Gender ideology and the treatment of gender dysphoria with "gender affirming care"

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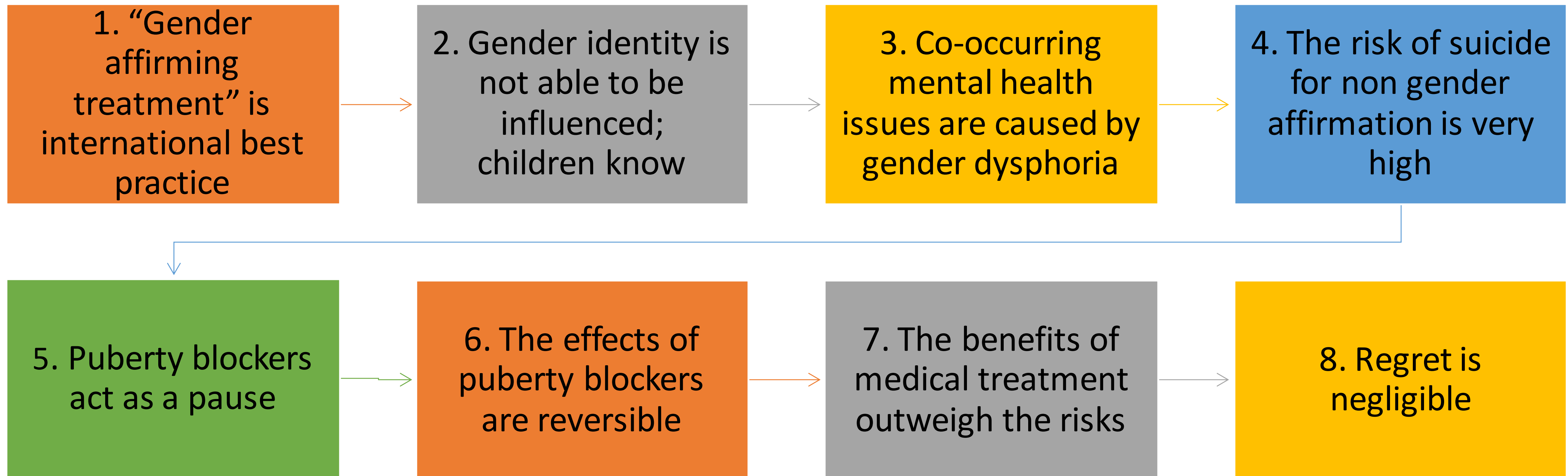
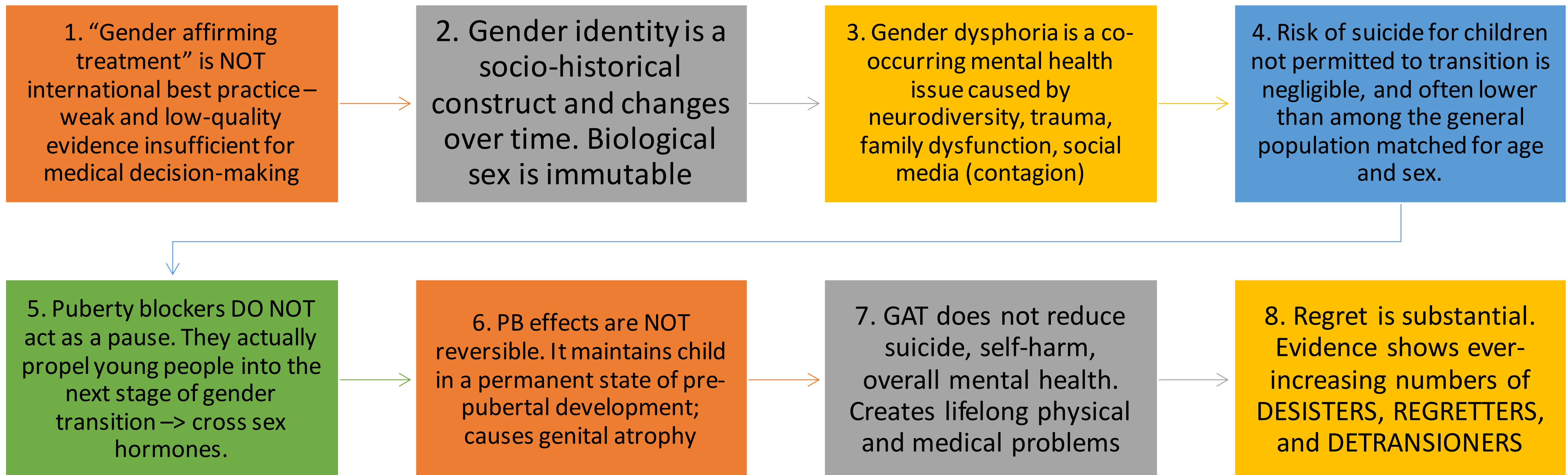
- Diagnostic & Statistical Manual Text Review (DSM) 5 TR (May 2022)
- "Gender dysphoria is the clinically significant distress that may accompany the incongruence between a person's experienced or expressed gender and one's gender "assigned at birth."
- NOTE: gender is not assigned at birth. It develops over the course of early childhood in response to socio-cultural milieu
- NOTE: Sex is not assigned at birth. It is determined at the point of conception with the union of sperm containing XX chromosomes and the ovum.

Trans lobby and gender affirming care advocates: The lies they tell!!



The truth must be told



Misinformation to parents: Overstating risks of not affirming

Understating POST transition increases in completed suicide

Studies show higher rates of suicide post-transition: (Bailey, 2017)

*Dutch 9 x higher than expected

*Swedish 19 x higher than general population

"The real concern was the statistics on suicide…I didn't want my son to be [a statistic] so I supported him in the decisions ahead and informed him as best as possible."
Father of 10-year-old trans boy [Queensland Children's Hospital Gender Clinic flyer]

Gender clinics tell parents that strong parental support of their gender diverse child leads to a 95% reduction in suicide attempts, compared with parents who are unsupportive or only somewhat supportive [Queensland Children's Hospital Gender Clinic flyer]

The **rise in social media use** is the prime candidate for the change in sex-based suicide patterns (Twenge, Joiner, Rogers & Martin, 2018). Greatest rise is in adolescent female suicide completions. Parallel increases observed in hospital admissions for self-harm, including attempted suicide, and completed suicides.

Strong independent evidence for the social transmission of suicidality

Suicide Risk

Inquest in Coroner's Court, Victoria commenced 27/11/23 into the **cluster suicide** of FIVE post- transition young people – all male to female; all with long history of mental health problems

"Australian data shows 80% transgender young people self-harm (SH) and 48% attempt suicide (AS) before the age of 24."
Note: Very elastic definitions of SH and AS – rates are overstated

RCH Foundation Website citing Transpathway survey (2017) & FCFCOA Case

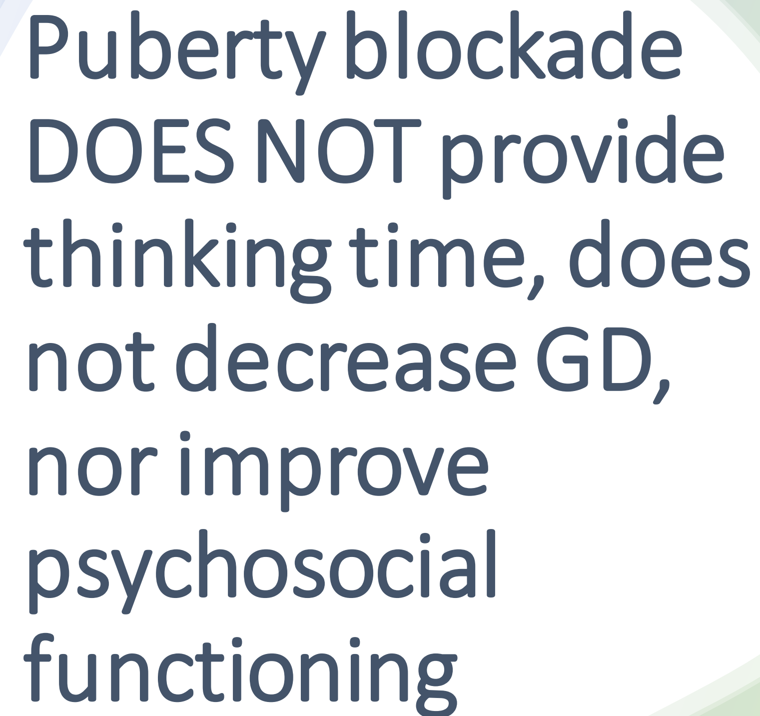
FACTS:

RCH Gender Service: 2012 – Nov 2022 – no recorded suicides

GIDS suicide rate=0.00013%. Study of 15,000 children over 10 years - 4 suicides (2 on waiting list, 2 being treated) (Biggs, 2022)

RCH Tollit (2021) – self-harm 25%, suicidal ideation 29.5%

Westmead study (2021) – self-harm 16%, suicidal ideation 48%



Puberty blockade DOES NOT provide thinking time, does not decrease GD, nor improve psychosocial functioning

Percentage of children who continued from puberty blockers to cross-sex hormones:

- 98% of 333 children – Dutch clinic (Wiepjes, 2018)
- 97% of 143 children – Dutch clinic (Brik, 2020)
- 98% of 44 children GIDS (Carmichael, 2021)
- 98% of 54 children RCHGS (Tolitt, 2021)
- 94% of 49 children Westmead (Elkadi, 2023)

- **Puberty blockade (PB)** did not improve **gender dysphoria** in boys and worsened gender dysphoria in girls (Dutch studies)
- After 18 months **no difference in psychosocial functioning** of children receiving psychological support and PBs and those just receiving psychological support (Costa, 2015)
- After 2 years on **PBs**, **no improvements in psychological function** or gender dysphoria (Carmichael, 2021) (UK)
- Florida Review (2022) – Most studies reporting benefits are of **low or very low quality, therefore unreliable**

WPATH SOC treatment guidelines are not "credible"

UK – The Cass Review	• Range of pathways/outcomes for gender dysphoric adolescents, not just GAC • Scarce and poor-quality evidence base supporting medical pathway • Primary intervention should be psychological and psychosocial • Main objective to alleviate distress • Final Report due 2023
Sweden – Swedish National Board of Health	• Lack of reliable scientific evidence concerning efficacy and safety of treatment and knowledge of detransition • Unexplained increase in numbers and rise of adolescent females (SOCIAL CONTAGION a primary candidate – see www.diannakenny.com.au) • Risks of treatment outweigh benefits • Restriction of service providers to clinical trials and hospital settings • Only exceptional cases receive medical intervention: Must meet 3 criteria: (i) onset of gender related distress in childhood (ii) persistence over time (iii) high levels of distress with the commencement of puberty

WPATH treatment guidelines are not “credible”

Finland – Council for Choices in Healthcare Finland	• First line of treatment psychological intervention to support identity exploration • Treatment to remission of severe MH disorders • Must have entered at least early stages of puberty • No surgery for minors
Norway – Norwegian Healthcare Investigation Board	• Recommended following Sweden, England, and Finland • Review of guidelines needed
Florida – Medicaid review	• Weak evidence base to support any aspects of the GAC pathway • Medical pathway banned for minors • 20 other US States have followed
France – Ministry for Health allows medical pathway provisionally	“The greatest reserve is required in their use given the side effects on growth, bone fragility, risk of sterility, emotional and intellectual consequences, for girls symptoms reminiscent of menopause”