Effect of a Conversion Therapy Ban
on Treatment of Children with Gender Dysphoria

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May 4, 2020

In late April news broke in the UK on the subject of treatment for gender dysphoria.

On April 22 the ***Telegraph*** reported:

> "**Trans children to be banned from surgery to change their gender, the equalities minister announces**
>
> "Children who wish to undergo surgery to change their gender will be banned from doing so in future, the equalities minister has announced.
>
> "In a landmark move, which has been criticised by trans rights charities as introducing "a new form of inequality into British medical practice", Liz Truss said that the Government will set out details of the plans later this summer.
>
> "Currently, people under the age of 18 are allowed surgery but with parental consent."

On April 23 the ***Times*** reported:

> "**Transgender rules will change to protect wellbeing of under-18s**
>
> **"**Children who believe they are transgender face new curbs on gender reassignment treatment to protect them from "irreversible" decisions.
>
> "Liz Truss, minister for women and equalities, told MPs that the wellbeing of under-18s was a key principle that would guide her response to a review of government policy on gender identity.
>
> "Earlier this year, Britain's National Health Service set in motion both a review of puberty-blocking drugs and the rules pertaining to when youth are allowed to begin gender-transitioning.
>
> "Truss also informed the House of Commons that additional protections for female-only spaces are coming such as changing rooms, women's refuges, and restrooms."

The ***Times*** article also stated:

> "Last month, the Alabama state Senate voted to ban the use of puberty blockers, cross-sex hormones and body-altering gender surgeries on minors.

This comes on the heels of the *4,440 %* spike in Gender Dysphoria cases noted in my paper and the *resignation of 35 psychologists* from the Tavistock Gender Clinic in 2019 *due to concerns of utilizing gender affirming treatments and medications too quickly.*

In 'Conversion Therapy in Canada' Wells (2019) states ***that conversion therapy includes 'any attempt to change… gender identity*** (p. 2). Currently emerging therapy bans are very precise in

their conclusions that gender dysphoric (GD) and transgender individuals should **not** be exposed to "conversion therapy" as identified by activists – i.e. ***the affirmation of birth gender***.

I wish to present to **you a summary of research and evidence** pertaining to the issue of Gender Identity and the Transgender movement.

According to the **American Psychiatric Association's DSM (Fifth Edition, 2013**), rates of **persistence of Gender Dysphoria** into adulthood are very low. **Resolution of biological sex** confusion occurs in up to **97.8% of boys and as many as 88% of girls** (American Psychiatric Association 2013 p. 455). This means that the vast majority of these children no longer continued to exhibit signs of Gender Dysphoria as adults.

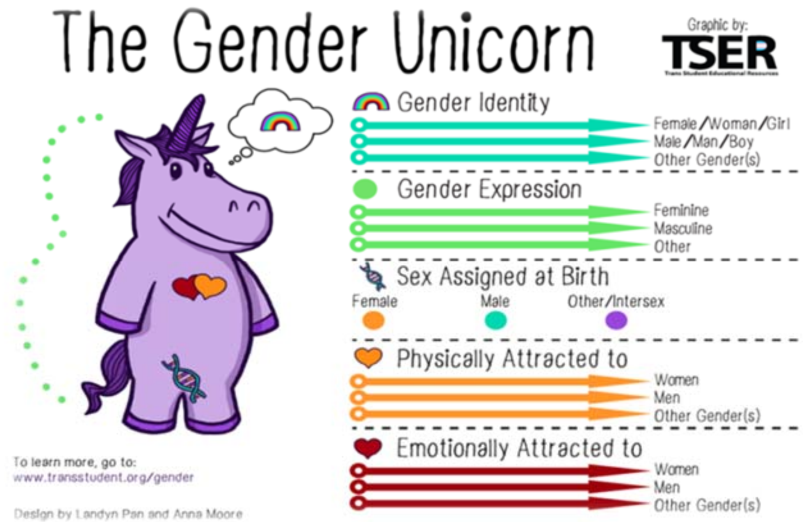
What has happened in the last several years is the development of a new category of personhood – the Transgender Child or Adolescent. Transgender is not a scientific or medical term. It is an activist and political term that has gained incredible acceptance due to media representation along with an educational agenda to train children under the guise of acceptance and diversity Such curriculum is now deeply ensconced in all levels of education and in each field of study (Biggs, 2019 in Brunskell-Evan and Moore, Eds, 2019, p.18).

The **result of such teaching at young ages has literally changed the brains of our children**. We now know that children are often confused with such teaching, even to the point of changing their "identity" several times a day. Daily affirmation by trusted adults that a boy is a girl or a girl is a boy, is likely to have a self-fulfilling effect.

According to Barbara Kay of the National Post (2019), "one Ontario family is asking a school board to ensure that lessons do not devalue, deny or undermine the female identity. The family filed a human rights complaint after their six year old watched two YouTube videos in school: "He, She and They?!?—Gender: Queer Kid Stuff #2." The video contained statements such as, "some people aren't boys or girls," and that there are people who do not "feel like a 'she' or a 'he,'" and therefore might not have a gender. The young teacher, whom I will refer to by her initials, JB, continued to teach gender theory throughout the semester. According to N's feedback to her mother, JB told the children that "there is no such thing as girls and boys," and "girls are not real and boys are not real" (June 25, 2019).

The child even asked her parents if she could go "to the doctor" to discuss the fact that she was a girl. The parents became alarmed by their daughter's confusion. She had never shown any signs of being confused about her gender before (Lawrence, Lifesite News, June 28, 2019).

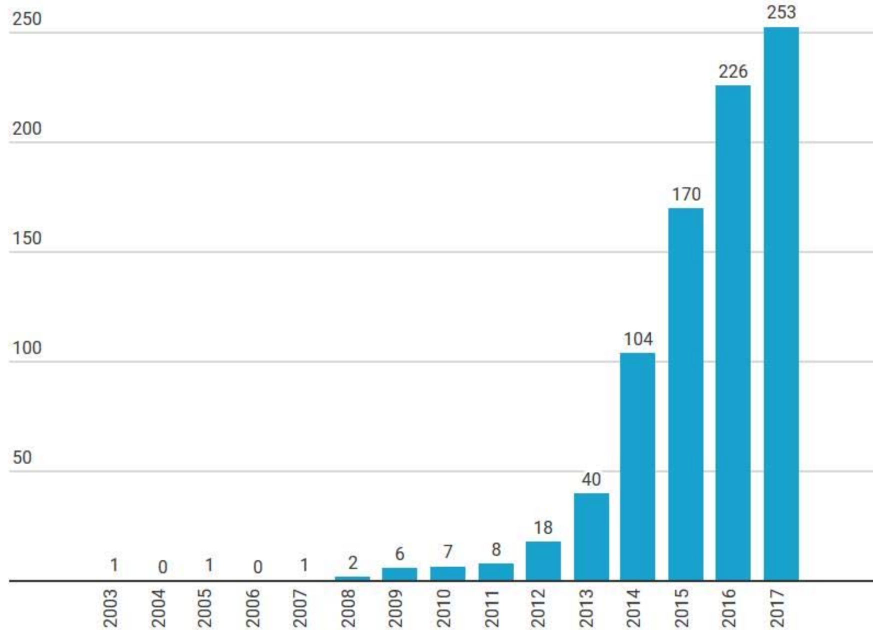
I would suggest Canadian children would benefit tremendously by minimizing such confusion rather than expanding it. We are now **experiencing an *exponential* rise in the number of children** and adolescents attending clinics either with a diagnosis of Gender Dysphoria or the



claim of being transgender, which I believe is the outcome of teaching on gender diversity as identified below in the Gender Unicorn (Sikkema, 2017) in our education system.

www.transstudent.org/gender

The following graph shows the rampant growth of referrals in one Australia hospital with a GD clinic from 2003 to 2017 (Hancock, 2018).



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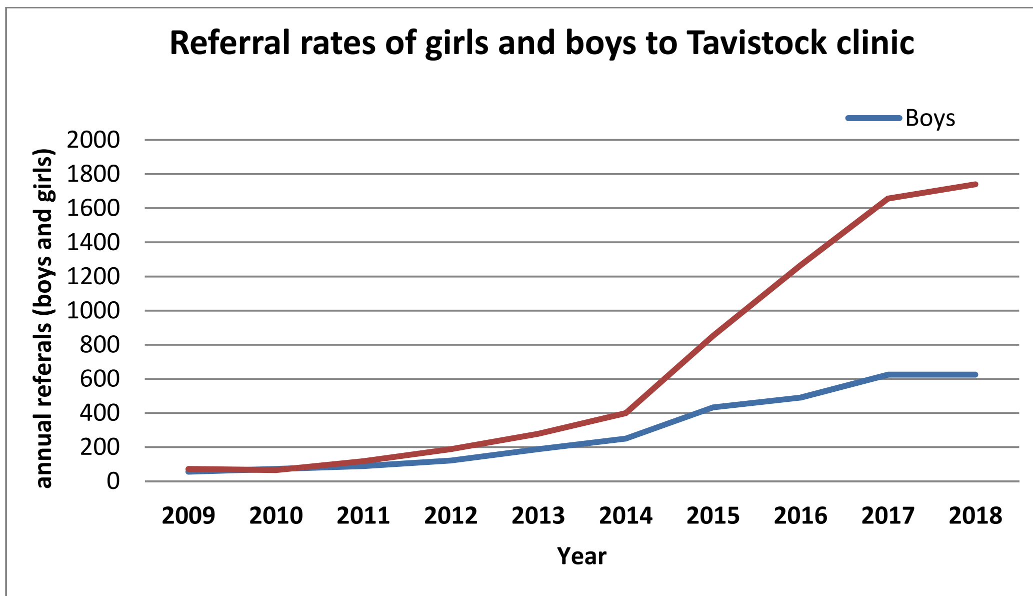


(*Transgender Trend*, July 1, 2019)

In both the graphs above note the rise from 1 or 0 admissions prior to 2008, then the aggressive growth of referrals since a "progressive" curriculum was implemented in elementary and high schools.

In 2018 CNSNews released a news report entitled "Transgender Kids in the UK: Number of Girls Jumps 4,415%, Number of Boys Rises 1,151%" (Bannister, 2018). "In 2017, 800 children were given drugs to stall the onset of puberty, including some aged 10, with some also given hormones to start the process of changing sex; 45 children age six or under were referred to the UK's National Health Service (NHS) for treatment, with at least one being only four years old" (Bannister, 2018).

The UK's Government Equalities Office is looking **into whether the influence of social media** and the teaching of transgender philosophy by the educational system have contributed to the striking increase in referrals (Rayner, 2018).

The Tavistock clinic opened 100 years ago and is world renowned in its application of Psychoanalytic ideas to the study and treatment of mental health. The Gender Identity Clinic is the largest and oldest in the UK. Last year Marcus Evans, one of the governors of The Tavistock and Portman NHS Foundation Trust resigned after accusing management of having an 'overvalued belief in' the expertise of its Gender Identity Development Service (GIDS) "which is used to dismiss challenge and examination" (Doward, 2019).

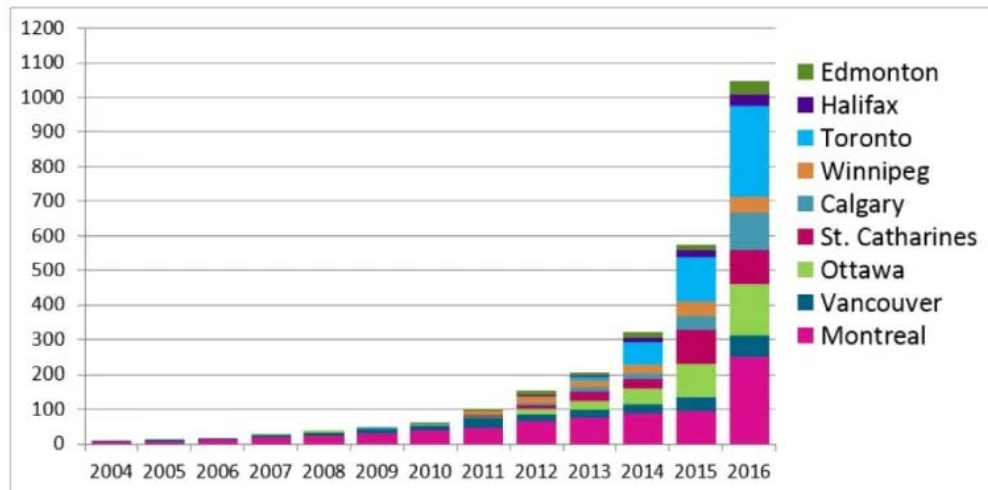
In **December 2019, the UK National Health Service warned of over diagnosing of children** having gender dysphoric treatment. According to The Telegraph (Laura Donnelly, December 12, 2019) since 2016, 35 psychologists have resigned from London's Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust. This service had 2,590 young patients referred to them last year, compared with just 77 patients a decade ago, over a thirty-fold increase (Lockwood and Lambert, 2019).

Carl Heneghan, director of the Centre of Evidence-Based Medicine at Oxford University asserts that "Given paucity of evidence, the off-label use of drugs [...] in gender dysphoria treatment largely means an unregulated live experiment on children (Heneghan, 2019, p.1).

Developments in Canada appear to be following the same trajectory as data reported in Australia and the United Kingdom. For instance the Hospital for Sick Children in Toronto reports that the number of GD related referrals they are receiving also has doubled since 2013. Stephen Feder, who co-directs the gender diversity clinic at the Children's Hospital of Eastern Ontario, explained that it's getting hard to keep up with the increasing demand his clinic is seeing. About a decade ago, Feder said his hospital would perhaps see one or two patients each year struggling with gender dysphoria. But in 2018, over 189 patients were referred to the CHEO gender clinic. The hospital serves patients living in eastern Ontario and western Quebec (Smith, March 6, 2019).

The following chart from Trans Youth Canada is broken down into Gender Dysphoric referrals by clinic across the country.

Pediatric patient referrals * to specialist clinics for hormone treatment for gender identity issues: 9 Canadian clinics



* Some referral numbers estimated. Some referrals are for prepubertal youth, though blockers are not prescribed prior to puberty.

* some referral numbers estimated — Lawson et.al (2017)

These reports seem to indicate the exponential spread of Gender Dysphoria and claims of Transgender identity. While not in the same category as a contagious disease, I would suggest that this ascending trajectory could indeed be considered a social contagion.

The Endocrine Society's guidelines suggest starting puberty blockers for transgender children when they hit a stage of development known as Tanner stage 2 — usually around 10 or 11 years old for a girl and 11 or 12 years old for a boy. The same guidelines suggest giving cross sex hormones — estrogen for transgender girls and testosterone for transgender boys — at age 16 (Hembree, et.al 2009). The **Canadian Medical Association Journal h**as published a review article **urging doctors to prescribe hormone blockers to "trans kids" as young as 10 years old** (Kirkley, 2019).

The current approach to the treatment of Gender Dysphoria in children and adolescents is to affirm their perceptions as reality. These guidelines are part of a commitment by medical professionals to 'affirm' a child's thinking that they are in the wrong body, supporting the highly experimental use of such medications for physically healthy children." ***These guidelines ignore decades of solid research on child development, as well as sound psychological interventions that act in the best interest of the child, parent, families and society***. Without ***thorough mental health assessments***, comorbid conditions such as Asperger's Syndrome, child abuse and neglect, early childhood trauma, disorganized parental attachment, etc., that have been discovered to be associated with Gender Dysphoria (formerly Gender Identity Disorder) teens are left untreated, thereby creating greater dysfunction and increasing the risk of suicidal

ideation. These children will be started on experimental medical interventions that have probable lifetime implications and many unknown risks. The medication will need to be taken for life, the multiple surgeries and body mutilation also continues with a high psychological, emotional, physical and financial cost.

As identified previously, children are receiving a multitude of messages that are likely to create gender confusion for a child.

Flawed Research?

In the early 2000s the National Health Service (NHS) of Britain was seen by gender specialists worldwide as a conservative outlier, offering puberty blockers only to young people aged 16 or over. Recognizing a weak evidence base for prescribing puberty blockers for children, the British Society of Pediatric Endocrinology and Diabetes recommended earlier use of puberty blockers but only as part of a research study (Cohen and Barnes 2019).

"In 2010 GIDS and University College London's Institute of Child Health applied for ethical approval to conduct a cohort study offering puberty blockers to a 'carefully selected group of adolescents; with gender dysphoria in early puberty" (Cohen and Barnes 2019, p.1). This **study has come under much criticism with critics saying the "researchers had downplayed interim findings that might suggest increased suicidality**" (p. 1). Despite the fact that the full study findings remaining unpublished, the National Health Service (**NHS) subsequently changed** its policy to allow Gender Identity Disorder Services (GIDS) to **prescribe these drugs to children under 12 in established puberty** (Cohen and Barnes, 2019, p. 1).

In 2014, just after the London study "had finished recruiting participants, NHS England approved policy changes to permit GIDS to offer puberty blockers as described in the study protocol, following evaluation" (Cohen and Barnes, 2019; p. 366). In addition to lowering the age limit from 16 to 12, as per the study, puberty blockers could now also be considered for children under 12 in established puberty declaring that the policy was changed on the basis of 'international evidence and clinical "expertise" (Cohen and Barnes 2019; p. 366).

Following the NHS change of policy regarding puberty blockers, the director of the Tavistock Gender Identity Disorder Service stated, "The results thus far have been positive." (Manning and Adams, 2014).

In **2019, new allegations came to light demonstrating that researchers might have broken rules** when seeking ethical approval. "Michael Biggs, an Oxford University sociologist, used freedom of information requests to obtain the early intervention study's protocol and information sheets for young people and parents and alleges that the GIDS has suppressed 'negative' data" (Cohen and Barnes, 2019, p. 1). **"Biggs concluded that data showed "no evidence for the effectiveness of GnRHa [puberty blocking drugs]…in addition, there is unpublished evidence that … puberty blockers exacerbated gender dysphoria" (Cohen and Barnes, 2019, p. 1).** Of further concern, Biggs found that **follow up has not been possible** because

transgender activists successfully lobbied the NHS to provide new numbers to patients as well as to change the 'gender' on their medical records.

Of the children placed on puberty blockers in the Dutch clinic that pioneered this treatment, every single one of them persisted in their transgender identity. For these children who persist in their transgender **identity, taking puberty blockers and then cross-sex hormones, leads to irreversible infertility (Greenall, 2019, p.1).** "Puberty blockers have not been certified as effective or safe in the treatment of gender dysphoria by the National Institute for Health and Care Excellence (NICE) or their manufacturers. They remain **an experimental treatment**, but new prescriptions were recently running at 300 per year (Greenall, 2019, p.1.).

Experts are extremely wary of speaking publically for fear of reprisal although they noted that the cohort study had no control group, outcome measures were not well defined and there was no definition of what would constitute a serious adverse event (Cohen and Barnes, 2019, p. 2).

While ignoring decades of successful treatment using wait and see or psychotherapeutic techniques***, the risk is that teens will be started on irreversible medical interventions that have lifetime implication and unknown psychological and physical risk. Those who regret transitioning are increasing in number and many are beginning to speak out*** (Transgender Trend (2016).

Multifactor Influencers in GD

As with homosexuality, there seem to be multiple influencers in the sexual development (Zucker, 2004; Zucker and Bradley, 1995) of children diagnosed with Gender Dysphoria.

The following list indicates just some of the complexities that therapists treating Gender Dysphoric children and youth need to be apprised of in order to effectively help the individual and family. "Affirmation only therapy" has become the only acceptable therapeutic treatment in Canada and resulted in the firing of Dr. Ken Zucker (Anderssen, 2016, Singhal, 2016) one of the forerunners and most respected clinicians and researchers on children experiencing Gender Dysphoria. There is little to no openness now to discussing the co-morbidity of conditions that exist with regard to Gender Dysphoria, but that does not negate the reality of mental health issues for this population.

1. Childhood traumatic experiences
    a. Tragic death of a loved one
    b. Sexual or severe physical abuse
    c. Shock of viewing death or disfigurement

2. Parental attachment systems
    a. Early childhood abuse

b. Foster home experiences
c. Adoption

3. Past or concurrent mental health problems
a. Anorexia
b. Autism Spectrum Disorder
c. Conduct Disorder
d. Personality disorders
e. Psychiatric disorders

The **potential link between Autism Spectrum Disorder (ASD) and gender dyspho**ria was noted by researchers as early as 1981, when they recognized that 10% of 30 children with a clinical diagnosis of autism had trouble answering a gender identity question ("Are you a little boy or a little girl?") that fewer than 1% of neuro-typical children of the same age struggle with (Vrangalova, 2017, p.1).

Gender dysphoria and Autism Spectrum Disorder are rare conditions. **Both conditions indicate low population prevalence rates "between 1 in 10,000 and 1 in 50,000 individuals exhibiting GD" (Zucker and Lawrence 2009 p. 8**). According to (Blumberg et al. 2013) between "1 in 50 and 1 in 500 individuals) exhibit ASD (in VanderLaan, et al. 2014, p.1). Significant increases in both conditions have been reported since 2007. "The magnitude of the increase was greatest for boys and for adolescents aged 14–17" (Blumberg et al. 2013, p. 1).

It wasn't until the 2010s that more systematic research on this topic began to emerge. Nine larger-scale studies have been published in medical and psychological literature, from the U.S., the UK, Canada, Finland, the Netherlands, identifying Autism Spectrum Disorder (ASD) as a contributor to gender dysphoria (Vrangalova, 2017) . Across all of these studies, almost without exception, rates of ASD or autism traits range from 5% to 54% among those with gender dysphoria, significantly higher than among the general population (Vrangalova, 2017, p.1).

The APA 2014 Handbook confirms that "***there is possible evidence that psychopathology may be related to the development of transgender identity***" (Bockting 2014, p.1). The use of puberty blockers and hormone therapy has been criticized. In the past, some specialists prefer a wait & see or biological affirming therapy (Zucker 2004; 2018; Zucker & Bradley 1995; Zucker et. al 2002). Yet, the only sanctioned treatment for children, adolescents and adults in Canada who self-determine their identity, is to affirm this new identity. This is all done without exploring personal attachment and abuse histories, childhood traumas or other kinds or concurrent pathologies caused by such traumas.

I believe that this is just the tip of the iceberg as new Gender Clinics are opening to keep up with the new demand for service across North America. **This escalation in the diagnosis and treatment of 'transgender children and youth' would be considered an epidemic if it were regarding any other health issue (see Marchiano, 2018). I**t is definitely a condition ***in need of sound scientific research*** without the ongoing pressure from a repressive academia to suppress

such studies. According to Butler and Hutchinson (2020***) there is now a pressing need for research and services for gender desisters/detransitioners***.

Conclusion

And what does all this have to do with the conversion therapy discussion? The significance here is stated in the 'Conversion Therapy in Canada' document (Wells, 2019) which states that conversion therapy includes '***any attempt to change… gender identity*** (p. 2). ***Successful therapies practiced up to 2015*** (see Zucker, 2004; Zucker et al.,2002) which specified a 'wait & see' method and ***helped the child identify with their biological designation*** showed a ***success rate between 80 and 97%.*** Such a success rate for any therapy is ***astronomically high*** in the field of psychology.

These children were not given puberty blockers, did not risk infertility, increased suicidality and multiple health risks associated with puberty blockers and hormone therapy. 'Conversion therapy' in this sense was extremely successful. ***But if a "conversion therapy" ban is enacted, this treatment will be illegal!***

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