

Proceedings: The Future of Youth Gender Medicine Seminar



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The Future of Youth Gender Medicine

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How Did We Get to Where We Are Today?

Associate Professor Peter Parry

Introduction

As a preface, I note that people with mental issues including Gender Dysphoria must be provided with empathy and strictest professional and respectful care. It is clear nearly all parents love their children and desire to support them whether they agree or disagree with them transitioning. Similarly, health professionals seek to provide the best care – whether adhering to the affirmative model or the traditional explorative model.

While we should strive to treat each other with respect and kindness at all times, it is also vital to seek the truth. We need to debate life-altering models of care for gender dysphoric children and teens – openly.

When you want to help people,
you tell them the truth.
When you want to help yourself,
you tell them what they want to hear.

Thomas Sowell

As Thomas Sowell implies – Truth is more important than kindness, because truth is kinder in the long run.

Psychiatric Diagnosis and Gender Dysphoria

Despite strident efforts to de-pathologise gender dysphoria, it remains a psychiatric diagnosis in the Diagnostic & Statistical Manual of Mental Disorders (DSM). I teach the subject of psychiatric diagnosis in the psychiatry training course and have taught developmental

psychology – that provides further context for defining psychiatric disorder.

The gender dysphoria debate has to be seen through the wider lens of historical psychiatric diagnosis controversies, so I’ll address these first. Here are 3 slides from my lecture:

It is as important to know the man who has the disease
as it is to know the disease the man has.

Hippokratês

As far back as Hippocrates it was recommended to consider the full context of a patient’s life not just focus on the main symptoms.

Figure A.11.1 Integrating the data as a diagnostic formulation: the diagnostic matrix

	Predisposition	Precipitation	Pattern	Perpetuation	Potential
Physical					
Psychological					
Family/Social					

From: Nurcombe B. Diagnosis and treatment planning in child and adolescent mental health problems. In *IACAPAP e-Textbook of Child and Adolescent Mental Health*.

The BioPsychoSocial model where factors are looked at from predisposing, to precipitating, to perpetuating and prognostic & protective – and not just the pattern of symptoms – is the basis for comprehensive psychiatric diagnosis.

“What is behind the symptom”
Karl Menninger, 1963

And I end the lecture with this pithy quote from a famous American psychiatrist.

As covered in the lecture, over-diagnosis & mis-diagnosis epidemics and individual case errors occur when we stray from applying the

biopsychosociocultural model and a form of reductionism intervenes – be that ‘biomedical reductionism’ that ignores psychosocial & cultural factors; or psychological or social reductionism – ignoring biomedical causes; or just informational reductionism – taking a fast superficial history, looking for symptoms in a checklist style without consideration of the overall context of the patient’s life.

Diagnostic controversies and over-diagnosis epidemics in psychiatry are as old as the field itself.

Paediatric Bipolar Overdiagnosis Epidemic

My doctoral research investigated a two-decade overdiagnosis epidemic of bipolar disorder in very young children in the United States, titled *“Paediatric Bipolar Disorder: Why did it occur? The iatrogenic consequences and implications for psychiatric nosology.”* Nosology being the classification of diagnoses.

A thin silver lining to this epidemic is that bipolar disorder was often diagnosed late, the epidemic of over-diagnosis did make us more vigilant for early signs of onset. However, this is dwarfed by the iatrogenic (which means harms caused by medical drugs, procedures & misdiagnoses) consequences of 25 years of over a million children and teens misdiagnosed and overmedicated – and according to peer-reviewed and FDA adverse event pharmacovigilance data – possibly several thousand deaths, mostly via cardiac conduction problems from high doses of psychiatric drugs. Such as 4-year-old Rebecca Riley, diagnosed with ADHD at 28 months and paediatric bipolar by age 3. But – also parents, teachers, the children and young people themselves identifying with an illness the vast majority did not have, and therefore other causes of their emotional and behavioural problems were neglected. Many may go through decades or their entire lives erroneously believing they are ‘bipolar’.

Powerful commercial forces fuelled the paediatric (and also adult) bipolar overdiagnosis epidemic, as subpoenaed internal pharmaceutical company documents released from criminal cases proved. Big Pharma funding of biomedical reductionist psychiatry departments drove ‘paediatric bipolar’ research and clinical guidelines, along with a biomedical ideology and the desire of both parents and prescribing clinicians for a simple answer and medical fix for dealing with messy multifactorial childhood behaviour problems.

Another aspect is the capacity for Groupthink, or what Rhodes & Thomas in a recent *Spectator Australia* article term ‘Crowdthink’, whereby our species undergoes mass hypnosis by a new narrative. It takes courage to seek and speak truth when all around you are in the grip of a Narrative.

A basic tenant of psychiatric diagnosis is: Don’t jump to conclusions. Psychiatry requires longer sessions and usually several to conduct a full assessment, and involves listening to family, teachers, and other relevant persons for collateral history. This was bypassed with the paediatric bipolar epidemic. The author of this book – “The Intelligent Clinician’s Guide to the DSM-5”, favourably reviewed by Sydney psychiatrist Prof Gordon Parker – is Prof Joel Paris, former chief-editor of the *Canadian Journal of Psychiatry* who 10 years ago said, “50 years from now paediatric bipolar will be seen as the greatest scandal to befall psychiatry”.

It can take time for an overdiagnosis epidemic to be fully acknowledged.

Increasing Incidence of Gender Dyphoria

Gender dysphoria, formerly ‘gender identity disorder’, is a cluster of symptoms or characteristics that has been studied for decades. At the individual level someone, particularly a minor with gender dysphoria, being uncomfortable with their observable birth sex as male or female (leaving aside extremely rare cases of intersex abnormalities) – needs a multi-session assessment and discussions with parents and the information be filtered through the biopsychosocial intersecting with time-dependent factors grid for a deeper understanding of why they feel this way. Prior to the last 15 years, that is what the few gender clinics for the rare gender dysphoria cases did.

Often a good biopsychosocial diagnostic formulation, fed back to the person in appropriate language that grants them deeper understanding of themselves and their symptoms, is therapeutic in itself. It sometimes causes symptoms to abate. It allows the therapeutic journey to begin.

With regards to gender dysphoria, in busy child & adolescent work, involving supervisory oversight of community teams, inpatient units and emergency departments since 1995 I don’t recall ever seeing a single female to male gender dysphoric patient until the late 20teens. There was less than one handful of very effeminate boys who seemed they might be more comfortable as females but probably were on track to being effeminate gay men and quite likely happy, particularly as modern society was far less homophobic.

What was strange was the inexorable rise in gender dysphoria cases since about 2017, the vast majority typically 13- to 15-year-old biological females not wanting to grow up into women.

Sex is binary at the cellular level, which is why lifelong hormones are required to maintain a transgender physiology. Increasingly these

young teens with two X chromosomes would describe themselves as “theys”, as “non-binaries”, though often that was a steppingstone to wishing to transition to transmales. From none in two decades to a trickle for 5 years and a deluge in the past 5 years. A couple of years ago, when working a week’s locum on a 6-bed adolescent mental health unit, there were seven 14-15yo biologically female patients over the course of the week of whom five identified as non-binary or male.

So, in the Western world, we’re dealing with a gender dysphoria epidemic.

Historical Psychiatric Epidemics

My doctoral research, and teaching the topic of nosology, has made me aware of diagnostic epidemics. Interestingly there’s sometimes a kernel of truth in the epidemic. For a quick run through of some:

Koro, aka ‘genital retraction syndrome’, is an anxiety syndrome where men believe their penises are retracting into their abdomens, or women believe their breasts are shrinking. It occurs in epidemic mass hysteria outbreaks in South-East Asia, India and Africa. Mass hysteria of agitated people with anxiety related symptoms and associated autonomic nervous system disruption based on increased focus on their bodily symptoms in a vicious cycle and seeing others with the same, have occurred through history. The medieval dancing manias where mostly young women would dance ‘til they dropped, or even died, being an archetypal example. Sometimes this manifested as contagious laughing epidemics, as infected nunneries in past centuries and Tanzanian schools in 1962, or an outbreak of factitious Tourette’s disorder in a New York school in 2011.

In socially repressive Victorian times, hysteria (which since ancient Greek medicine had been associated with the uterus) was a way for mostly young women to express distress they couldn’t otherwise

ventilate. Hypnosis and Freudian psychoanalysis began as cures for hysteria, Freud initially postulating histories of sexual abuse as the cause. In Germany women had their ovaries removed to treat their hysteria, or what we'd call dissociative and psychosomatic disorders today, until psychiatry and psychoanalysis identified psychosocial causation. On the other hand, a small proportion may have been suffering 'late luteal phase dysphoric disorder', which in its severe form is very rare, but an oophorectomy would treat.

The 1949 Nobel Prize in Medicine went to a Portuguese neurologist for pioneering lobotomies. These pacified some patients with severe schizophrenia and became popular from the mid-1940s to mid-50s with 10,000s performed, including on children and also on some homosexual men to render them quote "morally sane". These days tiny, targeted leucotomies can reduce severe OCD, but frontal lobotomies were obscene malpractice and recognised by many psychiatrists and neurologists as such at the time. The dissenters noted a groupthink mania took hold of the medical profession and society during the height of the lobotomy epidemic.

Soviet psychiatrists led the way banning lobotomies saying it just "changed an insane person into an idiot". But at the same time Soviet psychiatrists during Stalinism were diagnosing, incarcerating and medicating thousands for "anti-Soviet" thought and non-atheist religious beliefs as having "sluggish schizophrenia".

Australia had an epidemic of RSI, repetition strain injury, in the 1980s with the advent of increased keyboard usage. The occasional person still gets tenosynovitis from typing but it's no longer an epidemic threatening to bankrupt WorkCover. Most nations missed the social contagion of RSI, it seems the positive reinforcement of WorkCover payments might have been a perpetuating factor.

I recall the ‘Satanic Panic’ of the 1980s. Supposedly numerous day care centres performed satanic ritual abuse of children. Despite cases of paedophilia as we know from the Royal Commission into Institutional Child Abuse being more common than society likes to admit, the Satanic Panic was social contagion, and childcare workers were wrongfully incarcerated.

The 1990s ‘multiple personality disorder’ epidemic followed. Thousands of cases occurred as therapists explored interactions with their clients’ various alters, fostering increased identification with being a multiple. When the professions realised they were perpetuating cases via affirmative treatment, and precipitating the creation of new cases as the public was influenced by both the media and psychology literature, the epidemic faded. Today, genuine ‘dissociative identity disorder’ cases exist but are again rare. Psychoanalytic therapies and models such as Internal Family Systems therapy seek integration of our various ‘parts’ – rather than affirming autonomy for those parts.

We have an ADHD epidemic. The concentration-enhancing benefits of psychostimulants implies large numbers of us have ADHD. But it’s not that simple – a discussion for another day.

The autism spectrum epidemic directly relates to gender dysphoria. Diagnoses of ASD overwhelm the NDIS. The situation is nuanced. Cases missed in the past now recognised, pollutants and chemicals affecting foetal and infant brain development, increased survival of prem babies, older parents with older sperm and eggs, changes to microbiome from glyphosate in the food chain – are among hypothesised causes of a real increase. But educational and financial incentives drive ASD diagnoses, and some are simply introverted temperaments and a bit obsessive or quirky. Where the line is drawn becomes subjective. Teenage girls on the ASD spectrum or just shy and quirky comprise many of those presenting to Gender clinics.

‘Emo’, Social Contagion, and Rapid Adolescent Onset

In the 90s to early 2000s as a child psychiatrist, these shy or ASD girls and some boys would more likely present as Emo. It was a big movement, ‘Goth-lite’, with histrionic misery replacing Goths’ histrionic agro. Those identifying as Emo usually had anxiety, depression or eating disorder symptomatology and as the predisposing, precipitating, perpetuating factors for these comorbid problems were addressed by usual mental health practice, the urge to be Emo often faded. How many in their 30s and 40s remain Emo today?

I recall as a father being taken aback at the rapid onset Emo identification that occurred with my children’s social groups. Early adolescence is as the famous developmental psychologist Erik Erikson noted – a tumultuous time of ego-identity confusion and fluidity. It is not unsurprising that ‘rapid onset gender dysphoria’ particularly affects pubertal girls, as shown in Littman’s peer-reviewed paper.

As Prof Dianna Kenny summarises in her well researched book, much research shows peak susceptibility to social contagion occurs with 14-year-old girls. Though any astute parent, teacher or clinician is well aware of this without needing peer reviewed studies. Prof Kenny cites DSM-IV in 1994 stated that 5 times as many boys as girls were referred to paediatric gender clinics, but by 2020 the Tavistock GIDS showed a massive inversion to pubertal girls dominating referrals.

Pre-Affirmative Care Youth Gender Clinic Approach

Pre-Affirmative Care, there were child & youth gender clinics for rare cases of gender identity disorder. This is Prof Zucker , formerly of University of Toronto, chair of the DSM committee on gender identity disorder, subsequently sacked from his tenured post for not converting to a gender affirmative model. Prof Levine, Prof Kosky & Dr Hakeen (who worked at the Tavistock GIDS) are a few other leaders in the field

prior to when the so-termed “Dutch Protocol” became adopted beyond its initially narrow spectrum of male to female cases. And this coincided with increasingly liberal Standards of Care by WPATH (World Professionals Association for Transgender Health), originally called the Harry Benjamin International Gender Dysphoria Association in honour of Endocrinologist & Sexologist Dr Benjamin, an associate of influential sexologist Alfred Kinsey. Dr Benjamin treated rare 1950s transsexual cases and advocated medical & surgical transition rather than explorative psychotherapy.

Nonetheless the original child & youth gender clinics found high rates of desistance during normal puberty. There was also a lack of the positive reinforcers seen in current LGBTQIA+ perspectives incorporated into schools, jobs and societies. Zucker cited a desistance rate of 88% and persistence to transgender rate of 12% with a small fraction of today’s referral numbers.

With the explorative approach there was not just one trans phenomenon, but multiple causes and differing subtypes of gender dysphoria. These were elucidated by applying the norms of psychiatric diagnosis within a biopsychosocial model of care. And include: Disordered attachment histories and enmeshment with parents; child sexual abuse and effects on gender identity or phobia of being vulnerable as a woman, internalised homophobia against male homosexual or lesbian sexual orientation, having feminine interests as a boy, masculine interests as a girl or young adolescent, phobia of growing up to be a victim of domestic violence, transvestitism fetishes, and autogynephilia – which is the sexual arousal of a heterosexual male for fantasizing or acquiring a female body.

Legislative Changes, Queer Theory, Funding for GAC

But in recent years a bill with almost identical wording was introduced into many Western legislatures prohibiting health practitioners from too diligent exploration via a biopsychosocial assessment. Rather, it must be affirmation or possibly lose your licence or even go to jail.

The international coordination of that bill is interesting, in fact according to investigative journalism by Jennifer Bilek and others, it seems the transrights movement is global and extremely well-funded. Hormones cost significant sums over a lifetime, let alone costs of surgery. And, analogous to the bipolar disorder false diagnosis epidemic fuelled by \$millions of Big Pharma marketing, research grants and sponsored patient advocacy groups, the Transactivist movement – according to Bilek – receives many \$millions in financing from billionaires invested in the medical industry. Bilek names adult transwomen billionaires Jennifer (previously James) Pritzker and Martine Rothblatt for donating significant sums. Rothblatt, a lawyer by training, authored the first of the anti-conversion therapy legislative bills.

Bilek also cites Rothblatt as extolling the transgender agenda as a path towards a transhumanist agenda. Bilek says: “Reproductive sex is being deconstructed for the market: eggs, cervixes, hormones, breasts, wombs, etc. It is why women are being reduced to terms like chest feeders, birthing bodies, cervix havers, etc.” This sounds perhaps outlandish, but a former member of the executive of one of our political parties told me a few years ago when I had barely heard of transhumanism that this was a wealthy international political lobby group. It would be interesting if any of the MPs here have heard this?

What Bilek’s research suggests is that given funding and international coordination, the sudden rise of gender dysphoria is not simply a grass

roots phenomenon. Perhaps overshadowing the funding of the billionaires is US foreign aid being tied to promoting transactivist agendas, as per recent audits of USAID, and celebrated in this [2014 post](#) on the White House blog.

Also as described [here](#), the social science of Queer Studies arose from activism, which may be finding social truths, but then again is predicated on assumptions consistent with activist goals, rather than completely open-minded scientific exploration. Such assumptions are epistemologically more akin to theological studies in a particular religion, than to true social science.

Positive Reinforcers Abound

In terms of our biological driven psychology, we are an animal species like any other that responds to positive reinforcement cues, especially to be in harmony with herd or tribe and the group narrative. One of those reinforcers is the reported \$millions flowing from the billionaires. Another is the social media likes and shares that feed social contagion. Another is the new educational curricula teaching primary schoolers about a multiplicity of genders. And another is the ‘Gender Affirmative Care Model’ that could well be retitled the ‘Positive Reinforcement Model of Care’, and it minimises the level of questioning for underlying origins of symptoms which we would professionally practice for any other psychiatric disorder.

The only rational ethical reason to drop this exploration is the assertion that gender dysphoria is absolutely equivalent to sexual orientation, and the depathologising of homosexuality, lesbianism and bisexuality over the past half century now needs to be applied to gender dysphoria. But that is an assertion without evidence, and several detransitioners say their same-sex orientation was buried by the rush to transition. Prescribed disruption of normal sex hormones and permanent surgeries

in young developing bodies is deemed ethical on the basis of an unproven assertion.

It is true that feminine and masculine traits vary across a spectrum. Effeminate boys and tomboy girls always existed, many grew up to be gay and lesbian, which thankfully is easier today. Society was increasingly encouraging of men's feminine side and women's masculine side. But now the trans option is readily available. For some it may be the best path. But for gender confused youth there's so many positive reinforcers along that path and very few brakes in 2025 here in Australia.

Detransitioner Appeal for Explorative Care

Given the gender affirmation model deficiencies, the rise of detransitioners is unsurprising. I've met a couple & listened to over a dozen on YouTube. They ask, with eloquence crafted from deep introspection and fierce emotion, why were they not offered a full biopsychosocial explorative model of care? Because usually in their 20s, with greater capacity for abstract reasoning, as well as life experience, they've realised their gender dysphoria was due to other factors, unaddressed by gender transition. They describe intense grief over lost normal adolescence and of their biological sex capacities such as ability to orgasm, be fertile or to breastfeed. Some say they hear from many others who are still in the detrans closet or whose social and emotional sunk-cost in their transition means remaining as regret cases making the best of their transitioned bodies.

Short-term published outcome studies by WPATH compliant gender clinics describe tiny regret rates. But have high non-response rates and would not capture what the detransitioners say is commonly a 5-to-10-year journey. The UK Cass Review criticised the outcome studies as methodologically weak and noted that British adult gender clinics

refused to give access to follow-up data on the Tavistock paediatric cases.

Detransition and Regret cases would be far fewer with a return to a traditional explorative model of care, and a public and school education campaign about the wider range of factors that can create gender confusion particularly in early puberty. The UK, Scandinavia and now the USA are heading that way, and in Queensland a pause and review is occurring.

Regret cases are more likely as last month a large outcomes study post-gender affirming surgery showed significant worsening of depression, anxiety and suicidal ideation.

Two Personal Anecdotes

I have two anecdotes:

Firstly: I and child psychiatrist colleague Dr Cary Breakey presented with the AMA state president to a Qld parliamentary committee about the anti-conversion therapy bill. I argued that hypothetically two 14yo girls come into my clinic one after the other, each says the same thing – they’re morbidly obese and want anorectic drugs followed by gastric sleeve surgery. The first chews lollies, has a BMI of 41 and is pre-diabetic. I refer her to an obesity clinic. The second is skeletal, about to die of starvation, so I admit her to hospital for forced refeeding under the mental health act for anorexia nervosa. I went on to say , “Yet your bill in parliament doesn’t want me to make similar assessments of underlying causes for gender dysphoric teens?” The parliamentarians seemed impressed by this analogy. We got a slight amendment to the bill that makes us feel slightly safer as therapists. In the couple of weeks after our submission, 10 of my child psychiatrist colleagues in Queensland went out of their way to thank me, some said they were glad a couple of us had the courage to speak up.

Second: I saw a mother with her anxiety-suffering biological daughter who was identifying as male and receiving gender affirmative care. The mother was trying hard to use the preferred male name and pronouns for her now transitioning ‘son’. However, questioning revealed intergenerational domestic violence in a misogynistic patriarchal family culture and several male relatives incarcerated including for murder. The mother had in fact fled with her two daughters and some of her sons to our region.

Speaking with mother alone she said her sons were abusive to her, typical of their misogynist social modelling. Realising she could express her feelings; she became teary and said – to quote as it stuck in my mind: “I used to have my two girls who I could relate to as a woman – I’ve lost the older one who is now a son but has become aggressive like all males in our family. Now I’m going to lose my last remaining daughter!” And she cried. There’s much to unpack in that case, but the obvious is why would you want to grow up to be a woman and victim of a domestically violent family culture?

Conclusion

The current positive reinforcement situation provides parallels, as I see it, to 1990s multiple personality disorder or diagnosing thousands of preschoolers with bipolar disorder in the USA, something Prof Paris the editor of the *Canadian Journal of Psychiatry* said would one day be seen as “the greatest scandal to befall psychiatry”. Whether the gender affirmative care model is later seen as a rival scandal we shall find out in the coming years.

A Review of the Physiology and Side Effects of Puberty Blockers and Cross Sex Hormones

Professor John Whitehall

Introduction

I will give an overview of the physiology of Gonadotropin Releasing Hormone (GnRH) which is produced in the brain to exert a reproductive and a non-reproductive role, both of which can be obstructed or 'blocked' by intramuscular administration of a pharmacological compound which, though very similar in structure to GnRH, has components which will bind to the special receptors on the surface of cells awaiting stimulation by GnRH and not release them for subsequent rounds of pulsatile excitation which is basic for their continued function.

These chemical 'blockers' are employed by proponents for 'hormonal affirmation' of a child or youth to an identity incongruent with Nature's chromosomes. These proponents inject the 'blockers' to obstruct the natural process of puberty under the argument that such 'pausing' will permit time for the young person confused over gender identity to consider his or her sexual and reproductive future and maturely decide whether or not to pursue a pharmacological and probably surgical process of 'affirmation' towards an identity incongruent with chromosomal directives.

This process of 'affirmation' usually begins with social 'affirmation' towards the opposite sex, then administration of 'blockers' then, almost inevitably, to administration of hormones of the opposite sex (known as cross sex hormones) and then surgical modification of the body,

particularly breasts and genitalia, towards an ersatz similarity with the opposite sex.

Most of these stages of ‘affirmation’ involve irreversible, major interventions in body and brain and demand life-long dependence on medical care, not only for provision of pharmacological therapy and supervision of surgical modifications but also for detection and intervention (if possible) of side effects.

The administration of ‘blockers’ and cross sex hormones, however, is unregulated experimentation: it lacks biological plausibility, there are no ‘controlled’ studies with comparison to alternate therapies judged by independent researchers, there is an astonishing lack of preparatory studies in animals, there is a record of established side effects, a record of ‘regret’ by participants, and an associated rate of suicide multiple higher than in the general population.

Finally, the practice of ‘informed consent’ is traduced: vital information of limitations and side effects are not shared by even major institutions for the health of children and youths, and there is a presumption that the growing brains of children and youths are capable of sufficient ‘executive function’ to make life-long decisions regarding identity, sexuality, reproduction, the impact of medical ‘care’ (including castration) and subjection to life-long dependency on medical supply and management of side effects of both pharmacological and surgical interventions. This assumption of sufficient ‘executive function’ traduces not only the meaning of ‘informed consent’ but, also, simple, basic common sense. After all, society does not trust the mental powers of such children and youths to be able to drive a car, join the army, or even get a tattoo.

In fact, practice of administration of ‘blockers’ and cross sex hormones to children and youths also traduces the Australian High Court mandate

in *Rogers v Whitaker*¹ for full disclosure of limitations and side effects associated with any medical intervention (which might be as remote as 1/14,000 cases), in a process of fully ‘informed consent’ gained from a young person with sufficient ‘Gillick competence’ to comprehend the fully provided information and arrive at a learned and mature consideration of whether or not to proceed with the medical care.²

The process of ‘affirmation’ confronts the traditional model of medical ethics which is based on biological plausibility, beneficence, non-maleficence, justice and autonomy. In the process of ‘affirmation’ the fundamentals of traditional ethics have been overturned: ‘autonomy’ has been enthroned; the child now ‘informs’ the doctor as to what bodily modifications are being sought, and the doctor ‘consents’ to the demands.

I will argue the claim that ‘blockers’ provide time for mature consideration of future sexuality is not biologically plausible: how can this future be imagined when all of Nature’s hormonal directives have been ablated? And how can such future concepts be imagined by an immature brain in which the ‘hot’ emotional, driving impetus of the limbic system (very susceptible to external influence) is not yet disciplined by a later maturing ‘cold’ analytical pre-central cortex. Why should children now be denied the ‘justice’ of protection from unregulated experimentation? The codes of medical ethics which emerged from the trials of the egregious abuses by the medical professions in Nuremberg after WW2 were designed to prevent such abuse. Surely they have not been forgotten?

I will report there is but ‘weak evidence’ for beneficence^{3,4} in such studies as do exist on the effect of ‘blockers’ administered to children for gender dysphoria, and will provide an overview of published regulated studies that report or warn of strong evidence of maleficence

that, by any moral compass, should be shared with those entering a life altering process of medical ‘care’.

Physiology

Traditionally, it was thought that cells destined to produce GnRH originated in the olfactory placode on the face of the developing embryo, and then migrated to the brain with the help of fibres from olfactory nerve, from which they diverged to take up home in the hypothalamus, there to release GnRH in rhythmic fashion to be carried in blood to the nearby pituitary gland to cause it to release two hormones which had ‘tropic’ or growth effects on the gonads: hence the name ‘gonadotropic. These hormones were called Luteinising Hormone (LH) and Follicle Stimulating Hormone (FSH).

Activated for puberty, the GNRH cells initiate a cascading effect: causing the ovaries and testes to grow, produce eggs and sperm, and to produce and release yet another set of hormones, the sex hormones, oestrogen and testosterone, which direct the secondary sexual characteristics of girls and boys, including changes in the brain, and sexual drive.

However, other stages of activation of GnRH have been discovered. For example, one in the last trimester of pregnancy, and then after birth in a process known as ‘mini-puberty’ which lasts some 6/12 in boys and longer in girls. It appears mini-puberty (in which the sex steroids reach almost adult levels) is responsible not only for maturation of reproductive tissue, e.g. primordial eggs in the ovaries, but also for the great increase in brain size and activity which occurs in those early months in response to the *non-reproductive* role GnRH exerts on neuronal cells.

History

GnRH is a small protein whose 10 constituent amino acids were elucidated in 1971, provoking intense interest in where it was produced, what it did, how it did it, and whether its function could be altered for therapeutic effect. It was found to be released from the hypothalamus in pulsatile fashion every, say 90 minutes, which permitted time for it to dock with its special receptors on other cells, to be taken into those cells to stimulate special activities, then to release the receptors to allow them to return to the surface to be ready for the next pulse of GnRH. Continuous stimulation by natural GnRH exhausted the receptors and thus ‘blocked’ the system, as did exposure to similar, pharmacologically constructed molecules, that would dock with receptors, accompany them into the cell but would not then release them to return to the surface for re-activation.

This ‘blocking’ was found useful in such clinical conditions as precocious puberty in which the sex hormones are produced too early, and in adults in which excess or continued production of sex steroids exacerbates such illnesses as prostate cancer in males and endometriosis in females.

With the beginning of the epidemic of gender dysphoria, administration of ‘blockers’ began to be administered to children confused over gender identity in the belief that ‘blocking’ puberty would permit time for mature consideration of sexual and reproductive issues. This practice culminated, in the 1990’s, in what became known as the ‘Dutch Protocol’ for hormonal affirmation to a gender incongruent with chromosomes.

Meanwhile, the location of GnRH producing cells and receptors was demonstrated throughout the brain, from cortex to basal forebrain, hippocampus, limbic system, cerebellum and spinal cord confirming a

‘non reproductive’ role of GnRH in neuronal development and maintenance. Even more widespread influence of GnRH was indicated by finding of its cells in ovarian, uterine, placental, testicular and prostatic tissue, and in the intestine.

Side effects of ‘blockers’

Side effects of blocking GnRH became obvious from the start of human administration of blockers and were confirmed in laboratory and animal studies.

- In adults, disturbance was reported in mood, cognition and executive function but, of course, the confounding effect of associated disease and therapy could not be discounted^{5,6,7,8}.
- In laboratory dishes, neurons exposed to blockers did not extend appropriate communicating branches to other cells, suggesting impoverished synaptic potential in the brain.^{9,10} Conversely, in another centre, it was demonstrated that GnRH ‘increases both outgrowth number and length of neurites in cultured cerebral cortical neurons of rat embryos...suggesting... that besides its pituitary functions, GnRH may play a role as neuromodulator of neuronal plasticity’¹¹.
- Under the microscope, intestinal biopsies from women on ‘blockers’ for endometriosis, in whom there was an unexpected prevalence of associated intestinal symptoms, revealed marked reduction in the number of neurons in the walls of the intestine.¹²
- In the field, a number of studies have emanated from the veterinary school in the University of Glasgow where ‘blockers’ were administered to peri-pubertal sheep^{13,14,15,16,17,18}. It was found that ‘blockers’ resulted in pathological hypertrophy (enlargement) of the limbic system in the brain associated, at molecular level, with altered functions of multiple genes many of

which were involved in the integrity of that structure which is basic to integration of memory, emotion (including sexual) and cognition, and then translation of these forces into executive function which may be defined as ‘a set of skills...that... underlie the capacity to plan ahead and meet goals, display self-control, follow multiple-step directions even when interrupted, and stay focused despite distractions, among others’. In consequence, it was found that ‘blocked’ sheep suffered from reduced spatial memory (they could not decide which way to go in a known maze), increased emotional lability (they were unduly upset when separated from their peers), and a preference for the familiar over the novel (they were fearful of change). Moreover, the effect was sustained.

- In cages, ‘blocked’ rodents have suffered ‘profound effects’ in behaviour associated with altered ‘neural activity’ in the limbic system. These effects range from depression to hyperlocomotion (presumably based on anxiety), feeding disorder, and, as in sheep, preference for the familiar rather than exploration of the novel (that is fearfulness of change) and social disorder¹⁹.
- Under MRI imaging, it was found, in an adolescent, natal boy administered ‘blockers’ in pursuit of female identity, that expected structural development of the brain did not occur and was associated with reduction in IQ²⁰. In another MRI study of otherwise healthy women, it was found blockers interfered with neuronal connectivity in the limbic region and were associated with the ‘emergence of depressive symptoms’²¹.
- In association with Kallman Syndrome, in which the GnRH and olfactory cells do not migrate properly from the olfactory placode resulting in anosmia and delayed puberty, major interruptions in the development of the brain have been reported. According to Manara et al²² ‘Even though further validation is warranted, curvature, sulcation, cortical thickness, grey/white matter

volume, and bone changes in patients with KS point toward a profound structural and morphologic involvement of the basal forebrain that is far more consistent than a simple hypoplasia of the olfactory sulcus'²³. However, the exact role of deficiency of GnRH *per se* in the cerebral malformation remains unquantified, being difficult to distinguish from other effects of genetic misinformation that interfered with the original migration of cells producing GnRH. Nevertheless, as the matter is not settled it is impossible to provide unequivocal assurance the effects of 'blockers are safe and reversible' as repeated, mantra-like, by gender clinics in major children's hospitals.

- From 'leaked files' of internal communications between members and leaders of the World Professional Association for Transgender Health'²⁴ (of which AusPath is the Australian affiliate) it is revealed no-one had observed a natal boy, administered puberty blockers in the early stages of puberty, subsequently to be fertile or able to experience orgasm. Lack of testosterone is an obvious factor in restricted growth of the scrotum and penis and can be ascribed to lack of GnRH through its 'blocking', but erection, ejaculation and orgasm are based on neurological function and, as GnRH appears necessary for neuronal integrity, its absence may be causative. Either way, life-long effect of 'blockers' on fertility and sexual sensation mocks the assertion of WPATH and its affiliates, including gender centres in Australia, that the effects of blockers are 'safe and entirely reversible'.

Biological implausibility of 'blockers'

Basic to experimentation, let alone clinical practice, is proof of biological plausibility. Proponents for 'hormonal affirmation' declare 'blockers' provide time for mature consideration of future sexuality and reproduction, but this claim is flawed by biological implausibility.

- First, the natural discordance between the later developing, evaluating, disciplinary, ‘cold’ pre-frontal cortex, and the vulnerable, emotional ‘hot’ limbic system should, alone, counter arguments for the capacity of ‘mature’ consideration of sexual future by the brains of children and youths.
- Second, sexualisation is dependent on GnRH. For example, not long after elucidation of the structure of GnRH a midbrain centre was identified in certain studies, which, if stimulated,^{25,26,27} would induce sexualised behaviour in rodents and, if ablated, would prevent it²⁸.
- Also elucidated was the ‘ram effect’ in which an adult male sheep or goat would provoke ovulation in fertile ewes through smell but also sight, sound, touch and presence. GnRH was found to be of fundamental importance to this ‘socio-sexual’ phenomenon.²⁹
- Finally, the sexualising effect of testosterone and oestrogen are, surely, confirmed by any regard of the development of both physical characteristics and sexual drive in teenagers. While proponents argue ‘blockers’ will permit mature consideration of sexuality and reproduction the question must again be asked: ‘how can a young person consider these things with any sense of proportion if all of Nature’s scientific directives are negated?’
- Supporting the sexualising role of GnRH and sex hormones is recent research on kisspeptin, an upstream initiator of GnRH production. Reduction of its effect is associated with decreased libido: replacement with increased desire associated with increased production of GnRH.

Blockers promote ‘affirmation’

Another flaw in the argument that ‘blocker’s permit time for mature consideration of gender and sexuality, is the observation that ‘blocked’ children almost inevitably progress to the next stage on the pathway of

“affirmation”, receipt of cross sex hormones. Research on ‘blocked’ rodents and sheep provide biological explanation for this inevitability: on blockers, rodents and sheep prefer ‘the familiar’ to the ‘novel’^{30,31}, in other words, they prefer the status quo to exploration and pursuit of alternatives. Perhaps this is due to alteration in function of the limbic system, resulting in increased fearfulness but, whatever the neurological cause, blocked children, as with experimental animals, prefer the ‘familiar’. With children, the ‘familiar’ has become the new names, clothing, public role of a gender contrary to clothing, and encouragement by peers and other authorities, e.g. in schools and on the web, to continue in the process of ‘affirmation’ to a gender incongruent with chromosomes. The ‘novel’ is rejection of all those influences and return to the unfamiliar identity concordant with chromosomes. Thus, research on animals provides biological explanation for the observed phenomenon that almost all children on ‘blockers’ proceed to the next phase of ‘affirmation’, receipt of cross-sex hormones.

Recent findings

1. Down Syndrome (DS), GnRH and dementia

DS is a constellation of abnormalities associated with possession of three whole (or parts) of the 21st chromosome (as aligned in size under the microscope) when there should only be one intact pair. The result of the extra ‘gene dosage’ (called a trisomy) confirms that ‘too many chefs spoil the broth’: imperfect direction is provided for formation of the face and other structures, including the brain. As a result, the DS brain is smaller and grows more slowly than normal: its neurons lack connecting fibres, their layers are thin, and regional connectivity is reduced. Worse, there is a progressive decline in function with ageing, associated with the appearance of Alzheimer-like abnormalities in almost all by the age of 40.

An international team of researchers based in the University of Lille has reported the decline in cognitive power in DS can be ascribed to progressive reduction in the amount of GnRH produced in the brain, resulting from perturbation of a ‘switch’ in the cascade of compounds that initiates production of GnRH from its genetic base and guides its transformation through several developmental stages until the active form is released. Excess gene dosage from the ‘trisomic’ 21 is held responsible for the perturbation whose end result is progressive reduction in the production of GnRH, with consequent decline in cerebral faculties³².

In summary, the imperfect switch results in reduced production of GnRH, interfering with mini and real puberty, reproductive capacity (another feature of DS), and appropriate development of the brain while predisposing to its progressive impairment.

However, the Lille based researchers demonstrated that ‘cognitive performance’ in DS models of mice could be improved by replacement of GnRH. Using ultra-sophisticated techniques including the transplantation of GnRH producing cells into the brain of the DS mice and standard assessments of the cognitive powers of mice eg recognition of new objects, the researchers found cognition was improved by replacement of GnRH. Conversely, they confirmed that ‘silencing’ of GnRH production in normal mice was followed by cognitive loss.

Then, turning to human DS volunteers, the researchers found cognition was ‘rescued’ in 7 male subjects aged between 20 and 50 years by administration of GnRH beneath the skin every 2 hours for 6 months in mimicry of physiological release from the hypothalamus onto the pituitary gland. It was found that while the reproductive hormonal profile of DS patients did not change, their metabolic parameters were somewhat improved, and cognitive performance increased in six,

‘driven by sub-scores for visualisation function, executive function and attention, and a trend for episodic memory’ in association with ‘enhanced verbal comprehension’. Functional MRI studies revealed ‘increased’ connectivity in visual and sensori-motor regions and a return towards normal in the hippocampal system’.

The researchers summarised: ‘In our trisomic model...cognitive and olfactory deficits parallel a gradual loss of GnRH expression beginning in childhood and culminating in adulthood’.

The researchers concluded ‘GnRH plays a crucial role in olfaction and cognition, and pulsatile GnRH therapy holds promise to improve cognitive deficits in DS’. And they declared ‘Our results provide the rationale to launch a randomised multicentre study to confirm the efficacy of pulsatile GnRH therapy in correcting the neurodevelopmental trajectory and age-related decline seen in DS and other conditions such as Alzheimer’s Disease that share similar molecular or functional underpinnings.’

2. Long Covid and GnRH³³

Covid-19 infection has been linked to accelerated ageing, elevated risk of neurodegenerative conditions^{34,35}, and hypogonadism. Furthermore, ‘long covid syndrome’ with symptoms of ‘brain fog’, headache and persisting anosmia and reproductive hormone defects are consistent with viral infection of the brain, particularly of GnRH producing cells³⁶.

Pursuing this idea, the Lille researchers examined post-mortem brains from fetuses of mothers with Covid, and from adults who had succumbed to the infection. In the fetuses, there was ‘notable expression’ of 2 receptors crucial for Covid infection, and in the adult brains ‘GnRH neurons were found to be sick or dying, leading to a

significant reduction in GnRH expression' especially in the hypothalamus³⁷.

Chachlaki et al were particularly worried about maternal and perinatal infections because of the damage which might be inflicted on the neonatal brain about to undergo minipuberty. This damage could result in reduced fertility³⁸, and interruption to brain development³⁹.

3. GnRH population in the basal ganglia⁴⁰

In 2021, researchers in Hungary published immunohistochemistry findings of 150,000 to 200,000 GnRH producing cells in the basal ganglia and basal forebrains from three post-mortem brains. In 1994, earlier studies with less sophisticated methods had suggested only 6-7000 cells to be present in that area.

As well as the unexpected number of GnRH cells in the basal forebrain, it was also surprising that nearly all of the GnRH cells were revealed to possess the machinery to make acetylcholine (ACH) which is a major neurotransmitter, distributed throughout the brain

Moreover, cholinergic interneurons and other related cells revealed receptors for GnRH and also the machinery to make that hormone, suggesting GnRH acts on 'auto receptors' in a kind of 'connectome' fundamental to the production of acetylcholine.

The authors considered the unexpected finding of such a large number of GnRH producing cells and their integration with ACH producing cells in the basal forebrain argued against an origin in the nasal placode, wondering if they were a subset of ACH producing cells emanating from hypothalamic and hippocampal progenitors.

Nevertheless, they conclude the significance of the finding of association between GnRH production and that of ACH lies in the physiological contribution of the interneurons 'to the regulation of

pathways between cortex, basal and thalamic regions and thus motor control, learning, language, reward, cognitive function and addiction. Other cholinergic neurons of the basal ganglia project to the entire cortical mantle, olfactory tubercle and amygdala, implicated in attention, maintenance of arousal, learning and memory.’ Given that symptoms of Alzheimer’s Disease are due to the loss of basal forebrain neurons, the authors declared the role of GnRH ‘requires clarification’.

Whether or not replacement of GnRh will prove therapeutic for Alzheimer’s Disease is, of course, unknown. What the research certainly reveals is the extent of our ignorance of the widespread non-reproductive, neuronal, role of GnRH. Recognition of such ignorance should preclude assurances of beneficence in its unregulated blockade of the nervous system in growing brains of children and youths confused over gender.

4. Conclusion

The lack of convincing benefit for blockers, the biological implausibility, the evidence for side effects, the injustice of uniformed consent, and the growing weight of argument for a widespread role for lack of GnRH in neurodegenerating processes should disqualify it from unregulated experimentation. There is insufficient evidence for benefit and widespread evidence for maleficence.

Side effects of Cross sex hormones

In recent consideration of whether a 16-year-old natal female, known as Ash, should receive testosterone in hormonal affirmation to a gender incongruent with chromosomes, Justice Tree of the Family Court concluded the risks are ‘not unacceptable’⁴¹. Suppression of identities and submissions in the case do not permit clarification of what information the judge received upon which to base his fulsome assurance, but his judgement is focussed on what could be described as

the most minimal consideration of known side effects. He emphasises the minimal effect of polycythaemia in which testosterone inspires such over-production of red cells they ‘clog’ resulting in thrombosis, but he assures this side-effect is uncommon, easily diagnosed and treated by preventive taking of blood. Justice Tree would infer, as advised by an ‘expert witness’, that polycythaemia, and by extrapolation, other effects, are more nuisance than medical problem. Thus, Justice Tree was enabled to assure the risks of testosterone are ‘not unacceptable’ for the troubled teenager.

Justice Tree refrains from any mention of studies that, on the basis of MRI, have revealed the male brain shrinks at a rate multiples faster than in ageing, after only four months of administration of oestrogen in the process of transgenering. It is presumed brain cells ‘apoptose’ which is a euphemistic term for ‘die’^{42,43} Given GnRH is known for an anti-apoptosing effect, perhaps its reduction through negative feedback from oestrogen is causative. But the full reason is unknown.

In natal females administered testosterone in the process of ‘affirmation’ to incongruent with chromosomes, layers of the female brain have been shown to hypertrophy, reportedly due to osmotic forces generated by break-down of intracellular ‘fibres’ which have increased in response anabolic testosterone.⁴⁴ Other layers have shrunk. But, proponents for hormonal ‘affirmation’ have dismissed these changes as ‘subtle’ and associated with ‘masculinisation’ of the female brain.

Justice Tree dismissed these effects as ‘not unacceptable’ but consider the furore which would have ensured had a Covid vaccination been found to result in shrinkage of the brain.

Furthermore, Justice Tree did not consider it necessary for clinicians to inform Ash of the details of the next surgical steps in transgenering (mastectomies, genital ablation and creation of an ersatz model),

considering such knowledge of the possible future was not necessary for a temporal decision regarding testosterone.

And it appears he refrained from discussing not only known the associated high rate of mental disorder in people taking cross sex hormones, but also the very high rate of associated suicide. Proponents for transgending declare the suicides reflect the impact of societal transphobia, declining to recognise the possibility that victims may have ended their lives because they had found no ‘gold’ at the end of The Rainbow, were influenced by co-morbid psychopathology, or by iatrogenic, hormonal interference with brain structure.⁴⁵

Perhaps the older, male Justice might have learned of gynaecological side effects of administered testosterone had he read WPATH’s leaked files. Awareness of such effects might have persuaded the Justice they could be quite unacceptable to a teenage girl. Perusal of WPATH’s files would have revealed reports of major effects of the male hormone on the female vagina, including dryness, cracking, infection, unremitting discharge and pain, associated with urinary incontinence, hypertrophy of the clitoris and even incontinence of flatus.

In all, as emphasised above, proponents for affirmation do not disclose all the readily available knowledge of side effects of hormones and limitations of surgery, despite the injunction of the Australian High Court regarding *Rogers v Whitaker*.⁴⁶ Of the ethical pillars of beneficence, non-maleficence, justice and autonomy, the importance of the first three is ignored, while autonomy is enthroned, inverting the traditional interpretation of ‘informed consent’. Failure of the practitioner to proclaim the limitations and side effects of ‘affirmation’ not merely traduces the Hippocratic Oath, the Nuremberg Codes and the mandate of the High Court, worse, it ensures continuation of massive intervention in the brains and bodies of vulnerable children in pursuit of a psychological identity contrary to Nature’s physical design.

- ¹ Rogers v. Whitaker (1992) 175 CLR 479.
- ² *Rogers v Whitaker* *ibid.*
- ³ Taylor, J., Mitchell, A., Hall, R., Heathcote, C., Langton, T., Fraser, L., & Hewitt, C. E. (2024). Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: a systematic review. *Archives of Disease in Childhood*, Published Online First: April 2024. <https://doi.org/10.1136/archdischild-2023-326669>
- ⁴ [Final Report – Cass Review](#).2024.
- ⁵ Van Dam D, Wassersug RJ, Hamilton LD. Androgen deprivation therapy’s impact on the mood of cancer patients as perceived by patients and partners of patients. *Psycho-oncology*. 2016. 25(7):848-856.
- ⁶ Warnock JK, Bundren JC, Morris DW. Depressive symptoms associated with gonadotrophin-releasing hormone agonists. *Depression and anxiety*. 1998.7:1712-177.
- ⁷ Craig MC, Fletcher PC, Daly E et al. Gonadotropin hormone releasing hormone agonists alter pre-frontal function during verbal encoding in young women. *Psychoneuroendocrinology*. 2007. 32:116-1127.
- ⁸ Grigorova M , Sherwina B, Tulandib T. Effects of treatment with leuprolide acetate depot on working memory and executive functions in young premenopausal women. *Psychoneuroendocrinology* (2006) 31, 935–947.
- ⁹ Wu LM, Diefenbarch MA, Gordon WA et al. Cognitive problems in patients on androgen deprivation therapy: a qualitative pilot study. *Urol Oncol*. 2013.31(8).1533-1538.
- ¹⁰ Prange-Kiel J, Jarry H, Schoen M et al. Gonadotropin releasing hormone regulates spine density via its regulatory role in hippocampal oestrogen synthesis. *J Cell Biol*. 2008;180(2):417-426. Doi 10.1083/jcb.200707043
- ¹¹ Quintanar J, Salinas E. Neurotrophic Effects of GnRH on Neurite Outgrowth and Neurofilament Protein Expression in Cultured Cerebral Cortical Neurons of Rat Embryos. *Neurochem Res* (2008) 33:1051–1056
- ¹² Ohlsson B. Gonadotrophin_releasing hormone and its physiological and pathophysiological roles in relation to the structure and function of the gastro-intestinal tract. *European Surgical Research*. 2016;57:22-33.
- ¹³ Nuruddin S, Bruchhage M, Ropstad E et al. Effects of peripubertal gonadotropin-releasing hormone agonist on brain development in sheep—A magnetic resonance imaging study. *Psychoneuroendocrinology*. 2013. 38(10):1994-2002.
- ¹⁴ Nuruddin S, Krogenaes A, Brynildsrud et al. Peri-pubertal gonadotropin-releasing hormone agonist treatment affects hippocampus gene expression without changing spatial orientation in young sheep. *Behav Brain Res*. 2012; 242: 9-16.
- ¹⁵ Hough D, Bellingham M, Haraldsen IR et al., A reduction in long-term spatial memory persists after discontinuation of peripubertal GnRH agonist treatment in sheep.
- ¹⁶ Robinson, J. E., Evans, N. P., Dumbell, R., Solbakk, A. K., Ropstad, E., and Haraldsen, I. R. (2014). Effects of inhibition of gonadotropin releasing hormone secretion on the response to novel objects in young male and female sheep. *Psychoneuroendocrinology* 40, 130–139. doi: 10.1016/j.psyneuen.2013. 11.005

- ¹⁷ Evans N, Robinson J, Erhard H et al. Development of psychophysiological motoric reactivity is influenced by peripubertal pharmacological inhibition of GnRH action—results of an ovine model. *Psychoneuroendocrinology*. 2012; 37:1876-1884.
- ¹⁸ Houg R, Manara, A, Salvalaggio, A, Favaro et al. Brain Changes in Kallmann Syndrome. *Am J Neuroradiol* 35:1700 – 06 Sep 2014. <http://dx.doi.org/10.3174/ajnr.A3946h> D, Bellingham M, Haraldsen I et al., 2017 Spatial memory is impaired by peripubertal GnRH agonist treatment and testosterone replacement in sheep. *Psychoneuroendocrinology*. 2017; 75:173-182.
- ¹⁹ Anacker C, Sydnor E, Briana K et al. Behavioral and neurobiological effects of GnRH agonist treatment in mice—potential implications for puberty suppression in transgender individuals. *Neuropsychopharmacology* (2021) 46:882 – 890
- ²⁰ Schneider MA, Spritzer PM, Soll BM et al. Brain maturation, cognition and voice pattern in a gender dysphoria case under pubertal suppression. *Front Hum Neurosci*. 2017;11:528. Doi:10.3389/fnhum.2017.00528.
- ²¹ Fisher PM, Larsen CB, Beliveau V. Pharmacologically Induced Sex Hormone Fluctuation Effects on Resting-State Functional Connectivity in a Risk Model for Depression: A Randomized Trial. *Neuropsychopharmacology* (2017) 42, 446–453
- ²² Figueiredo CP, Fontes-Dantes FL, da Poian A et al. SARS-Cov2 vertical transmission with adverse effects on the newborn revealed through integrated immunohistochemical, electron microscopy and molecular analyses of Placenta. *Ebiomedicine*. 2020;59102951
- ²³ R. Manara, A. Salvalaggio, A. Favaro et al. Brain Changes in Kallmann Syndrome. *Am J Neuroradiol* 35:1700 – 06 Sep 2014. <http://dx.doi.org/10.3174/ajnr.A3946>
- ²⁴ The WPATH files. [The WPATH Files — Environmental Progress](https://environmentalprogress.org/big-news/wpath-files), <https://environmentalprogress.org/big-news/wpath-files>.
- ²⁵ Moss R, McCann S. Induction of mating behavior in rats by luteinizing hormone releasing factor. *Science*. 1973. 181:177-179.
- ²⁶ Riskind P, Moss R. Midbrain Central Gray:LHRH infusion enhances lordotic behavior in estrogen primed ovariectomised Rats. *Brain Research Bulletin*. 1979. 4:203-205.
- ²⁷ Pfaff D, Luteinising hormone releasing factor potentiates lordosis behavior in hypophysectomised ovariectomised female rats. *Science*. 1973. 182:1148-1149.
- ²⁸ Bentley G, Jensen J, Kaur G et al. Rapid inhibition of female sexual behavior by gonadotropin-inhibiting hormone (GnIH). *Hormones and Behaviour*. 2006.49:550-555.
- ²⁹ Hawken P, Martin G. Sociosexual stimuli and gonadotropin releasing hormone/luteinizing hormone secretion in sheep and goats. *Domestic animal endocrinology*. 2012.43:85-94
- ³⁰ Anacker C, Sydnor E, Briana K et al. Behavioral and neurobiological effects of GnRH agonist treatment in mice—potential implications for puberty suppression in transgender individuals. *Neuropsychopharmacology* (2021) 46:882 – 890
- ³¹ Robinson, J. E., Evans, N. P., Dumbell, R., Solbakk, A. K., Ropstad, E., and Haraldsen, I. R. (2014). Effects of inhibition of gonadotropin releasing hormone secretion on the response to novel objects in young male and female sheep. *Psychoneuroendocrinology* 40, 130–139. doi: 10.1016/j.psyneuen.2013. 11.005

- ³² Manfredi-Lozano M, Leyson V, Adamo M et al. GnRH replacement rescues cognition in Down Syndrome. *Science* 2022. 377 eabq4515.
- ³³ Chachlaki K, Le Duc K, Storme L and Prevot V. Novel insights into minipuberty and GnRH: implications on neurodevelopment, cognition and Covid-19 therapeutics. *J Endocrinol.* 2024;36:e13387.
- ³⁴ Monje M, Iwasaki A. The neurobiology of long Covid. *Neuron*2022;110(21):3484-3496.
- ³⁵ The Lancet Neurology. Long Covid: understanding the neurological effects. *Lancet Neurol.* 2021;20(4):247
- ³⁶ Sauve F, Nampoothiri S, Clarke SA et al. Long covid cognitive impairments and reproductive hormone deficits in men may stem from GnRH neuronal death. *EbioMedicine.*2023;96:104784.
- ³⁷ Sauve *ibid.*
- ³⁸ Pellegrino C, Martin M, Allet C et al. GnRH neurons recruit astrocytes in infancy to facilitate network integration and sexual maturation. *Nat Neurosc.* 2021;24(12):1660-1672.
- ³⁹ Figueiredo CP, Fontes-Dantes, da Poian AT et al. SARS-Cov-2 associated cytokine storm during pregnancy as a possible risk factor for neuropsychiatric disorder development in post-pandemic infants. *Neuropharmacology.* 2021;201:108841. Doi10.1016/j.pharm.2021
- ⁴⁰ Skrapits K, Sarvari M, Farkas et al. The cryptic gonadotropin releasing hormone neuronal system of human basal ganglia. *eLife* 10:e67714 <https://doi.org/10.7554/eLife.67714>
- ⁴¹ [Re Ash \(No 4\) \[2024\] FedCFamC1F 777 \(15 November 2024\)](#)
- ⁴² Hulshoff Pol HE, Cohen-Kettenis PT, Van Haren NE, et al. Changing your sex changes your brain: Influences of testosterone and estrogen on adult human brain structure. *Eur J Endocrinol.* 2006;155(1):S107–S111. Doi 10.1530/eje.1.02248
- ⁴³ Zubiaurre-Elorza, L., Junque, C., Gomez-Gil, E., & Guillamon, A. (2014). Effects of cross-sex hormone treatment on cortical thickness in transsexual individuals. *Journal of Sexual Medicine*, 11, 1248–1261.
- ⁴⁴ Guillamon A, Junque C, Gomez-Gil E. A Review of the Status of Brain Structure Research in Transsexualism. *Arch Sex Behav* 2016 Oct; 45(7):1615–1648.
- ⁴⁵ De Cuyper, Elaut E, Heylens G et al. Long term follow up: psychosexual outcome of Belgian transsexuals after sex reassignment surgery. *Sexologies.* 2006;15:126-133.
- ⁴⁶ *Rogers v Whitaker* *ibid.*

The Landscape of Gender Affirming Services in Australia

Dr Andrew Amos

Summary of the Argument

*The **political goal** of trans rights activists is to establish the right to pretend to change sex. The **political problem** is that 80% of western populations reject this demand because it is impossible. The **strategic solution** is to use the authority of medicine to replace the reality-based category of sex with the fantasy-based category of gender.*

Gender affirming care is the institutional implementation of this strategy.

Basic Facts

My talk provides a strategic understanding of gender affirming care, and first thoughts about all the different areas that will need to be changed to oppose and eventually end it.

The biggest mistake when analysing gender affirming care is to overcomplicate things. In thinking about this area it is vital to insist on a few basic facts:

- There are only two sexes
- It is impossible to change sex
- There has been a concerted political effort by a well-organised group to challenge these facts by any means available
- Gender affirming care is one of those means

Trans Demands are Self-Evidently Delusional

The biggest barrier to the political campaign to establish a right to pretend that it is possible to change sex is that overwhelming majorities of western populations know instinctively that this is not true.

In 2023 News.com did a survey asking 50,000 Australians what they thought about various social issues. 82% said males who identify as women should not be allowed to compete in women's sport.

Last year the NYT asked the same question of Americans and got almost exactly the same answer - 79% said men should not be allowed to compete in women's sport.

Obviously, if you believe that it is possible to change sex, you have no reason to prevent men who have changed into women from competing in women's sport, so these numbers can be taken as a good indication that at least 80% of Australian and US people don't believe it is possible to change sex.

Gender Identity Hides Trans Delusions

To overcome this fundamental problem, activist clinicians invented the idea of gender identity. Loosely speaking, gender identity can be thought of as a person's experience of their own sexual characteristics.

This is a topic that deserves more time, but in brief, gender identity does not exist as a valid, reliable clinical category. The only reason for the existence of gender identity is to distract attention from the fact that the impossibility of changing sex means that gender affirming care is not only self-evidently absurd, but actively harmful.

To start, there are no adequate descriptions of what gender identity is, how it can be validly and reliably assessed, or how healthy gender identities can be differentiated from gender identities caused by psychiatric illness.

Trans Identities Always Involve Mental Illness

Unlike psychiatric diagnoses like depression and anxiety, gender identity is entirely unconstrained. This is demonstrated by the subtypes of gender identity accepted as valid in the WPATH standards of care, the bible for gender affirming care.

Most familiar, of course, is a *trans* identity where someone who is male consistently believes they are female, or vice versa.

Less familiar is the *genderfluid* identity, where someone's experienced gender can change at any time for any reason from male to female and back again, or experience no gender at all.

Disturbingly, the WPATH standards include the category of *eunuch* as a healthy and valid gender identity. Being a eunuch involves the removal of the male genitals, including variations like the voluntary removal of one's own genitals, and the involuntary removal of one's genitals by someone else.

So, any scientifically valid account of gender identity as currently understood by gender affirming doctors would have to explain how all these identities can be understood as healthy variants of normal.

There is no such explanation.

As a psychiatrist one of the most disturbing features of gender affirming care is that my profession has abandoned its responsibility to protect patients and families.

Psychiatry has completely failed to correct the lie that trans identity does not involve mental illness. Basic psychodynamics illustrate there is always a component of mental illness in any of the gender identities described by gender affirming care advocates.

For example, a *trans* identity by definition involves discomfort with features of biological sex. According to psychiatric theory, the mature resolution is to learn to tolerate the reality of one's sex and merge positive and negative features into an integrated self.

A *trans* identity, by contrast, involves dissociation from unwanted sexual characteristics, and their repression from conscious awareness. Gender affirming care reinforces this dissociation and repression, first by social rewards, and later by medical and surgical modifications.

There is no greater psychopathology than to resolve an internal conflict by the removal of a functional body part; gender affirming care misuses the authority of medicine to entrench pathology.

A *genderfluid* identity combines the dissociation and repression of a trans identity with an inherently unstable sense of self. Essentially, promoting a *genderfluid* identity as a healthy variant of normal is like promoting borderline personality disorder as a functional approach to relationships.

Finally, the identity of *eunuch* is self-evidently pathological. While it shares the dissociation and repression of a *trans* identity, the specific desire for castration indicates a primitive level of psychological function and a high degree of pathology. The WPATH's own references

document a wide variety of extremely disturbed sexual fetishes and sado-masochistic fantasies associated with eunuch identities.

The Strategic Denial of Trans Psychopathology

So, the idea that sex can be changed is false, and it is also widely believed to be false. In order to address this, activist clinicians invented gender identity, which is a clinically empty category used to hide the various pathologies that prevent people from merging unwanted sexual characteristics into an integrated personality.

In the middle of the 2010s trans activists realised they were losing public support, and hired international consultancy Dentons to put together a strategy, which was published as *Only Adults? Good Practices for Legal Gender Recognition in Youth*. By studying trans rights campaigns across Europe, Dentons confirmed that western populations don't believe it is possible to change sex and don't support trans goals, by large margins.

Dentons concluded that there was little chance of changing public opinion, so they recommended trying to bypass public support for trans goals by avoiding scrutiny whenever possible.

Denton's most powerful recommendation was that trans goals be attached to more popular issues, and in particular the campaign for same-sex marriage. As reflected in branding like LGBT+, trans issues have been very successfully attached to the broader campaign for gay rights, and with the implementation of same-sex marriage across the western world much of the infrastructure created for that purpose has been redirected towards trans issues.

Finally, while the same-sex marriage campaign proved that widespread public support can cause political change in Australia, this was not an

option for trans goals, so Dentons recommended they focus on key decision-makers and influencers who could introduce changes without raising public awareness of problems. I'll briefly survey the areas implicated by gender ideology.

Overview of the Trans Landscape

- Socio-cultural
- Health-medical
- Political-legal
- Institutional

Socio-cultural

For the purposes of this talk I have divided the gender landscape into four regions. Ultimately the success or failure of the trans movement will be determined by social and cultural forces. So far, the strategies of avoiding scrutiny and focusing on influential people have been very successful, leading to widespread support by decision-makers and limited attention from others. The social effects have been broad and varied, down to the words we are allowed to use in describing people, relationships between family members, and the use of cultural exclusion to enforce a preferred agenda.

However, there is starting to be a significant reversal of previously asserted social expectations. For a long time there was public indifference to claimed rights like male access to female spaces because there was little awareness of legislative and administrative changes. The emergence of trans rights as a contested issue in the US presidential election last year has exploded Denton's recommendation to avoid scrutiny, and the public is strongly confirming Denton's prediction that trans claims would be publicly unpopular.

The specific issue of preventing men from participating in women's sport appears likely to play a key role in determining whether transgender claims are socially accepted or rejected. Unlike the complex issues tangled up in identity and healthcare, it is common to believe that it is unfair for men to compete physically with women, which has given the issue traction in the US and may do so here.

Health/medical

The publication of the Cass Review last year established that the rapid expansion of gender affirming services bypassed usual patient safeguards, driven by political activists.

All Australia's health authorities have followed Denton's advice to avoid scrutiny, for example by refusing to acknowledge the lack of evidence for the benefits and solid evidence of the harms of gender affirming care. My own medical college, the college of psychiatrists, doesn't even mention the final Cass Review in its position statement on transgender care.

Political

Two main political factors influence gender affirming care in Australia. First and most important, the Australian trans movement followed Denton's advice and attached themselves to the LGB movement before same-sex marriage was passed. Now they are part of a coalition of minority issue voters and parliamentarians who can leverage their votes on other issues to ensure the major parties don't touch trans issues.

The second factor is that most parliamentarians share the view of most Australians, that sex is binary and unchangeable, but it is not a high priority for them. While on a conscience vote legislation supporting gender affirmation would be reversed by large majorities, individual parliamentarians don't vote their conscience because they think they'll be targetted by activists, and don't think they'll be successful.

Legal

The legal landscape will be covered by Professor Parkinson this afternoon, but it is worth listing a few landmarks. Women's right to single-sex spaces, or even to a clear definition of what a woman is, was destroyed in 2013 when the Gillard government changed the *Sex Discrimination Act 1984*, effectively replacing sex as a protected characteristic by gender.

The SDA also established the right to gender self-identification, and this is now firmly entrenched in the state and federal bureaucracies. Among the results are that biological women can be legally forced to accept biological men who identify as women into their spaces.

Various acts banning so-called conversion therapy, or therapy intended to convert a patient from one gender to another, have been passed in parliaments around Australia. A predictable consequence has been for many therapists to stop providing exploratory therapy to gender confused people because of fear of litigation.

And finally, courts' reliance upon expert witnesses to establish standards of care has led to decisions that deny parents' right to be involved in their children's medical decision-making, or even the removal of the children themselves.

Institutional

The role of institutions in promulgating and maintaining gender affirming orthodoxy is often overlooked, but it is vital. There's a whole industry of LGBT+ non-government organisations which exist largely or entirely to build networks and harvest resources for the promotion of trans ideas throughout schools, universities, health departments, and corporations, usually embedded with other messages.

The model for the harmful influence of NGOs in spreading gender affirming care is best described in books on the deep infiltration of the Tavistock Institute in the UK by organisations like Mermaids. Nominally included on health teams to provide peer support to gender confused kids, the NGOs often acted as cultural enforcers encouraging clinicians to prioritise rapid transition over all other goals.

Similar dynamics have been described in Australia's gender clinics, as well as schools and universities. Quasi-independent organisations like the federal and state human rights committees, bodies with oversight of health professionals like AHPRA, and new mechanisms for controlling social media like the eSafety Commissioner also influence gender medicine.

Ending Gender Affirming Care in Australia

When contemplating what needs to be done to end gender affirming care in Australia, we must accept that it is firmly entrenched in multiple bureaucracies and supported by a committed group with established infrastructure and attached to the LGB community, which enjoys public support.

While as an Australian it is frustrating to see the progress being made in Europe and the US, we are earlier on the trajectory of trans growth, although we're quickly catching up. Unfortunately, we may be condemned to follow the pattern in other countries where public opposition started ramping up only after many patients had been harmed and some became widely known.

That said, we need to be ready and to be strategic in pursuing the end of gender affirming care in Australia. Denton's recommendations provide some guidance.

Table - ending gender affirming care

Affirmation advocates do:	Reality advocates should:
Avoid scrutiny	Closely scrutinise Raise awareness
Draft on more popular issues (LGB rights)	Draft on more popular issues (keeping men out of women's sports)
Influence decision-makers	Convince persuadable decision-makers Seek direct authority

While affirmation advocates seek to avoid scrutiny, we must bring them to the attention of politicians, medical and education authorities, and the public.

Greg Donnelly deserves special praise for his efforts to do this, both by support for days like today, but also by questions in Parliament, freedom of information requests, and tireless networking.

Just as affirmation advocates have attached themselves to the popular gay rights movement, we need to make use of popular campaigns to raise awareness of the dangers of gender affirming care, and be ready with convincing alternatives. While it is difficult to predict which causes will break through with the public, access to sport and a fair go are both key features of the Australian character, so preventing men from competing in women's sport might be the sort of cause that attracts wide attention

In addition, while the trans movement has derived great benefit from association with the broader gay rights movement, there are signs that some members of that community are starting to question whether their

interests are aligned. We should be doing everything we can to encourage this type of questioning.

Influencing decision-makers may be the most important missing piece of the puzzle from our side of this issue. Trans campaigners benefit greatly from the infrastructure built by the gay rights movement over decades. As their opponents, we will need either to be similarly persistent, organised, and ruthless, or we will need to come up with a creative political formula that cuts through with voters and convinces politicians and other decision-makers that it is in their interest to drop support for gender affirming care. The decision by the Queensland state government to pause initiation of puberty blockers and hormone therapy for minors suggests there is some appetite for this, and we must encourage such efforts.

If we cannot convince decision-makers to change their minds on gender, we may have to seek decision-making positions directly.

Shortlist of Necessary Changes

I've argued that gender affirming care exists within a social, political, and legal framework with many mutually reinforcing mechanisms. I've also started a shortlist of the most important changes needed to end the practice of affirmation in Australia and the reinforcing framework that sustains it.

Socio-cultural changes

The main battle over affirmation is social and cultural. If the majority of people are willing to pretend that sex can be changed, then affirmation is likely to continue.

The most important cultural change is a convincing reassertion of the universal truth that sex is binary and cannot be changed. While the

Trump administration has taken large steps in this direction, it is not yet clear whether he can be a convincing messenger for this message.

One of the core assumptions implicit in gender affirming care is that experts can overrule parents regarding the interests of their children. Reasserting parental rights over experts would significantly reduce the harms caused by affirmation.

The adoption of gender ideology as a symbol of personal virtue has been expressed in rituals like elaborate pronoun rules. A recent decline in pronoun use has been seen as an early step towards relaxation of the social enforcement of gender ideology, and we should hope this will continue.

Medical/health changes

The greatest failure of gender medicine has been to ignore the role of mental illness in the development of trans identities. The correction of this failure is the most important change required of doctors in this area.

With the publication of the Cass and similar Reviews we have taken the first steps towards reasserting evidence-based treatment of gender confused kids. However, in Australia we continue to ignore this evidence.

In my opinion, evidence-based treatment will only be restored by the elimination of gender affirming care entirely.

Political changes

Politicians perform two major functions - they provide leadership that informs and shapes the beliefs and behaviours of the people they lead; and they write legislation that provides a framework for the safe and fair expression of those beliefs and behaviours.

Politicians have a responsibility to lead the Australian people in a discussion to resolve the conflict between sex and gender I've been describing. Despite events in Queensland recently, no such discussion appears to be happening.

Two major steps towards such a resolution would be recognition of the majority position, that sex is binary and unchangeable, while seeking to reconcile trans claims with the rights of others.

Politico-legal

While legislation and its interpretation are quite distinct, I have grouped them together here. In my opinion, the removal of gender identity as a protected characteristic from the Sexual Discrimination Act may be the most important single step towards resolving the harms of gender ideology.

It would also be a necessary precondition for the reestablishment of binary sex as the standard for legal and administrative purposes, such as enforcing single sex spaces.

As a psychiatrist I have a vested interest in the elimination or reform of conversion therapy legislation to promote exploratory therapy for gender confused kids.

And the courts have been accumulating a set of harmful precedents which would need to be overturned, including the decision not to require court approval for treatment unless the parents disagree, and determinations that remove children from parents who oppose 'gender-affirming care'.

Institutional changes

It is well-known that western governments make intense use of non-government organisations to do things that governments are not permitted to do, or that they do not wish to be seen doing.

While the role of NGOs in gender medicine is murky, it is clear it has been a major role. Rather than list all the intermediate steps, I have listed three areas of NGO influence that will need to be ended before gender affirming care finally dies.

First, activist health groups which prioritise politics over health, like WPATH and AusPATH, should have no influence on the provision of healthcare.

Second, activist NGOs like Mermaids should have no influence over what healthcare is provided to gender confused kids.

And finally, activist NGOs which embed ideology in training materials should have no influence over what or how students are taught at any level of education.

Final Thoughts

My final thought will echo my first - gender affirming care is based upon a lie that is universally understood to be a lie: that it is possible to change sex. Gender ideology is a trick designed to obscure that lie. All the products of gender ideology discussed today are derived from that lie, and, as a result, full resolution of any of those products requires exposure and resolution of the lie.

To take the example of banning trans-identifying men from women's sport: trans ideology says that all trans identifying men are women, regardless of genitalia, muscle mass, or hormonal levels. If you take this seriously, then all trans women should be allowed to compete as women in women's sport. The current compromise allows trans identifying men who have not gone through male puberty and have female level hormones to compete with women. This explicitly rejects

gender identity as the characteristic which determines who can compete as a woman in favour of physical characteristics.

Some trans advocates have argued that re-asserting the right for women to compete against women would require invasive examinations, However, even leaving aside the possibility of non-invasive tests like cheek swabs, the simpler solution is to require that sex be accurately recorded at birth without the possibility of later change.

It would also require the removal of gender identity as a protected characteristic in the SDA.

I think this chain, where banning men from women's sport makes it necessary to remove gender identity as a protected characteristic under the SDA, which in turn makes it necessary to accurately record sex at birth and never change it, illustrates how the correction of any part of the hierarchy of gender ideas ultimately requires the correction of all of them. So, all we need is the right starting point.

And that's the end of my talk! I know I've left out many important features of the gender landscape, and I hope you'll help me fill in the blanks during the Q&A session.

The Post-Cass Landscape: Evidence, Debates and Shifting Rationales

Dr Alison Clayton

Child and adolescent gender medicine remains one of the most heatedly debated fields of medicine.

It is important to highlight that it is not just evidence of therapeutic effectiveness that is at issue, but there are other controversies, such as diagnostic criteria, changing clinical presentations and demographics; aetiology; natural history; the role of gender-affirming treatment (GAT) in causing iatrogenic persistence; treatment goals; and the capacity of minors to provide informed consent. My fellow presenters cover many of these issues, whereas my paper focuses on the evidence for therapeutic effectiveness and the risk of harms of GAT. It highlights some of the important published papers and discussions in the year that has followed the release of Cass's final Report. But, first, I discuss some key tenets of Evidence Based Medicine (EBM).

1. Evidence Based Medicine

The history of medicine is littered with examples of treatments believed to be effective and enthusiastically promoted, only later to be discovered as less effective than claimed and more harmful than acknowledged. The clinicians who developed EBM wanted to improve medical practice and evaluative standards to maximise the chances that treatments benefitted patients rather than harmed them. EBM acknowledges a role for all empirical observations but emphasises that controlled clinical observations generate evidence that is more trustworthy than uncontrolled observations or individual clinician's experiences or patient anecdotes. At the top of the EBM 'hierarchy of evidence pyramid' for treatment effectiveness are well-designed

randomised controlled trials (RCTs). EBM also emphasises the importance of cumulating evidence systematically by undertaking systematic reviews. A systematic review is a summary of research and addresses clinical questions in a systematic and reproducible manner. If performed well, according to recommended standards, they provide better quality evidence than individual studies because they look at the whole body of evidence, carefully rate the quality/risk of bias of each study and grade the certainty of evidence for predetermined clinical questions (Guyatt et al., 2015). Today's EBM has more complexity than the simple hierarchal pyramid conveys. For example, as outlined by the GRADE (Grading of Recommendations, Assessment, Development and Evaluation) approach. In this system, high-quality observational studies can give higher quality evidence than low quality RCTs (Djulobegovic and Guyatt, 2017). This is an important point, because post-Cass many claims have been made that only RCTs can provide high-quality evidence, and that Cass is demanding RCTs. Neither of these claims are true.

2. The 'Sax Review' (Bragge et al., 2024)

The NSW commissioned 'Sax Review' (Bragge et al., 2024), updating a previous 2020 review, looked at the effect of interventions for young people with gender dysphoria. It used the NHMRC grading system of evidence. The NHMRC (2009) unambiguously describes that a systematic review rating RCTs provides Level 1 evidence, but when rating other study designs, then the level of evidence is only as high as the level of the studies themselves. However, despite acknowledging this, the 'Sax Review' still designated systematic reviews of non-RCT studies as Level 1. This seems likely to have the effect of misleading readers into thinking evidence for GAT is greater than it is. The Sax review does note the limitations of the evidence. However, Sax's conclusions, for example that puberty blockers (PBs) are "safe,

effective, and reversible”, seem overly certain and are not supported by the findings of several recent systematic reviews.

3. The McMaster’s Systematic Reviews and Meta-analyses (Miroshnychenko et al., 2025a, 2025b)

For example, the recent systematic reviews by McMaster University, leaders in health research methods, are much more measured in their conclusions. They note the predominantly low to very low certainty evidence, which means that neither psychosocial benefit or absence of harms of PBs and cross-sex hormones (CSHs) can be claimed with any certainty. They emphasise that all decision makers should be aware of the large knowledge gaps and that more rigorous research is required.

4. The RCH Melbourne Gender Services Website and the Transcend Information Pamphlets

The problems of overstating the evidence base and ignoring harms is starkly apparent in the recent fact sheets and evidence briefs produced by the GAT advocacy organisation, Transcend. Links to these pamphlets, which provide unbalanced and factually incorrect information (for example, that a “suite of high-quality evidence” underpins CSH treatment) are prominently displayed on the RCH Melbourne’s Gender Clinic’s website. It is of great concern that the RCH Melbourne is promoting such misinformation, and it raises questions about clinical governance processes. The Transcend pamphlets frequently cite a non-peer review publication that is colloquially known as the ‘Yale paper.’ The claims made in the ‘Yale paper’ have now been subject to devastating critiques by three peer-reviewed publications (Clayton et al., 2025a; Cheung et al., 2024; McDeavitt et al., 2025).

5. Addressing the claim that other areas of medicine, particularly paediatrics, also have similarly low evidence to youth gender medicine

Weak evidence is an issue for other areas of medicine, but the evidence for GAT appears to be at the lowest end of ‘weak’. For example, Venus and Jamrosik (2020) reviewed 10 Australian Guidelines, and found only 43% of recommendations were based on Level I or II evidence. Thus, they concluded that contemporary medicine was evidence poor. However, all the reviewed guidelines had some recommendations based on Level II evidence, and eight of the 10 had Level 1 evidence. In contrast, the RCH Melbourne Guidelines for transgender/gender-diverse (TGD) youth have no Level 1 or II evidence. A recent paper by Clayton et al. (2025a) specifically refutes the claim that RCTs are not possible or are unethical in paediatric medicine and that GAT for youth has similar evidence to other areas of paediatric care. Moreover, it argued that “when the treatment being considered is an invasive intervention pathway which holds risks of serious harms (including to fertility and sexual function) for a poorly understood condition in children and adolescents, then, more caution is needed and there is a greater onus on the clinicians promoting such treatments to provide rigorous evidence for the benefits and to show that there are no less risky treatment alternatives”.

6. Are the RCH Melbourne Guidelines for TGD youth Trustworthy?

Recently the Federal Assistant Health Minister described the RCH Guidelines for TGD youth as “excellent”. But a recent systematic review of guidelines, gave these Guidelines a very low rating, on the AGREE guideline quality rating tool, and did not recommend their use

in practice (Taylor et al, 2024). My own evaluation of the RCH Guidelines according to the Institute of Medicine (2011) criteria also finds that they are not “excellent”, rather they fall well below the standards for trustworthy guidelines.

7. WPATH Standards of Care 8 and the Johns Hopkins Systematic Reviews

Recent documents released in a US Court case reveal that WPATH leadership interfered with the content and publication of the systematic reviews it had commissioned from Johns Hopkins University (Cheung et al., 2024). This should raise serious concerns about research integrity and publication bias in this field of medicine (Clayton, 2025).

8. Suicide Risk: the UK’s Good Law Project and the Appleby Inquiry

In 2024, the ‘Good Law Project’ (GLP) made claims that after the NHS placed restrictions on PBs for gender dysphoria, there had been a “shocking rise” in suicides. In response, an independent inquiry, led by Professor Louis Appleby from the University of Manchester, was commissioned. This inquiry found there was no evidence of increased suicides following the NHS’s PB restrictions. Furthermore, it strongly criticised the insensitive and “dangerous” manner this topic had been discussed on social media, which transgressed suicide-reporting guidelines (Appleby, 2024). Exaggerated narratives about suicide are dangerous, as they may, via self-fulfilling prophecy and social script mechanisms, exacerbate suicidality risk of vulnerable young people (Clayton, 2023).

9. Sexual Function: the impact of a treatment pathway of puberty blockers, oestrogen and vaginoplasty

A recent study suggests that serious impairment of sexual function is a likely outcome of a treatment pathway commencing with PBs (at any stage of puberty) followed by oestrogen, with or without progression to vaginoplasty (Van der Meulen et al., 2025; Clayton et al., 2025b)

10. Other:

- a) A systematic review on fertility risks of gender-affirming treatments has just been published and reinforces the concerns about the impact of PBs and CSH on fertility (De Roo et al. 2025).
- b) We are seeing the emergence of new rationales for GAT with some GAT proponents now suggesting that mental health outcomes should not be the rationale for GAT; rather GAT could be provided to meet a child's embodiment goals and 'life-project' plans (e.g., see Oosthoek et al., 2024). Critiques of this rationale have been published (e.g., Gorin 2024; Clayton, 2025). These argue that this new rationale misunderstands the meaning of 'autonomy' in medical ethics and is unbalanced with respect of other ethical requirements of beneficence and non-maleficence.
- c) Clayton (2025) discusses the newly revised Declaration of Helsinki (World Medical Association, 2024), arguing that the revisions support the position that if PBs and CSH are to be prescribed for minors with GD, then they should be restricted to ethics committee approved clinical trials.

11. Conclusions

There is extraordinarily weak evidence in support of the mental health and wellbeing benefits of GAT, an invasive treatment pathway with inherent risks of serious life-long adverse effects for a poorly understood condition. There is also emerging evidence that there has been a corruption of the usual research, clinical governance, guideline production, and medical practice standards in this field of medicine. A rigorous and independent federal inquiry with the powers of a Royal Commission into GAT for minors in Australia is required. In the meantime, if they are to be implemented at all, the key interventions of GAT (social transition, puberty blockers, cross-sex hormones and surgery) for youth should be designated as experimental treatments only to be implemented under ethics committee approved clinical trial conditions. Gender-respectful psychosocial support and care and psychotherapy, as the least harmful alternative, should be the mainstay of treatment for minors with gender-related distress. These recommendations are consistent with practice in several international jurisdictions.

References

- Appleby L (2024) Independent report Review of suicides and gender dysphoria at the Tavistock and Portman NHS Foundation Trust. Published 19 July 2024. Available at: <https://www.gov.uk/government/publications/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust-independent-report>.
- Bragge P, et al. (2024). Evidence Check: Evidence for effective interventions for children and young people with gender dysphoria—update: An Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the NSW Ministry of Health, 2024. doi: 10.57022/wgxc6524)
- Cheung CR, et al. (2024) Gender medicine and the Cass Review: why medicine and the law make poor bedfellows. *Arch Dis Child*.archdischild-2024-327994. doi:10.1136/archdischild-2024-327994. Epub ahead of print. PMID: 39401844.
- Clayton A. (2023). Gender-Affirming Treatment of Gender Dysphoria in Youth: A Perfect Storm Environment for the Placebo Effect-The Implications for Research and Clinical Practice. *Archives of Sexual Behavior*, 52(2), 483–494. <https://doi.org/10.1007/s10508-022-02472-8>

- Clayton A, et al. (2025a) Implications of the Cass Review for health policy governing gender medicine for Australian minors. *Australas Psychiatry*.33(1):89-95. doi: 10.1177/10398562241276335.
- Clayton, A., et al. (2025b). Letter to the Editor on "Timing of puberty suppression in transgender adolescents and sexual functioning after vaginoplasty (Van der Meulen et al., 2024)". *The Journal of Sexual Medicine*, qdaf030. Advance online publication. <https://doi.org/10.1093/jsxmed/qdaf030>
- De Roo C, et al. (2025) Fertility in transgender and gender diverse people: systematic review of the effects of gender-affirming hormones on reproductive organs and fertility, *Human Reproduction Update*, dmae036, <https://doi.org/10.1093/humupd/dmae036>
- Djulbegovic B and Guyatt GH (2017). Progress in evidence-based medicine: a quarter century on. *Lancet* 390(10092): 415–423.
- Gorin M. What is the aim of pediatric “Gender-Affirming” Care? *Hastings Center Report*. 2024; 54(3):35-50. doi:10.1002/hast.1583
- Guyatt G, et al. (2015) *Users Guides to the Medical Literature: a Manual for Evidence-based Clinical Practice*. New York: McGraw Hill Education.
- Institute of Medicine (2011) *Clinical Practice Guidelines We Can Trust*. Washington, DC: National Academies Press.
- McDeavitt et al. (2025) (2025): Critiques of the Cass Review: Fact-Checking the Peer-Reviewed and Grey Literature, *Journal of Sex & Marital Therapy*, DOI: 10.1080/0092623X.2025.2455133
- Miroshnychenko A, et al. (2025a) Puberty blockers for gender dysphoria in youth: A systematic review and meta-analysis. *Arch Dis Child*. doi: 10.1136/archdischild-2024-327909. Epub ahead of print. PMID: 39855724.
- Miroshnychenko A, et al. (2025b). Gender affirming hormone therapy for individuals with gender dysphoria aged <26 years: a systematic review and meta-analysis. *Arch Dis Child*. doi: 10.1136/archdischild-2024-327921. Epub ahead of print. PMID: 39855725.
- National Health and Medical Research Council (NHMRC) (2009) *Additional Levels of Evidence and Grades for Recommendations for Developers of Guidelines*. Canberra: Commonwealth of Australia.
- Oosthoek ED, et al. (2024) Gender-affirming medical treatment for adolescents: a critical reflection on "effective" treatment outcomes. *BMC Med Ethics*;25(1):154.. doi:10.1186/s12910-024-01143-8
- Taylor J, et al. (2024) Clinical guidelines for children and adolescents experiencing gender dysphoria or incongruence: a systematic review of guideline quality (part 1). *Arch Dis Child*; 109(Suppl 2):s65-s72. doi: 10.1136/archdischild-2023-326499. PMID: 38594049.
- Van der Meulen, et al. (2025) Timing of puberty suppression in transgender adolescents and sexual functioning after vaginoplasty. *J Sex Med.*; 22(1):196–204. 10.1093/jsxmed/qdae152
- Venus C, Jamrozik E. (2020). Evidence-poor medicine: just how evidence-based are Australian clinical practice guidelines? *Intern Med J*. 50(1):30-37. doi: 10.1111/imj.14466. PMID: 31943616.
- World Medical Association (2024) *Declaration of Helsinki, Ethical principles for Medical Research involving Human Participants*.

Psychotherapy for Gender Dysphoria in Adolescents: A Comprehensive and Ethical Approach

Professor Dianna Kenny

Introduction

This paper explores the multifaceted nature of gender dysphoria emphasizing the critical role of psychotherapy that takes account of the complex developmental pathways that must be navigated from birth to reach maturity. I will illuminate this developmental process because it appears to be universally ignored in the gender affirming care model which falls back on lazy concepts such as “mature minor”, outline the major models of care, situate gender dysphoria within the affective-perceptual disturbances focused on the body, present a detailed intake assessment that incorporates precipitating factors, potential aetiologies, affective-perceptual disturbances, the possible meanings of the wish to transition, and the critical issue of self-harm and suicidality. Finally, I will illustrate some of the hidden meanings of gender dysphoria symptoms through case studies and the elements of an ethical psychotherapeutic approach.

Developmental Processes from Infant Temperament to Adult Maturity

This schematic outlines the processes and achievements required to attain maturity.

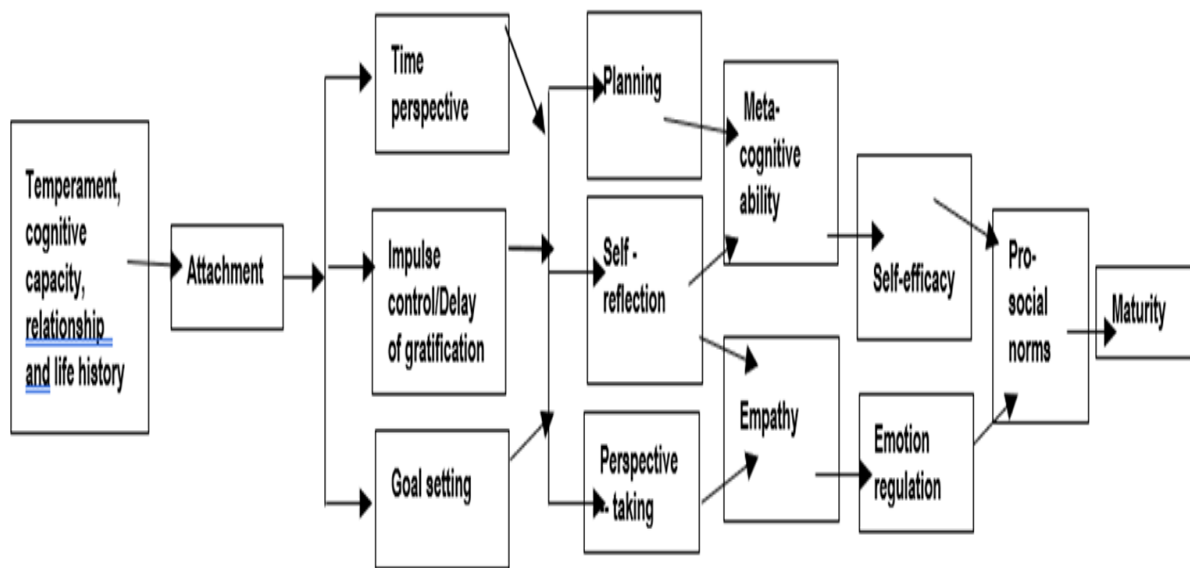


Figure 1 Model of proposed temporal and causal relationships resulting in psychosocial maturity
Source: (Kenny, 2016)

1. *Temperament, cognitive capacity, relationships, and life history*

The foundational characteristics with which the infant is endowed influence how individuals perceive and interact with their environment.

- *Temperament* refers to innate personality traits, such as emotional reactivity and self-regulation, which impact behaviour.
- *Cognitive capacity* includes intellectual abilities, problem-solving skills, and processing speed that shape learning and decision-making.
- *Relationships* comprise early interactions, particularly with caregivers, and play a crucial role in shaping emotional security and trust.
- *Life history* are the cumulative experiences, challenges, and opportunities an individual encounters, which influence development.

2. Attachment

Attachment refers to the emotional bond between individuals and their primary caregivers and significant others. A secure attachment fosters emotional stability, trust in relationships, confidence to explore and take risks, which lays the groundwork for social, emotional, and cognitive development.

3. Core processes

These processes are influenced by attachment quality and form the building blocks of higher-order skills that develop throughout childhood and adolescence.

- Time perspective involves the ability to think about the past, present, and future that enables individuals to prioritize long-term goals over immediate gratification, thereby enhancing planning goal setting skills.
- Impulse control/delay of gratification is the capacity to manage immediate urges and resist impulses in favour of achieving longer-term goals. It helps to develop patience, discipline, and the ability to assess the consequences of actions.
- Goal setting is the ability to identify, prioritize, and work toward meaningful objectives. It encourages motivation, direction, and a sense of purpose.

4. Cognitive and emotional development

These processes evolve from the core developmental skills:

- Planning involves strategizing and organizing steps to achieve a goal and enhances efficiency and effectiveness in decision-making.
- Self-reflection is the ability to evaluate one's own thoughts, emotions, and behaviours that fosters self-awareness and accountability.

- Perspective-taking is the skill of understanding and considering others' viewpoints and feelings. It promotes empathy and effective interpersonal interactions.

5. Higher-order abilities

- These represent advanced skills that integrate cognitive, emotional, and social competencies such as metacognitive ability (i.e., thinking about one's own thinking) which enables self-regulation, problem-solving, and adaptive learning strategies.
- Empathy is the capacity to recognize, understand, and share the feelings of others. It enhances compassion and strengthens social bonds.
- Emotion regulation is the ability to manage and respond to emotional experiences in a constructive manner. It helps maintain composure and resilience in stressful situations.
- Self-efficacy is a belief in one's ability to achieve goals and overcome challenges. It encourages confidence and perseverance.

6. Pro-social norms

Pro-social norms refer to socially acceptable behaviours that promote the well-being of others and society. Examples include cooperation, altruism, and ethical decision-making. These norms are shaped by empathy, self-efficacy, and emotional regulation.

7. Maturity

Maturity is the ultimate outcome of this developmental process, characterized by a balanced and adaptable personality, a sense of responsibility, independence, and accountability, and the ability to navigate complex social, emotional, and cognitive challenges effectively.

In summary, the model illustrates a dynamic process in which foundational traits (like temperament and attachment) guide the development of core skills (like impulse control and goal setting), which then evolve into higher-order abilities (like empathy and metacognition), ultimately leading to maturity. All of these capacities need to be assessed in a young person presenting with gender dysphoria, but this is rare, due to the singular focus on the endpoint symptom, which is a declaration of the wish to change sex.

Gender Dysphoria

Gender dysphoria arises from a complex interplay of biological, psychological, social, and developmental factors. It frequently co-occurs with other mental health conditions, including depression, anxiety, ASD and ADHD. Addressing these comorbidities is vital for effective treatment.

Comprehensive intake assessment

Gender dysphoria in each young person with arises from a complex interplay of factors. Recently, gender dysphoria has been conceptualized within a cluster of affective-perceptual disorders that shares characteristics with other body-focused psychopathologies such as anorexia nervosa, body dysmorphic disorder, and body integrity identity disorder. Individuals with this cluster of disorders may exhibit resistance to change, deny emotional discomfort, and project distress onto their bodies. The focus on the bodily symptoms of these disorders acts a defence from experiencing reflecting deeper emotional and psychological conflicts.

Given the complexities of the antecedents of personality formation and the presentations of gender dysphoria outlined above, a thorough intake assessment is essential. It should cover:

- **Developmental history:** The adolescent's developmental trajectory, including significant life events, attachment experiences, trauma, abuse history, and the level of maturity attained.
- **Psychological evaluation:** Assessment of psychological symptoms (anxiety, depression, ADHD, ASD, self-harm, suicidal ideation, psychosis), eating disorders, and body dysmorphia.
- **Family dynamics:** Family structure, dynamics (conflict, dysfunction, sibling relationships), communication patterns, the presence of trauma or adversity, and parental and family response to the transgender declaration.
- **Self-harm and suicidality:** Direct and empathic inquiry into self-harm behaviours, suicidal ideation, and suicide attempts, followed by safety planning (involving the adolescent, family, and other professionals) is a core element of the diagnostic work up.
- **Cognitive distortions:** Cognitive rigidity, concrete thinking, and maladaptive coping mechanisms (emotional suppression, anger directed at the body) can lead to and maintain gender dysphoria. Evaluation of cognitive maturity, abstract thinking, and critical thinking regarding gender identity, and cognitive distortions will assist in identifying the therapeutic approach.
- **Sexual history and orientation:** Exploration of sexual experiences (including abuse), sexual orientation, and any internalized homophobia or misogyny.
- **Social and cultural influences:** Internalized homophobia, misogyny, and transphobia, and the influence of societal norms and peer groups and social circles (e.g., schools, gender clinics, online communities) significantly shape gender identity development.

- Biological factors: While not fully understood, potential biological factors may influence gender dysphoria.
- Understanding of medical interventions: Assessment of the adolescent's comprehension of medical/surgical procedures, including irreversibility and potential long-term physical and mental health consequences (infertility, sexual dysfunction, lifelong medical dependence) are needed to ascertain capacity for consent.

The meaning of the wish to transition

The wish to transition can have various interconnected meanings, including alleviation of distress, as a means of resolving trauma experiences, attempts to seek and find a sense of belonging, homophily, and peer acceptance. The focus on transition may mask attempts to escape from other issues or psychological disorders such as depression, anxiety, anxious attachment trauma and/or unresolved grief. In some cases, the desire to transition arises from cognitive errors or rigid thinking, and an inability to consider alternative solutions to their distress.

Finally, the wish to transition may represent a yearning for symbolic transformation representing a broader desire “to be born anew” or “to start again” in the manner of a religious conversion that addresses deeper issues related to self-esteem, core identity, or life direction. In the next session, I illustrate how the symptom of gender dysphoria and the wish to transition may manifest in the young person through a series of case vignettes.

Case vignettes illustrating the hidden meaning of gender dysphoria

The following illustrate how psychotherapy can uncover the hidden meanings of gender dysphoria symptoms:

- Case 1 (Unresolved grief): A young boy's wish to transition emerged after the death of a beloved grandmother who was his

primary carer. Therapy revealed this transition wish was a way to cope with the profound grief and maintain a connection with the deceased.

- Case 2 (Trauma response): A history of physical and emotional abuse from a same sex parent significantly contributed to a female adolescent's gender dysphoria. Transition became a way to reclaim a sense of control and agency over her body and identity, attempting to transform the negative experience into something positive.
- Case 3 (Family conflict): An adolescent used the desire to transition to express anger and resentment towards a conflicted family environment, using the transition as a means to assert independence and escape feelings of invalidation and neglect.
- Case 4 (Social contagion): An adolescent's initial exploration of their gender identity was heavily influenced by online communities and peers. Therapy helped her to critically evaluate these external influences and develop a more authentic understanding of her own identity, separating and identifying her personal feelings from external pressures.
- Case 5 (Sexual abuse trauma and lack of safety as a female)
Prisha, a case in the public domain, became severely gender dysphoric following a brutal rape and subsequent pregnancy and miscarriage at age 14-15. She commenced testosterone shortly afterwards and had a double mastectomy at 16 with no therapy for her sexual trauma or mental health issues. She is now suing her treating doctors.
- Case 6 (Sibling rivalry)
A loved father appears to love her brother more than his daughter and spends much more time engaged in male pursuits with his son. She says, “I want to be close to Dad, but he spends all his

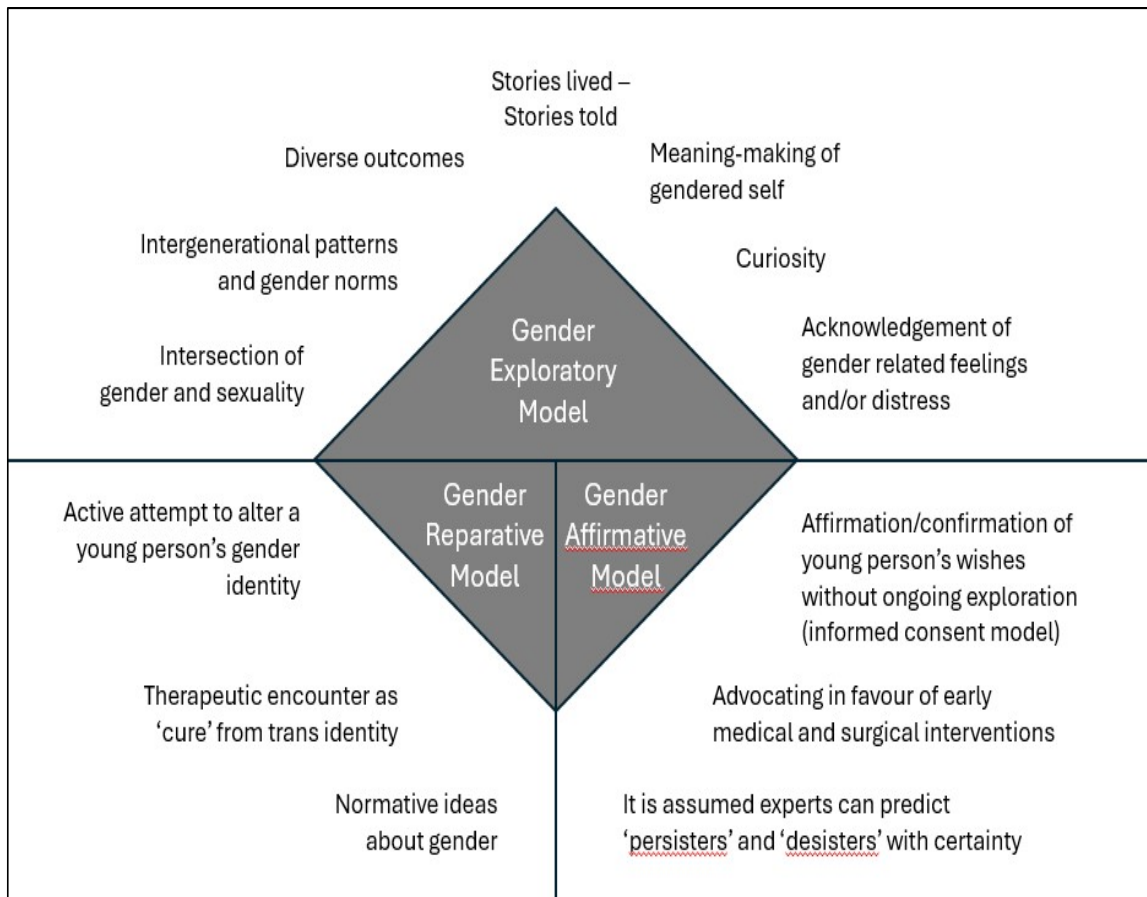
time with my brother and never with me.” She concluded it was better to be a boy and declared herself transgender. Now she is in a perpetual rage that her father does not accept her transgender identity because she feels she has nothing more to offer him.

Self-harm and suicidality

Gender dysphoria has often been linked to self-harm and suicidality. The link occurs after transition, not before as the gender affirming care camp promulgates repeatedly in the media. A psychotherapeutic formulation accounts for these impulses as follows: The vulnerable (traumatized) part of the self is hated so it is subsumed into the omnipotent self which is the part that suppresses doubts and anxiety and presses for transition. If the traumatized self pushes for recognition of psychic pain, the young person may resort to self-harm and suicidal ideation which is a form of acting out of their self-hatred against their bodies. Affirming clinicians collude with the patient’s own attacks on the traumatized self by “traumatizing” their bodies with cross-sex hormones and mutilating surgery. In the hope that transition will restore the young person to an ideal state, medics become omnipotent creators of this unachievable ideal. When this fails, the patient sinks into further self-hatred which is enacted through self-harming and suicidal states.

Treatment For Gender Dysphoria

There are currently three major models of intervention for young people presenting with gender dysphoria. These are the gender affirming model, the gender reparative model, and the gender exploratory model. Currently, only the gender affirming model is advocated as “best practice” and the two remaining models are deceptively conflated and subject to conversion therapy prohibition legislation in several Australian states. This is an ideologically and politically driven state of affairs that is detrimental to the wellbeing of minors.



(after Spiliadis, 2023)

The central role of psychotherapy in addressing gender dysphoria

Psychotherapy plays a pivotal role, going far beyond simply affirming an adolescent's gender identity and declarations. It involves exploring the root causes of distress, addressing trauma, attachment issues, and unresolved grief or other underlying psychological issues. Therapists equip adolescents with healthy coping mechanisms to manage emotional distress related to gender dysphoria and work on improving emotional regulation and self-awareness. The goal is to foster a deeper understanding of their own experiences, thoughts, and feelings regarding gender identity. Family involvement in therapy, when appropriate, can improve communication and support the adolescent's development and understanding. The therapeutic approach should

always remain sensitive to the adolescent's developmental stage and cognitive capacity.

The romantic and sexual histories of young people need to be understood. The majority of young gender dysphoric adolescents have had no sexual experience other than crushes from a distance, hand holding and kissing. They tend to disdain genital sex as “gross,” are indifferent to loss of sexual function and fertility wrought by cross sex hormones and genital surgeries and are confused about the nature of “trans” relationships.

An effective therapeutic approach incorporates several key aspects: It is developmentally sensitive, recognizing the evolving nature of self-understanding and identity that occurs in adolescence; it prioritizes informed consent, ensuring adolescents fully understand the implications of all treatment options; it is long-term focused, requiring regular contact to encourage the development of a therapeutic alliance and to provide consistent support and guidance; and it is collaborative, involving the adolescent, their family (when appropriate), and other medical professionals to facilitate comprehensive care. This collaborative model ensures a holistic approach tailored to the individual's unique needs and circumstances.

The aim is to equip the adolescent with the resilience and self-awareness needed to navigate the complexities of gender identity and the challenges of adulthood. Throughout, it is imperative to keep the developmental path open into adulthood because frontal lobe maturation is not completed until the mid-20s.

Psychological trauma from the past forms part of the young person's psychic structure in the present. The expression of these traumas is both intrapsychically and socio-culturally embedded (i.e., social milieu permits particular forms of “acting out” of these traumas). Envy and

rivalry are part of the human condition and unconscious envy is a factor in trans identification. Gender dysphoric adolescents need assistance to explore their defences and internal psychic conflicts and manage their psychic pain before irreparably altering their bodies. Clinicians should not collude with the phantasy that the “embodied” self can be altered or removed.

Conclusion

Treating gender dysphoria requires a holistic, ethical, and developmentally informed approach prioritizing long-term well-being. This involves comprehensive intake assessments, understanding the complex interplay of contributing factors, addressing self-harm and suicidality, and exploring the deeper meanings behind the wish to transition. A collaborative treatment plan, involving the adolescent, their family (when appropriate), and other professionals, is essential. The focus should be on addressing underlying psychological issues driving the distress, rather than solely on medical interventions. The goal is to equip adolescents with the resilience and self-awareness needed to navigate the complexities of gender identity and the challenges of adulthood.

References

- Kenny, D. T. (2016). The adolescent brain: Implications for understanding young offenders. *Judicial Officers Bulletin*, 28(3), 23-27.
- Kenny, D.T. (2025). *Gender ideology, social contagion, and the making of a transgender generation*. Cambridge: Cambridge Scholars Press.
- <https://www.cambridgescholars.com/product/978-1-0364-1478-8>
- Spiliadis, A. (2023). Models of care for gender dysphoria. Paper presented at the *Psychotherapeutic processes with young people experiencing gender dysphoria conference*, Tampere University, Finland.

Rebalancing Diagnosis and Clinical Treatment: The Contribution of NAPP to Clinical Discourse on Youth Gender Medicine

Professor Philip Morris AM

The management of gender dysphoria and gender incongruence in young people has become one of the most contested areas in contemporary medicine. Amid the evolving landscape of societal attitudes, legal frameworks, and medical practice, the National Association of Practising Psychiatrists (NAPP) has played a pivotal role in rebalancing clinical discourse. Through persistent advocacy, publication of clinical guidelines, and fostering professional dialogue, NAPP has sought to ensure that youth gender medicine is grounded in careful diagnosis, ethical clinical practice, and prioritisation of patient welfare.

Chronology of NAPP's Contributions

Since 2019, NAPP has been at the forefront of advocating for a rigorous, evidence-based approach to the treatment of young people with gender dysphoria. In October 2019, NAPP wrote to Commonwealth Health Minister Greg Hunt requesting a national inquiry into the treatment practices surrounding gender dysphoria in children. Despite opposition from the Royal Australasian College of Physicians (RACP), which argued such an inquiry might harm vulnerable patients and families, NAPP continued to raise valid concerns about the adequacy and safety of current approaches.

Between 2020 and 2021, NAPP made critical submissions to conversion therapy legislation proposed in Queensland, the Australian Capital Territory, and Victoria. The association cautioned that without precise definitions, conventional psychiatric assessments and treatments risked being misclassified as conversion practices, exposing healthcare providers to potential legal and professional repercussions. NAPP stressed that ethical psychotherapy aimed at exploring underlying causes of distress should not be conflated with coercive practices.

Further, in November 2020, NAPP queried the RACP regarding whether it would reconsider its guidance on gender dysphoria treatment, especially in light of emerging international concerns. Receiving no substantive update, NAPP proceeded to publish the NAPP Guide to Managing Gender Dysphoria/Incongruence in Young People in May 2021, offering clinicians a structured approach based on comprehensive bio-psycho-social assessment and cautious consideration of gender-affirming medical interventions.

In subsequent years, NAPP has remained engaged, revising its guide in December 2023 to incorporate findings from the preliminary report of the UK Cass Review. Its July 2024 webinar with Dr Hilary Cass covered the findings of the final report of the Cass Review.

NAPP published an update of its guide to managing gender dysphoria in March 2025 integrating advances from international reviews and policy shifts, including the UK government's 2024 ban on puberty blockers for individuals under 18 and more cautious approaches to the treatment of gender dysphoria by Scandinavian countries.

NAPP has also made repeated requests to the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to update guidance in light of these developments. Yet, the RANZCP has remained largely

unresponsive, further underlining the need for independent contributions like those of NAPP to shape responsible clinical standards.

Historical Parallels: Homosexuality and Transsexual Identity

The evolving classification of transsexual identity parallels, in some respects, the historical trajectory of homosexuality. Homosexuality progressed from being viewed as evil or immoral, through phases of medicalisation and pathologisation, to eventual acceptance as a normal variation of human sexuality.

Diagnostically, it was removed from the Diagnostic and Statistical Manual (American Psychiatric Association) (DSM) and the International Classification of Diseases (ICD) by the late 20th century.

Transsexual identity has followed a similar path. Initially labelled as a psychiatric disorder—Transsexualism in DSM-III (1980), later as gender identity disorder—trans identities have been progressively de-pathologized. The DSM-5 in 2015 introduced the diagnosis of Gender Dysphoria, focusing on the associated distress rather than the identity itself. The WHO removed gender incongruence from the mental disorders category in ICD-11 (2019).

Dilemma – The Fork in the Road

Homosexual orientation does not require medical intervention. A pressing question now emerges: if transgender identity is to be regarded as a normal variant, does it necessitate medical intervention, particularly when such interventions carry significant risks? Yet transgender advocates demand medical interventions to make trans individuals feel more comfortable with their chosen gender.

Ethical and Legal Considerations

The ethical framework guiding medical decision-making emphasises non-maleficence—"first, do no harm"—and beneficence, whereby doctors act in the best interests of the patient. In the context of youth gender medicine, this requires meticulous assessment to avoid unnecessary or harmful interventions.

Legal precedent underscores the importance of proportionate and appropriate treatment. Judges Tree and Brennan have articulated that diagnoses must result from proper assessment, and legitimate treatments must be directed at established pathology or psychiatric disorder and must be both therapeutic and proportionate to their intended purpose.

Applying these principles to gender medicine demands a clear diagnosis, consideration of differential diagnoses, and a careful weighing of anticipated benefits against potential adverse effects.

Clinical Framework: NAPP's Guide to Managing Gender Dysphoria

The NAPP clinical guide, available [online here](#), offers a non-ideological, patient-centred approach to youth gender medicine. The young person's view of their gender identity is genuinely respected, but not affirmed in the initial assessments. The approach outlined in the guide rests on several core principles:

1. **Comprehensive Bio-Psycho-Social Assessment:** A full exploration of the individual's symptoms and signs, family dynamics, mental health history, and social influences is essential prior to treatment. Co-existing psychiatric conditions and differential diagnoses must be considered. Co-existing psychiatric conditions are usually more than 'minority stress'.

2. **First-Line Psychological Interventions:** Explorative psychotherapy, psychoeducation, school-home liaison, and family therapy are prioritised. These therapies are exploratory, supporting the young person without promoting any specific gender outcome. NAPP stresses that such practices are distinct from conversion therapy.
3. **Medical Interventions as Second-Line Options:** Puberty blockers and cross-sex hormones are recognised as potentially harmful, with risks to cognitive, reproductive, and psychosexual development. The evidence of benefit is very limited. Therefore, the use of these hormonal interventions is restricted to second-line treatments. International reviews from Finland, Norway, Sweden, and the UK consistently advise caution, limiting or banning such interventions for minors or only allowing them to be used in the setting of research studies.
4. **Informed Consent and Capacity:** Ensuring that young people and their families fully understand the benefits, limitations, and long-term consequences of medical transition is paramount. The child's developmental stage and capacity to consent must be rigorously assessed.

International Trends and the Path Forward

Recent developments, including the Cass Review and the closure of the Tavistock Clinic in the UK and similar reviews in Scandinavian countries, signal a global shift towards more cautious, holistic approaches to gender dysphoria treatment in youth. NAPP has ensured Australian clinicians are informed of these trends, updating its guidelines accordingly.

Conclusion

Through sustained advocacy, scholarly contributions, and clinical leadership, NAPP has made an invaluable contribution to the evolving discourse on youth gender medicine. It has emphasised the importance of ethical practice, comprehensive assessment, and safeguarding the long-term well-being of vulnerable young people. As international evidence mounts in favour of a cautious, balanced approach, NAPP's efforts to rebalance diagnosis and treatment remain critical to ensuring that youth gender medicine in Australia aligns with best practices, legal principles, and ethical obligations.

Reference

<https://napp.org.au/2023/12/napp-statement-on-gender-dysphoria-in-young-people/>

Legal Issues in Treatment of Minors

Emeritus Professor Patrick Parkinson AM

Introduction

I want to address briefly in my contribution some of the legal issues which I see arising from the current practices in Australia in relation to the health of trans and gender diverse children and young people.

By way of background, I am a lawyer with expertise in family law, child protection and medico-legal matters and a sometime law professor and Dean. I have been involved in certain court cases where these issues are considered.

First, it is worth saying that there is a whole group of lawyers who have been very active in this space, concerned about the issues for young people in particular who may make irreversible changes to their bodies that they later regret. People have been acting pro bono, spending countless hours preparing for and participating in court cases concerning children and young people.

Consent to medical treatment – minors

The current law provides that both parents must give their consent to puberty blockers or cross-sex hormones for any child under 18. If one parent refuses consent, then the matter has to go to the Family Court, now known as Division 1 of the Federal Circuit and Family Court of Australia.

More and more cases are being filed in that court. Why, because the message has got out that gender identity isn't fixed and stable in children and adolescents, that hormone treatments are not the life-saving interventions claimed, that many adults regret the treatment that they experienced as children and young people, and wish they had been better advised or had waited. The word is out that so many of the claims that have been made about gender-affirming care are not based on any reliable evidence.

These cases are sometimes both long and complex. They are typically subject to stringent suppression orders, not just about the details of the case but even the State in which the case takes place. Some of these cases settle without a judgment. I was involved in one case where it settled after ten days of hearing, with the parent seeking puberty blockers for the child agreeing that no such treatment would be offered. There have been other cases I know of that have settled as well, and a couple of recent cases where the judge has delivered a judgment.

Re Ash¹

In this case, one parent supported, and one parent opposed, the provision of testosterone to a 16 year old female who had identified as male for some four years. It was heard in the Federal Circuit and Family Court of Australia. In these cases, the Court just has to make a decision in the best interests of the child.

In the published judgment in this case, there are certain deletions and facts not given. The gender of each parent is not recorded, and the names of all expert witnesses are suppressed. The gender of the experts who were supportive of providing this teenage female with testosterone is also suppressed. They are described using they/them pronouns,

¹ *Re Ash (No 4)* [2024] FedCFamC1F 777 (15 November 2024).

whereas the gender of the experts called in opposition to the treatment is not suppressed.

The judge gave a strong judgment in favour of allowing the treatment. He praised the experts on one side while disparaging the experts on the other. He endorsed the WPATH Standards of Care, version 8, as “authoritative”, while according the Cass Review “little weight” in determining where Ash’s best interests lie.

Notwithstanding that he said judges should avoid getting involved in politics, he went out of his way to offer commentary on the Cass Review, suggesting that it may have been driven by an “overt political imperative” and implying that perhaps the British government may have been motivated by financial issues, given that the National Health Service had been ‘overwhelmed’ by the increase in clients seeking gender-affirming treatment, particularly adolescent girls. He also cast aspersions on Dr Cass’s qualifications to lead the review and how she conducted it.

It is fair to say, in other words, that it is a somewhat extraordinary judgment.

However, the judge also sought to make clear that the judgment is not a precedent of any kind. This was a case about whether one teenager, Ash, should be allowed to receive cross-sex hormone treatment before the age of 18 in circumstances where s/he was likely to make that decision for him/her self after turning 18. It is not a precedent for any other case because each case is only about the best interests of the child as the judge sees it, on the basis of the evidence provided in the case. It is notorious that judges can reach quite different views about what is in the best interests of a particular child, and their judgments may be influenced by their personal values and beliefs.

What can we learn from it? Three things stand out. The first one is that in these cases, the closer a young person gets to 18, the harder it is for a parent to oppose the treatment successfully. In these cases, almost by definition, the young person really wants the treatment and is not put off by worries about adverse health consequences, loss of fertility, or the risk of later regret. The parent who is opposing the treatment is asking the judge to go against the strongly held wishes of an older adolescent concerning their body, in circumstances where, in a year or two, they will be able to decide for themselves. The older the child, the harder it is for the judge to say no.

The second point to make is that even this judge, who clearly had very strong opinions, acknowledged that the risks this young person wanted to take were considerable. He accepted the view of an expert witness that she should be afforded “the dignity of risk” to undergo testosterone therapy but he said he had no idea whether it would be for Ash’s benefit in the medium to long-term. This is because there really haven’t been long-term studies of more than about 6 years’ duration. There is so much we don’t know.

So the question in the judge’s mind was whether the risks of treatment were ‘unacceptable’. These risks included:

- a risk that Ash may live to regret – even bitterly regret – taking testosterone;
- that it may not alleviate his dysphoria, either materially or even at all
- that it would lead to unintended consequences, including pain and disease; and that
- it will likely impair, at least to some degree, and perhaps completely, his fertility.

The judge also acknowledged the risks that because Ash’s cognitive development is still ongoing, he may not fully comprehend:

- all the risks associated with the taking of testosterone;
- the limitations to the effects of testosterone;

However, he did not regard these risks as unacceptable when taking into account the expected benefits.

Clearly, there are other judges who might well take a very different view of those risks. Dr Cass, after a four year review of all the evidence, thought that cross-sex hormones should not be provided to teenagers without a clear clinical rationale, and that generally doctors should show ‘extreme caution’. At the end of the day, this judge authorised treatment because the young person really wanted it and his/her gender identity as male had been stable over a four year period.

The third point to make is that unless there is legislation specifically in this area, there is likely to be a lot of inconsistency between judges. If the only test is what is in the best interests of the child then inevitably, much will depend on the judge’s personal views as to what is in the young person’s best interests. In NSW, there is such legislation, at least for the under 16s. That legislation was considered in a recent case, *re Lisa*.²

Re Lisa

This was a case heard in the NSW Civil and Administrative Tribunal. The *Children and Young Persons (Care and Protection) Act 1998* (NSW) prohibits ‘special medical treatment’ for those under 16 without approval from the Tribunal, even if both parents consent. Special medical treatment includes treatment that is reasonably likely to have

² [2024] NSWCATGD 17 (8th October 2024).

the effect of rendering permanently infertile the person on whom it is carried out. Consent can only be given if the Tribunal is satisfied that the treatment is necessary to save the child's life or to prevent serious damage to the child's psychological or physical health. This law was originally introduced to create a strong barrier against the sterilisation of intellectually disabled teenage girls. Typically, this was done for menstrual management, particularly for girls who had a phobia about seeing blood, and to eliminate the risk of pregnancy.

In *re Lisa*, the Tribunal had to decide whether that law applied to cross-sex hormone treatment, given the risk of infertility for a 15 year old male child who takes oestrogen in the long-term. In this case, the boy was put on puberty blockers at Tanner Stage 2, so a long time before his body was capable of producing sperm.

There were two expert witnesses in the case on the issue of whether oestrogen in a male could cause fertility. They were in conflict on this issue. Both acknowledged that the evidence one way or another was very sparse indeed. The expert from overseas, drawing on a very small sample of cases, thought that taking oestrogen would not impair fertility. The other, an Australian expert, thought there was a significant risk it could do so, especially since the child had been on puberty blockers since Tanner Stage 2. The Tribunal preferred the evidence of the Australian expert, and found that the Stage 2 treatment sought for Lisa met the statutory test of being reasonably likely to have the effect of rendering Lisa permanently infertile.

However, once the Tribunal had decided that this was a case to which the law applied, requiring the consent of the Tribunal, it decided on the evidence to refuse treatment. Why? Because there was no risk to the life of the child or serious damage to his/her health if it refused consent to the treatment. The child was turning 16 in three months' time. S/he could go for the treatment at that time, with both parents' consent.

The case of Lisa illustrates so many of the issues with which many of us have been concerned when it comes to what is called gender-affirming care. The child had level 3 autism, and behavioural management was a challenge. The Tribunal recorded in a quite matter of fact way, the time that the clinician from a gender clinic in the Hunter region of NSW had spent with Lisa to diagnose gender dysphoria and to recommend this treatment. There were two sessions by telehealth.

The important contrast between *re Ash* and *re Lisa* is that the legislation that fell to be interpreted in *Re Lisa* provided a specific test - the treatment has to be necessary to save the child's life or to prevent serious damage to the child's psychological or physical health. It is most doubtful that such a test could have been satisfied in *Re Ash* on the evidence provided in the judgment. Whatever ultimately the legislation is, we need a clear legal test.

Civil actions

Apart from litigation that restrains treatment, the next issue is whether civil suits from those damaged by treatment will have an impact, not least on the willingness of insurers to cover this form of treatment. Already the MDA Australia has withdrawn cover from private practitioners for any gender affirming care before the age of 18.

The risk of litigation is not only from those who were treated under 18. There are cases currently in progress involving young adults with serious mental health issues who were provided with treatment in circumstances where there must be serious arguments about diagnosis and where it is most doubtful that they were able to give an informed consent.

There are two main reasons why I think the litigation pathway will be slow. There may eventually be a flood of claims but we are not seeing this yet. The first reason is that doctors will not be liable in negligence if they adhered to the standards of treatment which were accepted at the time, even if the medical profession subsequently takes a very different view of what is appropriate medical treatment.

It seems clear that gender affirming treatment is accepted by various medical associations and government health departments in Australia. So if the doctors do adhere to the relevant standards, they will be safe on this score from litigation. The most widely adopted standards in Australia are of course the Australian Standards of Care developed by the Royal Children's Hospital in Melbourne. These have not been endorsed by the NHMRC; but they have been widely adopted in practice.

The second reason why I am not expecting a flood of litigation is that for most young people who receive treatment, this is a choice they made and also a sunk cost. When the young person really wanted the treatment, and was insistent this was in his or her best interests, they may well not feel able to blame the doctors for providing that treatment to them further down the track when they have come to regret it. In other words, they may well feel responsible for their own choices, even though these were immature choices. There may also be a great reluctance to admit to themselves that they made a mistake.

The treatment is also a sunk cost. Precisely because the cross-sex hormone treatments are irreversible, especially the effects of testosterone on female bodies, the young adult may feel that they need to just accept what has happened and make the best they can of it. Litigation is stressful and it may not be successful. Money will not compensate for their losses of health and fertility, and so they may not see much point in litigation.

However, I do see avenues for civil liability. Just because there are Australian Standards of Care does not mean that they are being adhered to in practice. These clinics are overwhelmed by the numbers now. They have long waiting lists which makes the thorough assessment and evaluation of each child's case very challenging; even if the hospital gender clinics were well-run, many young patients are being seen in private practice and we have no idea of what is happening there.

I expect future cases to turn on the following issues:

1. Failure to apply the DSM-5 criteria properly

In Australian law, the prescription of puberty blockers or cross-sex hormones to a minor is only lawful if there is a diagnosis under the DSM-5 criteria of gender dysphoria.

In practice, I have found that the only criterion that seems to be applied is that the child has been insistent, consistent and persistent about their transgender identification for a period of six months or more. However, the DSM-5 criteria for diagnosis of gender dysphoria are much more rigorous than this, requiring, for example, clinically significant distress arising from the gender incongruence. I have not seen much rigour in the application of the DSM criteria, particularly for a diagnosis of gender dysphoria in childhood. Doctors need to be aware that if they are sued, the first thing the lawyers will seek is all their medical notes. And for some, those notes may well indicate a shoddy and wholly inadequate diagnostic process.

2. Failure to consider and rule out other explanations for gender incongruence

A quite startling failure that can be observed in some cases is a refusal (there is no other word) to consider any alternative explanation for gender incongruence other than that the child or young person has an innate gender identity that is discordant with their natal sex. The refusal

to engage in any serious process of differential diagnosis is likely to be a major cause of litigation in the future, particularly for people who are neurodivergent or have other psychiatric comorbidities, or have had adverse childhood experiences, including family breakdown. Consideration has to be given to whether complex factors are at work arising from the young person's mental health difficulties or a history of adverse childhood experiences or disordered attachments which may help explain their current gender identity.³

There has to be a comprehensive biopsychosocial assessment, and I would not be at all confident that such a careful assessment is being carried out across Australia in the practice of gender medicine.

3. Failure to take a history from both parents

If one of the markers of likely persistent gender incongruence is that it was evident from early childhood, then the history of the child's gendered interests and behaviours in early childhood is of considerable importance. Halasz and Amos have recently summarised best practice:⁴

Comprehensive treatment of gender dysphoria relies on in-depth individual and family interviews including exploration of childhood adversity and trauma and comprehensive formulation with differential diagnosis and treatment options.

The cohort of children who are referred to gender clinics is greatly affected by parental conflict and family breakdown, and so it is not at all uncommon for the parents to be living separately and apart and for

³ Kasia Kozłowska et al, 'Attachment Patterns in Children and Adolescents with Gender Dysphoria', (2021) 11 *Frontiers in Psychology* 582688: 1-21; Guido Giovanardi et al, 'Attachment Patterns and Complex Trauma in a Sample of Adults Diagnosed with Gender Dysphoria', (2018) 9 *Frontiers in Psychology* 60; Kasia Kozłowska et al, 'Australian Children and Adolescents with Gender Dysphoria: Clinical Presentations and Challenges Experienced by a Multidisciplinary Team and Gender Service' (2021) 1(1) *Human Systems: Therapy, Culture and Attachments*, 70.

⁴ George Halasz and Andrew Amos, 'Gender dysphoria: Reconsidering ethical and iatrogenic factors in clinical practice' *Australasian Psychiatry* 2024 Feb;32(1):26-31.

communication with the clinic to be primarily with the resident parent (typically but not invariably, the mother).

In my experience, there is sometimes a failure to see the non-resident parent as an important resource in terms of proper diagnosis.

It ought to be standard practice, whatever the history of the parental relationship, to find out as much as possible from both parents' perspectives about the history of the child, and when it is said that gender incongruence first emerged.

4. Failure to consider alternative treatment options

A fourth deficiency, which may result in a finding of negligence, is a failure to consider and rule out less drastic treatment options including psychotherapeutic approaches to manage distress and build resilience.

5. Unlawful treatment of non-binary adolescents

Another area where I think at least two gender clinics in Australia are exposed is in the provision of cross-sex hormones to minors who identify as non-binary. The problem is that none of the Family Court decisions have ever said that this is a proper purpose for medicalisation. If the treatment affects fertility, and is not for the treatment of an illness or disease, then it is outside of parents' capacity to consent. It needs court approval. It is very hard for me to see how any court could hold that it is clinically necessary and in the best interests of the child to provide body-altering treatments to a young person who identifies as 'non-binary' when this treatment does not have any proven therapeutic benefit and is not intended to help them 'pass' as the opposite sex.

6. Failure to assess Gillick competence properly

Clinics, rightly, insist that the young person must be *Gillick* competent before prescribing cross-sex hormones. This is a poorly understood concept in the medical profession. The *Gillick* case was about whether

it is lawful for a 15 year old girl to be given the contraceptive pill without parental knowledge and consent. The House of Lords said it could be lawful, if the girl was competent to consent. But they were at pains to emphasise that it was not enough for her just to understand the treatment and the potential risks. Lord Scarman said that she needs to understand the consequences of being sexually active at her age and seeking treatment without the involvement of a parent. Even for contraception, it is a test not lightly to be satisfied.

In *Bell v Tavistock*, more recently, the English Court of Appeal said “clinicians must satisfy themselves that the child and parents appreciate the short and long-term implications of the treatment upon which the child is embarking.” They went on:⁵

Clinicians will inevitably take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed by the advantages and disadvantages of the proposed course of treatment and in the light of evolving research and understanding of the implications and long-term consequences of such treatment.

7. Failure to obtain a fully informed consent

I suspect that the largest group of cases will turn on informed consent. To provide a fully-informed consent, the patient must be able to make an informed judgment about whether the likely benefits of the treatment outweigh the known impacts and risks to physical health, fertility and sexual function.

To weigh up the risks and benefits for themselves, patients need to be made fully aware of the medical controversies associated with the prescription of puberty blockers and cross-sex hormones for children and young people and the very mixed outcomes of research studies. Given this is now a very well-established area of controversy, reflected

⁵ *Bell v Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363 at [92]-[93].

in the leading medical and psychology journals, patients should be warned that according to some research studies, they may not gain any benefits in terms of their mental health, nor a reduction in suicidal ideation, as a consequence of the treatment program. Clinicians must be honest about this, not cherry-picking those studies that show benefits to some patients or referring only to their own clinical experience as authority, as so many gender clinicians in Australia do.

A particular risk in terms of informed consent, is that the young person, who has limited life experience, will have an unrealistic expectation of the extent to which they can be assisted to pass as being of the gender with which they identify.

Teenagers are particularly unlikely to understand the effects of the proposed treatment on reducing their dating pool and limiting their options in terms of sexual relations. These are vitally important aspects of wellbeing, and patients ought to be able to consider the adverse impact of the proposed treatment for their wellbeing in this area, before it can be said that they have given an informed consent.

To the future

We need new regulation and a new process. The legislation we need is something like the legislation that is already on the statute book in NSW. There must be a test along the lines that treatment with cross-sex hormones should only be permitted where necessary to save the child's life or to prevent serious damage to the child's psychological or physical health.

The second thing we need is a new process. Drawing upon the recommendation of Dr Cass in Britain, a good option would be for any case involving puberty blockers or cross-sex hormones for a young person under 18 to require approval by an expert panel based upon careful documentation. The Panel would need to be satisfied:

- that the diagnostic criteria are met,
- that a differential diagnosis has been carefully considered but rejected
- that no less radical interventions could address the mental health needs of the child,
- that the treatment is otherwise clinically necessary,
- and that both parents and child have given a fully informed consent.

That's at a minimum, what extreme caution looks like. If the Courts could be satisfied that such a rigorous process has been followed, then it will be much less likely that such cases will be litigated.