

# Is Gender Identity Discrimination a Religious Freedom Issue?

Prof. Patrick Parkinson, School of Law, University of Queensland

Paper for the Freedom for Faith Conference, Sydney, September 2019

*Currently, there are certain provisions in Australian law that exempt faith-based organisations from the operation of laws that prohibit discrimination on grounds of gender identity or 'being transgender'.*

*This paper explores whether there is a religious basis for discrimination on the ground of gender identity, with particular reference to how faith-based schools make decisions about children and young people who seek to transition to a new gender identity – with or without parental agreement. While it has long been the case that a very small proportion of people, from early childhood right through to adulthood, identify as feeling they are of the opposite sex, there are reasons to be concerned about the number of adolescents who are now claiming to be 'transgender' – especially natal females. The research indicates that many of these children and young people have multiple mental health problems or are on the autism spectrum, and may have experienced abuse and other adverse life events. There is also some evidence for social contagion amongst friendship groups.*

*The aetiology of transgender identification remains poorly understood from a medical perspective. Identification with a gender identity different to natal sex is often accompanied by various beliefs that are incapable of either validation or falsification by science. These include that biological sex and gender are two different things; that gender is what you feel, that gender is fluid, and that it is possible to be “non-binary”. These beliefs conflict not only with religious understandings of the created order, but also with a mainstream understanding that gender is innate and people are not just 'assigned' a gender at birth. The Christian response to children or young people who are experiencing gender identity issues must be pastoral and compassionate, and focused on their best interests; but this does not mean agreeing with their beliefs. There is thus a basis for a religious exemption to prohibitions on discrimination based upon gender identity, if the law is understood to require that the person be accepted as the gender with which they now identify. However, if the law is understood as requiring only that a person should not engage in discriminatory conduct (for example refusing service in a restaurant), then there is no valid basis for a religious exemption.*

*Beyond the issue of religious exemptions, there are compelling reasons not to legislate that any professional working with children or young people has to accept a young person's self-identified gender identity against his or her professional judgment. Schools need to be free to adopt a pastoral approach, guided by appropriate health professionals, and based upon their assessment of what is in the best interests of the child or young person.*

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## **The potential for conflict between self-declared gender identity and faith**

Issues concerning potential conflicts between religious beliefs and self-declared gender identity could arise in many different contexts. An issue may arise when a person of faith who does not share the beliefs of the person claiming a different gender identity is asked to treat that other person as a sex that they are not - in a biological sense. The issue may arise for the Catholic bishop faced with an application from a natal female who has undergone sex reassignment surgery to train for the priesthood. It may arise if a church, which does not allow its premises to be used to solemnise a same-sex marriage, is asked to allow the church building to be used, for the normal fee, by a couple who are of the same biological sex but where one of them has legally changed sex based upon nothing other than self-declaration. It may arise for the Principal of a co-educational school who is asked by a parent to facilitate the social transitioning of a child into another gender, involving a change of name, school uniform and eligibility to participate in their preferred gender in sex-segregated sports or other activities. It may arise for the church youth leader faced with a request from a natal male to be recognised henceforth as female, with the consequence that the young person asks to sleep in the girls' dormitory at the church camp. It may arise from a demand that other people use the pronouns that a person chooses, even if those preferred pronouns are not hitherto recognised words in the English language.

It is one thing to ask me to respect your beliefs. It is another to ask me to act towards you as if I share your beliefs about you. In this lies the fundamental problem with laws prohibiting discrimination on the basis of gender identity.

## **Discrimination on the basis of gender identity**

It is unlawful to discriminate against someone on the basis of their gender identity in circumstances where their gender identity is irrelevant. So for example, it is unlawful to refuse service to someone in a shop or a restaurant because they are transgender, or appear as a male dressed in female clothing. This is so in Commonwealth, State and Territory law. These laws vary in their detail, but the general position is clear; just as it is unlawful to discriminate against someone on the basis of their race, or gender, or sexual orientation, so it is unlawful to discriminate against them on the basis of their gender identity.

Gender identity is, however, something different from sex, and the law that prohibits discrimination on the basis of gender identity does not necessarily mean that others must accept a person as the sex with which they identify for all intents and purposes. Believing oneself to be of another gender does not change biological sex. So for example, section 21 of the *Sex Discrimination Act* 1984 (Cth) provides:

- (1) It is unlawful for an educational authority to discriminate against a person on the ground of the person's sex, sexual orientation, gender identity, intersex status, marital or relationship status, pregnancy or potential pregnancy, or breastfeeding:
  - (a) by refusing or failing to accept the person's application for admission as a student; or
  - (b) in the terms or conditions on which it is prepared to admit the person as a student.

That is the prohibition; but there is an exemption in subsection (3):

(3) Nothing in this section applies to or in respect of a refusal or failure to accept a person's application for admission as a student at an educational institution where:

(a) the educational institution is conducted solely for students of a different sex from the sex of the applicant; or

(b) except in the case of an institution of tertiary education--education or training at the level at which the applicant is seeking education or training is provided by the educational institution only or mainly for students of a different sex from the sex of the applicant.

So a girls' school may refuse an application from a male irrespective of his gender identity, because it is a school for a particular sex. A subjective identification of oneself as really male or really female, notwithstanding a different natal sex, does not actually change one's sex – at least not in Commonwealth law. The law in Tasmania and Victoria may be different;<sup>1</sup> but these States apart, the fact that someone declares a different sex to their natal sex does not mean that one must treat them for all purposes as of the sex they declare. In NSW, for example, it is unlawful to treat a “recognised transgender person”, as being of the person's former sex.<sup>2</sup> However, that term is confined to those who, two doctors verify, have undergone what the law calls a “sex affirmation procedure”.<sup>3</sup>

There are also special provisions governing sports. For example, s.42 of the *Sex Discrimination Act 1984* (Cth) states that it is lawful “to discriminate on the ground of sex, gender identity or intersex status by excluding persons from participation in any competitive sporting activity in which the strength, stamina or physique of competitors is relevant.” Section 38P of the *Anti-Discrimination Act 1977* (NSW) provides:

Nothing in this Part renders unlawful the exclusion of a transgender person from participation in any sporting activity for members of the sex with which the transgender person identifies.

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<sup>1</sup> The *Births, Deaths And Marriages Registration Act 1999* (Tas.) as amended by the *Justice And Related Legislation (Marriage And Gender Amendments) Act 2019* (Tas.) allows a person 16 years or older to register “another gender” and for parents to do so for a child under 16 (s.28A). The choices of gender identification are not limited to male and female. The registered gender could be an “indeterminate gender”; or “non-binary”; or “a word, or a phrase, that is used to indicate a person's perception of the person's self as being neither entirely male nor entirely female” (s.3A). Section 28D, provides:

(1) If there is a registered gender in relation to a person, the person is, for the purposes of, but subject to, any law in force in this State, a person of that gender.

(2) Subject to subsection (3), a reference to a person's sex in any law in force in this State is taken to be, in relation to a person whose birth is registered in this State, a reference to –

(a) the registered sex, if any, in relation to the person; or

(b) the registered gender, if any, in relation to the person.

It is almost impossible to know what the effect of s.28D is if a person registers some form of non-binary identity but another Tasmanian law is written presupposing that a person is either male or female. The same problem arises from the *Births, Deaths and Marriages Registration Amendment Act 2019* (Vic.) which amends s.30G of the *Births, Deaths and Marriages Registration Act 1996* to the effect that after an alteration to the birth certificate is made “the child is a child of the sex as altered”. This could be any sex descriptor that is not obscene, offensive, or that could not practically be established by repute or usage.

<sup>2</sup> *Anti-Discrimination Act 1977* (NSW), s.38B(1)(c).

<sup>3</sup> *Births, Deaths And Marriages Registration Act 1995* (NSW) s.32C.

So a person's identified gender is not the same, in law, as a person's sex; but the law on this may vary from State to State and is quite confusing.

## Religious exemptions

In Commonwealth law, and in the law of some States and Territories, there are exemptions that apply to faith-based organisations in relation to discrimination on the basis of gender identity. In Commonwealth law, s.38 of the *Sex Discrimination Act 1984* creates exemptions for faith-based educational institutions that make it lawful to discriminate on a number of grounds, including gender identity, if the institution is “conducted in accordance with the doctrines, tenets, beliefs or teachings of a particular religion or creed” and the discrimination is “in good faith in order to avoid injury to the religious susceptibilities of adherents of that religion or creed”. This exemption applies both to employment of staff and issues concerning students.

In NSW, a similar exemption applies to all private schools, whether or not religious.<sup>4</sup> Furthermore, religious bodies have a broadly-based exemption from anti-discrimination laws in relation to appointments of people “in any capacity by a body established to propagate religion” and in relation to “any other act or practice of a body established to propagate religion that conforms to the doctrines of that religion or is necessary to avoid injury to the religious susceptibilities of the adherents of that religion.”<sup>5</sup> In Victoria, the *Equal Opportunity Act 2010*, s.83 provides a similar exemption for educational institutions where the discrimination conforms with the doctrines, beliefs or principles of the religion; or is reasonably necessary to avoid injury to the religious sensitivities of adherents of the religion. Other sections of the Act provide exemptions in other contexts where the discrimination is on the basis of religious belief.<sup>6</sup>

In all these statutory provisions, the exemption is not based on the fact that the person discriminating happens to hold religious beliefs; rather, the exemption applies where the discrimination is based upon those religious beliefs or done in good faith to avoid upsetting other adherents of the religion.

The religious exemptions, insofar as they apply to school students, may not survive proposed reforms to the *Sex Discrimination Act 1984*. Following a leak of recommendations by the Ruddock Panel on religious freedom,<sup>7</sup> a debate erupted about whether religious exemptions should continue to apply in relation to faith-based schools. This was crystallised in particular, as an argument about whether faith-based schools should be entitled to expel a same-sex attracted student – although

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<sup>4</sup> *Anti-Discrimination Act 1977* (NSW), s.38K(3).

<sup>5</sup> *Anti-Discrimination Act 1977* (NSW), s.56.

<sup>6</sup> *Equal Opportunity Act 2010* (Vic.) ss. 82, 84.

<sup>7</sup> Jewel Topsfield, ‘Religious Freedom Review Enshrines Right of Schools to Turn Away Gay Children and Teachers’ *The Age*, 9<sup>th</sup> October 2018, p.1.

there was little evidence that this had happened or would happen.<sup>8</sup> Two Bills were introduced into Parliament by opposition parties, one seeking the removal of any discrimination in schools (whether in application to students or staff), and the other seeking to remove any right to discriminate in relation to students.<sup>9</sup> The Government agreed with the Opposition parties that the exemptions in relation to school students should be repealed, and in practice this meant the repeal of s.38(3) of the *Sex Discrimination Act 1984* which applies not only to discrimination on the basis of sexual orientation but also on the ground of gender identity. The Government was unable to agree with the Opposition parties on the detail of the amending legislation beyond this, and so the issues were referred to the Australian Law Reform Commission.<sup>10</sup> In addition, the Australian Human Rights Commission is examining possible reforms to anti-discrimination laws, with an agenda of reducing exemptions contained in the legislation.<sup>11</sup>

## Gender identity discrimination in the context of educational institutions

There are some particular complexities about applying laws prohibiting gender identity discrimination in the context of schools. The *Sex Discrimination Act 1984* (Cth) defines gender identity as “the gender-related identity, appearance or mannerisms or other gender-related characteristics of a person (whether by way of medical intervention or not), with or without regard to the person's designated sex at birth.” The application of the law seems reasonably clear in relation to an adult who has medically transitioned, and probably to an adult who, notwithstanding the retention of the genitalia associated with his or her natal sex, has taken various steps to live in his or her preferred gender including change of name and, for a transgender female, form of dress. Discrimination against that person, for example by refusing services such as renting out a hotel room, is unlawful.<sup>12</sup> In such contexts, his or her gender identity is not materially relevant to the provision of the service. It may be different if that service is offered only to one sex, for example, where accommodation is provided solely for persons of one sex who are students at an educational institution.<sup>13</sup>

While the position in relation to adults ought to be reasonably clear, there is much less certainty about what the law requires in terms of the obligation not to discriminate against a young person who, hitherto known in the school by the name and gender in which he or she was registered when entering the school, declares a wish from henceforth to live in the school as the opposite gender.

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<sup>8</sup> For example, Anglican Christian school principals endeavoured to explain that they had never sought the right to expel same-sex attracted students and would never do so. See <https://sydneyanglicans.net/news/anglican-educators-write-open-letter-to-mps>.

<sup>9</sup> *Discrimination Free Schools Bill 2018*, introduced by Senator Di Natale (Greens), 16 October 2018; *Sex Discrimination Amendment (Removing Discrimination Against Students) Bill 2018*, introduced by Senator Wong (Labor), 29 November 2018.

<sup>10</sup> Attorney-General, Australian Government response to the Religious Freedom Review (December 2018): <https://www.ag.gov.au/RightsAndProtections/HumanRights/Documents/Response-religious-freedom-2018.pdf>.

<sup>11</sup> Australian Human Rights Commission, *Discussion Paper: Priorities for Federal Discrimination Law Reform* (2019).

<sup>12</sup> See further, Neil Foster, ‘Transgender discrimination law in Australia- uncertainties’ at <https://lawandreligionaustralia.blog/2019/07/21/transgender-discrimination-law-in-australia-uncertainties/>

<sup>13</sup> *Sex Discrimination Act 1984* (Cth) s.34(2).

That wish may be expressed in terms of adopting a different name, and seeking for others to treat him or her in accordance with that preferred gender identity.

The difficulty in applying the law on gender identity discrimination is that the law does not specify how mature, sustained and well-formed a person's transgender identification must be before the law gives that person legal rights that impose upon others correlative obligations. As a general principle, a young person's right to decide a matter for himself or herself is dependent on the capacity to understand whatever decision is involved.<sup>14</sup> This is known as "Gillick competence", but it is a vague standard. It provides a test by which a judge is able to reach a determination on the matter in the event of a dispute, but otherwise, in matters of long-term significance such as a decision to adopt a gender identity that differs from natal sex, reasonable people might differ as to whether a child or young person is of sufficient maturity to make that decision. If a school relies on parental consent for decisions on the basis that the child is not Gillick-competent, can it be said that an immature child has a "gender identity" that differs from their natal sex within the meaning of the law? Does a child who is not "Gillick-competent" have a gender identity by derivation from a parent's belief that the child has a gender identity different from his or her natal sex?

Put another way, a child or young person who is experiencing doubts about his or her gender identity will at some stage be at the beginning of a journey to transition from which he or she may later desist. Where, on that journey of transition, does a right not to be discriminated against begin and what follows from saying there is such a right in an educational context? This may depend on what the case about discrimination involves. If, for example, it could be proven that a school, or a teacher within the school, has ill-treated or humiliated a child or young person on account of a declared gender identity different to natal sex, a case for discrimination is likely to be made out; but what if, as is far more likely, a school declines a child's request to be known by a different name at school (reflecting a newly adopted identity) to be known as being of the other sex, to participate in sex-segregated activities of the other sex, and for pronouns associated with the other sex to be used as appropriate?

No discrimination issues are likely to arise if a school simply accedes to the child's wishes, or even the parent's wishes on behalf of the child. Accommodations such as choosing a name that could be either male or female, use of non-segregated toilet facilities if need be, and other work-arounds may give some support to a child on embarking on the journey towards "social transitioning" to another gender identity without the school simply affirming uncritically a new gender identity for a child or adolescent. In some cases, a school may accept expert advice from a clinician to accept the change, with the child or young person undergoing the first stages of transitioning, involving hormone treatments.

However, there are grave reasons for caution about this newly developing movement to affirm and

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<sup>14</sup> *Gillick v West Norfolk & Wisbech Area Health Authority* [1986] AC 112. The test of Gillick-competence was used in the Family Court's decisions on whether to approve medical interventions for gender dysphoria prior to its decision that the consent of the court was not, in any event, needed: *Re Kelvin* [2017] FamCAFC 258.

accept teenagers' declared change of gender identity<sup>15</sup> – for there are reasons to believe that in some cases at least, social contagion may be a major factor at work; in others, a young person's self-declaration of a new gender identity may result from pre-existing psychopathologies. In these situations, a claimed legal right not to be discriminated against may clash with the school's duty of care towards a child or, possibly, its obligations under child protection legislation. For example, there may be situations where a parent's unreasonable insistence that their quite young child is 'transgender' could warrant referral to the relevant child protection department on the basis that the parent is causing serious psychological harm to the child or that there is a risk that such harm will occur.<sup>16</sup>

## **Eight reasons for caution about self-declared transgender identity**

### *The growth in referrals to clinics for gender dysphoria*

The first reason is the exponential growth in referrals for young people with gender dysphoria. There have long been children, young people and adults who, while being genetically either male or female, have so strongly identified as being of the opposite sex that they have eventually taken steps to identify publicly as having a different first name and gender. Other males have long engaged in cross-dressing without changing their public identity.

In the past, being transgender has been a recognised, but quite rare phenomenon. It used to be classified as a disorder – gender identity disorder. It ceased to be pathologised in version 5 of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association. There, the term 'gender dysphoria' is used. It describes a condition, causing a person psychological distress, in which they experience a disconnect between their unambiguous physical characteristics (male or female genitalia) and their feelings about what gender they are or how they want to identify. Undoubtedly, for some this is a very distressing and enduring condition, which may be alleviated by engaging in hormonal and surgical treatments that have the effect of bringing a person's external appearance and genitalia more into concordance with their subjective gender identity.<sup>17</sup> Such treatment is not without risks and deficits however. For example, to maintain the appearance of the preferred gender, people need to take cross-sex hormones for the rest of their lives and this carries significant health risks.<sup>18</sup> The medical treatment may also render a patient sterile, depending on what

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<sup>15</sup> See generally, Pat Byrne, *Transgender: One Shade of Grey* (Wilkinson Publishing, 2018) for a comprehensive and critical review of the issues.

<sup>16</sup> See e.g. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s.23(1)(e) and s.27 – a school would have a duty to notify the Department if it considers that “a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm.”

<sup>17</sup> See e.g. E. Castellano and others, 'Quality of Life and Hormones after Sex Reassignment Surgery'. (2015) 38(12) *Journal of Endocrinological Investigation* 1373–1381.

<sup>18</sup> See e.g. Darios Getahun and others, 'Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study' (2018) 169(4) *Annals of Internal Medicine* 205–213 (effects of estrogen treatment in natal males).

treatments are provided.<sup>19</sup>

Given the extreme seriousness of the decisions involved, there is properly a concern that people who undergo processes of transition from one gender to another do so only when this represents the optimal treatment plan for a medically diagnosed problem. If the condition has a physiological origin, or if biological factors have a major influence on transgender identification, then one might expect the number of those with such problems to remain relatively stable over time as a proportion of the population. An exponential increase in the apparent prevalence of any illness, disease or disorder requires explanation. In the case of communicable diseases, analysis would likely include the pathways by which it is spread. In the case of other illnesses, reasons may be sought to determine whether there has been a real increase in the population-wide incidence, or whether the illness has previously been under-diagnosed.

It may be that gender dysphoria has been under-diagnosed in the past; but even acknowledging this possibility, consideration needs also to be given to the role of other factors. Gender identity issues are being widely talked about, and normalised in the media and entertainment industries. Transgender is the “T” in the popular acronym LGBTI, and in recent years a high profile has been given to transgender issues.

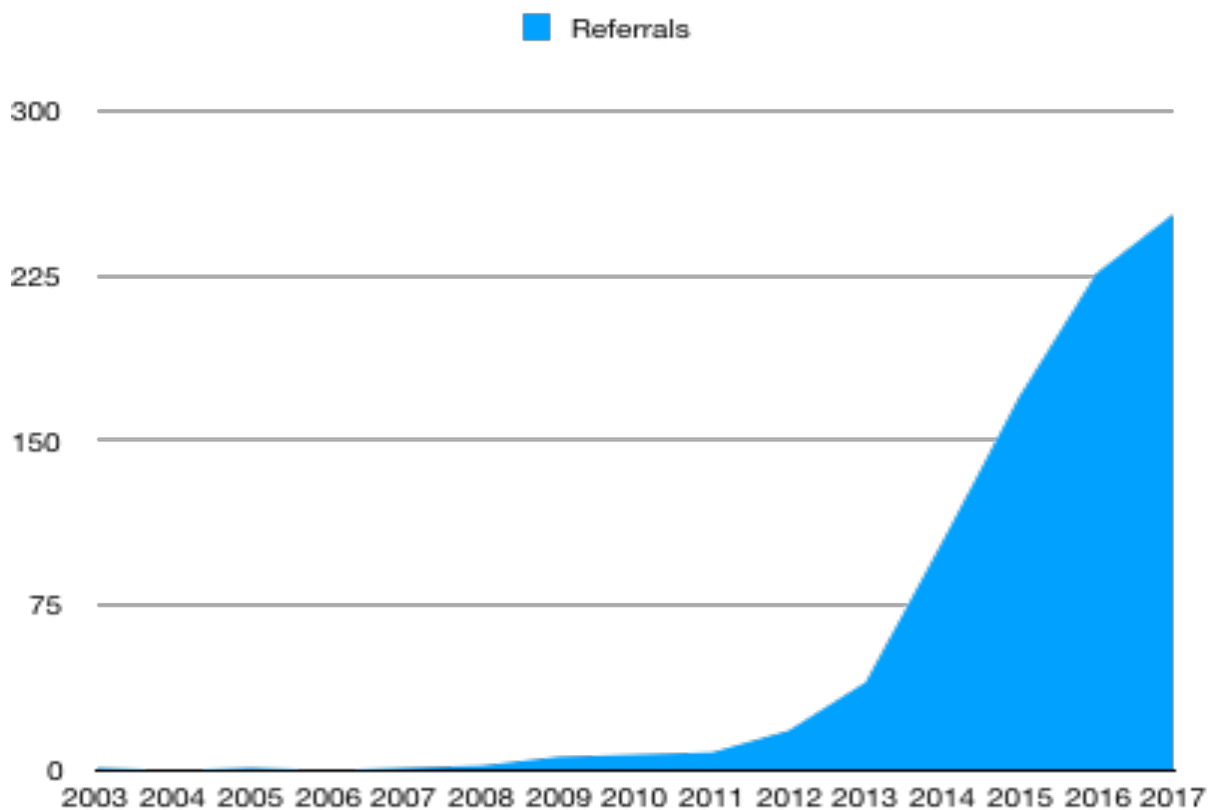
It is apparent in parts of Australia, as elsewhere, that the number of children and young people presenting at specialist clinics with gender identity problems has increased exponentially over a short period of time. For example, at a specialist clinic in the Royal Children’s Hospital, Melbourne, referrals have increased from one child or adolescent patient every 2 years after the clinic was established in 2003, to 104 new patients being in 2014.<sup>20</sup> By 2017 the number had increased to 253.

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<sup>19</sup> See generally, M. Telfer and others, *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* Version 1.1. Melbourne: The Royal Children’s Hospital; 2018 p.14.

<sup>20</sup> M. Telfer, M. Tollit, & D. Feldman, ‘Transformation of Health-care and Legal Systems for the Transgender Population: The need for Change’ (2015) 51 *Journal of Paediatrics and Child Health* 1051.





Referrals to the Gender Service at the Royal Children's Hospital, Melbourne.<sup>21</sup>

Exponential growth in the number of children and young people with referrals to such clinics has been reported elsewhere. For example, at the Gender Identity Development Service of the Tavistock Centre in London, there were 2,016 referrals for children and young people under 18 in 2016, more than six times more than the 314 referrals five years previously.<sup>22</sup> The Service, like others in the UK, is experiencing unprecedented demand, and now has a two year waiting list for a first appointment.<sup>23</sup>

*Percentage of adolescents identifying as transgender*

The second reason for caution about the new tendency to embrace a child or adolescent’s self-identification as transgender is that there is little correlation between estimates of adults who satisfy the clinical criteria for a diagnosis of gender dysphoria and the proportion of adolescents who will say they are transgender if asked in a school survey. That is, far more adolescents claim to be transgender than are clinically diagnosed as adults with gender dysphoria or who have undergone sex reassignment surgery.

<sup>21</sup> Source: <https://www.abc.net.au/news/2018-09-20/childhood-demand-for-biological-sex-change-surges-to-record/10240480>

<sup>22</sup> <https://www.telegraph.co.uk/news/2017/07/08/number-children-referred-gender-identity-clinics-has-quadrupled/>.

<sup>23</sup> <https://www.telegraph.co.uk/news/2019/08/23/two-year-waiting-times-nhs-gender-identity-clinics-amid-unprecedented/>.

In the DSM 5, rates for natal adult males are estimated at 0.005% to 0.014% of the population, and for natal females, from 0.002% to 0.003%.<sup>24</sup> A broader approach is to ask if adults self-identify as transgender. A study by the Williams Institute asked people in 19 States: "Do you consider yourself to be transgender?" If an explanation was sought for the question, the interviewer was asked to explain that if, for example, a man feels he is woman or lives like a woman, he is transgender'; 0.52% of respondents answered this question in the affirmative.<sup>25</sup>

However, school-based surveys yield much higher figures. A study of 9<sup>th</sup>-12<sup>th</sup> grade students in Boston schools conducted in 2006 found that 17 out of 1032 students reported being transgender (1.6%).<sup>26</sup> A survey of 2730 Californian students in years 6-8 conducted in 2011 found 1.3% identified as transgender when given the choice of male, female or transgender.<sup>27</sup> A larger-scale study of 8,166 high school students in New Zealand in 2012 found that 96 (1.2%) identified themselves as transgender, in response to a question: "Do you think you are transgender? This is a girl who feels like she should have been a boy, or a boy who feels like he should have been a girl."<sup>28</sup> An even larger percentage was found in a survey of nearly 82,000 students in Minnesota in 2016. The study found that 2.68% of students answered affirmatively to the question: "Do you consider yourself transgender, genderqueer, genderfluid, or unsure about your gender identity?"<sup>29</sup> This was more than double the number who identified as gay or lesbian.<sup>30</sup>

These surveys of adolescents should not be treated as reliable estimates of transgender people in the population. The proportion of those who answer such a question in a survey cannot be equated with the number who experience gender dysphoria in the clinical sense. Gender dysphoria cannot be diagnosed by survey. It is a medical diagnosis requiring careful assessment, using the diagnostic criteria in the DSM 5.<sup>31</sup> In any event, it is difficult to know what students mean when they say, in response to a survey of this kind, that they are 'transgender', 'genderqueer', or 'genderfluid'. They may be doing little more than signalling that they do not see themselves as fitting into stereotypical notions of what it means to be male or female. Alternatively, they could be indicating adherence to a particular belief or worldview about gender.

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<sup>24</sup> American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, (5<sup>th</sup> ed, 2013) p. 454.

<sup>25</sup> A Flores and others, *How Many Adults Identify as Transgender in the United States?* (Williams Institute, UCLA, 2016) p.7 at <http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf>.

<sup>26</sup> Joanna Almeida and others, 'Emotional Distress Among LGBT Youth: The Influence of Perceived Discrimination Based on Sexual Orientation' (2009) 38 *Journal of Youth and Adolescence* 1001.

<sup>27</sup> JP Shields and others, 'Estimating Population Size and Demographic Characteristics of Lesbian, Gay, Bisexual, and Transgender Youth in Middle School' (2013) 52 *Journal of Adolescent Health* 248–50.

<sup>28</sup> Terryann Clark and others, 'The Health and Well-being of Transgender High School Students: Results from the New Zealand Adolescent Health Survey (Youth'12)'. (2014) 55 *Journal of Adolescent Health* 93–99.

<sup>29</sup> Laura Baams, 'Disparities for LGBTQ and Gender Nonconforming Adolescents' (2018) 141(5) *Pediatrics* e20173004. For another analysis of the same dataset, see Nicole Rider and others, 'Health and Care Utilization of Transgender and Gender Nonconforming Youth: A Population-Based Study' (2018) 141(3) *Pediatrics* e20171683.

<sup>30</sup> Baams, *ibid*, Table 1 (1.27% identified as gay or lesbian and 4.98% as bisexual).

<sup>31</sup> Above n. 24.

Research on adolescents' self-identified sexual orientation demonstrates that a higher proportion of teenagers than of adults<sup>32</sup> will at some stage identify as gay, lesbian or bisexual,<sup>33</sup> but this identification is often transitory; for a substantial proportion of adolescents, self-identification as gay or lesbian does not persist into adulthood.<sup>34</sup> The disparity between the number of adolescents identifying as transgender and reliable estimates of the prevalence of gender identity issues in the adult population is similar to patterns for reported same-sex attraction. Could it be that many of the adolescents who respond in surveys that they are 'transgender' will not so identify a few years later?

There is no particular risk if young people tick the box on a survey to indicate that they consider themselves to be transgender. The issue arises if they go on to draw the conclusion that as a consequence, they need to seek hormone treatment in order to change their gender presentation.

#### *Gender ratio of adolescents claiming to be transgender*

The third reason for caution is that a much greater percentage of adolescent girls identify in surveys as transgender or having gender identity issues than would be expected from established patterns in the adult population. Among adults, the consistent evidence has been gender identity issues are most commonly experienced by biological males. This is reflected in the prevalence estimates given in the DSM 5.<sup>35</sup> Consistently with these estimates, studies in the past suggest that at least three times as many men identify as transgender as do females,<sup>36</sup> and, the ratio may be as high as 6-1,<sup>37</sup> although

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<sup>32</sup> Large-scale surveys in England, Australia and the USA put the figures on same-sex orientation in the adult population as between 1% and 3%. One of the largest studies ever conducted was a survey of 238,206 respondents in Britain in 2009–10. It found that 0.9% of the population identified as lesbian or gay, and a further 0.5% as bisexual. T. Joloza, J. Evans and R. O'Brien, *Measuring Sexual Identity: An Evaluation Report* (Office of National Statistics, London, 2010). In a study in Australia of 17,476 persons aged 15 years or older, 1.4% identified as gay or lesbian, and another 1.4% as bisexual: M. Wooden, *The Measurement of Sexual Identity in Wave 12 of the HILDA Survey (and Associations with Mental Health and Earnings)* Hilda Project Discussion Paper Series No. 1/14, February 2014. For similar figures in the US, see B. Ward and others, 'Sexual Orientation and Health among US adults: National Health Institute Survey 2013', (2014) 77 *National Health Statistics Reports*, 1; R. Savin-Williams, K. Joyner, & G. Rieger, 'Prevalence and Stability of Self-reported Sexual Orientation Identity during Young Adulthood' (2012) 41 *Archives of Sexual Behavior* 103.

<sup>33</sup> See e.g. Terryann Clark and others, *Youth'12 Overview: The Health and Wellbeing of New Zealand Secondary School Students in 2012*. The University of Auckland (2013).

<sup>34</sup> R. Savin-Williams & G. Ream, 'Prevalence and Stability of Sexual Orientation Components During Adolescence and Young Adulthood'. (2007) 36 *Archives of Sexual Behavior* 385; R. Savin-Williams, K. Joyner, & G. Rieger, above n.31; R. Savin-Williams, & K. Joyner, 'The dubious assessment of gay, lesbian, and bisexual adolescents of Add Health' (2014) 43 *Archives of Sexual Behavior* 413; Y. Hu, Y. Xu, & S. Tornello, 'Stability of Self-Reported Same-Sex and Both-Sex Attraction from Adolescence to Young Adulthood' (2016) 45 *Archives of Sexual Behavior* 65; M. Ott and others, 'Stability and Change in Self-Reported Sexual Orientation Identity in Young People: Application of Mobility Metrics' (2011) 40 *Archives of Sexual Behavior* 519.

<sup>35</sup> Above n. 24.

<sup>36</sup> International statistics are found in G. De Cuypere and others, 'Prevalence and Demography of Transsexualism in Belgium' (2007) 22 *European Psychiatry* 137.

<sup>37</sup> See e.g. J. Veale, 'Prevalence of Transsexualism among New Zealand Passport Holders' (2008) 42 *Australia and NZ Journal of Psychiatry* 887; M. Ross and others, 'Cross-cultural Approaches to Transsexualism: a Comparison between Sweden and Australia'. (1981) 63 *Acta Psychiatrica Scandinavica* 75.

there appear to be variations between countries.<sup>38</sup> Similar ratios have been found for children and young people who have been referred to gender identity clinics in the past, although the ratio is lower for adolescents than for children.<sup>39</sup>

Surveys of adolescents who identify as transgender show quite different ratios. In the New Zealand study, 54% of the respondents who identified as transgender were biological females.<sup>40</sup> In the Minnesota study, 68% who identified as transgender, genderfluid or similar, were female.<sup>41</sup>

This is reflected in the proportions of natal female and male adolescents being seen in clinics. A study in Finland of all the young people presenting at one of two clinics in the country over a two year period reported that 41 were natal girls and 6 were natal boys. In the other clinic in Finland the gender ratio was similar.<sup>42</sup> An inversion in the gender ratio in adolescent clinics since 2006 has also been observed in clinics in Toronto and Amsterdam,<sup>43</sup> and at the Tavistock Centre in London.<sup>44</sup> There is thus a disconnect between the proportion of female adolescents self-identifying as transgender, and the established patterns in the adult population in terms of male-female ratios. This seems to be reflected in applications to clinics for gender reassignment treatments.

#### *Socio-economic background, family situation and abuse history*

The fourth reason for caution is that many of the adolescents who identify in surveys as transgender, or who are seen at gender clinics, come from troubled family backgrounds and have histories of abuse. This is so for a much greater proportion of adolescents identifying as transgender, than in the general population.

In the New Zealand study, adolescents identifying as transgender were substantially more likely to come from households that had experienced high levels of deprivation (43% compared with 30% of those who did not identify as transgender).<sup>45</sup> They were also less likely to report that their family got along (64% compared with 81.5% of those who did not identify as transgender).<sup>46</sup>

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<sup>38</sup> De Cuypere and others, above n.35.

<sup>39</sup> H. Wood and others, 'Patterns of referral to a Gender Identity Service for Children and Adolescents (1976–2011): Age, Sex Ratio, and Sexual Orientation' (2013) 39 *Journal of Sex & Marital Therapy* 1–6; Kenneth Zucker, 'Epidemiology of Gender Dysphoria and Transgender Identity' (2017) 14 *Sexual Health* 404.

<sup>40</sup> Clark and others, above n.27 at p.96.

<sup>41</sup> Baams, above n.28.

<sup>42</sup> Riittakerttu Kaltiala-Heino and others, "Two Years of Gender Identity Service for Minors: Overrepresentation of Natal Girls with Severe Problems in Adolescent Development" (2015) 9 *Child and Adolescent Psychiatry and Mental Health* 9.

<sup>43</sup> M. Aitken and others, 'Evidence for an Altered Sex Ratio in Clinic-Referred Adolescents with Gender Dysphoria' (2015) 12(3) *Journal of Sexual Medicine* 756.

<sup>44</sup> N.M. de Graaf and others, 'Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016)' 2018) 47(5) *Archives of Sexual Behavior* 1301.

<sup>45</sup> Clark and others, above n.27 at p.96.

<sup>46</sup> *Ibid* at 97.

In the Minnesota study, those who identified as transgender, “genderqueer” or similar were about 75% more likely to have a parent or guardian in prison, nearly twice as likely to live with a problem drinker, over twice as likely to live with a drug abuser, and also reported much higher levels of physical abuse, psychological abuse and of witnessing domestic violence. They were about four times as likely as those who did not identify as transgender to have experienced childhood sexual abuse.<sup>47</sup>

This raises important issues for understanding both the aetiology of gender dysphoria and its treatment. If the explanation for gender dysphoria is primarily or entirely physiological (“being born into the wrong body”, as it is colloquially understood) then one would expect a demographic profile and range of family histories for transgender-identifying young people to be similar to the population as a whole.

### *Autism and mental health issues*

A fifth reason for caution is that many children and young people who identify themselves as transgender have other mental health issues or disorders. Numerous studies have found that children and young people who identify as transgender are many times more likely than the general population to be diagnosed as on the autism spectrum.<sup>48</sup> A leading study of 204 children or adolescents seen at the Gender Identity Clinic in Amsterdam indicated that the rate of autism diagnoses among those with gender dysphoria were about ten times as high as the general population.<sup>49</sup> A study in Finland of children and young people presenting at a gender identity clinic found that over 25% were diagnosed as being on the autism spectrum.

These children and young people are also much more likely to have depression and anxiety disorders. They are also more likely to experience suicidal ideation – in some cases leading to suicide attempts.<sup>50</sup> This is often explained in terms of the struggle they experience with the discordance between natal sex and gender identity, because of discrimination and parental disapproval or rejection on account of their gender identity. While these may be factors, other causes of depression, anxiety and suicidal ideation need to be considered – including a history of sexual abuse<sup>51</sup> and family dysfunction, as so many of them have.

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<sup>47</sup> Baams, above n.28.

<sup>48</sup> The data is summarized in John Whitehall, ‘Gender Dysphoria and the Fashion in Child Surgical Abuse’ (2016) 60(12) *Quadrant* 23.

<sup>49</sup> A. de Vries and others, ‘Autism Spectrum Disorders in Gender Dysphoric Children and Adolescents’ (2010) 40(8) *Journal of Autism and Developmental Disorders* 930-6. See also A. van der Miesen and others, ‘Autistic Symptoms in Children and Adolescents with Gender Dysphoria’ (2018) 48(5) *Journal of Autism and Developmental Disorders* 1537–1548.

<sup>50</sup> TA Becerra-Culqui and others, ‘Mental Health of Transgender and Gender Nonconforming Youth Compared With Their Peers’ (2018) 141(5) *Pediatrics* e20173845; Johanna Olson and others, ‘Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria’ (2015) 57(4) *Journal of Adolescent Health*, 374–380.

<sup>51</sup> A. Plunkett and others, ‘Suicide Risk Following Child Sexual Abuse’ (2001) 1 *Ambulatory Pediatrics* 262–266; M. Cutajar and others, ‘Suicide and Fatal Drug Overdose in Child Sexual Abuse Victims: A Historical Cohort Study’ (2010) 192(4) *Medical Journal of Australia* 184–187.

Anxiety and depression are not the only mental health issues for children with gender identity issues. In one study of children aged 3-9 years old identified as gender non-conforming, there was a much higher rate of attention deficit disorders than the control group.<sup>52</sup> Gender dysphoria may also co-exist with eating disorders.<sup>53</sup>

For some expert clinicians at least, the presence of other psychiatric disorders leads to caution about offering hormonal treatments and other interventions to children and adolescents that lead them on the pathway to full transition. One German team, that includes experts in adolescent psychiatry, sexual medicine, and pediatric endocrinology described its research findings as follows:<sup>54</sup>

All of the 21 patients who received a new diagnosis of GID in our clinic up to mid-2008 (aged 5 to 17; 12 boys, 9 girls) had psychopathological abnormalities that, in many cases, led to the diagnosis of additional psychiatric disorders. As a rule, there were also major psychopathological abnormalities in their parents. The "motive for switching" among the 15 adolescents in the group was mainly a rejected (egodystonic) homosexual orientation, the development of which would have been arrested by puberty-blocking treatments.

If not only the adolescents, but also their parents, suffer from “major psychopathological abnormalities”, there is reason for great caution in assuming that their gender dysphoria is entirely unrelated to these other problems. Indeed, earlier research on gender identity issues identified problems in the family of origin as important in understanding the aetiology of gender confusion.<sup>55</sup> Furthermore, there are compelling reasons not to accept an adolescent’s self-diagnosis of being transgender as the basis for affirming a new gender identity. As Finnish experts have advised:<sup>56</sup>

[F]or the majority of adolescent-onset cases, [gender dysphoria] presented in the context of severe mental disorders and general identity confusion. In such situations, appropriate treatment for psychiatric comorbidities may be warranted before conclusions regarding gender identity can be drawn. Gender-referred adolescents actually display psychopathology to the same extent as mental health-referred youth.

The wisdom of this approach is illustrated by a study conducted by two clinicians from the Tavistock Gender Identity Development Service in London. They reported on 12 cases of adolescents seen at the clinic who initially sought medical transition, and who met the criteria for a diagnosis of gender dysphoria, but who did not proceed to hormonal treatment. They arrived at a different

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<sup>52</sup> Becerra-Culqui and others, above n. 49.

<sup>53</sup> G.L. Witcomb and others, ‘Body Image Dissatisfaction and Eating-Related Psychopathology in Trans Individuals: A Matched Control Study. (2015) 23(4) *European Eating Disorders Review* 287–293.

<sup>54</sup> A. Korte and others, ‘Gender Identity Disorders in Childhood and Adolescence: Currently Debated Concepts and Treatment Strategies’, (2008) 105 *Deutsches Ärzteblatt International*, 834 at 838.

<sup>55</sup> John Whitehall, ‘Conversion Therapy and Gender Dysphoric Children’ (2019) 63(3) *Quadrant* 26–32.

<sup>56</sup> R. Kaltiala-Heino and others, ‘Gender Dysphoria in Adolescence: Current Perspectives’ (2018) 9 *Adolescent Health, Medicine and Therapeutics*, 31 at 38.

understanding of their distress through counselling.<sup>57</sup> Such counselling may become illegal, at least in Victoria, if it falls within the definition of ‘conversion therapy’.<sup>58</sup>

*Desistance with a cautious ‘wait and see’ approach*

The sixth reason for caution is that gender dysphoria may well be transitory.<sup>59</sup> There have been a number of studies of childhood gender dysphoria in which researchers and clinicians have followed up these children over time.<sup>60</sup> The great majority resolve their gender identity issues during puberty. Ristori and Steensma, in a review article, summarise the research evidence as follows:<sup>61</sup>

The conclusion from these studies is that childhood GD is strongly associated with a lesbian, gay, or bisexual outcome and that for the majority of the children (85.2%; 270 out of 317) the gender dysphoric feelings remitted around or after puberty.

Ristori and Steensma identify three different approaches to the management and treatment of childhood gender dysphoria. One is therapy to assist the child to accept his or her natal gender. Another is to support the child and alleviate social risks while keeping options open. This is known as “watchful waiting”. The third is to encourage and assist the child to transition. Ristori and Steensma explain that:<sup>62</sup>

The rationale for supporting social transition before puberty is that children can revert to their originally assigned gender if necessary since the transition is solely at a social level and without medical intervention. Critics of this approach believe that ...a child may ‘forget’ how to live in the original gender role and therefore will no longer be able to feel the desire to change back; or that transitioned children may repress doubts about the transition out of fear that they have to go through the process of making their desire to socially (re)transition public for a second time.

It may not be at all helpful to many children with gender dysphoria issues to encourage them to embrace an identity of being ‘transgender’ when for so many, it may be a transitory stage on their journey towards a sexually and mentally healthy – or at least more healthy – adulthood.

Gender dysphoria that is not resolved once the child or young person goes through puberty may be much more enduring,<sup>63</sup> but what is clear from all the literature is that gender dysphoria in

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<sup>57</sup> Anna Churcher Clarke & Anastassis Spiliadis, ‘Taking the Lid Off the Box’: The Value of Extended Clinical Assessment for Adolescents Presenting with Gender Identity Difficulties’. (2019) 24(2) *Clinical Child Psychology and Psychiatry* 338–352.

<sup>58</sup> Whitehall, above n.54.

<sup>59</sup> M. Wallien, & P. Cohen-Kettenis, ‘Psychosexual Outcome of Gender-dysphoric Children’ (2008) 47 *Journal of the American Academy of Child and Adolescent Psychiatry* 1413–1423.

<sup>60</sup> This research is contested. See Julia Temple Newhook and others, ‘A critical Commentary on Follow-Up Studies and “Desistance” Theories About Transgender and Gender-Nonconforming Children’ (2018) 19 *International Journal of Transgenderism* 212; and the responses to that critique from Kenneth Zucker, Thomas Steensma & Peggy Cohen-Kettenis in the same issue.

<sup>61</sup> J. Ristori and T. Steensma, ‘Gender Dysphoria in Childhood’ (2016) 28 *International Review of Psychiatry* 13 at 15.

<sup>62</sup> *Ibid* at 17.

<sup>63</sup> S. Leibowitz and A. de Vries, ‘Gender Dysphoria in Adolescence’ (2016) 28 *International Review of Psychiatry* 21.

adolescence requires careful and expert clinical management involving careful assessment of the child or young person's mental health.

### *Rapid-onset gender dysphoria and the problem of social contagion*

The seventh cause of concern is that at least some of the adolescents who identify themselves as transgender appear to be influenced by peers and the internet.<sup>64</sup> Lisa Littman, in a landmark study,<sup>65</sup> provided a 90 question survey to parents who reported that their child had a sudden or rapid onset of gender dysphoria, occurring during or after puberty. This would seem to be a new phenomenon, for hitherto, children and young people with gender identity issues seen at clinics have all had symptoms of gender dysphoria since early childhood. Particularly new is the phenomenon of adolescent onset gender dysphoria in young women.<sup>66</sup>

There were responses from 256 parents. Nearly 83% of the young people concerned were female and on average were 15 years old at the time they announced a new gender identification. The majority had been diagnosed with at least one mental health disorder or neuro-developmental disability prior to the onset of their gender dysphoria. None of them, based on parents' reports, would have met diagnostic criteria for gender dysphoria in childhood. Nearly half had been formally assessed as academically gifted. Over 40% expressed a non-heterosexual sexual orientation prior to identifying as transgender. Nearly half had experienced a traumatic or stressful life event prior to the onset of their gender dysphoria such as parental divorce, sexual assault or hospitalisation for a psychiatric condition.

For 45% of these young people, parents reported that at least one of the members of their friendship group came to identify as transgender. The average number of individuals who became transgender-identified was 3.5 per group; for 37% of the young people, the majority of friends in the group had come to identify as transgender. Parents reported that about 60% of the young people experienced increased popularity within their friendship group when they announced that they now identified as transgender. A similar proportion of the parents reported that the friendship groups were known to mock people who did not identify as lesbian, gay, bisexual, transgender, intersex, or asexual.

The majority of parents reported that when the young person disclosed the belief that he or she was transgender, the language came word for word from online sites. Two-thirds indicated, at the time

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<sup>64</sup> Lisa Marchiano, 'Outbreak: On Transgender Teens and Psychic Epidemics', (2017) 60(3) *Psychological Perspective*, 345–366.

<sup>65</sup> Lisa Littman, 'Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria' (2018) 13(8) *Plos One* e0202330. The article was heavily amended post-publication following complaints that she was spreading misconceptions about transgender people and employing biased methods. This is despite having gone through a conventional peer-review process prior to initial publication. The amendments were required by the editor following reviews by senior members of the journal's editorial team, two Academic Editors, a statistics reviewer, and an external expert reviewer. This illustrates how difficult it is to publish research which challenges favoured ideological positions within academia. See further: <https://quillette.com/2019/03/19/an-interview-with-lisa-littman-who-coined-the-term-rapid-onset-gender-dysphoria/>

<sup>66</sup> Littman, *ibid* at p.3.



of disclosing an identification as transgender, that they wanted to take hormones and over 50% wanted gender reassignment surgery. Again, more than half had very high expectations that transitioning would solve their social, academic, occupational or mental health problems.

Sudden, post-pubertal identification as transgender helps to explain the very high rates at which adolescents identify as transgender compared to the adult population. In the New Zealand study, 54% of the respondents first wondered about being transgender when they were at least 12 years old.<sup>67</sup> 65% had not disclosed to someone else their belief in being transgender.

#### *Young people who desist after irreversible treatment*

The eighth reason for caution is that there appears to be a growing number of young people who are now deeply regretting their decision to transition with hormonal or medical interventions. What is not known is the percentage this represents of all the adolescents and young adults who have received hormonal treatment or surgery in the last ten or fifteen years. It may still be the case that the majority of patients treated in Australia and other countries with well-resourced and affordable health care have made the optimal decision for their health and wellbeing, and a few years later do not regret their decision.

There is a paucity of research on this area. A Swedish study from 1960–2010 found 2.2% had sought to reverse the process surgically.<sup>68</sup> However, the research team found high rates of suicide among post-operative transsexuals compared with a general population control group, even after controlling for prior psychiatric morbidity.<sup>69</sup> The authors concluded that: “Even though surgery and hormonal therapy alleviates gender dysphoria, it is apparently not sufficient to remedy the high rates of morbidity and mortality found among transsexual persons.”<sup>70</sup> A recent study of a cohort of patients referred to a gender identity clinic in Amsterdam over a period of over 40 years found that rather less than 1% experienced regret about their sex reassignment surgery. However, for the most part this study covers a period when the numbers attending such clinics were very much smaller, and before the current trend to have substantial numbers of teenagers seeking treatment.<sup>71</sup> Clinic data on regrets may also understate the real incidence as the clinic may not be informed that the patient has had regrets.

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<sup>67</sup> Clark and others, above n.27 at p.96.

<sup>68</sup> Cecilia Dhejne and others, ‘An Analysis of All Applications for Sex Reassignment Surgery in Sweden, 1960–2010: Prevalence, Incidence, and Regrets’ (2014) 43(8) *Archives of Sexual Behavior* 1535. For results of a follow-up on satisfaction with the effects of the surgery, see Dmitry Zavlin and others, ‘Male-to-Female Sex Reassignment Surgery using the Combined Vaginoplasty Technique: Satisfaction of Transgender Patients with Aesthetic, Functional, and Sexual Outcomes’ (2018) 42(1) *Aesthetic Plastic Surgery* 178.

<sup>69</sup> Cecilia Dhejne and others, ‘Long-term Follow-up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden’. (2011) 6(2) *Plos One*, e16885.

<sup>70</sup> *Ibid* at 7.

<sup>71</sup> CM Wiepjes and others, ‘The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets’ (2018) 15(4) *Journal of Sexual Medicine* 582-90.

What we know about regrets among modern adolescents comes mainly from social media. This evidence, while anecdotal, is sufficiently voluminous to warrant attention. One study was conducted through Tumblr, Facebook groups, and on the Wordpress blog 4thWaveNow. The author of the survey invited responses from females who had formerly identified as transgender. The survey was posted for a two-week period and received 203 responses that met the criteria. On average they had transitioned for four years before detransitioning. Over 75% reported that detransitioning had helped them to cope better with their gender dysphoria – indeed 11% reported that it had completely gone. Disturbingly, of the 117 individuals who had medically transitioned, only 41 had received counselling beforehand. That is, 65% had received no therapy prior to receiving medical support to transition. The two most common reasons for detransition were shifting political/ideological beliefs (63%), and finding alternative coping mechanisms for dysphoria (59%). Over two-thirds indicated that they had been given inadequate counselling and information about transition.<sup>72</sup>

A detransitioning site on Reddit makes painful and sobering reading.<sup>73</sup> New posts on the site seem to be very frequent. Writers report a great deal of confusion about who they “really” are; profound regrets at having had irreversible medical treatments; suicidal ideation as a consequence of medically transitioning, issues with the effects of cross-sex hormones, especially natal females taking testosterone; views that the trans community are like a cult, regrets at the loss of sexual desire, and many other effects.<sup>74</sup>

## Beliefs in the transgender movement

A widely held belief in the community is that a certain section of the population has been ‘born into the wrong body’<sup>75</sup> and that while their bodies may be one sex, their brains are wired to identify as the opposite sex. Medical intervention is therefore needed to bring the body into line with a person’s ‘true’ gender identity. Such a view presupposes that we are born either male or female, with the exception of the relatively rare cases where a baby is born with an intersex condition that makes designation of a sex difficult.<sup>76</sup>

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<sup>72</sup> Cari Stella, ‘Female Detransition and Reidentification: Survey Results and interpretation’ (September 2016). Retrieved from <http://guideonragingstars.tumblr.com/post/149877706175/female-detransitionand-reidentification-survey>.

<sup>73</sup> <https://www.reddit.com/r/detrans/>. See also <https://sexchangeregret.com/>; Walt Heyer, *Trans Life Survivors* (2018); Jesse Singal, ‘When Children Say They are Trans’, *The Atlantic* July/August 2018 at <https://www.theatlantic.com/magazine/archive/2018/07/when-a-child-says-shes-trans/561749/>.

<sup>74</sup> These are based upon reading just one week’s posts on this site: August 17<sup>th</sup> 2019.

<sup>75</sup> See e.g. the British TV documentary series, *Born in the Wrong Body*, <https://www.imdb.com/title/tt5101244/>.

<sup>76</sup> While it is claimed by some that 1.7% of babies born are “intersex”, this is based on one article written 20 years ago that relies on a wide definition including all who “deviate from a Platonic ideal of sexual dimorphism” at the chromosomal, genital, gonadal, or hormonal levels: M. Blackless and others, ‘How Sexually Dimorphic Are We? Review and Synthesis’ (2000) 12 *American Journal of Human Biology* 151. Saks has pointed out that the definition used is much wider than as understood for intersex conditions in the medical literature. See L. Saks, ‘How Common is Intersex? A Response to Anne Fausto Sterling’ (2002) 39 *Journal of Sex Research* 174. Statistics on intersex conditions will depend upon how they are defined; Saks estimates the incidence in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female, is 0.018%. The Intersex Society of North America does not advocate the position that there are more than two genders or that intersex children should be brought up other than as male or female. See <http://www.isna.org/faq/third-gender>.

The search for a physiological basis for transgender identification has provided little support for such a view. The aetiology of gender dysphoria remains poorly understood.<sup>77</sup> A recent review of studies of the brain found that: “Despite intensive searching, no clear neurobiological marker or “cause” of being transgender has been identified”.<sup>78</sup> There is nonetheless some new evidence for possible genetic influences in male to female gender dysphoria.<sup>79</sup>

Perhaps because the scientific evidence to support a physiological explanation is so limited, the view that transgender identification arises because people are ‘born that way’ does not seem to underpin much clinical practice or transgender advocacy. Clinicians working with adolescents have quite a variety of opinions on the aetiology of gender dysphoria and about whether the lack of a clear physiological basis for it ought to affect treatment decisions. There are numerous other disagreements between the clinicians in this field.<sup>80</sup>

### *Two fundamental beliefs*

Rather than claiming a solid foundation in medical science, the transgender movement appears to be based upon two main beliefs. The first is that gender is not innate but “assigned at birth” and that such an assignment, based upon observation of the genitalia, is at best provisional. It follows from this that the idea that one’s “real” gender is a matter of subjective identification rather than biological reality. The second belief is that gender is fluid and gender identity may change over time.

These are not scientific claims. In their nature, they are incapable of either validation or falsification by science. The first is essentially a belief about subjective understanding versus objective reality, and about the nature of human sexual identity. The essence of who I am is who I consider myself to be rather than how, in a physical sense, I am made. The idea that gender is fluid is also a belief. It begins from the premise that gender is something different from biological sex. Previous generations would have regarded the two words as interchangeable when describing the binary nature of humankind.

It is important, therefore, to identify the beliefs and values that may underlie people’s viewpoints, and to distinguish them from agreed scientific facts.

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<sup>77</sup> The research evidence is reviewed in S.C. Mueller, G. De Cuypere, & G. T’Sjoen, ‘Transgender Research in the 21st Century: A Selective Critical Review from a Neurocognitive Perspective’ (2017) 174 *American Journal of Psychiatry* 1155–1162; Jack Turban & Diane Ehrensaft, ‘Research Review: Gender Identity in Youth: Treatment Paradigms and Controversies’ (2018) 59 *Journal of Child Psychology and Psychiatry* 1228–1243; Lawrence Mayer and Paul McHugh, ‘Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences: Part Three’ 50 *New Atlantis* (2016) available at <https://www.thenewatlantis.com/publications/part-three-gender-identity-sexuality-and-gender>.

<sup>78</sup> Mueller and others, *ibid*, at 1158.

<sup>79</sup> Madeleine Foreman and others, ‘Genetic Link Between Gender Dysphoria and Sex Hormone Signaling’ (2019) 104(2) *Journal of Clinical Endocrinology & Metabolism* 390–396.

<sup>80</sup> Lieke Vrouenraets and others, ‘Early Medical Treatment of Children and Adolescents With Gender Dysphoria: An Empirical Ethical Study’ (2015) 57(4) *Journal of Adolescent Health* 367 – 373.

### *Gender ‘assigned’ at birth*

The language of gender being assigned at birth has become mainstream in the medical and psychological literature, as well as in the popular literature of the transgender movement. While the terms ‘biological sex’ or ‘natal sex’ would be much more readily understandable, they may suggest too objective a concept of gender. Instead, the idea that sex is assigned by someone at birth assumes the exercise of a judgment, and one which is fallible. This, for example, is an answer provided on social media website Quora to a questioner about the idea of being born in the wrong body:<sup>81</sup>

Humans aren't a binary species. We now understand that that oversimplification taught in science classes about human sex and “sex chromosomes” is essentially wrong, and leads to widespread misunderstanding. We now understand that *the brains of trans people, even before HRT, are indistinguishable from the brains of cis people with the same gender.*

People are born with a wide range of genders, and with a wide range of sex traits. There is no way to “match” sexes and genders because *there are different numbers of each.* Humans are not born transgender or cisgender. Humans are *assigned* into one of those groups by essentially a weighted lottery. Sometimes the gender assigned to a child is correct, and sometimes it isn't.

This view makes genitalia almost irrelevant to the ascertainment of gender; but it also assumes that there is an objectively “correct” account of the gender of a child – just not one observable by looking at the genitalia.

### *Subjective reality and gender fluidity*

Typical of the belief that gender is fluid and may change over time is the material prepared for the controversial “Safe Schools’ program. In its manual, *All of Us* (p.30), teachers are instructed how to explain these ideas to early high school students:<sup>82</sup>

Explain that sex is about the body you are born with (male, female or intersex), while gender is about your identity, or how you feel inside. Gender refers to the way that you feel on the inside. It might be expressed by how you dress or how you behave and for some people these things may change over time.

These ideas in the popular culture are shared by at least some health professionals. Clinicians from four gender identity clinics in the USA explain their framework for treatment, which involves affirming the child or young person’s gender identity, with reference to similar ideas about gender fluidity. They believe that:<sup>83</sup>

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<sup>81</sup> <https://www.quora.com/Are-trans-people-born-with-the-wrong-brain-or-the-wrong-body> (italics in the original).

<sup>82</sup> Safe Schools Coalition, *All of Us* (2015) p.30. This resource can be found at <https://www.minus18.org.au/index.php/get-involved/campaigns/all-of-us>

<sup>83</sup> M. Hidalgo and others, ‘The Gender Affirmative Model: What we Know and What We Aim to Learn’ (2013) 56 *Human Development*, 285–290 at 285.

“gender may be fluid, and is not binary, both at a particular time and if and when it changes within an individual across time; ... if there is pathology, it more often stems from cultural reactions (e.g., transphobia, homophobia, sexism) rather than from within the child.”

They go on to explain their approach in terms of children’s rights:<sup>84</sup>

In this model, gender health is defined as a child’s opportunity to live in the gender that feels most real or comfortable to that child and to express that gender with freedom from restriction, aspersion, or rejection. Children not allowed these freedoms by agents within their developmental systems (e.g., family, peers, school) are at later risk for developing a downward cascade of psychosocial adversities including depressive symptoms, low life satisfaction, self-harm, isolation, homelessness, incarceration, posttraumatic stress, and suicide ideation and attempts.

Ideas such as these would appear to lie behind the decision of the Tasmanian Parliament to make the recording of sex on birth certificates optional.<sup>85</sup> They also lie behind Principle 3 of the Yogyakarta Principles, drawn up by some non-government human rights experts in 2006.<sup>86</sup> Adherence to the Principle in part requires that States shall:

- Take all necessary legislative, administrative and other measures to fully respect and legally recognise each person’s self-defined gender identity;
- Take all necessary legislative, administrative and other measures to ensure that procedures exist whereby all State-issued identity papers which indicate a person’s gender/sex — including birth certificates, passports, electoral records and other documents — reflect the person’s profound self-defined gender identity.

This idea that gender is what you feel, not a matter of biology, and that identification as ‘male’ or ‘female’ is a matter of gender identity, and not biology, explains the acceptance of hitherto absurd notions such as that men can have babies<sup>87</sup> – or put differently, that the capacity to give birth to a child is no longer an irrefutable marker of being (objectively) female. In Tasmania now:<sup>88</sup>

In any law in force in this State – (a) a reference to the pregnancy of a female, female person or woman includes a reference to the pregnancy of a person of another gender.

A man may also have an abortion, according to the *Reproductive Health Care Reform Bill 2019* in NSW. It uses the word ‘person’ rather than “woman” or “female” throughout.

Related to the two fundamental beliefs – that gender is a matter of subjective identification and that it is ‘fluid’ – is the belief that being transgender is not a matter for medical diagnosis. All that matters is self-identification.

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<sup>84</sup> Ibid at 286.

<sup>85</sup> *Justice And Related Legislation (Marriage And Gender Amendments) Act 2019*.

<sup>86</sup> <https://yogyakartaprinciples.org/principle-3/>

<sup>87</sup> For a study of transgender ‘males’ in Australia who choose to have babies after transitioning, see Rosie Charter and others, ‘The Transgender Parent: Experiences and Constructions of Pregnancy and Parenthood for Transgender Men in Australia’ (2018) 19 *International Journal of Transgenderism* 64–77.

<sup>88</sup> *Births, Deaths and Marriages Registration Act 1999* s.28D, as amended by the *Justice And Related Legislation (Marriage And Gender Amendments) Act 2019*.

*The belief that being transgender is not a medical issue*

Hitherto, it has been the norm that in order to have a change of gender recorded in official documents, it has been necessary to go through a medical sex reassignment process. An example of legislation in this area is Part 3A of the *Anti-Discrimination Act 1977* (NSW) which makes it unlawful to discriminate on the grounds of transgender status. A distinction is drawn between ‘recognised’ transgender status and unrecognised status. Recognition is where the birth certificate has been formally changed. This requires an application by someone over 18, supported by two doctors who certify that the person has undergone a sex affirmation procedure. It is unlawful to treat an aggrieved person, being a recognised transgender person, as being of the person’s former sex. There is no right for an ‘unrecognised’ transgender person to be treated as being of the opposite sex.

This idea that medical procedures, such as cross-sex hormonal treatment and gender reassignment surgery should be necessary in order for legal recognition of a person’s gender identity is anathema to those in the transgender movement who see this as a human rights issue. Thus Principle 3 of the Yogyakarta Principles states:

Each person’s self-defined sexual orientation and gender identity is integral to their personality and is one of the most basic aspects of self-determination, dignity and freedom. No one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity.

Principle 18, under the heading “medical abuses” states that gender identity is not a matter for medical treatment:<sup>89</sup>

Notwithstanding any classifications to the contrary, a person's sexual orientation and gender identity are not, in and of themselves, medical conditions and are not to be treated, cured or suppressed...

For that reason, they argue, States must ensure that any medical or psychological treatment or counselling does not, explicitly or implicitly, regard gender identity as a medical condition to be treated.

The insistence that transgender identification must not be medicalised or treated leads inevitably to the notion that gender identity is to be affirmed and not questioned. The Tasmanian legislation, for example, allows the Registrar for Births, Deaths and Marriages to require particular documents or information from a person who applies to change his or her gender, as long as the requirement is “reasonable”. The one document that the Registrar is not legally allowed to require is “a medical certificate, or other medical document, in relation to the sex, sexual characteristics or gender of the person”.<sup>90</sup>

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<sup>89</sup> <https://yogyakartaprinciples.org/principle-18/>

<sup>90</sup> *Births, Deaths and Marriages Registration Act 1999* s.28A, as amended by the *Justice And Related Legislation (Marriage And Gender Amendments) Act 2019*.

*The belief that being cisgender is not the norm*

Some advocates completely reject the essentialist idea that human beings are normally to be classified as male or female and that medical intervention to alter biological sex requires clinical justification. This arises from a belief that gender is socially constructed. So for example, legal scholar Florence Ashley writes:<sup>91</sup>

Most clinicians assume that the clinical starting point should be the absence of transition, with deviation from this starting point requiring justification. In other words, any step towards transition must be justified by showing that the child is sufficiently trans or gender creative to warrant it. Short of justification, the default is no-transition. This assumption is predicated upon a social organisation that centres cisgender ways of being as the default. In an alternate society that used the pronouns of the child's choice on any given day, the idea of changing pronouns as part of a social transition would not be perceived as an intervention that must be clinically justified; it would be the default, the status quo, and it is instead discouraging social transition that would be perceived as interventionist.

This idea that being cisgender is not even the norm illustrates how disconnected some social theorists are from the truths of medicine and science. Of course, they are welcome to their beliefs, and these beliefs are protected under Article 18 of the International Covenant of Civil and Political Rights which protects freedom of religion, thought and conscience. They must be recognised nonetheless as unscientific beliefs. Some treatment decisions of clinicians are also not evidence-based, and are reliant on judgments about a young person's best interests in the absence of knowledge about the long-term effects of treatment.<sup>92</sup>

While doctors may hold these beliefs, some are, in their nature political, ideological, ethical or value-based. They are not to be given additional weight merely because some medical professionals hold them.

*Avoiding harm – two contrasting positions*

Differences of belief and assessment of medical risks explain two almost irreconcilable views about what it means to fulfil the first of the obligations of a medical practitioner – to avoid harm. In a helpful essay, Bernadette Wren, of the Gender Identity Development Service at the Tavistock Centre in London, has explained the extent to which decisions about treatment for transgender or gender diverse youth rest upon clinicians' beliefs and ethical views:<sup>93</sup>

On one hand, we have considerations with respect to young people's right to self-determination based on their privileged access to something as seemingly intimate and personal as gender

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<sup>91</sup> Florence Ashley, 'Thinking an Ethics of Gender Exploration: Against Delaying Transition for Transgender and Gender Creative Youth' (2019) 24(2) *Clinical Child Psychology and Psychiatry* 223-236 at 228.

<sup>92</sup> Bernadette Wren observes that at the Tavistock Centre, "we regularly make the clinical judgement that the well-being of distressed children and young people can be improved by puberty suspension. Nonetheless, ethical issues are raised by this work as we remain in some doubt about what the long-term effects of early suppression may be on physical development, for example, on bone density, height, sex organ development and body shape or the reversibility of any changes or delays." Bernadette Wren, 'Ethical Issues Arising in the Provision of Medical Interventions for Gender Diverse Children and Adolescents' (2019) 24(2) *Clinical Child Psychology and Psychiatry*, 203–222 at 208.

<sup>93</sup> *Ibid* at 204.

identification and their right in law to consent to their own treatment if deemed capable. On the other hand, we have the responsibility, which many clinicians and parents/carers feel when considering the wisdom of medical intervention, to respect the shifting developmental dynamics of childhood, to be concerned about significant associated difficulties and to acknowledge the impact of powerful social communities of influence – and therefore to adopt a more cautious approach, where clinicians do the work of ‘gatekeeping’ with age limits and other criteria for accessing treatments.

What is emerging then, is a clash between policies based upon affirmation and those based upon child protection. The Standards developed by the Royal Children’s Hospital in Melbourne nail their colours firmly to the mast of affirmation. Under the heading of “Avoid causing harm”, the authors state:<sup>94</sup>

Withholding of gender affirming treatment is not considered a neutral option, and may exacerbate distress in a number of ways including increasing depression, anxiety and suicidality, social withdrawal, as well as possibly increasing chances of young people illegally accessing medications. In the past, psychological practices attempting to change a person’s gender identity to be more aligned with their sex assigned at birth were used. Such practices, typically known as conversion or reparative therapies, lack efficacy, are considered unethical and may cause lasting damage to a child or adolescent’s social and emotional health and wellbeing.

Even still, the Standards call for careful assessment of adolescents, including recognition that many adolescents seeking treatment have been diagnosed with autism spectrum disorder or suffer from other conditions such as anorexia nervosa.<sup>95</sup> The Standards nonetheless presuppose that some adolescents who are certain of their need for treatment will be denied it.<sup>96</sup>

Other clinicians express great caution about going down the path of cross-hormone treatment and surgical interventions such as double mastectomies, out of recognition that adolescence is a time of exploration of identity and concerns that they may do lasting harm by irreversible interventions. Thus the fundamental duty of a medical practitioner to avoid doing harm – particularly irreversible harm – may lead these medical practitioners to make quite different clinical decisions in deciding whether to offer medical interventions to adolescents who want them.

## **Religious beliefs about gender**

Given that the issue of gender identity is so much an issue of belief and worldview, to what extent should people of faith be subject to obligations towards people on the basis of their gender identity if this conflicts with their beliefs? Is there any justification for exempting religious organisations from the requirements of anti-discrimination laws that prohibit discrimination on the basis of gender identity?

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<sup>94</sup> Telfer and others, *Australian Standards*, above n. 19 at p.5.

<sup>95</sup> *Ibid* at 11–12.

<sup>96</sup> *Ibid* at 12.



The first thing that must be said from a Christian point of view is that the dominant response to those who suffer gender dysphoria must be compassion. The overwhelming evidence from all the research is that so many of the adolescents who present at clinics, or indeed those who identify at school as transgender and have not yet sought specialist medical treatment, are profoundly troubled young people with multiple mental health issues and histories of family dysfunction.

While recognising that there have long been people who have experienced profound and persistent discomfort with their natal sex and have found peace in transitioning with medical intervention, the eight concerns listed above justify schools in exercising great caution before accepting a young person's request to change gender, even if supported by a parent. A Christian professional such as a school principal may, after due consideration, decide that the most compassionate response to a young person who presents seeking to change gender is not to embrace his or her newly found gender identity. That may be for many reasons, including concerns about the rapid onset of gender dysphoria, observable influences in the young person's friendship group, awareness of other mental health disorders and concern that those other mental health issues may not receive the attention they warrant if transitioning is seen as the answer to all the young person's difficulties.

These are properly matters for expert medical, psychological and psychiatric advice; but of course that is in itself a point of view that many in the transgender movement emphatically reject. Inevitably, responses to a young person who wants to transition are likely to be influenced by the professional's own beliefs and ethical positions; but so are the views of clinicians. Making decisions about how to respond to a young person who identifies as transgender or "non-binary" simply does not occur within a belief or value-free zone.

The beliefs that a Christian professional may bring to the issue include a conviction that there are only two sexes, male and female, for "male and female He created them".<sup>97</sup> Furthermore, they may consider that sex is to be defined, as it always has been in the past, by reproductive function. Gender, as distinct from sex, is a completely alien concept within the Christian tradition. It is entirely orthodox Christian teaching for the Vatican's Congregation for Catholic Education to affirm the complementarity of the two sexes as fundamental to the created order.<sup>98</sup> In Jesus' teaching, this complementarity and interdependence of the sexes is the basis of marriage.<sup>99</sup> There is no conflict between theological and scientific truths about the human person in recognising that there are just two biological sexes. Indeed, that has been the universal understanding in the community until very recent times. Gender theory has emerged from the humanities, not the sciences.

Such a belief that God created us male or female does not mean that any particular way of living as a man or as a woman is divinely ordained. That is, the Bible does not teach or affirm particular

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<sup>97</sup> Genesis 1:27; 5:2.

<sup>98</sup> Congregation for Catholic Education, "*Male And Female He Created Them*": *Towards a Path of Dialogue on the Question of Gender Theory in Education* (2019) available at [http://www.educatio.va/content/dam/cec/Documenti/19\\_0997\\_INGLESE.pdf](http://www.educatio.va/content/dam/cec/Documenti/19_0997_INGLESE.pdf)

<sup>99</sup> Mark 10:6–7; Matt. 19:4–5.

gender stereotypes.<sup>100</sup> Nor does the belief that there are only two genders in any way exclude recognition that a very small proportion of babies are born with ambiguous genitalia,<sup>101</sup> or have hormonal or chromosomal features that differ from the norms of what it is to be male or female. Nor does it exclude recognition that a very small proportion of the population suffers from significant and sustained gender dysphoria, lasting beyond the search for identity in the adolescent years, through to an adulthood which is made more bearable by sex reassignment procedures.

Starting from a fundamental premise that God has made us male and female does nonetheless, greatly influence our approach to the difficult issue of transgender identification. The Social Issues Committee of the Anglican Diocese of Sydney, for example, states:<sup>102</sup>

The case for medical support of sex transitioning before adulthood is not evidence-based and should not be supported by Christian healthcare providers.

Others may take a broader view of the scope for medical intervention based upon a view of the best interests of the patient in the circumstances. These are issues on which medical professionals may disagree.<sup>103</sup> The debate may be illuminated by theological reflections on the created order, but is not resolved by it. Nonetheless, we may properly reject, on theological grounds, the idea that the medical profession has no place in determining the validity of a person's self-declared gender identity for the purposes of legal documents and societal organisation. We must also properly reject the idea that it is *only* a medical issue, for unless and until there is far more certainty within the medical profession about the aetiology of gender dysphoria and the best approach to treatment, the options necessarily involve matters of religion, conscience and belief.

A Christian perspective on the issue will almost inevitably involve a cautious approach to facilitating a child or young person's transition to another gender identification, given the limitations of our understanding of the aetiology of the condition, the multiple psychopathologies so many of these young people suffer, and the grave risks involved in making a misdiagnosis or choosing an inappropriate treatment.

Similarly, we are likely to reject, on theological as well as scientific grounds, that gender is fluid. On theological grounds also, we may regard being "non-binary" as a statement of belief, not a statement of fact; and we are likely to reject the falsehoods involved in rewriting birth certificates to state something which is not an accurate history of the known facts concerning gender and parentage at the time of the child's birth.

Likewise, we would have to affirm that what is now called being 'cisgender' is the normal state of being for humankind and that transgender identification is the exception, perhaps physiologically

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<sup>100</sup> For an excellent summary of biblical teaching on gender, see Social Issues Committee, Anglican Diocese of Sydney, *Gender Identity* (2017).

<sup>101</sup> This is possibly how Jesus' expression in Matthew 19:12 about being "born eunuchs" should now be understood.

<sup>102</sup> Above n.100 at 26.

<sup>103</sup> There is even significant disagreement between clinicians working with adolescents in gender identity clinics: see Vrouenraets and others, above n.80. For a strong critique of the current practice of irreversible treatment of adolescents, see John Whitehall, 'Experimenting on Gender Dysphoric Kids' (2018) 62(7/8) *Quadrant* 74–82.

based in some cases. To say this is not to deny in any way the spectrum of possibilities of what it means to be male or female. Our understanding of God is also informed by the understanding that all of us are made in the image of God and that image somehow encompasses both male and female.<sup>104</sup> To that extent, God is non-binary.

It may be seen how great a gulf there is between the non-scientific beliefs of so many transgender activists, and the views, informed both by theology and science, that are likely to guide the judgments of Christian professionals.

### **Anti-discrimination law, gender identity and religious belief**

What then, of religious objections to laws that prohibit discrimination on the basis of gender identity? Much depends upon what follows from saying that discrimination on the basis of gender identity is unlawful. If the law provides only that people who have a gender identity different to their natal sex should not suffer ill-treatment or discrimination as a consequence, then there is no legitimate religious objection to such a law. In Christian ethical thought, based upon the teachings of Jesus, the command to love one's neighbour applies irrespective of the gender of that neighbour or their beliefs about themselves. To adapt the well-known statement of Thomas Jefferson about religious belief,<sup>105</sup> it does me no injury for my neighbour to say that they are "non-binary" or "transgender". It neither picks my pocket nor breaks my leg.

The position is different though, if the law requires me to act against my beliefs and values; in other words if another person's self-identification imposes upon me obligations that I cannot, in all good conscience, fulfil. For the school Principal deciding on a request from a young person to change gender identification at school, the crisis of conscience may arise from a genuine belief that it is not in the best interests of the child or young person to affirm his or her transgender identification any more than it would be in the best interests of an adolescent girl with an eating disorder to affirm her body image as overweight. At the very least, a Principal's faith-informed duty of care may lead him or her to insist upon watchful waiting, or a program of counselling, or expert diagnosis together with advice to affirm the young person's gender identity, before agreeing to the transition she or he wishes to make. Breach of a professional's duty of care may lead to liability in negligence in relation to a child or young person who, a court decides with the benefit of hindsight, was not Gillick-competent at the time and harmed by a social transition facilitated by the school.

Thus as a society, we come to a rather fundamental clash of beliefs and values – and one which may, but need not be, resolved through the rather blunt instrument of the law. This paper has endeavoured to show just how many of the ideas strongly promulgated by some in the transgender movement are based upon unscientific beliefs, or otherwise beliefs and values that science can neither validate nor disprove.

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<sup>104</sup> Genesis 1:27; 9:6.

<sup>105</sup> Thomas Jefferson, *Notes on the State of Virginia*, Query 17 (1785).

What is the way forward? One option is to make clear that while no-one should experience discrimination based upon their gender identity, the law does not require that others treat a person as the gender with which they identify, except in circumstances that might be defined in law (for example, gender identity on passports). It is one thing for the Government to accept, for some purposes, that a person is “gender x” or “non-binary”. It is another to require all citizens to accept that person’s belief about themselves in a society organised in so many ways, on the objective reality of biological sex.

In terms of anti-discrimination legislation, at the very least, there needs to be clarification that nothing in the legislation prevents educational institutions and other service providers, organising or offering their services on the basis of biological sex rather than gender identity. Sex, or what it means to be male or female, needs to be defined in terms of reproductive function while gender identity can be defined in terms of subjective belief. The distinction between sex and gender is already implicit, if not explicit, in the *Sex Discrimination Act 1984* (Cth) which distinguishes at various points between them. However, the law could be more clearly stated so that people realise that gender identity is not to be equated with biological sex when it comes to the use of sex-segregated facilities or sex-segregated activities, except insofar as the law specifically provides. Such clarification in the law would go a long way to resolving the dilemmas now being created by laws which base changes to gender identity on nothing more than self-declaration.

Furthermore, all schools ought to have an absolute defence to a claim of discrimination against a young person under the age of 18 that they acted in good faith on the basis of what they considered at the time to be in the best interests of the child. Without such a provision, a professional may be unable to reconcile his or her duty of care towards the child with the requirements of anti-discrimination law. It would be contrary to fundamental principles of child protection if the law compelled, or was understood to compel, a professional with a duty of care towards a child to make decisions that are contrary to what he or she considers are the child’s best interests and which could cause them harm. The most the law can do in this respect is to accept good faith determinations by professionals. It cannot second guess a professional’s decisions about a child’s best interests a year or two later, particularly given the divide among health professionals about what the duty to avoid harm entails in the context of responding to transgender-identified young people.

None of these reforms rely upon religious belief; but if governments are reluctant to clarify the law in this way, then at the very least, religious exemptions need to remain; for on both religious and scientific grounds, people of faith cannot accept many of the beliefs of the transgender movement.

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