, and reason, found that "most adolescents, both continuers and discontinuers, and parents felt they did not have a full understanding and appreciation of all consequences, [nevertheless] they thought that they were able to make the decision to start [puberty blockers]."²⁴ "Several parents and clinicians wondered to what extent they themselves, and adults in general, are able to understand and appreciate certain consequences, let alone adolescents."²⁵

23 INTERVIEW: DR. JAY GIEDD, INSIDE THE TEENAGE BRAIN, PBS FRONTLINE (2014), AVAILABLE AT [HTTP://WWW.PBS.ORG/WGBH/PAGES/FRONTLINE/SHOWS/TEENBRAIN/INTERVIEWS/GIEDD.HTML](http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html)

JOHNSON, S.B., BLUM, R.W., JOHNSON, S. B., & GIEDD, J. N. (2009). ADOLESCENT MATURITY AND THE BRAIN: THE PROMISE AND PITFALLS OF NEUROSCIENCE RESEARCH IN ADOLESCENT HEALTH POLICY. *J ADOLESC HEALTH*, 45(3), 216-221. [HTTPS://WWW.NCBI.NLM.NIH.GOV/PMC/ARTICLES/PMC2892678/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2892678/)

24 LIEKE J.J.J. VROUENRAETS, SUPRA NOTE 13.

25 Id.

Assuming that parents are mature adults that have the capacity to communicate, understand, and reason, and therefore consent to "gender-affirming care" for their minor child, numerous reports indicate that many parents' consent has been neither voluntary nor based on adequate information. Many healthcare providers often fail to disclose all the necessary information regarding lack of supporting evidence for the treatments, risks, unknown consequences, and alternative treatments. Therefore, it cannot be said that consent is given based on adequate information. Lack of adequate information erodes both autonomy and the voluntariness of consent.

It is also reported that parents are threatened and intimidated by the false assertion that their child is at high risk of suicide and led to believe that their consent to "gender-affirming care" is urgently required.²⁶ This threat of harm is an act of coercion. Deceit and duress vitiate consent even if adequate information is provided.

The severity and irreversibility of the consequences of "gender-affirming care" are so grave and the benefits so uncertain that the question arises as to whether, and under what circumstances, parents should be permitted to consent. "The justifying side of consent raises some timeless and thorny questions. What if people consent to activities and results that are repugnant, or even evil? Even John Stuart Mill worried about consensual slavery. For Mill, one who enslaved himself failed to play by the rules, "missed the point" of his freedom."²⁷

The assertion by some gender clinicians that the "do no harm" principle is "paternalistic" and that children's subjective preferences should guide medical decision making starkly contradicts the essential requirement of free and informed consent. Ironically, treating a patient who is not well informed or does not have capacity to understand the consequences of the treatment is the ultimate act of paternalism, as it replaces the patient's informed judgment with the physician's choice of treatment. The law of consent does not allow for the shifting of responsibility to obtain informed consent from physician to patient by effectively abrogating the physician's fiduciary role, and by hollowing out the meaning of patient autonomy by turning it into a facile consumer choice. Principle 1 of the Nuremberg Code imposes a direct "personal duty" on the physician to inform and to assess the capacity and agency of the patient in obtaining consent. This requirement is universally recognized.

The principle of autonomy creates the negative obligation that one's actions should not be subject to undue constraints, and the positive obligation that adequate information is a precondition for multiplying options, avoiding cooptation, and making voluntary and more satisfactory decisions.

26 RESPAUT, R., & TERHUNE, C. AS CHILDREN LINE UP AT GENDER CLINICS, FAMILIES CONFRONT MANY UNKNOWNNS, REUTERS INVESTIGATES, OCT. 6, 2022, AVAILABLE AT [HTTPS://WWW.REUTERS.COM/INVESTIGATES/SPECIAL-REPORT/USA-TRANSYOUTH-CARE/](https://www.reuters.com/investigates/special-report/usa-transyouth-care/)
27 GARNETT, R.W. (1995-1996). WHY INFORMED CONSENT? HUMAN EXPERIMENTATION AND THE ETHICS OF AUTONOMY. 36 CATH. LAW. 455, 458, CITING J.S. MILL, ON LIBERTY 125-26 (OXFORD UNIVERSITY PRESS 1948) (1859).

5.3 Conflating conversion practices with psychotherapies

Conversion therapy is an umbrella term describing a variety of interventions intended to alter or suppress sexual orientation. Historically, homosexuality was classified as a psychopathology, and many gays and lesbians sought conversion or reparative therapy to alter their pattern of attraction and expression. Conversion therapy took many forms, from talk therapy, hypnosis, and verbal abuse to aversive treatments such as electroshock, nausea-inducing medications, and asexualizing medications such as cross-sex hormones. These practices reflected cultural beliefs that homosexuals were inferior and that homosexual behavior was immoral.²⁸ The more extreme treatments, such as asexualization, sometimes were imposed as punishment in jurisdictions where homosexuality was criminalized.²⁹ It is reported that aversion practices are still being carried out in a number of countries to this day. In some societies, homosexuals were and still are "pressured to undergo" gender reassignment surgeries to "neutralize their orientation".³⁰

Such interventions failed to alter sexual orientation and gave rise to depression, anxiety, addiction, low self-esteem, and even suicide. In 1973, the American Psychiatric Association (APA) removed homosexuality from its manual of mental disorders and created a new entry for Sexual Orientation Disturbance (SOD): a condition where sexual orientation is not in doubt but causes such distress that the individual may seek to change it. Some used this new diagnosis as justification for the practice of conversion therapy. Although the SOD diagnosis and its later versions were removed from the DSM in 2013, and from the International Statistical Classification of Diseases and Related Health Problems (ICD) in 2019, the occurrence of internalized homophobia remains a concern in the APA guidelines for psychological practice with lesbian, gay, and bisexual clients.

In 2009, the APA Task Force on Appropriate Therapeutic Responses to Sexual Orientation issued a report (APA Report) to communicate the outcome of its systematic review of sexual orientation change efforts (SOCE) and to make recommendations for appropriate psychological practice. The APA Report concluded that "enduring change to an individual's sexual orientation was uncommon"³¹ and can have harmful effects,

28 AMERICAN PSYCHOLOGICAL ASSOCIATION, REPORT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION TASK FORCE ON APPROPRIATE THERAPEUTIC RESPONSES TO SEXUAL ORIENTATION 22 (2009). [HTTP://WWW.APA.ORG/PI/LGBC/PUBLICATIONS/THERAPEUTIC-RESP.HTML](http://www.apa.org/pi/lgbt/publications/therapeutic-resp.html)
[HTTPS://WWW.APA.ORG/PI/LGBT/RESOURCES/THERAPEUTIC-RESPONSE.PDF](https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf)

29 JOHAN BREMER, ASEXUALIZATION (MACMILLAN 1959).

30 HUMAN RIGHTS COUNCIL, REPORT OF THE INDEPENDENT EXPERT ON PROTECTION AGAINST VIOLENCE AND DISCRIMINATION BASED ON SEXUAL ORIENTATION AND GENDER IDENTITY, VICTOR MADRIGAL-BORLOZ, 15 JUNE - 3 JULY 2020, A/HRC/44/53, 12.

31 AMERICAN PSYCHOLOGICAL ASSOCIATION, SUPRA NOTE 1 AT 3.

and that many gay, lesbian, and bisexual (GLB) individuals suffer from minority stress, self-stigma, and shame; it recommended adopting an affirmative approach in therapy when working with GLB individuals who seek to change their orientation. In 2012, the Pan American Health Organization found no medical justification for 'conversion therapies', concluding that they have a seriously harmful effect on the individual, and in 2016, the World Psychiatric Association also determined that "there is no sound scientific evidence that innate sexual orientation can be changed."³²

The current movement to ban therapeutic attempts to alter an individual's sexual orientation are appropriate and consistent with respect for the human rights of gay, lesbian, and bisexual individuals. Conversion therapy violates human dignity and human rights, to equality and non-discrimination, to freedom of conscience, free development of personality, freedom of expression, freedom of association, bodily autonomy, health, and privacy. State sponsored conversion practices that are cruel, inhuman, or degrading may constitute torture under international law.

A current movement seeks, by analogy, to also ban conversion of gender identity. While no person should be subjected to "conversion therapy" to dissuade them of any behavior or belief about themselves, this movement seeks to ban any therapeutic practice short of affirmation-on-demand. Although it is customary practice to include "T" with "LGB" in discussing these issues, the research on "conversion therapy" has investigated only sexual orientation, and its results cannot be generalized and applied to gender identity simply because they both reflect departures from cultural norms.

Sexual orientation and gender identity differ in many aspects. Sexual orientation is innate, immutable, and verifiable. Expressing homosexual and bisexual behaviors does not involve the use of harmful medical interventions. By contrast, gender identity is an unverifiable and unfalsifiable trait. It may be fluid rather than stable. To date, no biological marker has been identified as the cause or as an objective, physical indicator of gender identity. Unlike affirmation of one's sexual orientation, the affirmation of gender identity often entails harmful medical interventions which are not supported by evidence of benefit to mental health. Furthermore, there are other psychological and psychiatric conditions that imitate gender dysphoria that should be differentiated.

Failure to distinguish conversion practices from the practice of traditional psychotherapy poses a substantial risk to the health of those who suffer from gender dysphoria due to confusion or misinformation. Several other psychological conditions such as internalized misogyny, borderline personality disorder, or trauma which may be accompanied by dissociation from the body and the present self, can produce gender dysphoria and mimic its diagnosis, therefore a therapist must engage in differential

32 HUMAN RIGHTS COUNCIL, SUPRA NOTE 3 AT 5.

diagnosis³³ which requires exploration of the person's history, motives, sense of self, and expectations.

Lawmakers must not conflate conversion practices for sexual orientation with the practice of psychotherapy to explore the roots of a client's gender dysphoria. Psychotherapy involves a process of communication between clients and therapists intended to help the client find relief from emotional distress, seek solutions to difficulties in their lives, and modify ways of thinking and acting that interfere with their well-being. The term exploratory therapy is commonly used to describe this process, and laws that ban conversion therapy typically include an exception for "identity exploration and development."

A law that conflates conversion therapy for gender identity with exploratory psychotherapy may be found to violate the rights of same sex attracted individuals who may be confused or in distress due to their sexual orientation. Studies have shown that the leading cause of transition regret is internalized homophobia.³⁴

Transgender activism often redefines sexual orientation as however people identify their physical and emotional attraction to others on the basis of gender. In contrast, the APA defines sexual orientation as "a complex human characteristic involving attractions, behaviors, emotions, and identity." According to the APA, "sexual orientation refers to an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' gender and sex characteristics. Sexual orientation is tied to physiological drives and biological systems that are beyond conscious choice and involve profound emotional feelings."³⁵ Sexual orientation is complex, multi-dimensional, and innate.

The conceptual and language distortions advanced by transgender activism offer a seductive escape route to individuals suffering from internalized homophobia. The ramifications of labels cannot be underestimated when an individual has suffered parental and societal rejection precisely because of that identification and label. That label and its associated social disapprobation may be avoided by changing either one's sexual orientation or one's gender. The language game creates the possibility to use the socially accepted label of heterosexual and offers the superficial and unscientific explanation that the gay man was born in the wrong body. It is the task of the therapist to identify and unbundle its motivators and contributors.

33 IN MEDICINE AND PSYCHOLOGY, DIFFERENTIAL DIAGNOSIS REFERS TO THE PROCESS USED BY A CLINICIAN TO DETERMINE WHICH OF TWO OR MORE CONDITIONS WITH OVERLAPPING SYMPTOMS THE PATIENT HAS.

34 DE CUYPERE, G., & VERCRUYSE, H., JR. (2009). ELIGIBILITY AND READINESS CRITERIA FOR SEX REASSIGNMENT SURGERY: RECOMMENDATIONS FOR REVISION OF THE WPATH STANDARDS OF CARE. *INTERNATIONAL JOURNAL OF TRANSGENDERISM*, 11(3), 194–205.

35 AMERICAN PSYCHOLOGICAL ASSOCIATION, SUPRA NOTE 1 AT 29-32.

The APA Report notes that while sexual orientation does not change, sexual orientation identity may shift, and therapists should provide a safe space for exploration of the self, with targeted treatments that address personal beliefs, feelings of shame, and internalized homophobia. The APA Report supports affirmation of sexual orientation when a person instead seeks to change his or her sexual orientation. The elements of the affirmative approach are: "(a) acceptance and support, (b) a comprehensive assessment, (c) active coping, (d) social support, and (e) identity exploration and development."³⁶

The APA Report also explains that a comprehensive assessment should include: "understanding how a client's distress may involve (a) psychological disequilibrium from trying to manage the stressors (e.g., anxiety, depression, substance abuse and dependence, sexual compulsivity, post-traumatic stress disorder) and (b) negative effects from developmental experiences and traumas and the impact of cultural and family norms."³⁷ The Report further emphasizes "that identity issues, particularly the ability to explore and integrate aspects of the self, are central to the appropriate application of affirmative therapeutic interventions for adults presenting with a desire to change their sexual orientation."³⁸

The APA's description of affirmation therapy for sexual orientation is equally applicable to the exploration of gender identity, including social influences and developmental roots. It is through this exploration that a therapist is best able to make a diagnostic formulation. The requirement to affirm a client's gender identity by parroting back their self-labels and self-descriptions without exploration and assessment prevents a therapist from doing their job; that is, supporting the patient in reflection and exploration of difficult emotions. It also endows the therapist with undue power to approve or disapprove of the patient's thoughts, and thereby interferes with the patient's maturation process and ability to reach his or her own conclusions. The purpose of exploratory or psychodynamic therapy is not to dissuade anyone from belief in a particular identity, but rather to develop and deepen self-understanding. The process of exploration may reveal significant latent thoughts and emotions that may impact the person's ongoing identity development.

Therefore, it is important to distinguish psychotherapy from "conversion therapy" both in therapeutic practice and law-making. Failure to do so means that gender dysphoric persons receive inadequate and negligent care that may violate their rights to equal protection and non-discrimination in healthcare in two ways. First, conversion therapy laws that prevent a therapist from engaging in the exploration of various aspects of

36 ID. AT 55-63.

37 ID. AT 56.

38 ID. AT 60.

identity in effect violate the non-discrimination protection of homosexuals who suffer from internalized homophobia as well as the protection of females who suffer from internalized misogyny; by failing to account for sex specific mental health conditions, such laws disadvantage them in receiving healthcare appropriate to their condition. Second, therapists who exhibit indifference toward the client's internalized homophobia or misogyny may be found to be treating their patients in a discriminatory manner.

"Non-discrimination, together with equality before the law and equal protection of the law.... constitute a general principle relating to the protection of human rights." Any law that in purpose or effect nullifies or impairs the recognition, enjoyment or exercise of a human right on an equal footing is discriminatory. However, "on an equal footing" does not mean "identical treatment in every instance." Unique characteristics of a protected class must be given consideration in determining equal enjoyment of rights. States have an obligation to ensure that legislative measures are not discriminatory in law or in fact.³⁹

It is well established that the class of sex is protected under non-discrimination laws. It is less settled and thus unclear under what circumstances a person with mental health conditions may be able to claim discrimination in the context of an over-broad prohibition on conversion therapy. International human rights law is moving toward greater recognition of rights and protections accorded to persons with mental health conditions.⁴⁰

Legislation that unjustifiably interferes with the psychotherapeutic process also violates privacy and personality rights⁴¹ of the patient. In this context, protections for privacy and personality rights encompass the inner life, the intimate life, the right to establish mutual relationships, and the freedom to develop one's personality as one sees fit.

The right to free development of personality recognizes that harmonized integration of the inner and outer worlds is a core aspect of personality development. The psychotherapeutic process involves communication that is private and intimate and impacts the unfolding of the patient's personality. Therefore, the State must meet a

39 HUMAN RIGHTS COMMITTEE, GENERAL COMMENT 18: NONDISCRIMINATION, 1989, HRI/GEN/1/REV.1 AT 26 (1994). INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS, ARTS. 2, 26, 1966.

40 WORLD HEALTH ORGANIZATION (WHO) & OHCHR (2023). MENTAL HEALTH, HUMAN RIGHTS AND LEGISLATION: GUIDANCE AND PRACTICE. SEE ALSO CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES, 2006.

41 PRIVACY AND PERSONALITY RIGHTS ARE FOUNDED ON THE KANTIAN VIEW OF HUMAN DIGNITY AND PERSONHOOD, THAT HUMAN BEINGS HAVE A RIGHT TO SELF-DETERMINATION WITH RATIONALITY BUT INFORMED BY DUTY. PRIVACY RIGHTS ARE EXPLICITLY RECOGNIZED IN THE INTERNATIONAL COVENANT FOR CIVIL AND POLITICAL RIGHTS, ART. 17, 1966, AND THE EUROPEAN CONVENTION ON HUMAN RIGHTS, ART. 8, 1950. THE EUROPEAN COURT OF HUMAN RIGHTS HAS CONSISTENTLY INTERPRETED PRIVACY RIGHTS TO ENCOMPASS THE PHYSICAL AND MORAL INTEGRITY OF A PERSON. SEE, E.G., X AND Y V. THE NETHERLANDS, NO. 8978/80, 26 MARCH 1985, § 22. BOTH PRIVACY AND PERSONALITY RIGHTS ARE RECOGNIZED IN THE AMERICAN DECLARATION OF THE RIGHTS AND DUTIES OF MAN, ARTS. V, XXIX, 1949; AND THE AMERICAN CONVENTION ON HUMAN RIGHTS, ART. 11, 1969. THE SCOPE AND CONTENT OF PRIVACY AND PERSONALITY RIGHTS ARE INEXACT AND MAY VARY AMONG JURISDICTIONS DEPENDING ON DOMESTIC LEGISLATION AND JUDICIAL INTERPRETATION. SEE, E.G., EDWARD J. EBERLE, HUMAN DIGNITY, PRIVACY, AND PERSONALITY IN GERMAN AND AMERICAN CONSTITUTIONAL LAW, 1997 UTAH L. REV. 963 (1997).

high burden in justifying regulation of that communication, or the regulation may constitute an arbitrary and unlawful interference with privacy and personality rights. Conversion practices that are physically and psychologically harmful should, of course, be prohibited as human rights violations; this prohibition should include talk therapy intended to change the behavior and sexuality of same sex attracted persons even if requested by the patient. However, psychodynamic technique does not entail purposeful attempts to convert, change or shift an individual's sexuality or identity. Rather it aims to clarify the role of various overt or covert influences upon the patient's thoughts and behaviors, and its practice should be free of arbitrary interference by the State.

Psychotherapy that aims to differentiate among various mental health conditions that superficially resemble each other cannot be said to violate any rights. Legislation that does not distinguish between competent psychotherapy and abusive practices is arbitrary and encroaches upon the private sphere by impinging on personality rights, and also associational rights by having a chilling effect on therapeutic relationships.

5.4 Education or indoctrination

Schools are currently blending three topics: sex education, gender identity lessons, and non-discrimination. Those are three distinct topics.

5.4.1 UNESCO Guidelines for comprehensive sex education

The 2018 UNESCO Guidelines suggest that Comprehensive Sex Education must be age appropriate, factual, integrated with lessons in biology, provide gender perspectives, give information about puberty and its psychological challenges, promote healthy body image, emphasize health and safety, diversity of families and relationships, and the importance of healthy relationships. It is important for everyone to acquire an understanding of the whole body, including biological sex and reproductive functions; and that adolescents learn about the harmful effects of social media, pornography, and transactional sex.

The Guidelines include gender identity within the definition of sexuality, and suggest including lessons in gender identity, although the term itself is not defined, and no detailed recommendation or lesson plan is provided on how this concept could be taught to children. The prevalent school lessons on gender identity, however, give rise to numerous questions about age appropriateness and respect for children's rights.

5.4.1.1 Teaching gender identity

The idea of gender identity originates with clinicians John Money, the first person to use the term gender to distinguish between biological characteristics and behavioral traits that differentiate males from females. He promoted the notion that biological sex

characteristics do not determine whether we are male or female. This idea is also reflected in the post-modern philosophy of Judith Butler. Dr. Heather Brunskell-Evans saliently sums up Butler's notoriously obtuse theories:

Butler argues that binary sex categories (being female or male) and binary gender ("femininity" and "masculinity") although experienced by us as innate, do not pre-exist their human invention. The sexed body is gendered from birth, and then binary gender is continuously reproduced by us through our "doing" or performance. Naturalising binary gender as if "femininity" and "masculinity" arise from biological sex difference is "biologically essentialist" and thus, in this view, hetero-normative. Since binary gender is forged through performative action, Butler proposes that subversion of binary gender can occur by queering it, namely playing with gender expression and presentation in a range of ways that challenge and undermine hetero-normativity. Transgenderism "should be a matter of choice, an exercise of freedom". To choose one's gender is about "the ability to live and breathe and move and would no doubt belong somewhere in what is called a philosophy of freedom".⁴²

Gender identity is taught by using children's books filled with naive drawings, working gender identity concepts into all classes, and compelling children to choose an identity from within a gender spectrum. Some teachers even ask students for their pronouns or even proclaim their own, all of which may confuse children and disrupt the natural development of the understanding of the ways in which gender, sex and sexuality interconnect. Sex and gender are taught as discrete categories independent of one another, which is not supported by scientific literature. Gender identity is a psychological and sociocultural concept, not a scientific one. Gender identity is an abstract notion replete with contradictory elements that give rise to numerous questions. The theory is too abstruse to teach to children and adolescents. Therefore, it is oversimplified by teaching stereotypes as if they were facts. Further, refusing to employ a biological definition of boy and girl can cause additional confusion and have a disorienting and dissociative effect on young minds.

Gender reflects cultural norms associated with one's sex and the range of its expression by individuals. The concept of gender identity, however, does not acknowledge this aspect of gender, as gender identity is only seen as an inner essence of what it means to be a man or woman. Paradoxically, it is not possible to discuss or understand gender identity without reference to sex stereotypes based on sociocultural norms. Thus, gender identity theory strongly implies that these stereotypes are integral in the

42 HEATHER BRUNSKELL-EVANS, JUDITH BUTLER AT THE COURT OF APPEAL, TRANSGENDER TREND (UNDATED), CITING JUDITH BUTLER, GENDER TROUBLE: FEMINISM AND THE SUBVERSION OF IDENTITY (ROUTLEDGE 1990); JUDITH BUTLER, UNDOING GENDER 88 (ROUTLEDGE 2004), AVAILABLE AT [HTTPS://WWW.TRANSGENDERTREND.COM/WP-CONTENT/UPLOADS/2021/08/JUDITH-BUTLER-AT-THE-COURT-OF-APPEAL.PDF](https://www.transgendertrend.com/wp-content/uploads/2021/08/JUDITH-BUTLER-AT-THE-COURT-OF-APPEAL.PDF)

categorization of the sexes. Consequently, the message to children is that nonconformity with stereotyped gender roles associated with their sex means that one may be transgender. This is not only unscientific but may be harmful to children who are incapable of understanding such complex ideas. It is a manipulative message. Teaching regressive and offensive stereotypes is sex discrimination and violates States' obligation to combat sex stereotyping in education.⁴³ Consistent negative stereotyping of a group that reaches a certain level of severity can lead to erosion of self-confidence and self-worth among the group members, causing serious mental impairment that violates privacy rights.⁴⁴ The effect of negative stereotyping of girl/woman/femininity in schools, social media, and society at large is manifested as internalized misogyny⁴⁵ and the stress felt by girls "just by existing"⁴⁶ has been documented to influence adolescent girls to identify as male. The stereotyped misidentification of womanhood as a fixed hyper-feminine being (e.g., dainty and submissive) and the misidentification of boys as a fixed hyper-masculine being (e.g., aggressive and cruel) can cause confusion and inner turmoil for vulnerable children who will want to distance themselves from those extreme descriptors.⁴⁷ This may be particularly the case for gay and lesbian young people who are still in the process of understanding their sexuality. The discussion of gender being discrete from sex, further complicates issues for young gay and lesbian students. How do same-sex attracted young people work through their feelings when same-sex attraction is displaced in gender theory with same-gender attraction?

5.4.1.2 Education or indoctrination

Content, control, intent, and consequences are elements of teaching that require examination in determining whether the teaching is education or indoctrination. Is the content supported by evidence? Is the evidence examined critically? Are different views debated? Is the level of influence and control of the teacher such that it impacts the student's beliefs, decisions and actions? Are "cultural settings" accounted for? Is the teacher attempting to replace parents and become the "exclusive authority" in teaching? Is the student's mind closed to other rational views? Is the teacher's communication style "strategic action" intended to influence, or "communicative action" intended to

43 CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN, ART. 10(c), 1979.

44 SEE AKSU V. TURKEY [GC], NOS. 4149/04 AND 41029/04, ¶ 58-61, ECHR 2012. BUDINOVA AND CHAPRAZOV V. BULGARIA, NO. 12567/13, ¶ 63, ECHR, 16 FEB. 2021. DENISOV V. UKRAINE [GC], NO. 76639/11, ¶ 107 -1 114, ECHR, 25 SEPTEMBER 2018.

45 14% OF GIRLS TRANSITIONED DUE TO INTERNALIZED MISOGYNY. VANDENBUSSCHE, E. (2021). DETRANSITION-RELATED NEEDS AND SUPPORT: A CROSS-SECTIONAL ONLINE SURVEY. J. OF HOMOSEX. 69(9)1602-1620.
[HTTPS://WWW.TANDFONLINE.COM/DOI/FULL/10.1080/00918369.2021.1919479](https://www.tandfonline.com/doi/full/10.1080/00918369.2021.1919479)

46 BACKGROUND CANDY, HOW DO YOU GUYS GET THROUGH IT? R/DETRANS (2022).
[HTTPS://WWW.REDDIT.COM/R/DETRANS/COMMENTS/XDF50V/HOW_DO_YOU_GUYS_GET_THROUGH_IT/](https://www.reddit.com/r/detrans/comments/xdf50v/how_do_you_guys_get_through_it/)

47 SEE E.G., STEVEN A RICHARDS, PURIFICATION RITES: AN AUTOBIOGRAPHICAL ESSAY, SUBSTACK, APR. 26, 2022.
[HTTPS://CUTDOWNTREE.SUBSTACK.COM/P/PURIFICATION-RITES](https://cutdowntree.substack.com/p/purification-rites)

understand and explain?⁴⁸ Presentation of specific content in a manner that is not questioning, interactive, and evaluative is indoctrination.⁴⁹

Children are still in the process of forming their identity and thus highly susceptible to social influence. They have a strong need for belonging. The development of the sense of self, identity and morality is a cognitive process, in other words, children learn through their social encounters. Indoctrination is a teaching process that interferes with the child's ability to examine different perspectives, which is important to moral development.⁵⁰ Therefore, the age of the child is also relevant for determining the appropriateness of the educational content and method. Teachings with moral or philosophical implications at too young an age can constitute indoctrination. The quality of educational content must be proportionate to the children's capacity for critical thinking.

In prohibiting indoctrination in education, the European Court of Human Rights (ECtHR) stated that: "the State, in fulfilling the functions assumed by it in regard to education and teaching, must take care that information or knowledge included in the curriculum is conveyed in an objective, critical and pluralistic manner."⁵¹

Gender identity lessons are not taught in an objective and critical manner, nor are those lessons neutral and pluralistic as they marginalize other identities by over emphasizing stereotypes and gender identity. Any critical analysis of the concept of gender identity in society, much less in the classroom, is deemed hateful and non-inclusive. An oversimplified concept of gender identity is further reinforced by presenting it as universally applicable by working it into all classes and compelling students to choose a pronoun. Schools that compel students to choose their pronouns and state their gender identity and encourage them to keep that information a secret from their parents are damaging children's emotional ties to their parents. Schools that transition children secretly are violating parental rights. The Convention on the Rights of the Child (CRC) requires States to "respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and

48 TAPIO PUOLIMATKA, THE CONCEPT OF INDOCTRINATION, 61:2 PHILOSOPHIA REFORMATATA 109-134 (1996).
[HTTPS://WWW.JSTOR.ORG/STABLE/24709157](https://www.jstor.org/stable/24709157)

49 BRIAN S. CRITTENDEN, INDOCTRINATION AS MIS-EDUCATION, IN CONCEPTS OF INDOCTRINATION 131, 132-139 (I.A. SNOOK ED., 1972).

50 LAWRENCE KOHLBERG, THE PSYCHOLOGY OF MORAL DEVELOPMENT: ESSAYS ON MORAL DEVELOPMENT (1984).

51 KJELDSSEN V. DENMARK, 23 EUR. CT. H.R. 22, § 53 (1976).

guidance in the exercise by the child of the rights recognized in the present Convention."⁵²

Parents have a right to oppose educational material and pedagogy that is not neutral and pluralistic. The ECtHR has ruled: "The State is forbidden to pursue an aim of indoctrination that might be considered as not respecting parents' religious and philosophical convictions. That is the limit that must not be exceeded."⁵³ That ruling is consistent with the CRC, which "recognizes the right and duty of parents to provide direction to the child in the exercise of freedom of thought, conscience, and religion."⁵⁴ However, parents' ability to exempt their children from certain classes does not change the State's obligation to provide objective and pluralistic education.⁵⁵

Schools that instruct, support or encourage children not to inform their parents of the content of the curriculum, in effect, are operating to create a separation between parents and their children to unlawfully increase the authority and influence of teachers in the mind of the children when they have not yet developed the intellectual capacity to discern among facts and ideas for themselves. The ECtHR has emphasized the importance of children's intellectual capacity in finding indoctrination: "The schooling of children is a particularly sensitive area in which the compelling power of the State is imposed on minds which still lack (depending on the child's level of maturity) the critical capacity which would enable them to keep their distance from the message derived from a preference manifested by the State...."⁵⁶

Children have not acquired the knowledge, life experience, and critical thinking skills necessary to examine ideas that underlie gender identity, uncover contradictions, compare information, and independently evaluate the concepts that are being taught. Therefore, they are at risk of inappropriately internalizing these abstract and incoherent ideas. "Teaching an ideology as if it were the only possible one with any claim to rationality" clearly constitutes indoctrination.⁵⁷

Children are asked to state their gender identity, i.e., the internal sense of who they are, by reference to highly regressive sex role stereotypes, and sometimes also their sexual orientation. Requiring such disclosures violates the children's right to privacy, freedom of conscience, and their right to free development of personality, and may constitute compelled speech. It promotes adherence to the abstract idea of "gender identity"

52 CONVENTION ON THE RIGHTS OF THE CHILD, ART. 5, 1989.

53 KJELDEN, § 53.

54 CRC, ART. 14.

55 ZENGIN V. TURKEY, NO. 1448/04, § 68, ECHR 2007.

56 LAUTSI V. ITALY, NO. 30814/06, § 48, ECHR 2009.

57 I.A. SNOOK, INDOCTRINATION AND MORAL RESPONSIBILITY, IN CONCEPTS OF INDOCTRINATION, SUPRA NOTE 8, AT 152.

without critical examination. The practice of repeatedly asking for children's pronouns and gender identity can harm them by effectively forcing them to divulge information that they are not ready to share or by placing children in the position of having to lie.

It is also appropriate to scrutinize extracurricular activities, display of symbols by schools or teachers, and activities that create psychological or peer pressure to participate. The ECtHR imposes upon the State an obligation to provide a neutral public education system. That requirement applies to "all the functions" of education.⁵⁸ The ECtHR has held that extracurricular activities with moral implications are permissible only if they are completely voluntary and non-participation does not result in any detrimental effect.⁵⁹ If a student feels discomfort for not participating due to peer pressure, then there is a detrimental effect. Activities with moral implications should not be offered to children under a certain age, even if voluntary.⁶⁰ Teachers may not wear religious symbols in class or proselytize in class, because they are in a position of authority in relation to their students.⁶¹ While a passive display of a single religious symbol in class may be permissible, an ever-present display of symbols could violate the prohibition on indoctrination.⁶²

The presence of Pride and various gender flags in many schools, with teachers who wear gender flag pins and share stories about their personal lives with their students, are creating an environment that further reifies the indoctrinating messages of the gender identity lessons. Reprimands for non-participation or discomfort with participation in activities that are normally sex segregated, such as changing in locker-rooms, that some schools are now segregating based on feelings, is another enforcer of the indoctrinating lessons. After-school clubs where sexualities are discussed, and students are love-bombed are activities with moral implications. The after-school clubs offer a social community and create a sense of belonging for students who are open to the clubs' ideas of identity and sexuality. Non-participation may cause a student to feel socially uncomfortable, left out, or uncool. Students struggling with psychological issues or difficult home lives may be more vulnerable to feeling pressured to participate. Some student populations, such as those on the autism spectrum, may be particularly vulnerable. The desire for belonging is a notable factor in adolescents choosing a trans identity. In a study of 100 detransitioners conducted by Dr. Lisa Littman, 50.7% of

58 VALSAMIS V. GREECE, NO. 21787/93, § 27, ECHR 1996-VI.

59 GRZELAK V. POLAND, NO. 7710/02, ECHR 2010.

60 SEE CIFTCI V. TURKEY, NO. 71860/01, ECHR 2004-VI.

61 DAHLAB V. SWITZERLAND, NO. 42393/98, ECHR 2001.

62 LAUTSI V. ITALY [GC], NO. 30814/06, ECHR 2011. (MALINVERNI, G., & KALAYDJIEVA, Z., DISSENTING). SEE LAUTSI, § 55.

females and 45.2% of males identified with the comment, "I felt I would be treated better if I was perceived as the target gender."⁶³

The impact of such educational content and pedagogy on children's development may vary from child to child. However, it should not be necessary to show actual impact on children who are still developing, the theoretical risk to children should be sufficient to prohibit detrimental conduct.⁶⁴

The total immersion of students in gender identity ideology is not a neutral act. Unquestioning immersion in any purported identity, belief system, or lifestyle is indoctrination which can interfere with a child's moral development, and which violates the child's right to freedom of conscience. It is axiomatic that freedom of conscience is a pre-existing condition for the free development of one's identity and personality. International human rights law explicitly recognizes the right to freely develop one's personality.⁶⁵ The right of one group to assert its identity may not infringe on the rights of others; children's right to freely develop their personality may not be infringed upon by indoctrination in any particular view of personality, identity, or sexuality.⁶⁶

It is claimed that the gender identity curriculum is implemented to promote inclusivity and non-discrimination, and to combat bullying of sexual minorities. Those are legitimate goals consistent with human rights law but must not be promoted by prohibited means. It is not possible to prevent discrimination against one group by marginalizing other groups, by teaching stereotypes, by denying material aspects of identity, or by creating direct conflicts with the protections of others. Inclusivity means including everyone, and failure to do so is a deliberate act of discrimination, which can be particularly detrimental to the mental health of children who are still developing their sense of self and forming their self-image. A more appropriate curriculum would teach children about the harm of bullying, and the importance of tolerance and non-discrimination as important civic values. A more appropriate curriculum would be age appropriate and objective.

63 LITTMAN, L. (2021). INDIVIDUALS TREATED FOR GENDER DYSPHORIA WITH MEDICAL AND/OR SURGICAL TRANSITION WHO SUBSEQUENTLY DETransitioned: A SURVEY OF 100 DETransitionERS. *ARCH. SEX. BEHAV.* 50(8), 3353-3369. [HTTPS://DOI.ORG/10.1007/S10508-021-02163-W](https://doi.org/10.1007/s10508-021-02163-w)

64 DAHLAB. LAUTSI [GC].

65 UN GENERAL ASSEMBLY RESOLUTION 53/144, DECLARATION ON THE RIGHT AND RESPONSIBILITY OF INDIVIDUALS, GROUPS AND ORGANS OF SOCIETY TO PROMOTE AND PROTECT UNIVERSALLY RECOGNIZED HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS, A/RES/53/144, DEC. 9, 1998, ART. 18. EUROPEAN CONVENTION ON HUMAN RIGHTS, ART. 8, 1950. AMERICAN DECLARATION OF THE RIGHTS AND DUTIES OF MAN, ART. XXIX, 1948.

66 INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS, ART. 5, 1966. AMERICAN DECLARATION, ART. XXVIII, XXIX. ECHR, ART. 17, 1950. GENERAL ASSEMBLY RESOLUTION 53/144, ART. 17.

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Section Six: Conclusion

The Gender Framework offers a comprehensive perspective on the prevailing discourse surrounding gender issues. It not only addresses issues of gender with respect to the individual, but also how the concept of gender is currently understood at a societal level. This framework is rooted in the belief that sex is a biological reality, that gender is influenced by social norms and that everyone's rights and needs must be considered in impact analyses of policy changes and legislation, and when seeking resolution to conflicts. Our viewpoint is grounded in scientific evidence, respects the rights and experiences of all individuals, and takes a careful, thoughtful and compassionate approach to some difficult and currently unresolved issues.

Accuracy and neutrality are essential in this context. We are careful to ensure that the language in this document is fair, appropriate and accurate, and we have endeavored to carefully reference our work throughout. We recognize the conflicts that can arise when navigating the intricate interplay between privileges, rights, and needs, and we have approached this by recognizing the differences between privileges, rights and needs. Privileges can grant certain individuals or groups advantages or benefits that others do not possess, and this can lead to disparities in access to resources and opportunities. Meanwhile, conflicts of rights can be extremely challenging to resolve, and, in such situations, it has necessitated navigating between competing interests while respecting the dignity and rights of all parties involved. We recognize that rights are not absolute; rather, they exist within a broader framework of societal norms and legal regulations, and this is taken into account within the Gender Framework. Needs may encompass basic necessities such as food, shelter, healthcare, and safety. However, this issue is further complicated when there is no consensus about what is exactly meant by certain needs such as 'healthcare' or 'safety'. Nothing in life is perfect and so we seek reasonable, respectful solutions over perfection. Successfully addressing these multifaceted issues entailed striking a thoughtful balance between recognizing and mitigating privileges, safeguarding individual rights, and fairly addressing fundamental needs to create a more just and inclusive society.

This framework underscores the importance of maintaining a nuanced and evidence-based approach to issues related to sex and gender. It emphasizes that policies and practices must be based on empirical evidence and prioritize the well-being and safety of all individuals. The suggestions provided in our Gender Framework required a commitment to empathy and compromise. We have sought common ground and explored alternative solutions that may not have been initially apparent. Recognizing all individuals' inherent worth and dignity, even when their privileges, rights and needs appear to conflict, is fundamental to building an inclusive and just society. Our goal is not only to resolve conflict but also to strengthen the fabric of society by cultivating a

culture of civilized discourse and respectful disagreement, shared values, and a commitment to upholding the rights and needs of every individual.

The Gender Framework aims to address the complex challenges that have emerged recently within the domain of sex and gender. We hope this endeavor will be met with the good faith that underpinned our approach to writing it.

Section Seven: Glossary and Useful Terms

'AFAB': 'Assigned female at birth.' We suggest using the term 'female' instead.

Affirmative approach: A therapeutic and medical approach arguing that adults and children, no matter what age, should be affirmed in their chosen gender and supported in social and medical transition if desired. The affirmative approach generally sees exploration and differential diagnosis (i.e., seeing gender dysphoria as a symptom of distress rather than its cause) as undesirable.

'Agender': A person who feels themselves to be neither male nor female.

'AMAB': 'Assigned male at birth.' We suggest using the term 'male.'

'Asexual': Someone who is uninterested in sexual activity or is not sexually attracted to others.

Autogynephilia (or AGP): A diagnosable paraphilia listed in the DSM-5, which refers to a male's sexual fixation on the thought of himself as a female. A man who has autogynephilia is termed an 'autogynophile.'

'Cis, Cisgender': A term used to denote people who do not identify as trans. Many people object to this term because it implies a belief in innate gender identity.

'Cis-het': Short for 'cisgender' and 'heterosexual.' Often used derogatorily.

Complex conversion therapy: When the child is encouraged to transition to prevent a future declaration where they come out as gay, lesbian or bisexual.

'Deadname': The process of referring to someone by the birth name with which they no longer identify.

Desistance: The process of reversing a transition that was only social (e.g., by reverting to a birth name). Desistance typically implies that an individual who was once considering or seeking medical transition is no longer doing so.

Detransition: The process of changing a person's gender identification back to his or her biological sex by seeking to cease or reverse an earlier medical transition. Detransition may involve changing presentation, reversing a name change and legal documents, ceasing hormones, and in some cases reversing surgeries such as breast implants (female) or a mastectomy (male).

Developmental approach: A therapeutic and medical approach arguing that many factors (biological, psychological and social) can lead an individual to experience distress around gender.

DSDs: DSDs (differences of sexual development) are more than forty different conditions where sexual development does not rigidly adhere to the typical male or female pathway. DSDs are also known as intersex conditions, and the terms 'VSD' (variation of sexual development) and 'CCSD' (congenital condition of sexual development) are also in use. The proportion of people with DSDs is 0.018%.¹

'Femme boy': Initially this term described a male who is very feminine, but it can now describe a person who has been born a girl, identifies as male and now presents as a feminine boy.

FTM: 'Female to male' can mean either social or medical transition.

Gender: Once used interchangeably with 'sex' to mean male or female. Now denotes a person's social or cultural status as masculine, feminine or something else.

'Gender-affirming': A way of describing gender reassignment procedures. We suggest avoiding this term, as it implies that medical interventions are the only means by which people suffering with gender incongruence or gender dysphoria might address these feelings.

Gender critical: An outlook that believes gender is a social construct and (unlike biology, which is an objective reality) is neither an innate, essential nor deterministic quality.

Gender dysphoria: The distress caused by the discrepancy between one's experienced gender and one's primary or secondary sex characteristics. This is a diagnostic category in the DSM-5.

'Gender identity': An internal sense of one's own gender, which may or may not be at odds with one's biological sex. Make sure not to assume that everyone has a gender identity, as many people do not subscribe to this notion for themselves.

Gender identity disorder: A term that appeared in the DSM-3 and DSM-4 to describe what is now termed 'gender dysphoria'. This term is now disfavored and should only be used to describe diagnoses made before the terminology shift to 'gender dysphoria.'

Gender identity ideology: A belief that everyone has an innate gender identity that may be misaligned with biological sex, and that ought to take precedence over biological sex. Gender identity ideology undergirds such statements as 'transwomen are women,' and is one of the rationales for medical intervention to align one's body with one's felt sense of gender.

Gender incongruence: Where an individual's sex and gender are experienced to be at odds with one another. This is a diagnostic category in the International Classification of Diseases (ICD-11) defined as a marked and persistent discrepancy between an individual's sex and experienced gender.

Gender-questioning: Describes someone who is asking questions about or otherwise exploring his or her own gender identity. We suggest this term be used in lieu of ‘trans’ or ‘transgender’ for young people whose identity is still in a formative stage.

Gender reassignment: Also known as sex reassignment. Refers to any of the hormonal or surgical interventions undertaken as part of medical transition.

Internalized homophobia: The shame or discomfort a gay, lesbian or bisexual person feels about their sexual orientation.

Intersex: An umbrella term for the more than forty different conditions where sexual development does not rigidly adhere to the typical male or female pathway. Given that this word has entered common parlance, we suggest including the term ‘DSD’ in parentheses afterwards, as many people with DSDs find ‘intersex’ to be an ambiguous or contentious label—and vice versa.

LGB: An acronym that unites same-sex-attracted people (i.e., lesbians, gay men and bisexual women and men).

LGBT (or LGBTQ, LGBTI, etc.): An acronym which unites same-sex attracted people (i.e., lesbians, gay men, and bisexual women and men) with transgender people—and, in some iterations, with other groups, such as people with DSDs or “queer” people. We urge caution when using such terms, as many same-sex attracted people—or indeed, people with DSDs—do not consider themselves to be part of this community and prefer to remain distinct.

Medical transition: A range of medical interventions (such as hormones and surgeries) undertaken to present as a different gender.

‘Misgender’: The process of referring to someone using a pronoun that does not correspond to the gender with which they identify.

‘Mis-sex’: The process of referring to someone using a pronoun that does not correspond with their biological sex.

MTF: ‘Male to female’ can refer to medical or social transition.

‘Non-binary’: A gender identity where an individual’s sense of self is neither male nor female.

‘Pansexual’: Attraction towards people regardless of their sex or gender identity.

‘Queer’: Used by some as a general way of describing sexualities or gender identities that are seen as counter normative. ‘Queer’ was used as a slur against same-sex-attracted people for decades, and remains an offensive word to some homosexuals, lesbians and bisexuals. It refers to people who are same-sex-attracted and same-

gender-attracted. Some people consider it to be shorthand for promoting gender identity ideology above the rights of lesbians, gays and bisexuals.

Rapid onset gender dysphoria (ROGD): A description of a relatively new phenomenon whereby adolescents (girls especially) are experiencing starkly elevated rates of gender dysphoria, mediated by peer influence, and with high levels of co-occurring mental health conditions.

Retransition: The term used when a person who has previously detransitioned decides to revert to a trans identity.

Sex: The system by which humans are classified as male or female in utero or at birth, based on reproductive functions and bodily characteristics such as chromosomes and hormones.

'Skoliosexual': Someone attracted to a non-binary or trans person.

Social transition: The process of an individual changing name, asking people to use different pronouns to refer to them, or changing aspects of their appearance (such as clothing or hairstyle) to present as a different gender.

Trans or transgender: An umbrella term for both transgender people and transsexual people that is not related to their sexual orientation. Given the ambiguity of this term, we advise it not to be used to describe young people whose identity is still in a formative period.

'Trans-fem/trans-feminine': A biological man who identifies as feminine.

'Trans kid,' 'trans child': We strongly advise you not to use these terms, as they can concretize a young person's identity while that identity is still in a formative stage. Instead, we suggest saying 'a child who has undergone medical transition' or 'a gender-questioning child,' according to the circumstance.

Transition: The process of changing a person's gender presentation or sex characteristics to accord with their internal sense of gender identity. Transition can be social or medical.

'Transman' (aka a trans-identified woman): A natal female, whether heterosexual, bisexual or same-sex-attracted, who may have undergone medical intervention to appear male or who has adopted a male identity. Some transmen consider themselves to be gay men.

'Trans-masc/trans-masculine': A biological woman who identifies as masculine.

'Transphobia': originally a term to describe people who are prejudiced against the trans community, this has become a catch-all word to describe opposition to issues related to trans rights, such as self-ID or the use of compelled pronouns.

Transsexual (or 'transexual'): A now outdated term that describes individuals who have modified their bodies through hormones or surgery to present as a member of the opposite sex.

'Transwoman' (aka a trans-identified man): A natal male, whether heterosexual, bisexual or same-sex-attracted, who may have undergone medical intervention to appear female or who has adopted a female identity. Some transwomen consider themselves lesbians

Section Eight: Appendix

8.1 Model School Policy – Comprehensive Gender Identity Policy USA

8.1.1 Purpose

The purpose of this policy is to: 1. establish expectations for how schools can best support students with gender dysphoria, who are gender-questioning, who are gender non-conforming, or who identify as transgender, 2. establish expectations to ensure parents are informed about their child’s gender-related concerns and participate in any decisions about how best to support their child in school; and 3. to set expectations of the school as a whole on how to responsibly respond to situations in which a child requests gender related accommodations.

8.1.2 Definitions

Gender dysphoria: For the purposes of this policy, we define gender dysphoria as the distress that accompanies the persistent desire to become the opposite sex (or another non-traditional gender). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) requires that this distress lasts for at least six months in order to receive a formal diagnosis of gender dysphoria.

Child onset gender dysphoria: This is, historically, the most common type, with 75% of transgender males and 72% of transgender females first experiencing gender-related distress by age 7; and over 80% of both males and females reporting that experiencing this distress was one of their earliest childhood memories.¹ Research has shown that for the vast majority (70-98%, depending on the study and severity of dysphoria) of children with child-onset gender dysphoria, their dysphoria resolves naturally during puberty or early adulthood.²⁻⁴ This presentation is highly correlated with later homosexuality or bisexuality.³

Late onset gender dysphoria: This presents in adolescents and adults and is related to transvestic disorders with autogynephilia. This is seen almost exclusively in non-homosexual, and men who were gender conforming as children.⁵⁻⁷

Gender dysphoria associated with disorders of sex development: This presents in people with rare intersex conditions (prevalence 0.018%) where chromosomal sex does not match biological sex characteristics.⁸ Not all people with disorders of sexual development have gender dysphoria, but a small percentage do. A recent systematic review and meta-analysis found a 15% prevalence rate of gender dysphoria in those with a disorder of sexual development.⁹

Rapid onset gender dysphoria (ROGD): This term describes the relatively recent phenomenon, typically but not always involving adolescent females, who suddenly

develop an interest in transitioning despite no history of childhood gender dysphoria. There is often a history of gender expression that aligns with their biological sex. Dr. Lisa Littman, a physician and researcher with expertise in public health, coined the term rapid-onset gender dysphoria in her seminal paper after surveying parents of trans-identified adolescents who described that the onset of their children's gender dysphoria occurred in the context of belonging to a peer group where one, multiple, or even all of a child's friend group became gender dysphoric and transgender-identified during the same timeframe; and an increased use of social media/internet prior to disclosure of a transgender identity. This is not currently a clinically accepted diagnosis, and the idea of rapid onset gender dysphoria spreading as a social contagion is an area of active research and debate.¹⁰⁻¹¹

Gametes: Gametes are mature reproductive cells. There are two types of human gametes: sperm, which are produced by males, and eggs, which are produced by females.¹²

Biological sex: A person's biological sex is nearly always discernible by the gametes they produce or have the potential to produce. A person who produces sperm is male. A person who produces eggs is female. Before puberty, humans do not produce gametes, so biological sex is determined at birth by the presence of male or female anatomy due to the very high probability that the vast majority will eventually produce the gametes corresponding to their anatomy seen at birth. There are exceptions to this general rule for intersex children, which are described below. A person's biological sex does not change if their reproductive organs are not functional, are removed, or they choose not to procreate. Biological sex as determined by gametes is binary; there are no gametes "in between" sperm and eggs. There are only two types.¹³

Chromosomes: A structure found inside the nucleus of a cell that is made up of proteins and DNA organized into genes. Human body cells (somatic) contain 23 pairs of chromosomes, one set from each parent. Our gametes, however, have only one set of chromosomes. All eggs have an X chromosome. Each sperm carries either an X or Y chromosome. When an egg is fertilized (zygote), the egg's X chromosome is combined with either an X or Y chromosome from the sperm, resulting in somatic cells that are either XY (male) or XX (female). People with intersex conditions sometimes have a different set of sex chromosomes.¹⁴

Intersex: An umbrella term for the >40 different conditions where sexual development does not rigidly adhere to the typical male or female pathway, including, for example, Klinefelter Syndrome, Androgen Insensitivity Syndrome, and Congenital Adrenal Hyperplasia. These are rare conditions seen in approximately 0.018% of the population, where a person who has reproductive or sexual anatomy that would be considered atypical because it does not fit the standard appearance of male or female, such as

someone who has both a vulva and testicular tissue.⁸ A person who is intersex will typically only produce a single type of gamete or be infertile.

Gender identity: A theoretical concept introduced in the 1960's¹⁵ where a person's internal sense of their own gender can include being female, male, and more recently another gender or no gender.¹⁶ One's gender identity can be the same or different than their biological sex. It is believed that gender identity is less established in younger children, and typically becomes stable after a child undergoes puberty, though some adults experience gender fluidity throughout their lifetime.¹⁷ The general process of identity formation typically happens during adolescence and early adulthood. There is ongoing debate about how many gender identities there are, with some people believing there are only two, others saying as many as 112, and others saying there are as many gender identities as there are people in the world.¹⁸ Some people do not have an internal sense of a gender identity and, therefore, do not ascribe to this notion for themselves.¹⁹

Gender fluid: Gender fluidity refers to changes over time in a person's gender expression or gender identity, or both.

Gender expression: The way a person represents or expresses gender to others, often through behavior, clothing, hairstyles, activities, voice, or mannerisms.

Sex constancy: The endpoint in the developmental process in which a child understands that biological sex is fixed, and that clothing and other contextual factors do not change one's biological sex.²⁰ Research indicates that a more stable schema of sex begins at age 5, with sex constancy being achieved by the age of 7 for most children.²¹ Sex constancy delays have been observed in children with gender dysphoria²² and Autism Spectrum Disorder.²³

Cisgender: An adjective describing a person whose gender identity or expression is the same as that traditionally associated with their biological sex. Some people find this an offensive term.

Transgender: An adjective describing a person whose gender identity or expression is different from that traditionally associated with their biological sex. A person who is transgender may or may not have gender dysphoria.

Transition: The process in which a person goes from living and identifying as one gender to living and identifying as another. Transition is a process that is different for everyone, and it may or may not involve social, legal, or physical changes. There is no one step or set of steps that an individual must undergo to have their gender identity affirmed and respected. Social and physical transition are considered major therapeutic and medical interventions that require parental involvement and professional oversight by clinicians responsible for the individual's treatment plan.

Desistance: The process of reversing a social transition (e.g., by reverting to an earlier name) and reidentifying as their *birth-assigned sex*, thus individuals who were once seeking medical transition are no longer doing so.

Detransition: The process of seeking to change a person's gender presentation back to his or her biological sex, by terminating the use of hormones or puberty blockers, often seeking to reverse earlier medical transition. This process typically involves significant social, legal, or physical changes and often requires medical professional and therapeutic support.

Social transition: The process in which a person takes on a new name, changes their appearance (hairstyle, clothing, makeup, and other non-medical changes) and uses preferred pronouns (such as opposite sex pronouns or non-binary pronouns such as "they"). Schools may participate in a child's social transition by using preferred names and pronouns or by allowing the student to use different facilities. This is a powerful psychosocial intervention that requires considerable therapeutic support.

Comorbidities: A medical term that refers to having more than one mental or physical condition at the same time, which in some cases may be related to each other. A person who has diabetes may also have depression, for example, and it is possible that their diabetes may or may not play a role in their depression.

Primary sex characteristics: These are features that are typically present at birth that indicate a person's biological sex, such as a penis or vagina. These are clearly formed in the majority of cases, with the rare exception of people with intersex characteristics.

Secondary sex characteristics: These are features of males and females that develop during puberty, such as facial hair for males, breasts for women, and pubic hair for both sexes.

Tanner stages: These stages, also known as sexual maturity ratings, describe the physical changes occurring during puberty. There are five stages, starting with stage 1, which typically begins after age 8 in females and after age 9 in males, with stage 5 beginning around age 15 for both biological sexes.²⁴

Puberty blockers: These are drugs taken to suppress puberty. They may be given starting at Tanner stage 2 or beyond. Under the "gender affirmation" model, it is thought that such suppression would give a child time to consider their gender identity before developing secondary sex characteristics. However, 98% of children who take puberty blockers move on to cross-sex hormones and it is considered by many as the first step of a medical transition.²⁵

Cross-sex hormones: These are synthetic estrogen or testosterone prescribed by physicians to people who suffer from gender dysphoria and want to develop the secondary sex characteristics associated with the opposite sex to their biological sex.

Medical transition: A process in which a person takes cross-sex hormones to masculinize or feminize their body or undergoes surgical procedures to appear more masculine or feminine by removing tissue/organs or constructing facsimiles of opposite sex organs.

Gender affirmative therapy: A therapeutic or medical treatment afforded an individual based on their gender identity. For children it is sometimes called “early transitioning.” This approach to therapy is considered child-led, where adults affirm the child’s internal sense of identity, and therapists act as facilitators to support the child’s choice to identify as a gender different from their biological sex. Social transition is often offered in this approach. This may or may not be followed by a medical transition. This is a new model of treatment that has been used for the last ten years with the adoption of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), 7th edition, however it has gained traction quickly and is widespread in the U.S. Several European countries have moved away from childhood self-diagnosis and social and medical transition and now require extensive psychological evaluation before considering social or medical transitions.²⁶⁻²⁸

Psychotherapeutic approach: This approach offers conventional psychotherapy and allows children to explore their gender while being open to the possibility that they may grow comfortable in their biological sex. Approaches called “wait and see,” “watchful waiting,” “developmental” or “gender exploratory therapy” fall under this umbrella. The psychotherapist's approach may depend on their training—some are psychoanalytical, others are cognitive behavioral therapists, while more still are person-centered therapists. No matter what their training, psychotherapy offers a neutral, open-ended approach with a professional clinician seeking to understand factors relevant to the child’s development, including trauma, psychopathy, neurodevelopmental conditions, and other life factors that may be causing a child to see transition as a preferred path. The child may or may not eventually decide to socially transition or medically transition. This approach seeks to destigmatize both gender dysphoria and transgenderism, and supports cisgender, transgender, homosexual, heterosexual and asexual identities as valid outcomes. It does not steer a child toward any particular outcome. This approach to mental distress has been used and refined for over a century. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) recently published a position statement acknowledging the growing numbers of gender dysphoric youth. The College advocates for a developmental approach, considering personal and family history, comorbidities, and the context in which the dysphoria emerged.²⁹

Conversion therapy: An outdated and barbaric practice that was offered decades ago, but thankfully, no accrediting body in the world recommends conversion therapy any longer. Ethical therapists will never try to convert an individual and we also strongly condemn this practice.

World Professional Association for Transgender Health (WPATH): An international professional and lobbying organization working to further the understanding and treatment of gender dysphoria and those identifying as transgender.³⁰

8.1.3 Policy statement

This policy is intended to provide parents of children experiencing gender dysphoria with both information and options for working with the school to support their child at school. The underlying principles of this policy are as follows:

- **Transparency** – The parents of a child experiencing gender dysphoria, or who expresses concerns about their gender shall be informed when school staff become aware of the child’s gender-related distress.
- **Medical/psychological evidence and ethics** – Gender dysphoria can present in different ways, at different ages, and with different causes. The school will not pursue a “one size fits all” approach in which any child presenting with gender distress is automatically socially transitioned. The school will work within an ethical framework in which students are matched with a therapeutic approach that is appropriate for their particular presentation and age based on the best available scientific research. Such decisions will be undertaken in collaboration with parents, and where appropriate with other area experts.
- **Supportive neutrality** – Schools can best respect their students’ search for meaning and personal identity by creating space for uncertainty and exploration and remaining supportively neutral as to outcome or direction. The school considers variations in student interests and expression as normal and natural, not as signs that a student is necessarily transgender. The school will provide the same provisions for students seeking transition and detransition.
- **Informed consent** – Parents shall have the right to play a determinate role in defining the school’s approach to their child’s needs. They have a right to be informed about their options prior to granting consent to the approach the school uses to support their child at school, subject to the conditions and limitations of parental rights outlined in section 5 (8.1.5).
- **Non-stigmatization** – The school shall offer a non-judgmental environment for students with gender dysphoria, making every effort to de-stigmatize it, show acceptance and comfort in dealing with gender issues, and create a safe environment for students.
- **Privacy** – The school shall not disclose a child’s gender dysphoria to anyone other than the school staff who reasonably need to know to support the child, and to the child’s parents or guardians.

8.1.4 Gender dysphoria information pack

The school counseling department should produce an information pack for parents that explains gender dysphoria and treatment options based on the best available scientific evidence in layperson’s terms. This pack should be reviewed at least once annually to

ensure it reflects the best available research. This pack should be freely available in printed form and made available to all parents who request it and be available to the public on the school website.

8.1.5 Parental rights and the school's rights

The school recognizes and respects that parents know their child's history and may have different interpretations than that of clinicians, the school respects the parents' beliefs and value systems, and the school recognizes that parents and educators may receive different recommendations from mental and medical health professionals that may lead them to choose different approaches to support their child in school. The school shall support parents' right to choose affirmative therapy, conventional psychotherapy, or another approach as recommended by the child's mental health provider or medical doctor. At a parent's/guardian's request and with their written approval, the school may implement another approach when a child is participating in a clinical trial studying this approach. The school reserves the right to refuse to implement approaches that attempt to steer a child toward a particular gender identity through disciplinary or coercive means. In general, it is inappropriate for the school to act against parents' wishes unless the school has serious concerns about parents' fitness to support their child's wellbeing, which has been adjudicated via formal channels, such as Child Protective Services.

8.1.6 Scientific findings, history, and debates

At the time of writing, the scientific understanding of gender dysphoria, especially adolescent-onset gender dysphoria, is not settled. The school recognizes that this information may change and will update this section as scientific research continues to emerge.

8.1.6.1 Prevalence

From 2017-2022, the number of youth who identify as transgender in the United States has doubled, with youth between the ages of 13-17 identifying at a rate of 1.4%, all adults identifying at a rate of 0.5%, and adults aged 65 or older identifying at a rate of 0.3%.³¹ Historically, gender dysphoria was found in 0.01% of the United States population (mostly boys), and prior to 2012, there was little to no scientific literature about girls aged 11 to 21 having ever developed gender dysphoria.^{10,32} Currently, most gender dysphoric youth are female at a ratio of approximately 2:1.³³⁻³⁵ There is currently no consensus regarding the cause for the recent rapid rise in gender dysphoria, or why females are now experiencing it at a much higher rate than males. These phenomena have been observed in other Western countries as well.³⁶ Some have proposed that greater social acceptance has enabled more people to self-identify and regard this as a healthy development, while others have proposed that normal bodily discomfort accompanying puberty and identity development or other undiagnosed clinical conditions (such as personality disorders, autism) are leading impressionable children to be influenced by peers, the internet, and activists to inaccurately conclude they are

transgender. Some have also theorized that the phenomenon is medically mediated; that is the medical and therapeutic community's response and validation of gender dysphoria and trans-identification with treatment itself, may mediate the rapid increase.³⁷ The relative contributions of each of these proposed causes, or the existence of other possible causes is not well understood or agreed upon.

8.1.6.2 Persistence and desistance

Across all 12 long-term studies ever done on gender dysphoria, nearly 70% of children desist by the end of puberty, with a range of desistance from 61-98%.^{38-41,3} Even children with severe gender dysphoria can experience desistance.¹³ While most children's gender dysphoria resolves during puberty, some children experience increased feelings of dysphoria as they undergo puberty.³⁹ Currently, there is no accurate method to detect who will persist or who will desist.

8.1.6.3 Identity outcomes

For those with childhood-onset gender dysphoria, in 2.5%-20% of cases their gender dysphoria is the initial manifestation of transgenderism and they will ultimately identify as transgender as adults.⁴² After undergoing puberty, for 61-98% of these children, their gender dysphoria will resolve, with most identifying as homosexual or bisexual.^{3,43,44} No long-term data is available for the newer cohort characterized as rapid onset gender dysphoria, for whom gender dysphoria emerged post puberty.

8.1.6.4 Biological sex v. gender spectrum

Historically, science has accepted that there are only two biological, dichotomous sexes as determined by reproductive organs designed to produce one of two gametes. Some scientists have proposed a taxonomy that presents sex as a spectrum, based on various intersex conditions.⁴⁵ This interpretation has been adopted in government policy in Switzerland.⁴⁶ Critics, however, regard sex being on a spectrum as simply defining a range of atypical sexual anatomy and do not believe it establishes the existence of a third or more biological genders. Regarding gender identity, some evidence suggests that the brains of people with a transgender identity have shifts in the dimorphic parts of their brains that are more consistent with their gender identity rather than their biological sex. It has been suggested that this may be related to in utero testosterone levels.^{13,47} Given that these same brain correlates have been found for homosexuals, and that none of the studies on the brains of transgender individuals controlled for sexual orientation, it is highly likely that this shift reflects homosexuality not gender identity.⁴⁸⁻⁵⁰ Other confounding factors in various studies, such as neuroplasticity due to living as the opposite gender (in post mortem studies) and changes due to cross-sex hormone use are also not controlled for.⁵¹ Twin studies show that only 28% of twin pairs will have both twins develop a transgender identity, suggesting that genetic influence exists but is not determinative of identity outcomes.⁴⁷

8.1.6.5 Terminology and identity

With regard to terminology, newer terms such as “agender”, “genderqueer”, “non-binary”, “pangender”, “quadgender”, “gender-neutral”, “genderfree”, “neutrois”, “demigirl”, “demiboy”, “feminine-of-center”, “masculine-of-center”, “girlflux”, “boyflux”, “paragirl”, “paraboy”, “librefeminine”, “libremasculine”, “FTX”, “MTX”, and “genderfluid”, are just a few examples of ways in which some people describe their gender identity. Most parents are familiar with a limited set of descriptions, such as “girly girl,” “manly man,” “effeminate” (which some consider offensive), “transsexual” (usually considered an outdated term) or “tomboy”. With these newer, more highly differentiated labels only recently being added to the vocabulary of gender identity, scientists have not yet conducted studies to determine if these identities correspond to finer-grained differences in the brain, genetics, or other biological structures or processes. Even if such evidence is not discovered, this does not mean that using the older or newer terminology to describe one’s internal personal experience is invalid. Additionally, there is a well-documented overlap of 30% between masculine and feminine traits in both sexes, and whether or not a person conceptualizes themselves as transgender is subject to cultural and environmental factors.⁵² It is also important to recognize that some children ruminate a lot about their gender identity in fine-grained detail (such as wondering if they are a demiboy or masculine-of-center), and that excessive focus on one’s self seldom improves mental health outcomes.⁵³

8.1.6.6 Considering comorbidity

In the studies done in The Netherlands under the “Dutch protocol,” gender questioning youth were screened for comorbidities before undergoing medical treatment and strongly discouraged from socially transitioning prior to treatment. This contrasts with the current affirmative-only approach that allows for social transitioning without proper screening. Adolescents with gender dysphoria are more likely than the general population to experience mental health issues, with 40-45% presenting with clinically significant psychopathology compared to roughly 20% of the general population.^{39,54} There are multiple documented cases of individuals who socially and medically transitioned in order to relieve their gender dysphoria, but came to understand that other mental health issues caused their dysphoria.^{11,32,55} One study found that 61% of patients presenting with gender dysphoria have another psychiatric condition, and in 75% of these patients, gender dysphoria was a symptom of another mental illness.⁵⁶ An internationally recognized expert who was instrumental in defining gender dysphoria for the DSM-5 and helped write WPATH’s SOC 7th edition has stated that just because a person is fixated on gender as a source of their problems does not mean that transitioning will alleviate their distress. This scholar, who has sometimes advised his patients to transition, recommends that clinicians examine the entire person rather than immediately accepting someone’s self-diagnosis of being transgender.³² It is notable that WPATH’s SOC 8th edition does not require a diagnosis or assessment, stating that “health care professionals should not make it mandatory for transgender and gender

diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment.”⁵⁷

8.1.6.7 Suicide risk

Suicide risk is often mentioned in discussing the mental health of those identifying as transgender and is often used to justify the affirmation model. One of the most cited statistics, based on the National Transgender Discrimination Survey (NTDS) of adults, reported that as many as 41% of transgender adults have attempted suicide in their lifetime.⁵⁸ Similar increased risk of suicidality via surveys has been found in transgender youth.⁵⁹ While these and other statistics of suicidality are most concerning, they must be considered with caution. It has been pointed out, for example, that many studies of suicidality in this population may not be accurate population estimates because they rely on samples of convenience. Further, such surveys cannot discern whether the suicidality can be attributed to gender dysphoria or other mental health comorbidities common in this population.¹³ Comorbidities are important to consider as these, too, are associated with increased risk of suicidality.^{27, 60} A recent study using a large data set of youth seeking treatment at the Gender Identity Development Service at the Tavistock and Portman Foundation, found that the rate of completed suicide was 0.03%, 5.5 times greater than the suicide rate of adolescents of similar age.⁶¹ Suicide risk, therefore, requires judicious consideration.

8.1.6.8 Ethical decision-making

Several areas need to be considered to be able to make sound, ethical decisions for youth with gender dysphoria. Because social transition is a major psychological intervention, the ethical responsibilities of teachers and school administrators must be informed by the following considerations:

- **Online influencers:** There are documented cases where adolescents were influenced by online transgender influencers to transition so they would not end up killing themselves.³² The advice these influencers give included statements such as, “If you’re asking the question ‘Am I trans,’ the answer is probably yes” and “[Y]ou don’t need to be a hundred percent sure you’re trans to try hormones”, both of which are inaccurate and unethical.³² Some influencers coach children to answer clinicians’ questions with fabricated stories about their gender dysphoria in order to obtain puberty blockers or cross-sex hormones.³² Some online influencers encourage children whose parents doubt the clinical appropriateness of transition to establish a “glitter family” of online contacts who “truly understand them” and who will support the child’s choices.³² Aaron Kimberly, who transitioned from female to male as a young adult and has an intersex condition, has also been outspoken in his opposition to current trends in transgender care, stating that students are “picking up a culture, not evidence-based clinical information”.⁶² Researchers have also found that social media platforms, that push content using algorithms based on viewing history, are

associated with negative mental health outcomes for adolescents, particularly adolescent girls.⁶³ It is important to note that none of this means that transgender identities, in general, should be regarded as invalid or suspect, only that parents and school staff need to be aware that in many cases, children's interest in transitioning could be influenced by inaccurate information from social media or other sources.

- **Therapists:** The issue of informed consent in the context of youth gender transition has received considerable attention considering the low and very low-quality evidence supporting the affirmative care approach. Some affirming therapists sometimes tell parents that their choice is between “having a dead daughter or a live son” (for transgender males) or “having a dead son or a live daughter” (for transgender females). The ethics of such practices are questionable, given the complex evidence around suicidality and co-morbidities. Notably, under these conditions, consent to treatment is done under duress and cannot be considered informed. These professional debates have led mental health professionals to question affirmative practices without extensive psychotherapeutic assessment and support. The recommendations of the Interim CASS Review²⁷ and the Gender Exploratory Therapy Association specifically recommend traditional psychotherapy instead of affirmative-only therapy.⁶⁴
- **Schools:** Aside from pregnancy and time-sensitive emergencies, medical ethics for life-altering treatments for minors require that parents be aware of the child's condition and be provided with accurate and balanced information prior to obtaining informed consent to pursue treatment. Some school systems have made it their policy not to inform parents of their child's gender-related concerns and implement social transition without the knowledge or consent of parents. Litigation in such circumstances is emerging as school districts navigate these challenges.⁶⁵ Social transition is increasingly understood to be a major clinical intervention that should not be undertaken without the oversight of clinical professionals and parental consent/involvement.²⁷ Further, for young children, the literature on gender constancy should be consulted in considering social transition as the act of social transition may impede the development of sex constancy.⁶⁶ Schools engaging in social transition must be cognizant of the fact that they are embarking on a powerful psychosocial intervention they are not qualified to engage in. The mental and physical health risks, informed consent, and long-term implications of social transition require partnership and collaboration between families, treating clinicians and educators of any individual student with gender dysphoria.
- **Gillick competence:** The issue of whether children can be “Gillick competent,” a legal standard in the United Kingdom for minors to be able to consent to medical treatment without parental permission, has informed ethical debates in America.⁶⁷ After several rounds in the British courts both affirming and denying

Gillick consent for puberty blockers, the courts ruled that children under 16 could not meet this standard. Additionally, the UK shut down its Tavistock NHS Foundation Trust gender clinic amid long waiting lists, inadequate data collection, and ethical concerns about staff feeling pressured to only use the affirmative approach.⁶⁸

- **Internalized homophobia:** Sexual orientation conflicts, often associated with shame, are a central dynamic for many young people with gender dysphoria.⁶⁴ In some cases, transgender identification may be a strategy to address issues described as manifestations of internalized homophobia.¹¹ A psychotherapeutic process can help illuminate whether transgender identification is an important developmental attainment or whether gender is being recruited to solve other difficulties. The Gender Exploratory Therapy Association provides a guide to clinicians for exploring this with clients.⁶⁴
- **Positive medical outcomes:** Numerous clinical experts and activists have expressed concerns about the current rush to medical transition in today's clinical practice.^{69,70} However, in some cases medically transitioning is the most appropriate treatment for transgender adults.
- **Bullying:** Bullying is never acceptable for any reason, including for students who are gender-questioning or have a transgender identity. Schools must be cognizant of the fact that peer pressure can work in two directions—both influencing students to identify as transgender and also influencing them to not identify as transgender—and that staff should not underestimate this influence or assume it is always in one direction. Staff should also be aware that some students who socially transition desist and reidentify with their *birth-assigned* sex. These individuals are at considerable risk of bullying. Studies have noted that *trans-identified children* are as likely to be perpetrators as they are to be targets of bullying.⁷¹
- **Summary of ethical concerns:** The questionable advice of internet influencers and peers, the positive reinforcement of “glitter families,” and some schools covertly supporting transitioning, can create a situation in which children can become alienated from their families at a point in their lives where they need even more support. Parents should be aware that there are significant ethical and scientific questions regarding the quality of information parents and students are provided (or not provided), the lack of long-term scientific studies supporting social or medical transitioning, and minors' competence to make decisions about their own care.

8.1.6.9 Legal status

Schools must align with the laws of their state. To fall within the protection of the Equal Protection Clause, a protected personal attribute (such as biological sex) must be “immutable.” Changeable attributes such as hair color are not protected. Transgender rights advocates usually claim gender identity is immutable, which would have the

desired legal effect of falling within the Equal Protection Clause.³² The fact that gender identity is known to be flexible in children⁴¹, the existence of detransitioners and desisters^{11,55,72}, and the existence of adults who experience gender fluidity⁵⁵, calls into question whether gender identity is immutable. Whether or not gender identity is immutable, it is considered protected under Title VII of the Civil Rights Act of 1964, though this has been subject to multiple ongoing court challenges.⁷³

8.1.6.10 Considerations for socially transitioning

Some studies find that children who socially transition experience relief from gender dysphoria and a reduction in suicidal ideation⁷⁴. Others have found that gender transition does little, if anything, to relieve gender dysphoria, suicidality and mental health comorbidities, or improve life-functioning.⁷⁵ Further, there is speculation that “gender-affirming treatments” may be highly subject to the placebo effect⁷⁶, which is consistent with detransitioner accounts that they initially experienced euphoria, only to return to a dysphoric state later.^{55,72,77} Social transition is reversible in the sense that it involves temporary cosmetic and name changes, but the long term psychological effects of social transition or desisting are not known.^{78,79} It is important to consider that social transition is likely to impede the natural resolution of gender dysphoria as it is associated with higher persistence rates; some have argued it is iatrogenic leading to medical transition.⁸⁰⁻⁸² Further, once a child has made the transition public, reverting back may be embarrassing and cause considerable stress and anxiety, making hormonal and surgical interventions more likely.^{13,80} In some cases children will want to change schools to assume their new identity or return to their old identity more easily. For biological females, socially transitioning can involve binding their breasts, which poses considerable risks such as back, shoulder, chest and abdominal pain, rib and spine changes, shortness of breath and lightheadedness, and skin infections.⁸³ Tucking (for males) lacks long term studies but studies suggest that this can impact fertility by causing cryptozoospermia and testicular torsion.^{84,85} Schools affirming a student’s gender identity or publicly celebrating a transgender student’s courage are not neutral actions and can unintentionally influence students’ identity formation.^{81,86} There is currently no validated method to determine the likelihood of whether a person will or will not desist prior to socially transitioning.

8.1.6.11 Considerations for medically transitioning

Puberty blockers, which are used “off label” for the treatment of gender dysphoria are commonly prescribed at Tanner Stage 2. Once thought of as a harmless “pause button,” this is no longer the case. A recent study shows that in 98% of cases, children put on puberty blockers move onto cross-sex hormones.⁸⁷ The long-term physical and psychological effects of taking puberty blockers and delaying puberty are not fully understood.⁸⁸ Taking puberty blockers will delay brain development that typically occurs during puberty, a time in which significant brain development occurs, potentially impacting cognitive development.⁸⁹ There is also evidence that puberty blockers may negatively impact bone density and cause bone and skeletal issues.⁹⁰ The impact of

puberty blockers on sexual development and anorgasmia in adulthood is also of concern.⁹¹ Some research has found an association between puberty blockers, depression and other psychological issues. Discussing an experimental trial of puberty blockers in the UK, one scholar wrote, “There was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on [puberty blockers] children reported greater self-harm, and that girls experienced more behavioral and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria.”²⁵ If a person has not undergone puberty before taking cross-sex hormones, they will be permanently infertile. For biological males, who have taken puberty blockers to halt puberty, medically transitioning to female via vaginoplasty may prove challenging since there may not be enough tissue available to perform the operation.⁹² Cross-sex hormones result in irreversible secondary sex characteristics. Surgical procedures, including facial reconstruction, double mastectomy, breast construction, gonadectomy, and phalloplasty, involve risks in terms of undesirable health outcomes (infertility, infection, scarring, loss of sensation, and sepsis) and may result in less-than-desired cosmetic outcomes. Maintaining a cross-sex appearance requires lifelong hormonal treatment, which carries risks including hypertension, vaginal atrophy, higher cancer risk, stroke, liver damage, and bone mineral loss.⁹³ Since the affirmation model is relatively new, long-term research is needed to understand the full effects. Some people who medically transition have regret and detransition, while others are satisfied with the result. Approximately 25-35% of transgender people pursue medical transitioning of some sort.⁹⁴ There is currently no validated method to determine the likelihood of whether a person will or will not desist prior to medically transitioning, or who may regret medically transitioning. In sum, there are serious risks associated with medically transitioning. Despite its risks, most experts agree that medically transitioning is the most appropriate treatment in some cases.

8.1.6.12 Detransition evidence

There is currently limited data on the reasons people choose to detransition. One study found that trauma (including sexual trauma), difficulty accepting oneself as homosexual, dysphoria rooted in misogyny, peer influence, and social media and online communities influenced their development of a transgender identification and desire to transition. Some reported health concerns and found alternative methods to deal with their dysphoria. External factors such as a lack of support, financial concerns, and discrimination also occurred, but were much less common. This study found that only around 24% of people who detransition report their detransition to the doctor who facilitated their transition.¹¹ The rates of desistence and detransition have not been reliably established. One study of youth in the UK indicates that it may be as high as 10.3% within 12 months of seeking treatment.⁹⁵ A study of adolescents and adults

found that as many as 30% discontinue gender-affirming hormonal treatment within four years.⁹⁶

8.1.6.13 Standards of Care

The use of puberty blockers and cross-sex hormones for gender transitioning is considered an off-label use and has not been evaluated by the U.S. Food and Drug Administration to determine long term outcomes. In terms of therapy, the traditional psychotherapeutic approach is the most consistent with scientific evidence and was regarded as the standard of care up until roughly 2010, when countries began adopting a gender affirmative approach.¹³ Long term studies do not support the gender affirmative approach.²

Most American medical and psychological organizations have adopted the Standards of Care issued by WPATH, an organization that some professionals no longer consider credible. It is worth noting that despite its title, WPATH states the document aims to provide “clinical guidance,” and is not a Standards of Care,⁵⁷ since it does not meet the level of scientific rigor to qualify as a standards of care document. Genspect offers a different approach for the treatment of youth and young adults with gender distress and welcomes diversity of expression and self-acceptance free from medicalization.

In 2006, the 6th edition of WPATH Standards of Care set standards for medical transitioning, including requiring patients to live in their gender identity for a year, and obtaining a referral from a psychologist before obtaining surgical interventions. In 2012, the 7th edition of the WPATH Standards of Care removed the one-year requirement and recommended psychotherapy prior to transition but no longer required it.⁹⁷

The 8th edition of the WPATH Standards of Care removed any requirements to obtain a diagnosis of gender dysphoria, and no longer includes minimum age requirements for medical treatment with the exception of phalloplasty.⁵⁷ Notably, this latest edition also removed the chapter on ethics and added a chapter on eunuchs; those who “wish for a body that is compatible with their eunuch identity—a body that does not have fully functional male genitalia.” Instead of “first, do no harm” WPATH now supports the idea that a healthy male may be castrated so his body aligns with his internally felt identity that he is a neuter. Medical professionals have criticized these changes in the Standards of Care for not providing sufficient safeguards to ensure patients will be appropriately assessed to ensure they receive the appropriate treatments.⁹⁸ A petition has been started documenting the concerns shared by clinicians internationally.⁹⁹ Those in favor of the standards argue that these changes eliminate “medical gatekeeping” that could prevent transgender people from getting the care they need.

8.1.7 Procedures

The school staff shall take the following steps to support students experiencing gender dysphoria:

- School staff shall notify parents if a student states that they are transgender, questions their gender, or behaves in a manner consistent with the characteristics of gender dysphoria defined in Section 8.1.2. Staff are not expected to make a formal clinical diagnosis, only to inform parents if their child has gender-related concerns. Staff do not need to wait for six months to fulfill the DSM-TR-5 definition of gender dysphoria since a child's statements or behavior at school could mark the beginning of a six-month period in which this definition is fulfilled. The intent of this policy is to keep parents informed as early as possible so they can decide how to best support their child.
- Being homosexual or having interests or personality traits that are not traditionally associated with a student's biological sex are not indications of gender dysphoria or being transgender and should not be reported as such.
- School staff shall meet in person with the child's parents to share their reasons for believing the child has gender identity concerns and shall share the Gender Dysphoria Information packet described in Section 4 (8.1.4) that explains gender dysphoria in layperson's terms.
- The school and parents/guardians shall mutually agree on a plan to support the child, if needed. In the event of differences of opinion about the best approach, parents' approach will be determinant over the plan, subject to the conditions in Section 5 (8.1.5). The plan shall be written with a copy provided to the parents and a copy kept on file at the school.
- The school and parents will continue to keep each other informed as to the child's academic performance and mental health status. Either party may request additional meetings to adjust the plan at any time. Parents have the right to change or terminate the plan at any time, subject to the conditions in Section 5 (8.1.5).

8.1.8 Parent communication and triangulation

The school recognizes that young people can use triangulation as a communicative strategy. Triangulation occurs when a third party (the school) is used either as a substitute for direct communication with the subject of the communication (in this case, the parents), or used as a messenger to carry the communication. In this case, it expresses implicit dissatisfaction with the parents. The goal of triangulation is to divide, which often happens through the use of exclusion or manipulation of a situation. The school staff need to be aware of triangulation and endeavor to avoid allowing triangulation to occur between the student, parents, and school body. The school shall not exclude parents from decisions or information exchange unless this takes place within a formal structure and involves social services. The school shall not act against the parents' will unless there are adjudicated concerns about the fitness of the parents involving formal proceedings with Child Protective Services.

8.1.9 Student safety and secrecy from families

The school shall not encourage children to keep secrets from their families unless there is serious justification to do so. If there is good reason to believe that any student will become unsafe if their parents are made aware of their gender dysphoria or transgender identity, the school shall immediately follow the appropriate protocol, including contacting Child Protective Services. Unless otherwise warranted, the school shall assume the family unit is a safe and nurturing place. If parents have previously shown themselves to be reasonable, loving and engaged, the school should collaborate as far as possible with the family, and nurture healthy communication between students and parents.

The school recognizes that, historically, schoolteachers may have kept a student's secret because of a fear of serious repercussions from their family. The school acknowledges that there is a significant difference between a conversation that is kept in confidence between a student and school staff, and an open secret kept by the school staff and the entire school community. The latter can be humiliating for the parents and damaging to the family's wellbeing and ultimately the child. In some cases, families could end up being the last to know, even though the entire school community was fully aware of the child's social transition. The school should avoid creating these situations.

The school acknowledges that needlessly keeping secrets from parents can inadvertently cause divisions between the school body and the parents, and damage the parent-child relationship, leading to triangulation and even alienation. A child may end up changing clothing, names, and pronouns halfway between home and the school in order to live a "double life." The school is mindful of how distressing and potentially damaging this could be for everyone, including the child. The school shall help parents who feel distressed by their child's gender dysphoria by giving them information about family support groups. The school shall aim to uphold the integrity of the family unit to ensure the student's long-term mental and physical health.

8.1.10 Social transition

The school acknowledges that social transition is a powerful psychosocial intervention that should not be pursued before a student obtains a psychological evaluation from a qualified mental health professional, and that ongoing clinical assessment and support must be provided. It is important to recognize that schools agreeing to change a child's name and pronouns is not a neutral act to demonstrate respect or acceptance for the child's identity but affects the child's identity development. As such, socially transitioning shall only be permitted with the written permission of the parents, in accordance with the following:

- **Name changes:** The school recognizes that students often change their names and use nicknames during the process of identity exploration that occurs between the ages of roughly 12-25 years. Many teachers choose to

use their students' preferred names. However, teachers and other school staff should acknowledge the responsibility of their position and be careful not to give an official imprimatur on any given name, as doing so may inadvertently foreclose further exploration of a vulnerable student's identity or transient gender identity. Some gender non-conforming young people go through a series of different names, so staff should not concretize a current chosen name. The school shall retain students' official names on all official documents, and exercise caution with regard to teachers' use of students' new names. The school will not allow students to adopt new names against their parents' will, nor allow a student's new name to be interpreted as the official imprimatur of a student's gender identity, unless parents provide written approval to do so.

- **Pronoun changes:** The school shall retain the use of biologically accurate pronouns when referring to students, unless the child's parents have specifically requested in writing that different pronouns be used.
- **Desistance and detransition:** The school acknowledges that the adoption of a new name and pronoun can undermine a person's fluidity to re-adopt their birth name if they so choose, which often happens in cases of desistance and detransition.

8.1.11 Misgendering and deadnaming

"Misgendering" is a term to describe the situation when someone refers to or addresses a person with language that inaccurately represents the person's inner sense of gender identity, as indicated by the individual's preferred pronouns. "Deadnaming" refers to when someone calls a person by a name they used to be known as but no longer wish to be identified as. The school recognizes that this can be perceived as harmful to an individual. There is, however, no quality evidence that supports this perception, nor is there evidence to demonstrate the impact of referring to a person with terms that do not align with their biological sex is harmful. The best available evidence on social transition indicates that general peer and family support, not social transition, leads to better mental health.⁷³ The school recommends that the terms "misgendering" and "deadnaming" be de-emphasized. The school recognizes that some students with social communication difficulties will find it difficult to use the language that others might prefer when it comes to the social construct of gender identity. School staff shall not equate "misgendering" or "deadnaming" with violence or make other hyperbolic comparisons. Unless a broader pattern of bullying or other malicious behavior occurs, "misgendering" and "deadnaming" should not be punishable.

8.1.12 Bathrooms and changing areas

The school shall provide an option for additional single-occupancy toilets and single-occupancy changing rooms, so that vulnerable students can have privacy while accommodating students whose religious and cultural traditions prohibit sharing these

spaces with students of a different biological sex. Single-sex spaces shall be maintained, and a third space shall be provided where single-occupancy toilets and changing rooms are available, allowing anyone who wishes to use a gender-neutral space to do so.

8.1.13 Overnight stays

To the extent possible, the school shall retain single-sex residential stays and dormitories, while offering a viable alternative option for students who may find staying overnight with students of the same sex difficult. If a school needs to allow mixed-sex dormitories or sleeping arrangements to comply with a child's written and parent-approved plan to support their child or legal mandate, a comprehensive and documented risk and impact assessment shall be performed to ensure that safeguarding is upheld for all students. The parents of all pupils need to be provided with this risk assessment, and consent for all participating pupils must be obtained prior to commencing the overnight stay.

8.1.14 Binding and tucking

The school shall make materials available to parents about the health consequences of binding and tucking, especially during sports activities, to enable families to discuss whether their child's concerns about appearance should override serious health concerns. Under no circumstances shall the school provide students with binders or other clothing or devices to allow students to change their physical appearance.

8.1.15 Stealth transitions

Some families seek help from the school to maintain the secret transition of a child. This is often known as "stealth transition," and may involve failing to disclose that a child is staying overnight with or changing clothes alongside children of the opposite sex. In all situations, the needs of the student body as a whole should be balanced with the needs of the child seeking stealth transition. A full discussion with the child and family, with health professional input, should be sought, and a risk and impact assessment should be carried out before any decisions are made.

Schools shall prize openness and transparency wherever it is possible to do so. Vulnerable individuals should have access to extra counseling support so that they can live with honesty and integrity, liberated from the pressure to live a secret life. The school shall support these vulnerable students by nurturing a school community that is supportive of gender non-conforming behavior.

Psychologists and therapists often remind us that "we are only as sick as our secrets." The school shall encourage school administrators to focus on creating an environment of openness and transparency in staff dealings with students and parents and shall not compromise other members of the school community by keeping secrets inappropriately. The parents of all pupils in a school shall be provided with any risk

assessment associated with the school facilitating a “stealth transition,” along with all identifying information removed from the assessment to protect the students’ privacy.

8.1.16 Sports participation

The school recognizes that there is usually little morphological difference between boys and girls before puberty, and they can often compete with one another safely and fairly. For older students, however, the school shall endeavor to maintain single-sex sports and create viable alternative options and activities for students who do not want to engage in single-sex sports. The school recognizes that girls and young women must have opportunities to compete safely and that competing against biological males can be demoralizing. If allowing mixed-sex sports is required to comply with a legal mandate, a full risk and impact assessment should be conducted and documented according to the relevant protocols, addressing the impact not just on the individual concerned but in the broader student population. The parents of all pupils shall be provided with this risk assessment (with student identifying information removed), and consent for all participating athletes must be obtained prior to participating in the sporting activity. Any injury or negative impact must be documented and used to inform and update risk assessments.

8.1.17 Professional development

The school staff shall be provided with training to acquaint them with the symptoms of gender dysphoria and the scientific findings and history cited in Section 6 (8.1.6). This training shall include materials from the following organizations at a minimum:

- Genspect
- Gender Exploratory Therapy Association

8.1.18 References

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8.2 Model School Policy – Supporting Gender Questioning Children and Adolescents in Canadian Schools

8.2.1 Introduction

Good intentions do not necessarily lead to good outcomes. The policies and curriculum around gender identity and sexual orientation in Canadian schools are intended to create a safe and welcoming space for LGBTQ2S+ children and families. However, the underlying assumptions and flaws in the policy and its implementation are harmful to the very people it claims to benefit, as well as other vulnerable youth.

Over the last ten years, there has been a significant rapid increase in the number of children and adolescents experiencing distress over a perceived mismatch between their sex and sense of gender. This rise is consistent with the skyrocketing increase in mental health problems of all kinds among teens.

Current policies in Canada treat gender identity as a political and human rights issue and ignore the underlying mental health issues. Children and teens who are struggling with complex mental health problems are unquestioningly affirmed as “trans” and encouraged to seek social and then medical transition to the opposite sex under what is known as the “gender affirmation model” or “gender-affirming care.” Parental consent is not required, and parents are even excluded entirely when schools allow children to adopt a new name and pronouns without telling their parents. Social transition increases the risk of medical transition.

Schools further contribute to the problem by teaching about gender identity and sexuality in a way that ignores science and the principles of child development, beginning at an age where children are incapable of understanding the complex ideas within gender theory, especially when such theories are presented as fact.

One of the consequences of these policies is an increasing number of detransitioners who find themselves with their bodies permanently altered by puberty blockers, cross-sex hormones and surgeries, and still unresolved mental health problems.

The current policies on gender identity in schools need to be replaced with policies that allow gender-questioning youth the freedom to explore their identities without being told that they were “born in the wrong body” and started on the path to medical transition. The support for all students, including gender questioning students, should be based on a biopsychosocial framework, and informed by developmental models of human development. Changes in the education system need to be complemented by changes in the health care system to substitute a holistic approach based on neutral psychotherapy for the current affirmative model, which fast tracks medical intervention.

Chapter 2 (8.2.2) explains some of the terminology used in this paper. Many of the terms used in the discussion of gender issues are ambiguous or are used in a sense

that embeds ideological assumptions. Clarifying the use of language is a necessary first step.

Chapter 3 (8.2.3) examines three faulty assumptions on which current policies on gender identity are based. The first is that children develop a stable gender identity from an early age, when, in fact, gender identity is part of the larger process of identity development which takes place over decades. The second is that the transgender rights movement is simply an extension of the gay rights movement. In fact, gender identity and sexual orientation are different although interconnected. Cross-gender identification is often a stage in the development of awareness of sexual orientation, and many young gays and lesbians are being harmed by being labeled as transgender and started on a medical transition before their identity is fully developed. While sexual orientation is innate, such is not the case for those who experience gender-related distress or identify as transgender. The third error is to consider the mental health problems experienced by gender questioning youth primarily as a human rights issue and to disregard the complex interactions between gender related distress and other kinds of mental distress.

Chapter 4 (8.2.4) reviews the current state of the debate on medical transition of children and adolescents. Medical transition has substantial health risks, and the evidence of benefit is of very low quality. National healthcare systems in Finland, Sweden, and England have conducted systematic reviews of gender-affirming hormone treatments in young people, and all have rejected it in favor of neutral psychotherapy as the first line of treatment.

Chapter 5 (8.2.5) explores the mental health crisis in youth. The last ten years have seen a rapid increase in gender-related distress and other mental health problems in adolescents, with the largest increases in girls. The chapter discusses the connection between gender distress, other mental health issues, and the related issues of detransition and suicidality.

Chapter 6 (8.2.6) discusses one of the most concerning aspects of current policy: the extent to which they permit or even require social transition of gender-questioning children without their parents' knowledge. Social transition is a powerful psychosocial intervention that should only be undertaken with the involvement of a mental health professional and the support of the entire family.

Chapter 7 (8.2.7) looks at the role of school curriculum in promoting transgender identification. Rather than counteracting the questionable information students are exposed to on social media, schools reinforce it with teaching materials that are scientifically incorrect, biased, not age appropriate, or even sometimes pornographic.

Chapter 8 (8.2.8) has a human rights focus. Current policies make the unwarranted assumption that human rights legislation requires that students be given sports,

washrooms, changing rooms and overnight accommodation based on self-determined gender identity. The chapter explains why sex-separate spaces and sports are necessary to ensure safety and fairness.

The final chapter (8.2.9) proposes a new policy that incorporates these principles and will make schools a safe and welcoming place for everyone.

8.2.2 Terminology and definitions

The debate over gender identity is, to a considerable extent, a debate over language. Manipulating language through subtle changes to the meaning of words or the use of phrases is one of the ways in which a belief system is reinforced. To re-think the current policies on gender identity in schools, it is necessary to reject the use of some of the language that reinforces the faulty belief systems behind these policies.

- **Differences of Sexual Development (DSD):** An umbrella term for more than 40 conditions where sexual development deviates in some way from the typical male and female pathways. These conditions are extremely rare and seen in only 0.018% of births.¹ These conditions are also referred to as Disorders/Differences of Sexual Development or Congenital Conditions of Sexual Development. Persons with DSDs can still be classified as either male or female, not as a third or other sex. The outdated term is “intersex” (see below).
- **Desistance:** The process of stopping or reversing a social transition. It may also refer to the resolution of gender dysphoria.
- **Detransition:** Stopping or reversing (to the extent possible) the process of medical transition to resume a gender identity consistent with one’s natal sex.
- **Gender:** Sometimes used as a synonym for sex but now more commonly used to describe culturally influenced, societal expectations of behavior, aptitudes and appearance based upon sex, and a person’s social or cultural status as male, female, or something else. While in the context of gender theory, gender is considered distinct from sex, research from evolutionary psychology and neuroscience suggests otherwise.
- **Gender-affirming care:** Psychological, social, and medical interventions intended to support people who identify as transgender by aligning their bodies and social roles with their declared gender identity.
- **Gender dysphoria:** The distress caused by the incongruence between one’s experienced or expressed gender and one’s primary or secondary sex characteristics. In its capitalized form (“Gender Dysphoria”), is a diagnostic category in the DSM-V, defined by age-group-specific sets of criteria referring to the clinical and significant psychological distress resulting from gender incongruence.

¹ LEONARD SAX, “HOW COMMON IS INTERSEX? A RESPONSE TO ANNE FAUSTO-STERLING,” THE JOURNAL OF SEX RESEARCH 39, NO. 3 (AUGUST 1, 2002): 174–78, [HTTPS://DOI.ORG/10.1080/00224490209552139](https://doi.org/10.1080/00224490209552139).

- **Gender identity:** An internal sense of one's own gender, which may or may not be at odds with one's biological sex. Not everyone accepts the concept of gender identity or believes that everyone has one. While it is often stated that gender identity is separate from sexuality, research on gender dysphoric youth indicates a close relationship. Previous research indicates that those who experience gender dysphoria (and gender nonconformity) as children, often grow up to be gay, lesbian or bisexual.
- **Gender expression:** The way a person represents or expresses gender to others, often through behavior, clothing, hairstyles, activities, voice, or mannerisms. Gender expression may vary by culture.
- **Gender questioning:** Describes someone who is asking questions about or otherwise exploring a gender identity. This document will use this term in lieu of "trans" or "transgender" for young people whose identity is still in a formative stage.
- **Intersex:** An outdated term for conditions now described as Disorders/Differences of Sexual Development (see above).
- **LGB:** An initialism used for lesbians, gays, and bisexuals.
- **LGBTQI2S+:** One of many initialisms currently used to describe people with diverse sexualities and gender identities. These initialisms are a source of confusion because they are constantly shifting in content and meaning and do not describe a coherent community with similar needs and interests.
- **Medical transition:** Medical interventions intended to enable a person to take on the presentation of a different gender. These may include puberty blockers, cross-sex hormones, and various surgeries.
- **Non-binary:** A gender identity where an individual's sense of self is neither male nor female. It is important to note that many, mostly biological females, are now identifying as non-binary. Non-binary individuals have access to the same gender-affirming medical treatments, including surgery.
- **Sex:** The sex of an individual is determined by one of two developmental pathways (Wolffian - male or Mullerian - female). Sex is defined as the reproductive role an organism has developed to perform. The female sex develops to support the production of large gametes called eggs or ova, and the male sex develops to support the production of small gametes called sperm.² Sex in humans is determined at conception and does not change. The terms biological sex or natal sex are sometimes used for clarity.
- **Social transition:** The process in which a person takes on a new name, changes their appearance (hairstyle, clothing, makeup, and other non-medical changes) and uses preferred pronouns (such as opposite sex pronouns, non-binary pronouns such as "they" or neo-pronouns).

² ADITI BHARGAVA ET AL., "CONSIDERING SEX AS A BIOLOGICAL VARIABLE IN BASIC AND CLINICAL STUDIES: AN ENDOCRINE SOCIETY SCIENTIFIC STATEMENT," ENDOCRINE REVIEWS, NO. BNAA034 (MARCH 11, 2021), [HTTPS://DOI.ORG/10.1210/ENDREV/BNAA034](https://doi.org/10.1210/ENDREV/BNAA034).

- **Puberty blockers:** Drugs that inhibit the physical changes of puberty by acting on the pituitary gland to prevent the release of sex hormones. The scientific name is Gonadotropin Releasing Hormone (GnRH) agonists.
- **Queer:** A term used to describe counter-normative sexualities and gender identities. In the past, the term was used as a slur against gay people, and many still find it offensive.
- **Transgender:** An umbrella term describing people with a gender identity that does not match their biological sex. This term should be avoided for young people whose identity is still in a formative period.
- **Transsexual:** People who have modified their bodies through hormones or surgery to present as a member of the opposite sex. It is incorrect to describe them as having undergone a sex change since it is impossible to change sex.
- **Two-Spirit:** An umbrella term used to refer to gender non-conformity among indigenous communities. The term should be used with caution because different indigenous communities have different understandings of gender roles. Some communities recognize two-spirit people as a special group with a particular cultural role. In other cases, the term may be used to describe a lesbian, gay, bisexual, or transgender person who happens to be indigenous.³

8.2.3 Re-thinking some assumptions

The current policies on gender identity are based on a series of faulty assumptions about the nature of gender identity and its relationship to identity development, sexual orientation and mental health. These assumptions must be examined and corrected to develop a genuinely evidence-based policy.

8.2.3.1 The nature of gender identity

A fundamental assumption behind the current policies, which also underlies the gender-affirming model, is that everyone has a gender identity which they realize at an early age and that gender distress automatically means that one is transgender. Children who experience gender distress or those who say they are the opposite sex are transgender. Therefore, it is assumed that the only appropriate response is to affirm their identity. This view disregards well-known principles of child and adolescent development. It also ignores the growing research on detransitioners.

There is no reliable evidence that transgender identity has a biological basis. Contrary to popular belief, brain imaging studies have not been able to reliably identify any brain structures associated with transgender identity after controlling for hormone exposure and sexual orientation.⁴ The theory of biological determination also does not explain

³ MICHELLE FILICE, "TWO-SPIRIT," IN THE CANADIAN ENCYCLOPEDIA, 2015, [HTTPS://WWW.THECANADIANENCYCLOPEDIA.CA/EN/ARTICLE/TWO-SPIRIT](https://www.thecanadianencyclopedia.ca/en/article/two-spirit).

⁴ ALBERTO FRIGERIO, LUCIA BALLERINI, AND MARIA VALDÉS HERNÁNDEZ, "STRUCTURAL, FUNCTIONAL, AND METABOLIC BRAIN DIFFERENCES AS A FUNCTION OF GENDER IDENTITY OR SEXUAL ORIENTATION: A SYSTEMATIC REVIEW OF THE HUMAN NEUROIMAGING LITERATURE," ARCHIVES OF SEXUAL BEHAVIOR 50, NO. 8 (NOVEMBER 1, 2021): 3329–52, [HTTPS://DOI.ORG/10.1007/S10508-021-02005-9](https://doi.org/10.1007/s10508-021-02005-9).

why childhood gender dysphoria frequently resolves either on its own or after psychotherapy.⁵

Gender identity in children and adolescents should be considered part of the overall identity development process. Adolescence is a critical period of development, but may be particularly significant for gay, lesbian and bisexual youth who become aware of their sexuality. Many often experience gender dysphoria. Research has consistently shown that the vast majority of those experiencing gender dysphoria in youth grow out of their dysphoria and align with their sexed bodies; many growing up to be gay, lesbian or bisexual.⁶ Unfortunately, gender-affirming care, including social transition, can prevent the resolution of gender dysphoria⁷ and disrupt the natural identity development process.⁸

Even labeling a child transgender can become a self-fulfilling prophecy. This document will avoid the use of the term transgender or trans in connection with children and adolescents and instead use the word gender questioning to emphasize that their identities are still in a formative stage and that schools should not use labels that prematurely judge the outcome of a child's development.

8.2.3.2 Transgender rights and gay rights

The next assumption is that transgender rights are simply an extension of gay rights. This assumption arose because the political movements both supporting and opposing same-sex rights and transgender rights have been largely the same. However, it ignores important differences between the nature of sexual orientation and gender identity and the types of rights being claimed.

Sexual orientation is innate, has a biological basis, and cannot be changed. People usually realize their sexual orientation sometime during adolescence but may not disclose it until adulthood. A student's sexual orientation concerns private, intimate conduct. It does not affect other students or require any special response from the school. All students should receive age-appropriate sexual education including discussions of consent, contraception, sexually transmitted diseases, and safe-sex practices. All students should be protected from harassment and bullying.

5 J. COHN, "SOME LIMITATIONS OF 'CHALLENGES IN THE CARE OF TRANSGENDER AND GENDER-DIVERSE YOUTH: AN ENDOCRINOLOGIST'S VIEW,'" *JOURNAL OF SEX & MARITAL THERAPY*, DECEMBER 24, 2022, 1–17, [HTTPS://DOI.ORG/10.1080/0092623X.2022.2160396](https://doi.org/10.1080/0092623X.2022.2160396).

6 DEVITA SINGH, SUSAN J. BRADLEY, AND KENNETH J. ZUCKER, "A FOLLOW-UP STUDY OF BOYS WITH GENDER IDENTITY DISORDER," *FRONTIERS IN PSYCHIATRY* 12 (2021), [HTTPS://DOI.ORG/10.3389/FPSYT.2021.632784](https://doi.org/10.3389/fpsy.2021.632784).

7 KENNETH J. ZUCKER, "THE MYTH OF PERSISTENCE: RESPONSE TO 'A CRITICAL COMMENTARY ON FOLLOW-UP STUDIES AND "DESISTANCE" THEORIES ABOUT TRANSGENDER AND GENDER NON-CONFORMING CHILDREN' BY TEMPLE NEWHOOK ET AL. (2018)," *INTERNATIONAL JOURNAL OF TRANSGENDERISM* 19, NO. 2 (APRIL 3, 2018): 231–45, [HTTPS://DOI.ORG/10.1080/15532739.2018.1468293](https://doi.org/10.1080/15532739.2018.1468293).

8 STEPHEN B. LEVINE AND E. ABBRUZZESE, "CURRENT CONCERNS ABOUT GENDER-AFFIRMING THERAPY IN ADOLESCENTS," *CURRENT SEXUAL HEALTH REPORTS*, APRIL 14, 2023, [HTTPS://DOI.ORG/10.1007/S11930-023-00358-X](https://doi.org/10.1007/s11930-023-00358-x).

Gender identity, on the other hand, is frequently changeable. There is no biological marker or test to determine when a transgender identity will be stable. There are grounds to believe that some transgender identification, particularly when it first emerges during adolescence, may be transient and the result of social influence.⁹ The declaration of a transgender identity demands significant accommodations from other people. It can also lead to invasive and risky medical interventions.

There is one way in which sexual orientation and gender identity are connected. Research has found that there is a strong connection between adult homosexuality and a history of gender variance in childhood.¹⁰ Gay, lesbian, and bisexual adults often experience a period of cross-gender identification or gender dysphoria while growing up. They may have a strong preference for the clothes and activities of the opposite sex (gender nonconformity) and even believe they are the opposite sex. These feelings tend to resolve by the end of puberty as they begin to realize their same-sex attraction.¹¹

One of the dangers of the current approach to gender identity is that children who are affirmed in their identity and started on social and medical transition at a young age will not have the developmental experiences that allow them to realize their same-sex attraction. Indeed, in one study of 100 detransitioners, “coming to understand my sexuality” was reported by 23% of the participants.¹²

8.2.3.3 Human rights and mental health

Current school policies also make the error of regarding gender identity as primarily a human rights issue rather than also a mental health issue. To the extent that the mental health problems experienced by transgender people are acknowledged, they are assumed to be the result of minority stress which is best addressed through human rights initiatives. Any suggestion that mental health problems may be a contributing factor to gender questioning and gender dysphoria is rejected as stigmatizing to transgender people. This may seem appropriate considering the now rejected view of homosexuality as a mental disorder, but it disregards the fact that those with gender distress also present with other mental health conditions. This is particularly so with the adolescents claiming a trans identity in the last ten years.¹³

9 COHN, “SOME LIMITATIONS OF ‘CHALLENGES IN THE CARE OF TRANSGENDER AND GENDER-DIVERSE YOUTH: AN ENDOCRINOLOGIST’S VIEW.’”

10 THOMAS D. STEENSMA ET AL., “GENDER VARIANCE IN CHILDHOOD AND SEXUAL ORIENTATION IN ADULTHOOD: A PROSPECTIVE STUDY,” *THE JOURNAL OF SEXUAL MEDICINE* 10, NO. 11 (NOVEMBER 1, 2013): 2723–33, [HTTPS://DOI.ORG/10.1111/J.1743-6109.2012.02701.X](https://doi.org/10.1111/J.1743-6109.2012.02701.x).

11 SINGH, BRADLEY, AND ZUCKER, “A FOLLOW-UP STUDY OF BOYS WITH GENDER IDENTITY DISORDER.”

12 LISA LITTMAN, “INDIVIDUALS TREATED FOR GENDER DYSPHORIA WITH MEDICAL AND/OR SURGICAL TRANSITION WHO SUBSEQUENTLY DETRANSITIONED: A SURVEY OF 100 DETRANSITIONERS,” *ARCHIVES OF SEXUAL BEHAVIOR*, OCTOBER 19, 2021, [HTTPS://LINK.SPRINGER.COM/ARTICLE/10.1007%2Fs10508-021-02163-W](https://link.springer.com/article/10.1007%2Fs10508-021-02163-w).

13 RIITTAKERTTU KALTIALA-HEINO ET AL., “GENDER DYSPHORIA IN ADOLESCENCE: CURRENT PERSPECTIVES,” *ADOLESCENT HEALTH, MEDICINE AND THERAPEUTICS* 9 (MARCH 2, 2018): 31–41, [HTTPS://DOI.ORG/10.2147/AHMT.S135432](https://doi.org/10.2147/AHMT.S135432).

There should be no conflict. Removing the stigma around mental illness does not mean denying that it exists. It is possible to recognize that transgender-identified people have the right to be treated with dignity and respect and, at the same time, recognize that gender identity may fluctuate and be affected by various mental health conditions.¹⁴ Detransitioners, for example, have reported that their trans-identification was a result of borderline personality disorder. Others have attributed their once trans-identity to being autistic.¹⁵

Looking at gender identity solely through the lens of social justice and human rights is ultimately harmful to people who identify as transgender. It can result in their real mental health problems being overlooked in favor of promoting transition as a cure-all (in effect, diagnostic overshadowing). This is one of the most common complaints of detransitioners and desisters.¹⁶ The focus must shift from promoting group-rights based on identity to one that is centered around the long-term health and well-being of individuals as a whole person. Medical interventions cannot be assumed to treat all mental distress.

8.2.3.4 The affirming care model

The final faulty assumption, which requires a chapter of its own, is that gender-affirming care has been proven to be safe and effective in children and adolescents. In fact, gender-affirming care has substantial risks, and the evidence that it is beneficial is very low quality.

8.2.3.4.1 Low quality supporting evidence

While many major medical groups including the American Academy of Pediatrics (AAP) and the Endocrine Society, have endorsed gender-affirming care, these recommendations are less impressive than they seem. They reflect the views of a relatively small group of doctors with very little scientific support. The policy statement of the American Academy of Pediatrics is frequently cited in support of the gender-affirming model.¹⁷ Psychologist Dr. James Cantor examined the support evidence for this policy and came to the following conclusion:

The problems in Rafferty (2018), however, do not constitute merely a misquote, a misinterpretation of an ambiguous statement, or a missing reference or two. Rather, AAP's statement is a systematic exclusion and

14 HILARY CASS, "INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: INTERIM REPORT" (THE CASS REVIEW, FEBRUARY 2022), [HTTPS://CASS.INDEPENDENT-REVIEW.UK/PUBLICATIONS/INTERIM-REPORT/](https://cass.independent-review.uk/publications/interim-report/).

15 LITTMAN, "INDIVIDUALS TREATED FOR GENDER DYSPHORIA WITH MEDICAL AND/OR SURGICAL TRANSITION WHO SUBSEQUENTLY DETRANSITIONED."

16 LITTMAN; ELIE VANDENBUSSCHE, "DETRANSITION-RELATED NEEDS AND SUPPORT: A CROSS-SECTIONAL ONLINE SURVEY," JOURNAL OF HOMOSEXUALITY 69, NO. 9 (APRIL 30, 2021): 1–19, [HTTPS://WWW.TANDFONLINE.COM/DOI/ABS/10.1080/00918369.2021.1919479](https://www.tandfonline.com/doi/abs/10.1080/00918369.2021.1919479).

17 JASON RAFFERTY ET AL., "ENSURING COMPREHENSIVE CARE AND SUPPORT FOR TRANSGENDER AND GENDER-DIVERSE CHILDREN AND ADOLESCENTS," PEDIATRICS 142, NO. 4 (OCTOBER 1, 2018): E20182162, [HTTPS://DOI.ORG/10.1542/PEDS.2018-2162](https://doi.org/10.1542/peds.2018-2162).

*misrepresentation of entire literatures. Not only did AAP fail to provide extraordinary evidence, it failed to provide the evidence at all. Indeed, AAP's recommendations are despite the existing evidence.*¹⁸

The authors of the AAP policy have not responded to this criticism, and the AAP has resisted calls from its members to conduct a review of the policy.

The current policy statements endorsing gender-affirming care are consensus-based rather than evidence based. They reflect the opinion of a small group of practitioners, based on their clinical experience. This process has a risk of bias as professionals tend to favor studies that support their preferred model of care and ignore or downplay unfavorable studies. Evidence-based medicine is a set of practices that were developed to eliminate bias and develop more reliable standards of care.

An evidence-based standard of care begins with an independent, systematic review of scientific evidence. Systematic reviews evaluate the scientific evidence in support of a medical treatment through a process that is designed to minimize bias and conflict of interest. A systematic review is conducted by researchers with expertise in research methodology who have no financial or non-financial interest in the treatments under review.¹⁹ The systematic review rates the quality of supporting evidence ranging from high to very low according to specific standards that are agreed upon in advance. The strength of the recommendations in the standard of care should reflect the strength of the supporting evidence.

Neither the Endocrine Society guidelines nor the WPATH standards of care meet the standards for an evidence-based guideline. They did not conduct comprehensive systematic reviews and made strong recommendations based on weak evidence.²⁰ The WPATH SOC7 guideline was rated a low quality in an appraisal by the Canadian Agency for Drugs and Technology in Health²¹ and a review published in the *British Medical Journal*.²²

18 JAMES CANTOR, "TRANSGENDER AND GENDER DIVERSE CHILDREN AND ADOLESCENTS: FACT-CHECKING OF AAP POLICY," JOURNAL OF SEX & MARITAL THERAPY, DECEMBER 14, 2019, 1–7, [HTTPS://DOI.ORG/10.1080/0092623X.2019.1698481](https://doi.org/10.1080/0092623X.2019.1698481).

19 CANADIAN TASK FORCE ON PREVENTIVE HEALTH, "POLICY ON DISCLOSURE OF INTERESTS AND MANAGEMENT OF CONFLICT OF INTEREST," AUGUST 2020, [HTTPS://CANADIANTASKFORCE.CA/WP-CONTENT/UPLOADS/2020/10/COI-POLICY-202008FINAL.PDF](https://canadiantaskforce.ca/wp-content/uploads/2020/10/COI-POLICY-202008FINAL.PDF).

20 JENNIFER BLOCK, "GENDER DYSPHORIA IN YOUNG PEOPLE IS RISING—AND SO IS PROFESSIONAL DISAGREEMENT," BMJ 380 (FEBRUARY 23, 2023): P382, [HTTPS://DOI.ORG/10.1136/BMJ.P382](https://doi.org/10.1136/bmj.p382).

21 STELLA CHEN AND HANNAH LOSHAK, PRIMARY CARE INITIATED GENDER-AFFIRMING THERAPY FOR GENDER DYSPHORIA: A REVIEW OF EVIDENCE BASED GUIDELINES, CADTH RAPID RESPONSE REPORTS (OTTAWA: CANADIAN AGENCY FOR DRUGS AND TECHNOLOGIES IN HEALTH, 2020), [HTTP://WWW.NCBI.NLM.NIH.GOV/BOOKS/NBK563451/](http://www.ncbi.nlm.nih.gov/books/NBK563451/).

22 SARA DAHLEN ET AL., "INTERNATIONAL CLINICAL PRACTICE GUIDELINES FOR GENDER MINORITY/TRANSGENDER PEOPLE: SYSTEMATIC REVIEW AND QUALITY ASSESSMENT," BMJ OPEN 11, NO. 4 (APRIL 29, 2021): E048943, [HTTPS://DOI.ORG/10.1136/BMJOPEN-2021-048943](https://doi.org/10.1136/bmjopen-2021-048943).

8.2.3.4.2 Changing International Practice

The United Kingdom, Finland and Sweden, all countries with national health systems, have each conducted a systematic review of the affirming care model and, in each case have found that the evidence for gender-affirming care is weak and that the potential risks of such treatments outweigh potential benefits.²³ These countries have moved to a model of psychotherapy as the first line of care. Professional organizations in France, Norway, New Zealand and Australia have also openly called to limit medical gender transition for minors, advocating for a developmental approach and psychotherapy.

Finland was the first country to change course. It was one of the early adopters of gender-affirming care for youth, but by 2015 clinicians began to notice problems with the model.²⁴ They saw an overrepresentation of girls with significant mental health or neurodevelopmental conditions. This patient population of adolescents was very different from the patient population used in the foundational studies on gender-affirming care.²⁵ The Council for Choices in Health conducted a systematic review and issued a recommendation that psychotherapy be the first line of treatment for patients under 18 with puberty blockers and cross-sex hormones to be provided only in exceptional circumstances and as part of a research program.²⁶

In Sweden, the government was preparing to pass legislation that would have reduced the minimum age for gender surgery from 18 to 15 and removed the requirement for parental consent. Opposition from concerned parents, professionals and the media caused the government to reverse course and commissioned three government agencies to review the treatment of gender dysphoria in children and adolescents.²⁷ As a result of these reviews, the Swedish National Board of Health and Welfare issued recommendations that emphasize the role of psychotherapy and restrict access to hormonal treatment.²⁸

In the United Kingdom, therapists working at the Gender Identity Development Service (GIDS) for young people at the Tavistock Clinic, the youth gender clinic serving all of

23 BLOCK, "GENDER DYSPHORIA IN YOUNG PEOPLE IS RISING—AND SO IS PROFESSIONAL DISAGREEMENT."

24 LEOR SAPIR, "FINLAND TAKES ANOTHER LOOK AT YOUTH GENDER MEDICINE," TABLET MAGAZINE, FEBRUARY 21, 2023, [HTTPS://WWW.TABLETMAG.COM/SECTIONS/SCIENCE/ARTICLES/FINLAND-YOUTH-GENDER-MEDICINE](https://www.tabletmag.com/sections/science/articles/finland-youth-gender-medicine).

25 RIITTAKERTTU KALTIALA-HEINO ET AL., "TWO YEARS OF GENDER IDENTITY SERVICE FOR MINORS: OVERREPRESENTATION OF NATAL GIRLS WITH SEVERE PROBLEMS IN ADOLESCENT DEVELOPMENT," CHILD AND ADOLESCENT PSYCHIATRY AND MENTAL HEALTH 9, NO. 1 (APRIL 9, 2015): 9, [HTTPS://DOI.ORG/10.1186/S13034-015-0042-Y](https://doi.org/10.1186/s13034-015-0042-y).

26 COUNCIL FOR CHOICES IN HEALTH CARE IN FINLAND (COHERE), "MEDICAL TREATMENT METHODS FOR DYSPHORIA ASSOCIATED WITH VARIATIONS IN GENDER IDENTITY IN MINORS – RECOMMENDATION," 2020, [HTTPS://PALVELUVALIKOIMA.FI/DOCUMENTS/1237350/22895008/SUMMARY_MINORS_EN.PDF/AAF9A6E7-B970-9DE9-165C-ABEDFAE46F2E/SUMMARY_MINORS_EN.PDF](https://palveluvalikoima.fi/documents/1237350/22895008/SUMMARY_MINORS_EN.PDF/AAF9A6E7-B970-9DE9-165C-ABEDFAE46F2E/SUMMARY_MINORS_EN.PDF).

27 "THE SWEDISH U-TURN ON GENDER TRANSITIONING FOR CHILDREN," CANADIAN GENDER REPORT (BLOG), NOVEMBER 12, 2020, [HTTPS://GENDERREPORT.CA/THE-SWEDISH-U-TURN-ON-GENDER-TRANSITIONING/](https://genderreport.ca/the-swedish-u-turn-on-gender-transitioning/).

28 "SUMMARY OF KEY RECOMMENDATIONS FROM THE SWEDISH NATIONAL BOARD OF HEALTH AND WELFARE (SOCIALSTYRELSEN/NBHW)," FEBRUARY 27, 2022, [HTTPS://SEGM.ORG/SEGM-SUMMARY-SWEDEN-PRIORITIZES-THERAPY-CURBS-HORMONES-FOR-GENDER-DYSPHORIC-YOUTH](https://segm.org/segm-summary-sweden-prioritizes-therapy-curbs-hormones-for-gender-dysphoric-youth).

England and Wales, raised concerns about the quality of care being provided. The government appointed a commission headed by pediatrician Hilary Cass to review the service. The interim report found that there were serious gaps in the evidence base for the use of puberty blockers and cross-sex hormones in young people.²⁹ The National Health Service announced that it would be closing the youth gender service at the Tavistock Clinic and developing a new model of care.³⁰ The new interim service specification makes psychosocial support the primary intervention with puberty blockers and cross-sex hormones to be used only in the context of a research study.³¹ It also reiterates that social transition is not a neutral act, that it may increase the risk of medical gender transition and that it requires the support of a mental health clinician.

Other countries are also questioning the affirmative care model. Norway recently announced that it will be reviewing its guidance on pediatric gender treatment.³² The French National Academy of Medicine has issued a statement calling for medical transition of children to be used only with the greatest caution.³³ The Royal Australia and New Zealand College of Psychiatrists adopted a position paper that notes that the evidence supporting affirmative care is mixed and suggests a significant role for psychotherapy in treatment of gender dysphoria.³⁴ The National Association of Practicing Psychiatrists of Australia has also issued a guide to managing Gender Dysphoria/incongruence in young people which recommends that exploratory psychotherapy be the primary treatment and that medical transition be prescribed only with extreme caution.³⁵

8.2.3.4.3 Weak methodology in studies supporting affirmative care

The studies that are relied on to support the affirming-care model have major methodological problems.³⁶ The foundational studies for gender-affirming care for

29 CASS, "INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: INTERIM REPORT."

30 "CLINICAL DAMAGE: THE TAVISTOCK CLINIC'S CLOSURE FOLLOWS A DAMNING REPORT ON IDEOLOGICAL MALPRACTICE," THE TIMES, JULY 29, 2022, [HTTPS://SEGM.ORG/TAVISTOCK-CLOSURE-THE-TIMES](https://segm.org/tavistock-closure-the-times).

31 NHS ENGLAND, "INTERIM SERVICE SPECIFICATION FOR SPECIALIST GENDER INCONGRUENCE SERVICES FOR CHILDREN AND YOUNG PEOPLE," JUNE 9, 2023, [HTTPS://WWW.ENGLAND.NHS.UK/PUBLICATION/INTERIM-SERVICE-SPECIFICATION-FOR-SPECIALIST-GENDER-INCONGRUENCE-SERVICES-FOR-CHILDREN-AND-YOUNG-PEOPLE/](https://www.england.nhs.uk/publication/interim-service-specification-for-specialist-gender-incongruence-services-for-children-and-young-people/).

32 JENNIFER BLOCK, "NORWAY'S GUIDANCE ON PAEDIATRIC GENDER TREATMENT IS UNSAFE, SAYS REVIEW," BMJ 380 (MARCH 23, 2023): P697, [HTTPS://DOI.ORG/10.1136/BMJ.P697](https://doi.org/10.1136/bmj.p697).

33 FRENCH NATIONAL ACADEMY OF MEDICINE, "MEDICINE AND GENDER TRANSIDENTITY IN CHILDREN AND ADOLESCENTS," FEBRUARY 25, 2022, [HTTPS://WWW.ACADEMIE-MEDICINE.FR/WP-CONTENT/UPLOADS/2022/03/22.2.25-COMMUNIQUE-PCRA-19-GENDER-IDENTITY-ENG.PDF](https://www.academie-medicine.fr/wp-content/uploads/2022/03/22.2.25-COMMUNIQUE-PCRA-19-GENDER-IDENTITY-ENG.PDF).

34 THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS, "RECOGNISING AND ADDRESSING THE MENTAL HEALTH NEEDS OF PEOPLE EXPERIENCING GENDER DYSPHORIA / GENDER," SEPTEMBER 2021, [HTTPS://WWW.RANZCP.ORG/NEWS-POLICY/POLICY-AND-ADVOCACY/POSITION-STATEMENTS/GENDER-DYSPHORIA](https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/gender-dysphoria).

35 PHILIP MORRIS, "MANAGING GENDER DYSPHORIA/INCONGRUENCE IN YOUNG PEOPLE," NATIONAL ASSOCIATION OF PRACTICING PSYCHIATRISTS (BLOG), MARCH 17, 2022, [HTTPS://NAPP.ORG.AU/2022/03/MANAGING-GENDER-DYSPHORIA-INCONGRUENCE-IN-YOUNG-PEOPLE-A-GUIDE-FOR-HEALTH-PRACTITIONERS-2/](https://napp.org.au/2022/03/managing-gender-dysphoria-incongruence-in-young-people-a-guide-for-health-practitioners-2/).

36 E. ABBRUZZESE, STEPHEN B. LEVINE, AND JULIA W. MASON, "THE MYTH OF 'RELIABLE RESEARCH' IN PEDIATRIC GENDER MEDICINE: A CRITICAL EVALUATION OF THE DUTCH STUDIES—AND RESEARCH THAT HAS FOLLOWED," JOURNAL OF SEX & MARITAL THERAPY, JANUARY 2, 2023, 1–27, [HTTPS://DOI.ORG/10.1080/0092623X.2022.2150346](https://doi.org/10.1080/0092623X.2022.2150346).

youth were published in 2011 and 2014 by a group of researchers in Amsterdam. These studies outlined a treatment process known as the Dutch Protocol, consisting of puberty suppression at age 12, cross-sex hormones at 16, and surgeries after age 18. The results of these foundational studies were inconclusive.³⁷ However, the protocol was enthusiastically adopted by other countries, including Canada.³⁸ Further, as these treatments became seen more and more through a human rights lens, doctors began to ignore the cautious approach and thorough assessment used in the original study.

It is worth noting that the original Dutch Protocol was only applied to children who had experienced gender distress since childhood which worsened at puberty and had no other uncontrolled mental health problems. There was extensive psychological support, any mental health comorbidities were treated, and the parents had to be fully supportive. Today, gender clinics routinely give hormones to teens who did not experience gender distress until puberty and make little or no attempt to screen for other mental health conditions. Assessment does not involve consideration of mental health comorbidities, but the readiness for medicalization. Gender clinicians routinely dismiss parental concerns.³⁹

A study of youth treated with puberty suppression at the Tavistock failed to replicate any of the positive findings reported in the foundational Dutch studies, citing no improvement in mental health status.⁴⁰ Recent reanalysis of this Tavistock cohort found that contrary to the conclusion of no mental health improvements, mental health actually deteriorated for 15-34% of patients.⁴¹

8.2.3.4.5 Medical risks of transition

While the psychological benefits of gender-affirming care are unclear, the physical risks are significant at every stage of the process.⁴² There are very few studies on the physical effects of puberty blockers used to treat gender dysphoria. It is known that

37 POLLY CARMICHAEL ET AL., "SHORT-TERM OUTCOMES OF PUBERTAL SUPPRESSION IN A SELECTED COHORT OF 12 TO 15 YEAR OLD YOUNG PEOPLE WITH PERSISTENT GENDER DYSPHORIA IN THE UK," PLOS ONE 16, NO. 2 (FEBRUARY 2, 2021): E0243894, [HTTPS://DOI.ORG/10.1371/JOURNAL.PONE.0243894](https://doi.org/10.1371/JOURNAL.PONE.0243894).

38 MICHAEL BIGGS, "THE DUTCH PROTOCOL FOR JUVENILE TRANSSEXUALS: ORIGINS AND EVIDENCE," JOURNAL OF SEX & MARITAL THERAPY 49, NO. 4 (MAY 19, 2023): 348–68, [HTTPS://DOI.ORG/10.1080/0092623X.2022.2121238](https://doi.org/10.1080/0092623X.2022.2121238).

39 G. KNUDSON, DANIEL METZGER, AND B FINDLAY, "GENDER-AFFIRMING CARE IN BRITISH COLUMBIA, PART 2," BCMJ 64, NO. 2 (MARCH 2022): 64, [HTTPS://BCMJ.ORG/EDITORIALS/GUEST-EDITORIAL-GENDER-AFFIRMING-CARE-BRITISH-COLUMBIA-PART-2](https://bcmj.org/editorials/guest-editorial-gender-affirming-care-british-columbia-part-2).

40 CARMICHAEL ET AL., "SHORT-TERM OUTCOMES OF PUBERTAL SUPPRESSION IN A SELECTED COHORT OF 12 TO 15 YEAR OLD YOUNG PEOPLE WITH PERSISTENT GENDER DYSPHORIA IN THE UK."

41 SUSAN MCPHERSON AND DAVID E. P. FREEDMAN, "PSYCHOLOGICAL OUTCOMES OF 12-15 YEAR OLDS WITH GENDER DYSPHORIA RECEIVING PUBERTAL SUPPRESSION: ASSESSING RELIABLE CHANGE AND RECOVERY" (MEDRXIV, JUNE 1, 2023), [HTTPS://DOI.ORG/10.1101/2023.05.30.23290763](https://doi.org/10.1101/2023.05.30.23290763).

42 COHN, "SOME LIMITATIONS OF 'CHALLENGES IN THE CARE OF TRANSGENDER AND GENDER-DIVERSE YOUTH: AN ENDOCRINOLOGIST'S VIEW.'"

they may affect bone mineral density, which can lead to early onset of osteoporosis.⁴³ The combination of puberty blockers and cross-sex hormones can leave a child permanently sterile.⁴⁴

Puberty is also a critical period of brain development, and there is some evidence that disrupting puberty may impair brain development.⁴⁵ Some risks of cross-sex hormones include loss of fertility, vaginal atrophy and other menopausal symptoms, loss of sexual response, further interference with bone mineral density, and increased risk of heart attacks, strokes, multiple sclerosis and early onset dementia. In addition, some of the intended effects of hormones, such as a deeper voice from testosterone, will be irreversible if the patient later decides to detransition. Not every trans-identified person has “bottom surgery” to remove their ovaries or testicles, but those who do will be dependent on artificial hormones for the rest of their lives.

The complication rate for phalloplasty (construction of an artificial penis) is extremely high. A multi center survey published in 2021 found that out of 129 patients, there were 281 complications requiring 142 revisions.⁴⁶

Medical transition of young patients is still very new. Most of the patients treated with a combination of puberty blockers and cross-sex hormones are still under 30 years old. There has not been time to study the long term physical and mental health effects of these treatments.

8.2.3.4.6 Binding and tucking

One aspect of gender-affirming care, often erroneously regarded as a relatively benign aspect of social transition, is the binding of breasts and tucking of male genitals. Some school GSA clubs support these practices by assisting students in obtaining supplies without their parents’ knowledge.

Both these practices carry substantial health risks. A survey of transmen found that 68% were concerned about the health effects from binding. The most common symptoms associated with binding were back pain (65%), shortness of breath (48.6%), bad posture (32%), chest pain (30%), and light-headedness (30%). Another study found

43 MICHAEL BIGGS, “REVISITING THE EFFECT OF GnRH ANALOGUE TREATMENT ON BONE MINERAL DENSITY IN YOUNG ADOLESCENTS WITH GENDER DYSPHORIA,” *JOURNAL OF PEDIATRIC ENDOCRINOLOGY AND METABOLISM*, APRIL 26, 2021, [HTTPS://DOI.ORG/10.1515/JPEM-2021-0180](https://doi.org/10.1515/jpem-2021-0180).

44 T. H. R. STOLK ET AL., “DESIRE FOR CHILDREN AND FERTILITY PRESERVATION IN TRANSGENDER AND GENDER-DIVERSE PEOPLE: A SYSTEMATIC REVIEW,” *BEST PRACTICE & RESEARCH CLINICAL OBSTETRICS & GYNAECOLOGY* 87 (MARCH 1, 2023): 102312, [HTTPS://DOI.ORG/10.1016/J.BPOBGYN.2023.102312](https://doi.org/10.1016/j.bpobgyn.2023.102312).

45 DIANE CHEN ET AL., “CONSENSUS PARAMETER: RESEARCH METHODOLOGIES TO EVALUATE NEURODEVELOPMENTAL EFFECTS OF PUBERTAL SUPPRESSION IN TRANSGENDER YOUTH,” *TRANSGENDER HEALTH* 5, NO. 4 (DECEMBER 1, 2020): 246–57, [HTTPS://DOI.ORG/10.1089/TRGH.2020.0006](https://doi.org/10.1089/trgh.2020.0006).

46 ISABEL S. ROBINSON ET AL., “SURGICAL OUTCOMES FOLLOWING GENDER AFFIRMING PENILE RECONSTRUCTION: PATIENT-REPORTED OUTCOMES FROM A MULTI-CENTER, INTERNATIONAL SURVEY OF 129 TRANSMASCULINE PATIENTS,” *THE JOURNAL OF SEXUAL MEDICINE* 18, NO. 4 (APRIL 2021): 800–811, [HTTPS://DOI.ORG/10.1016/J.JSXM.2021.01.183](https://doi.org/10.1016/j.jsxm.2021.01.183).

that 97% of participants reported at least one of 28 negative outcomes attributed to binding including poor posture, long-term skin damage and sores, reduced skin elasticity, rib damage, spinal misalignment, fluid buildup in lungs and circulation issues.⁴⁷

Problems related to tucking included itching (28%), rash (21%), testicular pain (17%), penile pain (14%), and skin infections (12%).⁴⁸ Testicular torsion (twisting of the spermatic cord) is a rare but serious complication of tucking which can require removal of the testicles.⁴⁹ This is a particular danger for young teens who are tucking without their parents' knowledge and may therefore be reluctant to disclose their symptoms.

Binding and tucking should both not be encouraged by schools and should be done only under supervision of a medical professional. Schools that engage in promoting binding and tucking, especially to minors, should consider their role in the negative health impacts.

8.2.3.4.7 Informed consent and capacity

There is a reason we have laws to prevent young people from drinking alcohol until the age of 18, 19 or 21; driving cars until age 16; getting tattoos until age 18; obtaining piercings until age 16; and consenting to sex with adults until age 16. The human brain continues to develop well into the 20s and the prefrontal cortex, which regulates risk assessment and long-term decision making, is one of the last parts to develop.⁵⁰

Obtaining genuine informed consent for gender transition should be an extensive process that goes well beyond simply reviewing a form which lists potential side-effects of the treatment.⁵¹ Gender transition is a complex process that raises considerations beyond the experience of a child or even a teenager. A child who has never been on a date, felt the slightest stirring of sexual desire, and may even have a shaky understanding of the difference between males and females is being asked to consent to a course of treatment beginning with social transition that may leave him or her sterile and incapable of sexual pleasure.

47 SARAH PEITZMEIER ET AL., "HEALTH IMPACT OF CHEST BINDING AMONG TRANSGENDER ADULTS: A COMMUNITY-ENGAGED, CROSS-SECTIONAL STUDY," *CULTURE, HEALTH & SEXUALITY* 19, NO. 1 (2017): 64–75, [HTTPS://DOI.ORG/10.1080/13691058.2016.1191675](https://doi.org/10.1080/13691058.2016.1191675).

48 TONIA POTEAT, MANNAT MALIK, AND ERIN COONEY, "UNDERSTANDING THE HEALTH EFFECTS OF BINDING AND TUCKING FOR GENDER AFFIRMATION," *JOURNAL OF CLINICAL AND TRANSLATIONAL SCIENCE* 2, NO. SUPPL 1 (NOVEMBER 21, 2018): 76, [HTTPS://DOI.ORG/10.1017/CTS.2018.268](https://doi.org/10.1017/CTS.2018.268).

49 CLARENCE JOY M. DEBARBO, "RARE CAUSE OF TESTICULAR TORSION IN A TRANSWOMAN: A CASE REPORT," *UROLOGY CASE REPORTS* 33 (NOVEMBER 1, 2020): 101422, [HTTPS://DOI.ORG/10.1016/J.EUCR.2020.101422](https://doi.org/10.1016/J.EUCR.2020.101422).

50 MARIAM ARAIN ET AL., "MATURATION OF THE ADOLESCENT BRAIN," *NEUROPSYCHIATRIC DISEASE AND TREATMENT* 9 (2013): 449–61, [HTTPS://DOI.ORG/10.2147/NDT.S39776](https://doi.org/10.2147/NDT.S39776).

51 STEPHEN B. LEVINE, E. ABBRUZZESE, AND JULIA M. MASON, "RECONSIDERING INFORMED CONSENT FOR TRANS-IDENTIFIED CHILDREN, ADOLESCENTS, AND YOUNG ADULTS," *JOURNAL OF SEX & MARITAL THERAPY* 48, NO. 7 (MARCH 17, 2022): 1–22, [HTTPS://DOI.ORG/10.1080/0092623X.2022.2046221](https://doi.org/10.1080/0092623X.2022.2046221).

The sterilizing effects of the combination of puberty blockers and cross-sex hormones are a particular concern. Canada has a shameful history of coerced sterilization of women, especially indigenous women, suffering from mental health problems.⁵² Today indigenous youth represent 18.8% of patients at Canadian gender clinics⁵³ while indigenous people make up only 5% of the Canadian population.⁵⁴ The informed consent process for any treatment likely to result in sterility must be very thorough.

Another concern is that the laws which allow mature minors to consent to medical treatment were developed in the context of physical illnesses where there are objective means to diagnosis and treatments supported by strong evidence. A diagnosis of gender dysphoria, on the other hand, depends entirely on subjective, self-reported symptoms, and the treatment is supported only by weak evidence.

Moreover, many parents and even family physicians and pediatricians mistakenly believe that a gender clinic will do a differential diagnosis and assessment first, when evidence shows that this is no longer the case. The Dutch Protocol is no longer being followed as these treatments are being seen as a human right. Little consideration of known psycho developmental processes such as sex/gender constancy or adolescent identity development, as it is now believed that children know their gender identity regardless of age. Recently, the London Health Sciences Centre Children's Hospital Gender Pathways Service recommended that family physicians begin hormone suppression while waiting to be seen at their gender clinic.⁵⁵ A TransYouthCan study reported that 62% of children referred to a gender clinic at ten major Canadian gender clinics they studied were prescribed hormonal treatment on the first visit.⁵⁶ Of the ten major pediatric gender clinics, five do not require any psychological or psychiatric evaluation. Evaluation or psychotherapy before beginning hormonal treatment. One only requires it part of the time.⁵²

8.2.4 Gender identity and the youth mental health crisis

Over the last ten years, there has been a startling increase in young people experiencing gender dysphoria. Around the world, gender clinics for children which once saw only a few dozen patients a year now have caseloads of hundreds or thousands. Furthermore,

52 JENNIFER LEASON, "FORCED AND COERCED STERILIZATION OF INDIGENOUS WOMEN," CANADIAN FAMILY PHYSICIAN 67, NO. 7 (JULY 2021): 525–27, [HTTPS://DOI.ORG/10.46747/CFP.6707525](https://doi.org/10.46747/cfp.6707525).

53 GRETA R. BAUER ET AL., "TRANSGENDER YOUTH REFERRED TO CLINICS FOR GENDER-AFFIRMING MEDICAL CARE IN CANADA," PEDIATRICS 148, NO. 5 (NOVEMBER 1, 2021): E2020047266, [HTTPS://DOI.ORG/10.1542/PEDS.2020-047266](https://doi.org/10.1542/peds.2020-047266).

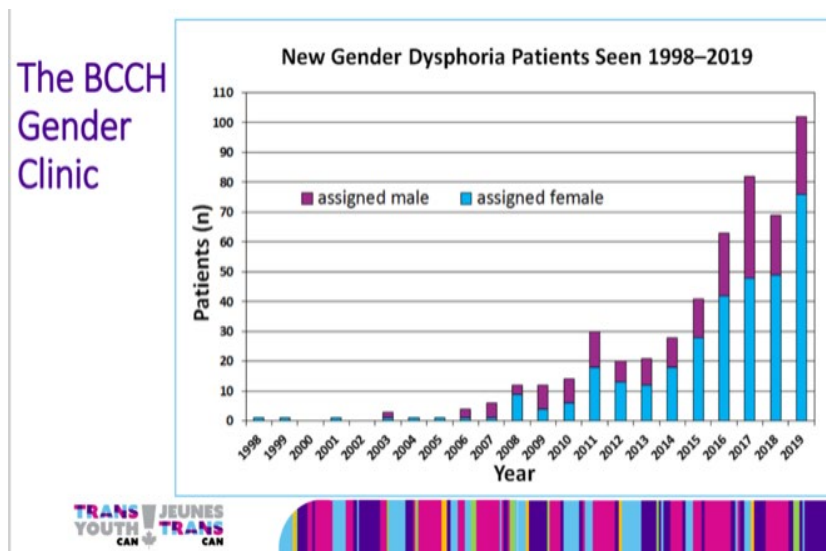
54 STATISTICS CANADA, "INDIGENOUS POPULATION CONTINUES TO GROW AND IS MUCH YOUNGER THAN THE NON-INDIGENOUS POPULATION, ALTHOUGH THE PACE OF GROWTH HAS SLOWED," SEPTEMBER 21, 2022, [HTTPS://WWW150.STATCAN.GC.CA/N1/DAILY-QUOTIDIEN/220921/DQ220921A-ENG.HTM](https://www150.statcan.gc.ca/n1/daily-quotidien/220921/dq220921a-eng.htm).

55 JONATHAN BRADLEY, "ONTARIO HOSPITAL ALLOWS CHILDREN TO TAKE PUBERTY BLOCKERS BEFORE FIRST ASSESSMENT," WESTERN STANDARD, AUGUST 3, 2022, [HTTPS://WWW.WESTERNSTANDARD.NEWS/NEWS/ONTARIO-HOSPITAL-ALLOWS-CHILDREN-TO-TAKE-PUBERTY-BLOCKERS-BEFORE-FIRST-ASSESSMENT/ARTICLE_B891269A-1348-11ED-AC35-E37C7D115C6B.HTML](https://www.westernstandard.news/news/ontario-hospital-allows-children-to-take-puberty-blockers-before-first-assessment/article_b891269a-1348-11ed-ac35-e37c7d115c6b.html).

56 BAUER ET AL., "TRANSGENDER YOUTH REFERRED TO CLINICS FOR GENDER-AFFIRMING MEDICAL CARE IN CANADA."

there has been a change in the patient population. Historically, young boys were in the majority. Now, teenage girls dominate.⁵⁷ Recent data also indicate that the mean age of those seeking services for gender dysphoria has decreased between 2017 and 2022, with females seeking support for gender dysphoria at a younger age than males.⁵⁸ This chart from the BC Children’s Hospital is typical of trends across Canada and worldwide. In 2009, just over 10 new patients were seen per year, evenly split between boys and girls. In 2019, the number had grown to over 100 new patients, with girls outnumbering boys by more than 3 to 1.

The most reliable data on gender dysphoria from the United Kingdom is similar. This chart of referrals to the gender clinic for youth and children shows the same rapid growth between 2010 and 2022, with the largest increase among females between the ages of 12 and 17. Referrals for both sexes under the age of 12 grew only slightly.

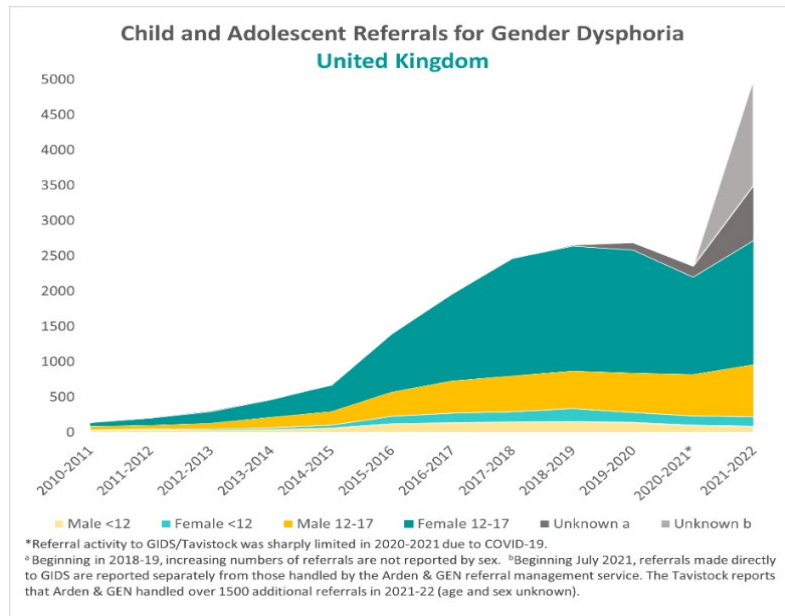


While the growth in total patient referrals could be explained by greater social awareness and acceptance of gender identity, this does not explain why this growth is concentrated in teenage girls, reflecting a similar increase for other mental health conditions over the same period.

57 KENNETH J. ZUCKER ET AL., "DEMOGRAPHICS, BEHAVIOR PROBLEMS, AND PSYCHOSEXUAL CHARACTERISTICS OF ADOLESCENTS WITH GENDER IDENTITY DISORDER OR TRANSVESTIC FETISHISM," JOURNAL OF SEX & MARITAL THERAPY 38, NO. 2 (MARCH 1, 2012): 151–89, [HTTPS://DOI.ORG/10.1080/0092623X.2011.611219](https://doi.org/10.1080/0092623X.2011.611219).

58 CHING-FANG SUN ET AL., "THE MEAN AGE OF GENDER DYSPHORIA DIAGNOSIS IS DECREASING," JOURNAL OF THE AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY 61, NO. 10 (OCTOBER 1, 2022): S265, [HTTPS://DOI.ORG/10.1016/J.JAAC.2022.09.392](https://doi.org/10.1016/J.JAAC.2022.09.392).

While the growth in total patient referrals could be explained by greater social awareness and acceptance of gender identity, this does not explain why this growth is concentrated in teenage girls, or why the growth of gender dysphoria parallels the increase for other mental health conditions over the same period of time, also particularly affecting teenage girls.⁵⁹



8.2.4.1 Social influence

An alternate explanation clinicians and researchers have hypothesized to account for the exponential number of adolescents, particularly females, declaring a trans identity is social mediated, both through peer influence and through sociocultural means such as social media influencers. Data suggests that another surge of trans-identified youth appeared during the COVID-19 pandemic. Researchers hypothesize that the combination of heightened isolation and heavy internet exposure may be causal or contributing factors.⁶⁰

The first published study to note the potential role of social factors was based on a survey of 256 parents of gender-distressed young people.⁶¹ The findings from this study are consistent with clinical findings. For example, 63% of parents reported that their child had at least one other psychiatric disorder or a neurodevelopmental disability. Parents also reported that their adolescent child had recently been more engaged in social media and had at least one trans-identifying friend, often more. Parents reported

59 U.S. SURGEON GENERAL, "SOCIAL MEDIA AND YOUTH MENTAL HEALTH," 2023; JON HAIDT, "AFTER BABEL," JUNE 21, 2023, [HTTPS://JONATHANHAIDT.SUBSTACK.COM/ARCHIVE?SORT=NEW](https://jonathanhaidt.substack.com/archive?sort=new).

60 LAURA EDWARDS-LEEPER AND ERICA ANDERSON, "THE MENTAL HEALTH ESTABLISHMENT IS FAILING TRANS KIDS," WASHINGTON POST, NOVEMBER 24, 2021, SEC. OUTLOOK, [HTTPS://WWW.WASHINGTONPOST.COM/OUTLOOK/2021/11/24/TRANS-KIDS-THERAPY-PSYCHOLOGIST/](https://www.washingtonpost.com/outlook/2021/11/24/trans-kids-therapy-psychologist/).

61 LISA LITTMAN, "PARENT REPORTS OF ADOLESCENTS AND YOUNG ADULTS PERCEIVED TO SHOW SIGNS OF A RAPID ONSET OF GENDER DYSPHORIA," PLOS ONE 13, NO. 8 (AUGUST 16, 2018): E0202330, [HTTPS://DOI.ORG/10.1371/JOURNAL.PONE.0202330](https://doi.org/10.1371/JOURNAL.PONE.0202330).

that trans identity tended to occur in clusters, with more than one adolescent in a peer group coming out as transgender at approximately the same time. These findings led to the “social contagion” hypothesis known as rapid onset gender dysphoria (ROGD), which states that trans-identification may be due to maladaptive coping mechanisms to psychosocial stressors mediated by sociocultural factors such as social media and peer influences.

Dr. Lisa Littman, who conducted the original research, coined the term not as diagnosis but as a description, “rapid onset” because these adolescents did not exhibit gender dysphoria as children, and many were not even gender non-conforming. Their gender dysphoria, according to the parent report, developed over a very short period of time, often within just a few months. Recent research presenting parent reports of 1655 cases of possible cases⁶² found similar results to the original ROGD study; although this study, like the original ROGD study, has also been contested.

The ROGD hypothesis is controversial⁶³ and has been contested by some clinicians and researchers.⁶⁴ Others, however, concur⁶⁵ that social contagion and maladaptive coping mechanisms are at play, for at least some portion of this adolescent-onset cohort. There is evidence that stressors such as family dysfunction, trauma and sexual assault may be implicating factors.⁶⁶ Although ROGD has met with criticism, no studies have tested and disproved the hypothesis.⁶⁷ Further, subsequent research on detransitioners⁶⁸ validates the hypothesis with some supporting evidence. Many detransitioners reported that at least part of their reason for adopting a trans-identity and medical transitioning was due to social media and peer influence. The following is

62 SUZANNA DIAZ AND J. MICHAEL BAILEY, “RAPID ONSET GENDER DYSPHORIA: PARENT REPORTS ON 1655 POSSIBLE CASES,” ARCHIVES OF SEXUAL BEHAVIOR, MARCH 29, 2023, [HTTPS://DOI.ORG/10.1007/S10508-023-02576-9](https://doi.org/10.1007/s10508-023-02576-9).

63 BECKY MCCALL, “‘RAPID ONSET GENDER DYSPHORIA’ IN ADOLESCENTS STIRS DEBATE,” MEDSCAPE, SEPTEMBER 13, 2018, [HTTPS://WWW.MEDSCAPE.COM/VIEWARTICLE/901951](https://www.medscape.com/viewarticle/901951).

64 ARJEE JAVELLANA RESTAR, “METHODOLOGICAL CRITIQUE OF LITTMAN’S (2018) PARENTAL-RESPONDENTS ACCOUNTS OF ‘RAPID-ONSET GENDER DYSPHORIA,’” ARCHIVES OF SEXUAL BEHAVIOR 49, NO. 1 (JANUARY 1, 2020): 61–66, [HTTPS://DOI.ORG/10.1007/S10508-019-1453-2](https://doi.org/10.1007/s10508-019-1453-2); GRETA R. BAUER ET AL., “DO CLINICAL DATA FROM TRANSGENDER ADOLESCENTS SUPPORT THE PHENOMENON OF ‘RAPID ONSET GENDER DYSPHORIA?’,” THE JOURNAL OF PEDIATRICS 243 (APRIL 2022): 224-227.E2, [HTTPS://DOI.ORG/10.1016/J.JPEDS.2021.11.020](https://doi.org/10.1016/j.jpeds.2021.11.020).

65 KENNETH J. ZUCKER, “DEBATE: DIFFERENT STROKES FOR DIFFERENT FOLKS,” CHILD AND ADOLESCENT MENTAL HEALTH 25, NO. 1 (FEBRUARY 2020): 36–37, [HTTPS://DOI.ORG/10.1111/CAMH.12330](https://doi.org/10.1111/CAMH.12330); MICHAEL BAILEY AND RAY BLANCHARD, “GENDER DYSPHORIA IS NOT ONE THING,” GD ALLIANCE (BLOG), SEPTEMBER 10, 2022, [HTTPS://WWW.GENDERYSPHORIAALLIANCE.COM/POST/GENDER-DYSPHORIA-IS-NOT-ONE-THING](https://www.genderysphoriaalliance.com/post/gender-dysphoria-is-not-one-thing); ZUCKER, “DEBATE”; LISA MARCHIANO, “OUTBREAK: ON TRANSGENDER TEENS AND PSYCHIC EPIDEMICS,” PSYCHOLOGICAL PERSPECTIVES 60, NO. 3 (JULY 3, 2017): 345–66, [HTTPS://DOI.ORG/10.1080/00332925.2017.1350804](https://doi.org/10.1080/00332925.2017.1350804).

66 SARAH C. J. JORGENSEN, “TRANSITION REGRET AND DETRANSITION: MEANINGS AND UNCERTAINTIES,” ARCHIVES OF SEXUAL BEHAVIOR, JUNE 2, 2023, [HTTPS://DOI.ORG/10.1007/S10508-023-02626-2](https://doi.org/10.1007/s10508-023-02626-2).

67 LISA LITTMAN, “SAYING THAT BAUER ET AL STUDIED RAPID ONSET GENDER DYSPHORIA IS INACCURATE AND MISLEADING,” THE JOURNAL OF PEDIATRICS 245 (JUNE 1, 2022): 250, [HTTPS://DOI.ORG/10.1016/J.JPEDS.2022.03.003](https://doi.org/10.1016/j.jpeds.2022.03.003); JOANNE SINAI, “RAPID ONSET GENDER DYSPHORIA AS A DISTINCT CLINICAL PHENOMENON,” THE JOURNAL OF PEDIATRICS 245 (JUNE 1, 2022): 250, [HTTPS://DOI.ORG/10.1016/J.JPEDS.2022.03.005](https://doi.org/10.1016/j.jpeds.2022.03.005).

68 LITTMAN, “INDIVIDUALS TREATED FOR GENDER DYSPHORIA WITH MEDICAL AND/OR SURGICAL TRANSITION WHO SUBSEQUENTLY DETRANSITIONED.”

a summary of responses received by Lisa Littman to an online survey of 101 detransitioners:

Sources of transition encouragement and friend group dynamics. Participants identified sources that encouraged them to believe transitioning would help them. Social media and online communities were the most frequently reported, including YouTube transition videos (48.0%), blogs (46.0%), Tumblr (45.0%), and online communities (43.0%). Also common were people who the respondents knew offline such as therapists (37.0%); someone (28.0%) or a group of friends (27.0%) that they knew in person. A subset of participants experienced the friendship group dynamics identified in previous work, including belonging to a friendship group that mocked people who were not transgender (22.2%), having one or more friends from the pre-existing friend group transition before the participant decided to transition (36.4%), and experiencing an increase in popularity after announcing plans to transition (19.6%).⁶⁹

There is also substantial anecdotal evidence from detransitioners of the link between social media use and transgender identification.⁷⁰ It is important to point out that the use of the term “social contagion” is not meant to be derogatory and is used here in the same manner as in social psychology research. The APA defines social contagion as:

The spread of behaviors, attitudes, and affect through crowds and other types of social aggregates from one member to another. Early analyses of social contagion suggested that it resulted from the heightened suggestibility of members and likened the process to the spread of contagious diseases. Subsequent studies suggest that social contagion is sustained by relatively mundane interpersonal processes.⁷¹

It is also important to point out that research suggests that we are not necessarily aware that we are affected by others in this way. Research suggests that our behavior and even our emotions are prone to a contagion effect.⁷² Social contagion has even been experimentally illustrated in the development of false memories.⁷³ At a societal

69 LITTMAN.

70 ELIZA MONDEGREEN, “TRANS IDENTITY AND DOUBT: MY TALK AT GENSPECT’S THE BIGGER PICTURE,” SUBSTACK NEWSLETTER, GENDERHACKED (BLOG), MAY 15, 2023, [HTTPS://ELIZAMONDEGREEN.SUBSTACK.COM/P/TRANS-IDENTITY-AND-DOUBT-MY-TALK?UTM_MEDIUM=EMAIL](https://elizamondegreen.substack.com/p/trans-identity-and-doubt-my-talk?utm_medium=email).

71 AMERICAN PSYCHOLOGICAL ASSOCIATION, “HEALTH ADVISORY ON SOCIAL MEDIA USE IN ADOLESCENCE,” [HTTPS://WWW.APA.ORG](https://www.apa.org), MAY 2023, [HTTPS://WWW.APA.ORG/TOPICS/SOCIAL-MEDIA-INTERNET/HEALTH-ADVISORY-ADOLESCENT-SOCIAL-MEDIA-USE](https://www.apa.org/topics/social-media-internet/health-advisory-adolescent-social-media-use).

72 BRIAN PARKINSON, “INTERPERSONAL EMOTION TRANSFER: CONTAGION AND SOCIAL APPRAISAL,” *SOCIAL AND PERSONALITY PSYCHOLOGY COMPASS* 5, NO. 7 (2011): 428–39, [HTTPS://DOI.ORG/10.1111/J.1751-9004.2011.00365.X](https://doi.org/10.1111/j.1751-9004.2011.00365.x).

73 MICHELLE L. MEADE AND HENRY L. ROEDIGER III, “EXPLORATIONS IN THE SOCIAL CONTAGION OF MEMORY,” *MEMORY & COGNITION* 30 (2002): 995–1009, [HTTPS://DOI.ORG/10.3758/BF03194318](https://doi.org/10.3758/BF03194318).

level, social contagion is believed to play a role in suicide⁷⁴ and non-suicidal self-injury⁷⁵ and violence⁷⁶ to name a few. Using large complex data sets, researchers have illustrated the role of social contagion in obesity. It is not simply the case that similar individuals gravitate toward one another, but rather that there is a causal mediating mechanism that illustrates that the probability of obesity increases significantly beyond three degrees of separation.⁷⁷

As such, it is important to be cognizant of how the role of social contagion may operate within schools and through larger sociocultural environments. The “spread” of eating disorders in adolescent girls in the past may be seen as similar to the spread of gender dysphoria and trans-identification. The parallel rise of other mental health conditions, such as depression, suicidality and anxiety, within the same timeframe, corresponding with the widespread adoption of social media, especially among adolescent females, noticeable after 2012 when smartphones with front-facing “selfie” cameras were first available,⁷⁸ is worth considering, as is the sudden number of teens who are experiencing Tourette’s-like tics and those claiming multiple personalities.⁷⁹ The American Psychological Association has issued a health advisory on social media use in adolescence.⁸⁰ Social media was recently identified as the cause of an outbreak of tics resembling Tourettes’ syndrome.⁸¹ A link has also been found between use of Instagram and anxiety and depression in teenage girls.⁸² Plastic surgeons have noted that social media sites like Snapchat and Instagram can influence patient desires for plastic surgery. This can be a sign of body dysmorphia, for which counseling and not

74 VANIA MARTÍNEZ, ÁLVARO JIMÉNEZ-MOLINA, AND MÓNICA M. GERBER, “SOCIAL CONTAGION, VIOLENCE, AND SUICIDE AMONG ADOLESCENTS,” *CURRENT OPINION IN PSYCHIATRY* 36, NO. 3 (MAY 2023): 237–42, [HTTPS://DOI.ORG/10.1097/YCO.0000000000000858](https://doi.org/10.1097/YCO.0000000000000858).

75 STEPHANIE JARVI ET AL., “THE IMPACT OF SOCIAL CONTAGION ON NON-SUICIDAL SELF-INJURY: A REVIEW OF THE LITERATURE,” *ARCHIVES OF SUICIDE RESEARCH* 17, NO. 1 (JANUARY 1, 2013): 1–19, [HTTPS://DOI.ORG/10.1080/13811118.2013.748404](https://doi.org/10.1080/13811118.2013.748404).

76 JEFFREY FAGAN, DEANNA L. WILKINSON, AND GARTH DAVIES, “SOCIAL CONTAGION OF VIOLENCE,” IN *THE CAMBRIDGE HANDBOOK OF VIOLENT BEHAVIOR AND AGGRESSION*, ED. ALEXANDER T. VAZSONYI, DANIEL J. FLANNERY, AND IRWIN D. WALDMAN, *CAMBRIDGE HANDBOOKS IN PSYCHOLOGY* (CAMBRIDGE: CAMBRIDGE UNIVERSITY PRESS, 2007), 688–724, [HTTPS://DOI.ORG/10.1017/CBO9780511816840.037](https://doi.org/10.1017/CBO9780511816840.037).

77 NICHOLAS A. CHRISTAKIS AND JAMES H. FOWLER, “THE SPREAD OF OBESITY IN A LARGE SOCIAL NETWORK OVER 32 YEARS,” *NEW ENGLAND JOURNAL OF MEDICINE* 357, NO. 4 (JULY 26, 2007): 370–79, [HTTPS://DOI.ORG/10.1056/NEJMsa066082](https://doi.org/10.1056/NEJMsa066082).

78 ZACH RAUSCH AND JON HAIDT, “THE TEEN MENTAL ILLNESS EPIDEMIC IS INTERNATIONAL: THE ANGLOSPHERE,” *SUBSTACK NEWSLETTER, AFTER BABEL (BLOG)*, MARCH 29, 2023, [HTTPS://JONATHANHAIDT.SUBSTACK.COM/P/INTERNATIONAL-MENTAL-ILLNESS-PART-ONE](https://jonathanhaidt.substack.com/p/international-mental-illness-part-one).

79 JOHN D. HALTIGAN, TAMARA M. PRINGSHEIM, AND GAYATHIRI RAJKUMAR, “SOCIAL MEDIA AS AN INCUBATOR OF PERSONALITY AND BEHAVIORAL PSYCHOPATHOLOGY: SYMPTOM AND DISORDER AUTHENTICITY OR PSYCHOSOMATIC SOCIAL CONTAGION?,” *COMPREHENSIVE PSYCHIATRY* 121 (FEBRUARY 2023): 152362, [HTTPS://DOI.ORG/10.1016/J.COMPPSYCH.2022.152362](https://doi.org/10.1016/j.comppsy.2022.152362); KIRSTEN R. MÜLLER-VAHL ET AL., “STOP THAT! IT’S NOT TOURETTE’S BUT A NEW TYPE OF MASS SOCIOGENIC ILLNESS,” *BRAIN: A JOURNAL OF NEUROLOGY* 145, NO. 2 (APRIL 18, 2022): 476–80, [HTTPS://DOI.ORG/10.1093/BRAIN/AWAB316](https://doi.org/10.1093/brain/awab316).

80 AMERICAN PSYCHOLOGICAL ASSOCIATION, “HEALTH ADVISORY ON SOCIAL MEDIA USE IN ADOLESCENCE.”

81 HALTIGAN, PRINGSHEIM, AND RAJKUMAR, “SOCIAL MEDIA AS AN INCUBATOR OF PERSONALITY AND BEHAVIORAL PSYCHOPATHOLOGY”; MÜLLER-VAHL ET AL., “STOP THAT! IT’S NOT TOURETTE’S BUT A NEW TYPE OF MASS SOCIOGENIC ILLNESS”; CAROLINE OLVERA ET AL., “TIKTOK TICS: A PANDEMIC WITHIN A PANDEMIC,” *MOVEMENT DISORDERS CLINICAL PRACTICE* 8, NO. 8 (AUGUST 9, 2021): 1200–1205, [HTTPS://DOI.ORG/10.1002/MDC3.13316](https://doi.org/10.1002/mdc3.13316).

82 GEORGIA WELLS AND DEEPA SEETHARAMAN, “FACEBOOK KNOWS INSTAGRAM IS TOXIC FOR TEEN GIRLS, COMPANY DOCUMENTS SHOW,” *THE WALL STREET JOURNAL*, SEPTEMBER 12, 2021, [HTTPS://WWW.WSJ.COM/ARTICLES/FACEBOOK-KNOWS-INSTAGRAM-IS-TOXIC-FOR-TEEN-GIRLS-COMPANY-DOCUMENTS-SHOW-11631620739](https://www.wsj.com/articles/facebook-knows-instagram-is-toxic-for-teen-girls-company-documents-show-11631620739).

surgery is the appropriate treatment.⁸³ There is also substantial anecdotal evidence from detransitioners of the link between social media use and transgender identification.⁸⁴

Considering what we know about the influence of social media on the mental health of adolescents, it is not reasonable to dismiss, without examination, the hypothesis that at least some part of the current cases of gender dysphoria are socially influenced.

8.2.4.2 Coexisting mental health conditions

Children and teens who identify as transgender frequently have one or more other mental health issues such as depression, anxiety, borderline personality disorder, or Obsessive-Compulsive Personality Disorder or a history of trauma.⁸⁵ There has been a strong association between gender dysphoria and neurodevelopmental conditions such as Autism Spectrum Disorders (ASD) and ADHD. Data from GIDS at the Tavistock, for example, found that 35% of their referrals presented with moderate to severe Autism traits.⁸⁶ School staff may not be aware of these associations, and they are very unlikely to be qualified to work with such complex conditions.

There are many studies that have found that children and teens referred to gender clinics have much higher rates of comorbid mental health issues than the general population. A study of patients at the gender clinic in Sick Children's Hospital in Toronto found that 78.8% reported more than one mental health problem. Depressive disorders were reported by 40% and anxiety disorders by 44.3%.⁸⁷

Although there is evidence of a link between ASD and gender dysphoria, the nature of this link is not well understood.⁸⁸ ASD is particularly difficult to diagnose in biological girls, and milder cases may not be noticed.⁸⁹ Social challenges and bodily discomfort

83 KAMLESHUN RAMPHUL AND STEPHANIE G MEJIAS, "IS 'SNAPCHAT DYSPHORIA' A REAL ISSUE?," *CUREUS* 10, NO. 3 (2018): E2263, [HTTPS://DOI.ORG/10.7759/CUREUS.2263](https://doi.org/10.7759/cureus.2263).

84 MONDEGREEN, "TRANS IDENTITY AND DOUBT."

85 TRACY A. BECERRA-CULQUI ET AL., "MENTAL HEALTH OF TRANSGENDER AND GENDER NONCONFORMING YOUTH COMPARED WITH THEIR PEERS," *PEDIATRICS* 141, NO. 5 (MAY 1, 2018): E20173845, [HTTPS://DOI.ORG/10.1542/PEDS.2017-3845](https://doi.org/10.1542/peds.2017-3845); KASIA KOZLOWSKA ET AL., "AUSTRALIAN CHILDREN AND ADOLESCENTS WITH GENDER DYSPHORIA: CLINICAL PRESENTATIONS AND CHALLENGES EXPERIENCED BY A MULTIDISCIPLINARY TEAM AND GENDER SERVICE," *HUMAN SYSTEMS* 1, NO. 1 (FEBRUARY 1, 2021): 70–95, [HTTPS://DOI.ORG/10.1177/26344041211010777](https://doi.org/10.1177/26344041211010777).

86 GARY BUTLER ET AL., "ASSESSMENT AND SUPPORT OF CHILDREN AND ADOLESCENTS WITH GENDER DYSPHORIA," *ARCHIVES OF DISEASE IN CHILDHOOD* 103, NO. 7 (JULY 1, 2018): 631–36, [HTTPS://DOI.ORG/10.1136/ARCHDISCHILD-2018-314992](https://doi.org/10.1136/archdischild-2018-314992).

87 ANNA CHURCHER CLARKE AND ANASTASSIS SPILIADIS, "TAKING THE LID OFF THE BOX: THE VALUE OF EXTENDED CLINICAL ASSESSMENT FOR ADOLESCENTS PRESENTING WITH GENDER IDENTITY DIFFICULTIES," *CLINICAL CHILD PSYCHOLOGY AND PSYCHIATRY* 24, NO. 2 (APRIL 1, 2019): 338–52, [HTTPS://DOI.ORG/10.1177/1359104518825288](https://doi.org/10.1177/1359104518825288); JULIA C. SORBARA ET AL., "MENTAL HEALTH AND TIMING OF GENDER-AFFIRMING CARE," *PEDIATRICS* 146, NO. 4 (OCTOBER 1, 2020), [HTTPS://DOI.ORG/10.1542/PEDS.2019-3600](https://doi.org/10.1542/peds.2019-3600).

88 JONATHAN H. LEEF ET AL., "TRAITS OF AUTISM SPECTRUM DISORDER IN SCHOOL-AGED CHILDREN WITH GENDER DYSPHORIA: A COMPARISON TO CLINICAL CONTROLS," *CLINICAL PRACTICE IN PEDIATRIC PSYCHOLOGY* 7, NO. 4 (DECEMBER 2019): 383–95, [HTTPS://DOI.ORG/10.1037/PPP0000303](https://doi.org/10.1037/cpp0000303).

89 LAURA HULL, K. V. PETRIDES, AND WILLIAM MANDY, "THE FEMALE AUTISM PHENOTYPE AND CAMOUFLAGING: A NARRATIVE REVIEW," *REVIEW JOURNAL OF AUTISM AND DEVELOPMENTAL DISORDERS* 7, NO. 4 (DECEMBER 1, 2020): 306–17, [HTTPS://DOI.ORG/10.1007/S40489-020-](https://doi.org/10.1007/s40489-020-)

related to autism may be mistakenly assumed to be signs of a transgender identity, resulting in many girls undergoing irreversible hormonal and surgical treatment before they receive a proper diagnosis of their condition:

Teachers and school counselors are not qualified as mental health practitioners. Social transition interacts with complex mental health conditions of which they may not even be aware. They should not be making decisions regarding social transition at all and definitely not without the involvement of a child's parents.

8.2.4.3 Desistance, detransition and regret

Under the "watchful waiting" model, before social transition of children became common, twelve studies showed that the majority of children who experienced gender distress desisted sometime during puberty.⁹⁰ A study of 139 boys at a Canadian clinic, for example, found a desistance rate of 87.8%.⁹¹ Another article reported that as of 2011, the desistance rate in 246 cases of gender identity disorder was 207 or 84.2%.⁹² By contrast, a study of 317 youth who had been socially transitioned found that 97.5% retained a transgender identity after five years.⁹³ Only 2.5% desisted, reidentifying with their birth sex

For many years, advocates of the affirming care model claimed that the rate of detransition and regret among transgender people was very rare. However, the studies which found low regret rates have multiple shortcomings. Some of them used a very restrictive definition of regret, others had very short follow-up periods or a high loss to follow-up. Most significantly, these studies involved a patient population of adults who transitioned only after extensive psychological assessment and therefore not likely relevant to the current population of child and adolescent transitioners who have received little to no assessment.⁹⁴

00197-9; GEORGIA LOCKWOOD ESTRIN ET AL., "BARRIERS TO AUTISM SPECTRUM DISORDER DIAGNOSIS FOR YOUNG WOMEN AND GIRLS: A SYSTEMATIC REVIEW," *REVIEW JOURNAL OF AUTISM AND DEVELOPMENTAL DISORDERS* 8, NO. 4 (DECEMBER 1, 2021): 454–70, [HTTPS://DOI.ORG/10.1007/s40489-020-00225-8](https://doi.org/10.1007/s40489-020-00225-8).

90 JAMES CANTOR, "DO TRANS- KIDS STAY TRANS- WHEN THEY GROW UP?," *SEXOLOGY TODAY* (BLOG), NOVEMBER 1, 2016, [HTTP://WWW.SEXOLOGYTODAY.ORG/2016/01/DO-TRANS-KIDS-STAY-TRANS-WHEN-THEY-GROW_99.HTML](http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html).

91 SINGH, BRADLEY, AND ZUCKER, "A FOLLOW-UP STUDY OF BOYS WITH GENDER IDENTITY DISORDER."

92 THOMAS D. STEENSMA AND PEGGY T. COHEN-KETTENIS, "GENDER TRANSITIONING BEFORE PUBERTY?," *ARCHIVES OF SEXUAL BEHAVIOR* 40, NO. 4 (AUGUST 1, 2011): 649–50, [HTTPS://DOI.ORG/10.1007/s10508-011-9752-2](https://doi.org/10.1007/s10508-011-9752-2).

93 KRISTINA R. OLSON ET AL., "GENDER IDENTITY 5 YEARS AFTER SOCIAL TRANSITION," *PEDIATRICS* 150, NO. 2 (AUGUST 1, 2022): e2021056082, [HTTPS://DOI.ORG/10.1542/PEDS.2021-056082](https://doi.org/10.1542/peds.2021-056082).

94 SARAH C. J. JORGENSEN, "TRANSITION REGRET AND DETRANSITION: MEANINGS AND UNCERTAINTIES," *ARCHIVES OF SEXUAL BEHAVIOR*, JUNE 2, 2023, [HTTPS://DOI.ORG/10.1007/s10508-023-02626-2](https://doi.org/10.1007/s10508-023-02626-2); J. COHN, "THE DETRANSITION RATE IS UNKNOWN," *ARCHIVES OF SEXUAL BEHAVIOR*, JUNE 12, 2023, [HTTPS://DOI.ORG/10.1007/s10508-023-02623-5](https://doi.org/10.1007/s10508-023-02623-5).

Media coverage is finally beginning to acknowledge that detransition is a real and growing concern.⁹⁵ Regret and detransition are difficult to measure. Studies conducted by gender clinics typically underreport regret because patients who regret their transition are not likely to return to the clinic.⁹⁶ There is evidence that regret rates are now much higher than once assumed. One study of youth in the UK indicates that it may be as high as 10.3% within 12 months of seeking treatment.⁹⁷ Another study of the United Kingdom NHS records documented the rate of detransition or regret as 12 percent, with 20 percent of patients stopping hormone therapy for various reasons.⁹⁸ Another recent study of the U.S. military healthcare system found that 30 percent of patients discontinued cross-sex hormone therapy after four years.⁹⁹

While the rate of regret and detransition is unknown, when it does occur, the pain is real and substantial.¹⁰⁰ Detransitioners will have to deal with permanent changes to their bodies. Their natural endocrine system will have been damaged or destroyed so they will need to take artificial hormones for life. If they have had “bottom surgery,” they will be infertile and may have diminished or absent sexual response. Women who are still able to bear a child will not be able to breastfeed if they have had a double mastectomy and will need emotional support.¹⁰¹ These are only the unavoidable consequences of transition. Complications from surgery or health problems caused by cross-sex hormones can be a source of ongoing pain. Currently, there are no official supports or medical treatment guidelines to support detransitioners’ physical or psychological needs.

Detransitioners are starting to sue. An Ontario woman who received testosterone, a double mastectomy, and a hysterectomy while suffering from mental health problems and autism has started a lawsuit which alleges that various healthcare providers were negligent in recommending irreversible medical procedures without properly assessing

95 ROBIN RESPAUT, CHAD TERHUNE, AND MICHELLE CONLIN, “WHY DETRANSITIONERS ARE CRUCIAL TO THE SCIENCE OF GENDER CARE,” REUTERS, DECEMBER 22, 2022, [HTTPS://WWW.REUTERS.COM/INVESTIGATES/SPECIAL-REPORT/USA-TRANSYOUTH-OUTCOMES/](https://www.reuters.com/investigates/special-report/usa-transyouth-outcomes/).

96 LITTMAN, “INDIVIDUALS TREATED FOR GENDER DYSPHORIA WITH MEDICAL AND/OR SURGICAL TRANSITION WHO SUBSEQUENTLY DETRANSITIONED.”

97 R. HALL, L. MITCHELL, AND J. SACHDEVA, “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* 7, no. 6 (NOVEMBER 2021), [HTTPS://DOI.ORG/10.1192/BJO.2021.1022](https://doi.org/10.1192/BJO.2021.1022).

98 ISABEL BOYD, THOMAS HACKETT, AND SUSAN BEWLEY, “CARE OF TRANSGENDER PATIENTS: A GENERAL PRACTICE QUALITY IMPROVEMENT APPROACH,” *HEALTHCARE* 10, no. 1 (JANUARY 2022): 121, [HTTPS://DOI.ORG/10.3390/HEALTHCARE10010121](https://doi.org/10.3390/HEALTHCARE10010121).

99 CHRISTINA M ROBERTS ET AL., “CONTINUATION OF GENDER-AFFIRMING HORMONES AMONG TRANSGENDER ADOLESCENTS AND ADULTS,” *THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM* 107, no. 9 (SEPTEMBER 1, 2022): E3937–43, [HTTPS://DOI.ORG/10.1210/CLINEM/DGAC251](https://doi.org/10.1210/CLINEM/DGAC251).

100 COHN, “THE DETRANSITION RATE IS UNKNOWN.”

101 KARLEEN D. GRIBBLE, SUSAN BEWLEY, AND HANNAH G. DAHLEN, “BREASTFEEDING GRIEF AFTER CHEST MASCULINISATION MASTECTOMY AND DETRANSITION: A CASE REPORT WITH LESSONS ABOUT UNANTICIPATED HARM,” *FRONTIERS IN GLOBAL WOMEN’S HEALTH* 4 (2023), [HTTPS://WWW.FRONTIERSIN.ORG/ARTICLES/10.3389/FGWH.2023.1073053](https://www.frontiersin.org/articles/10.3389/fgwh.2023.1073053).

her mental health problems and offering her psychotherapy as an alternative treatment.

¹⁰² Cases have also been filed in the UK ¹⁰³ and the US. ¹⁰⁴

The lawsuit in Ontario is still several years away from trial, but more claims are certainly coming, and there is a possibility that teachers and schools may be added as defendants. Schools have a duty of care to protect pupils which is equal to that of a careful and prudent parent in similar circumstances. ¹⁰⁵ These duties include an obligation to obtain medical assistance when required and not to undertake serious medical or psychological interventions without professional advice.

8.2.4.4 Suicidality

Any discussion of suicide is of the utmost importance both to families and to educational institutions. The belief that trans-identified youth are at exceedingly high risk of suicide are often based on online surveys which are unable to report accurate population estimates because they rely on samples of convenience. Further, many of these studies are self-reports of suicidal ideation, self-harm, and suicide attempts ¹⁰⁶ and consider suicidal thoughts, self-harm, serious suicide attempts, and completed suicides as equally important measures of suicidality. Although thoughts of suicide should never be disregarded, it is important to keep in mind that thoughts and behaviors are quite different. ¹⁰⁷ Further, such surveys cannot discern whether the suicidality can be attributed to gender dysphoria or other mental health comorbidities common in this population. ¹⁰⁸

A recent study using a large data set of youth seeking treatment at the GIDS at the Tavistock and Portman Foundation found that the rate of completed suicide was 0.03% over a 10-year period. While this is low, it is 5.5 times greater than the suicide rate of adolescents of similar age. This study also found that the rate of suicide was the

102 ADRIAN HUMPHRIES, "ONTARIO DETRANSITIONER WHO HAD BREASTS AND WOMB REMOVED SUES DOCTORS," NATIONAL POST, FEBRUARY 23, 2023, [HTTPS://NATIONALPOST.COM/NEWS/CANADA/MICHELLE-ZACCHIGNA-ONTARIO-DETRANSITIONER-SUES-DOCTORS](https://nationalpost.com/news/canada/michelle-zacchigna-ontario-detransitioner-sues-doctors).

103 SIAN GRIFFITHS, "NHS TRANS SURGERY DAMAGED MY BODY FOR EVER — IT'S NOT SAFE," JUNE 10, 2023, SEC. NEWS, [HTTPS://WWW.THETIMES.CO.UK/ARTICLE/NHS-TRANS-SURGERY-DAMAGED-MY-BODY-FOR-EVER-ITS-NOT-SAFE-JT2HHBRGK](https://www.thetimes.co.uk/article/nhs-trans-surgery-damaged-my-body-for-ever-its-not-safe-jt2hhbrgk).

104 PETE SURATOS, "KAISER PERMANENTE SUED OVER HORMONE THERAPY," NBC BAY AREA (BLOG), FEBRUARY 24, 2023, [HTTPS://WWW.NBCBAYAREA.COM/NEWS/LOCAL/KAISER-PERMANENTE-SUED-OVER-HORMONE-THERAPY/3164935/](https://www.nbcbayarea.com/news/local/kaiser-permanente-sued-over-hormone-therapy/3164935/).

105 MYERS V. PEEL COUNTY BOARD OF EDUCATION, 2 SCR 21 (SUPREME COURT OF CANADA 1981).

106 ROBERTO D'ANGELO ET AL., "ONE SIZE DOES NOT FIT ALL: IN SUPPORT OF PSYCHOTHERAPY FOR GENDER DYSPHORIA," ARCHIVES OF SEXUAL BEHAVIOR, OCTOBER 21, 2020, [HTTPS://DOI.ORG/10.1007/S10508-020-01844-2](https://doi.org/10.1007/s10508-020-01844-2); SANDY E. JAMES ET AL., "THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY" (ICPSR - INTERUNIVERSITY CONSORTIUM FOR POLITICAL AND SOCIAL RESEARCH, 2016), [HTTPS://DOI.ORG/10.3886/ICPSR37229](https://doi.org/10.3886/ICPSR37229); "THE TREVOR PROJECT NATIONAL SURVEY," 2021, [HTTPS://WWW.THETREVORPROJECT.ORG/SURVEY-2021/](https://www.thetrevorproject.org/survey-2021/).

107 E. DAVID KLONSKY, ALEXIS M. MAY, AND BOAZ Y. SAFFER, "SUICIDE, SUICIDE ATTEMPTS, AND SUICIDAL IDEATION," ANNUAL REVIEW OF CLINICAL PSYCHOLOGY 12 (2016): 307–30, [HTTPS://DOI.ORG/10.1146/ANNUREV-CLINPSY-021815-093204](https://doi.org/10.1146/annurev-clinpsy-021815-093204).

108 DEBRA SOH, THE END OF GENDER: DEBUNKING THE MYTHS ABOUT SEX AND IDENTITY IN OUR SOCIETY, FIRST THRESHOLD EDITIONS HARDCOVER EDITION (NEW YORK: THRESHOLD EDITIONS, 2020).

similar, if not higher, for those who had and had started medically transitioning,¹⁰⁹ suggesting that it may be imprudent to assume that transition will decrease suicidality. Studies have also found an unacceptably high risk of suicide continues post-affirmation and post-medical transition.¹¹⁰ It is critically important for school staff to know that social transition has not been shown to reduce suicidality.

Although increased risk of suicidality in those identifying as transgender has been documented, little is understood about the cause of suicidality in this population. It is well documented that those identifying as transgender are at risk of other mental health conditions.¹¹¹ In fact, adolescents with gender dysphoria are more likely than age-matched peers to experience mental health issues, with 40-45% presenting with clinically significant psychopathology, as compared to roughly 20% of the general population.¹¹² This increased risk is also true of the new cohort of gender dysphoric adolescents who present with significant mental health and neurodevelopmental conditions.¹¹³ Since these conditions of themselves¹¹⁴ are associated with suicidality and multiple comorbidities also significantly increases the risk of suicidality,¹¹⁵ it would be prudent not to attribute the increased risk of suicidality simply to being transgender. In fact, the Center for Disease Control points out that the cause of suicide is multifaceted.¹¹⁶ Students at risk for self-harm and suicidality should always be carefully assessed and directed to evidence-based suicide prevention protocols.

Lastly, in discussing suicidality, it is exceedingly important not to simplify the narrative to a causal one of being transgender or one based solely on minority stress, as these overly simplistic messages may become internalized by these vulnerable youth, thereby increasing their risk.¹¹⁷

109 MICHAEL BIGGS, "SUICIDE BY CLINIC-REFERRED TRANSGENDER ADOLESCENTS IN THE UNITED KINGDOM," ARCHIVES OF SEXUAL BEHAVIOR, JANUARY 18, 2022, [HTTPS://DOI.ORG/10.1007/S10508-022-02287-7](https://doi.org/10.1007/s10508-022-02287-7).

110 BIGGS; CECILIA DHEJNE ET AL., "LONG-TERM FOLLOW-UP OF TRANSEXUAL PERSONS UNDERGOING SEX REASSIGNMENT SURGERY: COHORT STUDY IN SWEDEN," ED. JAMES SCOTT, PLoS ONE 6, NO. 2 (FEBRUARY 22, 2011): E16885, [HTTPS://DOI.ORG/10.1371/JOURNAL.PONE.0016885](https://doi.org/10.1371/JOURNAL.PONE.0016885); AGNES WOLD, "GENDER-CORRECTIVE SURGERY PROMOTING MENTAL HEALTH IN PERSONS WITH GENDER DYSPHORIA NOT SUPPORTED BY DATA PRESENTED IN ARTICLE," AMERICAN JOURNAL OF PSYCHIATRY 177, NO. 8 (AUGUST 2020): 768–768, [HTTPS://DOI.ORG/10.1176/APPI.AJP.2020.19111170](https://doi.org/10.1176/APPI.AJP.2020.19111170).

111 BECERRA-CULQUI ET AL., "MENTAL HEALTH OF TRANSGENDER AND GENDER NONCONFORMING YOUTH COMPARED WITH THEIR PEERS."

112 KALTIALA-HEINO ET AL., "GENDER DYSPHORIA IN ADOLESCENCE."

113 CASS, "INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: INTERIM REPORT."

114 MAURIZIO POMPILI ET AL., "SUICIDE IN ANOREXIA NERVOSA: A META-ANALYSIS," THE INTERNATIONAL JOURNAL OF EATING DISORDERS 36, NO. 1 (JULY 2004): 99–103, [HTTPS://DOI.ORG/10.1002/EAT.20011](https://doi.org/10.1002/EAT.20011); SWEDISH NATIONAL BOARD OF HEALTH AND WELFARE, "UTVECKLINGEN AV DIAGNOSEN KÖNSDYSFORI: FÖREKOMST, SAMTIDIGA PSYKIATRISKA DIAGNOSER OCH DÖDLIGHET I SUICID" (SOCIALTYRELSEN, 2020), [HTTPS://WWW.SOCIALSTYRELSEN.SE/GLOBALASSETS/SHAREPOINT-DOKUMENT/ARTIKELKATALOG/OVRIGT/2020-2-6600.PDF](https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6600.pdf).

115 C. HOLMSTRAND ET AL., "LONG-TERM SUICIDE RISK IN NO, ONE OR MORE MENTAL DISORDERS: THE LUNDBY STUDY 1947–1997," ACTA PSYCHIATRICA SCANDINAVICA 132, NO. 6 (DECEMBER 2015): 459–69, [HTTPS://DOI.ORG/10.1111/ACPS.12506](https://doi.org/10.1111/ACPS.12506).

116 CDC, "RISK AND PROTECTIVE FACTORS | SUICIDE | CDC," MAY 11, 2023, [HTTPS://WWW.CDC.GOV/SUICIDE/FACTORS/INDEX.HTML](https://www.cdc.gov/suicide/factors/index.html).

117 SILVIA SARA CANETTO ET AL., "SUICIDAL AS NORMAL - A LESBIAN, GAY, AND BISEXUAL YOUTH SCRIPT?," CRISIS 42, NO. 4 (JULY 2021): 292–300, [HTTPS://DOI.ORG/10.1027/0227-5910/A000730](https://doi.org/10.1027/0227-5910/A000730).

This is especially the case given that suicide has been shown to be socially contagious. Organizations concerned with suicide prevention have developed guidelines for responsible media reporting on suicide which include avoiding sensational reporting of suicides, providing simplistic explanations for deaths by suicide, and portraying suicide as a means to an end.¹¹⁸

8.2.5 Social transition without parental consent

The most concerning aspect of the Canadian policies is that they expressly permit and encourage schools to support the social transition of students, of any age, without notifying their parents. For example, the Toronto District School Board Policy says:

There is no age limit on making an accommodation request, and young students have the same rights to privacy and to have accommodations made on their behalf with or without their guardians' knowledge.

*A school should never disclose a student's gender non-conformity or transgender status to the student's parent(s)/guardian(s)/caregiver(s) without the student's explicit prior consent. This is true regardless of the age of the student.*¹¹⁹

This means that a child of any age may be known by a different name and pronouns and at school, playing sports with the opposite sex or using the washroom and changing rooms of the opposite sex and the parents may not be told. This would also apply to sleeping arrangements on overnight field trips. The details of policies vary, but it is generally possible for a school to change a student's name and pronouns without notice to the parents. The student's legal name may remain on the student's records and be used in communications with the parents, but the school will also keep a separate record of the student's preferred name.

8.2.5.1 Privacy or active intervention?

The policy of non-disclosure is justified on the basis that they are necessary to protect a student's privacy. However, the legal position is not clear. The details of privacy legislation vary from province to province, but there will always be some provision which allows parents or guardians to access information that affects their children's health and welfare.

Furthermore, current practices in schools go beyond simply protecting confidence. If a child simply discloses private thoughts about his or her gender identity, that conversation may be regarded as confidential. Gender-questioning children need to be able to decide when and to whom they will share their feelings. However, once the

118 MARK SINYOR ET AL., "MEDIA GUIDELINES FOR REPORTING ON SUICIDE: 2017 UPDATE OF THE CANADIAN PSYCHIATRIC ASSOCIATION POLICY PAPER," *THE CANADIAN JOURNAL OF PSYCHIATRY* 63, NO. 3 (MARCH 2018): 182–96, [HTTPS://DOI.ORG/10.1177/0706743717753147](https://doi.org/10.1177/0706743717753147).

119 TORONTO DISTRICT SCHOOL BOARD, "TDSB GUIDELINES FOR THE ACCOMMODATION OF TRANSGENDER AND GENDER NON-CONFORMING STUDENTS AND STAFF," SEPTEMBER 9, 2019, [HTTPS://WWW.TDSB.ON.CA/PORTALS/0/DOCS/TDSB%20TRANSGENDER%20ACCOMMODATION%20FINAL_1_.PDF](https://www.tdsb.on.ca/portals/0/docs/tdsb%20transgender%20accommodation%20final_1_.pdf).

school begins to affirm a child's new identity with a new name and pronouns, it is no longer confidential. Instead, it becomes an open secret which is shared with all of the staff and students but withheld from parents.

Changing a child's name and pronouns is a major psychosocial intervention. Social transition tends to reinforce a gender-distressed child's discomfort with his or her body and increases the probability that he or she will proceed with medical transition.¹²⁰

According to the *Interim Report* of the Cass Review, social transition "is an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning."¹²¹ The interim service specification recently issued by the UK National Health Services calls for a multi-disciplinary team to "engage children and young people and their families in an in-depth process of discussion and thinking around the decision of social transition."¹²²

Dr. Riittakerttu Kaltiala is a leading expert on pediatric gender medicine and chief psychiatrist at Finland's largest gender clinic; she believes that social transition tends to solidify a gender identity that might otherwise be transitory:

*Evidence from a combined 12 studies to date demonstrates that when children with cross-gender or gender variant behavior are left to develop naturally, the vast majority—“four out of five,” according to Kaltiala—come to terms with their bodies and learn to accept their sex. When they are socially transitioned, virtually none do.*¹²³

Dr. Erica Anderson is a clinical psychologist and transwoman who has been a board member of both the World Professional Association for Transgender Health and President of USPATH (the United States branch of WPATH). Although she is generally supportive of the affirming model of care for young people, she believes that social transition of children without a psychological assessment and parental involvement is irresponsible. She has submitted an affidavit in a Wisconsin lawsuit which challenges a school board policy permitting social transition without parental approval. The conclusion of this affidavit is:

120 ZUCKER, "THE MYTH OF PERSISTENCE."

121 CASS, "INDEPENDENT REVIEW OF GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE: INTERIM REPORT."

122 NHS ENGLAND, "INTERIM SERVICE SPECIFICATION FOR SPECIALIST GENDER INCONGRUENCE SERVICES FOR CHILDREN AND YOUNG PEOPLE."

123 SAPIR, "FINLAND TAKES ANOTHER LOOK AT YOUTH GENDER MEDICINE."

*A school policy that involves school adult personnel in socially transitioning a child or adolescent without the consent of parents or over their objection violates widely accepted mental health principles and practice.*¹²⁴

*The Endocrine Society guideline is frequently referred to by supporters of affirmative care. It recommends that social transition of children and adolescents be undertaken only with the involvement of a “mental health practitioner or similarly experienced professional.”*¹²⁵

There is no clear research evidence that social transition has any real benefit for a child or adolescent’s mental health.¹²⁶ A German study found that peer relations and family functioning, not social transition, were the most important predictors of psychological functioning in children with gender dysphoria.¹²⁷ Based on this study, if the welfare of the child is the primary goal, schools should, with the aid of appropriate personnel, support and facilitate communication with parents.

The previous chapters of this document showed that gender questioning children often experience other mental health and neurodevelopmental issues. Teachers and school counselors may not be aware of a student’s entire mental health history and do not have the training necessary to deal with these complex conditions.

Teachers are restricted from giving a student so much as an over-the-counter painkiller without parental consent, but they are being allowed to undertake a far more serious intervention without even notifying parents. Some teachers who have concerns about the gender-affirming model that requires them to lie to parents are also having their free expression denied and are being forced to use compelled speech. If the well-being of children is truly the aim, a balanced, open, honest, informed dialogue must happen, and each child’s individual needs must be considered.

8.2.5.2 Children’s rights and the family

Canadian policies on gender identity in schools often reference the United Nations’ *Convention on the Rights of the Child* but ignore two foundational principles of this document. The first is that children (which is defined to mean anyone under the age of 18) require adult guidance and supervision. The second is that the primary source of

124 ERICA ANDERSON, “EXPERT AFFIDAVIT OF ERICA-ANDERSON IN B.F., T.F., P.W. AND S.W. V. KETTLE MORAINÉ SCHOOL DISTRICT, STATE OF WISCONSIN CIRCUIT COURT,” FEBRUARY 3, 2023, [HTTPS://WILL-LAW.ORG/WP-CONTENT/UPLOADS/2023/02/EXPERT-AFFIDAVIT-ERICA-ANDERSON-2023.02.0336.PDF](https://will-law.org/wp-content/uploads/2023/02/EXPERT-AFFIDAVIT-ERICA-ANDERSON-2023.02.0336.PDF).

125 WYLIE C. HEMBREE ET AL., “ENDOCRINE TREATMENT OF GENDER-DYSPHORIC/GENDER-INCONGRUENT PERSONS: AN ENDOCRINE SOCIETY CLINICAL PRACTICE GUIDELINE,” *THE JOURNAL OF CLINICAL ENDOCRINOLOGY & METABOLISM* 102, NO. 11 (NOVEMBER 1, 2017): 3869–3903, [HTTPS://DOI.ORG/10.1210/JC.2017-01658](https://doi.org/10.1210/jc.2017-01658).

126 JAMES S. MORANDINI ET AL., “IS SOCIAL GENDER TRANSITION ASSOCIATED WITH MENTAL HEALTH STATUS IN CHILDREN AND ADOLESCENTS WITH GENDER DYSPHORIA?,” *ARCHIVES OF SEXUAL BEHAVIOR*, APRIL 4, 2023, [HTTPS://DOI.ORG/10.1007/S10508-023-02588-5](https://doi.org/10.1007/s10508-023-02588-5).

127 ELISABETH DC SIEVERT ET AL., “NOT SOCIAL TRANSITION STATUS, BUT PEER RELATIONS AND FAMILY FUNCTIONING PREDICT PSYCHOLOGICAL FUNCTIONING IN A GERMAN CLINICAL SAMPLE OF CHILDREN WITH GENDER DYSPHORIA,” *CLINICAL CHILD PSYCHOLOGY AND PSYCHIATRY* 26, NO. 1 (JANUARY 2021): 79–95, [HTTPS://DOI.ORG/10.1177/1359104520964530](https://doi.org/10.1177/1359104520964530).

this guidance is to be the parents and not the state. This second principle is explicit in Article 5, which reads:

8.2.5.2.1 Article 5

States Parties shall *respect the responsibilities, rights and duties of parents* or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

128

8.2.5.2.2 Article 9

Provides that children are to be separated from their parents only by competent authorities in accordance with applicable law and subject to judicial review.

8.2.5.2.3 Article 14

Recognizes the right and duty of parents to provide direction to the child in the exercise of freedom of thought, conscience, and religion.

8.2.5.2.4 The family

The principle of the primary role of the family as the source of care and nurture of children is recognized in Canadian child welfare legislation. The preamble to *The Child and Family Services Act* of Manitoba is particularly emphatic on this point:

The Legislative Assembly of Manitoba hereby declares that the fundamental principles guiding the provision of services to children and families are:

The safety, security and well-being of children and their best interests are fundamental responsibilities of society.

The family is the basic unit of society, and its well-being should be supported and preserved.

The family is the basic source of care, nurture and acculturation of children and parents have the primary responsibility to ensure the well-being of their children.

Families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society.

Children have a right to a continuous family environment in which they can flourish.

Families and children are entitled to be informed of their rights and to participate in the decisions affecting those rights.

128 "CONVENTION ON THE RIGHTS OF THE CHILD," OHCHR, NOVEMBER 20, 1989, [HTTPS://WWW.OHCHR.ORG/EN/INSTRUMENTS-MECHANISMS/INSTRUMENTS/CONVENTION-RIGHTS-CHILD](https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child).

Families are entitled to receive preventive and supportive services directed to preserving the family unit.

Families are entitled to services which respect their cultural and linguistic heritage.

It is inaccurate to frame this issue as a conflict between parents' rights and the best interests of the child. Parents do not have rights over their children but the responsibility to look after their best interests and the authority necessary to carry out that responsibility.

Social transition without the knowledge of a child's parents undermines the authority of parents by denying them vital information which they may need to supervise their child's medical care and mental health care and protect their child. Parents who have known a child for his or her entire life are in a better position to make decisions about a child's best interests than school staff who see a child for a few hours each day.

There may be circumstances where the parents are not acting in the child's best interest in making decisions on medical treatment and it is justifiable to override their authority. However, that is a decision which would normally require a court hearing and the involvement of qualified health care professionals. These are not decisions that can be made without notice by a teacher or school counselor.

It is true that homes are not always safe spaces. Research has found that gender dysphoria is often associated with problems at home, which may include physical or sexual abuse.¹²⁹ However, this simply emphasizes the importance of trying to work with and through the parents rather than cutting them out. Even if the home environment is not completely supportive, the alternatives an unsupported child will find on their own will almost certainly be worse. Where there is reason to suspect abuse at home, the school should and must by law report to the child welfare authorities so that a qualified professional can investigate. If a child is genuinely at risk, subterfuge on the part of the school will almost certainly worsen the situation. Schools should be mindful that there may be a risk of parental rejection when a child comes out as transgender, but this should not be the default assumption behind a policy. Schools should also recognize that parental support encompasses many things. A parent can be loving, nurturing and supportive, even if they have doubts or concerns about a child suddenly identifying as transgender.

8.2.6 Gender identity in the classroom

Schools are contributing to the problem of socially influenced transgender identity because of how they now teach about gender and sexuality. Provincial departments of education, assisted by experts in child and adolescent development, should review the

129 MICHELLE ANNE TOLLIT ET AL., "WHAT ARE THE HEALTH OUTCOMES OF TRANS AND GENDER DIVERSE YOUNG PEOPLE IN AUSTRALIA? STUDY PROTOCOL FOR THE TRANS20 LONGITUDINAL COHORT STUDY," *BMJ OPEN* 9, NO. 11 (NOVEMBER 1, 2019): E032151, [HTTPS://DOI.ORG/10.1136/bmjopen-2019-032151](https://doi.org/10.1136/bmjopen-2019-032151).

materials used in sexuality education. Over the last ten years curriculum materials on sexual health have been replaced with materials built around sexual orientation and gender identity (SOGI). The content of much of this material is misleading and harmful.

Children develop a sense of sex constancy, that is an understanding that being a boy or girl is determined by biology and does not change, at around the age of 6 or 7.¹³⁰ SOGI and other similar curricula being taught today often introduces children as young as 4 or 5 to the idea that a gender identity based on conformity to stereotypical gender roles is more foundational to identity than biological sex. This creates confusion in the minds of children who have not reached the stage of cognitive development where they can understand the interplay between socially determined gender roles and sex. This may be particularly so for children on the autism spectrum who are often delayed in establishing sex constancy and tend to think in black and white terms¹³¹ and for children who are developmentally delayed.¹³²

8.2.6.1 Questionable science

The problems often begin with the teaching of the basic biology of sex. There are two sexes, male and female, which are defined by reproductive role. In humans, sex is determined at conception, observed at birth (or earlier by in utero scans) and cannot be changed. There are some variations within this binary system that are sometimes called Intersex but are more accurately known as Differences/Disorders of Sexual Development (DSD) or Congenital Conditions of Sexual Development (CCSD). These conditions are very rare (less than 0.018% of the population) and represent variations of the male or female development path, rather than third sexes.¹³³

These facts are now being obscured by teaching tools like the “Genderbread Person” or “Gender Unicorn,” which present sex as a spectrum of characteristics of “maleness” and “femaleness.” Young children may have difficulty distinguishing between sex and socially determined sex roles. Instead of helping to break down stereotypes and encourage acceptance of gender nonconformity, teaching materials focused on gender identity reinforce reductive stereotypes and the idea that gender non-conforming children may be born in the wrong body.¹³⁴ Children are learning that there is only one way to be male or female, rather than that our likes, interests and skills are not defined

130 LAWRENCE KOHLBERG, “A COGNITIVE-DEVELOPMENTAL ANALYSIS OF CHILDREN’S SEX-ROLE CONCEPTS AND ATTITUDES,” IN *THE DEVELOPMENT OF SEX DIFFERENCES*, ED. ELEANOR E. MACCOBY (STANFORD, CALIFORNIA: STANFORD UNIVERSITY PRESS, 1966).

131 YULIA FURLONG, “AUTISM AND GENDER IDENTITY,” IN *AUTISM SPECTRUM DISORDER - PROFILE, HETEROGENEITY, NEUROBIOLOGY AND INTERVENTION* (INTECHOPEN, 2021), [HTTPS://DOI.ORG/10.5772/INTECHOPEN.97517](https://doi.org/10.5772/intechopen.97517).

132 K. J. ZUCKER ET AL., “GENDER CONSTANCY JUDGMENTS IN CHILDREN WITH GENDER IDENTITY DISORDER: EVIDENCE FOR A DEVELOPMENTAL LAG,” *ARCHIVES OF SEXUAL BEHAVIOR* 28, NO. 6 (DECEMBER 1999): 475–502, [HTTPS://DOI.ORG/10.1023/A:1018713115866](https://doi.org/10.1023/A:1018713115866).

133 COLIN WRIGHT, “SEX IS NOT A SPECTRUM,” REALITY’S LAST STAND (BLOG), FEBRUARY 10, 2021, [HTTPS://WWW.REALITYSLASTSTAND.COM/P/SEX-IS-NOT-A-SPECTRUM](https://www.realityslaststand.com/p/sex-is-not-a-spectrum).

134 COLIN WRIGHT, “AMAZE IS INDOCTRINATING CHILDREN,” REALITY’S LAST STAND (BLOG), APRIL 21, 2021, [HTTPS://WWW.REALITYSLASTSTAND.COM/P/AMAZE-IS-INDOCTRINATING-CHILDREN](https://www.realityslaststand.com/p/amaze-is-indoctrinating-children).

by our biological sex. No one suggests that school programs on gender identity will make a mentally healthy child trans, but many children today are not mentally healthy. The monumental increase in mental health conditions among youth, as well as the real potential of the link to social media, are well documented.¹³⁵

Confusion over sex can lead to confusion over sexual orientation. Many young gays and lesbians go through a period of guilt and uncertainty as they come to terms with their same-sex attraction. The introduction of gender identity into the mix can make this process harder. Gay writer Ben Appel describes the conflict and confusion that ideas of gender identity based on queer theory have brought into the lesbian and gay community. He describes his experiences growing up in a conservative community, where bullies often asked him if he was a girl. Young gay boys today, he fears, are being convinced they really are girls and started on the medical pathway.¹³⁶

Another gay writer, Andrew Sullivan, explains that: “the difference between the gay and trans experience is vast, especially when it comes to biological sex.” Young gays need to understand the sex differences in the body in order to come to terms with their homosexuality.¹³⁷

Young lesbians face similar problems with the added burden that as they begin dating, they will face pressure to accept transwomen, who have not had “bottom surgery” as sexual partners.¹³⁸

8.2.6.2 Biased material on gender transition

If a child who is struggling with psychological and social problems is introduced to transgender identity in a simplistic manner, they may latch on to it as a solution to their problems. Detransitioners have reported that they interpreted their distress with their bodies, not fitting in, or confusion about their sexuality as being transgender. The message the school may be trying to convey is that transgender people should be loved and accepted - which they undoubtedly should be - but the message the unhappy child receives is that if they identify as transgender, they will be loved and accepted and that the distress they have been feeling is simply due to being transgender. The trans-identified child is then enthusiastically affirmed and celebrated in their new identity. The message the school tries to send is “you deserve respect and support,” but the message the child receives is “your gender identity makes you special and important.” Experimenting with identity is a normal part of growing up, and schools should support

135 HAIDT, “AFTER BABEL.”

136 APPEL, BEN, “HOMOPHOBIA IN DRAG,” SPIKED ONLINE, MAY 20, 2023, [HTTPS://WWW.SPIKED-ONLINE.COM/2023/05/14/THE-NEW-HOMOPHOBIA/](https://www.spiked-online.com/2023/05/14/the-new-homophobia/).

137 ANDREW SULLIVAN, “WHO IS LOOKING OUT FOR GAY KIDS?,” SUBSTACK NEWSLETTER, THE WEEKLY DISH (BLOG), APRIL 8, 2022, [HTTPS://ANDREWSULLIVAN.SUBSTACK.COM/P/WHO-IS-LOOKING-OUT-FOR-GAY-KIDS-A19](https://andrewsullivan.substack.com/p/who-is-looking-out-for-gay-kids-a19).

138 KATHLEEN STOCK, “WHY SHOULD LESBIANS SLEEP WITH MEN?,” UNHERD (BLOG), MAY 4, 2023, [HTTPS://UNHERD.COM/2023/05/WHY-SHOULD-LESBIANS-SLEEP-WITH-MEN/](https://unherd.com/2023/05/why-should-lesbians-sleep-with-men/).

such developmental exploration in age-appropriate ways. However, what schools are supporting with social transition in many cases leads to a pathway that ends in being a life-long medical patient.

Stories of gender transition are presented in a way that denies or minimizes the risks of transition. For example, *I am Jazz*, the story of Jazz Jennings, a “girl born in a boy’s body” is an extremely popular book to introduce young children to gender identity. No one tells children that Jazz needed three corrective surgeries to the neo-vagina and is still struggling with depression and obesity from binge eating. Jazz’s surgeon has warned that Jazz, like other children who have their puberty blocked, may never be able to experience an orgasm.¹³⁹

Similarly, the book *The Other Boy*, intended for students in grades 6 through 8, presents the medical transition of a female middle schooler.¹⁴⁰ The book presents the process of informed consent to puberty blockers and cross-sex hormones in a breezy, superficial way, ignoring the considerable risks involved such as loss of bone density and future infertility. By middle school, students will certainly be exposed to the possibility of medical transition and schools should not try to avoid the topic. However, the materials provided in the library should be balanced and include information on the risks of transition and the possibility of detransition and regret.¹⁴¹

8.2.6.3 Sexually explicit materials

Books for middle and high school students may contain extremely graphic descriptions or illustrations of sexual activity between minors that would have been considered child pornography not long ago. The book *Let’s Talk About It*, which is often available in middle school libraries, is an egregious example. Among other things, it minimizes the risks of sexually transmitted diseases and recommends researching kinks by watching internet porn.¹⁴² Early exposure to pornography may be another factor that drives transgender identity among teen girls. Sexual “kinks” often include dangerous practices such as choking which leave young teen girls terrified of the prospect of having sex as a female.¹⁴³

139 ABIGAIL SHRIER, “TOP TRANS DOCTORS BLOW THE WHISTLE ON ‘SLOPPY’ CARE,” THE FREE PRESS, OCTOBER 4, 2021, [HTTPS://WWW.THEFP.COM/P/TOP-TRANS-DOCTORS-BLOW-THE-WHISTLE](https://www.thefp.com/p/top-trans-doctors-blow-the-whistle).

140 “REVIEW OF THE OTHER BOY BY M.G. HENNESSEY,” ACCESSED JUNE 14, 2023, [HTTPS://UNMASKCULT.COM/CONTENTS/BOOK-REVIEWS/THE%20OTHER%20BOY%20BY%20M.G.%20HENNESSEY.PDF](https://unmaskcult.com/contents/book-reviews/the%20other%20boy%20by%20m.g.%20hennessy.pdf).

141 SARAH C. J. JORGENSEN, “IATROGENIC HARM IN GENDER MEDICINE,” JOURNAL OF SEX & MARITAL THERAPY 0, NO. 0 (JUNE 19, 2023): 1–6, [HTTPS://DOI.ORG/10.1080/0092623X.2023.2224320](https://doi.org/10.1080/0092623X.2023.2224320); JORGENSEN, “TRANSITION REGRET AND DETRANSITION,” JUNE 2, 2023; JORGENSEN, “IATROGENIC HARM IN GENDER MEDICINE.”

142 RIGHT SIDE OF HISTORY™ [@XXCLUSIONARY], “I GOT THE BOOK ‘LET’S TALK ABOUT IT,’ SO YOU DON’T HAVE TO. A THREAD,” TWEET, TWITTER, MAY 20, 2023, [HTTPS://TWITTER.COM/XXCLUSIONARY/STATUS/1660035667387088898](https://twitter.com/xxclusionary/status/1660035667387088898).

143 ABIGAIL SHRIER, IRREVERSIBLE DAMAGE: THE TRANSGENDER CRAZE SEDUCING OUR DAUGHTERS (WASHINGTON: REGNERY PUBLISHING, 2020), 153–55.

The Bluest Eye by Toni Morrison is another book available to students in school libraries. It presents graphic explicit sexual content of incest - child abuse by a father of his young daughter. While it may be important for young people to know that such heinous events occur, young students most certainly do not need to be exposed to such explicit content.¹⁴⁴

This is not a call to remove all references to gender identity and sexual orientation or books discussing sexual activity from schools. Children need to learn about sex and LGBT people, but they need to be taught in a way that is grounded in biology and sound principles of child development. There is a difference between discussing the fact that a small percentage of the population (.03%- APA) is transgender and telling children, whose understanding of sex is not yet fully developed, that all of us have a gender identity and that they should actively consider if they may be transgender. Porn of any kind should never be available in schools. Parents and guardians should have access to library holdings.

8.2.7 The Need for sex segregated spaces

8.2.7.1 Human rights law

School policies generally require that students who express a transgender identity must be affirmed by being allowed access to washrooms, change rooms and sports teams based on their gender identity. No consideration is given to the impact of these policies on girls (who are at a vulnerable time of development), who may be required to undress in close proximity to a sexually mature boy. These policies are justified on the basis that they are required to comply with human rights law. However, the law in this area is not at all settled.

The federal and provincial human rights codes all recognize gender identity and gender expression as prohibited grounds of discrimination. However, they also recognize other grounds including sex, sexual orientation, religion, belief and disability, which may give rise to claims that conflict with rights based on gender identity. When these conflicts arise, they need to be resolved based on established principles of reasonable accommodation to the point of undue hardship. There are very few actual Canadian human rights decisions that have dealt with transgender rights, and none of them are necessarily applicable to school situations.

The cases on washroom use pre-date the addition of gender identity as a ground of discrimination and were decided on the basis of discrimination based on sex. However, the context was very different from the present day.¹⁴⁵ These cases were decided at a time when a psychological assessment was necessary to access hormonal treatments,

144 "REVIEW OF THE BLUEST EYE BY TONI MORRISON," SEPTENBER 2022, [HTTPS://UNMASKCULT.COM/CONTENTS/BOOK-REVIEWS/THE%20BLUEST%20EYE%20BY%20TONI%20MORRISON.PDF](https://unmaskcult.com/contents/book-reviews/the%20bluest%20eye%20by%20toni%20morrison.pdf).

145 FERRIS V. OFFICE AND TECHNICAL EMPLOYEES UNION, BCHRT 55 (BCHRT 1999); SHERIDAN V SANCTUARY INVESTMENTS LTD (C.O.B BJ'S LOUNGE), 43 BCHRT (BCHRT 1999).

and they both heard evidence on a diagnosis of gender dysphoria. They also concerned washrooms used primarily by adults. In one case, the washroom was single use with a lock. Since those cases were decided, there has been a shift from a requirement of psychological assessment to unrestricted self-identification. There have been no Canadian cases which have held that an adolescent with a fully functioning male reproductive system has a human right to share changing, shower, or sleeping accommodations with adolescent girls.

Provincial human rights commissions have given differing guidance on this issue. The Ontario Human Rights Commission guidelines explain that there are different options for accommodation. It recommends that in the case of a fitness club member who is transitioning from male to female, an appropriate accommodation would be a privacy space in each change room or a single-user washroom with a shower.¹⁴⁶

The Manitoba guidelines are more equivocal. They talk about the need for accommodation but recommend that providing a gender-neutral space is an acceptable alternative.¹⁴⁷ The Saskatchewan human rights commission, on the other hand, says that refusing to allow a transgender woman access to the women's washroom would be discrimination.¹⁴⁸

None of these guidance statements are legally binding and until the provincial human rights tribunal has actually conducted a hearing and issued a decision on an issue, the contents of school policies are only political choices made by provincial governments and school trustees to favor the interests of one group over another.

8.2.7.2 Washrooms, change rooms and overnight accommodation

School policies which allow students to access washrooms and changing areas on the basis of gender identity rather than sex represent a serious breach of the right of women and girls to privacy and bodily autonomy.

Women are ten times more likely to be the victim of sexual assaults than men, and many assaults go unreported.¹⁴⁹ Women and girls are vulnerable at every age, but puberty is a particularly difficult time. They need to cope with changing bodies, the onset of menstruation, the beginnings of sexual attraction and the realization that they

146 ONTARIO HUMAN RIGHTS COMMISSION, POLICY ON PREVENTING DISCRIMINATION BECAUSE OF GENDER IDENTITY AND GENDER EXPRESSION, 2014, 26.

147 MANITOBA HUMAN RIGHTS COMMISSION, "DISCRIMINATION BASED ON GENDER IDENTITY: YOUR RIGHTS AND RESPONSIBILITIES," ACCESSED JUNE 15, 2023, [HTTP://WWW.MANITOBAHUMANRIGHTS.CA/EDUCATION/PDF/GUIDELINES/GUIDELINE_GENDERID.PDF](http://www.manitobahumanrights.ca/education/pdf/guidelines/guideline_genderid.pdf).

148 SASKATCHEWAN HUMAN RIGHTS COMMISSION, "HUMAN RIGHTS OF TRANSGENDER PEOPLE," SASKATCHEWAN HUMAN RIGHTS COMMISSION, ACCESSED JUNE 15, 2023, [HTTPS://SASKATCHEWANHUMANRIGHTS.CA/EDUCATION-RESOURCES/INFORMATION-SHEETS/HUMAN-RIGHTS-OF-TRANSGENDER-PEOPLE/](https://saskatchewanhumanrights.ca/education-resources/information-sheets/human-rights-of-transgender-people/).

149 ROXAN VAILLANCOURT, GENDER DIFFERENCES IN POLICE-REPORTED VIOLENT CRIME IN CANADA, 2008 (STATISTICS CANADA, 2010), [HTTPS://WWW150.STATCAN.GC.CA/N1/EN/PUB/85F0033M/85F0033M2010024-ENG.PDF?ST=LKMXGW1R](https://www150.statcan.gc.ca/n1/en/pub/85f0033m/85f0033m2010024-eng.pdf?st=LKMXGW1R).

could become pregnant. Meanwhile, the boys around them are becoming bigger and stronger and developing sexual interests of their own.

Women and girls need the privacy of single-sex spaces when they are undressing, changing and sleeping. Sex-segregated bathrooms have existed throughout recorded history, and in the nineteenth century they began to be required by law as a social reform measure for the protection of women and girls.¹⁵⁰

The vulnerability of women and girls to male intrusion of their spaces is a result of physical differences between males and females rather than gender identity. These differences are not affected by medical transition. In any event, most children and teens will not have started medical transition. Transwomen do not pose a threat to women and girls because of their trans identity but because of their male anatomy. Research on transwomen has found that they continue to show a male pattern of criminality. For example, data from the United Kingdom found that while sex offenders made up 16.8% of men in prison and 3.3% of women, they represented 58.9% of transwomen.¹⁵¹

This is not to suggest that all or even most transwomen are potential sexual predators. Society recognizes that only a very small percentage of males are a threat to women, yet women have won the right to their own spaces. The current policies of unrestricted self-identification do not provide any means of separating people who genuinely experience gender dysphoria from sexual predators who assume a female identity to gain easier access to victims.

The balancing of interests around washroom access raises multiple issues and may have to be worked out on a school-by-school basis. The physical layout of the toilets will determine the degree of risk. Some new schools have toilets which are enclosed from ceiling to floor and lockable for complete privacy. The risk to privacy and safety by designating this type of facility as mixed sex is minimal. However, most schools still have toilets where it is possible to see both under and over the partitions and the lock on the door is non-existent or flimsy. Many girls will not feel safe using this type of facility when males are present. Showers and change rooms where students have to undress completely in front of one another are another case. Girls should not ever be compelled to undress in the presence of boys.

Adult transwomen often claim that washroom use is not an issue and they seldom if ever encounter problems. (Many women would differ on this point.) However, it is important to remember that we are dealing with adults. Many will have undergone some stages of medical transition (although most have not had bottom surgery), and

150 W. BURLLETTE CARTER, "SEXISM IN THE 'BATHROOM DEBATES': HOW BATHROOMS REALLY BECAME SEPARATED BY SEX," YALE LAW & POLICY REVIEW 37, NO. 1 (2018): 227, [HTTPS://YALELAWANDPOLICY.ORG/SEXISM-BATHROOM-DEBATES-HOW-BATHROOMS-REALY-BECAME-SEPARATED-SEX](https://yalelawandpolicy.org/sexism-bathroom-debates-how-bathrooms-really-became-separated-sex).

151 "EVIDENCE AND DATA ON TRANSWOMEN'S OFFENDING RATES," NOVEMBER 2020, [HTTPS://COMMITTEES.PARLIAMENT.UK/WRITTENEVIDENCE/18973/PDF/](https://committees.parliament.uk/writtenevidence/18973/pdf/).

most will have developed the social skills to navigate female spaces without causing offense. On the other hand, teenage males are not noted for their social skills in dealing with females, and many gender-questioning teens are on the autism spectrum or have other neurodevelopmental or psychological problems.

Meanwhile, girls will have their own problems. Every school will have some students from religious backgrounds with strict rules about separation of the sexes. There will be others with a history of sexual abuse which would make undressing in close proximity to a male traumatizing.

The best solution, which is likely to result in the least overall hardship, is to retain sex-separated washrooms, showers and change rooms and provide designated all-gender facilities for use by students who express a transgender or non-binary identity. The alternative solution of providing a separate space for students (mostly girls) who object to changing or using the toilet in the presence of the opposite sex is less equitable. This will draw unwanted attention to the girls who use these facilities. A girl who absolutely requires a sex-segregated space because of her history of sexual trauma should not be put in a position where she has to defend herself against allegations of transphobia.

8.2.7.3 Sports

Sex-segregated sports were created to account for the physiological differences between males and females. Prior to puberty, the difference between males and females is small, and since girls generally go through puberty earlier than boys, there may be a short time around age 11 when they have an advantage. Once puberty starts, the release of testosterone in the male body gives males more muscle mass, more lean body mass and more efficient respiratory and cardiovascular function. The male bone structure is also designed to make males more effective at running than females. These advantages persist across categories based on height, weight and age and are only partly mitigated by hormone therapy in transwomen. The result is that males have a performance advantage of from 10% to over 50% in most sports.¹⁵² The results of these differences are obvious from an earlier age. By age 15, top male high school athletes outperform female Olympians in most events.¹⁵³

In individual sports, a mediocre male athlete can, by transitioning to female, move into the championship category. Girls who have trained for years will lose the opportunity for advancement, recognition and athletic scholarships.

In team sports, the risk of injury increases when males and females play on the same team. The World Rugby Federation conducted a scientific review of male and female

152 EMMA N. HILTON AND TOMMY R. LUNDBERG, "TRANSGENDER WOMEN IN THE FEMALE CATEGORY OF SPORT: PERSPECTIVES ON TESTOSTERONE SUPPRESSION AND PERFORMANCE ADVANTAGE," *SPORTS MEDICINE* 51, NO. 2 (FEBRUARY 2021): 199–214, [HTTPS://DOI.ORG/10.1007/S40279-020-01389-3](https://doi.org/10.1007/s40279-020-01389-3).

153 "BOYS VS WOMEN: MALE HIGH SCHOOL ATHLETES VS FEMALE OLYMPIANS," ACCESSED JUNE 3, 2023, [HTTPS://BOYSVSWOMEN.COM](https://BOYSVSWOMEN.COM).

performance and concluded that the risk of injury to females was unacceptably high when males and females played together at any level.¹⁵⁴ Different considerations apply to transmen. Hormone therapy can increase muscle mass to the point where it gives them an unfair advantage in the female category but not to the point where they can compete successfully in the male category.

Some international sports governing bodies are adopting eligibility policies for the men's and women's categories that align with the scientific evidence. World Aquatics and World Athletics have both adopted regulations which prevent athletes who have experienced any part of male puberty from competing in the women's category.¹⁵⁵

Policies in other sports vary. Some simply allow competitors to choose the class that reflects their gender identity. Others require transwomen to maintain their circulating testosterone below a certain level. Neither of these solutions is practical at the school level. Another possibility is to replace the boy's category with an open category and retain a girl's category for females who are not taking artificial hormones.

A Model Policy for Canadian Schools

8.2.8.1 Guiding principles.

- (1) Childhood and adolescence are a time of growth, exploration, and development. Every school will have some students who experience extreme discomfort with their sexed bodies and socially mandated gender roles. Schools need to provide students with a safe and welcoming space where they can explore their identity without being subject to bullying, discrimination, and harassment, and also without being exposed to the idea that they need social or medical transition to be their true selves.
 - a. Gender identity in children and adolescents is still in the process of development and is highly unstable. Unlike sexuality, gender identity is not innate. Cross-sex identification in children usually desists before adulthood. This policy will therefore use the term gender-questioning rather than transgender for children and adolescents.
 - b. Gender-questioning children and teens frequently have one or more other mental health issues such as depression, anxiety, borderline personality disorder, or Obsessive-Compulsive Personality Disorder or

¹⁵⁴ WORLD RUGBY, "TRANSGENDER GUIDELINES," 2021, [HTTPS://WWW.WORLD.RUGBY/THE-GAME/PLAYER-WELFARE/GUIDELINES/TRANSGENDER](https://www.world.rugby/the-game/player-welfare/guidelines/transgender).

¹⁵⁵ WORLD AQUATICS, "POLICY ON ELGIBILITY FOR THE MEN'S AND WOMEN'S COMPETITION CATEGORIES," 2022, [HTTPS://RESOURCES.FINA.ORG/FINA/DOCUMENT/2022/06/19/525DE003-51F4-47D3-8D5A-716DAC5F77C7/FINA-INCLUSION-POLICY-AND-APPENDICES-FINAL-.PDF](https://resources.fina.org/fina/document/2022/06/19/525de003-51f4-47d3-8d5a-716dac5f77c7/fina-inclusion-policy-and-appendices-final-.pdf); WORLD ATHLETICS, "ELIGIBILITY REGULATIONS FOR TRANSGENDER ATHLETES," MARCH 2023, [HTTPS://WORLDATHLETICS.ORG/DOWNLOAD/DOWNLOAD?FILENAME=C50F2178-3759-4D1C-8FBC-370F6AEF4370.PDF&URLSLUG=C3.5A%20E2%80%93%20ELIGIBILITY%20REGULATIONS%20TRANSGENDER%20ATHLETES%20E2%80%93%20EFFECTIVE%2031%20MARCH%202023](https://worldathletics.org/download/download?filename=c50f2178-3759-4d1c-8fbc-370f6aef4370.pdf&urlslug=C3.5A%20E2%80%93%20ELIGIBILITY%20REGULATIONS%20TRANSGENDER%20ATHLETES%20E2%80%93%20EFFECTIVE%2031%20MARCH%202023).

neurodevelopmental conditions such as Autism Spectrum Disorders or Attention-Deficit Hyperactivity Disorder. Based on detransitioner accounts, any of these conditions may result in distress that a child may interpret as gender dysphoria.

- c. Schools must embrace all types of diversity including female students with traditionally masculine interests and male students with traditionally feminine interests.
- d. School staff must recognize and respect the primary role of parents in the healthcare and moral and religious upbringing of their children.
- e. Gender identity and gender expression are recognized as prohibited grounds of discrimination under the *Human Rights Code* which gives all students and staff the right to a school environment free from discrimination and harassment and reasonable accommodation of their needs.
- f. The right to accommodation based on gender identity and expression is not absolute and may be limited when it would result in undue hardship to some other protected class.

8.2.8.2 Privacy and confidentiality.

- g. Students have a right to confidentiality regarding their sexual orientation and gender identity. These are private matters, and everyone has a right to choose when and to whom they disclose them. Not all students will feel comfortable having their first discussion of these issues with their parents and teachers need to respect this. A child's discomfort with not wanting to tell their parents cannot be interpreted as prima facie evidence that parents are unsafe. Consideration must be given to the implications of not involving loving, supportive parents.
- h. In conversations with students concerning sexual orientation and gender identity, teachers must refrain from disparaging a parent's religious or cultural beliefs or undermining a parent's authority.
- i. Confidentiality no longer applies when the student seeks active assistance in affirming the student's gender identity. The request must be dealt with in accordance with the policy on social transition.
- j. The practice of "open secrets" in which students are directed not to share information about another students' public gender transition while at school with their parents is unacceptable. It has the potential to fracture families and break down parent-child relationships, which is not in the long-term interest of the student.

8.2.8.3 Social transition (names and pronouns).

- k. Social transition is a powerful psychosocial intervention which can solidify an identity that would otherwise be transient, leading to unnecessary medical transition. Schools must consider the long-term consequences of social transitioning and must not promote social transition of a student under the age of 18 without the consent of the parents. The involvement of a mental health professional is highly advisable, but arranging for this is the responsibility of the parents.
- l. Gender-questioning students under the age of 16 will require parental consent in order for their preferred first name to be officially used for record-keeping purposes and daily management.
- m. If it is not possible to obtain consent to talk to the parent, the student will be directed to the appropriate professional (i.e., school social worker, school psychologist) to work with the student to develop a plan to speak with their parents if and when they are ready to do so. If it is not in the best interest of the child or could cause harm to the student (physical or mental threat), the student will be directed to the appropriate school professional for support.
- n. Where a student is being socially transitioned, all staff and students should use the students' preferred name and pronouns.
- o. The school must keep a record of each students' biological sex so that this information can be passed on to medical care providers in emergencies.
- p. Schools must be aware that some students who transition will desist or detransition and that this process can be as difficult as transition. Schools must be prepared to provide a safe and non-judgmental space for such students, including support from a school psychologist or social worker as needed.

8.2.8.4 Sports participation.

- q. All students are entitled to participate in sports and to enjoy fair and safe competition.
- r. After the onset of puberty, the physical differences between males and females require sex-separated teams in order to allow fair and safe competition for girls. Schools may establish open categories or teams which are open to all students, but they must also provide a female team or category which is reserved for biological girls who are not receiving male hormones.

8.2.8.5 Dress codes.

Dress codes should be gender neutral. Students should be able to express themselves through their clothing given that the attire is appropriate for a learning environment.

8.2.8.6 Binding and tucking.

For students who have socially transitioned, the school shall make materials available to parents about the health consequences of binding and tucking, especially during sports activities, to enable families to discuss whether their child's concerns about appearance should override serious health concerns. Under no circumstances shall the school provide students with binders or other clothing or devices to allow students to change their physical appearance. Schools should also refrain from directing students where to purchase such items.

8.2.8.7 Washrooms and changing rooms.

The school has a responsibility to provide all students with washrooms and change rooms in which they feel safe and secure. Single-sex spaces shall be maintained, and a third space shall be provided where single-occupancy toilets and changing rooms are available, allowing anyone who wishes to use a gender-neutral space to do so. Gender-neutral stalls should contain floor to ceiling walls to allow for privacy

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8.3 Model Legislation – Informed Consent

8.3.1 Chapter I - Informed Consent Requirements Prior to the Provision of Gender Transition and Reassignment Treatments and Procedure

8.3.1.1 SECTION 1 - DEFINITIONS.

- (a) "Gender transition" as used in this Chapter means psychological practices relating to assessment and treatment of gender incongruence or gender dysphoria.
- (b) "Gender reassignment treatment or procedure" means a medical treatment or procedure provided or performed for the purpose of altering an individual's primary or secondary sex characteristics. The term includes providing puberty-blocking drugs, providing cross-sex hormones, or performing genital or non-genital gender reassignment surgery.
- (c) "Health care provider" means an individual who is licensed, certified, or otherwise authorized by law to provide or render health care, including mental health care, or to dispense or prescribe a prescription drug in the ordinary course of practice of a profession.

8.3.1.2 SECTION 2 - INFORMED CONSENT REQUIRED FOR GENDER TRANSITION AND REASSIGNMENT TREATMENTS AND PROCEDURES.

- (a) Health care providers must obtain the patient's informed consent as defined in this chapter.
- (b) A mental health care provider shall:
 - 1. perform a comprehensive psychological assessment and make a differential diagnosis;
 - 2. disclose information relating to the psychological effects of affirmation, and the known and unknown psychological effects of "hormone therapy", and the range of possible life outcomes and psycho-social challenges after medical reassignment treatments and procedures; and
 - 3. disclose information related to alternative therapies and non-medicalized options.
- (c) A health care provider may not provide or perform a gender reassignment treatment or procedure unless the provider obtains the informed consent of the patient as defined in subsection (e).
- (d) A health care provider must obtain the patient's informed consent at each stage of treatment and for each procedure performed, including for each prescribed drug and any change in the dosage of the drug. A healthcare provider who has

prescribed medications for gender reassignment treatment has an obligation to monitor the patient for adverse side effects, and mental side effects in particular, and if such side effects occur, to discuss with the patient the risks and benefits of continued treatment and alternative treatments.

- (e) A patient may only provide informed consent for a gender reassignment treatment or procedure if the health care provider provides to the patient the following information:
1. a statement that gender is a behavior and sex is biological, and that there is not a known treatment or procedure to change an individual's sex, and there exist non-medical ways of expressing one's gender;
 2. a statement that hormone treatments and surgical interventions undergone to physically resemble the opposite gender involve known and unknown risks and side effects described by providing the following information;
 3. a thorough summary of up-to-date research on gender reassignment treatments and procedures, that include a rating based on a standardized grading system that indicates the quality of the cited evidence. This summary of research shall include:
 - A. links to studies or Internet websites that explain in an impartial manner the scientific evidence regarding the potential risks and benefits of receiving a gender reassignment treatment or procedure compared to a therapeutic approach; and
 - B. accurate statistics regarding the suicide rates of individuals before and after receiving a gender reassignment treatment or procedure.
 4. links to the most recently published studies on individuals who have undergone a gender reassignment treatment or procedure for gender dysphoria or incongruence and, because the individuals later regretted that decision, have stopped receiving gender reassignment treatments or procedures or have taken medical steps to detransition, including studies that contain information regarding the common reasons those individuals:
 - A. originally sought a gender reassignment treatment or procedure; and
 - C. later decided to detransition.
 5. up-to-date information from the patient satisfaction data bases established by this Chapter regarding the satisfaction rates of patients who have received gender reassignment treatments or procedures from the provider; and
 6. information regarding the expectations, realities, risks, benefits, permanent changes, likely reversible changes, potential short-term and

long-term side effects, alternative treatments, and short-term and long-term questions related to a gender reassignment treatment or procedure.

- (f) When obtaining consent, a healthcare provider shall assess the patient's capacity to consent by evaluating the patient's understanding of available options, risks and benefits, and the consequences of transition. In assessing capacity, the healthcare provider shall consider consistency between expressed values, goals, and potential outcomes.
- (g) A health care provider who provides or performs a gender reassignment treatment or procedure shall include in the patient's medical record:
 - 1. an attestation that:
 - A. the provider has provided to the patient or the patient's parent or legal guardian, as applicable,
 - D. the information required by this Section; and
 - E. based on the provider's professional medical judgment, the patient or the patient's parent or legal guardian, as applicable, possesses the intelligence, judgment, and capacity to understand the information and provide consent to the treatment or procedure that is meaningfully informed; and
 - 7. a signed statement by the patient indicating that the patient has provided informed consent for the treatment or procedure.

8.3.1.3 SECTION 3 - COLLECTION OF PATIENT SATISFACTION INFORMATION.

- (a) A health care provider or the facility that provides or performs a gender reassignment treatment or procedure in accordance with this Chapter shall obtain from each patient to whom the treatment is provided or on whom the procedure is performed information regarding the patient's satisfaction with the treatment or procedure. The provider must obtain patient satisfaction information one year, two years, five years, and ten years following the date on which the treatment or procedure was provided or performed.
- (b) The collection of the patient satisfaction information shall utilize a standardized methodology for each patient to describe the patient's level of satisfaction with the gender reassignment treatment or procedure; and
- (c) The information shall be collected using a secure database and the information shall be The information must be aggregated by:
 - 1. the type of the gender reassignment treatment or procedure; and
 - 2. patient demographics.

- (d) The healthcare provider and facility shall ensure that information maintained in the database does not include a patient's personally identifiable information or information that is confidential under applicable laws.

8.4 Model Legislation – Conversion Therapy

8.4.1 Chapter I - Conversion Therapy Prohibition

PREAMBLE - Recognizing that systemic reviews of scientific literature have found that (a) sexual orientation is innate and immutable, and (b) practices directed at changing a person's sexual orientation are: (i) psychologically injurious, and (ii) ineffective, the legislature enacts this prohibition on conversion practices to protect and safeguard same sex attracted persons from harmful practices.

Recognizing that gender dysphoria is not well understood, and influenced by various complex and often uncertain factors, the extension of the prohibition on conversion therapy to therapeutic practice with gender dysphoric individuals shall be consistent with Section 3.

8.4.1.1 SECTION 1 - PROHIBITED CONDUCT

- (a) It is unlawful for any person to offer or provide sexual orientation change efforts, commonly referred to as conversion therapy services.
- (b) Under no circumstances shall a mental health provider engage in sexual orientation change efforts with a person under the age of 18.

8.4.1.2 SECTION 2 - DEFINITIONS

- (a) "Mental health provider" means any person designated as a mental health professional under law.
- (b) "Sexual orientation" means an individual's patterns of sexual, romantic, and affectional arousal and desire for other persons based on those persons' biological sex characteristics. Sexual orientation is immutable.
- (c) (1) "Sexual orientation change efforts" means any practices by mental health providers that seek to change an individual's sexual orientation. This includes efforts to change behaviors or gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex.
- (2) "Sexual orientation change efforts" or "conversion therapy" does not include psychotherapies that:
 - (A) provide a comprehensive mental health assessment,
 - (B) provide acceptance, support, and understanding of clients or the facilitation of clients' coping, social support,
 - (C) explore identity and support its development,
 - (D) sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, and

(E) do not seek to change sexual orientation.

(d) (1) "Gender identity" means one's own internal sense of gender. Gender identity can correlate with a person's biological sex recorded at birth or can differ from it. Gender identity may be stable or fluid.

(2) "Gender" means the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviors and roles associated with being a woman, man, girl or boy, as well as relationships with each other.

8.4.1.3 SECTION 3 - APPLICATION TO GENDER IDENTITY

Gender identity is distinct from sexual orientation. In order to protect persons who may suffer from confusion or mental health conditions that give rise to or mimic gender dysphoria, any extension of the prohibition in this Chapter to gender identity shall not cover therapeutic practices that use psychodynamic techniques to differentiate among conditions, but do not make a purposeful attempt to alter identity.

8.4.1.4 SECTION 4 - ENFORCEMENT.

(a) Any person who violates this Chapter is liable to one or more of the following penalties:

(1) A civil penalty not to exceed \$1,000 for the first violation, \$5,000 for the second violation, and \$10,000 for each subsequent violation.

(2) Suspension or revocation of the mental health provider's license.

(3) Civil prosecution for deceptive practices.

(3) Criminal prosecution if the therapeutic technique includes or promotes infliction of physical pain.

(b) Any person who violates this Chapter, or any mental health provider who approves medical gender transition of any person without a comprehensive assessment and without engaging in a therapeutic process for the purpose of making differential diagnosis shall be liable for one or more of the penalties enumerated in subsection (a), and for any consequential harm to the patient under general torts

8.5 Model Legislation – Care Bill Draft 88r 8546

By: _____ .B.
No. _

A BILL TO BE ENTITLED

1 AN ACT
2 relating to prohibitions on the provision to certain
minors of
3 procedures and treatments for gender transitioning,
gender
4 reassignment, or gender dysphoria and to health
benefit plan
5 coverage related to those procedures and treatments.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

7 SECTION 1. The legislature finds that:

8 (1) medical procedures and treatments
resolving
9 gender dysphoria or the comorbidities of a minor are
medically
10 invasive and have long-term impacts; and
11 (2) it is necessary for this state to
place a
12 moratorium on those procedures and treatments, also
known as
13 "gender-affirming care," designed to alter sex
characteristics of
14 minors to provide time for the completion of
necessary and
15 appropriate research determining the short-term and
long-term
16 harms and benefits of those procedures and treatments.

17 SECTION 2. Chapter 161, Health and Safety Code, is
amended

18 by adding Subchapter X to read as follows:

19 SUBCHAPTER X. GENDER TRANSITIONING AND GENDER REASSIGNMENT

20 PROCEDURES AND TREATMENTS FOR CERTAIN MINORS

21 Sec. 161.701. DEFINITIONS. In this subchapter:

22 (1) "Health care provider" means a person other
than a
23 physician who is licensed, certified, or otherwise
authorized by
24 this state's laws to provide or render health care or to
dispense or

1 prescribe a prescription drug in the ordinary course of business or
2 practice of a profession.

3 (2) "Minor" means an individual younger than 18 years
4 of age for whom the disabilities of minority have not been removed.

5 (3) "Physician" means a person licensed to practice
6 medicine in this state.

7 Sec. 161.702. PROHIBITED PROVISION OF GENDER TRANSITIONING
8 OR GENDER REASSIGNMENT PROCEDURES AND TREATMENTS TO CERTAIN MINORS.

9 (a) For the purpose of transitioning a minor 's biological sex as
10 determined by the sex organs, chromosomes, and endogenous profiles
11 of the minor or affirming the minor 's perception of the minor 's sex
12 if that perception is inconsistent with the minor 's biological sex,

13 a physician or health care provider may not knowingly:

14 (1) perform a surgery that sterilizes the minor,
15 including:

16 (A) castration;

17 (B) vasectomy;

18 (C) hysterectomy;

19 (D) oophorectomy;

20 (E) metoidioplasty;

21 (F) orchiectomy;

22 (G) penectomy;

23 (H) phalloplasty; and

24 (I) vaginoplasty;

25 (2) perform a mastectomy on a biological female;

26 (3) perform a breast augmentation on a biological
27 male;

1 (4) prescribe, administer, or supply any of the
2 following medications that induce transient or permanent
3 infertility:

4 (A) puberty-blocking medication, including
5 anti-androgens, to stop, delay, or otherwise interfere with normal
6 puberty:

7 (B) supraphysiologic doses of testosterone to
8 biological females; or

9 (C) supraphysiologic doses of estrogen to
10 biological males; or

11 (5) remove any otherwise healthy or non-diseased body
12 part or tissue.

13 (b) A physician or health care provider may not perform or
14 provide a gender transitioning or gender reassignment medical
15 procedure or treatment, regardless of the diagnostic code.

16 Sec. 161.703. EXCEPTIONS. Section 161.702 does not apply
17 to the provision by a physician or health care provider, with the
18 consent of the minor's parent or legal guardian, of:

19 (1) puberty suppression or blocking prescription
20 drugs for the purpose of normalizing puberty for a minor
21 experiencing precocious puberty; or

22 (2) appropriate and medically necessary procedures or
23 treatments to a minor who:

24 (A) is born with a medically verifiable genetic
25 disorder of sex development, including:

26 (i) 46,XX chromosomes with virilization;

27 (ii) 46,XY chromosomes with

1 undervirilization; or

2
3 (iii) both ovarian and testicular tissue;
4 or

5 (B) does not have the normal sex chromosome
6 structure for a biological male or female as determined by a
7 physician through genetic testing.

8 Sec. 161.704. ATTORNEY GENERAL ENFORCEMENT. (a) If the
9 attorney general has reason to believe that a person is committing,
10 has committed, or is about to commit a violation of Section 161.702,
11 the attorney general may bring an action to enforce this subchapter
12 to restrain or enjoin the person from committing, continuing to
13 commit, or repeating the violation.

14 (b) Venue for an action brought under this section is in a
15 district court of Travis County or the county where the violation
16 occurred or is about to occur.

17 SECTION 3. Subtitle E, Title 8, Insurance Code, is amended
18 by adding Chapter 1372 to read as follows:

19 CHAPTER 1372. REQUIRED COVERAGE RELATED TO CERTAIN GENDER

20 TRANSITION PROCEDURES OR TREATMENTS FOR MINORS

21 Sec. 1372.001. DEFINITIONS. In this chapter:

22 (1) "Cross-sex hormones" means:

23 (A) testosterone or other androgens provided to a
24 biological female in a larger or more potent amount than would
25 naturally occur in a healthy biological female; or

26 (B) estrogen provided to a biological male in a
27 larger or more potent amount than would naturally occur in a healthy
28 biological male.

1 (2) "Licensed professional counselor" has the meaning
2 assigned by Section 503.002, Occupations Code.

3 (3) "Minor" means an individual younger than 18 years
4 of age for whom the disabilities of minority have not been removed.

5 (4) "Psychologist" has the meaning assigned by Section
6 501.002, Occupations Code.

7 Sec. 1372.002. APPLICABILITY OF CHAPTER. (a) This chapter
8 applies to a gender transitioning or gender reassignment procedure
9 or treatment described by Section 161.702, Health and Safety Code.

10 (b) This chapter applies only to a health benefit plan that
11 provides benefits for medical or surgical expenses or pharmacy
12 benefits incurred as a result of a health condition, accident, or
13 sickness, including an individual, group, blanket, or franchise
14 insurance policy or insurance agreement, a group hospital service
15 contract, or an individual or group evidence of coverage or similar
16 coverage document that is issued by:

17 (1) an insurance company;

18 (2) a group hospital service corporation operating
19 under Chapter 842;

20 (3) a health maintenance organization operating under
21 Chapter 843;

22 (4) an approved nonprofit health corporation that
23 holds a certificate of authority under Chapter 844;

24 (5) a multiple employer welfare arrangement that holds
25 a certificate of authority under Chapter 846;

26 (6) a stipulated premium company operating under
27 Chapter 884;

1 (7) a fraternal benefit society operating under
2 Chapter 885;
3 (8) a Lloyd 's plan operating under Chapter 941; or
4 (9) an exchange operating under Chapter 942.
5 (c) Notwithstanding any other law, this chapter applies to:
6 (1) a small employer health benefit plan subject to
7 Chapter 1501, including coverage provided through a health group
8 cooperative under Subchapter B of that chapter;
9 (2) a standard health benefit plan issued under
10 Chapter 1507;
11 (3) a basic coverage plan under Chapter 1551;
12 (4) a basic plan under Chapter 1575;
13 (5) a primary care coverage plan under Chapter 1579;
14 (6) a plan providing basic coverage under Chapter
15 1601;
16 (7) health benefits provided by or through a church
17 benefits board under Subchapter I, Chapter 22, Business
18 Organizations Code;
19 (8) group health coverage made available by a school
20 district in accordance with Section 22.004, Education Code;
21 (9) the state Medicaid program, including the Medicaid
22 managed care program operated under Chapter 533, Government Code;
23 (10) the child health plan program under Chapter 62,
24 Health and Safety Code;
25 (11) a regional or local health care program operated
26 under Section 75.104, Health and Safety Code; and
27 (12) a self-funded health benefit plan sponsored by a

1 professional employer organization under Chapter 91, Labor Code.

2 Sec. 1372.003. REQUIRED COVERAGE. (a) For a minor who
3 seeks a gender transitioning procedure or treatment or who receives
4 a gender transitioning procedure or treatment before January 1,
5 2024, a health benefit plan must provide coverage of any mental
6 health condition of the minor or the minor’s family.

7 (b) For a minor who receives a gender transitioning
8 procedure or treatment before January 1, 2024, a health benefit
9 plan must provide coverage of the continuation of the minor’s
10 gender transitioning procedure or treatment.

11 Sec. 1372.004. MENTAL HEALTH CARE REQUIREMENTS. A mental
12 health condition required to be covered under Section 1372.003(a)
13 must be treated by an unbiased psychologist or licensed
14 professional counselor or a psychologist or licensed professional
15 counselor approved by the Health and Human Services Commission. A
16 psychologist or licensed professional counselor authorized to
17 provide treatment under this section must be experienced in trauma,
18 autism, body dysmorphia, comorbidities, and appropriate modalities
19 for minors who seek a gender transitioning procedure or treatment.

20 Sec. 1372.005. PHYSICAL HEALTH CARE REQUIREMENTS. (a) The
21 continuation of a minor’s gender transitioning procedure or
22 treatment required to be covered under Section 1372.003(b):

23 (1) must be provided by an unbiased physician or
24 health care provider approved by the Health and Human Services
25 Commission;

26 (2) may not include any new treatments, including
27 injections or implants delivering gonadotropin-releasing hormone

1 analogues;

2
3 (3) must taper cross-sex hormones over a three- to
4 six-month period and must provide comprehensive psychological
5 support for the minor and the minor 's family during that period; and

6 (4) must include initial and ongoing testing regarding
7 the minor 's pituitary function, sex hormones, bone density, and
8 psychosocial development, including the following tests:

9 (A) a baseline and annual bone density scan;

10 (B) a baseline and annual thyroid function panel;

11 (C) a baseline and, as needed, follow-up
12 autoimmune panel;

13 (D) a baseline and regular blood pressure test;

14 (E) a regular follow-up fasting blood sugar and
15 glucose tolerance test;

16 (F) a baseline and regular follow-up blood
17 chemistry test, including a liver enzyme test;

18 (G) a baseline and annual cognitive performance
19 test; and

20 (H) a baseline and annual depression screening.

21 (b) On request, a physician or health care provider shall
22 make de-identified clinical data described by Subsection (a)
23 available to the Health and Human Services Commission and Texas
24 Medical Board. The information is confidential and not subject to
25 Chapter 552, Government Code. A physician or health care provider
26 shall comply with all applicable federal and state laws relating to
27 patient confidentiality.

SECTION 4. Section 164.052(a), Occupations Code, is amended

1 to read as follows:

2 (a) A physician or an applicant for a license to practice
3 medicine commits a prohibited practice if that person:

4 (1) submits to the board a false or misleading
5 statement, document, or certificate in an application for a
6 license;

7 (2) presents to the board a license, certificate, or
8 diploma that was illegally or fraudulently obtained;

9 (3) commits fraud or deception in taking or passing an
10 examination;

11 (4) uses alcohol or drugs in an intemperate manner
12 that, in the board's opinion, could endanger a patient's life;

13 (5) commits unprofessional or dishonorable conduct
14 that is likely to deceive or defraud the public, as provided by
15 Section 164.053, or injure the public;

16 (6) uses an advertising statement that is false,
17 misleading, or deceptive;

18 (7) advertises professional superiority or the
19 performance of professional service in a superior manner if that
20 advertising is not readily subject to verification;

21 (8) purchases, sells, barter, or uses, or offers to
22 purchase, sell, barter, or use, a medical degree, license,
23 certificate, or diploma, or a transcript of a license, certificate,
24 or diploma in or incident to an application to the board for a
25 license to practice medicine;

26 (9) alters, with fraudulent intent, a medical license,
27 certificate, or diploma, or a transcript of a medical license,

1 certificate, or diploma;

2 (10) uses a medical license, certificate, or diploma,
3 or a transcript of a medical license, certificate, or diploma that
4 has been:

5 (A) fraudulently purchased or issued;

6 (B) counterfeited; or

7 (C) materially altered;

8 (11) impersonates or acts as proxy for another person
9 in an examination required by this subtitle for a medical license;

10 (12) engages in conduct that subverts or attempts to
11 subvert an examination process required by this subtitle for a
12 medical license;

13 (13) impersonates a physician or permits another to
14 use the person's license or certificate to practice medicine in
15 this state;

16 (14) directly or indirectly employs a person whose
17 license to practice medicine has been suspended, canceled, or
18 revoked;

19 (15) associates in the practice of medicine with a
20 person:

21 (A) whose license to practice medicine has been
22 suspended, canceled, or revoked; or

23 (B) who has been convicted of the unlawful
24 practice of medicine in this state or elsewhere;

25 (16) performs or procures a criminal abortion, aids or
26 abets in the procuring of a criminal abortion, attempts to perform
27 or procure a criminal abortion, or attempts to aid or abet the

1 performance or procurement of a criminal abortion;

2 (17) directly or indirectly aids or abets the practice
3 of medicine by a person, partnership, association, or corporation
4 that is not licensed to practice medicine by the board;

5 (18) performs an abortion on a woman who is pregnant
6 with a viable unborn child during the third trimester of the
7 pregnancy unless:

8 (A) the abortion is necessary to prevent the
9 death of the woman;

10 (B) the viable unborn child has a severe,
11 irreversible brain impairment; or

12 (C) the woman is diagnosed with a significant
13 likelihood of suffering imminent severe, irreversible brain damage
14 or imminent severe, irreversible paralysis;

15 (19) performs an abortion on an unemancipated minor
16 without the written consent of the child's parent, managing
17 conservator, or legal guardian or without a court order, as
18 provided by Section 33.003 or 33.004, Family Code, unless the
19 abortion is necessary due to a medical emergency, as defined by
20 Section 171.002, Health and Safety Code;

21 (20) otherwise performs an abortion on an
22 unemancipated minor in violation of Chapter 33, Family Code;

23 (21) performs or induces or attempts to perform or
24 induce an abortion in violation of Subchapter C, F, or G, Chapter
25 171, Health and Safety Code;

26 (22) in complying with the procedures outlined in
27 Sections 166.045 and 166.046, Health and Safety Code, wilfully

1 fails to make a reasonable effort to transfer a patient to a
2 physician who is willing to comply with a directive; [øf]

3 (23) performs or delegates to another individual the
4 performance of a pelvic examination on an anesthetized or
5 unconscious patient in violation of Section 167A.002, Health and
6 Safety Code; or

7 (24) performs a gender transitioning or gender
8 reassignment procedure or treatment in violation of Section
9 161.702, Health and Safety Code.

10 SECTION 5. Subchapter B, Chapter 164, Occupations Code, is
11 amended by adding Section 164.0552 to read as follows:

12 Sec. 164.0552. PROHIBITED ACTS REGARDING GENDER
13 TRANSITIONING OR GENDER REASSIGNMENT PROCEDURES AND TREATMENTS ON
14 CERTAIN MINORS. The board may revoke the license or other
15 authorization to practice medicine of a physician who violates
16 Section 161.702, Health and Safety Code. The board shall refuse to
17 admit to examination or refuse to issue a license or renewal license
18 to a person who violates that section.

19 SECTION 6. (a) In this section, "commission" means the
20 Health and Human Services Commission.

21 (b) The commission shall designate an independent committee
22 to conduct a study regarding the treatment of gender dysphoria and
23 the provision of gender affirming care. The study must:

24 (1) examine the etiology of and testing for the
25 diagnosis of gender dysphoria;

26 (2) identify drugs used to treat gender dysphoria or
27 to provide gender affirming care, including:

- 1 (A) gonadotropin-releasing hormone analogues;
2 (B) cross-sex hormones; and
3 (C) anti-androgens;
4 (3) identify gender transitioning procedures,
5 including:
6 (A) double mastectomies;
7 (B) vaginoplasties;
8 (C) breast augmentations for a biological male;
9 and
10 (D) orchiectomies; and
11 (4) include an in-depth, exhaustive, incremental, and

12 independent systematic review of the available scientific studies
13 and literature related to the treatment of gender dysphoria and the
14 provision of gender affirming care.

- 15 (c) The review described by Subsection (b)(4) must include:
16 (1) studies related to children, adolescents, and
17 adults, aggregated by:
18 (A) age category;
19 (B) the age of onset for an individual with
20 gender dysphoria and the age the individual was diagnosed with
21 gender dysphoria;
22 (C) sex;
23 (D) perceived gender;
24 (E) short-term and long-term mental health
25 outcomes;
26 (F) distinct and well-defined mental health
27 outcome variables; and

1 (G) categories of physical risk, including
2 short-term and long-term risks; and

3 (2) studies evaluating the efficacy and safety of any
4 drugs or procedures used in the treatment of gender dysphoria,
5 including drugs that are approved by the United States Food and Drug
6 Administration.

7 (d) Not later than September 1, 2024, the independent
8 committee shall submit a written report to the commission with
9 Recommendations regarding the care of
10 children seeking gender affirming care.

11 (e) The commission, in consultation with the Texas Medical
12 Board, shall review and analyze the report submitted under
13 Subsection (d) of this section and make Recommendations regarding
14 the provision of gender affirming care to children in this state.
15 Not later than January 1, 2025, the commission shall submit a
16 written report to the legislature summarizing its findings and
17 Recommendations, including:

18 (1) whether gender transitioning procedures or
19 treatments on children should be performed or provided in this
20 state;

21 (2) safe and effective treatments for children
22 experiencing gender dysphoria; and

23 (3) Recommendations for the mental and
24 physical treatment of children seeking gender affirming care.

25 (f) The commission shall post the reports described by
26 Subsections (d) and (e) of this section on the commission's
27 publicly accessible Internet website.

