

1. I have agreed to act pro bono as the psychiatric expert instructed on behalf of Mr and Mrs Rowe. I understand that this report will be used for an administrative complaint pursuant to Education Act 1996, but also may be used in Court in due course. The opinions stated in this report represent my true and complete professional opinions on the matters to which they refer.

### **Instructions**

2. I have been asked to review the following documents:

a. Correspondence between Mr and Mrs Rowe and the [REDACTED]

[REDACTED];

b. “Schools Transgender Guidance” (more commonly known as the Cornwall guidance).

3. I have been instructed to prepare an expert report addressing, with reference to the existing policy as it appears to be from the aforementioned documents, the benefits and risks for physical and/or mental health of children under 16 if they are treated as ‘transgender’ at school.

### **Qualifications and Experience**

4. I currently am University Distinguished Service Professor of Psychiatry at the Johns Hopkins University School of Medicine. From 1975 until 2011, I was the Henry Phipps Professor of Psychiatry and the director of the Department of Psychiatry and Behavioral Science at Johns Hopkins. At the same time, I was psychiatrist-in-chief at the Johns Hopkins Hospital with overall responsibility for the proper care and treatment of patients with, among other issues, sexual disorders.

5. I received my M.D. from Harvard Medical School in 1956. I am Board Certified by the American Board of Psychiatry & Neurology (Neurology)(1967) and the American Board of Psychiatry & Neurology (Psychiatry)(1968).
6. I have well over 100 peer-reviewed publications in the field of psychiatry. In 1975, I co-authored a paper with Marshall and Susan Folstein, entitled "Mini-Mental State: A Practical Method for Grading the Cognitive State of Patients for the Clinician," which became the basis for the now widely used Mini Mental State Exam (MMSE), which quickly and accurately assess patients for cognitive impairment.
7. In 1992, I was elected to the Institute of Medicine, now the National Academy of Medicine. In 2001, I was appointed by President George W. Bush to the Presidential Council on Bioethics.
8. I have also done extensive research and publishing in the field of gender dysphoria and gender reassignment, including as to how it relates to children. In 1979, upon my recommendation, Johns Hopkins closed its gender identity clinic, thus ending Gender Reassignment surgery by the hospital for nearly 4 decades.
9. I have recently co-authored a criticism of medical treatment for youth who present with gender confusion for the American College of Paediatricians. In 2016, I co-authored an extensive review of scientific literature on gender and sexuality for which the *New Atlantis* devoted an entire journal volume.

**Opinion as to the Efficacy of Gender Affirming Policies, and in particular, the Cornwall Guidance**

10. Simone de Beauvoir wrote that “one is not born, but becomes a woman.” This notion is an early version of the now familiar distinction between sex as a biological designation and gender as a cultural construct: though one is born, as the APA explains, with the

“chromosomes, hormone prevalence, and external and internal anatomy” of a female, one is socially conditioned to take on the “roles, behaviors, activities, and attributes” of a woman.<sup>1</sup>

11. The view that gender, and thus gender identity, are fluid and plastic, and not necessarily binary, has recently become more prominent in popular culture. An example is Facebook’s move in 2014 to include 56 new ways for users to describe their gender, in addition to the options of male and female. As these terms multiply and their meanings become more individualized, we lose any common set of criteria for defining what gender distinctions mean. If gender is entirely detached from the binary of biological sex, gender could come to refer to any distinctions in behaviour, biological attributes, or psychological traits, and each person could have a gender defined by the unique combination of characteristics the person possesses. This *reductio ad absurdum* is offered to present the possibility that defining gender too broadly could lead to a definition that has little meaning.<sup>2</sup>

12. There is no scientific evidence that such gender-affirming mandates, such as the guidance being challenged herein, does anything to aid the children it aims to help. **I would strongly argue to the contrary that there is abundant scientific evidence that policies like the Cornwall Guidance does none of the children it is meant to serve any real or lasting good; that it harms the vast majority of them; and that it leads to catastrophic outcomes for many such afflicted children.**

13. The guidance being held out as best practice by the Department of Education suggests an approach which emphasises affirming a child’s preferred gender identity. This approach has become increasingly more common in the United States, where I practise.<sup>3</sup> This model

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<sup>1</sup> Lawrence S. Mayer, Paul R. McHugh, *Sexuality and Gender*, The New Atlantis, Issue 50, Fall 2016, A Journal of Technology and Society, p. 87.

<sup>2</sup> *Id.*, p. 88.

<sup>3</sup> See, for example, American Psychological Association, “Guidelines for Psychological Practice with Transgender and Gender Non-Conforming People,” *American Psychologist* 79 no. 9, (2015); and Marco A. Hidalgo *et al.*, “The Gender Affirmative Model: What We Know and What We Aim to Learn,” *Human Development* 56 (2013); 285-290.

focuses on helping the children involved by affirming them in whichever gender they choose to self-identify at the time. To be clear, there is no credible scientific literature that suggests a person's choice of gender affects their biology in any way. One's sense of self and one's desire to present to others as a member of the opposite sex have no bearing whatsoever upon the biological reality that one is male or female.

14. Sex and gender represent two very distinct features of our world. While sex is binary and objective, determined fundamentally by one's chromosomal constitution, and ultimately by clearly defined reproductive capacities, gender is a subjective sense of a social role generated by cultural norms.<sup>4</sup> Sex is immutable. The genetic information directing development of male or female gonads and other primary sexual traits, which normally are encoded on chromosome pairs "XY" and "XX" are present at conception. As early as eight weeks' gestation, endogenously produced sex hormones cause prenatal brain imprinting that ultimately influences postnatal behaviours.<sup>5</sup>

15. No matter how disturbing the condition of gender dysphoria may be, nothing affects the biological reality of that child. It is widely accepted that the science behind sex is simple and straightforward. Biological sex is a fixed principle, determined at conception.<sup>6</sup> More than 20% of the genes in the human genome are specific to one sex or the other.<sup>7</sup> In most tissue, there are over 6500 protein-coding genes with specific sex-differential expression.<sup>8</sup> The most sex-differentiated tissue in the human body relates to the reproductive organs, with the breast

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<sup>4</sup> Quoted from my expert brief before the United States Supreme Court: Brief of Dr. Paul R. MchHugh, M.D., Dr. Paul Hruz, M.D., PH.D. and Dr. Lawrence S. Mayer, PH.D. as Amici Curiae, Gloucester County School Board v. G.G., by his next friend and mother, Deidre Grimm, (January 10, 2017)(No. 16-273). See also: American Psychological Association, "Answers to Your Questions About Transgender People, Gender Identity and Gender Expression" (pamphlet), <http://www.apa.org/topics/lgbt/transgender.pdf>.

<sup>5</sup> See: Francisco I. Reyes *et al.*, *Studies on Human Sexual Development*, 37 J. of Clin. Endocrinology & Metabolism 74-78 (1973).

<sup>6</sup> Fauci, Anthony S.; Harrison, T. R., eds. (2008). *Harrison's principles of internal medicine* (17th ed.). New York: McGraw-Hill Medical. pp. 2339–2346.

<sup>7</sup> Prof. Pietrokovski, Shmuel; Dr. Gershoni, Moran. *The Landscape of Sex-Differential Transcriptome and Its Consequent Selection in Human Adults*, BMC Biology (2017) 15:7.

<sup>8</sup> *Id.*

mammary glands being the most differentiated to allow for lactation in females.<sup>9</sup> Men and women differ in their predisposition to certain diseases precisely because of this genetic architecture in our tissue.<sup>10</sup> This architecture also explains body physiology. For example, gene expression for muscle building is higher in men; and in women gene expression is higher in fat tissue because it relates to her biological capacity for having children and needing as a result to store fat.<sup>11</sup>

16. The central underlying basis for sex is the distinction between the reproductive roles of males and females.<sup>12</sup> In biology, an organism is male or female if it is biologically and physiologically designed to perform on the respective roles in reproduction. The objective definition of whether we are male or female has nothing to do with amorphous physical characteristics, internal feelings of the individuals involved or behaviours. Scientifically speaking, reproductive roles provide the conceptual basis for the differentiation of animals into the biological categories of male or female. There is no other credibly accepted biological classification of the sexes. Sex is a physiological reality which permeates every cell of an organism. It is this innate and immutable.

17. Even when we look to non-mammals, such as the emperor penguin, where male penguins take on many of the traditional female nurturing roles in parenthood, zoologists nonetheless do not conclude that the egg-laying member of the emperor penguin species is in fact the male. The only variable that serves as the fundamental and reliable basis for biologists to distinguish the sexes of animals is their role in reproduction, not some other behavioural or biological trait.<sup>13</sup>

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<sup>9</sup> *Id.*

<sup>10</sup> Rawlik K, Canela-Xandri O, Tenesa A. *Evidence for Sex-specific genetic architectures across a spectrum of human complex traits*. *Genome Biol.* 2016; 17: 166.

<sup>11</sup> Prof. Pietrokovski, Shmuel; Dr. Gershoni, Moran, *The Landscape of Sex-Differential Transcriptome (see fn. 20)*.

<sup>12</sup> Lawrence S. Mayer, Paul R. McHugh, *Sexuality and Gender*, *The New Atlantis*, Issue 50, Fall 2016, *A Journal of Technology and Society*, p. 89-90.

<sup>13</sup> *Id.*, 90.

18. Gender Identity Disorder is an obsolete term from an earlier version of the DSM that was removed from its fifth edition, and was used for psychiatric diagnosis. Comparing the diagnostic criteria for gender dysphoria (the current term) and gender identity disorder (the former term), we note that both require the patient to display “a marked incongruence between one’s experienced/expressed gender and their assigned gender.”<sup>14</sup> The key difference is that a diagnosis of gender dysphoria requires the patient additionally to experience a “clinically significant distress or impairment in social, occupational, or other important areas of functioning” associated with the incongruent feelings.<sup>15</sup> Thus the major set of diagnostic criteria used in contemporary psychiatry does not designate all transgender individuals as having a psychiatric disorder. Precisely stated, a person who identifies as the opposite sex but does not present with significant psychological distress at the incongruence does not meet the clinical definition of gender dysphoria. However, according to English law, a Gender Recognition Certificate may only be issued after receiving evidence of gender dysphoria, provided either by a medical practitioner practising in the field of gender dysphoria or a chartered psychologist in the field.<sup>16</sup>

19. If we, however, look at the Diagnostic and Statistical Manual for Mental Disorders diagnosis for gender identity disorder, which has many of the same substantive diagnostic attributes as gender dysphoria, we see a staggering amount of co-morbidities attributed to gender confusion.<sup>17</sup> Gender affirming policies, by merely accepting a child’s wishes (or those of his parents) to explore their own gender without querying the root cause of that confusion,

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<sup>14</sup> American Psychiatric Association, “Gender Dysphoria,” *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, [DSM-5], Arlington, VA, American Psychiatric Association, 2013, 452.

<sup>15</sup> *Id.*

<sup>16</sup> *Gender Recognition Act 2004 (c.7)*, §3(1)(a-b).

<sup>17</sup> These comorbidities include mood disorders such as major depression and dysthymia; substance related disorders such as sedative dependence or cannabis dependence; anxiety disorders such as panic disorder, agoraphobia, social phobia, specific phobia, generalised anxiety disorder, and posttraumatic stress disorder; and somatoform disorders such as undifferentiated somatoform disorder, pain disorder, and body dysmorphic disorder; schizophrenia and other psychotic disorders such as schizophrenia disorder and psychotic disorder otherwise not specified; and eating disorders such as anorexia nervosa.

may in fact be ignoring the symptoms of any number of other disorders. Thus rather than being able to treat the child's actual condition, these policies defer diagnosis and may lead to long term serious harm and persistence of symptoms. **There is no other area in medicine where we unconditionally allow children to choose their own diagnosis.**

20. Another objection to gender affirming policies is the extremely high rate by which gender confused children eventually settle into their birth sex as puberty develops. According to the American Psychiatric Association, and the Diagnostic and Statistical Manual of Mental Disorders (5<sup>th</sup> ed.), 98% of gender confused boys and 88% of gender confused girls eventually accept their biological sex after naturally passing through puberty.<sup>18</sup> This means with boys, that only 2 out of 100 who identify as being of a different gender continue to believe so after puberty.<sup>19</sup> Studies also show that gender confusion can persist as a result of family and peer dynamics including parental and school reinforcement of cross gender behaviour; not as a result of actual gender dysphoria.<sup>20</sup> This means that adults, however well meaning, are likely to be unnecessarily perpetuating gender confusion to the detriment of the long term psychological health of that child.

21. A particularly sinister component of the gender-affirming approach has been the use of hormone treatments for adolescents in order to delay the onset of sex-typical characteristics that are at odds with the gender with which they wish to identify. Not only does this artificial stunting of puberty delay the natural process whereby most children settle into their natural birth sex, it in essence treats puberty as a disease. To the contrary, puberty should be welcomed as the natural and healthy progression of that child into adulthood.

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<sup>18</sup> American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, Arlington, VA, American Psychiatric Association, 2013 (451-459). See page 455 re: rates of persistence of gender dysphoria.

<sup>19</sup> Lawrence S. Mayer, Paul R. McHugh, *Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences*, The New Atlantis, Fall (2016), part 3.

<sup>20</sup> Zucker, Kenneth J. *Children with gender identity disorder: Is there a best practice?*, *Neuropsychiatrie de l'Enfance et de l'Adolescence* 56, no. 6 (2008): 363, <http://dx.doi.org/10.1016/j.neurenf.2008.06.003>.

22. Puberty blocking hormones<sup>21</sup>, which would entail the next natural progression in the gender re-identification process, which can be begun as early as age 11, inhibit growth and fertility and will have life-long effects on any child taking them.<sup>22</sup> Children who take hormone inhibiting drugs may well never be able to conceive any genetically related children even through artificial reproductive technology.<sup>23</sup>

23. While these gender affirming policies do not themselves require pharmaceutical or surgical intervention, nonetheless corresponding puberty suppression, hormone therapy and surgical interventions are a common complement. As more gender affirmance is promoted to children, the natural consequent will be that more children can be expected to accept, and even pursue, these drastic medical courses.

24. These treatments are neither fully reversible or harmless.<sup>24</sup> Puberty suppression hormones prevent the development of secondary sex characteristics, arrest bone growth, decrease bone accretion, prevent full organisation and maturation of the brain, and inhibit fertility.<sup>25</sup> Cross-gender hormones increase a child's risk for coronary disease and sterility.<sup>26</sup> Oral estrogen , which is administered to gender dysphoric boys, may cause thrombosis, cardiovascular disease, weight gain, hyperglyceridaemia, elevated blood pressure, decreased glucose intolerance, gall bladder disease, prolactinoma, and breast cancer.<sup>27</sup> Testosterone administered to gender dysphoric girls may negatively affect their cholesterol; increase their hepatotoxicity and polycythaemia (an excess of red blood cells); increase their risk of sleep

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<sup>21</sup> The topic of the side effects and efficacy of medical interventions towards gender reassignment in adolescents *supra*. Paragraphs \_\_\_\_\_ .

<sup>22</sup> Hembree, WC, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2009; 94: 3132-3154.

<sup>23</sup> Moore, E., Wisniewski, & Dobs, A. "Endocrine treatment of transsexual people: A review of treatment regimens, outcomes, and adverse effects." *The Journal of Endocrinology & Metabolism*, 2003; 88(9), pp. 3467-3473.

<sup>24</sup> Michelle A. Cretella, *Gender Dysphoria in Children and Suppression of Debate*, 21 *J. of Am. Physicians & Surgeons* 50, 53. (2016).

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*, citing Eva Moore *et al.*, *Endocrine Treatment of Transsexual People: A Review of Treatment Regimens, Outcomes and Adverse Effects*, 88 *J. of Clin. Endocrinology & Metabolism* 3467-73 (2003).



apnoea; cause insulin resistance; and have unknown effects on breast, endometrial and ovarian tissues.<sup>28</sup> Girls may also eventually get a mastectomy, which carries its own unique set of problems and is irreversible.<sup>29</sup>

25. The Hayes Directory reviewed all the relevant literature for these different treatments in 2014 and gave them the lowest possible rating, which were that the research findings were

“too sparse” and “limited” to suggest conclusions.<sup>30</sup> Precisely stated, all treatments leading up to gender reassignment were deemed too experimental to deem either safe or efficacious.

When the Department of Education or schools propound an agenda that the transgender lifestyle is healthy, they are by extension (particularly with the natural extension of taking various treatments towards gender reassignment) using British children as Guinea pigs.

Children are not legally, psychologically or emotionally capable of assessing the severity of these risks or balancing the risks with the perceived benefits of gender affirmance (if any).

Neurologically, the adolescent brain is immature and lacks the adult capacity for risk assessment prior to the early mid-20's.<sup>31</sup> Gender-affirming policies urge gender dysphoric children, or even those who are not technically gender dysphoric as they do not exhibit a clinic level of distress over feelings of incongruity with their biological sex, to forego their fertility and jeopardise their physical health in order avoid the distress of natural physical development.

26. The result of such policies, despite the lack of epidemiological data on the outcomes of medically delayed puberty, has been the reality that referrals for sex-reassignment hormones and surgical procedures appear to be on the rise, and there is a push among many transgender

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<sup>28</sup> *Id.*, citing Moore, *supra*, at 3467-73.

<sup>29</sup> *Id.*, citing Laruen Schmidt, *Psychological Outcomes and Reproductive Issues Among Gender Dysphoric Individuals*, 44 *Endocrinology Metabolism Clinics of N. Am.* 773-85 (2015).

<sup>30</sup> Hayes, Inc., “Hormone Therapy for the Treatment of Gender Dysphoria,” *Hayes Medical Technology Directory* (2014).

<sup>31</sup> Michelle A. Cretella, *Gender Dysphoria in Children and Suppression of Debate*, 21 *J. of Am. Physicians & Surgeons* 50, 53. (2016).

advocates to proceed with sex reassignment at younger and younger ages. According to a 2013 article in *The Times*, the United Kingdom saw a 50% increase in the number of children referred to gender dysphoria clinics from 2011 to 2012, and a nearly 50% increase in referrals among adults from 2010 to 2012.<sup>32</sup> It is also reported from the same study that in 2012, 208 children were referred, whereas only 64 were so referred in 2008.<sup>33</sup> And staggeringly, in 2013 there were 18,000 people treated in comparison to 4000 15 years ago.<sup>34</sup> No doubt these numbers have grown significantly since this study was done.

27. Whether the increase can be attributed to rising rates of gender confusion, rising sensitivity to gender issues, growing acceptance of therapy as an option, or other factors, the increase itself, which has been exponential, must be very concerning. What is required is not affirmation, but rather further scientific inquiry into the family dynamics and other potential problems, such as social rejection or developmental issues, that may be taken as signs of childhood gender dysphoria.

28. Perhaps most tragically, the suicide rate among those who use cross-sex hormones and undergo sex-reassignment surgery is twenty times higher than among the general population. Prevalence of suicide at this rate is universal, including in countries, such as Sweden, which are among the most LGBT-affirming nations in the world.<sup>35</sup> This statistically debunks the notion that lack of acceptance is the cause of suicide among transsexuals.<sup>36</sup>

29. Policies and protocols that treat children who experience gender-atypical thoughts or behaviours as if they belong to the opposite sex interfere with the natural progress of psycho-sexual development. While forcing other's in the child's life to reinforce their gender

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<sup>32</sup> Chris Smyth, "Better Help Urged for Children with Signs of Gender Dysphoria," *The Times* (London), October 25, 2013, <http://www.thetimes.co.uk/tto/health/news/article3903783.ece>.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> Dhejne, C, et.al. *Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS ONE, 2011; 6(2). Affiliation: Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet, Stockholm, Sweden.

<sup>36</sup> Those who have undergone gender reassignment surgery.

dysphoria may cause that child less short-term distress, the long-term effect of reinforcing delusional beliefs and behaviour may be very damaging. Importantly, there are no long-term, longitudinal, control studies that support the use of gender-affirming policies and treatments for gender dysphoria.<sup>37</sup>

29. A gender dysphoric child experiences a marked sense of incongruity between the gender expectations linked to their biological sex and their biological sex.<sup>38</sup> Yet those subjective feelings, strong as they may be, cannot and do not constitute (or transform) the objective reality of their biological sex.<sup>39</sup>

30. As stated elsewhere in this opinion, the vast majority of children who suffer gender confusion naturally resolve the feeling of incongruity with their biological sex through puberty. While some researchers have reported that they have identified some factors associated with the persistence of gender dysphoria into adulthood<sup>40</sup>, there really is no evidence that any clinician can identify perhaps the one-in-twenty children for whom gender dysphoria will persist with anything approaching certainty.

31. In reality, the government guidance being relied upon by schools in implementing policies that affirm, rather than try to resolve, gender confusion, has *de facto* mandated a scientifically unwarranted, dangerous experiment, upon Britain's children without apparent regard to the far-reaching and long-term consequences.

32. While at best this may be viewed as a basically harmless expedient to make a child feel better about themselves during a difficult time in their lives, the reality is that there is substantial evidence that such an approach is harmful (despite the best intentions of those

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<sup>37</sup> Michelle A. Cretella, *Gender Dysphoria in Children and Suppression of Debate*, 21 J. of Am. Physicians & Surgeons 50, 52. (2016).

<sup>38</sup> *Infra fn.* 16.

<sup>39</sup> Michelle A. Cretella, *Gender Dysphoria in Children and Suppression of Debate*, 21 J. of Am. Physicians & Surgeons 50, 51 (2016).

<sup>40</sup> See, e.g., Thomas D. Steensma *et al.*, *Factors Associated with Desistence and Persistence of Childhood Gender Dysphoria: A Quotative Follow-Up Study*, 52 J. of the Am. Acad. of Child & Adolescent Psychiatry 582-90 (2013).

thinking that they are actually helping the child). The American College of Paediatricians recently declared:

There is an obvious self-fulfilling nature to encouraging young [gender-dysphoric] children to impersonate the opposite sex and then institute pubertal suppression. If a boy who questions whether or not he is a boy (who is meant to grow into a man) is treated as a girl, then has his natural pubertal progression to manhood suppressed, have we not set into motion an inevitable outcome? All of his same-sex peers develop into young men, his opposite sex friend develop into young women, but he remains a pre-pubertal boy. He will be left psycho-socially isolated and alone.<sup>41</sup>

33. Repetition and reinforcement of the disjunctive belief about a child's gender in relation to their biological sex also has some effect on the structure and function of that child's brain.

This phenomenon is known as neuroplasticity, and it means that a child who is encouraged to impersonate the opposite sex is less likely to reverse course later in life.<sup>42</sup>

34. The story of David Reimer is one example of the harm wrought by theories that gender identity can socially and medically be reassigned in children.<sup>43</sup> Reimer was a patient of Dr. John Money, a psychiatry professor at Johns Hopkins University who believed that gender identity in children was fluid and could be constructed. David's penis was damaged during circumcision as a child. His parents thereafter raised him as a girl named Brenda, receiving both surgical and hormonal interventions to ensure that he would develop female-typical sex characteristics. David however self-identified as a boy, his biological sex, and at the age of 14 his psychiatrist recommended that he be told the truth about what happened. David then began the difficult process of reversing the hormonal and surgical interventions that had been performed on him to feminise his body. At the age of 38, in 2004, David took his life as he continued to be tormented by his childhood ordeal.

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<sup>41</sup> American College of Paediatricians, *Gender Ideology Harms Children*, Aug. 17, 2016, available at <https://www.acped.org/the-college-speaks/position-statements/gender-ideology-harms-children>.

<sup>42</sup> See e.g. Giuseppina Rametti *et. al.*, *White Matter Microstructure in Female to Male Transsexuals Before Cross-sex Hormonal Treatment. A Diffusion Tensor Imaging Study*, 45 *J. of Psychiatric Res.* 199-204 (2011)

<sup>43</sup> An account of the David Reimer story can be found at: John Colapinto, *As Nature Made Him: The Boy Who Was Raised as a Girl*, (New York, Harper Collins, 2000).

35. While David's story may be atypical, what cannot be disputed are the staggering levels of self-harming rates and suicide attempts among children who identify as transgendered. The Campaign organisation Stonewall suggests that despite a 1/3 decrease in transphobic bullying<sup>44</sup>, 84 percent of young people who identify as transgender self-harm<sup>45</sup>, while an additional 45 percent have attempted to take their own lives.<sup>46</sup> This should amount to nothing short of a public health crisis. Rather than merely affirming a lifestyle with such measurable health consequences, government policy should be to find the root cause of why so many children are self-harming and attempting to take their own lives. Tolerance and acceptance is a weak default position which will only exacerbate the problem young people are facing today.

36. To be clear, gender dysphoria should be treated with psychotherapy, not surgery. The co-morbidities associated with gender dysphoria are many. The benefits of gender reassignment surgery are not scientifically significant, and the consequences (including a highly elevated rate of suicide) are troubling at best. The question of co-morbidities even extends to the more famous examples of transgenderism including Bruce Jenner. In 1976 Jenner was the Olympic decathlon champion. He was at one point considered one of the world's greatest male athletes. Today's Jenner, with medical and surgical reconstruction of his physique, made headlines as he posed, corseted, and breast-boasted, for the cover of *Vanity Fair*. In the photo he is flaunting himself as a "pin-up" girl in her twenties or thirties rather than a man in his mid-sixties. While I have never met or examined Jenner, his actions suggest that he fits the behavioural mold that Ray Blanchard has dubbed an expression of "autogynephilia"—from *gynephilia* (attracted to women) and *auto* (in the form of oneself).

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<sup>44</sup> Stonewall, *School Report: The Experiences of lesbian, gay, bi and trans young people in Britain's schools in 2017* (Stonewall, 2017), p. 20.

<sup>45</sup> Stonewall, *School Report* (2017), p. 7.

<sup>46</sup> *Id.*

37. The tolerance agenda associated with the transgenderism issue has silenced many. And the result has been the creation of a great deal of suffering. Parents who wish to help their gender dysphoric children connect with their biological sex are unable to find meaningful assistance of any kind because of the culture of fear associated with going against the prevailing tolerance zeitgeist, a spirit which can end careers or have one labelled as transphobic or hateful. It would seem that no one-- not doctors, schools or even most churches—will help rescue these children from these strange notions of being transgendered and the problematic lives these notions herald.

38. The most reliable long-term studies bare out the realities of the consequences of affirming gender reassignment instead of focussing on treating gender dysphoric people by reconciling them with their biological sex. The most thorough follow-up of sex-reassigned people extending over thirty years and conducted in Sweden, where the culture is highly LGBT affirming, documents their lifelong mental unrest. Ten to fifteen years after surgical reassignment, the suicide rate of those who had undergone sex-reassignment surgery rose to twenty times that of comparable peers.<sup>47</sup>

39. As with any mental phenomenon, what is crucial is noting its fundamental characteristics and then identifying the many ways in which that characteristic can manifest itself.

40. In standard medical and psychological practice, a child who has a persistent, mistaken belief that is inconsistent with reality is not encouraged in his or her belief.<sup>48</sup> A gender dysphoric child experiences a marked sense of incongruity between the gender expectations linked to their biological sex and their actual biological sex.<sup>49</sup> Gender dysphoric children

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<sup>47</sup> Cecilia Dhejne *et al.*, *Long-Term Follow Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden*, PLoS ONE 6(2): e16885. <https://doi.org/10.1371/journal.pone.0016885>.

<sup>48</sup> See: Anne Lawrence, *Clinical and Theoretical Parallels Between Desire for Limb Amputation and Gender Identity Disorder*, 35 *Archives of Sexual Behaviour* 263-78 (2006)(finding similarities between body integrity identity disorder and gender dysphoria).

<sup>49</sup> Tomer Shechner, *Gender Identity Disorder: A literature Review from a Developmental Perspective*, 47 *Isr. J of Psychiatry & Related Sci.* 132-38 (2010).

subjectively feel as if they are members of the opposite biological sex, according to their sense (as whatever stage of childhood they happen to be) of what that feeling of being a member of the opposite sex must be like.<sup>50</sup>

41. The DSM-5 criteria for a diagnosis of gender dysphoria in pre-pubescent children, while concrete, is still staggeringly flawed. It still requires clinically significant distress, but also looks at behaviours that are stereotypically used or engaged in by the other gender. So, for example, some of the diagnostic criteria include, “a strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.”<sup>51</sup> Such a criterion is fundamentally unsound. It appears to ignore the fact that a child could display an expressed gender-manifested by social or behavioural traits- incongruent with the child’s biological sex but without identifying as the opposite gender. Girls who are “tomboys” or boys not oriented towards violence and guns would be prime examples.

42. Even for those children who do identify as the opposite gender than their biological sex, diagnosis of gender dysphoria on such a subjective criterion still lacks in reliability. The reality is that they may suffer from any of the above highlighted co-morbidities.<sup>52</sup> They may also have difficulty with the expectations associated with the gender roles connected to their biological sex because of other psychological difficulties. Traumatic experiences can also cause a child to express distress with the gender associated with his or her biological sex.

43. A child’s gender cannot be objectively defined as being reflected by the extent to which he or she conforms to or deviates from socially normative behaviour for boys or girls. Defining it in the manner lacks precision and scientific certainty. There is no objective definition for what it means to be a boy or a girl. What is considered gender-typical behaviour for boys and girls also changes over time and within a given culture. Girls who

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<sup>50</sup> American Psychological Association, *Diagnostic & Statistical Manual of Mental Disorders* [DSM-5] 452 (5<sup>th</sup> ed. 2013).

<sup>51</sup> *Id.*, 452.

<sup>52</sup> *Supra* para. 19.

display male gender traits as ‘tomboys’ almost universally modify as they age. And boys who seem timid or feminine as children eventually develop interests in line with their gender expectations. As such, gender is a fluid concept with no objective meaning whatsoever.<sup>53</sup>

44. Traditional psychosocial treatments for gender dysphoria, which seek to reconcile the child to their biological sex, are prudent and natural; they work with and not against the facts of science and the predictable rhythms of children’s psycho-sexual development. Equally important, that this reconciliation, unlike affirming a gender confused child in their gender dysphoria, is done without any irreversible effects or the use of harmful medical treatments.

45. Dr. Kenneth Zucker has for decades been performing precisely this type of therapy; aligning patients’ subjective gender identity with their objective biological sex through different psychosocial treatments (talk therapy, organised play dates, and family counselling).<sup>54</sup> In a follow-up study of children treated by Dr. Zucker and colleagues over the course of thirty years at the Centre for Mental Health and Addiction in Toronto, they found that gender dysphoria persisted in only 3 of the 25 girls they had treated.<sup>55</sup>

46. Questions still abound as to the causes of gender dysphoria. Neurological differences in transgender adults might be the consequence of biological factors such as genes or prenatal hormone exposure, or of psychological and environmental factors such as childhood abuse, or they could result from some combination of the two. There are no serial, longitudinal, or perspective studies looking at the brains of cross-gender identifying children who develop to later identify as transgender adults.<sup>56</sup> Nor has gender reassignment shown any clinical evidence suggesting that it is beneficial.<sup>57</sup>

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<sup>53</sup> Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity*, 6-7 (1990).

<sup>54</sup> Kenneth J. Zucker *et al.*, *A Developmental Biopsychosocial Model for the Treatment of Children with Gender Identity Disorder*, 59 *J. of Homosexuality* 369-97 (2012).

<sup>55</sup> Kelly D. Drummond *et al.*, *A Follow-Up Study of Girls with Gender Identity Disorder*, 44 *Developmental Psychology* 34-45 (2008).

<sup>56</sup> Lawrence S. Mayer, Paul R. McHugh, *Sexuality and Gender*, *The New Atlantis*, Issue 50, Fall 2016, *A Journal of Technology and Society*, p. 102.

<sup>57</sup> For a useful summary of Arif’s findings, see: David Batty, “Mistaken Identity,” *The Guardian*, July 30, 2004, <http://theguardian.com/society/2004/jul/31/health.socialcare>.



## **Conclusion**

47. Policies that encourage gender dysphoric children to pursue transgender lifestyles do not exist in an ideological vacuum. The guidance and best practice being proffered by the Department of Education is not supported by medical and scientific evidence. Policies, particularly where third parties such as teachers, classmates, and parents, are required to change their behaviour (and even their beliefs in both the biological reality of the children involved or what they believe to be in the best interests of those children) as a means of “helping” gender dysphoric children are nested in a larger ideology.

48. Gender-affirming policies aggressively promote the false notion that a child is trapped in the wrong body; this is precisely the central theme in these policies’ presupposition. The consequent is that many gender dysphoric children will seek (once they have reached the age of maturity) the closest thing to the body they desire which modern medicine is able to provide them. Precisely stated, these policies will have the effect of causing many young adults who would have naturally realigned with their true sex to instead attempt to change it through incredibly invasive surgery and medical intervention. It will also use third parties, including other young children, to perpetuate this status quo to the detriment of everyone involved.

49. I therefore conclude, in the strongest of terms, that under no circumstance is it beneficial to treat a child as transgender in school. Policies should be aimed at identifying the root causes of the increase in gender confused children and to help them realign their subjective beliefs in their gender with the biological reality of that gender. The existing policies do far greater harm than they do help to children who are struggling with gender confusion. The question of gender confusion is contentious and multi-faceted. A “one size fits all” approach of affirmance and tolerance does not scratch the surface of what is needed in relation to truly helping the children involved. England’s children deserve better.