Submission

on

“Conversion” Practices

to the

Tasmania Law Reform Institute

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Table of Contents

1. **Terms of reference** 1
2. **Introduction** 1
3. **Christian sexual ethics** 1
4. **Parental rights** 2
5. **Same-sex attraction** 2
   - *5.1. Testimony from a distinguished psychiatrist* 2
   - *5.2. Ethical responsibilities of psychologists* 3
   - *5.3. Sexuality and genetics* 4
   - *5.4. Twin studies* 4
   - *5.5. What is 'reparative therapy'?* 5
   - *5.6. Can a person's sexuality change over time?* 6
   - *5.7. Why do some people seek to help change their sexual orientation?* 6
   - *5.8. Is reparative therapy harmful?* 6
   - *5.9. Is reparative therapy beneficial?* 8
6. **Gender "conversion" practices** 9
   - *6.1. What is gender dysphoria?* 9
   - *6.2. Does "transitioning" help mental health?* 9
   - *6.3. Can a person change their sex?* 10
   - *6.4. Social contagion* 10
   - *6.5. Most children learn to accept their bodies* 11
   - *6.6. Puberty blocker risks* 11
   - *6.7. Detransition movement* 12
7. **Conclusion** 14
8. **Endnotes** 15

1. Terms of reference

The Tasmanian Law Reform Institutes claims that it is:

> *… seeking public feedback on possible reforms to Tasmanian law to respond to sexual orientation and gender identity (SOGI) conversion practices. SOGI conversion practices are known to be demeaning and highly damaging to LGBQTA+ people and several jurisdictions have already banned or are in the process of banning them. The Institute is conducting an inquiry about the appropriate law reform options for Tasmania.*

FamilyVoice Australia is a national non-denominational Christian advocacy group – promoting family values for the benefit of all Australians. Our vision is to see strong families at the heart of a healthy society: where marriage is honoured, human life is respected, families flourish, Australia's Christian heritage is valued, and fundamental freedoms are valued and enjoyed.

Submissions close **7 January 2020**.

2. Introduction

In recent times, LGBTIQA+ activists have sought to ban any treatment or counselling by psychiatrists, clinicians, counsellors, parents and others to help people overcome unwanted same-sex attraction.

At the same time, these very activists have pushed to make it easier for people, including children, to be subjected to demeaning and highly damaging "gender conversion" practices, also known as "sex-reassignment" treatments, which are risky, mutilate body parts and result in infertility.

3. Christian sexual ethics

The Christian view of sexuality is that it is a faculty to be expressed within the confines of marriage between a man and a woman. The Catholic Church expresses it this way in the context of the impermissibility of homosexuality:

> *The community of faith today, in unbroken continuity with the Jewish and Christian communities within which the ancient Scriptures were written, continues to be nourished by those same Scriptures...Providing a basic plan for understanding this entire discussion of homosexuality is the theology of creation we find in Genesis. God, in his infinite wisdom and love, brings into existence all of reality as a reflection of his goodness. He fashions mankind, male and female, in his own image and likeness. Human beings, therefore, are nothing less than the work of God himself; and in the complementarity of the sexes, they are called to reflect the inner unity of the Creator. They do this in a striking way in their cooperation with him in the transmission of life by a mutual donation of the self to the other...The Church, obedient to the Lord who founded her and gave to her the sacramental life, celebrates the divine plan of the loving and live-giving union of men and women in the sacrament of marriage. It is only in the marital relationship that the use of the sexual faculty can be morally good. A person engaging in homosexual behaviour therefore acts immorally.*[1]

In terms of "sex-change" treatments, both Catholic[2] and Protestant theologians consider it immoral. Christian Apologetics and Research Ministry president Matt Slick comments on "sex-change" operations as follows:

> *The Bible does not address this issue because it was not around at the time. But, no, sex change operations are not okay. God created people as male and female (Gen. 1:27)... Therefore, to change the gender of a person through an operation is a violation of the natural birth gender that God has ordained for the person. It also violates the distinction of those attributes which designate a male from a female.*[3]

Regius Professor of Moral and Pastoral Theology at the University of Oxford, theologian Oliver O'Donovan, has argued:

> *"If I claim to have a 'real sex', which may be at war with the sex of my body and is at least in a rather uncertain relationship to it, I am shrinking from the glad acceptance of myself as a physical as well as a spiritual being, and seeking self-knowledge in a kind of Gnostic withdrawal from material creation."*[4]

4. Parental rights

A commitment to a free and just society commands respect for the rights of parents. The Article 18 (4) International Covenant on Civil and Political Rights (ICCPR) states:

> *The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to ensure the religious and moral education of their children in conformity with their own convictions.*

Likewise, Article 26 (3) of the Universal Declaration of Human Rights (UDHR) holds:

> *Parents have a prior right to choose the kind of education that shall be given to their children.*

These internationally agreed statements acknowledge the importance of the rights of parents to pass on their religious beliefs and moral values to their children, including about matters pertaining to sexuality.

5. Same-sex attraction

5.1. Testimony from a distinguished psychiatrist

Dr Joseph Berger, MBBS (hons) FRCP(C) DABPN, Consulting Psychiatrist Toronto, Distinguished Life Fellow, American Psychiatric Association, wrote a foreword to the 2013 book, *Beyond Critique: The Misuse of Science by UK Professional Mental Health Bodies*.[5] He said (in part):

> *Two years after the 1969 Stonewall riots, some homosexuals protested vociferously at the annual meeting of the American Psychiatric Association (APA), claiming that psychiatry's designation of homosexuality as a mental disorder stigmatised and promoted discrimination against them.*
>
> *The APA subsequently dropped this designation in order to reduce the stigma, and not because of the science. Indeed, many practising psychiatrists continued to protest that political pressures were not a good reason to change. Few, however, would have anticipated that the victims would become the persecutors. The outrageously unethical notion of banning psychotherapy*

for people who go voluntarily to a trained professional seeking to lessen their same-sex desires, even in order to marry or protect existing families, could not have been imagined.

But that is what therapists in the UK now face. The general public are unaware that activists have achieved such extreme restrictions without scientific justification.

I debated with Professor King and Mr Peter Tatchell recently in London, and was astonished to hear their weak arguments. Let it be understood very clearly:

1. *There is a very large body of quality scientific literature demonstrating successful treatment of people unhappy with same-sex desires who became comfortably heterosexual. I referred to about 50 such publications.*

2. *There is no significant body of scientific literature demonstrating harm from such therapy, only some personal anecdotes.*

3. *"Sexual orientation" is a way of thinking about people's sexual preferences. There is no specific location in the brain for "sexual orientation" and no scientific justification to claim that a person with same-sex attraction cannot with psychotherapy discover – or re-discover – opposite sex attraction. If people who once identified themselves as heterosexual can in later life identify as homosexual, then the opposite must hold.*

4. *Despite 30 years of research and many well-publicised claims, there is no substantiated body of evidence that homosexuality is inherited genetically. Neither is there any scientific support for an anatomical (in the brain) biochemical, physiological, physical or organic cause. There is no scientific support for a recent speculative fantasy that homosexuality might be caused by uterine hormones on the foetus.*

5. *There is no physical or biological laboratory test to determine who is, and who isn't, homosexual. It is purely a self-identification.*

The notion that a history of oppression justifies a gross interference with a process of treatment whose success has been demonstrated is absurd. Every ethical therapist offers psychotherapeutic help only to those who voluntarily seek it. In no other area of medicine or psychiatry would comparable client requests be denied.

5.2. Ethical responsibilities of psychologists

Psychologists generally understand the main principles of modern therapeutic practice. Client autonomy, or self-determination is one, and informed consent is another.

In the leading academic journal *Psychotherapy*, and again in the *American Journal of Family Therapy*, Dr Mark Yarhouse of Regent University argues:

> *Psychologists have an ethical responsibility to allow individuals to pursue treatment aimed at curbing experiences of same-sex attraction ... not only because it affirms the clients' right to dignity, autonomy and agency ... but also because it demonstrates regard for diversity.*[6]

A 2012 statement by the Association of Christian Counsellors notes:

> *Any client seeking counselling has the right to indicate their goals and aspirations within counselling and to be respected for that choice. If a client seeks to explore change to their lifestyle or behaviour then using the core conditions the counsellor needs to respect that desire*

> *and work with them to their benefit. For the counsellor to reject this out of hand implies that they are seeking to impose their own agenda on the client and this is unethical.*[7]

The accepted principles of client autonomy and informed consent imply that people with unwanted same-sex attraction have a right to request help to change their orientation.

5.3. Sexuality and genetics

The American Psychological Association (APA) asserts:

> *There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles; most people experience little or no sense of choice about their sexual orientation.*[8]

In fact, while there is significant evidence that genes play the major role in a person's biological sex, genes play little or no role in sexual orientation.

In various reports, it was found that there is no "gay gene". The choice to 'change' is in fact promoted through association with peers, social media and socio-economic circumstances.[9,10]

5.4. Twin studies

Some of the most important insights into the relative influence of genes and social environment on behaviour – nature and nurture – have come from twin studies. Since identical (or monozygotic) twins share the same genes, any genetic influence on one twin will be expressed equally in the co-twin. For example, since eye colour is genetically inherited, if one twin has blue eyes the co-twin will also have blue eyes. Recent twin studies have confirmed that identical twins have the same eye colour in almost 100% of cases.[11]

Why are some people sexually attracted to people of the same sex?

Several largescale twin studies have addressed the question of same-sex attraction in recent years, including: Bailey (2000);[12] Långström (2010)[13] and Burri (2011).[14] They have explored the influences of genes, family and life experiences.

All three studies found that the dominant influence on same-sex attraction is not genes, but unique life experiences – with estimates of the latter influence ranging from about 55% to 75%. In the Bailey and Långström studies, this was the *only* statistically significant influence found.

No study found any family influence, namely due to the twin's common social environment. The Burri study found a small but statistically significant heritability of 25%. How should this be interpreted? The influence could be genetic, or identical twins could influence each other towards same-sex attraction more than fraternal twins do.

What are the non-shared social environment factors that dominate the development of same-sex attraction?

All studies based on a comparison of identical twins and fraternal twins assume that the non-shared environment includes anything that individual twins experience differently. Even a shared home may

be a non-shared environment, since parents may treat different children differently. A family event, such as divorce, may affect children differently. Children may experience different interactions with siblings, relatives, peers, schooling and the media.

One non-shared environment factor has been identified: significantly higher rates of childhood or adolescent homosexual molestation are reported among homosexual men and women than among heterosexuals.[15] For example, Dr Tomeo reported that 46% of the homosexual men surveyed were homosexually molested as a child, compared with 7% of heterosexual men. And 22% of lesbian women reported childhood homosexual molestation compared with 1% of heterosexual women. Homosexual abuse during childhood or adolescence seems to be one of the major influences on later adult same-sex attraction.

Homosexuality is not caused by genes or any one particular factor. Identical twins have the same genes, along with essentially the same exposure to maternal hormones in the womb that they share. But unlike eye colour, which has 100% concordance in identical twins, homosexuality has only about 10% concordance. It is clear that while life experiences – in some cases at a very early age – are involved, genes and hormones play a very minor part, if any.

Homosexuality is a human behaviour on par with other behaviours that are influenced by many differing environmental factors. Like those other behaviours – which may have been practised and reinforced over many years – change may be difficult. But if such a change is strongly desired, it is certainly not impossible and should not be prevented by legislation

5.5. What is 'reparative therapy'?

The public conversation about conversion practices not infrequently refers to the rare examples of the use of electric shock treatment or other unacceptable forms of treatment. The assumption is that all reparative therapy is driven by homophobia.

This is not the case. For example, reparative therapy has become widely known since the 1990s through the work of US psychotherapist Dr Joseph Nicolosi.

- It is a "talking therapy" and doesn't involve electric shocks
- It does not involve repressing sexual feelings, nor any kind of "trying" to be interested in the opposite sex.

Rather, patients who seek this therapy are encouraged to learn to connect with men as brothers, along with developing an unconditional self-acceptance. If and when changes in sexual orientation occur, they flow naturally as a consequence of overcoming shame issues around men, and feelings of "not fitting in" with men and one's place in their world as equals.[16]

The term "reparative therapy" is often conflated or used interchangeably with "conversion" therapies, which have different origins and involve different processes.

Conversion therapy is based on discredited aversion-type behavioural therapies. It should not be confused with reparative therapy.[17]

5.6. Can a person's sexuality change over time?

Overseas studies have shown that significant numbers of younger people change their sexual orientation over several years – mostly without therapy of any kind. These studies demonstrate very clearly that sexual orientation can be a fluid condition. Change is certainly possible for some people.

A 1997 study of Dutch adult males found that, of those who had experienced same-sex attraction at some stage of their lives, about half reported that those feelings disappeared later in life.[18]

A New Zealand cohort study found that one half of females and one third of males with occasional same-sex attraction at 21 years had only opposite-sex attraction at 26 years.[19]

Sexual attraction is particularly unstable in adolescents. US longitudinal research on adolescent health, using large scale surveys of 16, 17 and 22 year olds, revealed major changes in romantic attraction and sexual behaviour between those ages.[20] Of the boys who identified at 16 years as same-sex attracted, 72% were opposite-sex attracted by the age of 22 years – they had "discovered" girls. And of the same-sex attracted girls at 16 years, 55% were opposite-sex attracted by age 22.

The common claim that sexual orientation is fixed and unchangeable is a myth.

5.7. Why do some people seek to help change their sexual orientation?

There are several reasons why a person might wish to change their sexual orientation – and religious beliefs and avoiding stigma are not necessarily among them.

For both men and women, it may be a desire to procreate children in the natural way, and to share the raising of those children with their other natural parent.

Research shows that alcohol, tobacco smoking and drug abuse generally are disproportionately associated with the gay and lesbian community.[21] It is understandable that some men and women may wish to quit this environment in order to help end their addictions.

For men in particular, a wish to change orientation may be a desire to avoid the serious health consequences that are linked with the male homosexual lifestyle. ACON (originally known as the AIDS Council of NSW) has reported that almost all homosexual men have tried anal intercourse at least once, and about 80% say they have had anal intercourse during the past six months. Over 60% have performed "rimming" (anal-oral contact) during that time.[22]

These practices, which involve contact with harmful faecal pathogens, may seriously damage the health of participants – quite apart from the risk of HIV/AIDS transmission, of which the incidence in Australia is overwhelmingly among men who have sex with men.[23]

It is understandable that individuals may wish to explore the possibility of orientation change. The current campaign to deny them any possibility of such exploration is an outrageous breach of human rights.

5.8. Is reparative therapy harmful?

Despite claims by LGBTIQA+ activists, there is no valid research showing that reparative therapy causes harm.

A 2002 study by Shidlo and Schroeder,[24] purporting to show such harm, was biased from the start. The researchers recruited subjects by asking: "Help us document the damage of homophobic therapies"!

Of around 200 men in this study, 23 said they had tried to kill themselves during their therapy, and 11 tried to do so after finishing therapy.

But the study did not prove that reparative therapy caused these serious consequences. No fewer than 25 participants had already attempted suicide before undergoing the therapy. A significant proportion of these men were psychologically very unstable.[25]

Indeed, *all* forms of therapy for *any* psychological condition carry some degree of risk of negative experiences. Extensive research has shown that 5-10% of adult clients across all forms of psychotherapy are worse after treatment and that higher deterioration rates – sometimes exceeding 20% – have been reported for children and adolescents in psychotherapy (Lambert, 2013; Lambert & Ogles, 2004; Nelson, Warren, Gleave, & Burlingame, 2013).[26]

Thus researchers would need to demonstrate reparative therapy deterioration rates significantly beyond 10% for adults and 20% for youth in order to substantiate harm. No such research exists.[27]

The American Psychological Association (APA) commissioned a task force on Appropriate Therapeutic Responses to Sexual Orientation Change Efforts (SOCE).

The task force presented its report in 2009. It set out its methodology regarding the assessment of harm as follows:

> *Based on Lilienfeld's (2007) comprehensive review of the issue of harm in psychotherapy, our systematic review examines harm in the following ways:*
>
> - *Negative side effects of treatment (iatrogenic effects)*
> - *Client reports of perceptions of harm from treatment*
> - *High drop-out rates*
> - *Indirect harm such as the costs (time, energy, money) of ineffective intervention.*

The task force had been strongly criticised for its unbalanced composition – its membership only included those who subscribed to the view that SOCE were not "appropriate".

Nevertheless, the APA task force concluded that there was "a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE."[28]

Jones and Yarhouse say: "(W)e found little evidence of harm incurred as a result of the involvement of the participants in the Exodus change process. These findings would appear to contradict the commonly expressed view of the mental health establishment that change of sexual orientation is impossible and that the attempt to change is highly likely to produce harm for those who make such an attempt.[29]

Valid research does not support claims that reparative therapy causes harm. The campaign against reparative therapy is driven not by evidence but by ideology.

5.9. Is reparative therapy beneficial?

Despite claims to the contrary, many studies show the benefits of reparative therapy.

Dr Robert Spitzer was the leading psychiatrist involved in persuading the American Psychiatric Association to stop classifying homosexuality as a mental disorder in its diagnostic manual in 1973.

So Spitzer caused a huge sensation in 2001 when he presented a study showing that it was possible for some homosexual men and lesbians to change their orientation. In 2003 his study was published in a peer-reviewed journal, and reported the high satisfaction rate of the majority of reparative therapy participants.[30]

But in 2005 Spitzer reported that many of his colleagues were outraged by the publication of his research. There was tremendous anger in the gay community, which felt he had betrayed them by his "wrong" conclusions. Spitzer said he was suffering "battle fatigue" from the controversy.[31]

By 2012 his battle fatigue had grown to the point where Spitzer contacted his publisher to apologise for his earlier interpretation of his results.[32]

Nevertheless, Spitzer's study stands. It did not falsify data, nor did it analyse them incorrectly. Some critics have argued that since his research was carried out retrospectively, its results could be skewed by inaccurate memories of participants. But if all such data are deemed invalid, a great many studies would have to be discarded – including the Shidlo and Schroeder study mentioned in the previous section.

Dr Spitzer's experience of continued harassment and persecution, merely because his research results did not please the homosexual community, would have had a chilling effect on others thinking of investigating similar areas.

A longitudinal study by Jones and Yarhouse found "empirical evidence that change of homosexual orientation may be possible through involvement in Exodus ministries, either:

1. in the form of an embrace of chastity with a reduction in prominence of homosexual desire, or
2. in the form of a diminishing of homosexual attraction and an increase in heterosexual attraction with resulting satisfactory heterosexual adjustment.

"These latter individuals regard themselves as having changed their sexual orientation; the former regard themselves as having re-established their sexual identities to be defined in some way other than by their homosexual attractions."[33]

Jones and Yarhouse report that nearly every study ever conducted on change of orientation found some evidence of meaningful change.

They say: "The average positive outcome across these studies is about 30%, with another 30% or so 'in process'. While this is surely not a stunningly high rate of success, it is in line with the reported success rates for change attempts dealing with complex relational issues that are often faced in marital or family therapy, or the more difficult and stable psychological conditions. Also, the lack of sophisticated methodology does not prove the treatments failed; rather, it challenges researchers to provide more sophisticated program evaluations and outcome studies to clarify what clients can expect from various programs."[34]

6. Gender “conversion” practices

6.1. What is gender dysphoria?

Gender dysphoria is a psychological condition in which an individual’s mental view of their gender does not line up with the biological reality.

6.2. Does “transitioning” help mental health?

Despite being fashionable and in vogue, a comprehensive recent study found that so-called “sex-reassignment” procedures do not help mental health. As Ryan T. Anderson of the Heritage Foundation noted:

> *The world’s largest dataset on patients who have undergone sex-reassignment procedures reveals that these procedures do not bring mental health benefits. But that’s not what the authors originally claimed. Or what the media touted.*
>
> *In October 2019, the American Journal of Psychiatry published a paper titled, “Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study.” As the title suggests, the paper claimed that after having had sex-reassignment surgeries, a patient was less likely to need mental health treatment.*
>
> *Well, over the weekend [1 August 2020], the editors of the journal and the authors of the paper issued a correction. In the words of the authors, “the results demonstrated no advantage of surgery in relation to subsequent mood or anxiety disorder-related health care.”*
>
> *But it’s actually worse than that. The original results already demonstrated no benefits to hormonal transition. That part didn’t need a correction.*
>
> *So, the bottom line: The largest dataset on sex-reassignment procedures—both hormonal and surgical—reveals that such procedures do not bring the promised mental health benefits.*
>
> *In fact, in their correction to the original study, the authors point out that on one score—treatment for anxiety disorders—patients who had sex-reassignment surgeries did worse than those who did not:*
>
> individuals diagnosed with gender incongruence who had received gender-affirming surgery were more likely to be treated for anxiety disorders compared with individuals diagnosed with gender incongruence who had not received gender-affirming surgery.
>
> *You would think patients suffering from gender dysphoria would want to know that.*[35]

Paul Dirks has highlighted that the longer the studies of individuals who have undergone “sex-change” treatments, the more negative the outcomes:

> *a Dutch study in 2011 of those on cross-sex hormones, found that, while outcomes for the female-to-males seemed generally positive, for the much larger male-to-female group—72.6 percent of the total—“total mortality was 51 percent higher than in the general population, mainly from increased mortality rates due to suicide, acquired immunodeficiency syndrome [AIDS], cardiovascular disease, drug abuse, and unknown causes.” The timing of the suicides also provides important information. None occurred within two years of treatment, but “there were six suicides after two to five years, seven after five to ten years, and four after more than ten years of cross-sex hormone treatment”.*
>
> *Cecilia Dhejne et al.’s 2011 Swedish study is among the most well-known studies on transition outcomes—partially due to its surprisingly negative results, and partially due to differences*

> *among authors in interpreting the data. The sample was of 324 post-surgery transsexuals with median follow-up time of over ten years, the largest study of those post-SRS (sex-reassignment surgery). Findings included 7.6 times more suicide attempts than controls and nineteen times more completed suicides. Psychiatric hospitalization was 2.8 times higher, even after adjusting for prior psychiatric morbidity.*
>
> *Most recently, a 2016 Danish study compared psychological treatment before and after SRS in a group of over one hundred transsexuals. Concerning psychiatric morbidity, "no significant differences were found between the number of MtF [male-to-female transitioning] and FtM [female-to-male transitioning] individuals suffering from psychiatric morbidity pre- and post-SRS." While psychological problems improved for some in the group, it worsened for others, and there was no statistically significant net benefit. Due to the lower numbers in this study, there was no analysis possible of the mortality data; but "ten individuals were registered as deceased post-SRS with an average age of death of 53.5 years," and there were two suicides—both surprising data.*
>
> *In fact, out of the six long-term outcome studies (over more than ten years) that have useful data on mental or psychological functioning, no less than five report mixed or poor outcomes. A small Swedish study in 1986 found that mental health and employment were highly mixed after SRS, leading the author to conclude that "it seems reasonable to expect only marginal improvement psychosocially after surgery." A Swiss study in 1998 with a high loss to follow-up found significant deterioration in a post-SRS clinical sample. The authors state that the negative outcomes, including a high percentage of regret and inability to work, are likely a function of time.*[36]

6.3. Can a person change their sex?

The reality is that "sex change" is a myth. Neither hormone treatment nor surgery can actually change a person's sex.

> *The DNA in every cell in the body is marked clearly male or female. Hormones circulating in an unborn child's brain and body shape his or her development. Psychiatrists and surgeons who have served transsexual clients know surgery does not change sex. George Burou, a Moroccan physician, admitted: "I don't change men into women. I transform male genitals into genitals that have a female aspect. All the rest is in the patient's mind."*[37]

Australian resident Alan Finch, who decided at age 19 years to transition from male to female and had genital surgery in his 20s, later regretted this action which he described as "genital mutilation". At age 36, he told the Guardian newspaper in 2004:

> *transsexualism was invented by psychiatrists… You fundamentally can't change sex … the surgery doesn't alter you genetically. It's genital mutilation. My 'vagina' was just the bag of my scrotum. It's like a pouch, like a kangaroo. What's scary is you still feel like you have a penis when you're sexually aroused. It's like phantom limb syndrome. It's all been a terrible misadventure. I've never been a woman, just Alan … the analogy I use about giving surgery to someone desperate to change sex is it's a bit like offering liposuction to an anorexic.*[38]

Clearly, sex change operations are illusory.

6.4. Social contagion

A recent study by Lisa Littman from Brown University suggests that social contagion plays a significant role in the rapid onset of gender dysphoria in children:

> *Parents have described clusters of gender dysphoria outbreaks occurring in pre-existing friend groups with multiple or even all members of a friend group becoming gender dysphoric and transgender-identified in a pattern that seems statistically unlikely based on previous research. Parents describe a process of immersion in social media, such as "binge-watching" Youtube transition videos and excessive use of Tumblr, immediately preceding their child becoming gender dysphoric. These descriptions are atypical for the presentation of gender dysphoria described in the research literature and raise the question of whether social influences may be contributing to or even driving these occurrences of gender dysphoria in some populations of adolescents and young adults.*[39]

Cathy Ruse of the Family Research Council noted that:

> *As part of the study, parents were asked to name the sources they thought influenced their child's gender dysphoric feelings. The top results were YouTube transition videos (63.6%), Tumblr (61.7%), a group of personal friends (44.5%), and a group of people that they met online (42.9%).*
>
> *Online "advice" is worse than you might think. According to the study, it goes far beyond "maybe you're transgender." Children are actually instructed on "how to deceive parents, doctors, and therapists to obtain hormones quickly."*[40]

This reinforces why parents, who know their children best, must not be sidelined with respect to matters pertaining to human sexuality.

6.5. Most children learn to accept their bodies

The reality is that most children who suffer from gender dysphoria will come to accept their biological sex, as Dr Paul McHugh, a former psychiatrist in chief at Johns Hopkins University has pointed out:

> *When children who reported transgender feelings were tracked without medical or surgical treatment at both Vanderbilt University and London's Portman Clinic, 70%-80% of them spontaneously lost those feelings.*[41]

Johns Hopkins University was the first American medical center to perform so-called "sex re-assignment" surgery but Dr McHugh closed the "sex-change" clinic in 1979 due to patients who underwent the procedure faring no better than those who did not.[42,43]

6.6. Puberty blocker risks

Professor John Whitehall has highlighted the risks associated with puberty blockers:

> *Following "social affirmation" of a child's insistence that he or she was born in the wrong body, the next step is the introduction of "puberty blockers". These drugs, developed in the 1970s, are similar to natural hormones. They can block the cascade of hormones that kick-start puberty deep in the brain and progress to the testes and ovaries, causing them to release testosterone and oestrogen. These sex hormones stimulate development of secondary characteristics, including the sexualisation of the brain. Puberty blockers were first used to block the pathological early development of puberty. They were also prescribed for adults suffering from diseases worsened by continued production of sex hormones, such as prostate cancer in men and endometriosis in women. In the 1980s the blockers began to be used to treat childhood gender dysphoria. They were said to reduce distress caused by the appearance of unwanted sex characteristics, and to give the children more time to consider their sexual identity and procreative future. Repeatedly, and under oath in Family Court of Australia proceedings, proponents declared the blockers' effects to be "safe and entirely reversible". However, research*

> *on sheep has proven this claim to be wrong. Researchers in universities in Glasgow and Oslo have shown that the administration of puberty blockers has resulted in changes to the limbic system of sheep. In those sheep on blockers, the limbic system became enlarged and the actions of many of its genes were disrupted. As a result, the sheep had reduced ability to learn and remember (cognitive performance) and increased mood swings (emotional lability).*
>
> *Studies of adult humans on blockers have found reduced cognitive and psychological performance, although confounders such as age, pathology and treatment could not be discounted. Furthermore, research on intestinal disorders in women receiving blockers to reduce the effect of oestrogen in endometriosis, reveals a marked reduction in the number of intestinal neurons. The claim of safety for the use of blockers in children is not substantiated by international research. In the Rogers vs Whitaker legal case, the High Court of Australia confirmed an obligation by a medical practitioner to reveal even a one in ten thousand possibility of a material side effect of therapy. Who will be responsible for compensation when vulnerable children later claim handicaps to be the result of uninformed treatment?*[44]

Professor Whitehall has also drawn attention to the irreversible nature of the use of hormones on children:

> *Cross-sex hormones suppress the activity of ovaries or testes. How long it takes for the suppression to become permanent is unknown, but chemical castration is the end result. Proponents of childhood transgendering confirm this, by suggesting eggs of females and biopsies of testicles be taken before undertaking cross-sex hormones in order to procure future artificial conceptions. The Australian Standards of Care and Treatment Guidelines for trans and gender diverse children and adolescents, promoted by the Royal Children's Hospital in Melbourne, state at page 14:*
>
> *For trans males, treatment with testosterone does not necessarily cause infertility… However, the degree to which testosterone may reduce one's reproductive potential when taken in adolescence and early adulthood is unknown… For trans females, there is evidence that oestrogen impairs sperm production, although whether these effects are permanent remain unknown.*
>
> *It is doubtful whether such advice would convey a full understanding of the likely irreversible loss of their fertility to teens facing treatment with cross-sex hormones. With surgery the next step in dysphoria treatment, international advice is that irreversible therapy should not be undertaken under the age of 18. But at least five biological girls have had double mastectomies under that age in Australia. Two were aged 15, one 16 and two, 17. Proponents of transitioning argue that mastectomies are "reversible". By this they imply the breast is merely a cosmetic structure whose shape may be restored by silicon implants, as if breast feeding is irrelevant.* [45]

6.7. Detransition movement

There is a growing number of people who are seeking to detransition – returning to living as their biological sex.

> *Hundreds of young transgender people are seeking help to return to their original sex, a woman who is setting up a charity has told Sky News.*
>
> *Charlie Evans, 28, was born female but identified as male for nearly 10 years before detransitioning.*
>
> *…*
>
> *Charlie detransitioned and went public with her story last year - and said she was stunned by the number of people she discovered in a similar position.*

> *"I'm in communication with 19 and 20-year-olds who have had full gender reassignment surgery who wish they hadn't, and their dysphoria hasn't been relieved, they don't feel better for it," she says.*
>
> *"They don't know what their options are now."*
>
> *Charlie says she has been contacted by "hundreds" of people seeking help - 30 people alone in her area of Newcastle.*
>
> *"I think some of the common characteristics are that they tend to be around their mid-20s, they're mostly female and mostly same-sex attracted, and often autistic as well."*
>
> *She recalls being approached by a young girl with a beard who hugged her after giving a public talk, who explained she was a destransitioned woman too.*
>
> *"She said she felt shunned by the LGBT community for being a traitor. So I felt I had to do something."*

Evans has formed the The Detransition Advocacy Network which aims to "improve the well-being of detransitioned people everywhere".[46]

The BBC reported on the case of European couple Ellie and Nele:

> *Ellie is 21 and Belgian. Her German partner, Nele, is 24. Both took testosterone to become more masculine, and they had their breasts removed in double mastectomy surgery. Now they have detransitioned, and live again as female - the gender they were assigned at birth.*
>
> *"I'm very happy I didn't have a hysterectomy," reflects Nele. "It means I can stop taking hormones, and my body will return to looking feminine."*
>
> *Last year, they both made the decision to end their use of testosterone and start using the female pronouns "she" and "her" again. Slowly their own natural oestrogen has begun to re-feminise their bodies.*
>
> *"I'm very excited to see the changes," says Ellie.*
>
> *Their faces have softened, their bodies become curvier. But years of taking testosterone has had one profound, irreversible effect.*
>
> *"My voice will never come back," says Nele. "I used to love singing and I can't sing any more - like my voice is just very monotone, it works very differently. When I call someone on the phone, I get gendered as male."*[47]

Keira Bell, 23, is perhaps one of the most high profile of detransitioners, having recently participated in a widely reported UK court case surrounding children's ability to consent to transgender treatments. Bell was prescribed puberty blockers at 16 and had a double mastectomy four years later.[48] Bell argued that the practice of prescribing puberty-blocking drugs to children under 18 was unlawful as they lacked competence to give valid consent to the treatment:

> *In 2013, [Bell] began puberty blockers and was warned about the risk to her fertility but at the time she was "not thinking about children" and "her priority was to move on to testosterone".*
>
> *She told the court her doubts about the wisdom of medicalised gender change were triggered by "really noticing how physically different I am to men as a biological female, despite having testosterone running through my body. There were also a lot of experiences I could not relate to when having conversations with men, due to being biologically female and socialised in society as a girl".*
>
> *"I started to realise the vision I had as a teenager of becoming male was strictly a fantasy. My biological make-up was still female … no matter how much testosterone was in my system … I*

> *started to just see a woman with a beard, which is what I was. I felt like a fraud and I began to feel more lost, isolated and confused than I did when I was pre-transition," Bell said.*[49]

"Given the long-term consequences of the clinical interventions at issue in this case, and given that the treatment is as yet innovative and experimental, the court recognised that clinicians may well regard these as cases where the authorisation of the court should be sought before starting treatment with puberty blocking drugs," the court judgment stated.

7. Conclusion

Given the absence of proven harm in Tasmania or anywhere else, and the clear evidence of beneficial outcomes in a significant number of cases, reparative therapy should be recognised as a valid option for those people who suffer distress because of unwanted sexual attractions, which are influenced far more by life experiences than genes or hormones.

The harmful conversion practice which should be banned is so-called "gender" conversions, especially for children. As has been pointed out, there is no such thing in reality as a sex-change. It is not biologically possible.

Such treatments cause lasting damage, particularly in terms of reproductive functioning. Medical professionals should not be telling individuals with gender dysphoria that they are "broken" or have been "born in the wrong body" but instead should be encouraging them to accept their body.

The crackdown on so-called conversion practices in other states provides no basis for the Tasmanian Government to do likewise, especially given the complete lack of evidence of harm in the State.

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