TASMANIA LAW REFORM INSTITUTE

Conversion Practices: Law Reform Options for Tasmania

Response to the Sexual Orientation and Gender Identity Conversion Practices Issues Paper

Brief submitted
by
FOR WOMEN SCOTLAND

Introduction

In 2017, gender identity was included in a *Memorandum of Understanding* banning conversion therapy in the UK in practice. This *Memorandum of Understanding* did not differentiate between sexual orientation and gender identity, which had unintended and chilling consequences for the clinical treatment protocols regarding children who identify as trans within our country, consequences which have led to harm for children diagnosed with gender dysphoria, amongst whom are now a disproportionate number of girls, especially lesbian and bisexual girls. We therefore welcome the opportunity to share our perspective with the Committee on Justice and Human Rights in the hope that this may inform the debate regarding this inquiry.

The Memorandum of Understanding

Abusive, coercive and degrading practices relating to sexual orientation are widely rejected by the British public and have no place in modern Britain. That's why Version 1 of the *Memorandum of Understanding* (hereafter MoU) focusing on conversion or "gay cure" therapies was signed by the leading professional bodies and healthcare services in the country in 2015. Two years later, gender identity was included in Version 2 of the MoU, a change hotly debated within the profession but not widely publicised nor noticed by the public.

For psychologists and psychiatrists treating children with gender dysphoria, the inclusion of gender identity and the preceding campaign in the lead up had a detrimental impact on their practice. The wording of the MoU did not allow for the differences between sexuality and gender identity where this matters most—in the treatment protocols regarding children who identify as trans.

> *For the purposes of this document 'conversion therapy' is an umbrella term for a therapeutic approach, or any model or individual viewpoint that demonstrates an assumption that any sexual orientation or gender identity is inherently preferable to any other, and which attempts to bring about a change of sexual orientation or*

gender identity, or seeks to suppress an individual's expression of sexual orientation or gender identity on that basis.[1]

Sexual Orientation vs Gender Dysphoria—Relevant Differences

A child who is gay, lesbian or bisexual needs no medical intervention to live a happy and fulfilling life. No studies have demonstrated that a child's sexual orientation is rooted in psychological or psychiatric causes. Therapy is therefore unnecessary, unless it is needed to cope with the effects of homophobia, whether internalised or socially experienced.

A child who rejects his or her sex however, and who suffers from gender dysphoria, may seek to medically transition—a pathway which leads to irreversible changes to the body, including but not limited to the permanent loss of fertility and sexual function, the need for lifelong medical treatments with as yet unknown long-term consequences, and—ultimately—genital surgeries with very high complication and failure rates. Until recently, a medical transition as a treatment for gender dysphoria which results in irreversible changes to healthy bodies has therefore been embarked upon only as a measure of last resort, reserved for adults alone and undergone only after years of intense psychological counselling aiming to avoid the risks posed by a medical transition by reconciling the individual with their sexed body.

During the reclassification debate surrounding gender dysphoria in the DSM-5[2] and ICD-11[3], much of the discussion centred on how to remove the stigma associated with mental illness while continuing to facilitate access to healthcare for those diagnosed with GD—an aim agreed upon by patient groups, medical professionals and transgender rights organisations alike. Indeed, better access to specialised healthcare, in particular provisions enabling a faster, safer and more successful medical transition is a major campaign goal of transgender rights activism. This represents a marked difference to sexual orientation for which no treatment has ever been required or campaigned for by gay rights organisations.

Another notable divergence from sexual orientation is the reported high co-morbidity with psychiatric conditions in children diagnosed with gender dysphoria. Amongst them are post-traumatic stress disorder, caused by physical and sexual abuse, neglect, bereavement and abandonment; autistic spectrum disorders; personality disorders; dissociative disorders and body dysmorphic disorders as well as depression and anxiety. A child's gender dysphoria may develop in response to or as a symptom of these traumata and conditions. Furthermore, trauma caused by homophobia and strict enforcement of traditional sex stereotypes and sex role stereotypes within the child's environment has also been shown to contribute to or accompany gender dysphoria.

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[1] *Memorandum of Understanding on Conversion Therapy in the UK. Version 2. October 2017. Page 2, paragraph 2.*

[2] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, D.C.: American Psychiatric Association; 2013.

[3] World Health Organization. International Classification of Diseases, 11th Revision. Geneva, Switzerland: World Health Organization; 2019.

Given the urgent need for better psychological treatment provisions for these children, it seems reasonable to us that legislators should therefore exercise caution in placing any kind of restriction on therapy and counselling for children diagnosed with gender dysphoria aiming to resolve their gender dysphoria by addressing these underlying conditions.

For some children suffering from gender dysphoria, a medical transition may prove to be the necessary step for a happy and fulfilling life regardless of the risks. However, as acknowledged even by the clinicians who pioneered the affirmative treatment approach now predominant in Australia and the UK, even for the experts it is extremely difficult to predict which children will persist and identify as trans as adults, and which children will desist and reconcile with their bodies.

Treatment Protocols for Children Who Identify as Trans

The previous best practice model in treating children diagnosed with gender dysphoria, an approach called *Watchful Waiting*, therefore recommends holding off on both a social and medical transition until after puberty is complete. This is when most children who do desist will have reconciled with their birth sex, often growing up to be gay, lesbian or bisexual. In this way, *Watchful Waiting* avoids iatrogenic harm to the vast majority of children diagnosed with gender dysphoria who desist and who would otherwise undergo the aforementioned risks of medical interventions unnecessarily.[4] Throughout this time, the children are supported through counselling seeking to help them manage their dysphoria and, if possible, identify and address any underlying issues until after puberty, when it is clear whether the child's gender dysphoria persists or desists.

As the physical changes caused by puberty are frequently a distressing time for children diagnosed with gender dysphoria, clinicians in the Netherlands developed an alternative treatment protocol designed to alleviate their suffering from the late 90s to early 2000s. As used today, the *Affirmative Approach,* also known as the *Dutch Approach,* accepts the child's innermost belief of being the opposite sex as the truth. Clinicians no longer seek to reconcile the child with his or her body by addressing the psychological root causes of their gender dysphoria. Instead, they first seek to medically stop the natural physiological maturation process of puberty through the use of so-called puberty blockers. Children who persist in their belief are then prescribed cross-sex hormones which prevents their natural puberty permanently, leading to the development of the secondary sex characteristics of the opposite sex, thus rendering them infertile and depending on the Tanner stage at which puberty was blocked unable to reach any sexual function in adulthood. Although these children merely undergo a muted puberty of the opposite sex and typically do not reach Tanner Stage 5, blocking their natural development does lead to better aesthetic outcomes, particularly for male children wishing to pass as the opposite sex.

The use of puberty blockers was then believed to give these children the necessary time to reach certainty about their gender identity without the stress of coping with the physiological changes of puberty. In *Treatment of Adolescents With Gender Dysphoria in the*

[4]Desistance rates are explored as part of a literature review in *Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study* by Steensma, Biemond, de Boer, Cohen-Kettenis (2011).

Netherlands, a carefully detailed paper[5] published in 2011, clinicians at the forefront of this approach set out the importance of a painstaking diagnostic process exploring the possible causes of a child's gender dysphoria as well as the importance of offering psychological treatment to their patients. This was intended to exclude from unnecessary treatment those children who will desist if the underlying causes are addressed and to delay treatment for children whose co-morbid psychological conditions cause instability until after these were treated. In short, as originally developed in the Netherland's only gender identity clinic, intense psychological treatment was an intrinsic part of the *Dutch Approach* in order to avoid unnecessarily treating the many children whose gender dysphoria will resolve with psychological treatment as well as those who will naturally desist.[6]

Since then, not only *Watchful Waiting* but also the painstaking diagnostic process and any psychological treatment intended to aid the child in reconciling with their birth sex offered by clinicians following the *Dutch Protocol* have been fiercely criticised by transgender rights organisations and activists who describe them as intrusive, demeaning and, increasingly, as conversion therapy. As a consequence, the *Affirmative Approach* used in the UK's only Gender Identity Disorder Service (GIDS) offered to children through the Portman and Tavistock Trust no longer offers children diagnosed with gender dysphoria any alternative to a medical transition. Although this change in treatment protocol followed pressure from trans rights campaigners in advance of the publication of the MoU in 2017, until then clinicians had far less to fear if they raised concerns about the lack of psychological treatment.

Since the MoU was published in 2017, a number of whistleblowers[7] within the GIDS reported that their attempts to support children to reconcile with their sex in cases where gender dysphoria occurred as a result of sexual abuse, co-morbid conditions or homophobia were described as transphobic and even likened to conversion therapy.

Such a rejection of clinicians' efforts is particularly concerning in the case of homosexual and bisexual children who are vastly overrepresented amongst children presenting to the GIDS. In *Sex, gender and gender identity: A re-evaluation of the evidence*[8], the authors report that in 2012 for instance only 8.5% of girls referred to the service described themselves as heterosexual. Given that the overall percentage of lesbian and bisexual women and girls in the UK is less than 5%, the underlying causes for this overrepresentation should be urgently investigated. Although empirical evidence[9] has shown that a cross-sex identification is a better predictor of a child growing up to be bisexual, gay or lesbian rather than growing up to identify as trans, these children were also put on the medical pathway. This happened to such an extent that clinicians at the service raised concerns they were practicing a form of gay conversion therapy.

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[5]*Treatment of Adolescents With Gender Dysphoria in the Netherlands*. Cohen-Kettenis, Steensma, Vries. (2011). In Child and adolescent psychiatric clinics of North America. 20. 689-700.

[6] In a study detailing their own experiences with desistance, a literature review revealed desistance rates between 73% and 98%, i.e., the vast majority of children treated for gender dysphoria were observed to reconcile with their sex. (Steensma, Biemond et al. 2011)

[7]An open letter to Dr Polly Carmichael from a former gids clinician by Kirsty Entwistle, 18 July 2019

[8]Griffin, L., Clyde, K., Byng, R., & Bewley, S. (2020).

[9]Childhood Gender-Typed Behavior and Adolescent Sexual Orientation: A Longitudinal Population-Based Study.

In 2019, staff interviews conducted as part of an internal review confirmed that homophobia was an underlying issue in many cases of children seeking to transition but children were referred onto the medical pathway to transition anyway. The Times of London reported:

> *So many potentially gay children were being sent down the pathway to change gender, two of the clinicians said there was a dark joke among staff that "there would be no gay people left".*
> *"It feels like conversion therapy for gay children," one male clinician said. "I frequently had cases where people started identifying as trans after months of horrendous bullying for being gay," he told The Times.*
> *"Young lesbians considered at the bottom of the heap suddenly found they were really popular when they said they were trans."*
> *Another female clinician said: "We heard a lot of homophobia which we felt nobody was challenging. A lot of the girls would come in and say, 'I'm not a lesbian. I fell in love with my best girl friend but then I went online and realised I'm not a lesbian, I'm a boy. Phew.' "*[10]

At the time, the Tavistock and Portman Trust rejected these criticisms and defended its safeguarding policies as robust and its treatment protocol as safe. However, as recently emerged during a Judicial Review against the GIDS[11], no psychological treatment seeking to resolve a child's gender dysphoria by addressing any underlying psychological and psychiatric causes are available to those patients referred to the service. This is despite the fact that the vast majority of these children will desist if they undergo a natural puberty.

In the case of R (on the application of) Quincy Bell and A v Tavistock and Portman NHS Trust and others, as heard at the High Court of Justice in London earlier this year, judges noted in their judgement issued on 1 December 2020 the "non-existent or poor evidence base, as it is said to be, for the efficacy of such treatment [puberty blockers] for children and young persons with GD" as well as "the limited evidence base of psychological benefit" of blocking puberty and go on to state: "In short, the treatment [affirmation and puberty blockers] may be supporting the persistence of GD in circumstances in which it is at least possible that without that treatment, the GD would resolve itself." The judges also repeatedly stressed their surprise not only at the lack of evidence available, but also the lack of data collection on the part of GIDS, "given the young age of the patient group, the experimental nature of the treatment and the profound impact that it has."

In the language used in the issues paper regarding conversion therapy in relation to gender identity, Tasmanian lawmakers suggest a clear preference for the kind of treatment offered by the *Affirmative Approach,* which was here judged to be severely lacking in evidence as to its risks and efficacy and potentially leading to harm for children. The Court of Protection therefore ruled that no child under 16 could consent to receiving puberty blockers and that clinicians using this approach who are seeking to treat 16 and 17-year-olds should most

[10] "It feels like conversion therapy for gay children say clinicians" Bannerman, Lucy. The Times, 8 April 2019.
[11] R (on the application of) Quincy Bell and A v Tavistock and Portman NHS Trust and others.

likely seek a ruling from the Court of Protection given the difficult implications of the treatment. As this judgement merely confirms existing UK law, it took immediate effect and so has also put an immediate stop to the further prescription of puberty blockers to under 16-year-olds in the UK.

As this judgement effectively bans clinicians following the *Dutch Approach* from putting children onto the medical pathway pioneered by this treatment protocol, it most likely means a return to psychological treatment. Given the increasing number of older children presenting at the GIDS with gender dysphoria, the *Watchful Waiting* approach will have to be complimented by a strong *Exploratory Approach* that focuses much more on identifying the root causes and underlying issues that may be causing the child's dysphoria, and through addressing these causes and issues seeks to aid the child in resolving their gender dysphoria and reconciling with their sex.

But this is precisely the approach that proposed legislation may result in banning in practice. Just as abusive and coercive therapies have no place in a progressive society, neither does state-sanctioned harm to children as an unintended consequence of the Tasmanian Parliament's legislative efforts in the proposed Bill.

<u>Recommendations</u>

We therefore urge you to read the judgement in this case in full to ascertain for themselves whether this Bill will help alleviate the suffering of children diagnosed with gender dysphoria, if parents, teachers and health care providers are discouraged from utilising an exploratory therapeutic pathway when failure to "affirm or support" a child's self-declared gender identity can result in civil and criminal sanctions. Furthermore,

- Given that there are markedly different needs present in those diagnosed with gender dysphoria, *we urge you not to conflate sexuality with gender identity within this Bill*.

- Given that the vast majority of children diagnosed with gender dysphoria will desist, *we urge you not to criminalise parents who seek to access therapies that will help their child reconcile with his or her sex*.

- Given that children with serious psychiatric conditions are overrepresented amongst those diagnosed with gender dysphoria, *we urge you to not to create additional barriers in how these children may access much needed support.*

- Given that conversion therapy was not defined in relation to gender identity within the MoU, which had a harmful effect on the treatment of children diagnosed with gender dysphoria in the UK, *we urge you to specify a ban on abusive, coercive and involuntary therapies for sexual orientation only*.

- Given that not only gay and lesbian rights campaigners but also clinicians treating them have described the medical transition of homosexual and

bisexual children as a form of conversion therapy and autistic rights campaigners have likened the medical transition of children with ASDs to eugenics[12], *we urge you not to ignore these concerns by banning therapies that may prevent such human rights abuses from occurring in Victoria.*

Who we are

For Women Scotland is a grassroots women's rights organisation composed of ordinary women from across Scotland. The primary motivation for forming was concern about the Scottish Government's proposal to reform the Gender Recognition Act 2004 and the potential impact this would have on the hardwon rights and protections for women and girls. We now campaign to protect the rights of women and girls in all proposed new legislation and have been called to testify as witnesses before the Scottish Parliament in regard to a number of Bills.

Bibliography

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, D.C.: American Psychiatric Association; 2013.

Bannerman, Lucy. "It feels like conversion therapy for gay children say clinicians." The Times, 18 April 2019. Available online at https://www.thetimes.co.uk/article/it-feels-like-conversion-therapy-for-gay-children-say-clinicians

Cohen-Kettenis, Peggy & Steensma, Thomas & Vries, Annelou. (2011). Treatment of Adolescents With Gender Dysphoria in the Netherlands. Child and adolescent psychiatric clinics of North America. 20. 689-700.

Entwistle, Kirsty. An open letter to Dr Polly Carmichael from a former GIDS clinician. 18 July 2019. Available online at https://medium.com/@kirstyentwistle/an-open-letter-to-dr-polly-carmichael-from-a-former-gids-clinician-53c541276b8d

Gender Critical Autistics – Statement on Tavistock Ruling. Dated 2 December 2020. Available online at https://gendercriticalautistics.wordpress.com/2020/12/02/gender-critical-autistics-statement-on-tavistock-ruling/amp/

Griffin, L., Clyde, K., Byng, R., & Bewley, S. (2020). Sex, gender and gender identity: A re-evaluation of the evidence. *BJPsych Bulletin,* 1-9.

Li, Gu & Kung, Karson & Hines, Melissa. (2017). Childhood Gender-Typed Behavior and Adolescent Sexual Orientation: A Longitudinal Population-Based Study. Developmental psychology. 53.

[12] Gender Critical Autistics – Statement on Tavistock Ruling.

Memorandum of Understanding on Conversion Therapy in the UK. Version 2. October 2017. Available online at https://www.bacp.co.uk/media/6526/memorandum-of-understanding-v2-reva-jul19.pdf

R (on the application of) Quincy Bell and A v Tavistock and Portman NHS Trust and others; judgement available online at https://www.judiciary.uk/judgments/r-on-the-application-of-quincy-bell-and-a-v-tavistock-and-portman-nhs-trust-and-others/

Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*. 2011;16(4):499-516.

World Health Organization. International Classification of Diseases, 11th Revision. Geneva, Switzerland: World Health Organization; 2019.