

ANOTHER UNFORTUNATE EXPERIMENT? NEW ZEALAND’S TRANSGENDER HEALTH POLICY AND ITS IMPACT ON CHILDREN

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PART 1. INTRODUCTION

More than 30 years ago in New Zealand, following an exposé by two feminist health advocates,¹ a Commission of Inquiry into medical practices at National Women's Hospital uncovered experimentation on women with cervical cancer, experimentation that the women were not aware of.² Since then, New Zealanders have generally believed that the medical conventions around informed consent were regulated in the form of a legislated Code of Patients' Rights.³ However, the *Guidelines for Gender Affirming Health Care for Gender Diverse and Transgender Children, Young People and Adults in Aotearoa, New Zealand*, published in 2018, raises questions as to whether, once again, we have a serious example of experimental treatment and inadequate information.⁴ This time it is children and adolescents who are the subjects involved.

At what is arguably one of the most potent stages of their physical, reproductive, emotional and social development, children and young people who are experiencing gender dysphoria, or who have been suggested by parents, doctors or counsellors as being 'born in the wrong body', are being put on a medical regime of powerful drugs that can have disastrous effects on both physical and mental health.

There is a startling dissonance between the argument that we must take account of neurological immaturity when sentencing young offenders, for example, but actively collude with children and adolescents in making profound, life-altering decisions, up to and including treatments that result in sterility and loss of sexual function. This paper will argue that in New Zealand, as elsewhere, there is unprecedented involvement of adults with a clear ideological agenda in the development and implementation of social and medical policy, and that young people and their parents/caregivers do not have enough information on which to give fully informed consent.

Concerns as to what is happening in the field of transgender medicine have arisen internationally and are multi-faceted. They fall broadly into three categories: the affirmative approach and insufficient diagnosis; the physical effects of hormone treatment; and the significant role of ideological influences. These concerns will be detailed in Part 2 of this paper. In summary:

Affirmative approach and insufficient diagnosis

An 'affirmative only' approach has overtaken earlier 'watchful waiting' approaches and inevitably leads to transition to a transgender identity.

Uniquely in medicine, the best practice guidance and the affirmative approach demand only self-diagnosis, while requiring no medical diagnosis.

The affirmative treatment regime ignores a significant tranche of the scientific literature that advises against medicine and surgery being the default solution

to gender dysphoria. Also ignored is significant evidence of poor prognosis, particularly for mental health, in both the short and long term.

There is a massive increase in young people seeking to transition. Yet there has been no consideration of what the causal factors might be. Children and young people are able to consent to a treatment path related to their unique self-perception, but there is no analysis of how that perception arose. Increasingly, there is evidence of both social contagion and rising levels of desistance and detransition.

Prior trauma, sexual abuse, serious mental health conditions, autism, anorexia and homophobia, as well as issues of sexism, misogyny, higher pornography consumption and the resulting expectations of sexual partners, remain unexamined as likely causes of gender dysphoria. This is because New Zealand's mental health professionals are not called on to address these issues, nor to be part of a transgender diagnosis.

Gay and lesbian young people are uniquely vulnerable to a diagnosis of gender dysphoria, when stereotypical ideas of sex roles are overlaid with homophobia.

Dangers of experimental treatment with puberty blockers

There are direct contradictions between the New Zealand transgender medicine Guidelines' assessment of puberty blockers as safe and fully reversible, and emerging research from overseas. United Kingdom findings from the Tavistock Gender Identity Development Service show puberty blockers to be a prescribing experiment. Patients were not told the treatment was experimental; nor that the drugs used are predominantly intended to treat prostate cancer in older men; nor that they have never been certified as safe and effective for treating gender dysphoria.

The New Zealand Guidelines and practice are comparable to those in the United Kingdom and elsewhere, as the approach to transgender medicine has been established internationally through the World Professional Association for Transgender Health.

The bar to being treated with puberty blockers is very low, yet it results in an almost 100% continuation to further treatment, including cross-sex hormones and surgery. Evidence shows that most children with gender dysphoria would, if left untreated, outgrow their dysphoria. A serious ethical question arises as to whether children who would otherwise live un-medicated and surgically unaltered lives – often as lesbian or gay adults – are best served by a medical regime that is turning them into life-long patients in a form of conversion therapy.

Serious mental health issues are appearing as a side effect of puberty blockers. There is no long-term data about their safety, but in both in the short and the long term, treatment prognoses appear to point to very poor mental health outcomes.

Important alternative approaches and research that differs from transgender advocates' perspectives are not considered in the New Zealand Guidelines.

Ideological influence

Transgender treatment regimes appear to be captured by an ideological worldview that transfers the beliefs and perceptions of the adult transgender community onto the bodies of vulnerable and sometimes damaged children.

Throughout the developed Western world, transgender advocates are setting the treatment approach for children who, if left alone, would mostly mature out of their dysphoria.

Gender is being reified as reality, while the biological reality of sex is minimised. The science-based practitioners in our public health system are being asked to endorse a treatment regime cast as a solution to a spiritual disconnection with the body, not a medical condition needing a diagnosis.

A more conservative approach, or any suggestion that 'gender identity' is psychological and sociological, is construed as 'transphobic'.

A hostile environment for science has developed internationally, where supporting gender ideology is more important than balancing evidence for and against treatment. A general climate of fear – of causing offence, of being accused of transphobia – means that reasoned debate has become almost impossible.

PART 2. INTERNATIONAL EVIDENCE AND ITS RELATIONSHIP TO NEW ZEALAND PRACTICES

1. AFFIRMATIVE APPROACH

The prioritisation of 'feelings' over science has been increasing for decades.⁵ Treatment models that helped children and young people come to terms with their bodies have been increasingly neglected in favour of medicalisation and a lifetime of drugs and potentially multiple surgical interventions.

The recently formed international Society for Evidence-Based Gender Medicine points out that:

Until recent years, medical interventions to achieve the appearance of the desired sex, known as the “gender-affirmative” model, have been reserved primarily for adults with long histories of dysphoria. However, in Western Europe, North America, and Australia, hormonal and surgical interventions are increasingly becoming the first line of treatment for adolescents and young adults with gender dysphoria, including those with relatively recent onset.⁶

The Society goes on to say:

In the past, medical interventions were preceded by a prolonged engagement with the patient, including ongoing psychological assessment. Now there has been a shift to a more automatic "affirmation" of the individual's view of themselves as transgender. As such, the provision of medical intervention now happens with a much-reduced psychological assessment.⁷

The New Zealand treatment regime adopts the same overall approach for children and young people as these other jurisdictions.

The Ministry of Health has promoted the 2018 Guidelines on its website, with the expectation, presumably, that District Health Boards and General Practitioners should follow them. Therefore, for medical staff to do other than affirm a gender identity and treat a child on the basis of initial presentation and beliefs, could be to risk censure.

However, the New Zealand Guidelines differ from those in the United Kingdom⁷ in the following important ways:

- They avoid medical diagnosis, preferring to support the child with an affirmative approach;
- Unusually for a medical document, the Guidelines are couched in the language of spiritual well-being;
- The New Zealand guidance advocates social transition (or living in the new gender), which the United Kingdom standard regards as controversial;
- The New Zealand guidance has been developed jointly with activists from lobby groups, rather than solely by medical experts.
- The effective impact of an affirmative approach is that any causal analysis is unlikely to be explored with children.

The New Zealand Guidelines say the gender-affirming approach:

involves assisting children to create an environment where their gender can be affirmed. This might require providing education and support for families and schools to be able to support the gender diverse child to navigate a social transition and helping children to

*develop the coping skills to address any negative reactions that they might experience for being gender diverse.*⁹

New Zealand's more extreme approach provides for a very limited role for mental health professionals. The Guidelines suggest mental health expertise is mainly needed in relation to support, advocacy advice and preparedness for treatment. Clinical diagnosis is downplayed in favour of affirmation – indeed the word 'diagnosis' is used only twice in the whole document, both times in relation to mental health, not transgender identity. This is also in direct contrast to a recent clinical practice guideline from the international Endocrine Society, whose view is that an expert multi-disciplinary team of medical professionals and mental health professionals are a crucial part of a transgender diagnosis and should manage treatment.¹⁰

Moreover, serious untreated mental health issues do not prevent “gender affirming care”. The Guidelines argue that not to treat medically is not an option:

*Withholding gender affirming treatment is not considered a neutral option, as this may cause or exacerbate any gender dysphoria or mental health problems.*¹¹

Clinicians are also encouraged to educate parents and whānau to affirm their child's identity and to believe in the self-diagnosis, because trans children are “*the expert of their own gender identity and their unique journey*”.

Meanwhile the *origins* of mental health issues, which are ascribed in the Guidelines to discrimination or body dysphoria, are likely to remain unaddressed despite the “*high prevalence of mental health problems among trans people*”, including suicide attempts and self-harm.¹²

In contrast, Dr Heather Brunskell-Evans,¹³ Professor Michele Moore,¹⁴ Dr Kenneth J. Zucker,¹⁵ Bob Withers,¹⁶ James Caspian,¹⁷ and La Scapigliata (a GP writing anonymously),¹⁸ who each have extensive professional backgrounds in the area, all counter the kind of relentless transitioning logic contained in the New Zealand Guidelines. The Guidelines make no reference to any such research, nor do they mention the risk of overdiagnosis – giving treatment to people who later detransition. Given that this important information is missing, it could be argued that the affirmative-only approach to care is in contravention of the usual conditions for making an informed choice.¹⁹ The Guidelines rely instead on a version of informed consent that:

*involves several conversations between the person and clinician(s) before they start treatments that have an irreversible component to increase certainty that they are adequately prepared and are making a fully informed decision.*²⁰

Between 2016 and 2019, the Tavistock Gender Identity Development Service (GIDS) in the United Kingdom was hit by 35 resignations of psychologists.²¹ Concerns raised by six of them involved overdiagnoses of gender dysphoria, with too many children being put on puberty-blocking drugs. They said they

were unable to properly assess patients because of fears they would be branded “transphobic”.

I didn't feel able to voice my concerns, or when I did I was often shut down by other affirmative clinicians. ²²

Another former staff member thought it unlikely that anyone presenting at the clinic would be directed away from a trans identity.²³

It seems highly likely that the same factors are in play in New Zealand transgender medicine. No-one has yet broken their silence, yet private conversations with health professionals indicate there is much disquiet about the current approach.

1.1 Existing mental health problems and/or trauma in those presenting with gender dysphoria

United Kingdom studies of the Tavistock GIDS, carried out by a New Zealand sociologist, Professor Michael Biggs of Oxford University, revealed that 35% of those attending the clinic presented also with autism syndrome conditions. The balance had a high rate of pre-existing mental health problems, self-harm, trauma, sexual abuse and chaotic and troubled family lives.²⁴

A former staff member of the clinic reported that:

*There are children who have had very traumatic early experiences and early losses who are being put on the medical pathway without having explored or addressed their early adverse experiences. At GIDS no one directly tells you that you're not allowed to suggest that perhaps these early experiences might be connected to a child's wish to transition but if you make the mistake of suggesting this in a team meeting you run the risk of being called transphobic.*²⁵

Psychotherapist Marcus Evans observed from his long experience of the Tavistock that:

*Patients who had a history of serious and enduring mental illness or personality disorder sometimes would also develop gender dysphoria. A common theme in their presentations was the belief that physical treatments would remove or resolve aspects of themselves that caused them psychic pain. When such medical interventions failed to remove their psychological problems, the disappointment could lead to an escalation of self-harm and suicidal ideation, as resentment and hatred towards themselves was acted out in relation to their bodies.*²⁶

American researchers, too, have found that:

There is also growing evidence [that] childhood abuse, neglect, maltreatment, and physical or sexual abuse may be associated with [Gender Dysphoria]. Individuals reporting higher body dissatisfaction and GD have a worse prognosis in terms of mental health. And...individuals with GD are found to have higher rates of depression, suicidal ideations, and substance use.²⁷

In another United States study,²⁸ parents said the clinicians they saw were resistant to even evaluating their child's pre-existing and current mental health issues and were only interested in fast-tracking gender-affirmation and transition.²⁹

What of New Zealand? Whereas earlier treatment advice issued in 2011³⁰ recognised frequent mental health comorbidities, that recognition has disappeared from the 2018 Guidelines. However, a self-reported survey issued in 2019, *Counting Ourselves*, reports high or very high levels of psychological distress in over-15-year-olds – 71% of the sample, compared with only 8% of the general population. The survey reports that “*more than half of the participants (56%) had seriously considered suicide in the last 12 months*” and more than 40% reported that they had deliberately injured themselves in the previous year.³¹

Surprisingly then, Waitematā District Health Board records from their youth services showed no instances of other mental health conditions in young people presenting with a gender identity disorder,³² despite the high levels of mental distress, suicidal ideation and self harm that were reported in the *Counting Ourselves* survey.³³

What needs to be examined is the possibility that the pre-existence of these morbidities may dispose some young people towards adopting a transgender identity at a time when being transgender is actively promoted as the answer to any psychological sense of anxiety or unease about, or disconnection from, the sexed body.

1.2 Stereotypes and homophobia as spurs to seeking transition

There has been little consideration of the cause of the rising numbers deciding to adopt a transgender identity. However, some thought is being given to the difficulties of female and lesbian and gay lives and the possibility that this is a spur to transitioning. Amongst the ideas receiving attention are the limiting and stereotyped expectations of behaviour, especially for girls; the promotion of ideas that gender change is possible and is trendier and more acceptable than just being homosexual; prior sexual abuse and trauma, as discussed above; and the increasing extent to which young people get their ideas about sexuality from pornography,³⁴ including pornography that is violent. These may each be playing a role in making the experience of adolescence more of a challenge than previously. In this respect there are similarities between the adoption of a transgender identity as a maladaptive

coping mechanism for dealing with trauma or societal expectations of womanhood, in the same way that has long been recognised in terms of anorexia and alcohol and drug use.³⁵

Transition as a drive to escape one's gender/sex, emotions, or difficult realities might also be considered when the drive to transition arises after a sex or gender-related trauma,³⁶ or within the context of significant psychiatric symptoms and decline in ability to function. Although trauma and psychiatric disorders are not specific for the development of gender dysphoria, these experiences may leave a person in psychological pain and in search of a coping mechanism.³⁷ With specific reference to the rise in numbers of young women transitioning, another researcher comments:

*My fear—and I am hardly alone in this—is that adopting a transgender identity has become the newest way for teen girls to express feelings of discomfort with their bodies—an issue adolescent girls typically experience. The problem here is that many young women are seeking transition after coming to identify as transgender, and transition can have extreme consequences.*³⁸

That homophobia plays a role in this issue is recognised as coming into play from an early age. Research has shown that homophobic name-calling causes children to internalise the messages they receive from peers and incorporate these messages into their views of themselves.³⁹ When children with gender dysphoria are aided through therapy instead of treatment, or 'watchful waiting' is practised, many will grow up to be lesbian or gay.⁴⁰

Many professional clinicians make assumptions that a non-conforming child who, for instance, prefers the toys usually played with by the opposite sex, is a 'trans' child, rather than a child who may grow up to be gay or lesbian – or, of course, neither. Stereotyping of roles is inherent in the very tool laid down for diagnosis by the American Psychiatric Association, the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition*. Criteria for recognition of gender dysphoria in children include:

In boys (assigned gender), a strong preference for cross-dressing or simulating female attire or, in girls (assigned gender), a strong preference for wearing only typical masculine clothing and as strong resistance in the wearing of typical feminine clothing.

A strong preference for cross-gender roles in make-believe play or fantasy play.

A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.

*In boys (assigned gender) a strong rejection of typically masculine toys, games, activities and a strong avoidance of rough-and-tumble play or, in girls (assigned gender) a strong rejection of typically feminine toys, games, and activities.*⁴¹

That such behaviour in children could be indicative of later identification as lesbian or gay was recognised by some former staff from the UK Tavistock GIDS.⁴² In 2019, in an article in *The Times*, some voiced their concern at the approaches taken at the clinic:

So many potentially gay children were being sent down the pathway to change gender that two of the clinicians said there was a dark joke among staff that “there would be no gay people left”.

“Young lesbians considered at the bottom of the heap suddenly found they were really popular when they said they were trans.”

A clinician said: “We heard a lot of homophobia which we felt nobody was challenging. A lot of the girls would come in and say, ‘I’m not a lesbian. I fell in love with my best girl friend but then I went online and realised I’m not a lesbian, I’m a boy. Phew.”

Several clinicians suspected that some of the “transgender” adolescents were reacting to homophobia at home. “For some families, it was easier to say, this is a medical problem, ‘here’s my child, please fix them!’ than dealing with a young, gay kid.”⁴³

British psychotherapist Bob Withers, in a Radio New Zealand interview in February 2019, said:

I see in my practice people who are struggling with same sex attraction. And for some of those young people where they have a kind of implicit homophobia, it’s very attractive to say ‘look, I’m not really a proto-lesbian, gay, butch woman, I’m actually a man trapped in a woman’s body’. They actually feel more at ease identifying as a heterosexual man trapped in a woman’s body than a lesbian woman. What they may be suffering from is internalised homophobia which pushes them along the route to transition.⁴⁴

Anecdotal evidence tells us that while a few years ago New Zealand high schools usually had a few students identifying as gay or lesbian, now those schools have trans-identified students instead. The gays and lesbians have “disappeared”.⁴⁵

1.3 Desistance – Growing out of gender dysphoria

Earlier New Zealand guidelines, published in 2011, advised that

*“Many children claim to be in the wrong body or to wish that they were the “other gender”...Most of these children (**about three***

quarters) will not be trans adults, but many will retain some sexual preference or gender issues.” [Emphasis added]⁴⁶

The 2018 Guidelines, however, greatly modified this statement, merely commenting that:

Some previously gender expansive children may shift along the gender spectrum to find their gender identity more aligned with the sex assigned at birth.⁴⁷

Many overseas practitioners point to evidence that gender dysphoric children who are treated using a ‘watchful waiting’ approach largely desist, no longer identify as transgender as adults, and accept their bodies as they are.⁴⁸

Canadian sexual behaviour scientist Dr James Cantor has analysed three large-scale follow-up studies and a handful of small ones. He states that

Despite the differences in country, culture, decade and follow-up length and method, all the studies have come to a remarkably similar conclusion: Only very few trans-kids still want to transition by the time they are adults. Instead, they generally turn out to be regular gay or lesbian folks. The exact number varies by study, but roughly 60-90% of trans-kids turn out no longer to be trans by adulthood.⁴⁹

2. THE DANGERS OF PUBERTY BLOCKERS AND CROSS-SEX HORMONES

In New Zealand, the bar to being treated with puberty blockers is very low. The recently revised Ministry of Health website says that:

Blockers are a safe and fully reversible medicine....to help ease distress and allow time to fully explore gender health options.⁵⁰

The 2018 best practice advice says that:

Although some neurodiverse people may have difficulty in articulating their gender identity, this should not create an unnecessary barrier to access any relevant gender affirming services. Some people may express their gender identity non-verbally.⁵¹

In other words children who may have autism, or be unable to explain abuse, trauma or homophobia, may be put on puberty blockers even if they cannot properly express what they feel.

In the United Kingdom, Professor Biggs showed that there are more side effects and health risks to puberty blockers than those listed on the Tavistock GIDS patient consent form. Patients were not told the treatment was experimental; nor that the drugs used are powerful, off-label drugs, intended to treat prostate cancer in older men; nor that they have never been certified as safe and effective for treating gender dysphoria.⁵² Neither was information about the possible impacts on bone density provided to children and caregivers.

Biggs' examination of the clinic's reporting of its experiment showed that it contained basic statistical errors, that the results were not properly analysed, and that negative findings had been ignored. This issue received wide attention in the British media.⁵³

To date, the news from that 2019 research appears to have had no impact in New Zealand. However, the consent information provided in New Zealand raises similar concerns.⁵⁴ Gender dysphoric young people and their parents are not told about the experimental nature of the treatment, nor are they advised of all the known side effects. The earlier (2011) consent form for puberty blockers asked the patient to:

*understand that the medical effects and safety of long term use of GNRH blockers are not fully understood and there may be long term risks that are not yet known.*⁵⁵

Yet while possible changes to height, lower bone density, possible infertility and other factors are listed as risks in the 2018 Guidelines, the caution has disappeared.⁵⁶ The research references in the Guidelines do not appear to provide evidence of any long-term studies that explain why the caution is no longer relevant. Indeed, anecdotal⁵⁷ and experimental data from the United Kingdom⁵⁸ show that puberty blockers may have additional serious impacts beyond those already identified, such as long-lasting effects on brain function or severe impacts on mental health.

New Zealand's advice and consent information is similar to that of the United Kingdom. A healthy diet, exercise and possible bone densitometry tests are advocated, while osteoporosis is mentioned as a risk only for those with existing risk factors.⁵⁹ Neither the UK nor the New Zealand guidelines make clear that while absolute levels of bone density do not fall by using puberty blockers, puberty is a time when bone density should be increasing considerably – by about 20% –and puberty blockers inhibit this increase. Twenty percent is as much as bone density reduces during the remainder of a lifespan.⁶⁰ Children are potentially being put at risk of fractures and joint issues, with minimal advice about the potential seriousness of the problem.

Biggs' findings from the Tavistock GIDS also show serious mental health issues appearing as a side effect of puberty blockers. Following such treatment,

natal girls showed a significant increase in behavioural and emotional problems, [and parents found] a significant decrease in the physical well-being of their child.

In addition,

a significant increase was found to the suggestion “I deliberately try to hurt or kill myself.”⁶¹

In sharp contrast, the New Zealand Guidelines suggest that mental health is likely to improve. They attribute many of the mental health issues that transgender people suffer to ‘minority stress theory’. This theory suggests that poor mental health can be due to the societal effects of anti-transgender attitudes and not to the drug treatment or to individual histories and circumstances. To date, this theory has been neither proven nor disproven.

Questions need to be asked about the ability of children and young people to make an informed decision about treatment. The pre-frontal cortex of the brain that is responsible for judgment and risk assessment is not mature until the mid-twenties.⁶² If the rational part of the brain is not fully developed, what are the ethical implications of expecting children and teenagers to make vital, life-changing decisions, even if they are given full information about the risks or possible negative effects of treatment? In the justice system, we see arguments of neurological immaturity being used in the sentencing of young offenders, so surely the health system should be considering the same factors.

Transgender Trend is a group of parents, professionals and academics, based in the United Kingdom. It advocates a cautious approach of watchful waiting for young people with gender issues. It concludes its online review of puberty blockers as follows:

Ethical questions remain about the capacity of children to consent to a treatment which blocks their natural development at puberty, especially given the evidence that this locks them into a medical pathway resulting in sterility and potential loss of sexual function.⁶³

2.1 Long-term effects of treatment

The New Zealand Guidelines present treatment as something that requires urgency. But even the references it cites in support of transition are not entirely convincing. A systematic review of the effects of hormone therapy and patients’ quality of life after commencement of treatment concludes that:

*Hormone therapy interventions to improve the mental health and quality of life in transgender people with gender dysphoria have not been evaluated in controlled trials. **Low quality evidence** suggests that hormone therapy **may** lead to improvements in*

*psychological functioning..... However...this review is unable to offer conclusive evidence regarding the effects of hormone therapy on quality of life for transgender individuals overall. [Emphasis added]*⁶⁴

Transgender Trend's United Kingdom head, Stephanie Davies-Arai, says she sees every day "*how the mental health problems of our most vulnerable young people are often made worse after 'coming out' as trans*".⁶⁵

One study of transitioning shows there is a severe lack of long-term evidence of the benefits of transitioning.⁶⁶ A Swedish study looking at long-term outcomes showed that people who have transitioned surgically have significantly higher risks of mortality, suicidal behaviour, and psychiatric morbidity than the general population, which surely brings into question whether that treatment was the right approach for them.⁶⁷

The children and young people whose distress, beliefs and perceptions are, according to the New Zealand Guidelines, to be faithfully endorsed by clinicians, are not told that the changes are only cosmetic – that it is not actually possible to change sex and that gender and sex are not the same thing. The Guidelines advocate for the importance of gender, describing it as "*A person's concept of their self as male, female, a blend of both or neither*". The document even uses the expression "*sex assigned at birth*", which was until recently reserved for people with intersex conditions. Providing children and young people with this confusing information could be a spur to their decision to transition, even as it misleads regarding what is possible. As Dr Heather Brunskell-Evans argues:

*The child needs to be made aware that procedures, including the prescribed hormones that accompany genital surgery, will only create the **appearance** of sexual characteristics that differ from her or his chromosomal makeup. The human body is a whole organism, and seeks homeostasis, or internal stability. Interventions – whether surgical or hormonal – cannot actually create the desired sexed body, but can only modify the appearance and functioning of the child's own sexed body. [Emphasis in the original].*⁶⁸

It is possible that this mismatch – being sold a false idea of what change is actually possible – contributes to the poor short-term and long-term results for transgender patients, post medication and surgery.

Meanwhile, children who move directly from puberty blockers to artificial sex hormones will inevitably become sterile and boys' penises will remain immature – at the size of a child's, into adulthood.⁶⁹ Given these permanent consequences, the question of young people's ability to make decisions about their treatment must surely be considered.

Indeed, unease about the treatment practices is beginning to lead to official investigations. In Sweden, an enquiry is underway following public criticism that hormone treatment and surgery on children is a "big experiment" that

risks becoming one of the country's worst medical scandals.⁷⁰ The United Kingdom has a ministerial investigation in process, while the Royal College of Paediatric and Child Health has begun a review of gender dysphoria treatment from an ethics standpoint, including the use of pubertal suspension.⁷¹ The United Kingdom GIDS clinics are also the subject of a High Court case taken by a former staff member, the parent of a transgender child and a young detransitioned woman.⁷²

Closer to home, In Australia, the Minister for Health in 2019 asked the Royal Australian College of Physicians (RACP) – the body that also covers New Zealand's physicians – to assess the issue of healthcare for trans children. This stemmed from a complaint by a group whose concerns centred around the Melbourne Royal Children's Hospital guidelines for treatment that includes gender affirmation, puberty blockers and hormone therapy for those under 18. However, in early 2020, the RACP dismissed the idea of a national inquiry, saying this would “*further harm vulnerable patients and their families*”. Instead, the College called for Australian governments to improve access to care across the states and territories, possibly through a national framework, as well as funding for research on the long-term outcomes for care and treatment of gender dysphoria. In a letter to the federal Minister of Health, the College cited the WPATH and New Zealand guidelines and did not mention the rapid increase in numbers or the alternatives to affirmation. It appears that only those physicians using the evidence base provided by transgender ideology and affirmative approaches were consulted about the letter.⁷³

3. IDEOLOGICAL INFLUENCE AND THE RISE IN NUMBERS

The change in approach to transgender medicine is international. It is associated with recently formed beliefs about the existence of ‘gender identity’, separate from sex, sex roles or sex stereotypes. Accompanying this is an enormous increase in the numbers of young people reporting their feelings of gender dysphoria and, more importantly, those feelings being interpreted as a medical problem of being ‘born in the wrong body’ and needing to be supported with ‘gender change’.

The work of aligning bodies with perceptions in children and young people starts with social transformation to the opposite gender. Puberty blockers can be administered from the age of 10 to prevent the activation of sex hormones and the development of secondary sexual characteristics.

While there have always been examples of individual people, usually men, wishing to present and live as the opposite sex, the rise of gender ideology – the idea that gender is innate, that biological sex is irrelevant, that a person is the gender they perceive themselves to be – began only in the 1990s. It arose from queer theory, initially taught in gender studies courses in universities. Its

influence now has caused a major ideological split. On the one hand are those who believe that the material reality of biological bodies is what defines us, and that gender is a social construct imposed by societal rules and expectations. On the other hand are those who believe that perceived gender is what counts, that one can be born in the 'wrong body', and that changing one's body to fit one's perceived gender is the path to take. The conflating of the concepts of sex and gender is a major contribution to this disagreement. It is beyond the scope of this paper to go further into this ideological split. Suffice it to say, current evidence is that those lobbying for what they describe as transgender rights are wielding sufficient power to be having an enormous influence in the medical field, and across society more broadly.

Marcus Evans, who was a practitioner and then a governor of the Tavistock GIDS in London, resigned from the clinic in protest at its affirmation-only practices. He comments:

What's worse, the effort to suppress unfashionable views has been joined by some leading organizations, including the American Academy of Paediatrics (AAP), whose policy statement on the issue...endorses[es] gender affirmation as the only acceptable approach...The AAP's approach, like that implemented by many clinicians at GIDS, appears to be driven more by political ideology than the clinical needs of presenting children.⁷⁴

3.1 Increase in numbers

There is a massive increase in young people seeking to transition. Reports from the United Kingdom indicate a 30-fold increase over the last decade in children and young people treated at the Tavistock GIDS in London.⁷⁵ In 2009/10 there were 97 referrals to GIDS, the majority being boys. In 2018/19 there were 2,590 referrals, 75% being girls. The clinic sees children under the age of 18 and, in rare cases, some as young as three.⁷⁶

It is the alarming increase in the numbers of girls being referred for transitioning treatment that resulted in 2018 in the UK Minister for Women and Equalities ordering the inquiry referred to above.⁷⁷

There appears to have been a similar sharp rise in numbers in New Zealand. Figures from the Wellington Endocrine Clinic show that in the years 2000-2007, annual first attendance rates were between 8 and 15 people identifying as transgender. In 2016, the number of referrals was 92 and by 2019 had risen to 193.⁷⁸ The Waitemata District Health Board, responding to an OIA request, offered figures beginning from only 2015/16. "[F]irst appointments by a person for the purpose of receiving gender affirming medical care" were recorded as 11 in 2015/16, 49 in 2016/17 and 90 in 2017/18.⁷⁹

Other than this information, it appears that record-keeping about transgender medicine in New Zealand, including the rapid increase and the associated

mental health conditions, has not been rigorous. The Wellington study reported that:

*There are few data on the prevalence of people identifying as transgender in New Zealand, and no indication as to whether the prevalence is increasing as it is in other countries.*⁸⁰

Official Information Act responses, too, report that the data is not being consistently collected.⁸¹

While there is a lack of data about reasons for the increasing rates of transgender identification in New Zealand, a clear factor could be the active promulgation of gender ideology taking place within all levels of education. Advocacy bodies such as Rainbow Youth and InsideOut,⁸² are delivering both to individuals and in communications to entire classes the belief that a child can be born in the 'wrong body'. Children should not be presented with ideological beliefs taught as facts.

There are recent examples in New Zealand of doctors and other health professionals so unquestioning of gender ideology that they are even suggesting to patients who present with other issues that they might be trans.⁸³ Is this happening because of something that is taking place in clinical training?

Unfortunately, there are moves to prevent therapeutic approaches that seek to help young people come to terms with their maturing body and sexual orientation by labelling such therapies as 'conversion therapy', on a par with gay and lesbian conversion therapy. This occurred in New Zealand in 2019, when the Justice Select Committee was considering a petition that would have outlawed homosexual conversion therapy. The Committee was urged by a petitioner to include transgender counselling that would have prevented counsellors and others from exploring the reasons why children and young people take on a transgender identity. The New Zealand government decided to delay the legislation, so the issues could be clarified.⁸⁴

Alongside the growing numbers of young people, especially young women, who are embarking on gender change is a growing movement of those regretting their decisions and deciding to detransition. Again, young women are highly represented in those numbers, with many realising that they are actually lesbians. In 2019, when a formerly trans-identified young British woman named Charlie Evans went public with her transition regret, she was contacted by several hundred others. They formed a group called the Detransition Advocacy Network,⁸⁵ to give them a voice and support in a contentious environment.⁸⁶

3.2 Influence of social media and social contagion

In 2018, Dr Lisa Littman, of Brown University School of Public Health in the USA, suggested social contagion among friendship groups and on social media as likely causes of the rapid increase in the number of adolescent girls presenting as transgender.⁸⁷ Littman coined the term 'Rapid Onset Gender Dysphoria' to describe this. Her research drew attention to a phenomenon that had attracted widespread concern among parents, but which had not yet been studied systematically in the scientific literature.⁸⁸

British psychotherapist James Caspian, who specialises in transgender cases, described a similar phenomenon:

*The young women that I had been hearing from said they had been drawn into trans as a kind of a movement. Many of them had discovered trans on the internet. They would spend hours online with a community of people that welcomed them. It seemed exciting, it offered promise as something that could resolve their considerable difficulties. But of course it didn't. Then when they detransitioned, that community rejected them.*⁸⁹

3.3 Lobby groups set the treatment approach for children

Following the revelations emerging from Tavistock GIDS staff in 2019, Transgender Trend UK commented that:

*Transgender lobby groups have been allowed to dictate an unquestioning 'affirmation' approach towards children and young people through pressure applied to the NHS [National Health Service], Tavistock GIDS and professional bodies, along with schools through the UK. These same transgender organizations lobby the NHS for drastic medical interventions at ever earlier ages, leaving children sterilised and with compromised sexual function.*⁹⁰

Tavistock clinical staff have spoken out about the pressures that were put on the clinic by transgender advocates, and efforts by some staff and board members to resist this.⁹¹

New Zealand, far from resisting any such pressure, has developed its treatment guidelines with input from transgender lobbyists, in an unusual example of patient-led medicine.⁹² An OIA response shows one public servant telling another that the Ministry of Health should change things because "*the community is not happy with them*", and then suggesting that progress "*would be worth signalling*".⁹³ It is therefore evident the Ministry of Health is working closely to community expectations. But the community in question is the transgender community of adults – not the part of the client base who are distressed children and adolescents. The medical model imposes a

transgender-affirmative-only worldview and an affirmative-only treatment regime on young people who may be confused or traumatised. Whose interests are being served by this? How can it be the right approach? Why has it been encoded in the Guidelines as if it is?

3.4 Gender change policy and research in an international context

The New Zealand Guidelines make reference to and rely on the World Professional Association of Transgender Health (WPATH), the international medical advocacy body that develops Standards of Care. But WPATH has been forced by transgender activists to fully adopt uncritical ideological perspectives.⁹⁴ Staff within the organisation have even been complicit in trying to *suppress* research on Rapid Onset Gender Dysphoria and desistance.⁹⁵ The organisation's reading list⁹⁶ ignores the same alternative voices as the New Zealand Guidelines do, despite arguing that it is evidence-based.

There is currently a hostile environment for scientific research on gender identity. To do research that contra-indicates the current pro-gender orthodoxy is to risk one's livelihood.

A former contributor to WPATH standards – Dr Kenneth Zucker, a Canadian (cited above) – was attacked by transactivists at a WPATH conference and cowed medics apologised for inviting him.⁹⁷ For recommending conservative treatment approaches, Zucker was fired from the clinic he had developed⁹⁸ – a decision that was later overturned.⁹⁹

In the United Kingdom, psychotherapist James Caspian had his proposed research into the experiences of people who had detransitioned rejected by Bath Spa University. Its ethics committee claimed that it was “politically incorrect”, might cause offence and could result in criticism of the university on social media.¹⁰⁰ After news of cancellation of the proposed research became public in 2017, Caspian was contacted by more than 50 people who had decided to reverse their gender assignment surgery.¹⁰¹

USA researcher Dr Lisa Littman's research (cited above)¹⁰² was withdrawn in the face of attacks. It faced an academic review and, when re-issued, the case it made was even stronger. However, she had already lost her consultancy job.¹⁰³ Dr Brunskell-Evans was sacked from the Women's Equality Party of which she was a founding member.¹⁰⁴ In Professor Michele Moore's case there has been a campaign to remove her as the editor of a prestigious journal.¹⁰⁵

Yet the accusations of ‘transphobia’ made against those who oppose gender orthodoxy lack substance. Transphobia is defined as including “fear, aversion, hatred, violence, anger, or discomfort felt or expressed towards people who do not conform to society's gender expectation”. Little evidence is ever presented that this is the case – the critics are not afraid of transgender

people. However, the accusation has become a default slur made by those whose intent is to shut down examination of the issues. It is made against anyone who opposes the relentless orthodoxy that sees gender change endorsed as the only outcome.

4. CONCLUSIONS: FIRST DO NO HARM

The authors of this paper do not deny the existence of gender dysphoria, or the distress it causes its sufferers. Our objective is the protection of children and young people. Gender dysphoria is by definition a disorder. Which other disorders are treated with affirmation? Would a doctor affirm an anorexic patient, agreeing with her that she is fat? These are mental health issues that need to be treated with psychotherapy, not physical intervention.

Pre-pubertal children are not mature enough to understand the risks they are taking with puberty blockers. Adolescents are not mature enough to make an informed decision about cross-sex hormones and surgery. The growing numbers of those regretting their decisions and speaking out about them should serve as a warning. There should be much more attention now paid to the phenomenon of detransition. While there is increasing anecdotal evidence of detransition, there are currently no mechanisms for tracking this growing trend.

Doctors are trained to heal, not to harm. Puberty is not a disease. Introducing puberty blockers is to introduce dis-ease into a natural, healthy body. Is there a precedent for this? Given the known risks of the drugs and the unknown long-term effects, it is pertinent to ask “What has happened to the principle of ‘First do no harm’?”. Where is the discussion on ethics?

The current data collection regime in New Zealand is inadequate. It appears that information related to mental health comorbidities is missing, despite the high levels of distress reported in the *Counting Ourselves* survey.¹⁰⁶ Full, accessible data is not being collected, nor collated nationally and there is no trend data. If, as appears from the Wellington study,¹⁰⁷ New Zealand is indeed experiencing the high rates of increase that have been observed overseas, with a significant reduction in age of presentation and a change in the sex of those presenting from mostly older and male to mostly younger and female, then this information is an important matter for both health policy and the public interest.

The 2008 Human Rights Commission report *To Be Who I Am*,¹⁰⁸ with its uncritical acceptance of the reality of gender identity, normalised the idea of transition as a solution to unhappiness with the body. This has been followed by extensive government and other funding to organisations that are working in schools, medicine and government departments to promote gender

ideology.¹⁰⁹ One youth worker stated that their role was to support people deciding whether to transition, and that they were aware of only one person who had ever discontinued a transition process once it was begun. A counsellor supporting transitioners commented that sex and gender were in a process of change and it was not possible to know how people would understand them in the future.¹¹⁰

Medical clinicians may think that the current toxic battles between gender ideologists and women's rights activists have nothing to do with them, that what they are dealing with are distressed individuals who need help. But the rising numbers of these individuals, and the ever lower ages at which they are being led to a doctor's door, should raise questions in the minds of practitioners as to what is driving such a recent phenomenon. Medical practitioners do not operate in a vacuum. They are an important part of society's fabric and are not immune from sociological movements and pressures, as the abortion and voluntary euthanasia issues well illustrate. There is always social context.

As shown in this paper, there is now increasing disquiet in many countries as clinicians, patients and parents begin to understand that the current treatment regime lacks a proper evidence base. How long can the New Zealand system persist in the face of overseas government reviews and court action? There are growing examples of harm and an increasingly vocal community of young people who not only regret their transitions but are able to explain that they belatedly understand the reasons for their beliefs. Their voices need to be heard.

From the evidence gathered in this paper, the following recommendations arise:

Ministry of Health

- Commit to linking actively with the transgender treatment reviews that are taking place in the United Kingdom, Sweden and Australia, to see what can be learned and applied in New Zealand.
- Halt all elective gender surgery and hormone treatment for those under 18 years of age.
- Begin to collate and analyse the data on the use of puberty blockers, sex hormones and elective surgery for people with gender dysphoria or with a self-diagnosis of transgender; and expand the detail of data collection to enable a much more comprehensive picture of what is happening in transgender medicine, including follow-up information.

Ministry of Education

- Remove from schools materials that teach students that sex is a spectrum. Replace these with materials that (a) demonstrate that gender is a social construct, and (b) encourage children to be happy in their own bodies.
- Provide materials that challenge and address gendered stereotypes of dress and behaviour.

Ministry of Justice

- When legislation to prevent homosexual conversion therapy is introduced, ensure it is made clear that this does not cover therapeutic practice with those suffering from gender dysphoria or who are considering or undergoing transgender treatment.
- Mandate relevant professional organisations to develop policies to prevent conversion therapy that acts by endorsing an assumed gender.

The authors of this paper give the last words to Standing For Women, a gender-critical feminist organisation in the United Kingdom, addressing an event on this topic at the House of Lords in London in May 2019:

At Standing For Women we firmly believe that if the general public understood what [is being done] to children, in the name of acceptance and progress, they would vehemently oppose it.... We ask [you] to do your own research and see if you can find any trusted resource that says what we are doing to children is good for their health; we ask you to look into the tactics of lobby groups and see if you are happy with the way they operate; we ask you to really think about the impact of puberty on a body and if you think stopping it for years is truly reversible; we ask you if you are happy to sterilise these children; to encourage the breast binding and surgeries on vulnerable young women. We ask you to think.¹¹¹

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109. Rainbow Youth Annual Charity Returns <https://www.register.charities.govt.nz/CharitiesRegister/ViewCharity?accountId=592fd82f-0ad5-dc11-8026-0015c5f3da29> Over the five years to 2019 Rainbow Youth more than tripled its annual revenue, from \$199,000 in 2013-4 to \$637,000 in 2018-9. Much of this is funded by government agencies, including the Ministry of Social Development (MSD). See <https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/official-information-responses/2019/february/20190204-details-regarding-msd-s-funding-of-rainbow-youth.pdf>. However, corporate and philanthropic donations are significant too.

Both InsideOut and Rainbow Youth are regularly funded by the Ministry of Youth Development, <http://www.myd.govt.nz/documents/funding/f20-funding/final-successful-applicants-from-2019-20-funding-rounds.pdf>, the Community Grants Scheme (COGS) <https://www.communitymatters.govt.nz/ask-us/view/1582>, and other public services agencies. This funding is for affirmative activities to adopting a transgender 'identity' that aligns with the stance adopted by the NZ Guidelines. For example, Rainbow Youth's website contains government-funded teaching resources for school classes. See <https://www.orangatamariki.govt.nz/assets/Uploads/Research/Inside-out/Inside-Out-Evaluation-Findings.pdf>. InsideOut has access to New Zealand's schools to promote affirmative policies to students and teachers both in person and with curriculum materials. See <https://www.rnz.co.nz/national/programmes/saturday/audio/2018727971/tabby-besley-advocate-for-lgbtqia-students> and <https://insideout.ry.org.nz/video-resources>

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