**IN THE FIRST TIER TRIBUNAL** **Claim No: CA/2021/0013**

**GENERAL REGULATORY CHAMBER**

**(CHARITY)**

**B E T W E E N:-**

**Mermaids** **(Appellant)**

**-and-**

**The Charity Commission for England and Wales** **(First Respondent)**

**The Trustees of LGB Alliance** **(Second Respondent)**

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**Witness Statement of Beverley Jackson**

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I, Beverley Jackson, of LGB Alliance, Kemp House 152-160 City Road London EC1V 2NX, shall say as follows:

(1) I am Beverley Jackson, co-founder and trustee of LGB Alliance. There are three sections to this statement:

(a) Terminology;

(b) My history and background; and

(c) Response to Appellant's witness evidence

(2) In the course of making this statement, I shall refer to a bundle of documents, which is now shown to me. References take the form '[Exhibit BJX]', where 'X' is the exhibit number.

**Terminology**

(3) It is necessary to given explanations of some of the terminology that I use and how it is used:

(a) **Sex** refers to biological sex, which is binary and immutable. Sex is observable in all humans. One is either male or female and one cannot change one's sex. While there are a number of medical conditions which are sometimes referred to collectively as "Intersex" (and more accurately as Differences in Sexual Development), these are rare and in nearly all cases such an individual will nevertheless be either male or female. Sex is not assigned to a newborn infant, but is observed as a material reality, either in the uterus or at birth.

(b) **Gender** is a term with various different meanings, which often overlap and sometimes conflict. In her book *Material Girls*, Professor Kathleen Stock OBE identifies four different meanings of the word gender **[Exhibit BJ1].** The first of these is a polite synonym for "sex" (as in "gender pay gap"). That will not feature in my statement. The second and third relate to gender roles and stereotypes projected onto girls and boys by society (or in some cases adopted by them). In that sense I see it as a *negative* word, reflecting constraints. The fourth meaning is a short form for **gender identity** – an inner self-definition based on how one feels and interprets one's place in society. This will be the main meaning at issue here. Some people maintain that *everyone* has a "gender" or "gender identity", which is either innate and fixed, or alternatively which can shift and change in a given individual over time. Those concerned also maintain that this "gender identity" should take precedence over biological sex in most, if not all, situations. In this statement I will refer to these positions as **gender identity theory**. Adherents to gender identity theory further maintain that there are many such genders in addition to male and female: indeed, some commentators assert that there are over 100 and perhaps an infinite number of genders. I do not subscribe to gender identity theory. Many people – myself included – do not have a gender identity.

(c) **LGB** refers to Lesbian, Gay and Bisexual. It is terminology which is used by many (including me) to indicate a definition of same-sex sexual orientation which is based on sex, rather than on gender. A gay man is a biological male who is sexually attracted to other biological males, a lesbian is a biological female who is attracted to other biological females, and a bisexual person is someone who is attracted to both biological sexes. Gender is wholly unrelated to LGB same-sex sexual orientation: sex and gender (in the sense of gender identity) are two wholly different things.

(d) Groups referring to themselves as **LGBT** (and its variations including but not limited to **LGBTQ, LGBTI, LGBTIA**, which in turn are often suffixed with a "**+**") subscribe to gender identity theory. This means that their definition of sexual orientation is based on gender identity rather than sex. Under this definition, a biological male who self-identifies as a woman and who is sexually attracted to biological females is a lesbian. This, I believe, is fundamentally in opposition to the definition of lesbian in "LGB".

(e) **Trans** (or transgender) is a word whose definition relies on the definition of "gender identity". It is based on the assumption that everyone has a "gender identity". LGBTQ+ groups refer to those whose gender identity differs from their biological sex as "trans" and those whose gender identity corresponds to their biological sex as "cis". Stonewall, on their website, gives a non-exhaustive list of 17 categories of individuals that fall under the "trans umbrella" **[Exhibit BJ2],** some of which (e.g. crossdresser) do not involve making any changes to the body, while others (e.g. neutrois) involve radical surgery. They range from teenage girls who identify as boys, many of whom seek puberty blockers and testosterone prescriptions, to middle-aged fathers who adopt the clothes, appearance and a name generally associated with the opposite sex ("social transition") but do not take hormones or make any other physical changes. They also include "gender-fluid" people (such as Phil/Pippa Bunce of Crédit Suisse, who is "he" for half the week and "she" for the other half. The article at **[Exhibit BJ3]** explains that Phil/Pippa Bunce is "gender fluid"

Aside from “social transition”, the following types of “transition” may be distinguished:

i. “Medical transition”, which might include hormonal treatment or surgery. In children going through puberty, puberty blockers may be taken to prevent the child from going through puberty;

ii. “Legal transition”, which is the process of securing a Gender Recognition Certificate under the Gender Recognition Act 2004.

But none of these forms of transition are required in order to be trans: a trans person only needs to identify as having a gender identity which is different from their biological sex.

(f) **Gender critical** refers to the belief that there are two sexes, male and female, and that sex is immutable. This is sometimes referred to by opponents as “anti-trans” (including by Paul Roberts in his witness statement) but I do not believe that it is. It simply recognises my assertion of the biological fact of human sex. It is a belief protected by law. There are many trans people who are vocally gender critical, which demonstrates that the belief is not anti-trans.

**My history and background**

(4) Kate Harris and I founded LGB Alliance in 2019.

(5) I have spent my life working as a teacher and translator and supporting diverse progressive causes – especially refugee rights. I have written a book about volunteering with refugees, see **[Exhibit BJ4].** I am proud to have been a founding member of the UK Gay Liberation Front at the London School of Economics. I was the spokesperson for GLF at our first march at Highbury Fields in November 1970. A newspaper article written at the time **[Exhibit BJ5]** sets out that I was on the GLF steering committee at the age of 19.

**Gender over Sex**

(6) In 2016 I became aware that something had, in my view, gone wrong with the gay rights movement. There was a switch in terminology from “sex” to “gender” (in the sense of “gender identity”). I believe that gay rights are the rights of those whose sexual orientation is towards people of the same sex. The removal of sex as a defining concept therefore completely changed the concept of what it meant to be lesbian, gay or bisexual, as explained above.

(7) Those that dissented from the definition of sexuality in relation to gender were (and continue to be) vilified as transphobic or bigots. By 2019, I had witnessed a surge of anti-lesbian prejudice. This was exemplified at the Pride march in London in 2018, when a group of lesbians went to the front of the march and loudly proclaimed that their lesbianism was avowedly a question of same-sex (rather than “same gender”) sexual orientation. They were vilified for doing so in an online article for Pink News **[Exhibit BJ6].** Such vilification recurred at a subsequent Pride event in Lancaster, and was endorsed by Stonewall’s chair, who posted a response to a Tweet by aspiring Labour politician Dominic Casoria The endorsement is at **[Exhibit BJ7]**

(8) I was particularly concerned about teenage girls getting the idea they could change sex to escape from womanhood. I had no doubt in my mind that were I growing up today, I would have leapt at the chance to “transition” to identify as a man. This would have meant that that I would never have had a family. People such as me, who define our sexuality based on sex, rather than gender, were being subjected to homophobic comments. What I have referred to as “gender identity theory” seemed to me to have become embedded in institutions, and was promoted by organisations claiming to be pro gay rights. I met Kate Harris, who had similar concerns, and we deliberated on what to do.

**Engagement with Stonewall**

(9) On 1 May 2019 I wrote a letter to Ruth Hunt, the then Chief Executive of Stonewall, after she had invited me on Twitter to contact her. My concerns focused mainly on the current issues facing young lesbians. She neither

responded to my letter nor acknowledged it. I later posted the entire letter on Twitter **[Exhibit BJ8].**

**The Need for LGB Alliance**

(10) Since its inception, Stonewall has become the main campaigner for gay rights in the UK and indeed in Europe. In 2015, Stonewall took the decision to focus on gender identity over sex. For those of us who define homosexuality as same-sex sexual orientation, this left us without representation, and indeed left us in fundamental opposition to the major organisation that was supposedly representing us. Stonewall refused to engage with those who were troubled by the change.

(11) On the change made in 2015, former Stonewall CEO Ruth Hunt later said in a podcast interview: "*I think we always knew that would be controversial, that it would be difficult, that people would lose by that. Yeah. And I think we collectively thought and the staff were profoundly clear about this. So that was a price worth paying.*" A transcript of the podcast can be found at **[Exhibit BJ9]**

(12) LGB Alliance disagrees. We represent the people who have lost and do not consider that this was a "*a price worth paying*". A great many LGB people felt that adding the "T" to LGB, and doing so in a way that insisted on the concept and dominance of gender identity, set up a conflict with LGB rights. This is not helped by the fact that Stonewall is often intemperate in the way that it advanced these beliefs. A pamphlet produced in conjunction with the General Medical Council entitled "Protecting patients your rights as lesbian, gay and bisexual people" portrays Stonewall as an LGB organisation **[Exhibit BJ10]**, and this is entirely characteristic of all of Stonewall's activities pre-2015**.** News articles have reported that Matthew Parris, a founder of Stonewall, said in the Times that Stonewall had become "tangled up in the trans issue" and "cornered into an extremist stance". The articles report that Stonewall has defended their strategy against this criticism **[Exhibit BJ11].**

(13) In February 2021 it was reported that Ruth Hunt had stood down as the head of Stonewall **[Exhibit BJ12].**

(14) In her statement, Kate Harris refers to the “No Debate” approach advanced by Stonewall. This meant that those who hold the views espoused by LGB Alliance had no charity servicing their needs. LGB Alliance formed to fill the vacuum created in LGB advocacy by the shift from “sex” to self-identified “gender” in all LGBTQ+ groups, and the refusal of Stonewall to engage with us on how to protect the rights of people with same-sex sexual orientation.

(15) We do not believe that LGBTQ+ groups are either malevolent or redundant. These groups serve the interests of TQ+ people and those LGB people who assert that their sexual orientation is based on gender identity. We take issue with how they conduct their campaigning, as set out below. But they have a place to represent, charitably, those who share their beliefs.

**LGB Alliance**

(16) I had been invited to join the panel of a public-facing event at the London School of Economics on 22 October 2019 to mark the 49th anniversary of the formation of the UK Gay Liberation Front. This event was cancelled in July 2019 immediately following an email I sent to the moderator outlining my views on the problematic composition of the panel. My email is at **[Exhibit BJ13].**

(17) Kate Harris and I then decided to hold an event nearby LSE on the same date, which would focus on our concerns about the direction taken by the LGB rights movement. This became the meeting at which LGB Alliance was formed.

(18) We spent three months preparing for the meeting on a full-time basis: drafting a provisional statement, writing our speeches, planning the different groups we proposed forming, and so forth. We spent many hours on social media identifying those who clearly shared our concerns about the erasure of sex within the meaning of what it was to be LGB, and invited around 80 people to attend. We contacted each person individually, to explain our views and what we were planning.

(19) Of the 80 invited, around 70 people attended. Aside from Kate Harris and myself, the speakers were Simon Fanshawe, one of the founders of Stonewall, and

Miranda Yardley, a trans person and human rights activist. It was a very upbeat meeting, radiating a sense of elation, shared purpose and solidarity. There was also a mood of determination, with speakers one by one expressing their concerns about the erasure of the concept of sex within the definition of sexual orientation and the importance of turning this around. In some respects the mood was reminiscent of the speeches that I had heard being given nearly 50 years previously when I had helped to set up the GLF: gay and lesbian people expressing solidarity and support for one another and a resilient determination to rectify injustice.

(20) After the meeting, one of the attendees, Allison Bailey posted a tweet about the meeting **[Exhibit BJ14].** There had been no plan for her to do so and it wasn't organised. The tweet went viral, and caused discussion and debate on social media, generating enormous support but also a huge amount of abuse. As a consequence of sending the tweet, Allison (a barrister) was disciplined by her chambers, at the behest of Stonewall, which is the subject of ongoing litigation.

(21) Kate and I set up LGB Alliance to help LGB people, because groups that once did so, most notably Stonewall, were no longer doing so and there was a need for us to step in and support LGB people.

(22) LGB Alliance was founded by two lesbians, one (myself) a founding member of the UK Gay Liberation Front and one (Kate Harris) a former volunteer fundraiser for Stonewall. Our management team is made up of people with a track record of fighting for LGB rights. In her statement, Eileen Gallagher gives more detail of our structure and work.

**LGB Alliance's core beliefs**

(23) We believe that the LGB rights movement has been largely replaced by the LGBT rights movement, which is governed by the theory that gender identity rather than sex is definitive of what it means to be lesbian, gay or bisexual. As far as I understand it, all or nearly all of these organisations now propagate the view that everyone has a gender identity, which should take precedence over biological sex in all areas of public life and in law. LGB Alliance rejects this view. LGB

Alliance maintains, and promotes the view, that sexual orientation is about biological sex. To my knowledge we are the only charity for LGB people that does so, whilst there are many charities that adopt the view that sexual orientation is based on gender.

(24) We believe that, as J.K. Rowling has said, “without sex there is no same-sex attraction”. There are many thousands of LGB people who tell us that they had felt abandoned, and now feel they once again have a voice – who thank us and encourage us, who say they wish they were able to speak out too. We believe that we are the heirs to the early gay rights movement: which was about sex, not gender. In fact, many of us come from that early struggle. At **[Exhibit BJ15]** there is a picture of Kate Harris at a Stonewall launch event and an article about my involvement in GLF in 1970 and in the LGB movement currently.

(25) Those who want to define their sexual orientation in terms of gender are of course entitled to do so. There are many groups that represent this position. We specifically uphold the rights of, seek to research the position of, and seek to provide services to, people who are attracted to their own sex, or to both sexes.

(26) It is our position that no organisation that promotes the belief that sexual orientation is based on gender can provide adequate representation for LGB people whose sexual orientation is based on sex. That is why there is an LGB Alliance.

(27) It is further our view that the attempt to dismiss or denigrate the term “same-sex attraction”, as Mr Roberts does at paragraph 29(b) of his statement, or to describe it as outdated, is an incredibly powerful and negative act. The dismissal or denigration of this term is an attempt to undermine our ability to describe ourselves as people with same-sex sexual orientation and therefore to organise and represent ourselves. For that reason, we consider that this view can be described as a form of homophobia.

(28) The debate is not always a pleasant one. All involved in setting up LGB Alliance have received abuse for doing so. We have been called a “hate group” and worse. Examples of this include Tweets by Christine Burns MBE, comments by

TV host Matt Lucas, Russell T Davies and John Nicolson MP **[Exhibit BJ16]** We have been accused of being a front for American religious conservatives. Some examples of these accusations are provided at **[Exhibit BJ17]** These accusations are not true. The strain of being subjected to constant abuse has at times affected my health. It has not diminished my resolve, however, to continue to represent the lesbians, gay men and bisexuals who thank us every day for existing and for refusing to give way to bullies. **[Exhibit BJ18]** are examples of the supportive messages we regularly receive.

**LGB Alliance serving a real need**

(29) At present, teens struggling with issues relating to sexual orientation have nowhere to go to discuss same sex attraction not based on gender identity. On the other hand, there are plenty of resources, including Mermaids, for those who are affected by gender identity issues. As set out above, anti-lesbian prejudice and fear is leading many teens, especially lesbians, to believe that they have "gender identity" issues when they are in fact grappling with their emerging lesbian/gay sexual orientation. The BBC News article at **[Exhibit BJ19]** provides context to the soaring numbers of teenage girls reporting a sudden gender crisis in the context of same-sex attraction. It quotes a young lesbian who had experienced homophobic bullying and then suddenly started identifying as trans as saying "My mum wants the hormone more than I do". The Times Investigation article at **[Exhibit BJ20]** examines this issue in greater depth.

(30) We have been spending the past few months elaborating our plans to create resources to help teens who are struggling with their sexual orientation. This is not about gender identity.

**Response to the Appellant's witness statements**

(31) I do not address every allegation in the statements filed against us but I try to address factual matters.

***General comment on the statement by Paul Roberts, LGBT Consortium***

(32) LGB Alliance's view as to its position follows that of the Employment Appeal Tribunal's decision in *Forstater.* Our position is one which is widely shared and also expresses (as far as I am aware) an accurate representation of the law according to the definition of sex and of sexual orientation under the Equality Act 2010. However, LGB Alliance does not seek to be the sole voice in the LGB world – merely *a* voice, which represents a widely shared body of LGB opinion. We believe that our voice should be heard alongside those of other charities. The respective views may conflict but those, like us, who are gender critical, have not been given a voice, research or facilities to represent their views or to serve our community. The speech given in the House of Commons by Joanna Cherry MP on Thursday 10 March 2022 **[Exhibit BJ21]** makes it clear that ours is a voice that needs to be heard.

***General remarks on the statement by Belinda Bell of Mermaids***

(33) Belinda Bell asserts in her statement that LGB Alliance, by the positions we adopt, undermines Mermaids and has damaged its reputation. I take the view that it is up to the public to listen to the views presented in good faith by different organisations, and to judge them on the basis of factual evidence. Diametrically opposed views may be expressed but it does not and should not mean that one view can or should be cancelled or denied the same treatment under the law as a charity.

(34) Mermaids is a charity that received an income of almost £2 million last year and has a staff of 33. LGB Alliance is a small charity that has thus far relied solely on individual donations and has two administrative assistants for a total of 3 days a week. It has recently appointed a managing director (in March 2022). Our new volunteer-led charity takes a different view to Mermaids, as they do to us, but that is all.

**LGBT organisations, trans organisations, and LGB organisations**

(35) LGB Alliance disagrees with Mermaids on many issues: these include gender identity, sexual orientation, puberty blockers, and gender dysphoria, and I have explained the bases for these below with reference to particular aspects of the Appellant's Witness Statements. There is plenty of room for organisations that take opposing views in the charity sector. Belinda Bell describes Mermaids as an "LGBT+ organisation". We do not believe that Mermaids is an LGBT+ organisation in the sense of representing Lesbian, Gay, Bisexual, Transgender people (and whoever is meant by the open-ended "+"). Rather, it represents only trans people. As set out in its charitable objects **[Exhibit BJ22]**, Mermaids sets out "to educate and inform wider society on gender identity" and is therefore only concerned with young people who have gender identity issues. Mermaids is not an organisation concerned with same-sex sexual orientation, or indeed with LGB people at all as defined, as we define ourselves, on the basis of sex.

(36) Just as some charities, like Mermaids, focus on trans-identified people (that is, relating to gender identity), LGB Alliance focuses on LGB people (that is, sexual orientation). These are separate issues and in our view are often best dealt with separately. That point also illuminates the fact that LGB Alliance is in an entirely different space to Mermaids.

(37) Trans rights are a different topic altogether from LGB rights. As I have sought to explain above, LGB and T have become conflated in recent years and part of what we need to do as an LGB rights organisation is to address issues which are expressly LGB, separate from the "T". I sometimes refer to this as a need to "unscramble the omelette": very different topics have been scrambled together that ought not to have been. We are seeking to unscramble them in order to campaign, proudly, for LGB rights. This is necessary, since the conflation of LGB with T has given the public the impression that the positions and interests of these (LGB and LGBTQ+) are synonymous and all coincide, and that something which is "pro LGBTQ+" is positive for all lesbian, gay and bisexual people. This is not the case, since things that are pro-LGBTQ+ are frequently based on

gender identity theory, which is something to which many LGB people, including us, do not subscribe.

**Representation**

(38) LGBT+ organisations that subscribe to the gender identity view are represented by hundreds of bodies. The Consortium website sets out a Members' Directory, this is exhibited at **[Exhibit BJ23].** The need for LGB Alliance is demonstrated by the fact that we represent a sufficient class of LGB people who otherwise would not have a voice. Our Twitter account has over 48,000 followers; as shown on the screenshot at **[Exhibit BJ24].** Indeed I would note the steady stream of messages of thanks, support, and relief we receive from LGB people, a handful of which are included **[Exhibit BJ18].** Nonetheless, LGB Alliance is excluded from membership of Paul Roberts's organisation.

**'Trans Equality'**

(39) In his statement, Mr Roberts presents the view that the fights for trans equality and for LGB equality are inextricably linked. He is entitled to his view. We disagree. While examples certainly exist of LGB and T causes and issues that are linked and compatible, there are also examples where LGB interests conflict with trans interests, and therefore they are not "inextricably linked". An example of this conflict might be a lesbian event or service. In our view, this would necessarily exclude males, regardless of their gender identity. Even if LGB Alliance's view is a minority view, which we dispute, it deserves representation.

**Gender-critical beliefs**

(40) We believe that the ruling on "gender-critical beliefs" in the *Forstater* appeal represents the law**. [Exhibit BJ25]** is a newspaper article which sets out the importance of this decision for people, who like myself, have gender critical beliefs. We do not therefore campaign for a change in the law, because we understand that the law as it stands already protects us. We do stand in opposition to those that seek changes in the law to prioritise gender identity over sex because we believe, as the law sets out, that sex is immutable**.** LGB Alliance

is a voice that frequently explains where our position differs from the position adopted by LGBTQ+ groups.

**Charitable Objects**

(41) It is an important part of our charitable objects to educate the public on the importance of biological sex to upholding LGB rights. As we stated in our application for charitable status "*In educating the public about human rights and equality issues relating to the LGB community, LGB Alliance's position will be there are only two sexes and gender is a social construct, and that this perspective should form part of the discussion about these issues*." Our application to register as a charity is at **[Exhibit BJ26]** and our charitable objects are detailed on page 3**.** LGB Alliance serves the rights and interests of people whose sexual orientation is towards the same sex (or in the case of bisexuals, both sexes) regardless of gender identity.

**Campaigning Activities for our aims**

(42) Paul Roberts suggests that LGB Alliance exists to campaign against trans rights. This is incorrect. Our charitable aims simply reflect the law that there are only two sexes and we seek to protect the sex-based rights of lesbians, gay men, and bisexuals in accordance with our aims.

(43) Other charities campaign to change the law. For example, The Equality Network and other charities in Scotland during the Scottish elections of 2021 ran political campaigns including an LGBTI Equality Pledge to support the LGBTI Equality Manifesto, which included a commitment to introduce self-ID (i.e. "based on the principle of statutory declaration"). Their supporters then publicly hounded any politician who had not signed the Pledge [**Exhibit BJ27].**

(44) Just as these charities advocated their views, we advocated our own, consistent with our charitable aim, which is to protect the rights of those who believe LGB rights are rights in respect of same-sex sexual orientation.

**My Speech at the #ExpelMe rally on 9 March 2020**

(45) On 9 March 2020, a meeting was held in London, known as the #ExpelMe rally. The event was held in response to the signing by candidates for the Labour leadership and deputy leadership of a so-called "Trans Pledge" branding Woman's Place UK and LGB Alliance "hate groups" and calling for anyone who supported either group to be expelled from the Labour Party [see **Exhibit BJ16].** A protest was held outside the hall, at which smoke bombs were let off **[Exhibit BJ28]**. I was one of those who made speeches at this event.

(46) Mr Roberts makes reference in his statement to this speech **[Exhibit BJ29],** in which I set out that our aims for the coming year included:

(a) Focusing on retaining the current law, which aligns with our beliefs on sex and same-sex attraction;

(b) Stopping the teaching in schools of gender identity as a fact and as a generally accepted phenomenon;

(c) Gaining representation in all policies and bodies dealing with LGB issues in a similar way to the other charities such as Stonewall;

(d) Seeking the intervention of the Equality and Human Rights Commission (EHRC) regarding what I termed as "*the damage Stonewall is wreaking across the public and private sectors*". I return to this below.

(47) However, there is more to our work than merely this. Our activities, meetings and planned provision of services for our young charity are dealt with by Ms Gallagher in her statement.

**Diversity Champions Scheme**

(48) Mr Roberts refers to the Stonewall Diversity Champions Scheme. I believe that it is clear from the BBC's Nolan Investigates podcasts (material related to which is at **[Exhibit BJ30]**) that Stonewall's Diversity Champions programme has departed from its initial, laudable aim of encouraging equality for LGBT people in the workplace. I believe that LGB Alliance has contributed to resetting the

dominant narrative so that the Diversity Champions scheme approach, which had rarely been challenged, started to be examined more closely. The fact that many high-profile organisations are now leaving the scheme **[Exhibit BJ31]** is in my view evidence that our position in this regard – of sex-based rather than gender-based rights - has public support.

(49) Our positive message that rights are based on sex obviously conflicts with the views of those who believe that gender identity should define rights to be male or female. However, our message is not intended primarily to be a negative one against gender identity but a positive one for sex-based rights. Of course these views conflict and so the advocacy for one is oppositional to the other in some areas. However, our aims are to provide a voice and facilities for those who share our views and positions.

**Gender Identity and Children**

(50) We take the view that aspects of LGBTQ+ campaigning are damaging to children. We are of the view that there are no objective criteria for diagnosing gender dysphoria, because the diagnosis is based entirely on the individual's own account, and I am aware of no evidence to the contrary. At paragraph 14 of her statement, Belinda Bell states that "LGB Alliance appears to take the view that trans children do not exist". This is incorrect. LGB Alliance does not believe that any child can be "born in the wrong body" (a phrase to which I have returned below). Some children are distressed by a sense of alienation from their sexed body. That is gender dysphoria. Those children need compassionate, non-judgmental care. They do not need to be labelled "trans", which as I have set out above is a word with no clear definition. As I set out below, I believe (and LGB Alliance takes the position) that this very often leads to harmful medicalised treatment. Recent articles from Finland, Sweden and France make similar points and signal changes in policy in policy in those countries **[Exhibit BJ32].**

(51) Our campaign against puberty blockers and our "focus on children" (including a van we commissioned, referred to at paragraph 26 of Belinda Bell's statement **[Exhibit BJ33])** fulfils our aims based on our belief that there are two sexes and

that sex is immutable, and that this has particular impact on LGB young people. We believe that many of the young people who are placed on an "affirmation only" pathway of gender identity would otherwise grow up LGB without any need for lifelong medication. A summary of the reasons for this are set out in a document prepared by Dr Michael Biggs of the University of Oxford, which is at **[Exhibit BJ34].** We believe that many children are placed on a pathway leading to the irreversible effects of cross-sex hormones. Some young people later change their mind on decision and wish to "detransition" (I have referred to this in more detail below). We believe that puberty blockers are not harmless and there is no clear evidence that their effects can be entirely reversed **[Exhibit BJ35, internal page 2, bottom of second column].** As the Court of Appeal Judgment accepted in Bell v The Tavistock, there are many contested issues of fact, causation and clinical judgment in this field.

(52) The Defendant in that case, the Tavistock and Portman NHS Foundation Trust, operates the Tavistock GIDS (Gender Identity Development Service) clinic, which is the centre of child and adolescent gender medicine in the UK. Discussions of the treatment of children with gender dysphoria necessarily therefore require a discussion of the Tavistock GIDS. There are a wide range of views as to the Tavistock GIDS. It has many critics, including us but also including others:

(a) The Tavistock GIDS was rated "inadequate" by the Care Quality Commission **[Exhibit BJ36];**

(b) Former clinicians at the Tavistock GIDS referred to homophobia in the clinic. **[Exhibit BJ37, internal page 4, paragraph below image];**

(c) BBC Newsnight reported on widespread homophobia among the families using GIDS **[Exhibit BJ38];**

(d) There are examples of cases in which there was no proper assessment of patients, for example see **[Exhibit BJ39].**

(53) Our central concern is that the treatment of children at the Tavistock GIDS has lost medical objectivity meaning that children are placed onto dangerous and potentially unnecessary medical pathways, often at a very young age. For example 315 children under the age of 15 were placed on puberty blockers in the period 2012-2020 **[Exhibit BJ40].** This is a very young age to be receiving this potentially very serious treatment. This is particularly relevant to us as an LGB charity because of the evidence that LGB children are over-represented in the patients of the Tavistock GIDS. This evidence is set out below.

(54) In response to concerns raised by clinicians at the Tavistock, Dr David Bell conducted a report into the clinic in 2019. As part of his report, he recorded that many of the physicians there had become concerned that the children under its care were gay and had homophobic parents, who would rather have a trans child than a gay child. This was reflected in interviews given by other clinicians at the Tavistock who recalled hearing the dark joke among staff that there would be "no gay people left" **[Exhibit BJ20, page 2 fourth paragraph].** This is a recognised issue and is sometimes referred to "transing the gay away". This is an issue of concern to LGB Alliance and to those, who believe like us, that same-sex sexual orientation should be protected and that sex is immutable. We believe that an alternative viewpoint should be expressed to that of the LGBTQ+ organisations: that is, the view that gender clinics may be involved (albeit unintentionally) in "transing the gay away".

(55) Bell v Tavistock was a case brought by Keira Bell who was a former patient of the Tavistock clinic who had been prescribed puberty blockers and then testosterone, and underwent a double mastectomy, but later changed her mind and accepted her sex – an example of "detransitioning", dealt with further below). A further piece of litigation was brought by the Head of Safeguarding at the Tavistock, Sonia Appleby **[Exhibit BJ41].** The judgment made various findings as to the steep rise in referrals (judgment paragraph 19), and that although historically the majority of children referred to the clinic were boys, in recent years this has been significantly reversed so that now some 76% are girls (judgment paragraph 20). The Court also highlighted the unhelpful influence of trans rights

campaigners and was critical of Mermaids (paragraph 21). It also recorded that concerns had been voiced that that sexual orientation was being mistaken for gender identity (the process of "transing away the gay" referred to above).

(56) Currently, a detailed review of the Tavistock is underway, led by Dr Hillary Cass. I have referred below to findings from the Interim Report of the Cass Review, published on 10 March 2022.

(57) I do not set out these matters to show that we are right. We understand that the Tribunal cannot judge these complex matters in this hearing. We merely maintain that there is a legitimate need for an LGB charity, especially given that there seems to be an overrepresentation of LGB teenagers within the population of teenagers referred to gender clinics, and that there are differing views. We believe that we are serving the public good by highlighting these problems and that we are giving voice to the many LGB people who are concerned, as we are, about these issues.

(58) We recognise that there are children who suffer from gender dysphoria and certainly believe they should receive good professional care. But we believe that the glamorised online promotion of breast binders, puberty blockers, cross-sex hormones, double mastectomies (sometimes euphemistically called "top surgery") and so-called sex reassignment surgery **[Exhibit BJ42]** represents an extremely serious threat to young "gender non-conforming" people to the extent that it glamorises extremely serious and dangerous medical treatments.

**Conversion therapy**

(59) Reference is made in the Appellants' statements to LGB Alliance's work on conversion therapy. As set out above, my view (which is shared by LGB Alliance) is that counselling and "watchful waiting" (that is providing care and support but being very cautious in terms of proceeding to a medicalised pathway of puberty blockers) are increasingly recognised as central to the treatment of gender dysphoria.

(60) The Government has put forward proposals to ban conversion therapy in two forms. One of these is “gay conversion therapy”. LGB Alliance supports the government in closing any remaining loopholes in this respect. It is crystal clear what “gay conversion therapy” means: it is coercion or pressure applied in an attempt to turn a gay person straight. There is plenty of evidence that it is harmful – and also ineffective. LGB Alliance is utterly opposed to gay conversion therapy and supports a ban on it. That is entirely consistent with our aim in which we stand for same-sex sexual orientation.

(61) The other element of the proposals is a ban on “transgender conversion therapy”. One potential implication of these proposals is that counsellors and psychotherapists who wanted to undertake reasonable and proportionate therapy with gender dysphoric children to explore whether or not a medicalised pathway is necessary for them would be criminalised for doing so because it could be defined as failing to recognise their identity. It would potentially therefore fall under the definition of conversion therapy which might be criminalised.

(62) The government has stated in respect of this that *“It is also vitally important that no person is forced or coerced into conversion therapy, and that young people are supported in exploring their identity without being encouraged towards one particular path. This is especially the case for those who are under 18 and where this might result in an irreversible decision. These proposals therefore do not alter the existing clinical regulatory framework or the independence of regulated clinicians working within their professional obligations.”*

(63) In my view, which is shared by LGB Alliance, the government’s reassurances are inadequate and naïve for two reasons: First, many of the teenagers who arrive at a gender clinic have no wish to “explore their identity”. They have already decided on it. They do not believe they need any psychotherapy. They think it is a waste of time and undermines their agency: they know “who they are”. As set out below, there is evidence that they learn pre-prepared scripted words with the effect that counsellors advise medical treatment without having a proper

understanding of what is in the child's best interests. Second, the existing clinical regulatory framework is firmly controlled by LGBTQ+ campaigners who advocate a medicalised pathway so the bodies governing the psychotherapy and counselling professions are themselves arguing for the changes to be brought in and cannot therefore reasonably be entrusted to enforce appropriate regulation of it.

(64) Indeed, this is in part where the proposals have come from. An organisation called the Memorandum of Understanding on Conversion Therapy, chaired by Igi Moon, (which has produced two iterations of a document which shares the name of the organisation) advocates for the introduction of a Bill to ban Conversion Therapy as proposed by the Government, with all the problems I have described above**.** To that end, the organisation is supported by many individuals and organisations from that profession but is also opposed by many others, whose voices have difficulty making themselves heard,

(65) We believe that an alternative view should be set out in line with our views that talk therapies for those referred to a gender clinic should be a primary aspect of treatment. This was recently also recommended by the Interim Report of the Cass Review **[Exhibit BJ43, paragraph 4.20]:**

> *"Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach. Some clinicians feel that they are not supported by their professional body on this matter. Hence the practice of passing referrals straight through to GIDS is not just a reflection of local service capacity problems, but also of professionals' practical concerns about the appropriate clinical management of this group of children and young people."*

(66) James Esses, a trainee psychotherapist who holds gender-critical beliefs opposes the Memorandum of Understanding organisation I have referred to above. Mr Esses shares the widely-held clinical belief that children struggling with gender dysphoria deserve access to exploratory therapy without a pre-determined outcome. He was expelled from his Masters' degree and volunteer counselling role at Childline, for launching a Parliamentary Petition asking the government to safeguard this therapy. Such is the support for his view that the petition received over 11,000 signatures [**Exhibit BJ44]**. In other words, the "existing regulatory framework" is already broken, in our view, and the current proposals would make it worse. James is currently bringing formal legal action against his course provider and therapeutic regulatory body, since his expulsion from his course was apparently as a consequence of starting the Parliamentary Petition.

(67) Criminalising "transgender conversion therapy" may sound benign but it isn't. This is clear from similar legislation introduced elsewhere. As stated in LGB Alliance's response to the Government Consultation on Banning Conversion Therapy **[Exhibit BJ45, internal page 6]:**

> *"Are our concerns justified? Consider the grave errors made in similar legislation introduced in Victoria, Australia – legislation that has astonishingly been praised by MPs in the UK House of Commons as 'best practice'. This Victoria Bill, the Change or Suppression (Conversion) Practices Prohibition Bill 2020, makes it illegal to provide talking therapy or psychiatric support to any young people convinced that they have been born in the wrong bodies."*

(68) As we have argued at length, there is evidence that many of these minors, some three-quarters of whom are girls **[Exhibit BJ37**, page 6, paragraph beginning "Last January"**]**, are lesbians who confuse sexual orientation with a "gender identity" issue and don't realise it until many years later. That is why we say that the proposed ban would actually *promote* rather than stop gay conversion

therapy, because it will in some cases convert gay and lesbian teens into "straight" trans teens.

(69) There is neither a clear definition of "transgender conversion therapy", nor any firm evidence that it is actually taking place. The Coventry University research on this topic, which initially formed part of the government consultation, is seriously flawed, as set out in a report by the organisation Sex Matters **[Exhibit BJ46]** (see conclusions from internal page 23)**.** In my view, shared by LGB Alliance, it is essential to wait for the final report of the Cass Review before attempting to formulate any legislation on "transgender conversion therapy". The Interim Report published by the Cass Review on 10th March 2022 **[Exhibit BJ43]** contains extremely important warnings and recommendations. We believe that most of the teens prescribed puberty blockers would grow up LGB with no need for lifelong medication if they were not given these drugs.

**Avoiding the word 'Trans'**

(70) In his statement, Paul Roberts states that LGB Alliance *"sometimes goes out of its way to avoid using the word "trans" at all*." This is true, but that is because our focus is not on trans issues. As set out above, part of the reason for our formation was that trans issues have become conflated with LGB issues, which is what we are concerned with. We therefore do avoid the word because it can result in LGB issues being overlooked in favour of trans issues, which is obstructive to any discussion of LGB rights.

**"Trans lesbians"**

(71) At paragraph 29(I) of his statement, Paul Roberts refers to "trans lesbians". This is not a term which makes sense to me. These are people born male. My view (which is shared by LGB Alliance) is that "trans lesbians" (sometimes referred to as "transbians") are not lesbians since it implies that a person with a penis can be a lesbian. As set out above, for me (and for LGB Alliance) "lesbian" is a term that can only apply to a female whose sexual orientation is towards other females. We therefore oppose the notion of "trans lesbians" because it

fundamentally changes the meaning of the word “lesbian”, which has a clear and well-defined meaning. “The word is taken”, as Allison Bailey said in her keynote address to the 2021 Conference.

(72) Contrary to what Mr Roberts says in his statement, we have not “invented” the notion that persons born male are trying to date lesbians. Some do so with great persistence. “Lesbian” dating sites now have a large percentage of participants with male bodies. **[Exhibit BJ47**, internal page 19**]**

(73) A lesbian who states in her bio on a supposedly lesbian dating site that she is only attracted to biological females is likely to be thrown off the dating site (an article describing this is at **[Exhibit BJ48]).** It is not always about pressure to sleep with someone, but there is evidence that this does happen **[Exhibit BJ49].** LGB Alliance advocates against anything which would apply pressure on lesbians to be open to the possibility of dating someone with a male body who self-identifies as a lesbian, and against the correlating position of applying pressure on a gay man to date someone who is female but identifies as a gay man. These ideas explicitly challenge the existence of same-sex sexual orientation. To that extent, we regard it as a homophobic position.

(74) We think an LGB organisation should stand up, as we do, for the rights of lesbians to be attracted to others of the same sex, not to be encouraged out of this sexual orientation. Lesbians should be able to have our own dating sites, without males.

**Statement in rebuttal of a letter by Shadow Equalities Minister Taiwo Owatemi**

(75) In his statement, Paul Roberts refers to my rebuttal of a letter by Shadow Equalities Minister Taiwo Owatemi **[Exhibit BJ50].** In that rebuttal, I referred to “new-style homophobes from within the LGBTQ+ movement”. For the reasons set out in this Statement, I think this is sadly an accurate description of how we at LGB Alliance view statements or suggestions that LGB people should face any obstacle or criticism for being explicitly same-sex attracted.

(76) I have given examples of this above, but there are others. For example Stonewall CEO, Nancy Kelley, has used the phrase “sexual racists” in reference to lesbians who exclude male-bodied people from their dating pool **[Exhibit BJ11].** This abuses lesbians for being same-sex attracted. In my view, this is homophobic. To the best of my knowledge and belief, Nancy Kelley’s position in this regard (if not this exact terminology I have cited) is held by all LGBTQ+ groups, because it is founded on the principle of gender identity, which LGBTQ+ groups all adopt. This is why I wrote in my rebuttal of Taiwo Owatemi’s letter: "all the LGBTQ+ groups around the country are essentially now homophobic".

(77) At paragraph 52(a) of her statement, Belinda Bell quotes LGB Alliance as stating “*There is profound homophobia at the heart of gender identity theory*”. LGB Alliance regards the assertions that “some lesbians have penises” and “some gay men have vaginas” as homophobic because they deny same-sex sexual orientation. These assertions are made by the gender identity lobby (a term I explain below) and LGB Alliance firmly opposes them. We are LGB people who take a different view from LGBTQ+ groups. Many of us would say that not only do we *not* have a gender identity, but that to the extent that it defines people according to reductive stereotypes of what it means to be a man or a woman we consider it is often a sexist, and ultimately homophobic, concept. Lesbians who do not accept males who self-define as lesbians as potential sexual partners, and indeed do not accept that such persons are lesbians at all, have been described as sexual racists **[Exhibit BJ11]** and gender-critical beliefs have been compared to antisemitism **[Exhibit BJ51].**

**“Trans rights are human rights”**

(78) Reference is made in the Statement by Belinda Bell to the slogan “Trans rights are human rights”. I (and LGB Alliance) entirely agree with the plain meaning of this assertion. However, as a slogan, it can also be used to mean something quite specific and different from the bare words of that slogan. In my experience the phrase is often used to prioritise trans rights over other sets of rights, and in so doing to subjugate the rights of anyone whose rights might conflict with the

view that gender identity should take precedence over sex. It can therefore have a narrow, subjective and campaigning definition in pursuance of a form of trans rights. Where there are conflicts of rights between trans people and other groups (including women and LGB people), the slogan is therefore deployed to restrict other people's rights, which I (and LGB Alliance) object to.

(79) This is of course quite complex and may not be understood by all of those who repeat the slogan "Trans Rights are Human Rights". Those people may believe they are being kind and inclusive and intend to be so in good faith. But we disagree with the slogan to the extent that it means that that the word "woman" now means "anyone who identifies as a woman". It is not "inclusive" to exclude from LGBTQ+ groups lesbians who affirm that they are only attracted to other biological women.

**Self-ID**

(80) A phrase commonly used in campaigning around trans issues, and which appears in the statements, is "self-ID". Self-ID refers to a system whereby anyone can legally identify for *all* purposes into a gender identity in such a way as to supplant biological sex. This would mean the end of the process currently set out in the Gender Recognition Act 2004, whereby a person can obtain a Gender Recognition Certificate following a medical diagnosis of gender dysphoria and two years "living as" their identified gender. There are different forms of proposed self-ID (I have dealt with the Scottish proposals below), but in broad terms it means that a person would have full legal recognition of their self-identified "gender" – supplanting birth sex – for all purposes without these stages, based purely on their personal declaration.

(81) LGB Alliance is opposed to self-ID. The specific impact of self-ID on LGB people is that any male-bodied person who identifies as a woman could, without any medical diagnosis or any physical change, identify as a lesbian, and achieve full legal recognition as such (and vice versa for a female person identifying as a gay man).

(82) I do not – and LGB Alliance does not – seek to remove the right of someone who wants a Gender Recognition Certificate to acquire one. We do not seek to change the law, or to restrict that existing right. But we also do not want to change the law to enable self-ID because of the loss of rights that this would cause to women and LGB people, as explained elsewhere in this statement.

(83) It may be noted that self-ID had existed in California for just a few years before an event in a spa called Wi-Spa. A male transactivist who was a campaigner for self-ID was naked in a women's sauna with children present. When a woman complained about this, she was called "transphobic" and told that the male person was a woman. The male person, who had a criminal record including sex offences, was subsequently charged with indecent exposure **[Exhibit BJ52].** Women and young girls in a women-only space were distressed by this incident of indecent exposure, and when they complained they were abused and called bigots.

(84) The Wi-Spa incident is one example which shows how the issue of self-ID can impact on women-only spaces. If a trans-identifying male can be charged with indecent exposure, it makes it much more likely in my view that *non-trans* male-bodied exhibitionists will exploit the situation. This is not a comment on trans people: it is a comment on males, regardless of their gender identity.

(85) Self-ID is also relevant in sport. Lia Thomas is a swimmer born male who still has a male body and identified as a woman less than four years ago. When competing in male sport, Thomas ranked 493 in national competition. Since identifying as a woman, Thomas is now the number 1 swimmer in women's events including in sprints and long distance **[Exhibit BJ53]** We believe that Thomas is denying women the ability to compete and to win in their sport. It has been my experience that lesbians are over-represented in organised sport (compared to their representation in the population as a whole), and therefore lesbians will lose out.

(86) Self-identification would accelerate moves over the last decade to confuse and conflate sex with gender identity which have led to a male-bodied person like the

bearded trans rights activist Alex Drummond **[Exhibit BJ54]** visiting schools as a “lesbian” **[Exhibit BJ55]** in order to educate young girls on what it means to be a lesbian**.** We think that this is very confusing and potentially damaging to young lesbians because it means they are at risk of being unable to understand what it is to be attracted to others of their own sex and therefore they are unable to understand who they are.

**Suicide Statistics**

(87) At paragraph 34(b) of his statement Paul Roberts refers to “fake” suicide statistics. It is our firm view as an organisation that inaccurate information and statistics relating to suicide among trans people are used by other organisations and charities in a way which can encourage suicidal ideation. The organisation Fair Play for Women has set out why the statistics that are commonly used are wrong **[Exhibit BJ56].** These statistics are frequently repeated by media and politicians **[Exhibit BJ57]**, the relevant section in the article about David Lammy is on page 5 of that article]**.** This is expressly contrary to accepted best practice in reporting suicides, which states that:

(a) [People and organisations should] "*Avoid dramatic headlines and strong terms such as ‘suicide epidemic*’" (**Exhibit BJ58,** page 4 point 3)

(b) "*Speculation about the ‘trigger’ or cause of a suicide can oversimplify the issue and should be avoided*" (**Exhibit BJ58** page 4 point 9).

(88) It is also often suggested that puberty blockers, cross-sex hormones and surgery can help to prevent suicide. Those referred for gender “treatment” often suffer from a range of mental health issues. It should be noted that evidence exists to show that suicide statistics can be high for persons who have gone through full sex reassignment surgery **[Exhibit BJ59]**, so the picture is very far from clear**.**

(89) We therefore believe that there is a strong public benefit in campaigning against the misleading and irresponsible use of suicide statistics in this way.

**Tweets: The tweets of 12-13 August 2021 and the open-ended "+"**

(90) At paragraph 34(d) of his statement, Mr Roberts refers to tweets by Allison Bailey, Malcolm Clark and LGB Alliance.

(91) The tweet by Allison Bailey, retweeted by LGB Alliance, was accurately commenting on an article, republished online in 2020 by Cambridge University Press, written by Kathy Rudy, Professor of Women's Studies at Duke University **[Exhibit BJ60**]. The article advocated including bestiality under the LGBT+ umbrella. Both Ms Bailey's tweet and the retweet by LGB Alliance expressed revulsion for this idea.

(92) In the article **[Exhibit BJ61]** (which Ms Bailey quoted in her tweet thus making it abundantly clear that it was specifically *this article* she was referring to) Professor Rudy wrote**:**

(a) Page 601: "*In this essay, I draw the discourses around bestiality/ zoophilia into the realm of queer theory in order to point to a new form of animal advocacy, something that might be called, in shorthand, loving animals. My argument is quite simple: if all interdicts against bestiality depend on a firm notion of exactly what sex is (and they do), and if queer theory disrupts that firm foundation by arguing that sexuality is impossible to define beforehand and pervades many different kinds of relations (and it does), then viewing bestiality in the frame of queer theory can give us another way to conceptualize the limitations of human exceptionalism. By focusing on transformative connections between humans and animals, a new form of animal advocacy emerges through the revolutionary power of love."*

(b) Page 601-2 *"I start my thinking with two conflicting and competing realities. The first is the pervasive social taboo against bestiality and zoophilia; the act of sex with animals is so prohibited in contemporary American culture that it is often difficult to speak of such things in public. This is interesting. Humans can kill animals, force them to breed with each other, eat them, surround them, train them, hunt them, nail them down and cut them open for science, and for the most part, the humans who perform those acts can be thought of*

*as normal, functioning members of society. Yet having sex with animals remains an almost unspeakable anathema…. Why, then, in this most intimate domain, is our use of animals most vociferously condemned?*

(c) Page 602: *"As Midas Dekkers aptly expresses it, "the high regard in which love for animals is held is matched only by the fierceness of the taboo on having sex with them" (Dekkers 1994, 149). Enter queer theory. At the most cursory level, queer theory persuasively teaches us that sex itself is difficult to define; sexuality pervades many different levels of many different relationships; and sexual identity is famously unstable. Sex is an energy that can be tapped into but never nailed down. So in relation to bestiality, queer theory points out that the "that" that is performed between humans and animals by necessity must remain unnamed. Stated differently, the widespread social ban on bestiality rests on a solid notion of what sex is, and queer theory persuasively argues we simply don't have such a thing. The interdict against bestiality can only be maintained if we think we always/already know what sex is. And, according to queer theory, we don't"*

(d) Page 604: "*So here I sit with my six dogs, wondering, from the theory-world Eve bequeathed to me, what could it mean to love animals? What does it mean to make myself in relation to the love I have for these dogs? How do they help me construct my gender, my class, my race, the inward, internal topography of identities and desires that connect me to the world ? How does living inside this 3-D, big-screen movie with dogs all around me look to the rest of the world? How does it feel to the dogs themselves? And how does it look to me, inside it? There is not an adequate name for the kind of life I lead, the way my desires organize themselves around animals. In the first half of the twentieth century, the heterosexual public either detested or felt sorry for women who were named by the then emerging category "lesbian." They thought that the only women who would ever choose lesbianism were ugly, or unfeminine, or somehow lacking in the ability to capture a man. Now, on the other side of gay rights, feminism, and queer theory, such ideas seem*

*silly or quaint, almost forgotten. But can people like me even hope for such liberation, when choosing animals as partners*"

(93) The article carries on in the same vein for some 16 pages, arguing that Queer theory, under which gender identity theory and thus the LGBTQ+ umbrella sits, may permit sex with animals. This is a repulsive idea because it brackets lesbian, gay and bisexual people in a common group with people who engage in bestiality. The idea that lesbian, gay and bisexual people engage in perverse sexual acts (of which bestiality is one) has been a common homophobic trope throughout history. This, in my view quite rightly, led to the forceful rejection of the article in the tweets by Ms Bailey and LGB Alliance, as explained in the tweet by Mr Clark to which Mr Roberts refers in his statement. The article was explicitly arguing in favour of giving "the green light to paraphilias like bestiality" as Ms Bailey wrote in her tweet.

(94) Other Tweets have also been referenced out of context by Mr Roberts in his witness statement. At paragraph 34 e (ii) Paul Roberts refers to a tweet by Malcolm Clark asking "*Is the Beeb careless about paedophilia?"* But Mr Roberts omits Malcolm Clark's reason for posing this question, which was that the BBC was still showcasing a film presented by Ian Dunn, one of the founders of the Paedophile Information Exchange. At **[Exhibit BJ62]** is a series of tweets in which Malcolm Clark explains this**.** The Paedophile Information Exchange was a group that lobbied on behalf of paedophiles in the 1970s and 1980s.

(95) I did not post that tweet, and I do not speak for Mr Clark, but when I read it I took two important points from what he was saying: First, that the BBC has an extremely close relationship with Stonewall (or did at the time; as a result of the Nolan Investigate podcasts, the BBC has since distanced itself from Stonewall). And second, that LGBTQ+ organisations tend to be blasé about child safeguarding. All the points made in this statement about children and gender identity theory are examples of this.

**“Born in the Wrong Body”**

(96) We have consistently opposed the use of the phrase “born in the wrong body”. We do not believe anyone is ever born in the wrong body. It was however a phrase used repeatedly by Mermaids (**[Exhibit BJ63]** until government guidance was issued in 2020 that children should not be taught “that either their personality or their body is wrong and in need of changing” **[Exhibit BJ64].** Although Mermaids ceased to use the phrase after this, their explanation of the change of position appears to me to be contradictory: “Saying you have the wrong body … is not the same as saying ‘I need to adjust my body to be my true self’” **[Exhibit BJ63].** Material bearing the phrase remains on its website (including that material which is exhibited at **BJ63**).

(97) LGB Alliance objects to the term “gender-affirming healthcare”. We regard it as a euphemism for experimental drugs and surgery prescribed to persons with gender dysphoria. A chart from the interim report by the Cass Review, giving the diverse “presentations and pathways” that are possible in this area. **[Exhibit BJ65],** a chart from p. 57 of the Interim Report of the Cass Review.

(98) Those changes can be permanent, while gender dysphoria often is not. There is no research or evidence that enables doctors to identify whether a person’s gender dysphoria will subsequently desist. Individuals whose dysphoria does desist but who have undergone permanent medical treatment will therefore have no way of “changing back”.

(99) In the absence of medical evidence to the contrary, our view is that in the case of adults, medical treatment should of course be available. But in the case of people under 18, we believe they should be protected from making decisions that will have a permanent effect on their adult lives with consequences on sexual and overall health and relationships that they are too young to appreciate. **[Exhibit BJ66].**

(100) We do not take a position that no teenager should ever be given drugs that block puberty, merely that this should be a last option and only where it is clinically appropriate. In her statement, Belinda Bell states that “the medical intervention

of puberty blockers (the only form of intervention available to someone under 16) will be the best option for some children with gender dysphoria." This is an expert medical opinion which she is not qualified to provide, and appears to leave psychological counselling out of consideration. No longitudinal studies have been conducted to track the long-term effects of puberty blockers.

(101) We do not take a dogmatic position on this issue, however: were medical evidence to be provided which demonstrates that a different approach should be taken then of course we would revise our position accordingly.

**Gender dysphoria**

(102) Belinda Bell incorrectly refers to gender dysphoria as "discomfort". According to DSM-5 **[Exhibit BJ67],** which provides the formal medical classification of the condition, gender dysphoria is associated with "clinically significant distress or impairment" related to "a strong desire to be of another gender, which may include desire to change primary and/or secondary sex characteristics." Of course it is true that some children suffer from this debilitating condition. They deserve to receive the best possible care.

(103) The most recent studies suggest, on my reading (though I stress that, like Ms Bell, I am not a doctor), that this care should initially consist of in-depth psychotherapy combined with watchful waiting to explore the causes of their distress**.** An article from the Economist which sets this out is at **[Exhibit BJ68].**

(104) Watchful waiting is a course of action that is increasingly being adopted around the world in countries that had previously pursued "gender affirming healthcare" (the latter generally understood to mean access to a medical pathway including puberty blockers, cross-sex hormones and often surgical interventions in order to change a person's body to "affirm" their gender identity) because of evidence that has emerged of the dangers of "gender affirming healthcare". This includes France, Sweden, Norway and Holland, and reports of these are at **[Exhibit BJ69].**

(105)I stress again, I am not a doctor and am not qualified to make medical pronouncements and I do not seek to do so. But the fact that there is a developing medical debate on this condition and that treatments are evolving demonstrates that the tendency to prioritise "gender affirming healthcare" is at best misguided. A patient referred to a clinic on account of distress about his or her sexed body requires and deserves the best, evidence-based, compassionate care that medical science can provide.

(106)Elsewhere in her statement Belinda Bell rightly refers to gender dysphoria as a "condition". As set out above, gender dysphoria is a form of distress with one's sexed body. It is indeed a "condition" and not an "identity". Those concerned need help and support, not unquestioning affirmation in the absence of conclusive medical evidence in our view. Medical treatment is given to people who have medical conditions. Confusing a medical condition (which one might hope to alleviate) with an "identity" or LGB sexual orientation is a harmful conflation. One requires medical treatment, the other doesn't. Gender dysphoria (like other largely unrelated conditions such as anorexia) are medical conditions that may require psychotherapy or other medical treatment. In contrast, LGB sexual orientations are not medical conditions and do not require treatment. But in any event, the interim report from the Cass review recommends that "assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs" **[Exhibit BJ43**, Interim Advice, point 9, page 22**].**

(107)Belinda Bell refers to "someone whose gender does not match the one they were given at birth". This presupposes that everyone has a "gender" which is "given". Nobody is given a gender at birth. A child's sex is objectively observed at birth or in utero. Saying there might a "mismatch" suggests that there is a right and a wrong way to be a girl or a boy. LGB Alliance rejects this assumption, which is effectively a restatement of the now-rejected terminology of being "born in the wrong body". There is of course absolutely no way of determining a "right body" and a "wrong body, or a "match" and "mismatch".

**Self-diagnosis**

(108) In her statement, Belinda Bell criticises me for having said that a diagnosis of gender dysphoria is a self-diagnosis on the part of the patient. I believe that this is accurate however. There are no objective criteria for diagnosing gender dysphoria (An article setting this principle out in more detail is at [**Exhibit BJ70]**)**.** The diagnosis of gender dysphoria is based solely on the patient's own account of his or her experiences and feelings. In that sense it is based on the patient's self-diagnosis. There is evidence to suggest that many children memorise scripts (learnt from online sources) to relate to the doctor to maximise their chances of getting puberty blockers. This is recorded in the academic peer-reviewed paper "Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria" by Dr Lisa Littman at **[Exhibit BJ71].** The relevant section is on page 9, bottom paragraph "Internet/Social Media Exposure"**.**

(109) The point that children may memorise "scripts" is also made in the interim report of the Cass Review. **[Exhibit BJ43,** page 45-6, paragraph 4.5]:

> "*We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation. We have also heard that many of those seeking NHS support identify as non-binary, gender non-conforming, or gender fluid*.

(110) Of course, children who are in distress should be believed: the child reports distress. It is up to the clinician to decide how to help and support the child. Including by reason of the evidence I have referred to above, I believe (and this belief is shared among LGB Alliance) that a child who is in distress about his or her sexed body needs first and foremost compassionate talking therapy to discover the underlying factors, including comorbidities such as anxiety and depression, ASD, loss, trauma, abuse and homophobia **[Exhibit BJ72]**. Study 3 listed on that page is exhibit **BJ71**, and the section cited at **BJ72** is at page 7 of

**BJ71**, final paragraph**.** We believe that the evidence supports our view that the majority of children with gender dysphoria outgrow it unless medicalised [**Exhibit BJ73].**

(111)However, in the current social climate, just as earlier generations of teens have embraced specific identities and styles of rebellion, it is considered admirable to be trans. The phrase “stunning and brave” is frequently used for girls who wear binders and have their breasts removed. We know from detransitioners, former GIDS clinicians and scientific research that many lesbians undergo “transition” in a flight from being lesbian (as set out above, but also see **[Exhibit BJ74]).** This is often reflective of underlying homophobia. The scale is significant: On the crowdfunding website “GoFundMe” there are over 42,000 results for the search term “top surgery” (the surgical removal of breasts as an intervention relating to gender identity). It is not possible to check each of those entries to make sure that all of them are seeking to remove their breasts for specifically this reason, but in preparing for this statement I reviewed 30 of them at random, and all of them are. 1,678 of these are in the UK **[Exhibit BJ75].** We strongly oppose the trend to encourage these interventions.

(112)At paragraph 13 of her statement, Belinda Bell refers to people “genuinely” transitioning their sex. I do not understand the word “genuine” in this context: we stand by the scientific truth that it is impossible for humans to change sex. We do not suggest that medics are deliberately “transing” LGB teens. But we do believe that this is the tragic consequence of the current emphasis on “gender identity”. We made this point in a response to a DCMS consultation [**Exhibit BJ76**], in which we stated (page 4 of 8) that prominent influencers “*appear to be driving a cultural shift in which the extreme and harmful medicalisation of children (many of them likely to grow up lesbian and gay if not medicalised) has become accepted and immune to challenge*”.

(113)At paragraph 33 of her statement, Belinda Bell denies that the gender identity lobby and the medical establishment is involved in pushing children towards thinking they are trans. The continuing activities of GenderGP, the company run

by suspended GP Helen Webberley, which prescribes drugs via the internet to children identifying as trans **[Exhibit BJ77],** conflicts with Ms Bell's statement in this regard. It also gives context to Ms Bell's assertion at paragraph 34 of her statement that "Mermaids is not directly involved in medical treatment of children with gender dysphoria". Mermaids referred young people to GenderGP until the latter received negative publicity in the autumn of 2020 **[Exhibit BJ78].**

**Reform of the Gender Recognition Act in Scotland**

(114) Paul Roberts refers to our campaign, which is in accordance with our aims, against plans to reform the Gender Recognition Act in Scotland. As I have stated above, we do not campaign to change the law. But we object to three proposed changes because we believe they would particularly undermine the rights of people with same-sex sexual orientation to have our own spaces: namely, the introduction of "self-ID", the lowering of the age limit for change of gender from 18 to 16, and the proposal to abolish the diagnosis of gender dysphoria. In addition, we campaign for proper research on the factors underlying the huge increase in the number of children, especially girls, seeking "gender treatment".

(115) We debate and advocate the issues in respect of Gender Recognition reform in Scotland on the basis that women cannot know who has a GRC and who doesn't, and they are not allowed to ask. This means that opening the GRC up to a much wider group of males – without any properly effective safeguarding – has an impact on women, and lesbians specifically. Women would be forced to assume any male who enters their space (or is on their dating service if they are a lesbian) is a transwoman. The loss of single-sex spaces also means a loss of *same-sex* spaces, which is detrimental to people with same-sex sexual orientation, the section of society that we represent.

(116) These points have recently been reflected by the EHRC in a letter to the Scottish Government about self-ID **[Exhibit BJ79].** We also discussed this with the Charity Commission before it granted us charitable status.

(117) Our opposition to the lowering of the age limit for Gender Recognition Certificates is because teenagers have an imperfect understanding of the consequences of

a “medical change of gender” which in most cases will mean massive physical changes, and in many cases infertility and loss of sexual feeling. The teenage years are not the right time for such a life-changing decision. As set out above, evidence shows that if not medicalised, most gender non-conforming teens will outgrow gender dysphoria and become (often LGB) adults, who do not need lifelong medication.

(118) We oppose the removal of the need for a diagnosis of gender dysphoria for a GRC because without such a diagnosis it is unclear what the rationale is for applying for a Gender Recognition Certificate.

(119) Gender dysphoria is considered a medical condition by all leading medical organizations including the NHS **(Exhibit BJ80)** and global transgender health group WPATH. Indeed, WPATH states: “Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder”. **(Exhibit BJ81; p.5).** Gender dysphoria is a diagnosis that is required by doctors before they prescribe hormones or refer patients to get surgery. It is not in the interests of transsexuals (by which I mean specifically people who have gone through full gender reassignment surgery), or others who wish to access medical care, to remove the medical diagnosis requirement. That is because it would blur the boundaries between those trans people who have genuine dysphoria and a much wider group of people who don’t feel any actual physical or mental distress but are simply electing to change their bodies or identify as trans as a choice. It changes the trans category into a consumer choice, which for the reasons I have stated above is not good for trans people or the rest of society, in particular LGB people.

(120) A medical diagnosis and a reasonable period of reflection allows proper time for maturing. These safeguards were in the Gender Reform Act 2004 for precisely this reason. Young people need to be protected from making life-changing decisions that they may come to regret.

**LGB Alliance newspaper adverts**

(121)Mr Nicolson refers to an advert we placed in the newspapers regarding proposed self-ID reform. We pointed out in the advert to which Mr Nicolson refers, and have done so ever since, that self-ID prevents anyone from policing single sex spaces properly – in respect of *males* – not transwomen. Once the position is that any male can be a transwoman and there are no ways to determine this identity, then any male (including those who are *not* transwomen) who enters a girls' changing room or a lesbian bar or dating service cannot be excluded. This is problematic for women and girls. Given this context, the term "predators" obviously does not refer to transwomen but to men exploiting the system to gain access to women and girls for the purposes of criminal activity.

(122)The ASA dismissed complaints about the advert and the Charity Commission questioned LGB Alliance about these specific adverts before deciding to grant us charitable status. We understood our subsequent entry on the register to indicate that the Charity Commission accepted the points that we made to them.

(123)Mr Nicolson asserts that materials published by LGB Alliance are "riddled with falsehoods" but he fails to identify why anything we have said is false. I cannot therefore substantively respond to this allegation. We have explained above that a system that removes the requirement of a diagnosis of gender dysphoria can easily lend itself to abuse by those who are not "trans" at all. We believe that it is naive to suggest that a three-month period of "living in the acquired gender" (which we say in any event is based on sexual stereotypes) and a statement of intent constitute "extensive safeguards".

(124)LGB Alliance entirely rejects the suggestion that self-ID would not make any difference to the rest of society. As the EHRC has recently pointed out **[Exhibit BJ79]** the Gender Recognition Act 2004 was devised for a time when a tiny minority of people (an estimated 200 in Scotland and 5,000 UK-wide) were expected to apply for a Gender Recognition Certificate – specifically those who had a longstanding and permanent condition of gender dysphoria.

(125)The current proposals in Scotland are to open up the GRCs to a vastly wider group of people – a recent article estimated that there are some 24,000 people in Scotland identifying as "trans" and around 600,000 UK-wide **[Exhibit BJ82],** including those who do not suffer from gender dysphoria. As the EHRC has made clear, self-identification would significantly impact on other people's rights, including I believe the LGB people we represent.

**LGBTQ+ Action Plan in Wales and other campaigns**

(126)Paul Roberts refers to our campaign against the LGBTQ+ Action Plan in Wales. We campaigned against it because the Action Plan focused heavily on gender identity and did nothing to help young LGB people who might be struggling with their sexual orientation. It scarcely mentioned lesbians at all, nor did it suggest any materials that might be useful for young LGB people. (The action plan is at [**Exhibit BJ83**])**.** It was an example of how LGB has been sidelined by the "T" – that is, by gender identity theory – in the LGBT campaigning. We wrote to the Welsh Government **[Exhibit BJ84]** asking to be included in the consultations and requesting cross-party discussions but were denied the opportunity to participate. As a result, no LGB voice was included.

**Sex in the Census**

(127)At paragraph 38(e) of his statement, Paul Roberts refers to the campaign "Sex in the Census" which we supported. We strongly believe that it is vital to continue to register natal sex in the census, for statistical analyses in a variety of areas. There was a separate question on gender identity, to which we naturally did not object. The campaign resulted in litigation, which was successful, and a question about a person's natal sex was included in the census as a result.

**Hate Crime Bill in Scotland and categorization as a 'hate group'**

(128)At paragraph 38 (f) of his witness statement Paul Roberts refers to our objections to the Hate Crime Bill in Scotland. Such is the hyperbole and vitriol which we face, LGB Alliance is regularly and falsely accused of being "hateful" or "a hate group" merely for stating our positions on the importance of sex, rather than

gender, as the basis for sexual orientation. The “Hate Crime Bill” would make our positions potentially criminal and would do the same thing to other gender critical people, despite the recognition of gender critical beliefs as protected under the Equality Act in *Forstater*.

(129)Among the vast number of examples of us being called a “a hate group” is **[Exhibit BJ85]** an excerpt of a transcript of an interview given by Jolyon Maugham QC on 2 March 2022, in which he discussed this Appeal and his role in it. He called us a hate group at time stamp 47:18 on page 4 of the Exhibit. At time stamp 41:54 on page 2, Mr Maugham also referred to the untrue allegation that we are funded by the Christian and/or American right wing. In this interview, he tempered this slightly by saying that we cannot prove that we are *not* funded by the American right because it is impossible to vet each small donation we receive and therefore it is possible that – unknown to us – Christian fundamentalists are secretly conspiring to send us individual small donations. We derive absolutely no funding from any right-wing organisation, domestic or foreign, religious or otherwise. But this is an example of the kind of false allegation that is made about us in order to justify the label of “hate group”.

**Gender identity lobby**

(130)From the perspective of LGB Alliance there is a “gender identity lobby”. The gender identity lobby includes groups such as Gendered Intelligence, Depend, Mermaids, Stonewall, the Trans Alliance, Butterflies, CliniQ, Gender Matters, A-gender, the Gender Trust, Galop, THT, Press for Change, THE Action Youth, Afternoon, Transtastic, Sheena Amos Youth Trust, T and Coffee, Transformers (Allsorts), Trans Kids, Transfigurations, Gender Jam, Beyond Gender, InfiniT, Trans Youth Glasgow, Trans London, FTM London, and a great many other organisations: it has even influenced the policy of the trade union movement **[Exhibit BJ86].** It includes its own media outlets such as Pink News, DIVA, Gay Times, openlynews.com, and the Advocate. These organisations and outlets promote the view that gender identity is universal and takes priority over biological sex. These organisations tend to take the view (although I can’t say

this about all of the above-named groups) that we are a “Hate Group”. Accordingly, they tend to vilify us.

(131)Many organisations from the gender identity lobby objected to recent statements by the Equality and Human Rights Commission (**[Exhibit BJ87]** is a response from the LGB Consortium)**.** However, LGB Alliance sits with other organisations such as numerous grassroots women’s organisations and the Gay Men’s Network and several lesbian groups in supporting the EHRC in its important and difficult task of balancing the rights of different protected characteristics. **[Exhibit BJ88].**

**Children and Education**

(132)At paragraphs 39 (a) and (b) of his statement Paul Roberts refers to a campaign to stop gender identity being taught as a fact at schools and a campaign to lobby the EHRC to correct confusions in relation to sex and gender. I have stated our foundational principles above, which include the point that gender identity is a subjective feeling or belief held by some people rather than a fact. As stated, we believe that conflating objective sex with subjective gender identity is causing confusion and harm to children and young people, especially those who are “gender non-conforming” and likely to grow up LGB.

(133)Belinda Bell’s statement quotes LGB Alliance's original Mission Statement (which was archived on 2 February 2020 and is exhibited at **[BB1/15-16])** as including as one of LGB Alliance's four *"Aims": "3. To protect children and young people from being taught unscientific gender theories, particularly the idea that they may have been born in the wrong body, which may lead to life-changing and potentially harmful medical procedures."* It stated: *"In our view, current gender ideologies... are confusing and dangerous to children".*

(134)This is an accurate statement of LGB Alliance’s position. Rather than teaching girls and boys that they can be anything they want, which would be liberating and progressive, many children are being told – online, by peers and in some cases in the classroom -- that it might be appropriate to take drugs and have surgeries to change their bodies. They are getting the message that they might really be

the opposite sex – or no sex at all. LGB Alliance is furthering its charitable objects by presenting its own alternative view to the narrative promoted by gender identity organisations.

**Conference**

(135)In his statement, Paul Roberts refers to the 2021 LGB Alliance conference at the QEII Centre, which was a huge success. We received extensive expressions of gratitude **[Exhibit BJ89].** We are engaged in raising awareness about sex and gender in a climate which discourages debate on this issue, and the conference was one example of this. We are very proud of this work, and the conference in particular. The conference is dealt with in more detail by Eileen Gallagher in her witness statement.

**Attendee Julia Long**

(136)At paragraph 42 of his statement Paul Roberts refers to the interventions of an attendee to the conference who expressed views that could be described as offensive. These views, expressed by the attendee Julia Long, are not the views of LGB Alliance. She was applauded by an estimated two dozen supporters, out of an auditorium of almost 500 people.

(137)We believe in freedom of expression. We allowed Long to say her piece, in which she mocked me and the words I had used, and those used by other members of the panel that were on stage. After she said her piece, her views were forcefully rebutted from the stage, most notably by Jane Clare Jones. Julia Long did not represent the views of LGB Alliance, and nobody who was present in the hall could have been in any doubt about that.

(138)It is worth adding that we received criticism from those who felt we had closed down Long's contribution and should have allowed her to speak at greater length. We are always trying to strike the right balance: we believe in freedom of speech but will forcefully rebut hostile statements. We have numerous examples of tweets in which have urged people to be respectful **[Exhibit BJ90].**

(139)Belinda Bell refers to an incident at the conference involving a provocateur, Jen Ives, who attended the conference while wearing a recording device for the purposes of an article that was later published. I did not witness Jen Ives's behaviour myself, but watched a long video later in which Ives boasted of having worn a recording device to the conference. Ives said nothing at all about the content of the conference in this video but appeared to have been more interested in provoking responses from other attendees. We took the view that any attendee who had paid for a ticket was entitled to stay. Our conference was open to everyone. That includes people who disagree with each other on a range of issues. Eventually Ives turned attention to a conference attendee (who I was later told had quite severe autism) who became quite irate. This attendee was subsequently extremely upset and had to be calmed down by security and Kate Harris, who witnessed the incident.

(140)Belinda Bell makes several references to us (and our supporters) referring to the fact that we have charitable status. She is quite correct that we are proud of this, and that it is of significant assistance to us and that we are the only charity focusing exclusively on the rights of people with same-sex sexual orientation.

**Gender-diverse**

(141)LGB Alliance is run by people who would undoubtedly be regarded as "gender-diverse" by most people in society if the term were explained to them. We are lesbians, gay men and bisexuals who do not adhere to sex stereotypes, who all possess a range of "masculine" and "feminine" characteristics, and who are attracted to people of the same sex, or both sexes.

(142)But we do not think it helpful or necessary to label ourselves "gender diverse", since it is our view that most people are "gender diverse". To say otherwise would be to suggest that most people largely adhere to the presentation and characteristics that are described by traditionalists as "masculine" and "feminine", and that to be different from these binary models is unusual.

(143)It is the position of LGB Alliance that every girl and every boy should be unconstrained by gender stereotypes as to modes of dress, activities and

personality. Indeed, we support “boyish” girls and “girlish” boys to be themselves and to resist pressure to conform.

**Healthcare Advice**

(144)In her statement, Belinda Bell asserts that LGB Alliance falsely claims that Mermaids lobbies for the lowering of age limits for children seeking untested puberty blocking medication. Mermaids has lobbied for children as young as twelve to be able to receive puberty-blocking medication and this has been reported in the Sunday Times **[Exhibit BJ91].** In its response to the Scottish Government **[Exhibit BJ92]**, Mermaids lobbied the Scottish government to legislate that there should be *no* minimum age for legal gender recognition. It is not made clear whether this also applies to the availability of puberty-blockers, but I infer from her statement that it is Mermaids’ position that pubescent children – which includes those of 12 and younger – should have access to puberty blockers, as this is regarded as “gender affirming healthcare”.

(145)Belinda Bell refers to the campaigns conducted by LGB Alliance to remove lobby groups such as Mermaids from children’s healthcare and education. In the case of healthcare, this relates to our opposition to puberty blockers, as explained above. In the case of education it refers to the need to remove the teaching of gender identity as fact from schools – in line with the Guidance issued in September 2020 by the Department for Education; this Guidance is reproduced at **[Exhibit BJ93].**

**Denying that Trans People Exist**

(146)At paragraph 16 of her statement, Belinda Bell states that we are “*arguing that children should not be educated about the existence of trans people”*. We do not believe this and have never argued for it. Everyone exists. People identifying as trans exist and should be treated with respect and dignity like everyone else. These protections are rightly enshrined in UK law, including the protected characteristic of “gender reassignment” in the Equality Act. That does not mean affirming to children that they are the opposite sex. We do not

agree with such practices, but that is not by any means the same thing as denying that trans people exist.

(147)At paragraph 16 (a) of her statement, Belinda Bell refers to "*claims that education on trans issues is harmful*". We do not believe that such education is *de facto* harmful, but we do think that some education on trans issues is harmful as set out above.

**Gender Identity and Gender Critical debate**

(148)Many charities such as Stonewall, Mermaids and the Consortium promote their views in support of gender identity. We occupy a different space and promote our own, gender critical, views. Like the other charities in this space we hold regular meetings with politicians and civil servants to present our views. Everything we do is in the interests of LGB people who believe, as we do, that sexual orientation is based on sex rather than "gender". LGB Alliance contributes to the debate by seeking to have the existing law maintained and upheld, which is in line with our charitable objects to protect the rights of people with same-sex (rather than "same gender") sexual orientation.

(149)As the gender identity charities do, we also meet Ministers and officials. These meetings further our charitable aims to ensure that lesbian, gay and bisexual people continue to be recognised, and protected under the current law, as people who are attracted to others of the same sex (or in the case of bisexuals both sexes).

(150)The debate is an intense one. Recently, some 20 LGBT organisations, most of them charities, have lobbied the UN and other international bodies in order to have the status of the EHRC downgraded, following the publication of two recommendations that, in our view, correctly sought to balance competing rights and interests. This has been reported as "Major LGBTQ+ organisations spark international review of the EHRC" on Stonewall's website **[Exhibit BJ94].**

(151)We do indeed oppose the "purposeful elision of sex and gender" and have done, quite explicitly, from the start, as part of our aims. As part of that, we encouraged

our supporters to submit responses calling for the Gender Recognition Reform Bill to be withdrawn, and drafted a model response for it, as did many other organisations such as, for instance, other charities including Stonewall Scotland to which John Nicolson linked. This guidance on 'how to make your voice heard' was on the website for Stonewall Scotland **[Exhibit BJ95].**

(152)However, we are aware that there is homophobia, online and throughout today's culture, and we believe that the suggestion, propagated by Mermaids and other organisations, that all children have a "gender identity" – which can only be defined in a circular fashion, or based on stereotypes, reinforces that homophobia and leads many LGB teens, especially girls, to demand "gender treatment". We have never said "transing the gay away" is a deliberate goal. However, it is an unintentional consequence of the current approach.

**Detransitioners**

(153)We are concerned about detransitioners. We have written to the Minister of State for Mental Health on the issue. Our letter is at **[Exhibit BJ96].** We are concerned that there is no specialist unit to provide care for detransitioners. They are frequently embarrassed, depressed and sometimes angry about the lack of appropriate care. They seldom want to go back to the clinic that treated them. They have complex needs and there is an urgent need for a specialist unit to cater for them.

(154)At paragraph 43 of her statement Belinda Bell cites three studies in an attempt to prove that very few of those who undergo "transition" experience regret and consequently become detransitioners. We believe that these studies are unreliable:

(a) The 2019 study cited by Belinda Bell "Detransition rates in a national UK Gender Identity Clinic" is not peer reviewed. The background, methods, results and conclusions of this study are set out at [**Exhibit BJ97,** page 118] This study only gathered information from people who were still having appointments during this period – which is obviously not the time when a decision is made to detransition.

(b) The Swedish study, '*An analysis of all applications for sex reassignment surgery in Sweden, 1960-2010: prevalence, incidence, and regrets*' is at **[Exhibit BJ98].** This study did not investigate "experienced regret", it investigated legal sex marker reversals and is about "legal detransition". It did not address those who detransitioned, but had not done so "legally" (a very difficult course). This would exclude, for instance, prominent detransitioners such as Keira Bell and Sinead Watson. The authors also note that it may be that recent cases (which were a great number of the cases) had not had enough time to 'regret' it yet.

(c) The third reference is to "Regret after Gender-affirmation Surgery: A Systematic Review and Meta-Analysis of Prevalence", published in the Journal PRS Global Open **[Exhibit BJ99].** This study has been severely criticised in a detailed article by JL Cederblom and a detailed letter to the editor of the journal [**Exhibit BJ100**]. There is therefore no settled view of this.

(d) It should be added that a study conducted by Lisa Littman about individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned found that 76% of respondents did not inform their clinicians that they had detransitioned. See **[Exhibit BJ101]** which is an abstract of the study**.** I think that any study that fails to acknowledge this can be seen as unreliable. Where high numbers of patients are reported lost to follow-up, it is impossible to classify these patients as "without regret". Nothing can be assumed about these people.

(e) Most importantly perhaps, it is essential to distinguish between the sexes. None of these studies analyses the recently presenting cohorts, most of whom are young women. These recent cohorts include *thousands* of visible detransitioners and two papers from clinics show 10% regret after just 1.5 years. The typical time to regret we believe is about 10 years. My information is from the Society for Evidence Based Gender Medicine and its analysis of the scientific debate on regret **[Exhibit BJ102].**

(155)Belinda Bell claims that LGB Alliance makes false claims about detransition. The claims we make are based on actual evidence from detransitioners and from clinicians who treat them. We support detransitioners and help them tell their stories [**Exhibit BJ103**] is a Tweet by one such detransitioner. The number of detransitioners is not known, but is significant – the Detransitioners' forum on the popular Internet forum Reddit has over 26,000 members, a screenshot of their page is at **[Exhibit BJ104]**

**Women's Groups**

(156)Both Mr Nicolson and the First Minister use the term "transgender rights" in a way with which LGB Alliance disagrees. It is not a *right* to define oneself as the opposite sex (or indeed as a different height or age). If someone does so, it inevitably sets up a clash with those of the opposite sex who object, who may rely on their legal rights (including to be same-sex attracted or gender critical and have freedom of speech, belief and association in doing so). It is my understanding that the Sottish Government only consulted with groups that agreed with its position. As researchers Murray, Blackburn and Mackenzie point out in their article at **[BJ105]**: "*The analysis highlights a marked bias in engagement towards those who agree with the Government position. Despite a manifesto commitment to a consultative approach, the Scottish Government did not set up any meetings with groups that submitted critical comments to its last consultation*."

(157)In addition to this, women are oppressed worldwide on the basis of biological sex, for example: Female children are subject to selective abortion, infanticide, under-nourishment and a lack of education; women suffer from prejudice in matters relating to menstruation, contraception, pregnancy, abortion, childbirth, and rape as an instrument of war. Lesbians are, in our view, doubly oppressed: as women and as people with same-sex sexual orientation. Our experience is that lesbians suffer from prejudice for having the temerity to exclude men from their sexual partners. Women's rights and LGB rights are both fundamentally

"sex-based rights" since it is biological sex and not subjective gender identification that forms the basis of our oppression.

**Gender Identity**

(158)In his statement John Nicolson MP quotes LGB Alliance calling the concept of gender identity "meaningless". What we mean by this is that no one is able to define gender identity (so that literally, it has no meaning) without relying on circular arguments or sex stereotypes (some variation on "a woman is a person who identifies as being a woman"). All of the points raised above about the impact on LGB people of what we consider to be the unscientific notion of gender identity were made in our original application for charity status and were considered by the first respondent. Again, we do not say that our view should be monopolistic, merely that it serves a widely-shared view held by our constituency.

**Male-bodied persons in women's prisons**

(159)At paragraph 13 (c) of his statement, John Nicolson rejects the points we make about women prisoners. We don't think male-bodied people with or without a GRC should be in places where women (including lesbian and bisexual women) may be vulnerable to attack. The risk posed to lesbian and other women from allowing males into their space is not any less in the case of males identifying as women. In 2018 the MOJ released statistics showing half of the people in prison who declare themselves transgender have been sentenced with one or more sexual offences. Fair Play for Women has data which is recent evidence confirming the vast majority of these trans sex offenders were born male **[Exhibit BJ106].**

(160)I understand initially 200 people in Scotland may have used women's spaces when they "passed" as women. We take the view that that is markedly different from allowing any male who self-identifies as a woman to enter them. Further, as it is forbidden to ask to see someone's GRC, women are forced to assume *any* male entering their spaces has one**.**

**Disagreement with Mr Nicolson**

(161) In his statement, Mr Nicolson recounts a disagreement between him and us that took place on Twitter. The accurate chronology has been prepared by Dave Hewitt, entitled Unreliable Narrators and is at **[Exhibit BJ107].** As set out, the events occurred differently from how Mr Nicolson has depicted them in his witness statement.

(162) The issues arose when Mr Nicolson tweeted about a documentary on BBC Scotland called Transsexual Lives on 15 April 2020. He suggested that those opposed to the GRA should watch the programme "and learn". Some people, who I think included people who support us, took issue with Mr Nicholson's tone which I think they felt (as I did) that it was patronising and unnecessarily rude, and then engaged with Mr Nicolson.

(163) On 20 April 2020, he began describing us as "sinister" and said we had organised a "pile-on". He repeated the falsehood, often repeated by our detractors (dealt with above) that we are funded by the far right. We invited him several times to discuss our differences of opinion. He declined to do so.

(164) Some of the critics of Mr Nicolson's original tweet pointed out that the GRA Reform he was tweeting in support of would have undermined the status of those covered in the documentary. The documentary was about transsexuals, who undergo or are planning to undergo physical changes. The GRC in the 2004 Act is reserved for this small vulnerable minority.

(165) We had been running a Crowdfunder at the time and so on 21 April 2020 we asked our supporters to donate money in his name. It was intended as a light-hearted response to Mr Nicolson's unprompted – and we felt vicious – attacks on us. We retweeted a number of these hundreds of messages, some of which referred to John Nicolson as a misogynist and a male chauvinist. We believe that in his approach to lesbians and his lack of concern about them, Mr Nicolson does indeed behave like a male chauvinist, and expresses views which are misogynistic.

(166) One of these messages, on reflection, should not have been retweeted. That was a mistake. Another comment, which we considered to be offensive, prompted us

to contact the Crowdfunder site to ask them to remove it. Our Crowdfunder was closed down. I believe that this was done by or at the behest of Mr Nicholson. This belief is based on the congratulations tweeted out when it and a successor online Crowdfunder was taken down. These Tweets are at **[Exhibit BJ108].**

(167) In response to the comments by one of our supporters, mentioned by John Nicolson at paragraph 25(a) of his witness statement, I would say that it is a common argument by those who support self-ID and seek to change the legal definition of same-sex attraction to same-gender attraction that gay men should not rule out dating transmen (biological females who say they are gay men), just as the same is said of lesbians and transwomen (examples of which are cited above). Our supporter was pointing out that if you redefine "gay men" to include those who date transmen, you are essentially redefining "gay men" to include those who are open to dating females. For the reasons I have set out above, I believe that this is homophobic.

**Miscellaneous Communications**

(168) The comment cited in paragraph 25(e) of Mr Nicolson's witness statement goes to the heart of the debate about gender identity and the threat to lesbians. Lesbians are attracted to females, not males – however they may identify.

(169) In his statement, I believe that Mr Nicolson has repeated at paragraph 26 a misrepresentation of the comments from our supporters, none of which were violent. Hundreds of comments were made by donors, demonstrating the breadth of support that our position has. Of those hundreds, two, I accept, were inappropriate. They were over-reactions to Mr Nicolson's false allegations that we are "sinister", "transphobic", and "far right". But they were not violent.

(170) We did not engage in a campaign of abuse. The suggestion that people should donate in his name was mischievous but not malicious or abusive. We used a fundraising idea that we would not use again.

(171) I reject accusations that are frequently levelled against us. One of these is that we have connections with the Heritage Foundation, an American right wing

organisation. This falsehood is based on a misrepresentation of a tweet by me about the Heritage Foundation, a misrepresentation that has long since been debunked, for example in another article by Dave Hewitt **[Exhibit BJ109].** For the sake of clarity: we have no ties with the Heritage Foundation or any other organisation that opposes women's reproductive rights or LGB rights. Our money comes from individual donations.

(172)Another accusation frequently made relates to Gary Powell, who worked with us for a few weeks. The misrepresentations relating to Mr Powell have been thoroughly explained in an article by him **[Exhibit BJ110].**

(173)A tweet pointing out that same-sex marriage is still controversial among gays and lesbians (indeed, it was initially opposed by Stonewall, as explained in an article for the Independent dated 2 October 2010 at [**Exhibit BJ111])** was misinterpreted to suggest that we oppose same-sex marriage. That is obviously not true.

(174) A tweet stating that LGB people had never asked for laws to be changed was a stupid mistake. It referred to the fact that that we had not demanded compelled speech and imposed our beliefs on society at large, but the tweet was of course worded incorrectly and was deleted almost immediately as soon as the error was noticed (but not, regrettably, before it was screenshot).

(175)A post by Malcolm Clark pointing out the safeguarding issues involved in after-school groups focusing on sexuality was misinterpreted. He has explained his position in a series of Tweets, which are set out at **[Exhibit BJ112**].

(176)The constant attacks, compelling us to defend ourselves from false accusations and misrepresentations, as we are doing in this case, have substantially impeded us in our work.

(177)The framing of the vigorous debate in this area and the need for the charity to give a voice and facilities to our constituency can be seen from the constant stream of criticism levelled at LGB Alliance in articles from Pink News and comments by Peter Tatchell, Christine Burns, India Willoughby, Owen Jones,

John Nicolson MP, Crispin Blunt MP, Baroness Barker, Michael Cashman, Jolyon Maugham and numerous others. Some examples of the stream of criticism are at [**Exhibit BJ113]** (Pink News), **[Exhibit BJ114]** (Peter Tatchell), **[Exhibit BJ115]** (Christine Burns), **[Exhibit BJ116]** (India Willoughby), **[Exhibit BJ117]** (Owen Jones), **[Exhibit BJ118]** (John Nicholson), **[Exhibit BJ119]** (Crispin Blunt), [**Exhibit BJ120]** (Baroness Barker), **[Exhibit BJ121]**(Michael Cashman), [**Exhibit BJ122]** (Good Law Project / Jolyon Maugham)**.**

(178) This stream of criticism does not deter me, however. I am immensely proud of the work we do at LGB Alliance and believe our charity is serving LGB people and the public good in an essential way.

**Statement of Truth**

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

**SIGNED** 

**DATED 18 March 2022**

overlapping in terms of people they apply to, but standing for different things. Here they are.

GENDER1: A polite-sounding word for the division between men and women, understood as a traditional alternative word for biological sex/the division between biological males and females. This word is thought to have the benefit of an absence of embarrassing connotations of sexiness in the copulatory sense. When a passport application, say, asks for 'gender', it's intended in this sense. In Elizabeth Gaskell's *Cranford*, a character refers to the 'masculine gender', meaning males/men.

GENDER2: A word for social stereotypes, expectations and norms of 'masculinity' and 'femininity', originally directed towards biological males and females respectively. These can and do differ from culture to culture, though there are many overlaps too.

GENDER3: A word for the division between men and women, understood, by definition, as a division between two sets of people: those who have the social role of masculinity projected on to them, and those who have the social role of femininity projected on to them. This is the view of womanhood and manhood, as such, discussed in Moment 1 above. As mentioned, in the late twentieth century it was enthusiastically endorsed by some feminists as a putative shield against accusations of 'biological determinism': the idea that female anatomy is domestic destiny. It will be examined critically in Chapter 5.

GENDER4: A shortened version of the term 'gender identity'. What exactly a gender identity is will be investigated in Chapter 4, but a common idea is that it is the 'private experience of gender role' – roughly, whether you relate to yourself psychologically as a boy or man, girl or woman, or neither, in a way that has nothing directly to do with your sex.

Keeping these different senses in mind is crucial when trying to decipher various claims made by feminists and trans

# List of LGBTQ+ terms

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Download easy read definitions of lesbian, gay, bi and trans.

**A**

**Abro (sexual and romantic)**

A word used to describe people who have a fluid sexual and/or romantic orientation which changes over time, or the course of their life. They may use different terms to describe themselves over time.

**Ace**

An umbrella term used specifically to describe a lack of, varying, or occasional experiences of sexual attraction. This encompasses asexual people as well as those who identify as demisexual and grey-sexual. Ace people who experience romantic attraction or occasional sexual attraction might also use terms such as gay, bi, lesbian, straight and queer in conjunction with asexual to describe the direction of their romantic or sexual attraction.

**Ace and aro/ace and aro spectrum**

Umbrella terms used to describe the wide group of people who experience a lack of, varying, or occasional experiences of romantic and/or sexual attraction, including a lack of attraction. People who identify under these umbrella terms may describe themselves using one or more of a wide variety of terms, including, but not limited to, asexual, ace, aromantic, aro, demi, grey, and abro. People may also use terms such as gay, bi, lesbian, straight and queer in conjunction with ace and aro to explain the direction of romantic or sexual attraction if and when they experience it.

**Allo (sexual and romantic)**

Allo people experience sexual and romantic attraction, and do not identify as on the ace or aro spectrum. Allo is to ace and aro spectrum identities, as straight is to LGB+ spectrum identities. It is important to use words that equalise experience, otherwise the opposite to ace and aro becomes ‘normal’ which is stigmatising.

**Aro**

An umbrella term used specifically to describe a lack of, varying, or occasional experiences of romantic attraction. This encompasses aromantic people as well as those who identify as demiromantic and grey-romantic. Aro people who experience sexual attraction or occasional romantic attraction might also use terms such as gay, bi, lesbian, straight and queer in conjunction with asexual to describe the direction of their attraction.

**Aromantic**

A person who does not experience romantic attraction. Some aromantic people experience sexual attraction, while others do not. Aromantic people who experience sexual attraction or occasional romantic attraction might also use terms such as gay, bi, lesbian, straight and queer in conjunction with asexual to describe the direction of their attraction.

**Asexual**

A person who does not experience sexual attraction. Some asexual people experience romantic attraction, while others do not. Asexual people who experience romantic attraction might also use terms such as gay, bi, lesbian, straight and queer in conjunction with asexual to describe the direction of their romantic attraction.

**Ally**

A (typically) straight and/or cis person who supports members of the LGBT community.

**B**

**Bi**

Bi is an umbrella term used to describe a romantic and/or sexual orientation towards more than one gender.

Bi people may describe themselves using one or more of a wide variety of terms, including, but not limited to, bisexual, pan, queer, and some other non-monosexual and non-monoromantic identities.

**Biphobia**

The fear or dislike of someone who identifies as bi based on prejudice or negative attitudes, beliefs or views about bi people. Biphobic bullying may be targeted at people who are, or who are perceived to be, bi.

**Butch**

Butch is a term used in LBT culture to describe someone who expresses themselves in a typically masculine way.

There are other identities within the scope of butch, such as ‘soft butch’ and ‘stone butch’. You shouldn’t use these terms about someone unless you know they identify with them.

**C**

**Cisgender or Cis**

Someone whose gender identity is the same as the sex they were assigned at birth. Non-trans is also used by some people.

**Coming out**

When a person first tells someone/others about their orientation and/or gender identity.

**D**

**Deadnaming**

Calling someone by their birth name after they have changed their name. This term is often associated with trans people who have changed their name as part of their transition.

**Demi (sexual and romantic)**

An umbrella term used to describe people who may only feel sexually or romantically attracted to people with whom they have formed an emotional bond. People may also use terms such as gay, bi, lesbian, straight and queer in conjunction with demi to explain the direction of romantic or sexual attraction as they experience it.

**F**

**Femme**

Femme is a term used in LGBT culture to describe someone who expresses themselves in a typically feminine way.

There are other identities within the scope of femme, such as ‘low femme’, ‘high femme’, and ‘hard femme’. You shouldn’t use these terms about someone unless you know they identify with them.

**G**

**Gay**

Refers to a man who has a romantic and/or sexual orientation towards men. Also a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian. Some non-binary people may also identify with this term.

**Gender**

Often expressed in terms of masculinity and femininity, gender is largely culturally determined and is assumed from the sex assigned at birth.

**Gender dysphoria**

Used to describe when a person experiences discomfort or distress because there is a mismatch between their sex assigned at birth and their gender identity.

This is also the clinical diagnosis for someone who doesn’t feel comfortable with the sex they were assigned at birth.

**Gender expression**

How a person chooses to outwardly express their gender, within the context of societal expectations of gender. A person who does not conform to societal expectations of gender may not, however, identify as trans.

**Gender identity**

A person’s innate sense of their own gender, whether male, female or something else (see non-binary below), which may or may not correspond to the sex assigned at birth.

**Gender reassignment**

Another way of describing a person’s transition. To undergo gender reassignment usually means to undergo some sort of medical intervention, but it can also mean changing names, pronouns, dressing differently and living in their self-identified gender.

Gender reassignment is a characteristic that is protected by the Equality Act 2010, and it is further interpreted in the Equality Act 2010 approved code of practice. It is a term of much contention and is one that Stonewall's Trans Advisory Group feels should be reviewed.

**Gender Recognition Certificate (GRC)**

This enables trans people to be legally recognised in their affirmed gender and to be issued with a new birth certificate. Not all trans people will apply for a GRC and you currently have to be over 18 to apply.

You do not need a GRC to change your gender markers at work or to legally change your gender on other documents such as your passport.

**Gillick competence**

A term used in medical law to decide whether a child (under 16 years of age) is able to consent to their own medical treatment, without the need for parental permission or knowledge.

**Grey (sexual and romantic)**

Also known as grey-A, this is an umbrella term which describes people who experience attraction occasionally, rarely, or only under certain conditions. People may also use terms such as gay, bi, lesbian, straight and queer in conjunction with grey to explain the direction of romantic or sexual attraction as they experience it.

**H**

**Heterosexual/straight**

Refers to a man who has a romantic and/or sexual orientation towards women or to a woman who has a romantic and/or sexual orientation towards men.

**Homosexual**

This might be considered a more medical term used to describe someone who has a romantic and/or sexual orientation towards someone of the same gender. The term ‘gay’ is now more generally used.

**Homophobia**

The fear or dislike of someone, based on prejudice or negative attitudes, beliefs or views about lesbian, gay or bi people. Homophobic bullying may be targeted at people who are, or who are perceived to be, lesbian, gay or bi.

**I**

**Intersex**

A term used to describe a person who may have the biological attributes of both sexes or whose biological attributes do not fit with societal assumptions about what constitutes male or female.

Intersex people may identify as male, female or non-binary.

Stonewall works with intersex groups to provide its partners and stakeholders information and evidence about areas of disadvantage experienced by intersex people but does not, after discussions with members of the intersex community, include intersex issues as part of its current remit at this stage.



**L**

**Lesbian**

Refers to a woman who has a romantic and/or sexual orientation towards women. Some non-binary people may also identify with this term.

**Lesbophobia**

The fear or dislike of someone because they are or are perceived to be a lesbian.

**LGBTQ+**

The acronym for lesbian, gay, bi, trans, queer, questioning and ace.

**N**

**Non-binary**

An umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'. Non-binary identities are varied and can include people who identify with some aspects of binary identities, while others reject them entirely.

**O**

**Orientation**

Orientation is an umbrella term describing a person's attraction to other people. This attraction may be sexual (sexual orientation) and/or romantic (romantic orientation). These terms refers to a person's sense of identity based on their attractions, or lack thereof.

Orientations include, but are not limited to, lesbian, gay, bi, ace and straight.

**Outed**

When a lesbian, gay, bi or trans person's sexual orientation or gender identity is disclosed to someone else without their consent.

**P**

**Person with a trans history**

Someone who identifies as male or female or a man or woman, but was assigned the opposite sex at birth. This is increasingly used by people to acknowledge a trans past.

**Pan**

Refers to a person whose romantic and/or sexual attraction towards others is not limited by sex or gender.

**Passing**

If someone is regarded, at a glance, to be a cisgender man or cisgender woman.

Cisgender refers to someone whose gender identity matches the sex they were 'assigned' at birth. This might include physical gender cues (hair or clothing) and/or behaviour which is historically or culturally associated with a particular gender.



**Platonic partnerships**

People who are on the ace and/or aro spectrum may have platonic partnerships. These are relationships where there is a high level of mutual commitment which can include shared life decisions, shared living arrangements, and co-parenting of children. These partnerships can include more than two people. Like allosexual and alloromantic people, ace and aro spectrum people may be monogamous or polyamorous.

**Pronoun**

Words we use to refer to people's gender in conversation - for example, 'he' or 'she'. Some people may prefer others to refer to them in gender neutral language and use pronouns such as they/their and ze/zir.

**Q**

**Queer**

Queer is a term used by those wanting to reject specific labels of romantic orientation, sexual orientation and/or gender identity. It can also be a way of rejecting the perceived norms of the LGBT community (racism, sizeism, ableism etc). Although some LGBT people view the word as a slur, it was reclaimed in the late 80s by the queer community who have embraced it.

**Questioning**

The process of exploring your own sexual orientation and/or gender identity.

**R**

**Romantic orientation**

A person's romantic attraction to other people, or lack thereof. Along with sexual orientation, this forms a person's orientation identity.

Stonewall uses the term 'orientation' as an umbrella term covering sexual and romantic orientations.

**S**

**Sex**

Assigned to a person on the basis of primary sex characteristics (genitalia) and reproductive functions. Sometimes the terms 'sex' and 'gender' are interchanged to mean 'male' or 'female'.

**Sexual orientation**

A person's sexual attraction to other people, or lack thereof. Along with romantic orientation, this forms a person's orientation identity.

Stonewall uses the term 'orientation' as an umbrella term covering sexual and romantic orientations.

**Spectrum**

A term used to cover a variety of identities that have a root commonality or shared experience.

**T**

**Trans**

An umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth.

Trans people may describe themselves using one or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer (GQ), gender-fluid, non-binary, gender-variant, crossdresser, genderless, agender, nongender, third gender, bi-gender, trans man, trans woman,trans masculine, trans feminine and neutrois.

**Transgender man**

A term used to describe someone who is assigned female at birth but identifies and lives as a man. This may be shortened to trans man, or FTM, an abbreviation for female-to-male.

**Transgender woman**

A term used to describe someone who is assigned male at birth but identifies and lives as a woman. This may be shortened to trans woman, or MTF, an abbreviation for male-to-female.

**Transitioning**

The steps a trans person may take to live in the gender with which they identify. Each person's transition will involve different things. For some this involves medical intervention, such as hormone therapy and surgeries, but not all trans people want or are able to have this.

Transitioning also might involve things such as telling friends and family, dressing differently and changing official documents.

**Transphobia**

The fear or dislike of someone based on the fact they are trans, including denying their gender identity or refusing to accept it. Transphobia may be targeted at people who are, or who are perceived to be, trans.

**Transsexual**

This was used in the past as a more medical term (similarly to homosexual) to refer to someone whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth.

This term is still used by some although many people prefer the term trans or transgender.

**U**

**Undetectable**

HIV medication (antiretroviral treatment, or ART) works by reducing the amount of the virus in the blood to undetectable levels. This means the levels of HIV are so low that the virus cannot be passed on. This is called having an undetectable viral load or being undetectable.

For more information, visit the Terrence Higgins Trust.

Learn how you can help LGBTQ+ people

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# 'Gender fluid' Credit Suisse director named on FT list of Top 100 Women in Business



Philip Bunce was named on a list of the top 100 women in business / Credit Suisse/Twitter

By Asher McShane | 22 September 2018

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A "gender fluid" senior director at Credit Suisse has been awarded a place on a list of the Top 100 Women in Business.

Philip Bunce, who is known to sometimes go to work in a wig and women's clothing, was named on the Financial Times & HERoes Champions of Women in Business list, an annual ranking of 100 "company leaders who support women in business."

Known as Pips Bunce, the director who is Credit Suisse's Head of Global Markets, Core Engineering Integration Components, came 32nd on the FT's list of 100 female business champions.

> After receiving the award he said in a statement: "I am truly honoured and humbled by this award and am proud of the progress we are making towards all forms of gender diversity & equality."
>
> Credit Suisse posted on Twitter: "Congratulations to Pips Bunce on being listed on the Top 100 Female Executives list in the 2018 @HeroesinB & @FT champion of #WomeninBusiness #FTHERoes18"

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Everyone on the list is nominated by peers and colleagues at their place of work.

Nominations are reviewed by the FT and a judging panel of senior City executives.

Mr Bunce had previously described in interviews how he waited until he was "established" at Credit Suisse before he started to cross dress four years ago.

In an interview with website Financial News in 2017 he said he knew he was different "from the age of four."

He said: "For me, being gender fluid means I am non-binary, at no fixed point on the gender expression spectrum. I personally have no desire to transition — it doesn't affect my physical makeup, whereas for others that identify the same, they do wish to transition — there really are no hard and fast rules as these are only labels.

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"I have two amazing children, aged 18 and 21, and have been married for over 22 years. At home my children have never known any different. They have always known that dad likes to express differently at different times. It always amazes me how supportive and strong they are. They get the importance of what this means to me and I know that they all love me unconditionally for who I am, not how I choose to express.

"I decided to come out at work about three and a half years ago and for me, this was a big deal.

"I'd reached a point in my life where I thought, It's really silly me hiding this, why am I putting on this facade and keeping all this hidden at work."

Suki Sandhu, Founder of INvolve and HERoes, said of the list: "These lists have been created with one aim – to create gender parity in workplaces across the globe."

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# A Month with Starfish: Volunteering with refugees on the Greek island of Lesbos Paperback – 9 Feb. 2016

by Bev Jackson (Author)

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What is it like to spend a month working with refugees in 'the most complicated patch of land in the world'? When Bev Jackson's holiday to India is cancelled, in October 2015, she feels an odd sense of relief. She has spent months watching the arrivals of refugees in Greece and is dismayed at the lack of support from the European Union for people fleeing war zones. In 2015, a million refugees, most of them from war-torn Syria, Iraq and Afghanistan, arrived in Europe. Well over half of them passed through the small Greek island of Lesvos. Bev and her wife decide to spend their month's holiday volunteering with refugees on Lesvos as members of Starfish, one of the volunteer groups helping to receive and care for people who have crossed the Aegean Sea from Turkey in search of safety. A Month with Starfish is a largely light-hearted account of a trip to a kaleidoscopic world. In these surroundings, Bev finds that her professional talents are of little use and instead she needs to learn how to register dates of birth for people who use a different calendar and how to draw a decent tortoise on a bus ticket. Volunteering with refugees proves an astonishingly joyful experience: Bev meets some of the most compassionate and resilient people in the world, volunteers and refugees alike, and makes many new friends. Amid this varied cast of characters, she finds herself on a crash course in human possibilities and her own potential for change.

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### Review

"... wonderful book. I read it in one go and was profoundly moved and educated too. It is a fresh, honest and compassionate insight into the life of a Lesvos volunteer." Esther Freud

### About the Author

Bev Jackson was a founding member of the UK Gay Liberation Front. She then moved to Amsterdam, where she raised two daughters, worked as a teacher and translator, and now lives with her wife and two dogs.

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## Bev Jackson

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# Homosexuals demonstrate for equal rights

By Geoffrey Wansell

The first public demonstration in Britain by the Gay Liberation Front, a movement dedicated to altering public attitudes towards homosexuals, whether men or women, was held last night on Highbury Fields, London.

Some 80 members of the front gathered to hear the aims of the movement read out at the scene of the arrest of a man for gross indecency.

They ask that homosexuals should be allowed to kiss and hold hands in public, just as heterosexuals are; that all discrimination against "gay people, male and female, by the law, by employers and by society at large should end"; and that they should be allowed to contact each other through newspaper advertisements or on the streets in exactly the same way as heterosexuals.

Miss Bev Jackson, aged 19, a member of the steering committee of five, said: "It is important to know that we are not ashamed to be homosexual." She explained that the front had been organized in Britain for six weeks and had about 250 members, although it was a large organization in the United States.

Mr. John Breslin, aged 41, an actor, said he felt the acting profession was one of the few in which homosexuality was tolerated.

At the peaceful meeting members of the front criticized the public attitude to homosexuals. As one said: "We don't want to be a freak show. We just want to be the same as anyone else."

At the end of the 90-minute torchlight demonstration members of the front emphasized that their membership included ordinary people. One said: "There are straight people, lesbians, and male homosexuals in the front."




https://www.pinknews.co.uk/2018/07/07/anti-trans-group-allowed-to-lead-pride-in-london-march-after-hijack/

and "drown them out". This tweet got 4,000 likes including from many luminaries of the LGBT establishment.




Jan Gooding, the Chair of Stonewall tweeted, "thank you. Exactly the right instinct!".

Steve Taylor, Board Member of Europride and and Head of Special Projects at Pride in London tweeted "My #Pride heroes of the day are the amazing young people at @LancasterPride who surrounded the transphobes to obscure them from view".

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THE SPECTATOR

*Josephine Bartosch*

# The limits of Stonewall's tolerance | 31 July 2018

31 July 2018, 1:00am




'Acceptance without exception' is the aspirational slogan emblazoned across the website, merchandise and literature of Stonewall, the UK's largest LGBT charity. The problem is that there are exceptions. Those who are not accepted include those who refuse to believe that a person can change their sex simply by saying: 'I identify as.'

The fractious nature of the LGBT alliance – and Stonewall's intolerance for dissenting voices within the community – is becoming increasingly clear. At this year's London Pride, a group of protestors from 'Get the 'L' Out' made their feelings known by marching to the front of the parade with banners, including one reading 'Transactivism Erases Lesbians.' The actions of this small group of lesbians drew a furious response from Stonewall. Instead of listening to the concerns of the women protesting, or acknowledging that there is a discussion to be had on this subject, Stonewall simply stuck to its line that transwomen are women, dismissing any deviation from this as 'transphobic'. Stonewall's chief executive Ruth Hunt said that the lesbians involved in the protest 'have deserted the fight for LGBT equality' and 'have no place at Pride'.

So much for 'Acceptance without exception'.

Thankfully, Hunt's outrage that there are other perspectives on transgender identities is not shared by all of those originally involved in setting up Stonewall. Simon Fanshawe, one of the co-founders of the charity, argues that Stonewall has 'a historic responsibility to enable calm reasoned debate'. It is hard to see how Hunt's response meets that test. Fanshawe says he fears that voices – including those of transgender people, some of whom prefer to describe themselves as 'transsexual' – are in danger of being drowned out by the reaction of the likes of Stonewall. He says:

*'Some transgender people are proud to identify themselves as 'transmen' and 'transwomen,' not simply as 'men' and 'women' and they feel marginalised by the language and ideology that seeks to diminish this difference. I do not wish to invalidate anyone's experience, but by not acknowledging there is a debate to be had Stonewall are failing in their duty to LGBT communities to enable self-determination for all trans people.'*

So why are alternative voices being ignored? A brief glance at the Stonewall Trans Advisory Group perhaps offers an answer: those who were born male appear to outnumber females by about two to one (a similar ratio to MPs in the House of Commons). Do those who sit on the advisory group have to hold the view that stated gender identity takes precedence over biological sex? It would seem so. Take Alex Drummond, for example, a transwoman who claims to be 'widening the bandwidth of how to be a woman' by sporting a full beard alongside the accoutrements of femininity (skirts and make-up). It is not transphobic to suggest that someone with a male body who wears female clothes has no place identifying as a lesbian; it is simply a different perspective.

In an interview in the *Guardian* in 2014, Hunt said: 'I am not interested in being the thought police.' Yet four years on, lesbians who fail to accept male bodied transwomen like Drummond as women are demonised by Hunt as apparently 'working against' the LGBT community.

So what explains the change in thinking? In 2015, Ruth Hunt announced that Stonewall would make its campaigns trans-inclusive; she later said that, for transgender people: "it's their turn now. They really, really need us." But at what price has this focus on the T in LGBT actually come?

A cynic might suggest that Hunt's new found focus was an attempt to make the organisation seem relevant again in the wake of the vote to allow same sex marriage. If so, this is a strategy that appears to be paying off: Stonewall's funding has increased dramatically in recent years, from £4.33m in 2013, to £7.24m in 2017, according to data from Open Charities.

But what is all this money being spent on? Britain is finally catching-up with the legal changes LGBT individuals and organisations have spent decades campaigning for. It's true that

prejudice against lesbians and gays does still exist but it is no longer sanctioned by the state. So with at least some of the battle won, the fights are increasingly becoming internal. As a result,

the rainbow is beginning to fracture. Despite the attempts to dismiss them as something of a fringe group, 'Get The L out's protest at this year's Pride actually reflects a deeper malaise in the lesbian, gay and bisexual communities. There is a desperate need for reasoned debate in order to allow all sides to have their say. Unfortunately, the response of Stonewall has been to shout louder and smear those who do not toe the trendy identity politics line. By championing the rights of male-bodied lesbians, Stonewall are abandoning the very people they should exist to support and making a mockery of the struggles we still face. It is somewhat depressing that, in 2018, the views of lesbians, bisexual people and gay men are being cast aside by the very organisation that claims to push for 'acceptance without exception.'

*Josephine Bartosch is director of the campaign group Critical Sisters*

WRITTEN BY

*Josephine Bartosch*



CURRENT AFFAIRS

# Anti-trans group allowed to lead Pride in London march after hijack

HAZEL SOUTHWELL | JULY 7, 2018 | SAVE FOR LATER



Anti-trans protesters took over the front of Pride in London

## Pride in London has been "hijacked" by a group of anti-transgender campaigners who forced their way to the front of the march.

The annual Pride march today was set to be led by Mayor of London Sadiq Khan and NHS staff, but has been disrupted as an anti-trans group forced their way to the front of the parade.

A PinkNews reporter filmed live from the scene and witnessed the group of about ten women take the lead spot of Pride, with security and police doing nothing to remove them.

The group carried signs with anti-trans slogans, such as "transactivists erase lesbians", while they distributed leaflets opposing trans-friendly reforms to the Gender Recognition Act, and calling for trans women to be banned from women's spaces.

The campaigners briefly lay on the ground to physically block the march from continuing, but after negotiations with Pride staff were permitted to get up and march the entire route.

PinkNews interviewed several of the protesters as they led the parade across much of the city, to a confused reaction from the crowds.

They were allowed to continue unhindered by organisers, even as physical crowd management was repeatedly used to push back members of the media.

Speaking to PinkNews, one of the women said: "We want to get the L out of Pride, a man cannot be a lesbian, a person with a penis cannot be a lesbian." She purported that there was "a bit of sympathy in the crowd" for this view, despite boos and shouts of "shame" at the group.

Another marcher said: "Men are saying they are trans, they are lesbians and they pressure lesbians to have sex with them."

Asked in what way this happened, she stated that she and others had been called TERFs (Trans-Exclusive Radical Feminists) online.

There were several altercations between the women and other LGBT people at the event as the marched, with many angered that Pride was being led by a group seeking to exclude trans people.

One of the people involved in the confrontation told PinkNews "They hate trans people, they hate sex workers ... they are just as bad as bigots saying gay people go to hell. It's disgusting, this is a problem with what Pride has become.

"They were taking a bunch of photos [of me], I guarantee they're going to go after me. They were trying to get my friend arrested for no *****ing reason.

"This is what happened when we ignore that Pride started as a riot led by trans women of colour."

Update: Pride in London has now issued a statement.

More: London

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(https://fairplayforwomen.com/)

# Are Lesbians Welcome at Pride? The answer at Lancaster Pride is no.

1st July 2019 by FPFW (https://fairplayforwomen.com/author/fpfw/)




Guest post by Greater Manchester ReSisters.

We are a group of lesbian women (and a couple of allies) from Lancashire (https://twitter.com/LResisters) and Greater Manchester Resisters (https://twitter.com/GMancReSisters) who attended Lancaster Pride on June 22nd to demonstrate support for lesbian visibility and protest the pressure on lesbians to accept people with penises as dating partners (http://www.gettheloutuk.com/blog/category/research/lesbians-at-ground-zero.html). We faced a barrage of hostility, which, shockingly, was supported by Pride organisers, and members of the LGBT establishment.

You can watch a full video of the protest here.

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We came with banners bearing the simple messages: “Lesbians are female homosexuals,” and “Lesbians don’t have penises,” and stood on the steps of the Town Hall. We were not in the way of anyone, but wanted our message to be heard, as members of the LBGT community.





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We conducted our protest peacefully, using a handheld megaphone to speak from our vantage point of high visibility across the main square. All of our speech was factual and did not express hate, or include swearing or personal insults. We called out, ‘lesbians matter!’ ‘Lesbian rights matter,’ ‘lesbians don’t have penises’ and, ‘pro woman not anti trans!’

Initially, passers-by mainly watched and listened, then people started to approach us to try to get us to desist in an initially condescending, then increasingly aggressive manner.

A crowd began to gather on the other side of the road, making rude hand gestures, shouting and swearing angrily at us. Within minutes, around 40 people had surged right to the top of the steps, and surrounded us, chanting over us, and holding up flags to block our signs from public view.




Local aspiring Labour politician Dominic Casoria (https://twitter.com/DominicCasoria/status/1142476938474397697)boasted on twitter that he led the group to “stand in front of the transphobes” and “drown them out”. This tweet got 4,000 likes including from many luminaries of the LGBT establishment.

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Jan Gooding, the Chair of Stonewall (https://twitter.com/Jan_Gooding/status/1142715461769076736) tweeted, "thank you. Exactly the right instinct!".

Steve Taylor, Board Member of Europride (https://twitter.com/danophile/status/1142453727896489984) and and Head of Special Projects at Pride in London tweeted "My #Pride heroes of the day are the amazing young people at @LancasterPride who surrounded the transphobes to obscure them from view".

Tim Roache the General Secretary of the GMB Union, Ruth Hunt of Stonewall and Emma Dunn of the civil service "agender" network also tweeted their approval, Emma Dunn retweeting a message calling us TERFS.

Pamela Richie of the Women's Equality Party said (https://twitter.com/WEPamela18/status/1142582081123508225), "I'm grateful to people standing up to hate speech in our streets in a peaceful way."

Mermaid's Head of Marketing Helen Islan (https://twitter.com/mimmymum?visibility_check=true), who earlier this year notably attempted to prosecute Transsexual Miranda Yardley for hate speech against Transwomen, meanwhile called our statements, "exclusionary propaganda"


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However as the video shows we were simply a small group of lesbian women calling for the sexual orientation of same-sex attracted females to be respected. There was no hate speech. Female homosexuality should not be an unutterable taboo, especially within the very community tasked with representing us.

Contrary to the many laudatory messages on Twitter, the atmosphere of the counterprotest was neither peaceful nor respectful. Nor did it appear to be spontaneous. While most of the people who surrounded us were teenagers seemingly excited to be part of a protesting tribe, it is evident from the video that there are older people who come in through the back of the crowd and encourage them. “Miss Ivy Rose” a drag queen who was part of the official entertainment also leads the young people in the chant ‘Transwomen matter!’

While most of the teenagers simply repeated the chants they were given, other protesters grabbed at our banners. We were spat at by an adult woman and her Trans partner and some protestors screamed confrontationally in our faces. One male individual attempted to wrestle our megaphone away. The police did not control the situation and did not keep a buffer zone between the crowd and ourselves.

Shockingly, Robert Mee, CEO of Lancaster Pride encouraged the situation. At one point he shouted at us, ‘fuck off you fucking dogs, you’re ruining it’ and can seen holding a corner of one of the counterprotester’s flags and smiling in the protest footage. He later went to tell the crowd of people watching main stage (https://www.facebook.com/garystevens500/videos/10157198673640782/), ‘we made them go away, politely’. In fact we left when the situation had escalated to the point we felt unsafe to continue.

## So if lesbians asserting their sexual boundaries aren’t welcome at Lancaster Pride, who is?

On our way to the town hall we passed a brightly coloured shelter which appeared to be a children’s play area with a ball pool and children’s toy box. We were surprised to see it occupied by a group of men in leather costumes and dog masks. One was positioned on all fours attached at the collar while another participant held them on a lead.

This tent belonged Dog House Stoke a group based around the sexual fetish of dressing up as ‘puppies’ with rubber outfits, ‘puppy’ masks, collars and chain leads, and engaging in sexualised puppy play.

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We were shocked and disturbed to see young children playing unaccompanied with these men in their tent and made a complaint to the police about our safeguarding concerns.




A more in depth write up about these Dog play fetishists activities at UK Prides can be found here (https://www.objectnow.org/news/2019/6/27/puppy-paedophilia-at-pride).

Both the ambiguous presentation of the pups tent (is this an adults oriented activity or a children's play area?) and the whipping up of a group of excitable teenagers into an angry mob were an enormous dereliction of concern for the well-being of children by the organisers of Lancaster Pride, and show a flagrant disregard for the idea of sexual boundaries.

Whilst Lancaster Pride promotional materials states, 'all are welcome,' we lesbians certainly did not receive a welcoming reception. Organisations and individuals that have presented our beliefs as hateful are contributing to the climate of hostility and aggression towards homosexual women (https://www.oxygen.com/crime-time/lesbian-couple-attacked-on-london-bus-speak-out-against-hate-crimes) which we experienced, and are acting irresponsibly in their duty of care towards children.


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We remain unshakeable in our conviction that there is nothing wrong about women loving women, and that children should not be involved in adults' sexual fetishes. We are proud of what we stand for, the shame belongs to Lancaster Pride.

More on why Resisters (https://twitter.com/ReSistersU) felt called to protest can be found on their website www.resistersunited.org (http://www.resistersunited.org/)

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## Prisons, crime and protecting women

The facts about transgender prisoners (https://fairplayforwomen.com/transgender-prisoners/)
Karen White & prison review (https://fairplayforwomen.com/prison-review/)
Sex attacks in female prisons (https://fairplayforwomen.com/sex-attacks-mps-must-investigate-risks-of-transgender-prisoners/)
Female inmate suing the government (https://fairplayforwomen.com/why-female-inmate-suing-government-transgender-prisoners/)
Refuge shelters deeply worried (https://fairplayforwomen.com/rebirth/)
How do women in prison feel about sharing with transgender prisoners? (https://fairplayforwomen.com/insidetime/)
Can you believe what you read about sexual and violent crimes? (https://fairplayforwomen.com/ipso/)
Factsheets (https://fairplayforwomen.com/factsheets/)

## Sport and the human body

Biological sex differences (https://fairplayforwomen.com/biological-sex-differences/)
Chromosomes, sex and gender (https://fairplayforwomen.com/chromosomes-biological-sex-gender/)
Guidelines for single-sex sport policy (https://fairplayforwomen.com/sport_policy/)

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A scientist reviews the IOC's transgender inclusion policy (https://fairplayforwomen.com/emma_hilton/)

The science and statistics behind the transgender debate (https://fairplayforwomen.com/science-statistics-behind-transgender-debate/)

Safeguarding in sport still matters (https://fairplayforwomen.com/safeguarding_sport/)

Testosterone reduction policies (https://fairplayforwomen.com/compliance/)

Rachel McKinnon transwoman cyclist (https://fairplayforwomen.com/mckinnon/)

You can help (https://fairplayforwomen.com/donate/)

## Making policy and the law

The Equality Act 2010 and women's rights (https://fairplayforwomen.com/equality-act-2010_womens-rights/)

GRA reform (https://fairplayforwomen.com/campaigns/gra-reform/)

Advice and guidance for policy makers (https://fairplayforwomen.com/policy-guidance/)

Equality impact analysis advice (https://fairplayforwomen.com/mbm/)

Public Sector Equality Duty (https://fairplayforwomen.com/equality-act-2010_womens-rights/#jump2)

Changing room policy advice (https://fairplayforwomen.com/changing_rooms/)

Scottish Government omits women's evidence (https://fairplayforwomen.com/eqia/)

The Scottish bill that stole the word woman (https://fairplayforwomen.com/scottish_stole_woman/)

What can I do now? (https://fairplayforwomen.com/equality-act-2010_womens-rights/#jump10)

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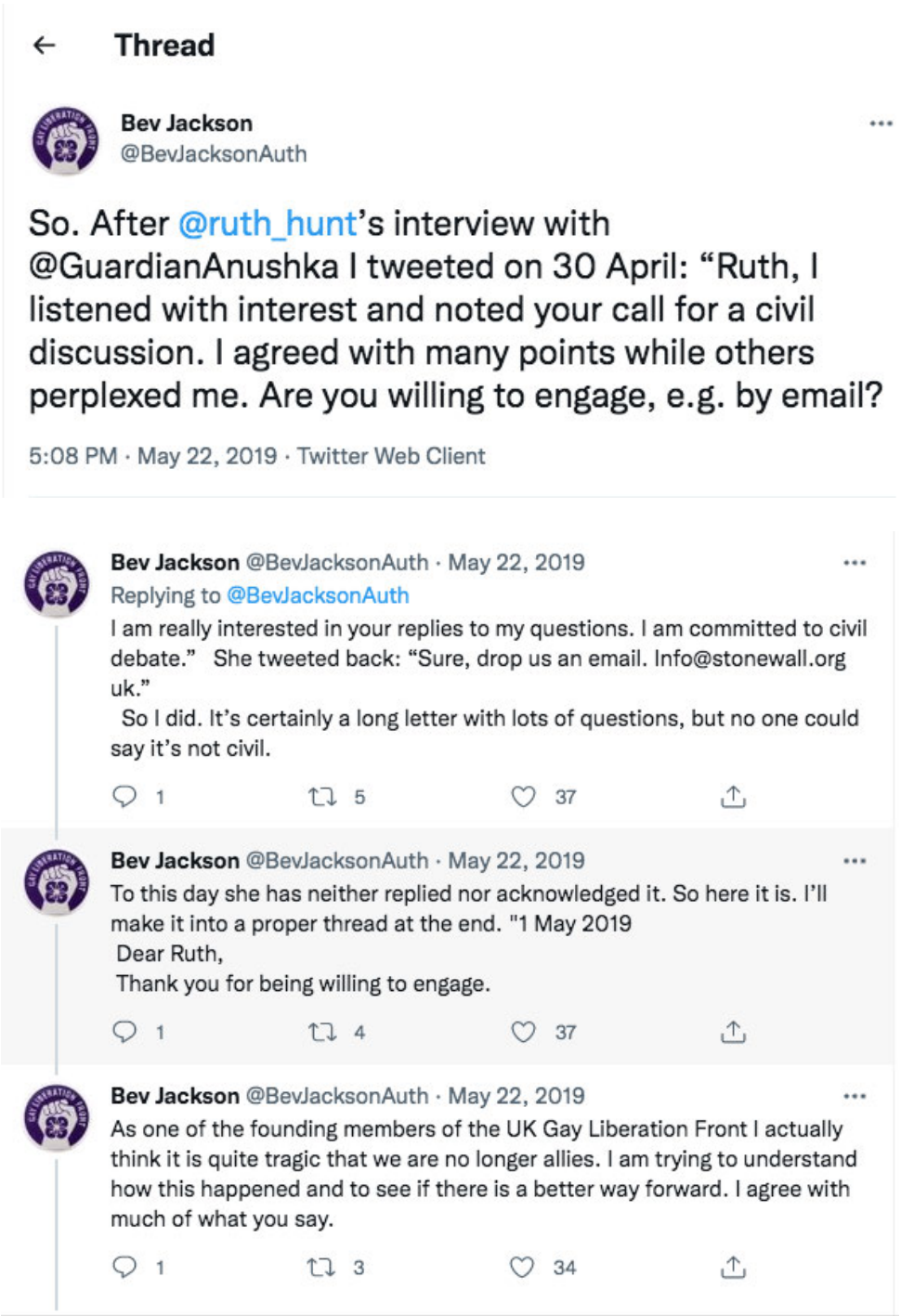

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9:46 AM · Jun 23, 2019

https://twitter.com/jan_gooding/status/1142715461769076736

https://twitter.com/BevJacksonAuth/status/1131230465032105984?s=20&t=-Y6yeZu5PUZsL5bNp7yLNA



**Bev Jackson** @BevJacksonAuth · May 22, 2019

I totally oppose Trump's disgusting ban on trans people serving in the military, and very much agree with your comments on the alarming situation facing gay men and lesbians in countries such as Chechnya.

1 2 25

**Bev Jackson** @BevJacksonAuth · May 22, 2019

In your interview, you said that "it isn't legitimate to say that all transwomen are men masquerading as women in order to exploit a system." I totally agree. That would be an outrageous thing to say.

1 2 24

**Bev Jackson** @BevJacksonAuth · May 22, 2019

But as a gender-critical feminist who communicates with hundreds of other gender-critical feminists, I have never heard anyone at all say such a thing. At most, it is pointed out that when a system has loopholes, there are bound to be some people who will abuse it.

1 6 55

**Bev Jackson** @BevJacksonAuth · May 22, 2019

So why did you make this strawman argument? You said: "when the discussion starts from the assumption that transwomen are fundamentally deceptive and out to harm, that is a position that we cannot engage with". Again, I totally agree.

**Bev Jackson** @BevJacksonAuth · May 22, 2019

That would be a totally vile, obnoxious assumption. But again, I have never heard any gender-critical feminist say that. So why did you make this strawman argument?

1 5 36

**Bev Jackson** @BevJacksonAuth · May 22, 2019

While refuting these non-existent claims, you did not address any of the actual concerns raised by gender-critical feminists. So I would be grateful if you would be willing to answer the following questions.

1 3 28

**Bev Jackson** @BevJacksonAuth · May 22, 2019

You say that the way trans people are treated "reminds me exactly of how lesbian and gay people were treated in the late 80s and early 90s." How do you respond to the reports, some of them by desisters and detransitioners,

1 3 29

**Bev Jackson** @BevJacksonAuth · May 22, 2019

that some children and young adults are identifying as trans precisely because of homophobia? Do you believe that these reports are true, false, exaggerated, or malicious propaganda?

1 3 44



**Bev Jackson** @BevJacksonAuth · May 22, 2019

Where do you stand on the reports of young lesbians finding numerous male-bodied people identifying as lesbians on their dating sites and experiencing harassment for not considering these people as sexual partners?

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

Do you believe that these reports are true, false, exaggerated, or malicious propaganda? Do you believe that homosexuality is same-sex attraction or attraction to someone of the same gender identity?

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

Do you support the rights of homosexuals to be exclusively attracted to persons of the same biological sex?

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

Does the recent huge increase in the number of teenage girls identifying as trans worry you? Do you think it needs to be researched?

1 2 35



**Bev Jackson** @BevJacksonAuth · May 22, 2019

You referred to the media coverage of trans issues in The Times. One of the subjects covered related to concerns about the treatment being offered to children at the Tavistock clinic. Do you think The Times was wrong to publish articles about these concerns?

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

Do the long-term effects of puberty blockers worry you?
Does the use of incorrect suicide statistics as a pressure tool worry you, or do you not believe this to be the case?

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

Given that female children are subject to selective abortion, infanticide, under-nourishment and a lack of education, and that women suffer from prejudice in matters relating to menstruation, contraception, pregnancy, abortion, childbirth, and rape as an instrument of war,

1 5 43

**Bev Jackson** @BevJacksonAuth · May 22, 2019

do you accept the importance of retaining the word “woman” as a term relating to biological sex, since it is biological sex and not subjective identification that underlies the oppression of women? If not, why not?

**Bev Jackson** @BevJacksonAuth · May 22, 2019

This appears to be the crux of the division between the transactivist movement and gender-critical feminism, so I would really like to hear your thoughts on this issue.

1 3 37

**Bev Jackson** @BevJacksonAuth · May 22, 2019

Do you believe that it is right to allow male-bodied people access to shelters set up for women who have suffered abuse? Do you think it is fair to expect separate facilities to be created for male-bodied people who have suffered abuse?

4 2 39

**Bev Jackson** @BevJacksonAuth · May 22, 2019

Do you believe that “misgendering” should be a criminal offence?Do you think that women are entitled to refuse to be called “cis”?Do you believe that women should be free to debate all these concerns without being non-platformed and without harassment by transactivist protesters?

2 3 46

**Bev Jackson** @BevJacksonAuth · May 22, 2019

These are just a few of my actual concerns. I very much applaud the valiant support for women’s rights that is consistently voiced by transsexuals like Debbie Hayton and Kristina Harrison.

**Bev Jackson** @BevJacksonAuth · May 22, 2019

Let me say a few words about my own background.
When I was young, I had an intermittent sense of myself as a boy: a boy called Sam when I was three, and at eleven I used to stuff objects in my underwear to look like a boy.

1 1 22

**Bev Jackson** @BevJacksonAuth · May 22, 2019

When I was fifteen, I called myself William, and once threw a girl across the classroom because she wouldn’t call me that. I was lonely and isolated and hardly had any friends.

1 1 22

**Bev Jackson** @BevJacksonAuth · May 22, 2019

I have no doubt whatsoever that if transitioning had been possible, and if I had encountered a welcoming trans crowd on social media, I would have come out as trans and transitioned as soon as possible.

1 1 30

**Bev Jackson** @BevJacksonAuth · May 22, 2019

But that was in the 1960s, and times were different. I gradually came to terms with being a woman, and at 31 I had my first child. I now have a wonderful wife, I have two daughters and two granddaughters, and have a good life.

**Bev Jackson** @BevJacksonAuth · May 22, 2019

I do not have a “gender identity”. If I had transitioned, I would not have this amazing family life, and I am so incredibly thankful to have grown up in an age when transition was impossible.

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

Many gender-critical feminists are people like me, who read the stories of girls who are transitioning or who have desisted or detransitioned. They sound just like us.

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

I am extremely worried that teenage girls, whose problems with body image are well documented (anorexia, self-harm etc.) and for whom social media may well exacerbate or distort existing confusions,

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

are susceptible to transing without the factors underlying their dysphoria being fully explored. This is backed up by numerous accounts of girls who write of their regret. Really a lot of girls, Ruth.

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**Bev Jackson** @BevJacksonAuth · May 22, 2019

I am not suggesting that all teenage girls identifying as trans are like me. Of course not. Some undoubtedly benefit from transition. But some don’t.

1 1 21

**Bev Jackson** @BevJacksonAuth · May 22, 2019

And for those girls, who might go down a path leading to sterility and regret it, I will continue to fight for better medical practice.

1 2 24

**Bev Jackson** @BevJacksonAuth · May 22, 2019

I realize that I have asked a lot of questions, and re-reading my letter, it looks a bit like an interrogation! But I seriously don’t understand what your position is on these issues, and would be really grateful if you could respond as best as you feel able.

1 1 26

**Bev Jackson** @BevJacksonAuth · May 22, 2019

Thank you again for being willing to engage with me in this debate.
Kind regards,
Bev Jackson

# Ruth Hunt on Virginia Woolf

Transcript of History Becomes Her podcast

00:00
Speaker 1
Hey, here's a little brain teaser. How many T's are in the following sentence? Get a same day doctor's appointment with Livi. Did you hear five as well? Regular brain training is good for your cognitive health. Need a GP download the Livi app now? That's li vi to see a GP by video. Appointments cost 39 pounds, including prescriptions, sick notes and referrals.

00:37
Speaker 2 (Rachel Thompson)
Welcome to history becomes her. a Mashable podcast about women making history right now and the women who paved the way for them. I'm your host, Rachel Thompson, senior reporter at Mashable. Ruth Hunt is one of Britain's leading LGBTQ campaigners, and has played a central role in campaigning for same sex marriage in England and Wales, and access to fertility treatment for lesbians. After becoming Chief Executive of LGBTQ rights charity Stonewall in 2014, Hunt spearheaded the organization's commitment to campaigning for trans equality. She is credited with transforming Stonewall from an LGB charity to a fully trans inclusive LGBTQ charity during her tenure, Hunt left Stonewall in 2019. And that year, she was made a cross bench peer in the House of Lords.

01:27
Speaker 3 (Ruth Hunt)
My name is Ruth Hunt, and I am a director of a company called deeds and words, which I run with my partner, my life partner and my business partner. And I am a crossbench peer in the House of Lords.

01:39
Speaker 2 (Rachel Thompson)
So basically, we start off each episode by asking the same question, which is, is there a particular woman from history who's had a profound effect on your life or has inspired you in some way?

01:52
Speaker 3 (Ruth Hunt)
I think there are so many women scattered through through my life, I think and have kind of come at different stages in my growth, that have had a profound impact. But I suppose the one I always revisit is Virginia Woolf. To be frank, there are all those types of women in my life. But I think Virginia Woolf shows such core vulnerability in her work also speaks such incredible truths about women and space and voices, and the need for those things. And her own mental health charts a journey in her creativity that is everything from playful to profoundly existential. And I can't help but continue to be moved by that really,


Transcribed by https://otter.ai

02:37
I am obsessed with Virginia.

02:39
I'm obsessed. I have a tattoo of one of my quotes. I know that that's…

02:43
Speaker 2 (Rachel Thompson)
Yeah. So yeah, speaking of kind of women from history, that the achievements of LGBTQ people are notably absent from recorded history. And I was wondering what your thoughts were on kind of how we can begin to address this.

02:57
Speaker 3 (Ruth Hunt)
There's obviously a straight washing that goes on in history. And I know that throughout all my studies and things like that any glimmers of queerness, would always send a freeze on my spine and my colleagues as well. I think I think there are two things. The first is we've got to be really careful that we don't go back and clear up stuff that isn't quite queer, I think we can sometimes presume that people had identities that they may not have had, and, and kind of wish wish fulfillment on some of the complexities. But I do think that also it's about changing our lens, a little bit on how we look at some of these stories. And even if we don't know for sure what the nature of that relationship was, it describing it in the terms that have not yet been described is really important. And I think, I think that goes for women as well. I think we can look at lots and lots of major incidents in history. And particularly, I've been struck by the GCHQ celebrations of the last 100 years and how many women played a role in some of those key moments that you wouldn't have ordinarily heard about. So the people writing the stories need to be a bit more imaginative, but we also need to be careful that we don't make someone trans when they're not. Perhaps they're just living their lives. So I think I think there's there's a bit of wish fulfillment we need to be careful about.

04:17
Speaker 2 (Rachel Thompson)
So during your time at Stonewall, what is the achievement that you're most proud of, or that felt particularly special to you personally,

04:25
Speaker 3 (Ruth Hunt)
when I worked at Stonewall for 14 years, so started in 2005, and finished in 2019. And during that time, I was a junior member of staff when some of the most significant legal changes happened that affected lesbian and gay people. And I think that and I use those words deliberately lesbian and gay. And I think that some of those moments, of course had a profound impact on society in the way they work, same sex marriage is hugely powerful. But of course, I think it was the introduction of civil partnerships that was actually the most groundbreaking because that for the first time acknowledged that same sex couples existed. But my personal pride rests in introducing and bringing in properly into the fold trans

people's experiences into that movement. And shifting Stonewall from a movement that was, was one that was primarily preoccupied with I would argue an assimilationist approach to gay rights to one that was more ready to acknowledge the complexity of our movement, and that we are not one community but many communities who interact and have different needs. And I think we always knew that would be controversial, that it would be difficult that people would lose by that. Yeah. And I think we collectively thought and the staff were profoundly clear about this. So that was a price worth paying.

05:48
Speaker 2 (Rachel Thompson)
Which actually brings me to my next question, because you've said previously that Stonewall was late to the game and supporting the trans community. And when you joined, you face some resistance when when attempting to address this lack of trans inclusion. Wonder if you could tell me a little bit about that time

06:04
Speaker 3 (Ruth Hunt)
when I first started. So so let's think from 2005 to 2008, press for change, were in a kind of equal position to Stonewall, in terms of legislative campaigning and I, as a campaign, I'm very much that that campaign should be led by and for the people who most represents. And I think that was a happy balance in 2005, to 2008. What happened in 2008, is Stonewall got a lot bigger, our reach got a lot deeper. We were working with schools, we were working with employers. And I think that's the moment where we should have had a more adult conversation about trans inclusion. And I take responsibility for that I didn't push that enough as a member of staff. And I think we we comforted ourselves in the knowledge that trans people were were secure and able to lobby for themselves. I think what became abundantly clear from certainly 2010 onwards, when we had a coalition government when it was clear that there was a the end of that era of left wing majority labour left leaning majority would have, for better or worse, I think we should have been more proactive in building alliances. I think that had we campaigned for marriage, and at the same time campaigned for gender recognition act reform, that would have been an easier run. So I've played my part in that, you know, I also have a responsibility that that I didn't push hard enough for that. But when I became acting CEO and was interviewing for CEO, I was absolutely clear that the question had to be asked how were trans communities best served by Stonewall. And that may have been through complete inclusion of transgender in our work, or it could have been us supporting trans communities to build their own movement. And that was the question on the table. But it had to be an explicit and active and positive move on our part. And I am immensely pleased that that trans people, the vast majority of trans people said, We want Stonewall to run with this, we don't want to just be the T at the end. We don't want you to have generic statements of LGBT, when you're really talking about LGB, we want you to take our issue seriously. And we want you to create an opportunity for people who identify as trans to develop a career and a place of work and to be advocating and lobbying on their own behalf with the expertise and security of Stonewall around them. And that's what we set out to do. And it was messy. We made plenty of mistakes. And I've not been at Stonewall for a few months now. But I'm sure the team would continue to say we keep making mistakes. But the decision was absolutely the right one. And I'm incredibly proud of what we've done and how we're doing it.

08:48
Speaker 2 (Rachel Thompson)
British feminism seems to be divided on the matter of trans rights. And there are, you know, so called Gender critical feminists who object to trans women occupying women's toilets, for instance. How do you feel about this particular strand of British feminism?

09:06
Speaker 3 (Ruth Hunt)
I think social media doesn't help anything. I think that I have had Stonewall staff have had series of very good ongoing conversations, often in confidence and in private to protect everybody really, about how we resolve some of what we would call the tricky issues, about prisons, about sport about access to particular services. And what's interesting about those conversations is that 90% of the ground is common. So in the state of, for example, domestic violence services, those who run those domestic violence services say that they've been supporting trans women for decades, that they've never turned anyone away, that they would always find the most appropriate service for the individual, and that the politicizing of their services is very distressing in particular. Even the big political issue for their services is the significant cuts to their ability to run the services. In sports, the headline that that the summary is often trans women attempting to get into sports, the reality is, is that trans women do not get an immediate right to participate in sport, the mechanism by which that is assessed is through a level of hormone levels. And that is imperfect. So there's a discussion to be had about what is the best mothod. In terms of prisons, I know trans men would not be safe in a men's prison so well, so there's always space for these conversations. The issue is, is that there is a significant amount of unhelpful hyperbole that often dehumanizes trans people that I think, often by accidents, sometimes by design misrepresents the factual reality of what is being proposed and what's being considered. And I am deeply concerned that a lot of the commentary comes from a place of unequivocal transphobia. Not all and the positions that are not based in transphobia that how good faith conversations, I've enjoyed many of those conversations, whether it's over my dinner table, or in meeting rooms, those that are based on bad faith transphobia I have less patience with and that that bad faith transphobia manifests itself by presuming that trans women are inherently out to deceive, and that trans women are men. And that I that's something that doesn't really provide much space for discussion and negotiation about how best to manage prisons.

11:40
Speaker 2 (Rachel Thompson)
And what do you think we can do to challenge the transphobia? That seems to be, you know, certainly from what I've seen on social media, and it seems to be thriving in this country,

11:49
Speaker 3 (Ruth Hunt)
Social media is deceptive. So when I was at Stonewall, we did an exercise that mapped exactly where the opposition was coming from and the nature of that opposition. And I think I think there are two sorts of opposition. There's that opposition that says trans women are men, and we brook no discussion. And I think that is a small but very vocal community that has the ear of the media. And often what is said is accepted without challenge. And that's, that is a cause of grave concern. There is a middle group who

would say trans women or trans women, and we find it a bit puzzling. And that's, that's the nature of campaigning, you know, that's, that's let's carry on, let's talk let's meet. And I know that Stonewall is, and others, organizations like gendered intelligence, and mermaids and all about trans, are doing brilliant work, just slowly having these very, very good conversations and nudging the discourse along. There is a significant group of people. And I think the majority, who are appalled by the way in which trans people have been spoken about, are deeply concerned about what this signifies about a wider polarization of attitudes towards minority communities, that they see that transphobia is often a proxy for wider prejudice and discrimination, that the way in which trans people are spoken about is is easily extended to people who are LGB women who are non traditional non conforming, all those kinds of things. And people are also looking at where the money comes from, for some of these campaigns. And I think people are very deeply concerned both for their trans siblings, and what this signifies about where we're at as a society. And I think it requires a huge amount of courage for people in that category to use their power to start saying, actually not in my name. And that doesn't have to be done on Twitter, because Twitter rarely achieves anything. Very rarely people move to change their mind. But stating unequivocally and clearly, that they support trans people is is more important now than I think ever before. And the level of vitriol against trans people, is I think, the equivalent to the level of vitriol levied against gay men and HIV in the late 1980s. It is it is similar in its pitch, its fever, and its intention, which is to divide

14:17
Speaker 2 (Rachel Thompson)
and circling back to your work at Stonewall. The organization was founded in the UK as a response to Section 28. And that's a law that passed in 1988 by Margaret Thatcher that stopped councils and schools promoting the teaching of the acceptability of homosexuality as a pretended family relationship. How did this law affect students who went to school during during the time that this legislation was was in place?

14:43
Speaker 3 (Ruth Hunt)
Well, it was I mean, I was at primary school. So so that says, my age, I'm 39, 40 40 in March, and we'd, the words lesbian, gay, bi or trans or anything like that was not mentioned at all. And any books that positively depicted those things were removed from the shelves, so it was prompted by a book called Jenny Lives with Eric and Martin, which is a book about a young girl called Jenny, who lives with her dad, Eric and his boyfriend, Martin. And they do really boring kids things to get, you know, they go to the shops, and they go to the park, and they go to school. And there's one scene in the middle of it, where Jenny is seen having, in Wales we call it a morning cwtch, which is where you kind of snuggle down with with your parents and have a chat about your day. And the dads didn't have pajama tops on. And this was considered to be so dangerous, as the answer was to ban that book. And the issue was, is that it caused a significant degree of confusion. And my partner who's older than me was, was at school at the time in sixth form. And she wanted to hold a debate on section 28. And wasn't, she certainly wasn't out then but but knew she was different and went on to put posters up for this debate on section 28. And the head teacher called her in and said that having the debate was in itself a breach of section 28. So she had to go around the school and take the posters down. And that's in the backdrop when you were seeing the Daily Mail arrive on your living room table every morning, saying

HIV and gay men are killing people. I mean, that that has created a hostile, degrading and intimidating environment for us. That remains today. And I think it really struck us that young people who were leaving school now the first generation have come through without section 28. It took a considerable long time to repeal section 28 and a considerably long time to then reverse its damage. And arguably, I don't think we have reversed its damage. The discussions that are had about primary schools, and what can be taught in primary schools is the equivalent to the discussions that were being had around section 28. And

16:45
Speaker 2 (Rachel Thompson)
Actually, that's my my next question. In the headlines recently was a school in Birmingham that's had to install an exclusion zone to prevent protesters campaigning against LGBTQ equality messages being taught in school. So the protesters were chanting things like let let kids be kids, and we'll we'll do placards that read Adam and Eve, not Adam and Steve. How's that make you feel to see that?

17:08
Speaker 3 (Ruth Hunt)
Well, I think that certainly when I when I was at Stonewall and the staff at Stonewall would say we knew that had never gone away. I think what we are also aware of is that a lot of those protests aren't just about LGBT issues. They're about the general role of schools in in educating kids. But what's interesting is that those protesters have learned that the media reported when they talk about LGBT issues. So there is something there is still an underbelly, that cannot be just attributed to those handful of protesters. There's something that people are concerned about their children learning about the fact that gay people exist. And and I think that that is that's never been away. So Stonewall works with, you know, 20,000 primary schools, they work with 2000 a year. Getting as quickly and deeply as possible into an on what we do. What stable does it support the teachers to have those conversations. And I think that what's happening in Birmingham is a sad indictment of some of the changes in how people feel about vocalizing their opposition to minority communities. And it's because people are overworked. And there's not enough resources for any of that building of communities that used to be you know, the McPherson report, under the Equality Act made clear that public bodies had a responsibility to build good relations between communities, they can barely afford to keep social services on the ground right now, you know, that the luxury of spending time building good relations between communities is not happening. And that's what would be derided as political correctness or dismissed as namby pamby, you know, whatever the it's what builds good relationships, and good relationships are the foundations to good society and good society is the foundations to wellbeing and happiness. So these are all fundamental traits of what keeps this world ticking that are all being de prioritized. And that is incredibly dangerous. Yeah.

19:01
Speaker 4
Not all stories online can be trusted. Some are designed to reel you in with misleading facts, extreme opinions, or even outright lies. So before you share a story with friends or family online, check, are the spelling errors. Do images or videos look at it? Do the facts seem believable? Do they come from

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19:31
Speaker 1
Hey, here's a little brain teaser. How many T's are in the following sentence? Get a same day doctor's appointment with Livi. Did you hear five as well. Regular brain training is good for your cognitive health. Needed GP. Download the LIVVIE app now. That's li vi to see a GP by video appointments costs 39 pounds, including prescriptions, sick notes and referral

20:04
Speaker 2 (Rachel Thompson)
So, two women on a bus were beaten up in a violent homophobic attack. And their names were Melania Gamina, and Chris Hannigan and they were subjected to homophobic abuse and coins were thrown at them after they refuse to kiss. A lot of people were shocked and said, You know, it's 2019 How is this happening? But Hannigan Lita wrote an op ed stating that, you know, she disagreed with the sentiment. Do you think a lot of people in society aren't aware of the kind of persistent threat posed by homophobia?

20:34
Speaker 3 (Ruth Hunt)
Absolutely. And I think I think that there is a degree of complacency about about how far attitudes have shifted, and a kind of ease with which people say, Well, it's an older generational objection, and this will pass and change. That's certainly not what Stonewall sees. And it's not what I experienced as a lesbian wandering around town. You know, London is no more immune to this as as Dorset is, and I think that what the two women explained was a real insight into the low level of persistent anxiety that exists if you are queer, if you are LGBT, because what you are constantly doing is risk assessing and assessing whether a situation is safe or not, and whether that situation has changed. And there's a reason why I cycle everywhere in my sometimes my three piece suits, my tweets tucked into my local boots, you know, it is infinitely safer to be on a bike as a dike, frankly, and get around quickly. And and I think that my partner, I often talk, you know, we don't even have to communicate when we're out, when we know that suddenly something doesn't feel safe. And we'll let go of each other's hands and we'll move away. I think also, there has always been low level, homophobic abuse by phobic abuse, and certainly significant transphobic abuse. That is that is much more surface now. And I think that LGBT people are getting less patients with that they are being less, almost accepting of it. And I think that social media has served as a good for that because you can immediately let people know, on your follows list that this has happened to you. And I am really grateful that those two women pursued their case. And they took it so seriously, because we need more of that. But but it wasn't new at Stonewall. It didn't feel new to us, it just felt that people were listening in a different way. But I also know that if it had been a trans person, it would not have received the publicity as as the Op Ed stated that the fact that they were to white women who were feminine, meant that they received greater outrage than they would have done if they were a person of color, or if they were trans or if they look like me. And I think that's, you know, we are we are in danger of perpetuating the inequalities by talking about what's good gay and bad, gay, and which which good gays deserve not

22:58
to be not to be beaten up in which bad gays had it coming because they were a bit too gay is still I think a common discourse.

Speaker 2 (Rachel Thompson)
And that story in particular, also raised the issue of the the misogyny and homophobia experienced by the lesbian community, which can take the form of sexualized comments and abuse. And I'd love to know your thoughts on how we as a society can work to address this particular strain of homophobia and misogyny?

23:21
Speaker 3 (Ruth Hunt)
Well, I think it is, I think it's through compulsory sex and relationship education in schools. I mean, and I think that starts in primary schools with good conversations about how boys treat girls and what and what good behavior looks like and how we respect women. And that isn't about shouting at Alexa, which kids learned to do eight and nine, and learn how to be derogatory, and it's not helped through accessing pornographic images from a young age on filtered sites and learning everything about sex through that medium. I mean, it's one thing that Stonewall in the Church of England were utterly aligned on that, that young people learning about sex and relationships through pornography is deeply unhealthy. And the lesbian, lesbian porn is designed to demean diminish and to derive and if men are only learning about lesbian identities through pornography, then that feels the misogyny that that relates to homophobia. So the answer is to start talking to men much more talking to boys much more about respect and what sex looks like, but also talking to women about about what's what's their own pleasure, I find it extraordinary in this day and age, and I certainly probably wouldn't say this if I was still in Stonewall, but but as I know, I'm my own woman, that we don't talk to girls about their own pleasure and what they need and what they want and what they can say yes to and what they can say no to and, and how and how that's as much part of education as what sex isn't. You know, how we can have a healthy relationship with sex is I think, incredibly important. And then the kind of the way in which lesbians because either a figure derision or fantasy will hopefully decrease. Yeah.

25:07
Speaker 2 (Rachel Thompson)
So you're now the Director of deeds and words, can you tell me a bit about what your current work focuses on.

25:14
Speaker 3 (Ruth Hunt)
So me and my partner, we run a lovely little consultancy business where we help organisations who are really struggling to achieve an optimum inclusive workplace. And so so they may have had some problems, they may have had specific issues, but are struggling to kind of help their workforce, have good quality conversations and work in a way that enables everybody to contribute to their best of their ability. And we work with a range of different clients, just in the middle of some brilliant work with Liberty, the civil civil liberties organization, helping them read it. And what they came to us and said is if

we are advocating to ensure that young black men aren't stopped and searched, and that's an abuse of human rights, we cannot do that as a group of white people, you know, so how are we going to, and that can't be clicked. That's something about how we work who we work with how we operate. And that work is quite subtle. And and in depth, we run a creative young leaders program for the Roundhouse, which is an arts venue up in north London. So we have some lovely clients like that. And we do quite a lot with government. So we're quite we're quite deeply involved with lots of government departments. And I think what what government departments are increasingly realizing is that if you do not create an environment where different perspectives can be heard, you make very poor decisions. And I'm in the House of Lords. Tell me about that. What the hell is that? I don't know. It's quite random. It's not what I was expecting. Yeah. So I was expecting to finish off in Stonewall and slowly kind of retreat into a different space for a while. And yeah, I feel very young. I feel very gay. I feel a little out of my depth, but I also feel like it's the most important place I can be right now. Absolutely. Yeah.

27:05
Speaker 2 (Rachel Thompson)
Well, congratulations.

Speaker 3 (Ruth Hunt)
Thanks

27:06
very much. It’s a bit scary.

27:08
Thank you so much for coming on the podcast and talking to thank you very much for having me. If you'd liked this episode of history becomes her please subscribe, rate and review. If you have suggestions of history making women we should feature on our podcast, or you simply want to get in touch. Find us on Twitter at hBH pod and you can find me on Twitter at our VT nine. History becomes a is a Mashable podcast created by Rachel Thompson and Maria dalmunzie. Our artwork is by Vicki Lita. Our music was produced by Christiane Stryker, special thanks to Shannon Kanalen and Nikolai Nikolov. And why not check out our sister podcast fiction predictions. Thank you so much for listening.

28:07
Speaker 1
Hey, here's a little brain teaser. How many T's are in the following sentence? Get a same day doctor's appointment with Livi. Did you hear five as well? Regular brain training is good for your cognitive health. Need a GP? Download the LIVVIE app now? That's li vi to see a GP by video appointments costs 39 pounds, including prescription sickness and referrals.

# Protecting patients

*your rights as lesbian, gay and bisexual people*



Stonewall

General Medical Council

Regulating doctors
Ensuring good medical practice

# Protecting patients

## *your rights as lesbian, gay and bisexual people*

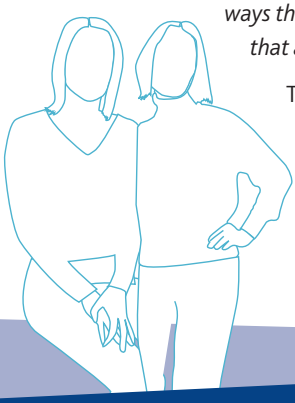
**Patients must be able to trust doctors with their lives and health. This includes lesbian, gay and bisexual (LGB) patients and their families. They have the same rights as anyone else to safe, effective, and appropriate care.**

The General Medical Council (GMC) sets out the principles of good practice in our core guidance to doctors, *Good Medical Practice.*

We tell doctors:

*'You must not unfairly discriminate against [patients] by allowing your personal views… about sexual orientation… to affect adversely your professional relationship with them or the treatment you provide or arrange.'*

*'…You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress.'*



This guidance applies to doctors' personal beliefs about sexual orientation.

## How doctors should work with you

Doctors should work with you to reach decisions about your care that are right for you. They should treat you as an individual; and respect your dignity and your right to confidentiality. If they do not, they will be breaching our guidance. It is also unlawful under the Equality Act 2010 for doctors to discriminate unfairly against you.

Stonewall (the lesbian, gay and bisexual charity) have told us that LGB people have sometimes found that doctors have:

- failed either to examine or to respond to a patient properly, for example they have not been willing to offer a smear test to lesbians
- told others that a patient is gay, when this had nothing to do with their treatment
- refused to accept someone as a patient because of their sexuality
- made offensive or discriminatory comments about LGB sexuality.

If you have experienced anything like this, you may want to talk to someone to try to prevent it happening again.

## What you can do if you are concerned

Remember, you have a right to complain if you have faced discrimination. First, contact the place where you received care, because this is the best way to settle complaints quickly. The GMC can take action if we need to stop doctors from practising or to restrict their practice in some way. Both local organisations and the GMC need to know who you are if we are to investigate your concerns. It will be difficult to go ahead if you want to remain anonymous.

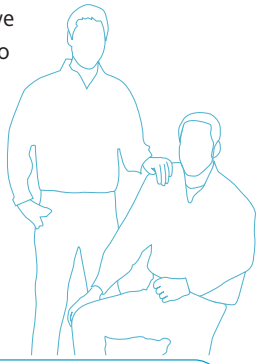
If you think your doctor is not fit to practise, or may be a risk to patients, then please contact us by:

- ringing our helpline on 0161 923 6602; or
- emailing us at **gmc@gmc-uk.org**; or
- writing to us at the General Medical Council Fitness to Practise Directorate, 3 Hardman Street, Manchester M3 3AW.

We have a useful leaflet, *How to complain about a doctor*, that explains what happens when you make a complaint and gives examples of the types of cases upon which we may need to act. It also contains a form for you to fill in. The leaflet is on our website at **www.gmc-uk.org**, or you can ask for a copy by calling our helpline on 0161 923 6602 or by emailing **publications@gmc-uk.org**.

If you decide to make a complaint, we will review it carefully and respond to you as quickly as we can.

**Above all, we promise to treat you fairly and equally.**



**Remember:**

- **You have the same rights as everyone else**
- **Make sure you understand your rights as a patient**
- **Try to resolve your complaint locally**
- **If you think your doctor is not fit to practise, or may be a risk to patients, then contact the GMC**

GMC Helpline **0161 923 6602**

## Further reading

### GMC

*How to complain about a doctor: A guide for patients*

*Good Medical Practice*

*Treatment and care towards the end of life: good practice in decision making*

*Consent guidance: patients and doctors making decisions together*

### Stonewall

*The colour of your money: A guide to goods and services*

*Living Together: British attitudes towards lesbian and gay people*

### The Department of Health

*An introduction to working with lesbian, gay and bisexual people: Information for health and social care staff*



Stonewall

General Medical Council

www.stonewall.org.uk

www.gmc-uk.org

www.nhsdirect.nhs.uk

## General Medical Council

3 Hardman Street
Manchester M3 3AW

## GMC Helpline 0161 923 6602

Outside the UK tel: +44 (0)161 923 6402
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**www.stonewall.org.uk**

*Leaflet part funded by the Department of Health.*



# Stonewall boss defends new strategy amid criticism

By Jessica Parker & Eleanor Lawrie
BBC News

29 May 2021




Nancy Kelley: "I'm comfortable with our direction as an organisation"

**Stonewall head Nancy Kelley has defended the organisation's position amid a freedom of speech row and criticism from a founder.**

Matthew Parris said in the Times that Stonewall had become "tangled up in the trans issue" and "cornered into an extremist stance".

But Ms Kelley told the BBC she was "really comfortable" with the direction the charity was going in.

She likened so-called "gender critical" beliefs to anti-Semitism.

The Equality and Human Rights Commission (EHRC) has said its defence of the right to hold "gender critical beliefs" - that sex cannot be changed - "does not have an impact on our commitment to uphold

the rights of transgender people".

## Freedom of speech 'has limits'

The new EHRC chair, Lady Falkner, has said women have the right to question transgender identity without being abused, stigmatised or risking losing their job.

Ms Kelley said while Stonewall believed in freedom of speech, it was "not without limit".

"With all beliefs including controversial beliefs there is a right to express those beliefs publicly and where they're harmful or damaging - whether it's anti-Semitic beliefs, gender critical beliefs, beliefs about disability - we have legal systems that are put in place for people who are harmed by that."

Challenged as to whether it might be considered offensive to compare anti-Semitic beliefs to gender-critical views, she insisted it was appropriate.

"We're talking about protected groups. We're talking about people that are protected on the basis of their sexuality, people that are protected on the basis of gender identity, people who are protected on the basis of race and that's why I think the analogy is apt."

Journalist and former Tory MP Matthew Parris, one of Stonewall's 14 founders, recently suggested the charity had "lost its way".

In an article for the Times, he said: "The organisation is tangled up in the trans issue, cornered into an extremist stance on a debate that a charity formed to help gay men, lesbian women and bisexual people should never have got itself into."

Ms Kelley said while Mr Parris was entitled to his views, being trans-inclusive was the "absolute norm" for LGBT organisations.

She also denied Stonewall had approved incorrect advice on transgender issues for the University of Essex, which is part of its Diversity Champions workplace inclusion scheme.

A recent report found the university had unlawfully blacklisted a speaker after some protesters labelled her a "transphobe".

Ms Kelley said Stonewall had "nothing to do" with the university's process for deciding external speakers and was "really confident" in its legal advice.

Stonewall's been criticised for using the term "gender identity" when referring to the Equality Act's protected characteristic of "gender reassignment".

But Ms Kelley described that as "the difference between natural language and statutory language".

She also expressed frustration that the volume of media coverage and debate around trans rights meant "it can be difficult to get across all the work we do... focusing on the experiences of LGB [lesbian,

gay and bisexual] people."

She said the organisation's work could still benefit people, whether or not they agreed with its position, such as improving access to IVF.

That aim is part of the organisation's new "free to be" strategy, which includes campaigning for "hate crime and hate speech laws in the UK that protect LGBTQ+ communities" and a pledge to champion inclusion across schools.

- Human rights body quits Stonewall diversity scheme
- Groups criticise conversion therapy 'Groundhog Day'

## Conversion therapy ban delay 'unnecessary'

GETTY IMAGES

Liz Truss is Equalities Minister as well as Secretary of State for International Trade

The strategy also prioritises a "legally enforceable ban on conversion therapy".

Ms Kelley said the consultation process, planned for September, was an "unnecessary delay" but promised to work closely with the government on the ban.

Conversion therapy is defined by health groups, including NHS England, as attempts to change someone's sexuality or gender identity.

It is understood part of the consultation will look at how to ensure certain medical or other accredited professionals will not be criminalised.



Ms Kelley said a therapist helping someone explore their gender identity or sexual orientation

Ms Kelley said a therapist, helping someone explore their gender identity or sexual orientation, wouldn't be caught by a ban, "because that's not seeking to suppress or change something. That's exploring with you."

A government Equality Hub spokeswoman said: "The consultation will seek further views from the public and key stakeholders to ensure that the ban can address the practice while protecting the medical profession; defending freedom of speech; and upholding religious freedom."

Ms Kelly has also called for an "individual cabinet level post" to focus on the equalities brief. Liz Truss holds the role as well as being international trade secretary.

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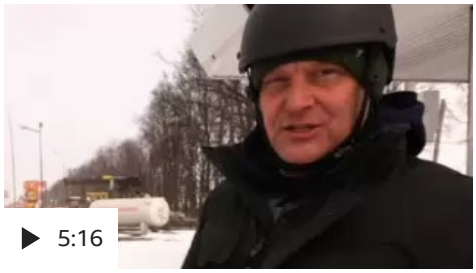
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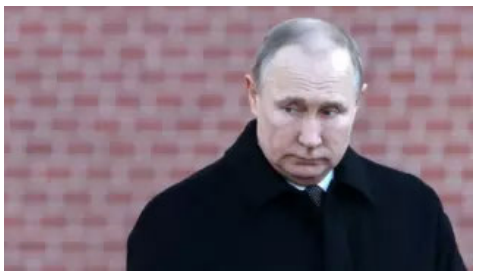
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# Trans lobby group Stonewall brands lesbians 'sexual racists' for raising concerns about being pressured into having sex with transgender women who still have male genitals

By JOSEPHINE BARTOSCH FOR THE MAIL ON SUNDAY
**PUBLISHED:** 22:01, 20 November 2021 | **UPDATED:** 06:11, 21 November 2021

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For many, it was a brave and long-overdue airing of an important and distressing subject: a painstaking investigation into claims that predatory trans women have been pressuring lesbians for sex, published on the **BBC** News website.

But a leaked email shows that the influential trans lobby group **Stonewall** attempted to suppress the investigation before it had even been published – and made the extraordinary claim that debating the issues was equivalent to 'sexual racism'.

This latest move to try to stifle free speech will add to growing concerns about the influence of Stonewall, which is paid millions of pounds for advising public bodies – including Government departments, police forces and universities – plus a range of private companies.

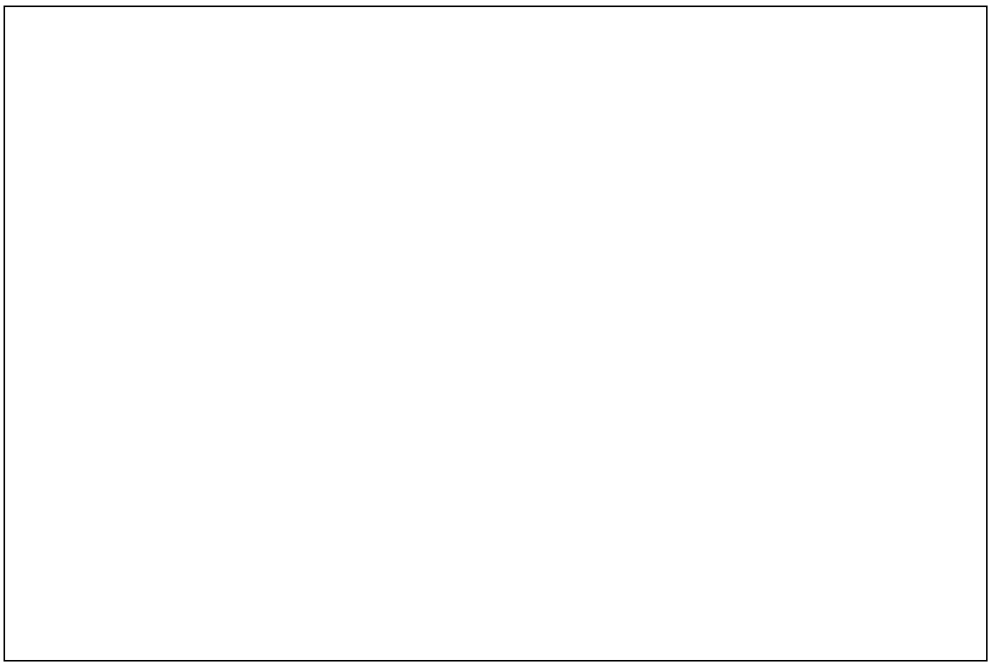
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**DON'T BETRAY US: Lesbians protest at being ostracised by trans activists. Over 30,000 participants march at Pride in London Parade in 2015**

Stonewall started as a campaign group for gay rights and has been widely applauded for its vital work.

Today, however, it is dominated by the campaign for trans rights and controversially sets out to promote self-declared 'gender identity' – the doctrine that people are whatever gender they say they are – ahead of biological sex.

It supports the belief, for example, that people with penises can be lesbians and those with vaginas can be gay men. Those who disagree, says Stonewall, are bigots.

Such is Stonewall's influence that a former aide to Boris Johnson has claimed the group has been allowed to dictate Government policy by advisers who present him with 'skewed' pro-trans information.

Earlier this month, the BBC followed several other high-profile bodies, including Whitehall departments, in dropping its membership of Stonewall's Diversity Champions programme.

Under the scheme, employers pay the lobby group to help 'embed LGBTQ+ inclusion' in the way they work.

The BBC's announcement came two weeks after the Corporation published an investigation by journalist Caroline Lowbridge in which some lesbians told how they felt pressured into having a sexual relationship with trans women – specifically, men who say they are women but who have retained their male genitals.

THE investigation cited three lesbian women who said they feared being labelled 'transphobic', and risked being shunned and threatened by the gay and trans community if they refused to take trans women as partners.


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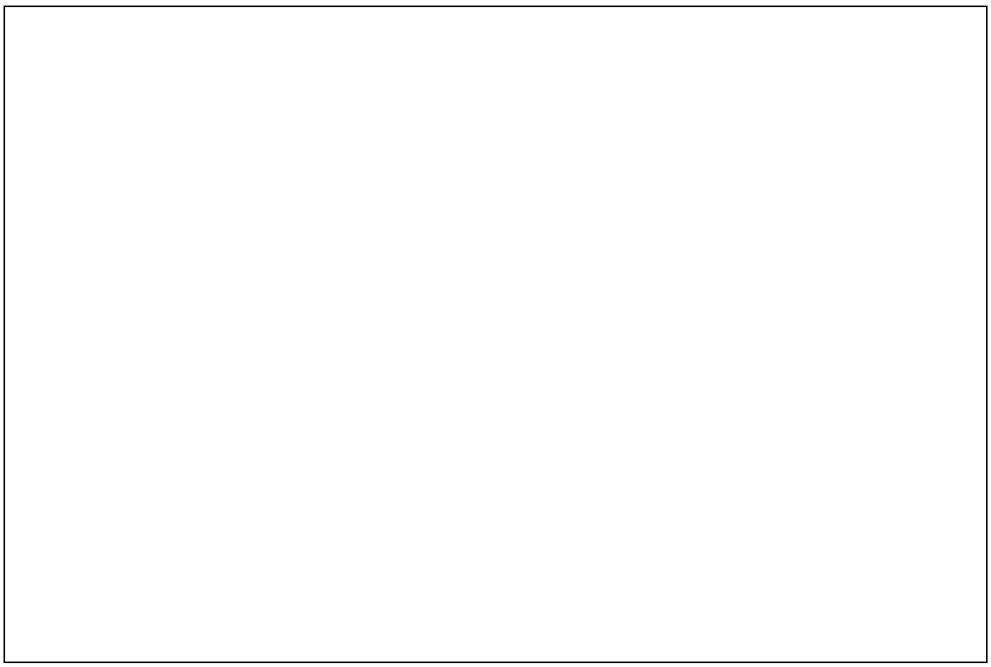
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**People supporting the organization Stonewall which works for the equality and justice for lesbians, gay men and bisexuals, during the Pride London on July 27 2015**

They told Lowbridge they felt under a bizarre form of pressure to 'accept the idea that a penis can be a female sex organ'.

One told how she had been described as a 'genital fetishist' for only wanting to have relationships with biological women.

Another said: 'I was told I owed it to my trans sisters to unlearn my "genital confusion".'

The article also included a controversial argument made by several trans activists that expressing any preference in sexual partners should be considered 'discriminatory' as such preferences often exclude trans people.

This is sometimes referred to as 'the cotton ceiling' – a distasteful reference to underwear suggesting that trans women are systematically blocked from having sexual relationships with biological females.

The BBC won much praise for its investigation, which prompted some lesbians to express their anger at how they felt ostracised for wishing to form relationships only with women.

Campaigner Kat Howard wrote that she was 'incredibly grateful to Caroline Lowbridge, and the BBC for this article', adding: 'We need help protecting young lesbians everywhere from an LGBT community that would rather see them silenced than stand up to the male perpetrators of assault.'

Yet now it has emerged that months before the article appeared Stonewall's chief executive Nancy Kelley wrote to the editorial director of BBC News to denounce Lowbridge's work in an apparent attempt to get her piece stopped.

In her email, Kelley suggested that the BBC article would end up being 'transphobic' because it represented trans women as 'sexual predators', which was a 'central anti-trans argument'.

She further complained that the 'highly toxic' cotton ceiling issue was 'analogous to issues like sexual racism'.


Paris Jackson flashes her legs in quirky strapless dress with thigh-split as she attends Vivienne Westwood's Paris Fashion Week show



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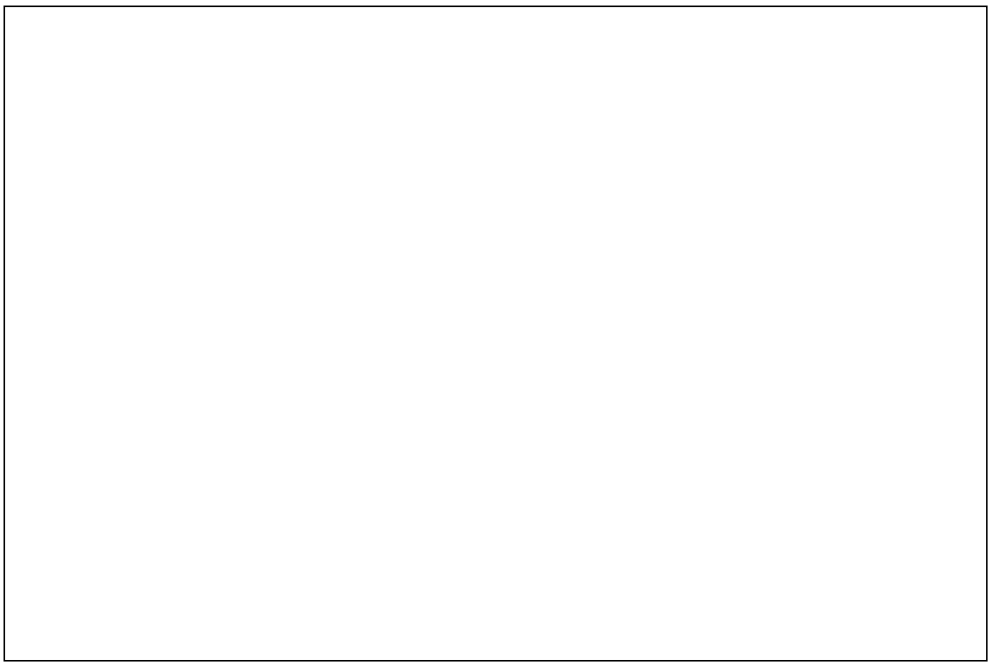
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Kim Kardashian clone Chaney Jones, 24, shows off her incredible figure in a brown bikini and Yeezy boots... after



**The annual Trans Pride parade makes its way from Wellington Arch next to Hyde Park down to Soho square on 14 September 2019**

And although she acknowledged that in sexual relationships 'consent is paramount and we all want who we want', she added that 'structural oppression can influence who we want'.

Which is to say that social bias, in this case against those who say they are trans, can affect even our most private thoughts.

It is understood that it took many months of editorial discussions before the article was published on October 26.

Stonewall has appeared to confirm that changes were made to the original piece, although it remains unclear whether this was as a direct result of the leaked email, sent in September 2020.

Nor is it known whether the editorial director of BBC News at the time, Kamal Ahmed, took any action based on the specific concerns raised by Kelley. He was made redundant in February.

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As well as praise, the article prompted mass complaints from trans rights groups.

An open letter, from Trans Activism UK, had 20,000 signatures and described the article as 'incredibly dangerous' for suggesting the issue of lesbians being coerced into sex with trans women was widespread.

The BBC received 4,819 complaints in the days following publication, while 5,520 messages praised its coverage.

Angela Wild, a member of lesbian campaign group Get The L Out who was quoted in the article, told The Mail on Sunday: 'For years lesbian activists have been trying to get the message out that it is not bigoted to say "no" to sexual pressure from males who identify as women.

'The fact that Nancy Kelley has framed the reporting of this issue as transphobia is disgusting. Stonewall are a disgrace and no longer represent the interests of lesbians.'

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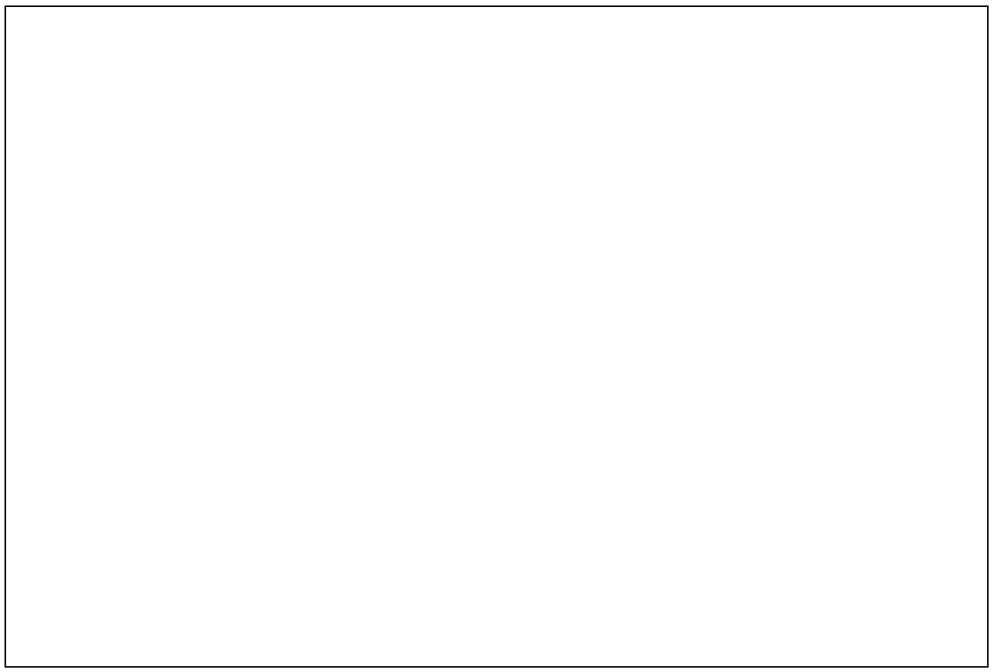
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Author John Boyne described Stonewall as authoritarian for 'telling gays how to think, who to date and betraying lesbians completely.'

The BBC rejected the complaints against the article arguing it had gone through 'rigorous editorial processes'. adding that its journalism should explore issues 'even where there are strongly held positions'.

Last month, former BBC foreign correspondent Paul Wood told The Mail on Sunday there has been a 'climate of fear' at the Corporation around issues of race and gender, with self-appointed censors among the broadcaster's own staff.



**rotesters hold a banner during a rally at Parliament Square in October this year**

Wood wrote that concerned executives had found themselves at the centre of a 'culture war'.

Last month an independent report into the BBC warned that 'networks' of internal influence – including those representing sexual minorities – could affect its impartiality.

In a statement to The Mail on Sunday, Stonewall said: 'We can confirm that we wrote to the former editorial director 14 months ago to raise a concern about a previous version of the article that was relevant to his role in upholding the BBC's editorial guidelines.'

The broadcaster's withdrawal from Stonewall's Diversity Champions programme prompted a huge backlash, with many complaints from BBC staff.

When the announcement was made, Corporation executive Rhodri Talfan Davies refused to confirm whether Stonewall had ever successfully swayed its journalistic output.

But speaking to Radio 4's Women's Hour last week, Kelley was open about her group's intentions. 'I want Stonewall to have more influence on the editorial policy of the BBC,' she said.

The Corporation's decision to abandon ties with Stonewall – and publish the article – suggests the BBC is taking a much more robust approach

The issue of the lobbyists' influence on the BBC was also covered in a ten-part investigative podcast titled Stonewall, made by presenter Stephen Nolan and released on BBC Sounds.

Stonewall chose not to engage with the series' makers.


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Stonewall first opted to include transgender issues in 2015 under the leadership of Ruth Hunt, now Baroness Hunt of Bethnal Green, a crossbench peer who previously worked for the Equality Challenge Unit, advising on sexual orientation and gender identity equality.

She was succeeded by Kelley last year. The group has since become a vociferous champion of transgender rights, prompting some – including two of the charity's founders, broadcasters Simon Fanshawe and Matthew Parris – to accuse Stonewall of abandoning the interests of lesbians, gay men and bisexual people.

Under Kelley's leadership, Stonewall believes that individuals have a 'gender identity' based on how they feel inside, which is more important than their sex at birth.

Terms including 'homosexual', 'gay' and 'lesbian' have now been reframed to refer to 'same-gender' attraction – rather than 'same- sex' attraction – to avoid excluding trans people.

This means, in effect, that trans men – biological females – who still retain their vaginas can be gay if they are attracted to men, while trans women – biological males – with penises can be lesbians.

The BBC, which has paid substantial sums to Stonewall under its Diversity Champions programme, recently adopted these new definitions in its internal editorial style guide. It is unclear whether these will remain.

Programmes such as Diversity Champions earn Stonewall millions as businesses pay to be vetted on their woke policies.


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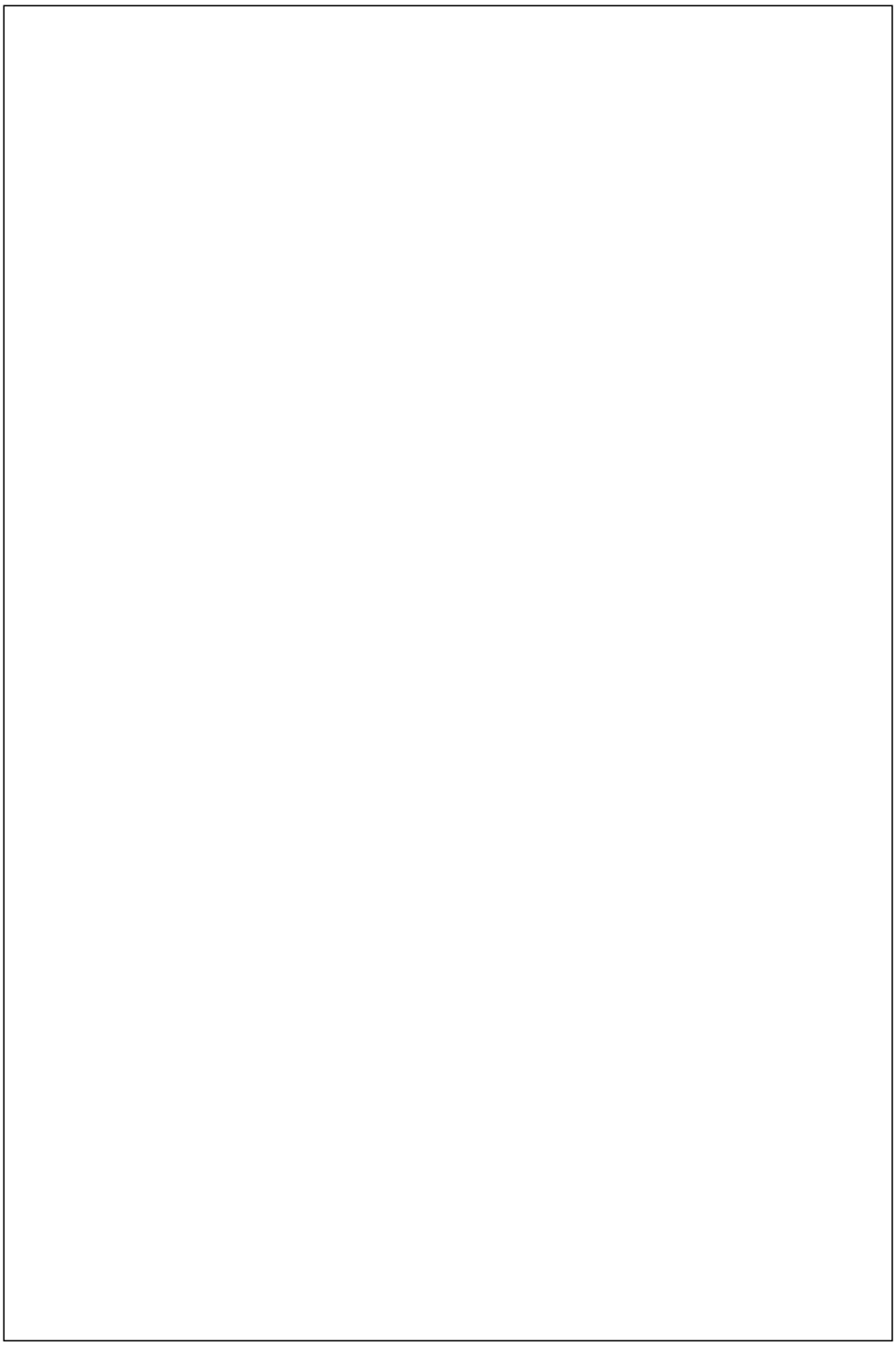
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**Terms including 'homosexual', 'gay' and 'lesbian' have now been reframed to refer to 'same-gender' attraction – rather than 'same- sex' attraction – to avoid excluding trans people (File photo)**

Hundreds of thousands of pounds have been spent on the programmes by Government departments alone.

Being part of the scheme gives employers the chance to appear in the charity's coveted Top 100 workplace index if their policies meet Stonewall's approval.

Last year's list included Sainsbury's, MI6, Oxford University, Sussex Police, Barclays, the Ministry of Justice and the Army.

But those who have cut their links with the scheme include Channel 4, Ofcom, Ofsted, the University of Essex, the Equality and Human Rights Commission and several Whitehall departments.

Philosophy professor Kathleen Stock – who was hounded out of Sussex University for saying that biological sex matters and wrote about her experience in the MoS this


Kristen Stewart joyfully reunites with Snow White And The Huntsman co-star Charlize Theron as the glam duo pose up during the Santa Barbara International Film Festival

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month – has accused Stonewall of helping drive a climate of bigotry in British universities.

A BBC spokesman said: 'Many people and organisations make representations to the BBC about various aspects of our coverage.

'BBC News is editorially independent and the BBC alone decides what we broadcast or publish. The story is on our website for anyone to read.'

The BBC's experience with Stonewall is just one fascinating example of how a host of organisations – both public and private – are coming under intense pressure by a powerful lobby group that many fear is causing profound damage to the rights of women.

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THU FEB 21, 2019 / 1:19 PM EST

# Head of Britain's leading LGBT+ lobby group quits as trans debate rages

Hugo Greenhalgh

LONDON (Thomson Reuters Foundation) - The head of Britain's leading LGBT+ rights group, Stonewall, said on Thursday that she was stepping down after a tenure marked by debates that have "not always been a comfortable conversation" as transgender rights took greater prominence.

Ruth Hunt has been with gay and transgender lobby group Stonewall for 14 years and chief executive since 2014. She will step down in August with her replacement yet to be announced.

Her decision to leave comes at a time when Stonewall has faced increasing criticism for the group's decision to lobby more for trans rights alongside its fight for lesbian, gay and bisexual equality.

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"Recognizing the diverse experiences and needs within LGBT communities ... has not always been a comfortable conversation for Stonewall to have but it has been a vital one," Hunt, 38, said in a statement.

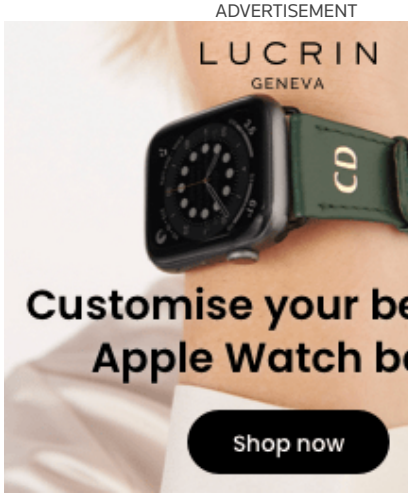
"Expanding our work to ensure we are more closely speaking alongside and sharing power with these communities is a journey we are still on."

Stonewall's message has been clear: "Trans women are women."

But many feminists believe hard-won rights for women should remain ring-fenced for those born into that gender, pitting former allies against each other in the battle for rights.

Stonewall was criticized in a letter to Britain's Times newspaper last year by prominent LGBT+ campaigners for "demonising as transphobic" those who dissented from its line.

Last week, 14 British and U.S. transsexual men and women published an open letter to Stonewall distancing themselves from the organization, saying they disagreed "profoundly" with the organization's decisions and statements.

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"As transsexuals we cannot continue as part of this Stonewall umbrella, which, we feel, conflates a sex based medical condition with lifestyle choices and gender expression," they wrote.

Stonewall declined to comment on the letter.

Under Hunt's leadership, Stonewall grew significantly, more than doubling overall staff numbers to 160 and seeing income rise by almost two-thirds to about 9 million pounds ($12 million).

Stonewall said Hunt's work to include trans issues would remain "integral to our development as an organization".

Jan Gooding, chair of the board of trustees of the organization, said Hunt had been a "visionary, bold and inspirational leader" during her years at Stonewall.

"Over the course of her tenure, she has changed the organization's culture, expanded our remit and shown an unequivocal commitment to supporting parts of the LGBT communities that have been traditionally excluded," she said.

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(Reporting by Hugo Greenhalgh, Editing by Belinda Goldsmith @BeeGoldsmith. Please credit the Thomson Reuters Foundation, the charitable arm of Thomson Reuters, that covers humanitarian news, women's and LGBT+ rights, human trafficking, property rights, and climate change. Visit http://news.trust.org)

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# Trans women are women

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BY RACHEL STEIN, EXECUTIVE DIRECTOR OF CAMPAIGNS AND STRATEGY

PUBLISHED 05 MARCH 17

NEWS BLOG COMMUNITIES SOCIAL EXCLUSION

## In today's Sunday Times, Jenni Murray writes an article in which she enters into what she calls one of the most "vicious, vulgar and threatening debates of our day". She is talking about trans women, and their right to be called 'real women'.

Whether you are trans or not, your identity is yours alone. I do not question your identity Jenni, and in return, I wouldn't expect you to question mine - or anyone else's. What right would you have to do so? My experiences of being a woman are undoubtedly different to yours. However, their differences do not make them in any way less valid.

> My experiences of being a woman are undoubtedly different to yours.

Trans women have every right to have their identity and experiences respected too. They are women – just like you and me - and their sense of their gender is as engrained in their identity as yours or mine.

Being trans is not about 'sex changes' and clothes – it's about an innate sense of self. To imply anything other than this is reductive and hurtful to many trans people who are only trying to live life as their authentic selves.

> Why do we think we have the right to debate others' identities?

Why must this be so 'vicious, vulgar and threatening'? And why do we think we have the right to debate others' identities? In a world of increased hostility, fuelling divisions doesn't help anyone. Please talk to more trans women Jenni; understand their experiences, understand their identities, understand why being an ally is so incredibly important.

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From: **Beverley Jackson** <info@jacksonacademic.nl>
Date: Wed, 10 Jul 2019 at 12:27
Subject: GLF anniversary event
To: <[redacted]>
Cc: Challis,D <d.challis@lse.ac.uk>

Dear [redacted] (if I may),

It is with a heavy heart that I disrupt your sabbatical on a difficult issue that cannot, I fear, wait until mid-September. My concern relates to the GLF event planned for 22 October and the composition of the panel.

As I understand it, the primary focus of the event is to be on the early years of GLF, partly in celebratory mode and partly looking critically at some aspects that have echoed down the decades, like the under-representation of women. But now another subject looms, which I fear threatens to overshadow the event altogether.

Until a few weeks ago, my only knowledge of Nettie Pollard was of her recent activism in trying to hold BAe to account for its hypocrisy in sponsoring Pride events while selling arms to Saudi Arabia with which to bomb Yemen. Not to mention Saudi Arabia's appalling policies on gay people and women. These efforts struck me as wholly laudable.

When I heard she was to be invited onto the panel, which will be focusing on the early years of GLF, I Googled her name to see what role she had played in the 1970s. I was extremely disturbed by what I read. I double-checked and triple-checked, avoiding right-wing tabloids, to see if there had been some vile fake news campaign. According to all the sources I have found, Nettie was a member of the Paedophile Information Exchange (PIE), and helped to earn this body some standing with the NCCL and one branch of Gay Liberation. Then I read her own chapter in a book published in 1993. There was no doubt. Nettie had herself believed in and promoted the "liberation" of the sexuality of children.

The 1970s were a turbulent era. I wrote to Nettie, asking how she now stood in relation to the events of the 1970s and her essay of 1993, and she declined to reply to my questions. I wrote again, urging her to respond, and she did not reply at all, instead asking a friend to reply. This friend expressed the view that the information found online reflected a right-wing plot to smear Labour and certain Labour MPs.

I find all this extremely troubling. The charge of paedophilia within the Gay Liberation movement has parallels with charges of antisemitism within the Labour party. On the one hand, it is absurd to insist that it is endemic, but it is equally absurd to pretend that it does not exist at all, or that it has been properly acknowledged and dealt with.

Indeed, the subject of boundaries and safeguarding is at present highly topical:

--Consider the question of the NSPCC worker who recently filmed himself masturbating in fetish gear in a toilet at the NSPCC and posted a picture of himself online, proudly mentioning where he was. When some people protested that this was outrageous and the man should be fired, others responded with cries of "homophobia." It strikes me that it is in fact more homophobic to suggest that such behaviour is entirely the sort of thing that may be expected of a gay man.

--Then there is the case of eleven-year-old Desmond, who is all over the internet in his drag act. He is acclaimed as a wonderful star – "Desmond is Amazing." But when Tom O'Carroll wrote online that Desmond was a "sexy kid" and it was fabulous to see him embracing his own sexuality, Desmond's parents were outraged that a paedophile was looking at their son in a sexual way. Tom O'Carroll was the chairman of PIE, a former associate of Nettie's. Indeed, Nettie helped to edit one of his books. In a YouTube

interview conducted recently with Tom O'Carroll, which I have seen, he discusses the mutually satisfying masturbation sessions he might have with children aged 7 or 8. He has served two custodial sentences.

The question of paedophilia, and how to restore boundaries, is an issue that needs to be examined fearlessly. Is this the right occasion on which to do so? Such a discussion is likely to provoke a considerable amount of negative publicity, including on social media, which could end up overshadowing the main subject, the history of GLF.

Please understand my position. I am known (Twitter account @BevJacksonAuth) as an ardent feminist and lesbian activist seeking to combat lesbian erasure. My own views are also controversial within a section of the gay community. I oppose non-platforming, so I will not say that I refuse to take part in the panel alongside anyone who believes in abolishing the age of consent. But I will need to protect my reputation by making my own views on the subject perfectly clear if and when the topic is raised, either in the panel discussion or in the Q&A session.

I cannot solve this difficult problem. I simply offer it to you, in the hope that you can decide on the best course to take.

Kind regards,

Bev Jackson

*Not for publication*

--
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Image of Kate Harris launching Stonewall Fundraising Walk sponsored by American Express with Brian Paddick - 2009

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# The first woman in the Gay Liberation Front in 1970 is fighting again for lesbian and gay rights in 2021



by David Bridle — February 20, 2022 in Activism, Interviews, Politics 13 min read




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**Bev Jackson was at the inaugural meeting of the Gay Liberation Front at the London School of Economics in October 1970. She was the only woman there.**



**Now Jackson is helping to lead LGB Alliance, which she co-founded with Kate Harris, in its fight against the promotion of gender identity policies and their corrosive impact on lesbians' and gay men's lives. And LGB Alliance enjoys the support of another of the Gay Liberation Front's founders, as she revealed to David Bridle.**

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**How did you first hear about the Gay Liberation Front meeting?**

I was a student at LSE. I started there in 1969, I was studying maths, and I walked down the corridor and I saw a poster which said: "First meeting of the UK Gay Liberation Front." It was the most astonishing thing because I had to translate it in my head as to what it might mean. I had heard that "Gay" was a new word for homosexual, and I knew "Liberation" was about freedom and "Front" sounded a bit militant. It sounded very exciting and I thought "I think I want to be on there that sounds right." I went to this first meeting and there were 19 men there, and just one woman – me – so I was immediately voted on to the steering committee.

**What happened in the first meeting?**

Aubrey Walter and Bob Mellors had just come back from the United States where they'd been at the Revolutionary People's Constitutional Convention in Philadelphia, a meeting called by the Black Panther Party. They were real liberationists and it was very clear that this was going to be a revolutionary movement. What was very clear from the beginning was that gay liberation must be aligned with women's liberation because they wanted to break through the sexist principles that society was based on. That was the theory anyway. At the second meeting there were a few more women.



*19-year-old Bev Jackson was a student at LSE in 1970*

**How did the gay men and lesbian women get on?**

I did notice that while a lot of the gay men were very interested in aligning with the women's movement and breaking through sexist role patterns, there was also a certain amount of misogyny among some of the gay men. I can remember thinking it's going to be difficult for men and women to work together. I was among the minority of lesbians who decided to work within gay liberation; most lesbians worked within women's liberation because of feeling more in common with other women's issues. The fact of lesbians being doubly oppressed both as women and as homosexuals is just a really important part of understanding what it means to be a lesbian. Some men really get that – and some men really don't.




**What was the first Gay Liberation Front demonstration?**

We organised our first demo in November 1970 at Highbury Fields and that was just astonishing. We're demonstrating and there's crowds lining the street looking at us in disgust. It really is quite something to be walking down the street and to see these people looking at you with revulsion in their faces. You stand taller because you think we're together and we're out. Our main message was "Come out of the closet", show the world there's lots and lots of gays and lesbians – and your ideas about them are all wrong. I was the spokesperson for the demonstration and my telephone was the number for Gay Liberation Front. I spoke to the

reporter at The Times and I said "It is important to know that we are not ashamed to be homosexual". For years id thing to have said.



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# Homosexuals demonstrate for equal rights

By Geoffrey Wansell

The first public demonstration in Britain by the Gay Liberation Front, a movement dedicated to altering public attitudes towards homosexuals, whether men or women, was held last night on Highbury Fields, London.

Some 80 members of the front gathered to hear the aims of the movement read out at the scene of the arrest of a man for gross indecency.

They ask that homosexuals should be allowed to kiss and hold hands in public, just as heterosexuals are; that all discrimination against "gay people, male and female, by the law, by employers and by society at large should end"; and that they should be allowed to contact each other through newspaper advertisements or on the streets in exactly the same way as heterosexuals.

Miss Bev Jackson, aged 19, a member of the steering committee of five, said: "It is important to know that we are not ashamed to be homosexual." She explained that the front had been organized in Britain for six weeks and had about 250 members, although it was a large organization in the United States.

Mr. John Breslin, aged 41, an actor, said he felt the acting profession was one of the few in which homosexuality was tolerated.

At the peaceful meeting members of the front criticized the public attitude to homosexuals. As one said: "We don't want to be a freak show. We just want to be the same as anyone else."

At the end of the 90-minute torchlight demonstration members of the front emphasized that their membership included ordinary people. One said: "There are straight people, lesbians, and male homosexuals in the front."

***Bev Jackson spoke to The Times: "It is important to know that we are not ashamed to be homosexual"***

**How do you feel about that now in 2021?**

I look back now and I think – God, we have to say the same thing again – that is insane! What on earth has happened? That's what drives us, the idea that our legacy has been trashed. They're making homosexual into a dirty word and even trying to avoid saying "gay" and "lesbian". We're not a string of letters. It's absolutely fine to be attracted to people of the same sex. It's beautiful. It's wonderful. The idea that people are reintroducing the notion of shame into same-sex sexual orientation is quite appalling.

**What was your most important experience growing up?**

When I was 11 years old I went to a new school and I really wanted to make friends but I was Jewish in a very anti-Semitic neighbourhood. We had this teacher who kept making anti-Semitic remarks and then at one point she looked around and said "I suppose nobody here is Jewish?" And the whole class burst out laughing. They thought that was such a hilarious idea that anybody in the class could be Jewish – and I put my hand up. I said, "Please Miss, I have some Jewish relations" – in fact I'm totally Jewish – and then I had to go to the toilet and throw up. Later my class teacher found out and she said if anybody made any anti-Semitic remarks again, I should tell her and she'd kick them down the stairs. So it wasn't the case that everybody was anti-Semitic. Having found myself able to speak out at that time, feeling the terror of being alone, but also the need to say the truth, that's been the most important moment of my life. It made me strong. It enabled me to come out as a lesbian in a very hostile homophobic environment when I was 16 and it's enabled me now to stand up against

the forces in the wider LGBTQIA+ movement as someone who is critical of the whole concept of gender

> I look back now and I think – God, we have to say the same thing again – that is insane! What on earth has happened? That's what drives us, the idea that our legacy has been trashed. They're making homosexual into a dirty word and even trying to avoid saying "gay" and "lesbian". We're not a string of letters. It's absolutely fine to be attracted to people of the same sex. It's beautiful. It's wonderful. The idea that people are reintroducing the notion of shame into same-sex sexual orientation is quite appalling.

**Was there a point – prior to the formation of LGB Alliance – when you personally followed the issues around gender identity and their impact on same-sex attraction?**

In 2015 I was mostly involved with refugee rights. I worked with refugees on the island of Lesbos and I wrote a book about it. I was only vaguely aware of what was going on in terms of the LGB rights movement. I remember at Christmas 2016 expressing my views about children thinking there was something wrong with their bodies, and changing their bodies, and being critical of this. I discovered that this was seen as quite a reactionary view and I thought that was odd. It didn't seem reactionary to me. So I started researching it and the more I researched it the more worried I became. What was happening that young lesbians were no longer welcome in the LGBT rights movement? It just didn't seem possible and I thought people must be exaggerating. I researched it more and more, and then came that moment in 2018 when Angela Wild went to the front of the Pride march with her "Get the L Out" group, and I thought "what is she doing?" I soon realised that this action had actually been quite necessary because it attracted attention and focused people's minds.

**You wrote to Ruth Hunt who was then in charge of Stonewall?**

I wrote her a very long letter with all my concerns about young lesbians having nowhere to meet, not being able to call themselves lesbians any more, about the way in which people were encouraging children to think that they might be born in the wrong body and a whole range of other concerns that really worried me. She didn't write back. She ignored my concerns. Eventually I published the whole letter on Twitter because I wasn't going to get a response. I also wrote to other people at Stonewall saying, "Can we talk please? I'm one of the founding members of the Gay Liberation Front and I'm concerned."

**What happened to Stonewall in the years prior?**

What happened is in 2015 Ruth Hunt decided to add the T to LGB. It was basically following what had happened in the United States. In the US it had been LGBT much longer than that and there was pressure on her to do the same. Since the T has been added to Stonewall the whole ethos has changed. The emphasis is now all on gender identity. The issue is presented as if it's about trans rights, but it isn't really. I don't know what a middle-aged man who's got several children and then decides he's a woman has in common with a 14-year-old girl who is feeling distressed for various reasons and feels that she must be a boy. It's very difficult to see that those two people can come under the same heading. According to Stonewall's website, "trans" includes crossdressers or people who are male part of the week and female another part, and people who are non-

binary – and it's not clear what that means either. None of these words are defined and therefore you don't [redacted] ime. Laws are based on facts and it's really important to define the words that are used. The shocking thing that's happened at Stonewall, and at all LGBTQ+ organisations, is that the word "sex" has been replaced by "gender". This is not a small thing. Instead of "same-sex attraction" they now talk about "same-gender attraction".

> Here's this young lesbian standing up against this clinic and on the other side you've got Stonewall opposing her. How is this possible and why are people not seeing that Stonewall has stopped supporting gay and lesbian rights and is instead promoting gender ideology or whatever you want to call it?

**What do people like Stonewall think gender means?**

A lot of the gender identity campaign is about changing the meanings of words or making words slippery. So you don't quite know what you're talking about. Gender is one of the worst examples. As soon as they try to explain it they end up with stereotypes. There isn't any other way to do it. What can it possibly mean? Is there some sort of girly essence that can live inside a male body? That is just the most sexist thing I've ever heard. It's not progressive. It's awful. It seems to me that this whole idea of gender identity has been stuck in between reality – which is the sex of your body, you're male or female – and the imagination, the feelings you might have, as a sort of intermediate thing. It's kind of loosening people's grip on reality. Look: you can be a lovely gentle male and you can wear dresses and you can call yourself Lilian and it's absolutely fine. But you're still a male and you can imagine you might be all sorts of things, but you're still a male. And with girls what's going on is really unfortunate, a kind of way to escape from being a woman because it's not very easy to be a girl growing up.



Wednesday December 2 2020 | THE TIMES

# 'I couldn't sit by while so many others made the same mistake'

**At 16 Keira Bell was prescribed puberty-blocking drugs. Now, at 23, she regrets it. She tells Janice Turner why she fought a High Court battle to make it harder to obtain the treatment**

Standing outside the High Court, Keira Bell said that she hoped the court's judgment marked the end of gender clinics "playing God with our bodies [by] experimenting on the young and vulnerable with [illegible] harmful drugs".

With her deep masculine voice, cut hair and the loss of her breasts [illegible] double mastectomy, Bell bears on her own body the scars of irreversible [illegible] she began at Tavistock's

friends were mainly male. "No one tried to change me and I didn't feel any discomfort in my body," she says. "Lots of adult women would say, 'Oh, I was like that at your age.'"

Yet Bell's home life was turbulent. Her "quite distant and very religious" Christian father left when she was four, leaving Bell and her sister with their mother, an alcoholic. "We didn't speak about her problem, but we were both embarrassed and didn't bring friends home."

Then Bell started high school and

"What is your preferred name? Do you want to transition?" And a lot of stereotype talk about whether I played with boys' toys, preferred boys' clothes. There was no discussion about my sexuality."

After three further equally superficial sessions, Bell was referred to the endocrinology department, which prescribed a year on puberty-blocking drugs. "It was briefly mentioned this might damage my fertility. They said I could freeze my eggs, but that isn't available on the

into menopause. "I couldn't sleep or think. I had hot flushes, night sweats, brain fog, concentration issues. My bones ached and I felt less strong." While in this supposed thinking period before she committed to her full transition, she received no psychological counselling from GIDS, just brief catch-up sessions. "There was no discussion of my future, whether I was on the right path." Nor were her underlying problems — anxiety, depression, social isolation and troubled home life

Keira Bell

"It was

90

***Keira Bell interviewed by Janice Turner in The Times***

**Can you talk about the Keira Bell case?**

Most astonishingly perhaps you've got Stonewall opposing Keira Bell, this young lesbian who sued the Tavistock GIDS Clinic for not giving her the care she had needed. Instead she was given puberty blockers and had her breasts removed and she now knows it was all a mistake. She won her case. The judges used the word "surprised" I think five times in the judgment because they were astonished that the clinic doesn't keep proper records, doesn't know the proportion of child patients who are on the autistic spectrum, doesn't follow up patients after treatment, doesn't keep notes on consent, doesn't have evidence for the treatment. Here's this young lesbian standing up against this clinic and on the other side you've got Stonewall opposing her. How is this possible and why are people not seeing that Stonewall has stopped supporting gay and lesbian rights and is instead promoting gender ideology or whatever you want to call it?

**How was the inaugural meeting of LGB Alliance set up?**

I was asked to take part in a commemoration in the run-up to 50 years of the Gay Liberation Front that was going to take place at LSE on 22nd October 2019. They sent me a train ticket and I was going to take part in the panel. Around the same time, I met Kate Harris. She had published a petition, together with Johnny Best, calling on Stonewall to enter into dialogue about the course it had taken. They refused to do so even though a massive 10,000 people had signed the petition. Then the LSE meeting was cancelled, but I already had my train ticket. So I said to Kate "why don't we just have our own meeting on that day, and start something new?" We went looking for people who were expressing similar ideas and invited each one separately. We decided to have the meeting at Conway Hall because it had a history of involvement with social movements. We knew that if news got out there would be tremendous antagonism, maybe aggression, and so we hired four security officers just in case. But everyone kept the secret. Not one of the 70 people we invited gave away the meeting at which we formed LGB Alliance.

> I was contacted just a few days ago, for the first time in half a century, by Aubrey Walter, one of the founders of the Gay Liberation Front in the UK, who edited a book about the early years entitled *Come Together* and now lives in Spain. He wrote to express his support for LGB Alliance. When I asked him to provide a comment for this article he wrote this: "What is our movement about if not same-sex love? Good to see LGB Alliance standing up for this principle against false gender ideologies."

**What would you like the Conservative Government to do?**

We were very pleased that the government decided not to go through with gender self-ID. That would have severely undermined the rights of women and gay and lesbian people. The argument is always cast in terms of trans rights. It's not about trans rights. Of course trans people have rights under the law and we fully support those rights. The argument is really about gender identity. We're also extremely glad that the Department for Education issued new guidance saying that relationships and sex education has to be based on evidence – on facts – and schools should not be working with external groups that teach children that if they don't fit into old-fashioned stereotypes they might have been "born in the wrong body". We are paying attention to see that schools actually keep to the new guidance, however. Then there is the matter of single-sex spaces – in prisons,

rape shelters etc. Single sex spaces are guaranteed in the Equality Act but they are being misinterpreted. We [redacted]r and cleared up these misunderstandings and also clarified that for a woman to request a female doctor is a perfectly lawful and reasonable request – and a woman, of course, is an adult human female.

**Has LGB Alliance ever been invited to meet Stonewall, Pride in London or Mermaids?**

No, and all our invitations are just ignored or declined. We did of course write to Nancy Kelley [CEO of Stonewall] when she was appointed to congratulate her and to invite her to meet us, but no.

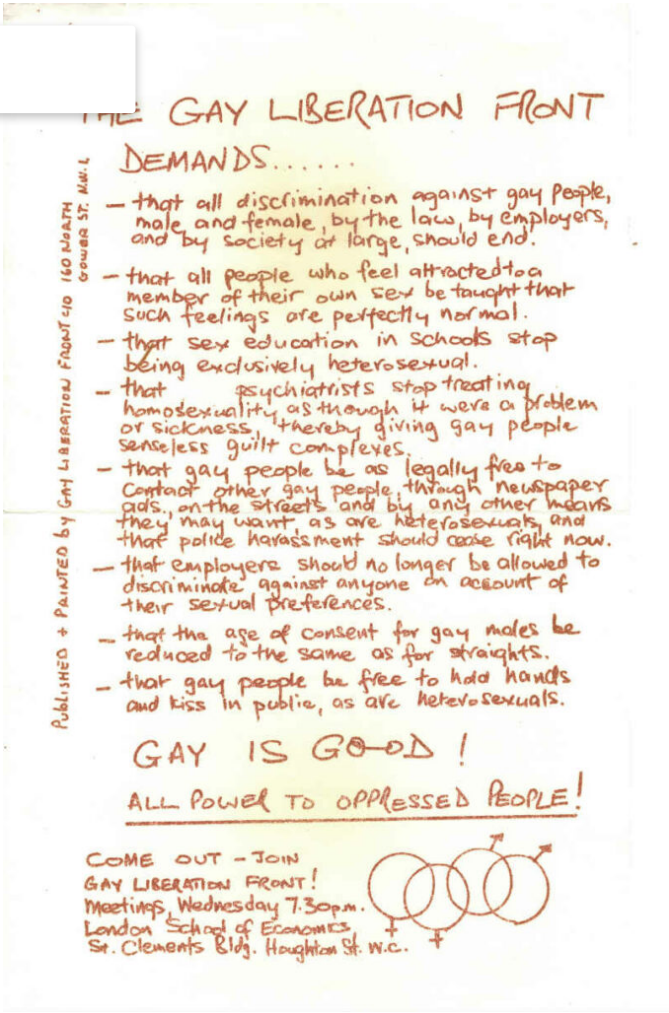
**LGB Alliance is often accused of being a "hate group". Why has this stuck and is there nothing you can do to counter it?**

Anybody who actually listens to us, reads what we write and watches our webinars gradually realises that it isn't true. But it's a very clever tactic. If you've got no arguments, what do you do? People have a right to their own beliefs but they don't have a right to impose those beliefs on the rest of us – but in order to shut us up, all they have is insults. We certainly don't hate anybody and more and more trans people are coming over to our side because they see that actually they're really suffering from all this. They're being drawn into this really nasty atmosphere which is not about trans rights. It's about imposing a belief system that some people have on the whole of society. "No debate" and "you're hateful" is all they've got. They have to stop us talking.

> Gay men and lesbians need spaces of their own and they have a right to spaces of their own – and that we have to say this now in 2021 is an absolute outrage. We could really lose a lot here if we don't stand together and fight against this madness.

**Looking back on yourself going to that first meeting of the Gay Liberation Front in 1970 and now fighting for lesbian and gay rights all over again, how does it feel?**

I feel I have a duty to expose this monstrous Injustice for what it is. Most of the people who oppose us and who call us a hate group, I think they're probably very well-meaning. They've been misinformed. They listen to people who they trust and they say "that LGB Alliance, it leaves out the 'T'. That sounds mean, it must be a hate group." Since the Keira Bell case we're getting some light now. People are starting to realise that something terrible is happening to kids who would in most cases be lesbian and gay if they grow up – that they are being persuaded that they need medication, and maybe surgery. How could anybody think that's a progressive thing?




***The Gay Liberation Front demands in 1970***

**What about single-sex spaces for lesbians and gay men?**

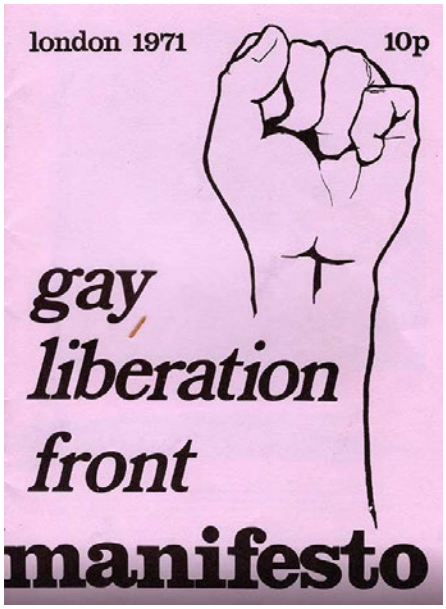
We get messages all the time from young lesbians who are excluded from LGBT clubs because they say they're not interested in people with penises. "Oh you're transphobic!" they're told. Where are they supposed to go? Why are there no places for lesbians any more? It affects gay men too. A very sad group of gay men who had their own reading club contacted us. They had run this group for years and are now being told they can't have it anymore. They have to have trans men in there because otherwise they're not being inclusive. They're just totally baffled. Why are gay rights and lesbian rights going backwards? How dare anybody call this progressive! Gay men and lesbians need spaces of their own and they have a right to spaces of their own – and that we have to say this now in 2021 is an absolute outrage. We could really lose a lot here if we don't stand together and fight against this madness.



**Aubrey Walter, one of the founders of the Gay Liberation Front in the UK**

**What is your message to the people who once marched with you in the Gay Liberation Front but now attack you?**

I would say that some of those who marched with us then see us, as the veteran gay rights campaigner Fred Sargeant sees us, as reviving the spirit of gay liberation. In fact quite by coincidence I was contacted just a few days ago, for the first time in half a century, by Aubrey Walter, one of the founders of the Gay Liberation Front in the UK, who edited a book about the early years entitled *Come Together* and now lives in Spain. He wrote to express his support for LGB Alliance. When I asked him to provide a comment for this article he wrote this: "What is our movement about if not same-sex love? Good to see LGB Alliance standing up for this principle against false gender ideologies." – Aubrey Walter, co-founder of the London Gay Liberation Front, 1970.




**What are LGB Alliance's plans for the future?**

Reviving LGB rights everywhere. There are now 15 LGB groups set up along the same lines as ours, from [redacted]nd. Our aim: global revolution!

**For more information about LGB Alliance go to: https://lgballiance.org.uk**

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**Krystyna** 11 months ago

"I look back now and I think – God, we have to say the same thing again – that is insane! What on earth has happened?" sums up my thoughts and I feel so betrayed by those claiming to advocate for LGB people. However I think the tide is turning as people start critically thinking about these issues rather than accepting a be kind stance without really thinking it through.

Reply

**Angela Stewart-Park** 1 year ago

A great article and well done Bev Jackson, what a contribution you've made to lesbian and gay history. Thank you.

Reply

**The EDI Jester** 1 year ago

Cracking read I would love to know if Bev ever met Esme

Reply

**Josephine Bartosch** 1 year ago

Really great to read this and learn a bit more about Bev Jackson.

Reply

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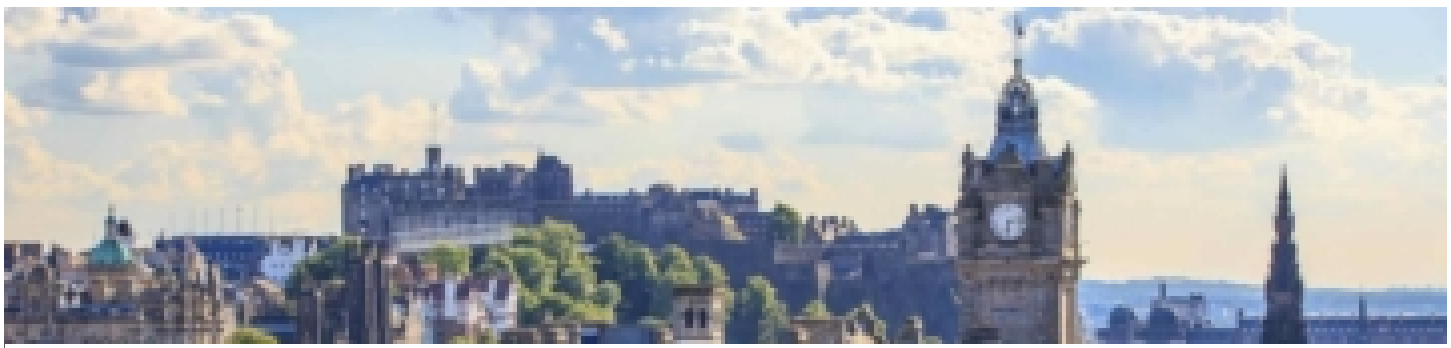
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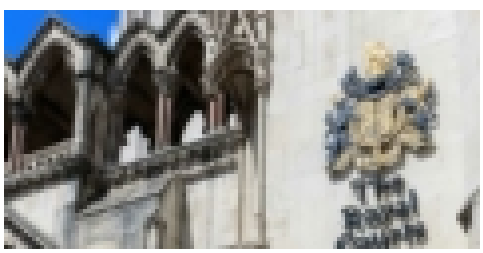
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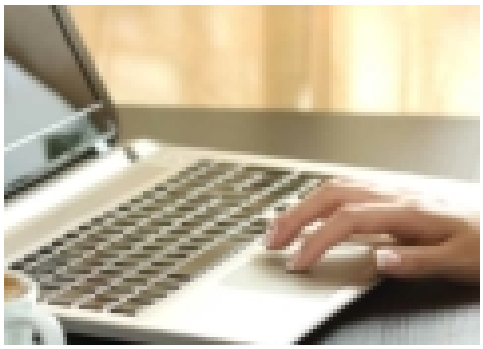
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UK

# Bake Off's Matt Lucas dubs LGB Alliance an 'anti-trans group' that doesn't represent gay people

EMMA POWYS MAURICE | OCTOBER 1, 2021

SAVE FOR LATER

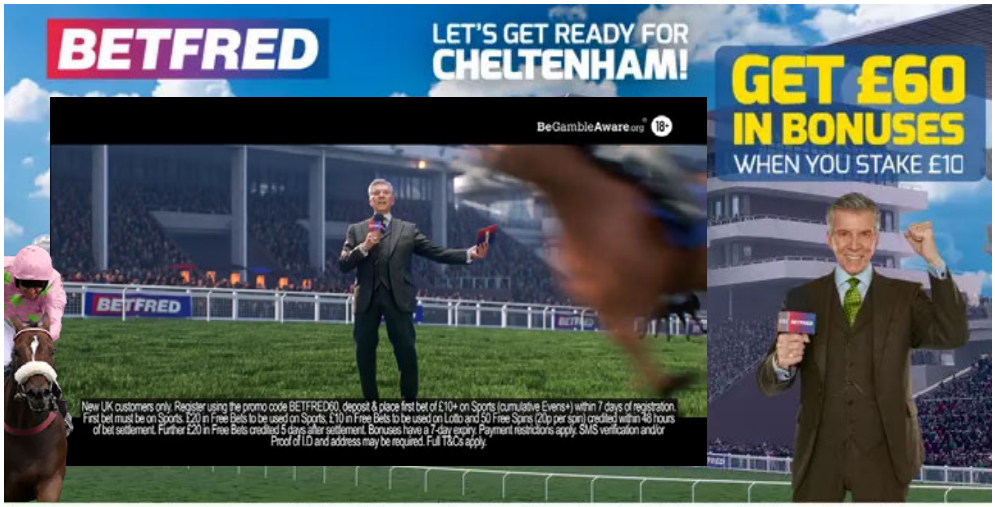



Matt Lucas at a photocall before the screening of the first episode of Series 10 of Doctor Who in 2017 (Jeff Spicer/Getty)

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The charity and political group was founded in 2019 in opposition to Stonewall's policies on transgender inclusion. Its website says it promotes the interests of lesbian, gay and bisexual people, but its goals have largely focused solely on trans people.

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The group's followers have hounded mental health charities, midwifery magazines and animal rescue centres that advocate for trans rights, and the group itself recently compared LGBT+ inclusion to bestiality.

Despite this the Tories have agreed to provide the group with a promotional stand at the Conservative Party Conference next week, a decision that has dismayed many in the wider LGBT+ community.

Matt Lucas made his thoughts clear in a tweet on Thursday (30 September), saying: "The LGB Alliance is an anti-trans group. That's all it is. It doesn't represent me or any gay people I care to know."

The *Great British Bake Off* host is among the best-known queer people on British television, though he himself has faced criticism in the past for the use of transphobic stereotypes in *Little Britain* sketches.

Lucas has apologised for the inclusion of the character, as well as the show's use of Blackface and other outdated stereotypes.

"If I could go back and do *Little Britain* again, I wouldn't make those jokes about transvestites," he said in 2017. "I wouldn't play Black characters. Basically, I wouldn't make that show now. It would upset people."

The LGB Alliance has yet to respond to Lucas' tweet. It has previously denied that it is a transphobic group, claiming on its website that this accusation is a "myth".

"The issues and priorities for people who are attracted to the same sex (homosexual/bisexual) are different from those of transgender people, and so, with a number of organisations focused on trans people and trans issues, our focus is on lesbians, gay men, and bisexual people and their issues," they write.

Privacy

But in a March 2020 speech, L
challenge the dominance of those who promote the damaging theory of gender identity".

The Charity Commission's decision to register the LGB Alliance as an official charity is now subject to an appeal lodged by the trans children's charity Mermaids.

"Charitable status is for those who serve the public good," said Jolyon Maugham, director of the Good Law Project.

"Denigrating trans people, attacking those who speak for them, and campaigning to remove legal protections from them is the very opposite of a public good. We do not believe they meet the threshold tests to be registered as a charity."



More: conservative party conference, conservatives, lgb alliance, Matt Lucas

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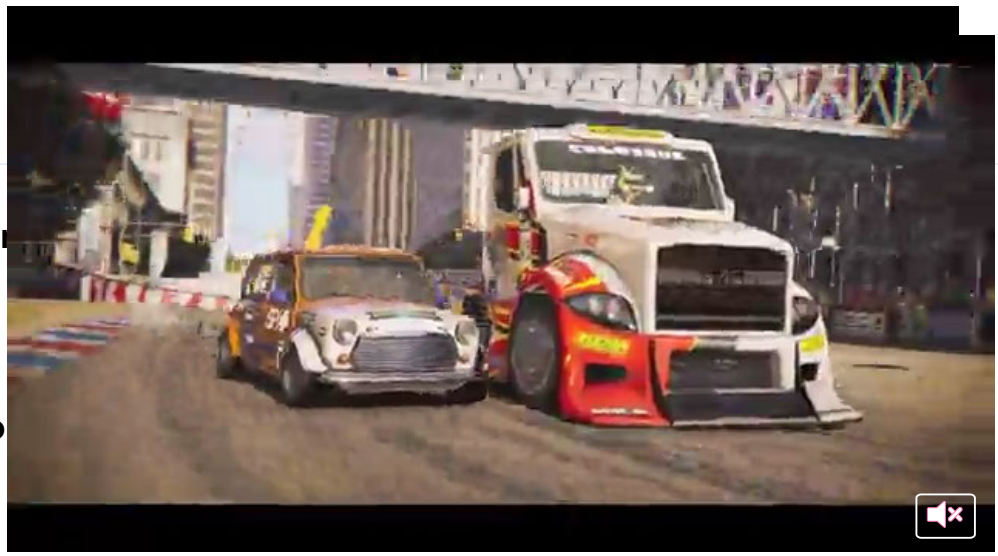
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**Drag Race leaves fans gagging for the wrong reasons with abysmal Snatch Game**

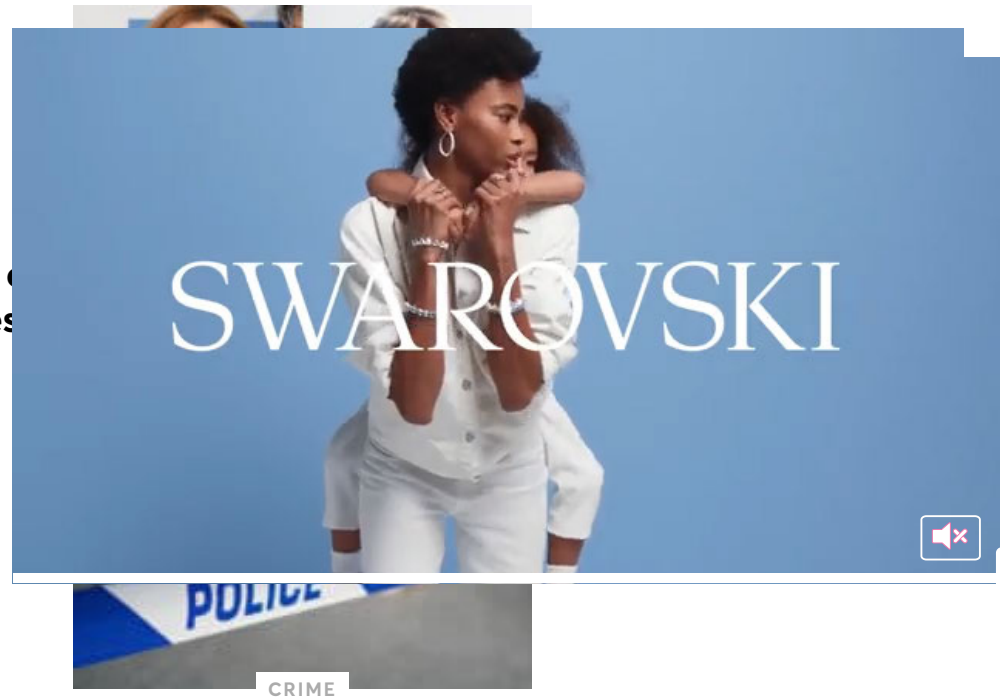
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**Christine Burns MBE** @christineburns · Oct 23, 2019

#LGBAlliance is a hate group, pass it on

> **Theresa Davis** @helresa · Oct 23, 2019
> #LGBAlliance is a hate group, pass it on twitter.com/SennaLoveAlway...

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**Roz Kaveney**
@RozKaveney

Replying to @RozKaveney and @ALLIANCELGB

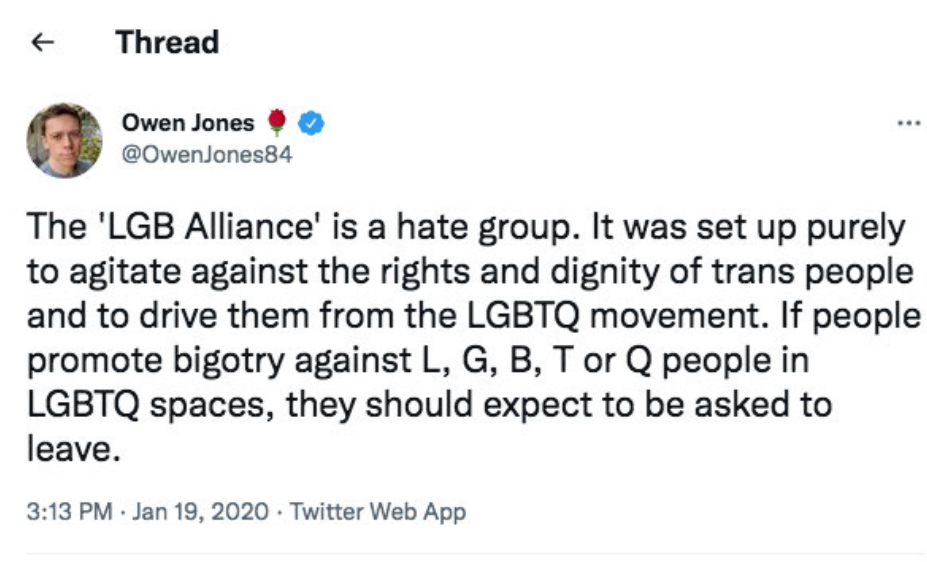
If people cannot safely use toilets, they are barred from participation in civil society.

You hate trans people, even those who act as Judas goats for you.

And once toilet bans exist, they will soon be applied to all LGBTQI people.

9:03 AM · Nov 2, 2019 · Twitter for Android


Thread
Jo Maugham
@JolyonMaugham
The third point is they have quoted the so-called LGB Alliance - a dark money funded astro-turfed hate group - on the healthcare of trans teenagers. What next? Will the BBC be quoting white supremacists on whether sickle cell anaemia should be treated on the NHS?
6:49 AM · Nov 23, 2020 · Twitter for Android
Jo Maugham @JolyonMaugham · Nov 24, 2020
Even that headline "Boy launches..." is a powerful rebuke to the dark money funded hate groups like the LGB Alliance that the BBC chooses to legitimate.
8
12
183


Thread
Owen Jones
@OwenJones84
The 'LGB Alliance' is a hate group. It was set up purely to agitate against the rights and dignity of trans people and to drive them from the LGBTQ movement. If people promote bigotry against L, G, B, T or Q people in LGBTQ spaces, they should expect to be asked to leave.
3:13 PM · Jan 19, 2020 · Twitter Web App


Tweet
David Paisley
@DavidPaisley
Please sign and share.
UK Media: Stop Uncritically Platforming LGB Alliance "Hate Group".
change.org
Have you seen this petition yet?
UK Media: Stop Uncritically Platforming LGB Alliance
1:58 PM · Dec 12, 2020 · Twitter Web App


Katy Montgomerie @KatyMontgomerie · Jan 26
Hate group "LGB Alliance" saying the quiet part out loud
They aren't just anti-trans, they are anti-LGBT
oppose the UK govt's proposed conversion therapy ban. A bill that promotes the sterilisation of LGB teens isn't the ban gay men have long wanted. Great work by Rob Jessel and @HassanMamdani in @TheCriticMag
thecritic.co.uk

**Michael Cashman** @mcashmanCBE · Mar 17, 2021

Stop Uncritically Platforming Anti-LGBT Hate Group **LGB Alliance** - Sign the Petition! chng.it/GsBv8VZd via @UKChange



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UK Media: Stop Uncritically Platforming LGB Alliance

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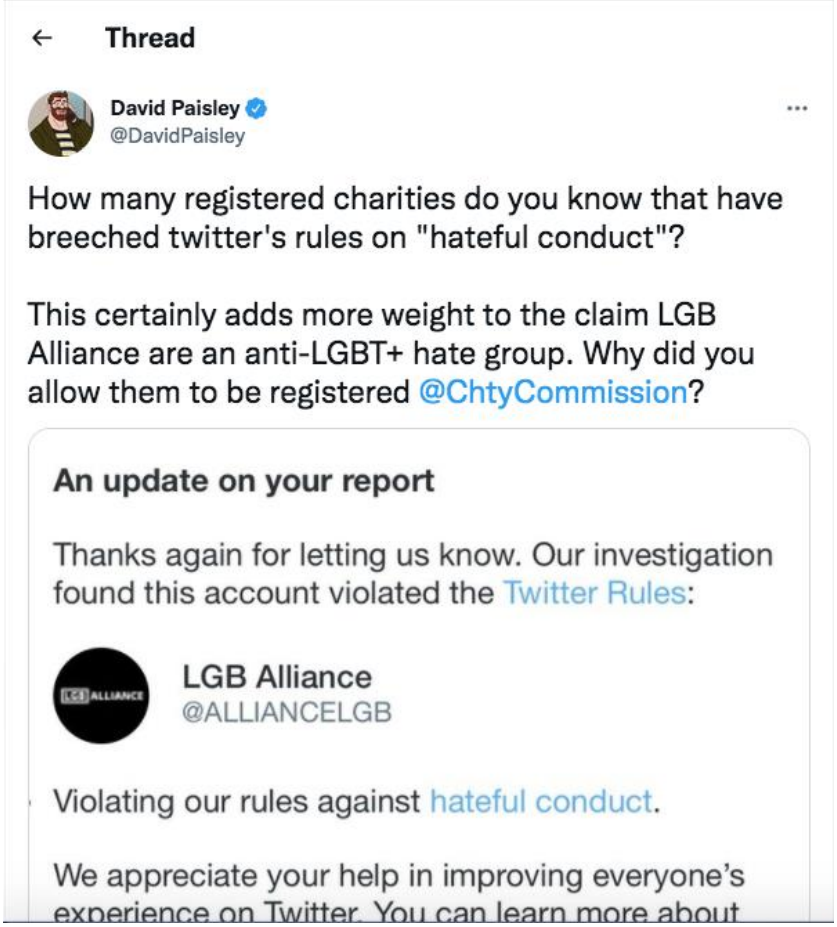
← **Tweet**

**JOHN NICOLSON M.P.**
@MrJohnNicolson

I see the sinister LGB Alliance has, finally, gone too far even for Twitter. Past time to take down this hate group's account @twitter And no excuse, ever, for the BBC to platform it.



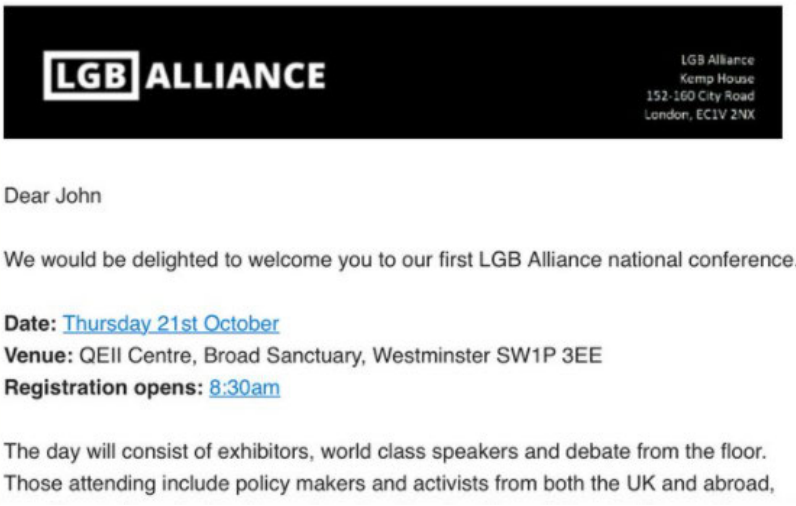

8:36 AM · Aug 13, 2021 · Twitter for iPad


Thread
David Paisley
@DavidPaisley
How many registered charities do you know that have breeched twitter's rules on "hateful conduct"?
This certainly adds more weight to the claim LGB Alliance are an anti-LGBT+ hate group. Why did you allow them to be registered @ChtyCommission?
An update on your report
Thanks again for letting us know. Our investigation found this account violated the Twitter Rules:
LGB Alliance
@ALLIANCELGB
Violating our rules against hateful conduct.
We appreciate your help in improving everyone's experience on Twitter. You can learn more about

← **Tweet**

**JOHN NICOLSON M.P.**
@MrJohnNicolson

Can't imagine a less appropriate e mail to arrive in my parliamentary mailbox than this, just now, from the awful hate group, the LGB Alliance. Having been on the receiving end of their relentless on line trolling for months, they really do have some gall.



LGB ALLIANCE

LGB Alliance
Kemp House
152-160 City Road
London, EC1V 2NX

Dear John

We would be delighted to welcome you to our first LGB Alliance national conference.

**Date:** Thursday 21st October
**Venue:** QEII Centre, Broad Sanctuary, Westminster SW1P 3EE
**Registration opens:** 8:30am

The day will consist of exhibitors, world class speakers and debate from the floor. Those attending include policy makers and activists from both the UK and abroad,

**Helen** @mimmymum · Oct 21, 2021
Your regular reminder that **LGB Alliance** is an anti-trans hate group.

#LGBWithTheT



ANTI TRANS | GENITAL OBSESSED
ATTACKS THE T | HATE GROUP

6 43 158


Helen @mimmymum · Oct 21, 2021
Replying to @mimmymum
LGB Alliance is an anti-trans hate group.
#LGBWithTheT
LGB ALLIANCE
WHO STANDS WITH CALLING GAY TEACHERS 'PREDATORS'?
News > Scottish News
BOSS CLAIMS LGB Alliance co-founder claims there should be no LGBT clubs in schools due to
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I am a 37-year-old gay man, I grew up with the inequality of section 28 and questioning my identity as a gay man. I know only too well that trans people and trans young people have things much harder than I did and the media and campaign groups have becoming increasingly hostile towards them. I have volunteered at a LGBT+ youth group and know first-hand the transphobia that young people face and the harm it does to the education, self-esteem and mental health. The LGB Alliance does not speak for me and for many other gay men, they are a hate group who have publicised misleading claims[1] and have homophobes and neo-nazis amongst their supporters[2]. Also, I would like to express that women's rights and trans rights are not mutually exclusive. Given all this, please find my personal submission for evidence:

- Will the Government's proposed changes meet its aim of making the process "kinder and more straight forward"?

From my experience of volunteering with trans young people and talking to trans friends, self id would make the process easier. At the moment there are too many barriers and it takes too long and this causes undue distress and negatively impacts mental health.

- Should a fee for obtaining a Gender Recognition Certificate be removed or retained? Are there other financial burdens on applicants that could be removed or retained?

There should be no fee, the barrier of cost should be removed as part of making the process simpler.

- Should the requirement for a diagnosis of gender dysphoria be removed?

At the moment it can be difficult to get a diagnosis and in situations where young people are not supported by their family it can be difficult to get a diagnosis. From my experience of volunteering with young trans people being able to self-id would make things easier for them. There should also be consideration of options for non-binary people.

- Should there be changes to the requirement for individuals to have lived in their acquired gender for at least two years?

This requirement should be removed and there should be more consideration for non-binary people.

- What is your view of the statutory declaration and should any changes have been made to it?

[1] https://www.pinknews.co.uk/2020/02/06/lgb-alliance-warned-advertising-standards-authority-misleading-gender-recognition-act-scotland/
[2] https://www.pinknews.co.uk/2020/04/03/lgb-alliance-neo-nazi-homophobia-spinster-death-head-charity-commission/

- Does the spousal consent provision in the Act need reforming? If so, how? If it needs reforming or removal, is anything else needed to protect any rights of the spouse or civil partner?

The spousal consent provision should be removed, someone's spouse should not have any say in how a person identifies. Spousal consent puts trans people at risk of abuse from their partners.

- Should the age limit at which people can apply for a Gender Recognition Certificate (GRC) be lowered?

Yes, this would help trans young people live with how they identify.

- What impact will these proposed changes have on those people applying for a Gender Recognition Certificate, and on trans people more generally?
- What else should the Government have included in its proposals, if anything?
- Does the Scottish Government's proposed Bill offer a more suitable alternative to reforming the Gender Recognition Act 2004?

**Wider issues concerning transgender equality and current legislation:**

- Why is the number of people applying for GRCs so low compared to the number of people identifying as transgender?

Because the process is so difficult and dehumanising.

- Are there challenges in the way the Gender Recognition Act 2004 and the Equality Act 2010 interact? For example, in terms of the different language and terminology used across both pieces of legislation.
- Are the provisions in the Equality Act for the provision of single-sex and separate-sex spaces and facilities in some circumstances clear and useable for service providers and service users? If not, is reform or further guidance needed?
- Does the Equality Act adequately protect trans people? If not, what reforms, if any, are needed

The Equality Act has already been used to protect trans people, but given the current hostile climate towards trans people the Government should look at strengthening protection for them.

- What issues do trans people have in accessing support services, including health and social care services, domestic violence and sexual violence services?

The current debate particularly around trans women being able to access women's services has become very toxic, with many arguing that trans women pose a risk to women – despite there being no evidence that this is the case. In countries where self-id has been allowed

there has been no evidence that there has been an increased in abuse to women. By providing safe spaces and support services for both trans and cis women, the rights and wellbeing of both will be strengthened. Trans rights do not come at the cost of women's rights, they are in addition to, it is not a zero-sum game as some would try to suggest.

- Are legal reforms needed to better support the rights of gender-fluid and non-binary people? If so, how?

Yes, currently many legal services, organisations and services do not recognise and support non-binary and gender fluid people. Despite what the LGB alliance will say, gender cannot and should be reduced to biological sex, and gender is not binary and everyone deserves to identify how they see fit and live their life with the appropriate dignity and support.

**November 2020**

# LGBT+ LABOUR PLEDGES

## Leadership and Deputy Leadership Elections 2020

### *Fully inclusive LGBT+ Sex and Relationships Education for all children in the UK*

I will campaign for: greater training and support for teachers; buffer zones to protect children, parents and staff from protests; and the removal of any exemptions for non-council maintained schools and an end of the parental right to remove children from these classes.

### *Trans rights and reforming the Gender Recognition Act*

I will campaign to reform the Gender Recognition Act to introduce a self-declaration process and for the introduction of legal recognition for non-binary gender identities. I believe that trans women are women, that trans men are men, and that non-binary gender identities are valid and should be respected.

### *Tackling the rise in anti-LGBT+ hate crime*

I will campaign for a change in the law on anti-LGBT+ hate crimes to bring them in line with hate crimes based on race and faith, by making them aggravated offences.

### *A healthcare system that supports the LGBT+ community*

I will campaign for the provision and funding needed for: the full rollout of free PrEP across the UK; IVF treatment for lesbians, bisexual women, trans men and non-binary people; the reduction of waiting times for trans people to access hormones and surgery; and specific LGBT+ mental health services.

### *Supporting LGBT+ homeless people*

I will campaign to ensure all plans to tackle the homelessness and rough sleeping crisis in the UK have specific provision tailored to understanding the needs and issues unique to LGBT+ homeless people who make up a disproportionate number of the current homeless people in the UK.

### *Ending Conversion Therapy*

I will campaign for a complete ban on the archaic practice of conversion therapy throughout the UK, which believes that LGBT+ people can be 'cured'. This is a harmful and dangerous practice.

### *LGBT+ rights globally*

I will campaign to reform the cruel and inhumane rules for LGBT+ people seeking asylum in the UK and will advocate for the appointment of an international envoy for LGBT+ rights.

### *LGBT+ Leadership within Labour*

I commit to the implementation of a Leadership Programme for LGBT+ members as recommended in the democracy review, such as the Bernie Grant BAME & Jo Cox Women in Leadership Programmes to increase diverse LGBT+ representation. I will review why certain LGBT+ and intersectional minorities are underrepresented at all tiers of internal party democracy.

### *Fully Independent Complaints process*

I will introduce a fully independent complaints process to tackle incidences of homophobia, biphobia, transphobia and all forms of discrimination within the Labour party.

### *Keeping LGBT+ Labour at the heart of decision making*

I fully commit to consulting LGBT+ Labour, as Labour's official LGBT+ affiliate, when making political and policy decisions that directly affect the LGBT+ community.

LGBT+ Labour

# Labour Campaign For Trans Rights



## Our Pledges

1. Accept the material reality that trans people are oppressed and discriminated against in British society, facing a rising risk of hate crime, and difficulty accessing public services, healthcare, housing and employment.

2. Believe that trans liberation must be an objective of the Labour Party, and that transphobia is antithetical to our collective aims.

3. Commit to respecting trans people as their self-declared gender, and to ensure that the Labour Party is an inclusive environment for trans people.

4. Accept that trans women are women, trans men are men, and non-binary people are non-binary.

5. Accept that there is no material conflict between trans rights and women's rights, and that all trans women are subject to misogyny and patriarchal oppression.

6. Listen to trans comrades on issues of transphobia and transmisogyny, allowing trans people to lead the way on our own liberation.

7. Support the work of trans members and organisers within the Labour movement, including supporting motions on a local, regional and national level which are presented for the furthering of trans liberation.

8. Oppose transphobic motions which run contrary to our own party equalities policy, and support the NEC striking down such motions on this basis.

9. Organise and fight against transphobic organisations such as Woman's Place UK, LGB Alliance and other trans-exclusionist hate groups.

10. Support the expulsion from the Labour Party of those who express bigoted, transphobic views.

11. Support reform of the Gender Recognition Act to improve transgender rights, as well as supporting policies which would improve trans people's access to necessary healthcare, housing, and employment.

12. Organise against and oppose any further transphobic policy from our own party or any other.

LGB ALLIANCE

LGB Alliance
Kemp House
152-160 City Road
London
EC1V 2NX

Angela Rayner MP
House of Commons
London
SW1A 0AA

Sent via email to angela.rayner.mp@parliament.uk

03 March 2020

Dear Angela Rayner

LGB Alliance and your endorsement of the Labour Party "Trans Rights Pledge"

LGB Alliance has been formed by leading campaigners for LGB rights, including veterans of groups such as Stonewall, in order to campaign on behalf of and offer a voice to LGB people who have legitimate concerns about the use of gender ideology in many contexts that affect the rights, and sometimes the safety of LGB people. LGB Alliance is seeking registration as a charity.

LGB Alliance campaigns for the protection of rights based on biological sex and on sexual orientation and is concerned that aspects of gender ideology are used in ways that are inconsistent with the sex-based and sexual orientation-based rights of LGB people, including rights that are protected by the Equality Act 2010.

LGB Alliance and its officers, members, and supporters are not in any way hostile to trans people, but are concerned by misuses of gender ideology, and also consider that the interests of LGB people do not always coincide with some of the positions adopted by some trans rights campaigners, especially those who campaign for self-identification as the basis for legal reforms.

You recently lent your public support to a pledge on trans rights, in which LGB Alliance, together with another legitimate campaign group, is falsely described as a hate group. You committed yourself to the stance that members of the Labour Party who support LGB Alliance should be expelled from the Party. Your public commitment to these positions has received widespread media coverage.

LGB Alliance's supporters include members of the Labour Party. We are concerned that you have publicly associated yourself with the false claim that LGB Alliance is a hate group. By doing so you have libelled LGB Alliance, and by implication our leading figures and supporters.

We remind you that the Labour Party has a manifesto commitment to recognise rights based on sex and sexual orientation. The Labour Party also has a long-established public commitment to human rights, and these include the rights to freedom of expression and of association, which are protected by Articles 10 and 11 of the European Convention on Human Rights, and given effect to by the Human Rights Act 1998. Your commitment to the position that members of the Party who support LGB Alliance should be expelled from the party is contrary to that position.

We therefore invite you to dissociate yourself from the pledge, and to work with groups representing LGB people, women, and all affected groups, as well as groups representing trans people. We invite you to meet with us in order to understand our concerns, and the campaigning work that we are doing to promote the rights of LGB people.

Please let us have a substantive reply to this letter as soon as possible, and no later than 17th March 2020.

Yours sincerely

Kate Harris & Bev Jackson

Founders LGB Alliance

lgballiancefuture@gmail.com

@alliancelgb

# LGB Alliance

From RationalWiki

**LGB Alliance** is a British anti-trans hate group. It was launched in October 2019 and its supporters include lawyer Allison Bailey, Bev Jackson (co-founder of the Gay Liberation Front), former comedian Simon Fanshawe, and anti-trans campaigner Miranda Yardley. Their T-less name makes their stance pretty clear as well as lumping anything that isn't "LGB" as part of that umbrella. Most of their members are trans-exclusionary radical feminists. Despite claims to be "Asserting the right of lesbians, bisexuals and gay men to define themselves as same-sex attracted" they don't wish to extend this right to trans people.[1][2] Some media sources inaccurately claimed it had split from the LGBT charity Stonewall, but despite one or two former Stonewall people (like Fanshawe) being involved, none of Stonewall's staff or trustees left to join LGB Alliance.[3][4] In an interesting move, a branch known as "LGB Alliance Ireland" was established in October 2020... as a British company operating out of London.[5] This has drawn a great deal of criticism, as the majority of Irish feminists are not anti-trans, and many consider TERFism to be an imperialist, colonialist movement that is unwanted in Ireland.[6]

On 20 April 2021, the UK Charity Commission investigated and rejected allegations of LGB Alliance engaging in discrimination against transgender people.[7] This ruling was condemned by over 50 UK LGBT Pride groups, who published a joint open letter in response.[8]


Part of a series on
Gender



Spectra and binaries

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- Misandry
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## Political positions

The LGB Alliance state that their goal is "Asserting the right of lesbians, bisexuals and gay men to define ourselves as same-sex attracted."

"*We believe that biological sex is observed at birth and not assigned. In our view, current gender ideologies are pseudo-scientific and present a threat to people whose sexual orientation is towards the same sex, or to both sexes. In addition, we believe that these ideologies are confusing and dangerous to children.*"[9]

They have also said they are not anti-trans.[10] However this has been disputed by many[11][12], not least due to the actions and behaviours of the LGB Alliance, along with the affiliations and stated beliefs of their supporters, key or founding members, etc.

LGB Alliance Ireland appears to have introduced itself to the Irish by spreading a slew of transphobic inaccuracies[13], including a suggestion that a CBT treatment for obsessive-compulsive disorder could also be applied to gender dysphoria in order to get the transgender patient to "learn to love the skin you live in." Proposing a solution that sounds an awful lot like conversion therapy isn't too surprising for a group which has called laws that ban the practice of conversion therapy “Trojan Horses" while sharing an article which refers to transgender teenagers as a "global epidemic."[14]

The LGB Alliance tweeted a list of 12 questions they had for "prospective parliamentary candidates." None of the questions related to LGB rights; instead every single one related to trans people.[15] They routinely share links on Twitter from anti-trans groups and publications including 4thWaveNow,[16] *The Times*,[17] communist publication *Morning Star News*[18] *The Federalist*, *Conservative Woman*, and hard-right magazine Spiked (best known for defending Alex Jones, Tommy Robinson and Viktor Orbán, the homophobic prime minister of Hungary, among others).[19][20]

They have also misrepresented, insulted and rejected the existence of non-binary people.[21][22]

They also claim to find the term "cisgendered" to be offensive—a common transphobic stance reminiscent of the homophobic aversion to the words "straight" or "heterosexual."[23]

The LGB Alliance has long rubbed shoulders with Transgender Trend, an anti-trans hate group who target children via propaganda and medical or educational policy, including a package of stickers which they withdrew after educators pointed out that they would facilitate bullying. The LGB Alliance has asked people to donate to them, promoted a book associated with them, and endorsed teaching materials they produce for use in schools.[24][25][26][27][28]

Regarding the conversation around trans-supportive parents and doctors, the LGB Alliance have also suggested for *somebody* here to be criminally prosecuted, though it may not be clear who. Non-transphobic LGBTQ+ groups who follow WPATH guidelines and help trans-supportive parents may be who they are saying should be prosecuted:[29][30]

> "Clinicians have been pressured for years by lobby groups arguing on the basis of narrow ideological views and false suicide statistics. ... Much of the blame lies with leading LGBTQ+ orgs that have persuaded parents their children urgently need medicalization. When criminal prosecutions follow, this will become painfully clear."

While it's perhaps not clear who they are suggesting should be prosecuted for providing medical treatment for gender dysphoria to minors, it would seem fairly reprehensible no matter what the answer is—doctors, LGBTQ+ rights activists, or parents. If they want LGBTQ+ rights organizations to be prosecuted for supporting treatment of dysphoria in minors, it reminds one of the effects that Russia's "gay propaganda" law has had on gay youth—a law that has also lead to gay people in Russia being unable to seek mental health support tailored to their needs, and being unable to voice this need in the first place.[31] If they want for doctors to be criminally prosecuted, they certainly have an ally in American conservatives, including the anti-gay Heritage Foundation.[32]

Most recently—and bafflingly—they tweeted Eddie Izzard to let her know that her recent decision to go by she/her pronouns was a "let down." They magnanimously assured Izzard that they were sure she hadn’t 'meant to offend' anyone by being herself and invited her to chat. [33]

## Founders' views

Founder Allison Bailey tweeted that trans people had no right to children.[34][35] At the time of the LGB Alliance's founding in London, Bailey stated that "gender extremism is about to meet its match."[36] She also stated *"The LGBTQ lobbying juggernaut that created & then weaponised 'gender identity' theories, gave birth to a cult... No cult ends voluntarily. They must be **stopped***." This could be considered a rather chilling threat against non-transphobic LGBTQ people. [37].

Their co-founder, Kate Harris, explicitly stated intersex people "necessitate medical treatment."[38]

Another co-founder, Simon Fanshawe, published an article[39] in the Guardian back in 2006 (!) that claimed "[s]ociety now accepts gay men as equals" and accused gay men of "behaving like teenagers" for things like having kinky sex. "[W]e have to grow out of our teenage years of sex and drugs and mocking the old, and embrace a future of fidelity and responsibility," he wrote.

## Anti-LGB Positions

Co-founder Malcolm Clark, who apparently works on contract for the BBC, has stated that LGBT school clubs are "unnecessary and dangerous" and "encourage predators,"[40] Victim blaming children for the existence of predators because they organised supportive social clubs is a curious stance for a supposedly pro-LGB organisation—it is usually heterosexual right-wingers that assume orientation is inherently sexual (think of the children). His position on the topic certainly seems to have drawn the interest of the UK-based evangelical Christian conservative[41][42] organization *Christian Concern*, which published information about the incident on its website for its readers.[43]

One of the speakers at the LGB Alliance launch event was Gary Powell, a man who has allied with the Heritage Foundation against gay surrogacy rights and has written for Public Discourse, a division of The Witherspoon Institute which staunchly opposes gay marriage.[44][45]

Twitch streamer Casey Explosion has highlighted the LGB Alliance's other links with Conservative evangelical think tank the Heritage Foundation.[46]

The LGB Alliance argued on Twitter that it isn't "homophobic" to not be in favor of gay marriage, because most people identified as lesbian, gay or bisexual in the United Kingdom aren't in same-sex marriages.[47] The chart they use to support this argument shows an increase in the proportion of gay marriages every year relative to the LGB population in the UK.

Notably, legalisation of equal marriage rights has been linked to a decrease in suicide attempts among young people, and especially LGBT youth in many countries.[48][49][50]

However, while they consider being against equal marriage *not* homophobic, apparently the entire modern, mainstream LGBT movement *is* homophobic, because it isn't transphobic.[51]

In August 2020, the LGB Alliance claimed that a rainbow lanyard "reflects alignment with gender identity campaigners who promote self-ID. There is a clash between self-ID and the rights of LGB people and women." Additionally, they suggested agreement with the sentiment that wearing a rainbow lanyard "undermines the impartiality of the police."[52][53][54]

They also falsely and ahistorically stated that gay and lesbian activists "never demanded society change its laws" or "cursed people who disagreed";[55] a baffling and incorrect statement from a group purporting to serve LGB people, and rather insulting to the lesbian and gay activists who fought and died to change homophobic laws[56] and in some countries, still give their lives in support of the cause.[57]

The LGB Alliance also "object" to non-binary people and imply that they think non-binary people do not exist.[58]

The Ireland LGB Alliance tried to pressure schools into withdrawing from an anti-bullying campaign, designed to help LGBT children. The campaign, BeLonG To, distributes packs to schools across the country that draw attention to the violence, discrimination and bullying LGBT+ young people often face in school. The group was lambasted by Irish scientist and artist Robert Bohan, who branded the LGB Alliance Ireland "an infamous hate group masquerading as a gay rights organisation."[59]

## Biphobia

The LGB Alliance recently stated that the presence of bisexual people in opposite sex relationships in gay bars and clubs was disrespectful and offensive. [60]

## Conversion "therapy"

While the LGB Alliance claim they do not support conversion therapy, they opposed a ban on conversion therapy,[61] and claimed that "gender identity" campaigners having given "conversion therapy" a new meaning. This is untrue, and trans people subjected to conversion "therapy" experience the same enormous increase in suicidal ideation that LGB people do, which is why every reputable psychological organisation denounces it.[62]

Despite claiming to oppose conversion therapy, the LGB Alliance still supports the radical feminist idea that gender identity doesn't really exist and is simply an "ideology" that should be rejected.[63] The logical conclusion of rejecting gender identity is that there is no legitimate medical reason for any trans people to transition, and that all gender dysphoria should be treated with psychotherapy.

## Criticism from the LGBTQ community

The initial LGB Alliance announcement was met with widespread condemnation by the LGBTQ community.[64] They have been criticised by Out magazine.[65] Pink News charted the immense backlash from LGBTQ people against the group, with LGB people describing the group as "transphobic," "disgusting" and "vile." At the time of the group's founding, several commentators claimed that the LGB Alliance's founding signatories were primarily composed of heterosexuals.[66][67][68]

Former Chief Executive of Stonewall, Ruth Hunt, has said:[69]

> "It feels to me that the old, homophobic attitudes have simply morphed into new transphobic ones. The same hatred is behind all of it. When those who spread such prejudicial views present themselves as our friends, merely trying to defend us from the malignant danger of trans people, it is completely disingenuous."

A bisexual woman went to a queer club in Glasgow wearing an LGB Alliance T-shirt in what seems like a deliberate attempt to offend. She was asked to turn her T-shirt inside out, and when she refused, was ejected. She was monitored and quickly provided with her jacket. While some TERFs have supported this person, the wider LGBT community, particularly cis bisexual women, have applauded the club for ejecting someone wearing a T-shirt representing a hate group.[70]

At a Manchester Pride protest in August 2021, a man wearing an LGB Alliance T-shirt was escorted away by two police officers whilst protesters chanted "Trans lives matter" towards him.[71]

## Support from the right wing

Many right-wing newspapers and organisations have supported the LGB Alliance. These include anti-trans trans woman Debbie Hayton, in the *Spectator*,[72] reactionary libertarian publication Quillette and noted TERF Helen Joyce,[73] who edits the *Economist*, a publication that suggested trans people should be subject to mandatory sterilisation before being recognised.[74] Other supporters have included TERF website After Ellen,[75] right wing and anti-trans newspaper *The Times*,[76] Andrew Sullivan,[77] and Conservative Woman.[78]

It is perhaps telling that both Breitbart[79] and Conservative Woman are otherwise firmly homophobic.

Self-identified butch lesbian Ruth Hunt has wryly noted how lovely and surprising it is to see a previously rather anti-LGB media become positively friendly towards LGB rights when they can be weaponised against trans people:[69]

> "Truly, I am touched and thrilled to have the support of so many sections of the media. If I'm honest, I thought they hated butch lesbians. I'm delighted that they are now passionately championing our right to exist and be proud of who we are."



## Questionable propaganda

LGB Alliance co-founder Bev Johnson has previously used the organization's Twitter to share a rather... dubious anecdote. A tale is described of meeting a young, weeping woman at a party in 1969. She had apparently grown up in a small village and had never heard of homosexuality. Instead, she had—again, in a small English village in the 60s—obtained a double mastectomy and hysterectomy, on request and without counseling or psychiatric assessment.[80] This story was meant to demonstrate the dangers of the trans agenda—and is unlikely to actually happen in real life, to say the least. In response to skepticism about the claim, Bev Johnson responded:

> "As I say, I can't verify it. But impossible things do happen. I knew a healthy woman who had an elective abortion in the UK in 1950. Absolutely impossible but it happened. BJ"[81]

While trans healthcare had begun in the 1960s in England, it was centered on one London clinic.[82] While there is a legitimate feminist discussion to be had whether hysterectomy is overused—particularly in the United States, where 1 in 3 women have the procedure, compared to 1 in 5 in the U.K.[83]—it is extremely unlikely that a young, healthy, child-free woman would have been able to obtain one, then or now, especially because that person wanted to transition, and especially not without psychiatric intervention. Both Roberta Cowell and Michael Dillon had to speak to psychiatrists before they could obtain hormones, let alone surgery. In short, even if the story in question was accurate, the surgeries would not have been obtained on the basis of transition.

## OHCHR submission

The LGB Alliance submitted a document to the OHCHR seminar on academic freedom claiming that:

> "Thus, those who Google our organization, LGB Alliance, are initially directed by Google's algorithm to a RationalWiki page with false and defamatory information about us. In our view, this constitutes interference with the right to seek information."[84]

They did not clarify which statements were allegedly false or defamatory. Their submission also objected to the fact that social media companies have begun to consider transphobia on par with racism.

> "The aforementioned companies that control the online media landscape suppress other views: those deemed to be fascistic or racist, for instance. By suppressing views.., such as what is called "misgendering," along with views that are widely regarded as obnoxious, these companies create the suggestion that emphasizing the reality of biological sex belongs in the same category as these objectionable ideas."

## See also

- Trans-exclusionary radical feminism
- Transphobia
- Transmisogyny

## References


1. Petter, Olivia. 'LGB Alliance' group faces criticism for being transphobic (https://www.independent.co.uk/life-style/lgb-alliance-group-transphobic-alison-bailey-lesbian-gay-bisexual-a9169091.html). The Independent, October 24, 2019.
2. Cursed E. UK's first transgender hate crime case, feat Miranda Yardley; abusive transphobe (https://medium.com/@notCursedE/uks-first-transgender-hate-crime-case-feat-miranda-yardley-abusive-transphobe-10d1fb73c2b3). Medium, March 20, 2019.
3. Kay, Liam. Stonewall denies newspaper reports that it has split (https://www.thirdsector.co.uk/stonewall-denies-newspaper-reports-split/management/article/1663534). Third Sector, October 24, 2019.
4. Jones, Gareth. LGBT charity hits out at split reports (https://thirdforcenews.org.uk/tfn-news/lgbt-charity-hits-out-at-split-reports). Third Force News, October 24, 2019.
5. Donohoe, Katie. New 'Irish' anti-trans 'hate group' believed to be a British import (https://gcn.ie/new-irish-anti-trans-hate-group-british-import/). Gay Community News (GCN), October 27, 2020.
6. Open Letter to UK feminists coming to Ireland to "Talk" (https://docs.google.com/document/d/1XzWaNU4R9y6VbrmGVw13zPdqwZTNWtLd0WGHwx-QO38/edit)
7. LGB Alliance - Full decision (https://www.gov.uk/government/publications/lgb-alliance/lgb-alliance-full-decision)
8. UK Pride groups unite against anti-trans LGB Alliance being granted charity status (https://www.pinknews.co.uk/2021/04/29/lgb-

alliance-uk-pride-organisers-network-charity-commission-letter/)
9. About (https://lgballiance.org.uk/about/). LGB Alliance.
10. [1] (https://archive.is/CZWel)
11. Petter, Olivia. ‘LGB Alliance’ group faces criticism for being transphobic (https://www.independent.co.uk/life-style/lgb-alliance-group-transphobic-alison-bailey-lesbian-gay-bisexual-a9169091.html). The Independent, October 24, 2019.
12. Parsons, Vic. New lesbian, gay and bisexual group facing immense backlash for being anti-trans… from lesbians, gays and bisexuals (https://www.pinknews.co.uk/2019/10/23/lgb-alliance-facing-backlash-from-lesbians-gays-bisexuals/). PinkNews, October 23, 2019.
13. Thomas, Siobhan D.. Debunking the misinformation outlined by LGB Alliance Ireland (https://gcn.ie/debunking-misinformation-lgb-alliance-ireland/). Gay Community News (GCN), November 12, 2020.
14. “Conversion therapy laws are Trojan Horses, ostensibly about banning attempts to change sexual orientation in adults, actually about banning therapy to help gender-dysphoric children and youth become comfortable with their anatomic sex.” (https://archive.is/yXqrl) by LGB Alliance (10 Feb 2020) *Twitter*
15. Parsons, Vic. The ‘LGB Alliance’ has 12 questions for potential MPs and none of them are about lesbian, bi or gay issues (https://www.pinknews.co.uk/2019/11/13/lgb-alliance-questions-candidates-general-election-anti-trans-rights/). PinkNews, November 13, 2019.
16. AllianceLGB on Twitter (https://twitter.com/BluskyeAllison/status/1186767223555272719): Sharing 4thWaveNow material.
17. AllianceLGB on Twitter (https://twitter.com/AllianceLGB/status/1210974275479506945): Sharing *The Times* material.
18. AllianceLGB on Twitter (https://twitter.com/AllianceLGB/status/1208313988179775488): Sharing *Morning Star News* material.
19. LGB Alliance share article from Spiked (https://mobile.twitter.com/ALLIANCELGB/status/1280079926553718784)
20. Monbiot, George. “Its articles repeatedly defend figures on the hard right or far right: Katie Hopkins, Nigel Farage, Alex Jones, the Democratic Football Lads’ Alliance, Tommy Robinson, Toby Young, Arron Banks, Viktor Orbán.” (https://www.theguardian.com/commentisfree/2018/dec/07/us-billionaires-hard-right-britain-spiked-magazine-charles-david-koch-foundation). The Guardian, December 7, 2018.
21. [2] (https://archive.is/otCV4)
22. [https://twitter.com/hotcistakes/status/1277767840808996865/photo/1
23. LGB Alliance find the term cisgendered ‘offensive’. (https://twitter.com/ALLIANCELGB/status/1281571844013924353)
24. “One brave doctor speaks out about the harms of 'transgender medicines' for young people.” (https://archive.is/nGbve) by TransgenderTrend (21 Apr 2018) *Twitter* (archived from Dec 7, 2020).
25. “It's concerning that children are being taught that medical intervention is crucial to save their lives but mental health care for underlying problems is 'conversion therapy.'” (https://archive.is/97Amd) by TransgenderTrend (26 Apr 2020) *Twitter* (archived from Dec 7, 2020).
26. LGB Alliance promote a book associated with TransgenderTrend (https://archive.is/66jEF) by LGB Alliance (6 Dec 2020) *Twitter* (archived from Dec 7, 2020).
27. “The outstanding teaching materials of @Transgendertrd are accepted under government guidance. Talk to your school. Make sure children are taught fact based RSE not indoctrinated with ideas belonging to a damaging fantasy world.” (https://archive.is/9bDF3) by LGB Alliance (Oct 20, 2020) *Twitter* (archived from Dec 7, 2020).
28. LGB Alliance encourages followers donate to “Transgender Trend” (https://archive.is/XpDt4) by LGB Alliance (15 Jul 2020) *Twitter* (archived from Dec 7, 2020).
29. [3] (https://twitter.com/ALLIANCELGB/status/1335519007647076352) LGB Alliance seem to suggest non-transphobic LGBTQ groups should be prosecuted
30. “Clinicians have been pressured for years by lobby groups arguing on the basis of narrow ideological views and false suicide statistics. ... Much of the blame lies with leading LGBTQ+ orgs that have persuaded parents their children urgently need medicalization. When criminal prosecutions follow, this will become painfully clear.” (https://archive.is/7Wdmb) by LGB Alliance (6 Dec 2020) *Twitter* (archived from Dec 7, 2020).
31. As one mental health provider explained, “The whole situation is just worsening. As of today, teachers and teachers-psychologists are not allowed to speak positively ... on LGBT topics. They can’t just say to a kid, ‘Hey, everything is normal with you.’” (https://www.hrw.org/report/2018/12/11/no-support/russias-gay-propaganda-law-imperils-lgbt-youth) Human Rights Watch, December 11, 2018.
32. Lam, Kristin. “"There have been policy meetings among groups like ... The Heritage Foundation, who have long had a mission of pushing anti-LGBTQ policies, to push two types of bills this year," Strangio said. "One being the medical care bans and the other being bans on trans athletes participating in sports. So it's a coordinated effort that's coming from national groups."” (https://www.usatoday.com/story/news/nation/2020/02/06/transgender-youth-transition-treatment-state-bills/4605054002/) USA Today, February 6, 2020.
33. [4] (https://mobile.twitter.com/JaneyGodley/status/1343592776328507394/photo/1) LGB Alliance Tell Eddie Izzard She’s Let People Down by Being Trans
34. Allison Bailey says trans people have no right to children (https://twitter.com/Transsomething/status/1299335081027305476)
35. Allison Bailey on Twitter, archived (https://archive.is/19fTm)
36. Allison Bailey on Twitter, archived (https://archive.is/2uoOz)
37. [5] (https://pbs.twimg.com/media/EoY6iCcWMAE9W4A?format=jpg&name=small) Allison Bailey appears to make threat
38. Parsons, Vic. The LGB Alliance, which claims to fight for lesbian, gay and bi people, has changed its logo and people are pointing out the obvious (https://www.pinknews.co.uk/2019/12/24/lgb-alliance-logo-colour-black-and-white-sex-binary-straight-pride/). PinkNews, December 24, 2019.
39. Fanshawe, Simon. Society now accepts gay men as equals. So why on earth do so many continue to behave like teenagers? (https://www.theguardian.com/commentisfree/2006/apr/21/gayrights.comment). The Guardian, April 21, 2006.
40. Parsons, Vic. LGB Alliance founder says there shouldn’t be LGBT clubs in schools because of ‘predatory gay teachers’ (https://www.pinknews.co.uk/2020/01/23/lgb-alliance-co-founder-malcolm-clark-predatory-gay-teachers-anti-gay/). PinkNews, January 23, 2020.
41. Sherwood, Harriet. “Christian Concern, a conservative evangelical organisation” (https://www.theguardian.com/education/2018/nov/20/christian-parent-legal-action-heavers-farm-school-pride-parade). The Guardian, November 20, 2018.
42. About (https://web.archive.org/web/20120329233434/http://www.christianconcern.com/about). Christian Concern.
43. LGB Alliance founder criticises RSE lessons (https://web.archive.org/web/20200301045335/https://christianconcern.com/comment/lgb-alliance-founder-criticises-rse-lessons/). Christian Concern, January 28, 2020.
44. Fairchild, Phaylen. New LGB Alliance Aims to Evict Trans People From Activism (https://medium.com/@Phaylen/new-lgb-alliance-aims-to-evict-trans-people-from-activism-9f4835a0d548). Medium, October 26, 2019.
45. Parsons, Vic. Activist instrumental in the launch of the LGB Alliance linked to anti-abortion and anti-LGBT+ hate groups (https://www.pinknews.co.uk/2020/06/03/lgb-alliance-gary-powell-center-bioethics-culture-alliance-defending-freedom-anti-lgbt/). PinkNews, June 3, 2020.
46. CaseyExplosion on Twitter (https://twitter.com/CaseyExplosion/status/1187746002419310592): "If anyone was wondering if this "LGBAlliance" thing was yet

more astroterfing from US religious fundamentalists, there's your obvious Heritage Foundation connection."
47. https://archive.is/IgT7u
48. Kennedy, Andrew; Genç, Murat; Owen, P. Dorian "The Association Between Same-Sex Marriage Legalization and Youth Deaths by Suicide: A Multimethod Counterfactual Analysis" (https://pubmed.ncbi.nlm.nih.gov/33812751/). The Journal of Adolescent Health, (June 2021) 68 (6): 1176–1182. doi:10.1016/j.jadohealth.2021.01.033. ISSN 1879-1972. PMID 33812751.
49. Segal, Corinne "Same-sex marriage laws linked to fewer youth suicide attempts, new study says" (https://www.pbs.org/newshour/health/same-sex-marriage-fewer-youth-suicide). PBS NewsHour, Feb 20, 2017.
50. Henley, Jon "Suicide rates fall after gay marriage legalised in Sweden and Denmark" (https://www.theguardian.com/world/2019/nov/14/suicide-rates-fall-after-gay-marriage-laws-in-sweden-and-denmark). The Guardian, November 14, 2019.
51. LGB Alliance say mainstream LGBTQ community is homophobic on Twitter (https://archive.is/vAy48)
52. “A rainbow lanyard expresses a political view. It reflects alignment with gender identity campaigners who promote self-ID. There is a clash between self-ID and the rights of LGB people and women. The police authorities fail to understand this.” (https://archive.is/WxVgw) by LGB Alliance (17 Aug 2020) *Twitter* (archived from August 18th, 2020).
53. “Bob Fousert showed he understood that displaying the rainbow lanyard undermines the impartiality of the police.” (https://archive.is/3P9jS) by LGB Alliance (17 Aug 2020) *Twitter*
54. https://twitter.com/GcHomophobia/status/1295636073088012288 screenshots of LGB Alliance on Twitter
55. [6] (https://mobile.twitter.com/GcHomophobia/status/1303670891235217409/photo/1) LGB Statement
56. [7] (https://www.apa.org/pi/lgbt/resources/history) History of Lesbian, Gay, Bisexual and Transgender Social Movements
57. [8] (https://www.bbc.com/news/world-europe-49081626) LGBT Activist Murdered
58. [9] (https://mobile.twitter.com/MammothWhale/status/1335549165519204354/photo/1) Why We Object to Non Binary
59. [10] (https://uk.news.yahoo.com/lgb-alliance-ireland-launch-insidious-130223972.html) LGB Alliance Ireland launch insidious email campaign encouraging schools to pull out of vital anti-LGBT+ bullying initiative
60. [11] (https://twitter.com/ALLIANCELGB/status/1329817417304993792) LGB Alliance state that bisexual people in opposite relationships should not go to gay bars
61. [12] (https://mobile.twitter.com/GcHomophobia/status/1329145590903672840/photo/1) LGB Alliance oppose a ban on conversion therapy
62. [13] (http://assets2.hrc.org/files/assets/resources/National_Orgs_Letter_in_Support_of_Legislative_Efforts_to_End_Conversion_Therapy.pdf?_ga=2.210753365.1990277098.1608286028-1007905376.1608286028) Declaration on the Impropriety and Dangers of Sexual Orientation and Gender Identity Change Efforts
63. [14] (https://twitter.com/ALLIANCELGB/status/1361422100058177536)AllianceLGB on Twitter
64. BluskyeAllison on Twitter (https://twitter.com/BluskyeAllison/status/1186767223555272719): "This is an historic moment for the Lesbian, Gay and Bisexual movement. *LGB Alliance* launched in London tonight, and we mean business. Spread the word, gender extremism is about to meet its match." Note the responses.
65. Sonoma, Serena. LGBTQ+ Community Rallies Against Anti-Trans 'LGB Alliance' (https://www.out.com/transgender/2019/10/25/lgbtq-community-rallies-against-anti-trans-lgb-alliance). Out, October 25, 2019.
66. Parsons, Vic. New lesbian, gay and bisexual group facing immense backlash for being anti-trans… from lesbians, gays and bisexuals (https://www.pinknews.co.uk/2019/10/23/lgb-alliance-facing-backlash-from-lesbians-gays-bisexuals/). PinkNews, October 23, 2019.
67. joss_prior on Twitter (https://twitter.com/joss_prior/status/1186969029447208961): "Here are the signatories to a previous petition ... Less than half are lgbt, and its only a handful."
68. BellaRizinti on Twitter (https://twitter.com/BellaRizinti/status/1186947642242355201): "LGB Alliance of mostly cis-hets. 😂 Transphobes are ridiculous."
69. Hunt, Ruth. When transphobic people try to pretend they're defending butch lesbians like me, I see the cynical tactic for what it is (https://www.independent.co.uk/voices/transphobic-people-try-defend-lesbians-tactic-transgender-transsexual-gay-bisexual-uk-equality-ruth-a8058256.html). The Independent, November 16, 2017.
70. Parsons, Vic. Bisexual woman claims Glasgow queer bar kicked her out for wearing LGB Alliance T-shirt (https://www.pinknews.co.uk/2020/01/19/lgb-alliance-supporter-kicked-queer-bar-glasgow-t-shirt-anti-trans/). PinkNews, January 19, 2020.
71. Wakefield, Lily. Alliance campaigner shows up to Manchester Pride Protest, and is promptly told where to go (https://www.pinknews.co.uk/2021/08/29/lgb-alliance-manchester-pride-protest/LGB). PinkNews, August 29, 2021
72. Hayton, Debbie. In defence of the LGB Alliance (https://blogs.spectator.co.uk/2019/10/in-defence-of-the-lgb-alliance/). The Spectator, October 31, 2019.
73. Joyce, Helen. Meet the Gay Activists Who’ve Had Enough of Britain’s Ultra-Woke Homophobes (https://quillette.com/2019/11/04/meet-the-gay-activists-whove-had-enough-of-britains-ultra-woke-homophobes/). Quillette, November 4, 2019.
74. Morgan, Joe. The Economist Apologises for Saying Trans People Should be Sterilised (https://www.gaystarnews.com/article/the-economist-sorry-for-suggesting-trans-people-should-be-sterilized/). March 20, 2019.
75. Heuchan, Claire. LGB Alliance asks Human Rights Watchdog to Investigate ‘Stonewall Law’ (https://www.afterellen.com/general-news/573118-lgb-alliance-asks-human-rights-watchdog-to-investigate-stonewall-law). AfterEllen, November 7, 2019.
76. Hellen, Nicholas. Lesbian barrister: my bosses bowed to transgender ‘hate mob’ (https://www.thetimes.co.uk/article/lesbian-barrister-my-bosses-bowed-to-transgender-hate-mob-shm6x09v8). The Times, October 27, 2019.
77. Munro, Neil. Andrew Sullivan: Transgender Ideology Targets Gays, Lesbians (https://www.breitbart.com/politics/2019/11/18/andrew-sullivan-transgender-ideology-targets-gays-lesbians/). Breitbart, November 18, 2019.
78. ffiske, Caroline. Gender zealots faced with a fightback (https://conservativewoman.co.uk/gender-zealots-faced-with-a-fightback/). Conservative Woman, November 12, 2019.
79. Steve Bannon (https://www.glaad.org/tap/steve-bannon). GLAAD.
80. The Weeping Lesbian (https://archive.is/vlKeE)
81. [15] (https://archive.is/QvHwS)
82. Transsexual Pioneers (https://historicengland.org.uk/research/inclusive-heritage/lgbtq-heritage-project/trans-and-gender-crossing-histories/transsexual-pioneers/)
83. Hysterectomy FAQ Women’s Health (https://web.archive.org/web/20040225072225/http://4women.gov/faq/hysterectomy.htm)
84. [16] (https://www.ohchr.org/Documents/Issues/Opinion/Submissions/NGOs/LGB_Alliance.docx) LGB Alliance submission to OHCHR seminar on academic freedom

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Categories: Gender | Hate groups | United Kingdom | Internet hate sites | Pissed at us | Internalized discrimination | Transphobia

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NEWS

# LGB ALLIANCE 'SERVES ONLY TO DIVIDE AND DENIGRATE', SAYS JOHN NICOLSON MP

**Exclusive: John Nicolson tells Attitude the government's Charity Commission should "reflect" on its decision to award the group charitable status.**

2021-06-07

*Words: Alastair James; pictures: John Nicolson*

John Nicolson MP says the government's Charity Commission should "reflect" on its decision to grant charitable status to the LGB Alliance.

Speaking exclusively to Attitude, the Scottish MP for Ochil and South Perthshire says that the group "serves only to divide and denigrate" and must be monitored closely.

The LGB Alliance was founded in 2019 purportedly to "advance the interests of lesbians, gay men and bisexuals". It has since publicly campaigned against reforming the Gender Recognition Act to make it easier for trans people to gain legal recognition and describes the affirmation of transgender children by charities and medical professionals as "a form of conversion therapy."

On its website, the group state they oppose trans women being admitted "into lesbian spaces" as well as trans men being admitted "into gay men's spaces", but insist they are not "anti-trans".

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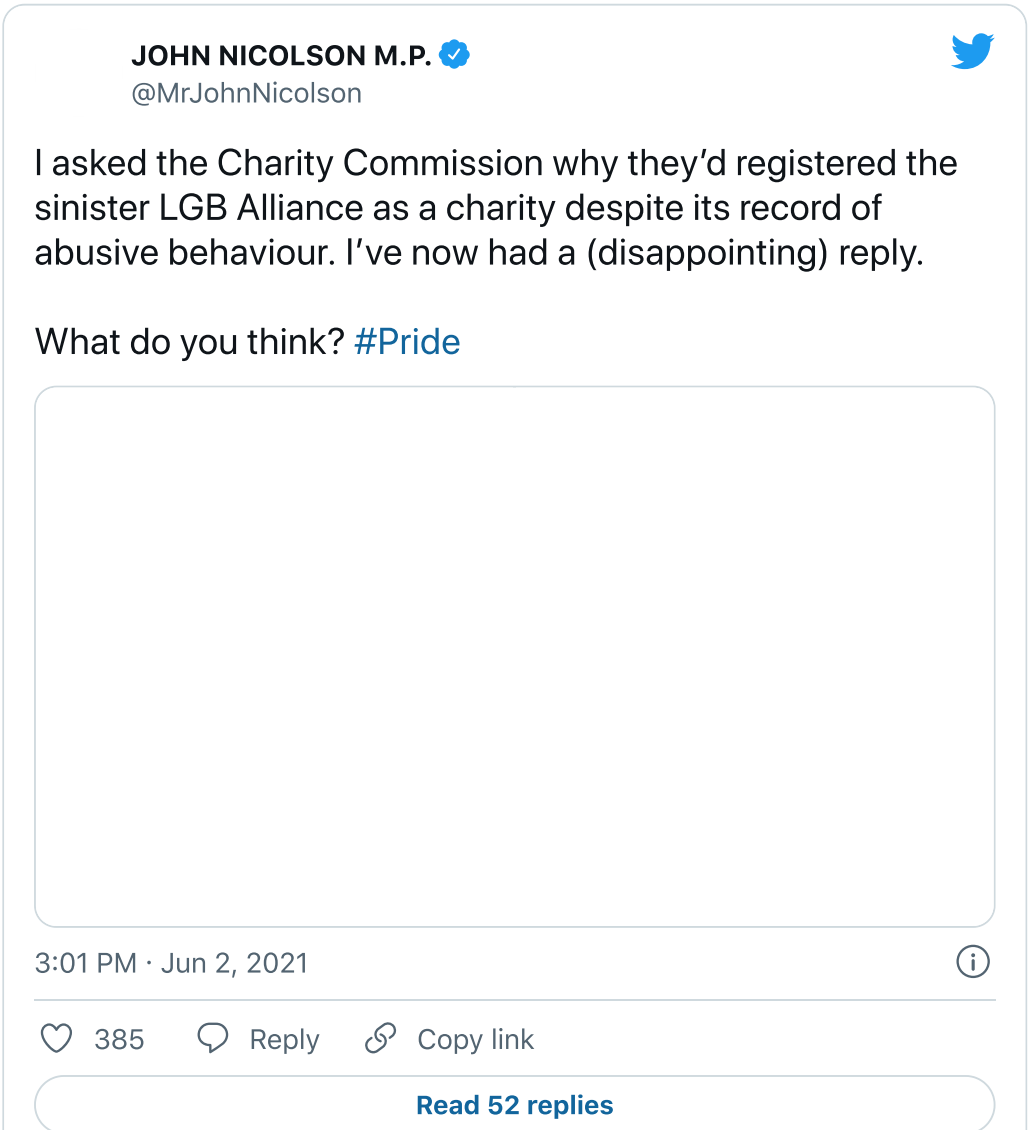


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LGB Alliance has previously been denounced as a transphobic hate group by a range of LGBTQ organisations including Pride in London and by political figures including Labour MPs Angela Raynor, Dawn Butler and Rebecca Long-Bailey.

The organisation was granted charitable status in April despite a petition against it gaining more than 36,000 signatures and after the Commission says it received a “number of objections”.

**“This is entirely unacceptable”**




Mr. Nicolson, who is gay, has been speaking to Attitude after posting his correspondence with the Commission on Twitter last Wednesday (2 June). After contacting the organisation a day after it was announced the LGB Alliance would be made a ‘charity’ in April, he received a response the following month, which he has now made public.

“The response from the Charity Commission was very disappointing. Not least because, in their reply, they raise their own concerns about the LGB Alliance's record of abusive behaviour," NIcolson tells Attitude.

“In their response to my letter, the Charity Commission even acknowledged that the LGB Alliance's social media appeared to involve demeaning or denigrating the rights of others. This is entirely unacceptable from an organisation which aspires to be a charity.”


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*John Nicolson MP (Photo: John Nicolson)*



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attitude

and offensive" social media activity from the LGB Alliance, which it said, "appeared to involve, at times, demeaning or denigrating the rights (recognised by law) of others."

The Commission repeated in its response to Mr. Nicolson that it had contacted the Alliance about this, which it said had resulted in changes so their social media approach would be “less defensive and confrontational”.

Mr. Nicolson isn’t convinced.

"If the Alliance and its directors continue in their old ways, they must have their charitable status removed," he tells Attitude.

“It’s up to all of us to monitor them and keep sending evidence to the Commission. I will also be interested to monitor their [financial] accounts which must now be provided.”

**“I suspect the law does need to change.”**

In its response to Mr. Nicolson’s questioning of their decision, the Charity Commission said it was operating around “the legal definition of a charity” as set by Parliament. We ask if that definition is something that needs to be changed by Westminster.

“I certainly don't think that organisations with track records of abusing others and denigrating the rights of vulnerable minorities should be given charity status. So yes, I suspect the law does need to change."

Referring to the appeal launched against the Charity Commission's decision by the transgender youth charity Mermaids, supported by The Good Law Project, Stonewall and other LGBT organisations, he says: "But let’s see how the Mermaids legal action goes.”

The groups leading the appeal have already raised over £60,000 towards their costs on a crowdfunding website, and Mr Nicholson backs the action.

“Charitable status is intended for those who serve a public good. The LGB Alliance serves only to divide and denigrate. I can't think of any other 'charity' apart from the LGB Alliance which has to promise that it will stop posting abuse.”

**“We should all monitor and report”**

Asked about what should happen next, Mr. Nicolson replies that “the Charity Commission should reflect on their decision”.

“The Alliance has given the Charity Commission assurances that it and its trustees will no longer be abusive and won't post hate. I doubt they're capable of keeping that promise. We should all monitor and report” he added.

The MP had this advice for people, especially LGBTQ youth: “The Alliance and their supporters are a threatening and abusive presence online and target the vulnerable. It must be hideous for trans kids to read some of their appalling posts.

“Don't hesitate to mute or block the myriad anonymous accounts posting venom. And if you are a young LGBT reader, in particular, remember that many of those posting are angry obsessives hiding behind their keyboards.

**“My team are incredibly supportive”**



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*The LGB Alliance has tweeted John Nicolson messages of people who've donated to their cause under his name (Photo: John Nicolson)*



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Mr. Nicolson says he's experienced abuse from LGB Alliance on social media in the past, with the group previously sending him messages of donations falsely made to them in Nicolson's name.

But the MP tells me that there's been an outpouring of support as well. "I have also received some lovely letters from friends and strangers alike. I've made new friends on social media both by sending messages of support and getting messages of support.

"I've had some great chats with the author Damian Barr, the actor David Paisley, and the comedian Janey Godley, amongst others. I'm looking forward to meeting all of them when things get back to normal!

"And, as always, my office staff have been brilliant. My team are incredibly supportive and get much more upset about the abuse I receive than I do."

The LGB Alliance says it's "working hard to protect the rights of LGB people."




Anti-trans anti-transgender John Nicolson LGB LGBTQ News

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CULTURE

# Russell T Davies takes down LGB Alliance in incendiary speech: 'To cut out the T is to kill'

EMMA POWYS MAURICE | OCTOBER 14, 2021

SAVE FOR LATER



Russell T Davies speaking at the 2021 Attitude Awards (@AttitudeMag)

## Russell T Davies ridiculed the LGB Alliance in a powerful speech that highlighted just how sinister its anti-trans rhetoric is.

The BAFTA-winning TV writer spoke passionately of the need for trans allyship as he collected the Inspiration Award for his seminal drama, *It's a Sin*, at the 2021 Attitude Awards.

After commending "inspiring" HIV and AIDS workers and condemning the "b*****d" Tories, he made no secret of his scorn for the LGB Alliance, an anti-trans charity created in opposition to Stonewall's policies on transgender inclusion.

"When people belittle us, they love taking the p**s out of us, they love othering us, they love making us look small and funny and insignificant," he began.

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"But then along comes the LGB Alliance, and they say: 'No, we can only have three letters, we're going to cut off the T. You can't have LGBT, we're going to cut LGB off from the T.' So what they're saying is, you can only have words that are three letters long? Is that how it's going to work?"

"So I thought to myself, can you do that?" Davies asked, before demonstrating just how limiting it is to talk only in words of three letters or less.

"Can you tal- in wor- tha- are onl- thr- let-? Yes I can! Yes you can! We can tal- in wor- of onl- thr- let-. But why? Why do that?

"We can-, cause whe- you tal- lik- tha-, you are cru-, you are pra-, you are big-, you are bia-, you are ugl-, you are laz-," he said. "And in the end, you kill.

"To cut out the T is to kill."

The power of these simple words saw the audience erupt in applause.

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The LGB Alliance gained charitable status earlier this year in spite of fierce objections from multiple LGBT+ charities and a petition signed by more than 44,000 people.

It claims to advocate for the rights of lesbian, gay and bisexual people, but doggedly concentrates its efforts on opposing trans inclusion.

The charity reached a new low in August when it compared the LGBT+ acronym to bestiality.

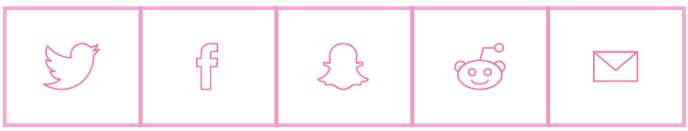
"Adding the + to LGB gives the green light to paraphilias like bestiality – and more – to all be part of one big happy 'rainbow family'. Wake up policy makers," it said in a now-deleted tweet.

"LGB people refuse to be used in your artificial and dangerous argument that we must all be lumped together. #NoToHomophobia."

The LGBT+ acronym is used to describe all people who fall under the queer umbrella, including the intersex, asexual and aromantic communities, and its use is widely encouraged to promote inclusion and acceptance.

The LGB Alliance's shocking tweet breached Twitter's rules on hate speech and prompted discussions with the Charity Commission, the official regulating body for charities in England and Wales.

The decision to register the LGB Alliance as an official charity is now subject to an appeal lodged by the trans children's charity Mermaids.



More: It's a Sin, lgb alliance, russell t davies

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**Charlie Stross** ✓
@cstross

Reminder that the LGB Alliance is funded by the Heritage Foundation—an American Christian conservative pressure group with backing from right-wing homophobic billionaires. It's n anti-LGBT false front, using transphobia as a wedge issue to falsely legitimize anti-gay hate speech.

> **LGB Alliance** @ALLIANCELGB · Nov 23, 2020
> While #LGBAlliance is trending we would like to say that we felt the need to set up this organization a year ago because we felt the existing LGBTQ+ organizations no longer represented our interests. We soon discovered that many thousands of LGB people felt the same way.
> Join us!

11:20 AM · Nov 24, 2020 · Tweetbot for iOS

← **Thread**



**David Thomas Moore**
@dtmooreeditor

tfw you're so hateful you'll attack the rights you purport to defend, just to avoid them accidentally also extending to people you hate

(j/k, groups like LGB Alliance are a front for straight conservative Christian orgs who hate all LGBT people)

10:47 PM · Jan 21, 2021 · Twitter for Android

**1** Retweet **10** Likes

← **Thread**



**Kareshy**
@Kareshy_Altah

LGB Alliance is a literal front for a conservative group. Far more concerned with maintaining a level of prestige for their leadership than the work of gaining equality. The absence of solidarity benefits them on an emotional level and nothing more.

1:46 PM · Jan 21, 2021 · TweetDeck

← **Tweet**



**Zoidbob (he/him)**
@doodle_bobby

Replying to @andrew_b72 @LGBAllies_Cymru and @MerchedCymru

For sure. We all know the LGB Alliance is a front for conservative straight people to dismantle LGBT+ protections.

They get aggressive with us because we call them out on it.

5:59 PM · Dec 11, 2021 · Twitter for iPhone

← **Tweet**



**Crash(She/They)🌻🤷‍♀️🏳️‍⚧️🦕#VotesForWomen💜🤍💚**
@StarCrashr

Replying to @Pomegranate2021 @BBC and @ALLIANCELGB

Because LGBA isn't a legitimate organization. It's widely known to be a front for big right wing conservative anti-gay lobby groups who are openly working to divide and conquer the entire LGBTQIA+ community because they know that we're stronger together.

7:35 AM · Feb 11, 2022 · Twitter Web App

← **Tweet**

**🌙Radical Dreamingnoctis⭐🏳️‍⚧️🔞**
@dreamingnoctis

Reminder; LGB Alliance, TERFs, and “gender crits” are just a front group/puppet group for the religious right.

7:24 AM · Nov 27, 2020 · Twitter for iPad

**Mochyn Brwnt🐷🏴🏳️‍🌈**
@ofnwchyrhenwaed

The LGB Alliance is nothing but a front for wealthy right wingers and Christian fundamentalists who are weaponising transphobia as a means to undermine the LGBTQ community. Followed by...*shocker* #sackhelenmaryjones

**Owen J Hurcum** 🏴🏳️‍⚧️🏳️‍🌈🟠🌤️ @OwenJHurcum · Mar 5, 2021

The LGB Alliance promote the idea that trans and Non-Binary people like me are nothing more than sexual perverts or confused gays/lesbians... They are a hate group plain and simple. Why do you still follow them @HelenMaryCymru? Do you really care that little about our community!?




LGB ALLIANCE

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**LGB Alliance**

# BBC article

1 message

**WordPress** <wordpress@lgballiance.org.uk> 27 October 2021 at 21:39
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: BBC article

Message Body:
I am an openly gay man who works in a role which prevents me from making public statements which may be considered controversial. I peaked in June 2020 due to the appalling abuse I could see lesbians receiving because of their same sex attraction. I wanted to send a message to LGB Alliance and its founder members to say, despite the fact I am unable to make public statements, I stand with lesbians.

My employer remains part of Stonewall's Diversity programme but I have today written to my HR department expressing my serious concern at Nancy Kelley's disgraceful comments comparing same sex attraction to racism and asking they urgently review their membership of Stonewall. I suspect this will fall on deaf ears but is the best way I can see to support lesbians.

Yours

[redacted]

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# Thank you

1 message

**WordPress** <wordpress@lgballiance.org.uk> 12 November 2021 at 17:20
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Thank you

Message Body:
I just wanted to say thank you so much for sticking up for children. Im a mum whose 12 year old is obsessed with gender ID, and to my utter shock, I found out a few days ago was seriously thinking about chest binding. I had to have a big sit down with her and tell her just where all this might eventually lead for her. It is utterly chilling that no one, including health care services and schools, are safeguarding children for fear of being branded transphobic or being cancelled. I have signed up for a regular donation to the LGB Alliance, in support of the vital work that you are doing at what must be great cost to those involved personally and professionally in the current climate.

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# So far, so good.

**WordPress** <wordpress@lgballiance.org.uk> 2 June 2021 at 09:15
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: So far, so good.

Message Body:
Hello,
For a long time now I have felt that LGB people have been "lumped" in with every other differing sexuality and we no longer had a voice that represents us. I am a healthcare professional and I'm beginning to form the impression that the transgender ideology is the ultimate form of conversion therapy. I have read many stories of gay boys being transitioned as it is "better having a girl than a gay son".

I'm interested to learn more about you and will read more of your work, but I am happy to see a group that recognises me as a gay, same sex attracted male; and one that recognises biology over feelings.

I wish you luck

[redacted]

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# Thank goodness for LGB Alliance

1 message

**WordPress** <wordpress@lgballiance.org.uk> 30 October 2021 at 00:51
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Thank goodness for LGB Alliance

Message Body:
Just want to say how pleased I am to have found you. I've given up with stonewall. Useless!!!
I'm an older lesbian (cis female) and am disgusted by the way trans activists are bullying and intimidating the world. Even the leader of the Labour Party is scared of them! What's going on??
Respect to every human being, all opinions, all views and respect for everyone to make their own choices without fear of retribution. This is what we have to teach trans activists. The rest of us already know!
They are ruining decent people's lives and livelihoods, they are ruining lesbian dating sites!
And why is it only female trans who cause the trouble, don't hear a peep from male trans do we!
I can't wait to receive your emails and get involved. Lesbians need support now more than ever, There's nothing wrong with having a cis lesbian site, there's nothing wrong with having penis free spaces.
And of course equal support for gay men. I have nothing against bi sexuals but couldn't date one. I have nothing against trans people but couldn't date one, I could be and am friends with them but I'm not sexually attracted to them. Love and peace to all.
Trans activists need to calm down and stop being so defensive. Live and let live.

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# How far you've shifted the Overton Window

1 message

**WordPress** <wordpress@lgballiance.org.uk> 4 February 2022 at 13:41
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: How far you've shifted the Overton Window

Message Body:
Hello All, A quick email from my real email address, and my real name to let you know the impact you have had in less than a year.

I first sent you a donation not long after your inception from another email and with no name. I was so paranoid I rang afterwards and asked you to check no records would be kept.

Yet yesterday - less than a year later - I attended a work meeting wearing one of your hoddies. (I'd love to say this went down well, but it was not entirely without consequence. I've since been 'invited' to a meeting to 'discuss' my views on sex and gender, which I expect will be a reprimand.)

However, I'm also very happy to attend this 'discussion', because the issues are ones that I believe need to be discussed more and more openly. The best way to bleach bad ideas in the light.

But most strikingly of all, these are no longer views I am frightened to own or share, and thanks in no small part thanks to you all.

So huge thanks and best wishes from me,

[redacted]

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# Sending love and support

**WordPress** <wordpress@lgballiance.org.uk> 30 October 2021 at 16:11
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Sending love and support

Message Body:
Thank you for being there
I don't know why these awful people are so intent on doing you down - you stand for me. Lesbian same sex attracted.
Have donated again - this action is ridiculous - I blame RH wholeheartedly for this toxic mess - no debate was a desperately stupid, ignorant and arrogant stance to take. And why we find ourselves in this world of make believe. Solidarity to you all.

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# Starting to feel scared

1 message

**WordPress** <wordpress@lgballiance.org.uk> 9 May 2021 at 14:49
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Starting to feel scared

Message Body:
Dear LGB Alliance
Firstly, Thank you for existing and congratulations on the Charity status. I am a medical doctor. A feminist. A Lesbian.

I am increasingly concerned about the creep of gender identity into the health sector at large outside of gender dysphoria clinics and services. Reading how women and feminists and lesbians in particular are being targeted by TRAs for expressing gender critical or feminist views is starting to feel very scary indeed. Are you able to approach the Royal colleges, GMC and BMA to seek reassurance that feminist lesbian doctors like myself who share the views of the LGB Alliance will not find ourselves disciplined and fired - or reported to the GMC. I don't know if this is something you can help with or not - I feel that by writing myself could in itself draw attention to me and get me in trouble. How did it come to this?

Today I have read an article about a medical school introducing patient scenarios based around the new Trans Speak. Women with penises, Men with ovaries, transgender children... I tried to have a conversation with a friend about these issues yesterday and found I feel really frightened about being a lesbian and feminist - for the first time in my adult life. I also felt completely ill-equipped to discuss the issue with them - as it is so bizarre what is happening - how to explain that women are being dissolved in front of our eyes.
Many thanks for all that you are doing. We really need you and others like you who are not too scared to speak up.
Much love in solidarity [redacted] x

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# Thanks and appreciation

1 message

**WordPress** <wordpress@lgballiance.org.uk> 3 November 2021 at 20:23
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Thanks and appreciation

Message Body:
Thank you to the whole LGB Alliance for the work you do, which I fully support; and in particular thanks to Professor Stock for her bravery in speaking her mind on this issue, but also on the horrors of the cancel culture in our society and particularly in academia, which are destroying the possibility of civilised discourse, dialogue and debate. Your bravery Professor Stock and that of your colleagues is essential not just for LGB people but for the whole of society's need to be able to discuss and disagree well. THANK YOU for everything.

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# Well Done

**WordPress** <wordpress@lgballiance.org.uk> 2 June 2021 at 19:11
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Well Done

Message Body:
I´m appalled at the campaign against you, both as an organisation and and individuals within it.
Unfortunately living in rural Shropshire, as I do, there will be little that I could do to help. The trans movement is really undermining LGB rights and positive attitudes-especially out here in the shires. And as much as I would stand up for anybody facing hate, whether it be due to race or being trans...I can´t speak for either-we don´t have shared experiences; including coming out.
It is becoming incredibly hard to speak about genuine abuses and prejudices faced by our community without being drowned out by straight people who identify as being queer to join what they see as a glamorous party...certainly for me it never was. I lost my entire family due to their views on my sexuality, and I feel as though now I am losing my community as well.

Keep it up.

[redacted] x

--
This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

# Personal message when joining LGB Alliance

2 messages

**WordPress** <wordpress@lgballiance.org.uk> 3 March 2022 at 00:22
Reply-To: [redacted]
To: contact@lgballiance.org.uk

From: [redacted]
Subject: Personal message when joining LGB Alliance

Message Body:
Thank you Bev Jackson and Kate Harris for setting up the LGB Alliance. We need this organisation to defend our rights as same-sex attracted people and to speak up for our legitimate interests and concerns within fact and evidence based policy making.

Stonewall has clearly abandoned this role and is ploughing a different course by conflating sex with gender and privileging the spurious claims of gender identity over the established rights in law of same-sex attracted people. When Stonewall's CEO unilaterally added the 'T' and decided to lobby for two distinct but ontologically opposed categories: sexual orientation & gender identity, she created an incoherence that could not hold. As JK Rowling said "if sex isn't real there is no same-sex attraction". As the notion of 'gender identity' is a social construct how can it be a matter of individual feelings alone? If gender is fluid and sex isn't real what does 'transition' actually mean? From what to what? As Alison Bailey points out, the protected gender characteristic is 'gender reassignment' not gender identity. Without reassignment natal sex determines rights. I'm really grateful that many of the original founders of Stonewall were alert and wise enough to oppose its incoherent & harmful changes. And I'm glad they braved the baying mobs to set up LGB Alliance.

It's a very real problem that the Stonewall has already captured and embedded itself in our key public institutions and is now in a position to do us continuing harm by propagating counter-factual beliefs about sex and gender and more seriously promoting experimental 'treatments' like puberty-blockers at the Tavistock for those too young or emotionally vulnerable to consent. Stonewall is now encouraging homophobic trans-activism that seeks to erase women, lesbians & gay men.

LGB Alliance's online briefings and particularly the screening of the 2021 Conference have helped me understand "what the fuck is going on". I'm very grateful that in October 21 you managed to assemble so many excellent speakers with real expertise in their fields, able to speak with genuine authority utilising good old-fashioned evidence & facts. I'm glad facts are not totally out of fashion yet!
It's great to hear strong critical analysis of trans ideology and learn of its real and lasting harms and get an overview from professional practitioners as to its damaging impacts in the law, the Tavistock, psychiatry, the universities, schools, public institutions, Parliament, and politics.

It's an outrage and major medical scandal that the NHS and big-pharma are being allowed to sterilise our kids at the Tavistock. They must be stopped and held to account.

I wish to join LGB Alliance and help as far as I can. I would like to donate some money by sending a cheque in the post to help with the work.

Sincerely, [redacted] 02MAR22

Brief Biography— Gay Rights involvement
I am a 77 years old gay man and retired teacher who lost my civil partner three years ago. I am now feeling rather beleaguered and cut-off in covid-isolation. Furthermore I don't trust the BBC, the Guardian and other organs of woke to report impartially on LGB and Stonewall issues.

In 1975 two men stabbed me in a homophobic attack. After I received treatment for stab wounds and concussion at the local hospital, rather than being kept in for observation, they released me back to the police in Altrincham where four South Manchester policeman aggressively cross-examined me throughout the night until dawn. They urged me to confess to being homosexual which they said would be of real interest to my employers at the Local Education Authority. They told me that if I were homosexual I deserved everything I got. I realised then that despite the 1967 act, as a gay man I could expect no protection from the police and neither could I expect anything like equality before the law. I had no civil rights. That was my awakening. (It also made me reflected on the plight of those women courageous and/or naïve enough to report being raped to the police—and get twice violated).

After this formative experience I swiftly joined the Campaign for Homosexual Equality in 1975 (successor to the North-Western Law Reform Committee, Manchester 1964—decades before Stonewall—BBC please fact-check your own propaganda), Gay Lobby, and Gay Speakers and became one of the founder member of the then Gay Christian Movement. Later in North Wales in the 1980s I worked on the local gay switchboard, organised workshops on Aids awareness with input from THT and local GUM clinic. I befriended a person living with Aids who was being hounded by the local press and media which were publishing confidential medical information supplied by NHS personnel.

I was co-opted onto the local health authority's Aids Liaison Committee - an experience confirming that the major dynamic in hierarchical public institutions, like the NHS, is career progression. I also worked for a short period on a young gay men's HIV health initiative. In all these years of working & campaigning for LGB equality before the law and freedom from discrimination, I

never encountered a single trans-person who wanted to help.

Some Feedback on the Excellent Sessions at the First Conference, October 21:

Education or genderbread indoctrination—
Tanya Carter and Stephanie Davis-Arai speak a lot of sense. Teaching contested beliefs and abstract gender theory to young children who are cognitively and emotionally unready is not education but indoctrination—genderbread indoctrination. Teachers who often lack confidence in their own knowledge base, feel out of their depth and are frightened of being branded transphobic will invariably take the easy way out and reach for materials & resources produced by the trans ideologues. This is how potentially harmful propaganda gets into schools. Just ask the BBC.

LGB Alliance a broad coalition ? -
Bev Jackson and Dr Jane Clare Jones are right LGB Alliance must be able to include people who hold differing ontological positions in good faith. “The line we need to draw is about the political recognition and the political erasure of sex and the impact of that on women, homosexuals and young children.” Bev Jackson assures us that from the start LGB Alliance was about building bridges and promoting dialogue. One of the very few negatives at the conference were the reactions of some attendees who didn’t understand that those Conservative speakers apologising for being Tory were actually being ironic and sarcastic. The stakes are too high for ideological purity and point scoring. Language is important but coerced language prevents dialogue. It cannot be allowed to fracture this alliance which has its work cut out preventing gender non-conforming girls & boys being fed puberty blockers, young women are having their breasts sliced off and gay kids being sterilized!

Escalating Transgender demands at Strasbourg—an LGB or a Women only issue .
Prof Wintemute points to the escalation of transgender demands which activists have successively pursued in the European Court of Human Rights over last 20 years. Of course authentic human rights have to take account of the rights and freedoms of others which the trans lobby consistently fail to do. Specifically in this case, that means the rights and freedoms of LGB people and heterosexual woman. It is not, as Prof Wintemute would have it, just about the rights and freedoms of lesbian, bisexual and heterosexual women. Bev Jackson was right to ask whether the gender cases coming before ECHR are also important to LGB people and not just women? I’m not sure why the professor thinks that’s an awkward question at an LGB conference.

Surely male-bodied ‘lesbians’ dating genuine lesbians while failing to disclose their true sex and heterosexual intent must, prima facie, be pursuing non-consensual sex which would be assault? Conversely a female-bodied pretend-gay man dating a genuine gay man for the purposes of gay sex is also attempting non-consensual sex which is assault or attempted assault? In other words lack of informed consent, fraudulent concealment of natal sex and sexual preference, etc. are not just social issues but are potentially important criminal issues.

The latest transgender demands to stop the registration of sex on all official documents is about erasure of sex and its binary reality in law. Such a ‘right’ would be at at the expense of the rights and freedoms of most of us not just LGB people.
.....

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This e-mail was sent from a contact form on LGB Alliance (https://lgballiance.org.uk)

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**Contact@** <contact@lgballiance.org.uk> 3 March 2022 at 15:17
To: Bev Jackson <lgballiancebev@gmail.com>, Kate Harris <kate.harris@lgballiance.org.uk>

Received via the website.

Thanks,
Kerry
[Quoted text hidden]
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www.lgballiance.org.uk
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Health

# NHS child gender clinic: Staff concerns 'shut down'

By Hannah Barnes and Deborah Cohen
BBC Newsnight

19 June 2020




The Gender Identity Service is based at the Tavistock and Portman NHS Trust

**Staff at England's only children's NHS gender clinic say concerns about patient welfare were shut down, leaked documents reveal.**

Clinicians reported worries that some patients were referred onto a gender transitioning pathway too quickly.

BBC Newsnight has seen transcripts of staff interviews from a review into the Gender Identity Development Service.

The Tavistock and Portman NHS Trust, which runs the service, defended the

review and its practices.

The review was published in Spring 2019 after the Trust asked its medical director, Dr Dinesh Sinha, to investigate serious concerns about children's welfare raised by staff in an internal report.

**BBC Newsnight** has read transcripts of some of the interviews conducted with staff as part of the review.

- **NHS gender clinic 'should have challenged me more'**
- **Transgender patients self-medicating over NHS waits**

The Trust said it had not identified any immediate issues in relation to patient safety or the overall approach taken by the gender identity service (GIDS), yet in the transcripts clinicians claim child protection and safeguarding concerns were "shut down".

In the transcripts, staff are damning in their assessment of some parts of the service

"Let's pray that I am wrong because if I am not wrong, very many vulnerable children have been very poorly treated and will be left with, potentially, a lifetime of damage here," one says.

"The reality is, by not doing anything, children are potentially still being medically mismanaged."

The Tavistock - like other NHS organisations - has a named person clinicians can turn to discuss specific safety concerns.

But staff allege they were discouraged by GIDS Director Polly Carmichael from going to see the Trust's safeguarding lead, and from referring cases to social services.





Dr Polly Carmichael was interviewed on the BBC's The Victoria Derbyshire Show earlier this year

According to the transcripts, these included cases where staff feared a child had suffered sexual abuse or trauma.

"In all of my previous work, if you had a concern, you refer them on," it's claimed.

"And that did not happen."

## Approach felt 'unsafe'

The Trust said a safeguarding lead was created specifically for GIDS in August 2018 to reflect the growth in the service.

But in their interviews, staff didn't view this as adequate and argued there was wide variation in practice at GIDS.

"There was a very clear message from senior management about being really cautious about how we talk to the safeguarding team at the Tavi[stock], and specifically [the Trust's safeguarding lead]."

Staff have told Newsnight this approach felt unsafe.

"I would say that perhaps that's why more than 40 clinicians decided to leave the service within three years," one, who left GIDS last year, told the BBC.

The review acknowledges staff had raised concerns over a period of years. But staff claim in the transcripts that when they did so, they were seen as the problem.

"People who raise concerns are seen as trouble making and difficult," one staff member argued.

"When I raised concerns I was told that I had to toe the line or I would never progress in my career," another said.





It's unlikely all staff will have been as critical of GIDS as the ones whose interviews were read by Newsnight.

But the number of transcripts seen by Newsnight amount to a sizeable proportion - albeit a minority - of the total number of frontline GIDS staff interviewed for the review.

The Tavistock and Portman Trust said it "stands by" the 2019 review of GIDS and is "confident that it fairly addressed the issues raised".

"Safeguarding is of the utmost importance to the Trust," it added.

## Puberty blockers

The transcripts detail a range of worries about the service.

Homophobia in families attending GIDS is mentioned in all the transcripts Newsnight has seen.

As well as seeing young people struggling with their sexuality, staff say some parents appeared to prefer their children to be transgender and straight, rather than gay.

In one example, a GIDS clinician describes a young person who had come out as a lesbian and faced homophobic bullying, "within the family and quite openly in school".

"Suddenly the young person changed their mind and they started identifying as trans."

In some of these cases, clinicians thought that it wouldn't be appropriate for the patient to be referred for puberty blockers, with one child apparently saying: "My mum wants the hormone more than I do."

But staff could be overruled by GIDS director Polly Carmichael, the transcripts suggest.

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## What are puberty blockers?

Puberty blockers stop a young person's body developing breasts, periods, facial hair or a deeper voice.

Recently updated **NHS guidance** on puberty blockers acknowledges that little is known about their long-term effects, or what impact they might have on

children's brains and bones

NHS England says young people should only be referred for this treatment after a minimum of three sessions.

*Read more:* **What are puberty blockers?**

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However, the review heard from several staff that one member of the GIDS leadership, Sarah Davidson, would sometimes refer children for treatment after only one or two appointments.

"Absolutely it should never happen because this is a pathway that will lead to huge, huge changes for this young person, potentially, infertility," one GIDS clinician said.

Such a quick referral, staff claim, could risk putting young people on potentially life-changing medicines who may have been struggling with issues such as their mental health and sexuality.

- **NHS use of puberty blockers legal challenge begins**
- **Transgender people face NHS waiting list 'hell'**

The Tavistock Trust said "there are many pathways for patients using the service" and many would not be referred on for consideration for hormone blocking drugs.

"GIDS is a safe and caring service which supports a wide range of children,' it said. "[We] strongly refute the allegations put to us by Newsnight," it added.

Newsnight showed some of the transcripts to the Children's Commissioner for England and contacted the healthcare regulator, the CQC.

Both were interested in speaking to the people involved.

The CQC encouraged anyone with specific concerns about safety or safeguarding at the trust to contact them directly. It had been due to inspect GIDS, though routine inspections are currently paused because of the coronavirus pandemic.

You can watch **Newsnight** on BBC Two weekdays at 22:45 BST or on **iPlayer**. Subscribe to the programme on **YouTube** or follow on **Twitter**.

### More on this story






# NHS child gender clinic Staff welfare concerns shut down

Transcript of BBC Newsnight broadcast

00:02
Young people struggling with their gender identity may be referred to England only specialist clinic, the Gender Identity Development Service or GIDS, based at London's Tavistock and Portman Foundation Trust.  It's a difficult area to work in. And last year following serious staff concerns over children's welfare, the trust conducted an internal review of the service. It recommended areas for improvement but did not identify any immediate issues in relation to patient safety. Yet evidence exclusively seen by news night reveals serious tensions at the heart of GIDS. We've seen well over 100 pages of transcripts of interviews conducted with staff as part of the review, they make a series of claims. Staff say they were discouraged from going to the lead safeguarding officer with concerns about children's welfare. They say decisions about medical treatment were taken too quickly. And they say that some parents appear to prefer the child was transgender and straight rather than gay, pushing them towards transition. The transcripts have been voiced in this film by actors and edited for clarity. But the words were all relayed by Jude's clinicians to the trust's Medical Director as part of the review process.

01:27
Let's pray that I am wrong. Because if I'm not wrong, very many vulnerable children have been very poorly treated, and we'll be left with potentially a lifetime of damage here. We're not talking about little things. The reality is, by not doing anything, children are potentially still being medically mismanaged.

01:52
When a child is assessed by GIDS, they may be offered a drug called a puberty blocker. These stop a young person's body developing breasts periods, facial hair, or a deeper voice. The NHS has recently updated its guidance on these drugs, acknowledging that little is known about their long term effects, or what impact they might have on children's brains and bones. GIDS said in the past, it finds itself caught between people who want these treatments to be given quickly, and those who think they shouldn't be given at all. Many children refer to GIDS are extremely distressed, and have complex needs. The clinicians we've spoken to say there's often lots to explore before medication should be considered. But they say there's wide variation in practice. It's claimed in the transcripts that many staff are worried and openly discuss their fears. Maybe we are

02:49
medicating gay kids. Maybe we're medicating kids with autism, maybe we are medicating traumatized children. And if we are, we're doing bad things to these vulnerable kids.

03:09


Transcribed by https://otter.ai

NHS England says that young people should be referred for medical treatment, puberty blocking drugs, after a minimum of three sessions. Put the review heard from several staff that one member of the GIDS leadership, Sarah Davidson would refer children for treatment after only one or two appointments.

03:30
I was working with an executive on one case of assessment of a young person, and the executive member agrees to refer this person to the medical pathway within the first hour of meeting him. And that was not supposed to happen. Absolutely, it should never happen. Because this is a pathway that will lead to huge, huge changes for this young person. You know, it could lead to potentially infertility and so on.

03:56
We've been told that cases like this have been discussed at team meetings in GIDS. When some staff raise concerns about the speed of assessment. We understand the response was typically that the young person was experiencing very intense and severe gender dysphoria. Such a quick referral wouldn't allow for full exploration of what else is going on staff claim. They say this could risk putting young people on potentially life changing medicines, who may have been struggling with issues such as their mental health and sexuality.

04:35
Homophobia in families is mentioned in all of the transcripts Newsnight has seen. Staff say that while there was some discussion in the service about this, they didn't feel the issue was properly addressed. We've spoken to a number of staff off the record, most didn't want to go on camera, even on the condition of anonymity, but the transcripts are backed up by this format. clinician who left kids last year. Their words are being voiced by an actor. We did

05:05
have a lot of families and parents who would actively tell us that, Oh, I'm so glad at least my child is not gay or lesbian, implying that having a trans outcome would be better for their children.

05:17
I had a case, there was a lot of trauma in the family. The young person had come out initially as a lesbian, and had faced a lot of homophobic bullying, both very subtly within the family and quite openly in school. And suddenly the young person changed their mind and they started identifying as trans.

05:34
In some of these cases, clinicians thought that it wouldn't be appropriate for them to refer for puberty blockers, but they will be overruled by GIDS director Polly Carmichael. The transcripts suggest the young

05:47

person had very clearly told me and my colleague that my mum wants the hormone more than I do. And when we took it to senior management, Polly Carmichael, she suggested that we refer even though this was not clinically indicated.

06:06
These are only some of the examples mentioned in the transcripts. Staff also voiced concerns about the degree of trauma they're witnessing in children, and the process of gaining consent for medical treatment. It's accepted in the review that staff raised these concerns over a number of years, both to the leadership of kids and to senior figures in the Tavistock trust, but in the transcripts, staff say they weren't listened to.

06:34
The reality is that our concerns were raised all the time and will shut down

06:39
and that when they did speak up, they were then seen as the problem

06:44
people who raised concerns are seen as troublemaking and difficult. I think it is the case that somehow the organization works to evacuate people who are not compliant. When I

06:55
raised concerns, I was told that I had to toe the line, or I would never progress in my career.

07:01
Staff also say that senior management were not able to reassure them that their concerns were unfounded.

07:08
I kept saying to her, are we hurting children? And she did not say no. I kept saying to Will we get sued? She did not say no. The only solace she gave me was that she said it would not be me that would be sued. It would be the Tavistock that would be sued. She was not able to say to me, it's fine. We are not hurting the children.

07:30
In the transcripts we seen clinicians are worried about the impact different kinds of abuse might have on young people trying to resolve questions about their gender identity. These could be seen as safeguarding issues. Staff claim they were discouraged from referring these cases to social services and from seeking advice. The Tavistock like other NHS organisations has a named Person clinicians can turn to to discuss specific safety concerns. That person is Sonia Appleby, but the transcripts allege that staff were discouraged from speaking to her by the director of GIDS Polly Carmichael.

08:14


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There was a very clear message from senior management about being really cautious about how we talked to the safeguarding team at the taffy and specifically Sonia Appleby.

08:24
I know that Polly feels she does not like Sonia Appleby. I think that is odd. She is the trust safeguarding lead.

08:33
I've had some consultations with Polly Carmichael about some of the young people I was seeing and some of the concerns I've raised. And Polly very directly told me not to go to Sonia to share those concerns. Is that safe? No. And I would say that perhaps that's why more than 40 clinicians decided to leave the service within three years.

08:56
We've been told that if clinicians did approach Sonia Appleby, they felt she understood the complexity of the GIDS work and was supported by her. Mrs. Appleby's solicitor told us that she'd started legal proceedings against the trust last year, and it wouldn't be appropriate to comment further. It's unlikely that all staff will have been as critical of GIDS as the ones whose interviews we've read, but the transcripts we've seen represent a sizable minority of the total conducted with frontline GIDS staff. The review acknowledged the need to address unwarranted variation at GIDS and accepted the need to be more robust in resolving concerns raised by staff. It's also recommended new regular audits of safeguarding practices and social services referrals. But some staff don't feel it went far enough and are not confident in the current management's ability to enact change. Newsnight has seen evidence that the Tavistock's Chief Executive and Chair have been told that the interview transcripts may contain concerns about child protection issues, and they've been encouraged to read them themselves. We showed some of the transcripts to the Children's Commissioner for England and contacted the healthcare regulator, the CQC, about what we'd seen, both were interested in speaking to the people involved. The CQC encouraged anyone with specific safeguarding or safety concerns to contact them directly. It added that it is due to inspect GIDS there because of COVID routine inspections are currently paused until autumn. An official NHS review is underway into how young people visiting GIDS should be best supported. That is good practice taking place at the surface. But for some staff this review cannot be completed soon enough.

10:54
No one from the Tavistock and Portman NHS Foundation Trust agreed to be interviewed on the program. But in a statement the trust said GIDS is a safe and caring service which supports a wide range of children and young people grappling with distress about their gender identity. The Tavistock and Portman NHS Foundation Trust stands by its 2019 review of the service, we are confident that it fairly addressed the issues raised and strongly refute the allegations put to us by Newsnight. Safeguarding is of the utmost importance to the trust. In August 2018, a safeguarding lead was created specifically to reflect the growth in the service. This rule fits within the well understood safeguarding pathway and procedures across the trust. While the trust said that any safeguarding issues that were identified during the review were further investigated and were appropriate, addressed in the reviews recommendations, and that they have kept both NHS England and the Care Quality Commission fully

informed. The trust added that the majority of patients using the service will not be referred to an endocrinology service for consideration for hormone blocking drugs. Well, details of organizations offering information and support but some of the issues raised in that film are available at bbc.co.uk forward slash action line or you can call for free at any time to hear recorded information on 0800 077077
[Ends]


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TIMES INVESTIGATION

# It feels like conversion therapy for gay children, say clinicians

## Ex-NHS staff fear that homophobia is driving a surge in 'transgender' young people

Lucy Bannerman

April 8 2019, 12:01am, The Times




Polly Carmichael is director of the NHS Gender Identity Development Service in north London. The service has been accused of failing to warn young people about the long-term impact of treatment

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Inside the clinic rooms of the Tavistock, the private heartache of a new generation of "transgender" youngsters is being laid bare. There used to be about 50 referrals a year, mainly males with a history of gender issues.

Now there are thousands of young females reporting a sudden gender crisis for the first time. Many are convinced that transition — and the powerful drugs that make it happen — will be the solution to their problems.

Until now the specialists struggling to keep up with caseloads have stayed silent, but alarm over the number of adolescents being prescribed body-altering drugs, has prompted five former clinicians to speak out for the first time.

All five have resigned from the Gender Identity Development Service (GIDS) in the past three years as a matter of conscience.

“This experimental treatment is being done not only on children, but very vulnerable children, who have experienced mental health difficulties, abuse, family trauma, but sometimes those [other factors] just get whitewashed,” one female clinician said. “If someone was suggesting plastic surgery or any other permanent change we’d be saying, hang on a minute.”

The clinicians have warned that complex histories and adolescent confusion over possible homosexuality are being ignored in the rush to accept and celebrate every young person’s new transgender identity.

Clinical psychologists carry out each initial assessment at the Tavistock. They are the gatekeepers who decide whether to refer transgender youngsters to the endocrine clinic for the next stage of treatment. Therapists once had months to work through underlying issues before making decisions on medical intervention, but the clinicians claim that young people are now routinely referred for hormone therapy after as few as three hour-long sessions.

They believe that physically healthy children are being medicated in response to pressure from transgender lobby groups and parental anxieties.

So many potentially gay children were being sent down the pathway to change gender, two of the clinicians said there was a dark joke among staff that “there would be no gay people left”.

“It feels like conversion therapy for gay children,” one male clinician said. “I frequently had cases where people started identifying as trans after months of horrendous bullying for being gay,” he told *The Times*.

“Young lesbians considered at the bottom of the heap suddenly found they were really popular when they said they were trans.”

Another female clinician said: “We heard a lot of homophobia which we felt nobody was challenging. A lot of the girls would come in and say, ‘I’m not a lesbian. I fell in love with my best girl friend but then I went online and realised I’m not a lesbian, I’m a boy. Phew.’”

The specialists expressed concern at how little confusion over sexuality was explored when a young person requested treatment to change their body.

“I would ask who they wanted to have relationships with, but I was told by senior management that gender is completely separate to sex,” a third female clinician said. “I couldn’t get on board with that, because it isn’t. Some people were transitioning their gender to match their sexuality.”

The service said it was “a welcoming place for people from all sections of the LGBT community”, adding that it had made exploration of sexuality a “more explicit” part of the assessment in response to staff concerns.

Nevertheless, the clinician said that her unease grew after meeting an adult woman whose transition to become a man involved having a double mastectomy. She had since changed her mind.

“What can we do? We can’t reverse that. Do we suggest fake breasts?” she said. “We have such a duty of care to these confused young adolescents, but I think we are failing them.”

The clinic rejected the claims. “We always place a young person’s wellbeing at the centre of our work,” it said. “GIDS staff are engaged daily in thinking about the serious ethical dimensions of our practice. The diversity and complexity of individual cases will always be respected.”

Several clinicians suspected that some of the “transgender” adolescents were reacting to homophobia at home.

“For some families, it was easier to say, this is a medical problem, ‘here’s my child, please fix them!’ than dealing with a young, gay kid,” the third female clinician said. At the service’s “family days”, a parent was allegedly heard saying that they did not want their child to have gay friends because they “didn’t want them mixed up in that hedonistic lifestyle”. “It is converting people into heterosexuals,” one of the clinicians said. “We had so many families who would talk about not wanting their daughters to be lesbian.” Young people “repeatedly” confided their own “disgust” that they may be gay, according to the clinician.

In other cases, she felt young people had concluded they were trans because they didn’t fit traditional gender roles.

“Children’s bodies are being damaged in order to treat societal issues,” she warned. She recalled a case of a 13-year-old child “whose parents were really pressurising us for puberty blockers”. When the clinician refused to refer him, she claims one of the parents, a lawyer, wrote threatening legal letters to the service. The child was eventually referred for blockers.

She would have nightmares about her years at the Tavistock. “I would talk about it as an ‘atrocity’. I know that sounds quite strong, but it felt as if we were part of something that people would look back on in the future, and ask, what were we thinking? In the future I think there will be lots and lots of de-transitioners who feel their bodies were mutilated as young people and who will ask, why did you let me do this? It is very disturbing.”

Studies show that the vast majority of youngsters who begin puberty blockers go on to have irreversible hormone treatment

at 16. Some go on to have gender reassignment surgery as adults.

All five clinicians expressed concern over how little young people and their families were being told about the impact of hormone treatment on fertility and sexual function as adults. One claimed young people were unable to give “informed consent” because it was regarded as taboo to discuss the impact of medical intervention on later sexual function in such a young cohort.

The clinic said there were no “taboo” subjects in its work, and that it did not “recognise this allegation as reflecting what happens in the service”. It rejected allegations of conversion therapy and insisted that youngsters were being properly advised on the risks of and about what is unknown about medical intervention. Time and care was taken at every stage to ensure that individuals grasped the potential consequences of their choices, it said, adding that the service had become “increasingly aware” of the need to discuss the impact of treatment on future sexual function.

The GIDS’s own internal review identified procedures around consent as an area of concern. It has recommended that written consent should be obtained before referral for blockers.

Another clinician described how youngsters entered his room enthusing about Alex Bertie, a transgender YouTuber, and *My Life: I Am Leo*, a documentary about a transgender teen broadcast in a teatime slot on CBBC.

“These are very simplified stories about how easy it would be to transition into being trans. . . that transition is a solution to feeling shit. That is very appealing to lots of teenagers,” the first male clinician said. I felt for the last two years what kept me in the job was the sense there was a huge number of children in danger and I was there to protect them from the service, from the inside.”

One female clinician estimates that she referred about 50 young people for puberty blockers. She now believes she referred too many. Their outcomes remain unclear. “When you start them on puberty blockers, you’re putting them on a pathway that

could lead to sexual dysfunction problems and, for the younger kids, will definitely make them infertile. In what other specialism would physical intervention that leads to permanent change to the body be the first line of treatment for a vulnerable child? Activists will tell you it's unethical not to intervene. But we know that not everyone with gender dysphoria will go on to identify as trans for the rest of their lives."

One case has haunted her. "All the pushing was coming from the father to put the kid on puberty blockers. Thinking back on it now, I fear that the father was a paedophile and the child was being abused." There is no suggestion the service knowingly ignored the case, and the outcome is unknown.

The clinic, which is run by the Tavistock and Portman Foundation Trust and whose director is Polly Carmichael, says it is tracking the progress of 44 young people who began puberty blockers in 2011, and that all available evidence is discussed with families. "This is a rapidly developing field and psychosocial and medical professionals are working hard to ensure that we respond to emerging evidence in an appropriate and considered way," a spokesman said. The growing body of international evidence showed that "thus far, there is little reported evidence of harm," he added.

"The service undertakes careful assessments over time and continues to see young people whether or not they attend the endocrine clinic following this assessment," the spokesman said.

The clinic said it was aware of concerns and tensions between different perspectives raised by staff and "clinicians have a duty of care to raise safeguarding concerns", adding that there were "safe spaces" and structures in place for staff to discuss anything that worried them. It would not comment on specific cases but stressed that a young person's motivations and choices were discussed at each step.

What began in 1989 as a specialist clinic for gender issues is now under intense scrutiny. A report by David Bell, a former governor at the trust, revealed ethical concerns over "woefully inadequate care". Staff were furious with the GIDS executive's

response to the report, which stated that its own review found no safeguarding concerns.

The whole service should have been halted when the number of "transgender" cases first exploded, one of the clinicians said. "That's the point we should have stopped because we didn't know what we were doing. Are we a service for kids with gender dysphoria, a medical disorder? Or are we a service for 'transgender kids'?"

A GIDS spokesman said: "We are aware of tensions between different perspectives. These differences are inevitable in such complex work."

One clinician said it was understandable if her former employer was defensive, saying: "If they are getting it wrong, you have to ask, are they making kids infertile by mistake? Because if they are to truly acknowledge [our concerns], then they will have to ask themselves, what the f*** have we done to thousands of children?"

Gires, GI and Mermaids all denied they viewed transition as a cure-all or that they exerted any undue pressure. Susie Green of Mermaids said the charity "does not encourage parents to demand any particular treatment." Gendered Intelligence said the allegations against it were "unfounded". Bernard Reed, founder of Gires, said: "In medical literature . . . failure to provide timely treatment is described as 'psychological torture'. As far as we are aware, GIDS has adequate safeguards against irreversible treatments being given inappropriately."

Law






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the early modern period in Scotland. I hope she would also extend some sympathy to the vict mostly women, but also men—are vilified, cancelled, professionally destroyed or physically threatened for their beliefs. They are people who simply believe in a biological difference between men and women. I pay particular tribute to the hon. Member for Canterbury (Rosie Duffield) and the hon. and learned Member for Edinburgh South West (Joanna Cherry) for their courage on this topic. I call attention to the interim report from Dr Hilary Cass, which is just out, which highlights the vertiginous increase in young teenage girls presenting as trans. I am afraid I do not believe that we have suddenly discovered a whole new population of trans people who were repressed or denied. I fear that, by telling people that they can change sex, we are further confusing a lot of very confused young people at the most confusing time of their life.

Just as great a concern is the biological males deciding in adulthood that they want access to women-only spaces. I echo the points made by my hon. Friends the Members for Harwich and North Essex (Sir Bernard Jenkin) and for Thurrock (Jackie Doyle-Price). I hope there is some value in a man saying that. I think that trans activism is a new form of misogyny. It involves the essential denial of reality. I think we need a legal definition of what a woman is. A woman is an adult female. It is a biological and immutable reality and it is time to recognise that in the law.

## 3.56pm

**Joanna Cherry** >

(Edinburgh South West) (SNP)

Share

I am pleased to follow the hon. Member for Devizes (Danny Kruger). There are many things about which we disagree, but there are some things about which we agree, and I thank him for his kind comments. I congratulate the right hon. Member for Basingstoke (Mrs Miller) on securing this debate, and the many hon. Members who have made interesting and valuable contributions, especially my hon. Friend the Member for Motherwell and Wishaw (Marion Fellows), who is such a doughty campaigner for disability rights and the rights of disabled women in particular.

During this International Women's Day debate, it is the women of Ukraine who should be uppermost in our minds. This morning I and other female MPs—a cross-party group—met the Ukrainian ambassador's wife. She impressed on us the terrible burden that Ukrainian women face as they flee their country with their children, often leaving their male relatives behind and uncertain of their destination. The majority of the now millions of refugees fleeing Ukraine are women and children, and they need visa-free access to the United Kingdom with their children. We must match the European Union on this, no ifs and no buts. Let's get on with it.

Women are particularly vulnerable in war because of their sex. This is because women are particularly vulnerable to sexual violence at the hands of men. That violence is sex-based and directed at women because of our biology and the fact that we are weaker than men. Sex matters. I do not know why we call it gender-based violence, because it is not gender-based violence; it is sex-based violence. Gender is a social construct. Sex is a material reality. I would like to hear us talk more about sex. I would like to hear us talk about the sex-based pay gap. I would like to hear us talk about the fact that, as Professor Alice Sullivan has said so powerfully in *The Guardian* today, it is mothers and not fathers who bear the burden of parenthood. Research shows that men often get a pay premium as a result of parenthood, but women's pay goes down.

I would also like us to be able to say, as is the case in law, that lesbians like myself are same-sex attracted women, not same-gender attracted. What you cannot define you cannot protect, and what you cannot name cannot be properly discussed and debated. That is why the stealthy erasure of sex-based language from our statute book and public and private policy making should be resisted.

It is also why politicians and policy makers should be precise in their language, and should not conflate sex and gender.

Last month, one of Scotland's Supreme Courts reminded lawmakers that reference to the protected characteristic of sex in the Equality Act 2010 is a reference to a man or a woman for which purpose

"a woman is a female of any age."

The court said:

"Provisions in favour of women"

based on the protected characteristic of sex

"by definition exclude those who are biologically male."

That is the law. I am quoting from paragraph 36 of the judgment by the highest court in Scotl Limited against the Lord Advocate and the Scottish Ministers. So I defy anyone to claim that what I have just said is transphobic. It is not; it is the law, and it is based on the Equality Act, which also protects trans people from discrimination by means of the very widely drawn protected characteristic of gender reassignment.

The Equality Act was passed by the Labour party; all credit to them for doing so. I know that the right hon. and learned Member for Camberwell and Peckham (Ms Harman)—who is not in the Chamber, but for whom I have the highest regard—was instrumental in the passing of that Act. It is also hugely valued by my party, so much so that when our current First Minister was drafting the constitution for an independent Scotland in 2014, she decided to enshrine in that constitution the protections afforded to women and the other protected characteristics in the Equality Act. It was going to be part of the fundamental law of Scotland. I think it would be good if more Scottish politicians remembered that and celebrated it.

I want to quote from an excellent column in today's *Telegraph*. I am not in the habit of buying or reading the *Telegraph*, although a very dear friend of mine—who is now dead—used to say that she bought it every day so that she would have something reliable with which to disagree. However, this is a very good column by Suzanne Moore, who says:

"Words matter, because women naming ourselves and our experience matters. As the American social reformer and women's rights activist Susan B Anthony had it: 'No self-respecting woman should wish or work for the success of a party who ignores her sex.'"

And, in my view, no self-respecting woman should wish or work for the success of a political party that makes her rights as a woman or a lesbian conditional on her acceptance of gender identity politics. My rights as a woman and a lesbian are not conditional on my accepting gender identity politics. Nevertheless, as a member of the advisory group of the organisation Sex Matters—and I refer the House to my entry in the Register of Members' Financial Interests in this respect—I am aware of many cases across the United Kingdom of women being harassed and investigated at work for expressing gender-critical views.

Now, however, we can fight back. Thanks to the courage and resilience of a woman called Maya Forstater and her legal team, we have an Employment Appeal Tribunal ruling that gender-critical beliefs are protected under the Equality Act. That was a major victory for freedom of belief and freedom of speech across these islands. Professor Jo Phoenix of the Open University and postgraduate student Raquel Rosaria Sanchez of Bristol University are just two of the brave women who are taking their universities to court for failing to defend them from harassment because of their gender-critical views. Across the United Kingdom, many women, and indeed men, are now taking their employees, and membership organisations such as the Green party of England and Wales, to court for discriminating against them on the grounds of their belief that sex is real and immutable.

I say to all the gender-critical women who are watching this debate today that we are starting to win this debate, and people like me will not give up no matter what is thrown in our road. Maya Forstater's win is not the only significant one since the last International Women's Day. I have already mentioned For Women Scotland's win in Scotland's Supreme Courts; Fair Play for Women also achieved a major court victory in a case about the meaning of "sex" in the census in England and Wales, although it was not so successful in Scotland.

**Sir Bernard Jenkin** ›

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The hon. and learned Lady is making a terrific speech. Would she agree that men have to stand up for women's rights, too? There are too many men who stand back from this debate and say, "Oh well, this is a women's issue. I'm not going to get involved." I think that is a shame, and that is why I spoke in today's debate.

**Joanna Cherry** ›

Share

I entirely agree with the hon. Gentleman. Even worse, there are many men—young men—involved in this debate who have embraced a new form of misogyny. I know that to my cost, and I hope that that will start to change.

But I am trying to be positive, and I want to list a couple of the other successes there have been in the last year for gender-critical women such as myself. My friends at the LGB Alliance are registered as a charity now, and they held a major conference that was attended by many parliamentarians. I see some of them here today. Sadly, however, a straight, married Member of this House saw fit to protest outside the conference, which was organised by lesbians to discuss the rights of same-sex-attracted people. I thought I had seen the last of that sort of lesbophobia in the '90s, but it turns out I was wrong. I repeat that lesbian rights are not conditional on our accepting gender identity theory.

on our accepting gender identity theory.

Another positive development has been the Equality and Human Rights Commission entering the debate on self-identification and on how to frame the quite appropriate ban on conversion therapy. The commission entered the debate with a voice of calm common sense, reminding us that human rights are universal and that all protected characteristics under the Equality Act deserve protection. Others have mentioned the very welcome interim report on the Cass review today, and I hope the Minister will be able to assure us

that the Government will look carefully at that report and look into the alarming phenomenon of so many young women feeling so uncomfortable with their identity as women as they go through puberty in our society that they feel they have to change their identity to cope with those pressures.

**Sir Peter Bottomley** ›

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Can I make two points to, and through, the hon. and learned Lady? First, Suzanne Moore ought to have been able to write her column for *The Guardian*, and I hope that *The Guardian* will report the hon. and learned Lady's speech in full tomorrow and explain why Suzanne Moore cannot publish her thoughts in her own newspaper, as it once was. Secondly, on the LGB Alliance conference, which I attended, I went up to some of the people protesting outside and asked if they had read the book "Trans" or the book "Material Girls". They said no. I invited them to join me in asking Liam Hackett, the chief executive of the anti-bullying charity Ditch the Label, if he would withdraw his words describing Kathleen Stock as a dangerous extremist for giving her plain views on women's rights.

**Joanna Cherry** ›

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I agree with what the hon. Gentleman says, and I am proud to call Professor Kathleen Stock a friend. She is an admirable scholar, a feminist and a lesbian who has written carefully about these issues, and the way she has been traduced by students at her university and, sadly, by some politicians in one of my favourite cities, Brighton, is absolutely disgraceful. I want to be positive today, however, and I think that on this issue the tide is turning. I am living proof that cancellation does not always work.

Just before I sit down, I have a couple of questions for the Minister. Will she back the Equality and Human Rights Commission to produce solid guidance on the definitions of protected characteristics and single-sex services? A lot of the harassment I have described stems from women setting out the case for single-sex services and then facing wrongful accusations of transphobia. Secondly, will she push for Government Departments to end the use of external human resource benchmarking schemes for legal compliance with the Equality Act? As we saw in the Akua Reindorf report from Essex University, some external benchmarks—sadly, some from Stonewall, of which I used to be, but no longer am, a supporter—have been wrong in law. Finally, once the EHRC has published some decent guidance, will she review civil service HR policies to ensure that they are in line with the law of the land under the Equality Act, rather than in line with prejudiced lobbying groups?

4.09pm

**Laura Trott** ›

(Sevenoaks) (Con)

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It is a pleasure to follow the hon. and learned Member for Edinburgh South West (Joanna Cherry), and I salute her courage in talking about these issues. They are not always easy, but they must be discussed.

I congratulate my right hon. Friend the Member for Basingstoke (Mrs Miller) on securing this important debate. Many important topics have been discussed today, not least early access to telemedicine for early-stage abortion, which merits much further discussion in this House, but I will concentrate on a topic that my right hon. Friend the Member for Romsey and Southampton North (Caroline Nokes) so movingly covered: women and girls in Ukraine.

Images from war are often characterised by tanks, physical destruction and the loss of life in combat, but conflict is as much about those on the sidelines as about those on the frontline. We know from history that, in war, rape is routinely used as a weapon—a barbaric weapon. It causes incomprehensible damage to victims, it subjugates women through fear and stigma, and children born as a result of these violent acts often struggle with issues of identity.

Sexual violence in conflict has rightly been recognised as a war crime by the International Criminal Court. Such violence has been a

stain on our history, and I am appalled that we are already hearing reports of history repeating itself. At a recent online event hosted by Chatham House, the Ukrainian Foreign Minister reportedly shared details of how Russian soldiers are raping Ukrainian women in the occupied territories. Julie Bindel, the investigative journalist, has reported that well-known porn sites have had new videos uploaded by Russian soldiers documenting disgustingly brutal crimes. We cannot let these atrocities go unpunished.

Under the leadership of this Government, and following an initiative spearheaded by the noble Lord Hague, there has been a great deal of progress to end sexual violence in conflict. The integrated review set out clearly the mission to "strengthen justice for survivors", the G7 communiqué set out plans to prevent and end sexual violence against women and girls in conflict, and last year the UK, alongside its allies, issued a strong statement that the use of sexual violence as a weapon in conflict is a red line akin to the use of chemical weapons. The Prime Minister has spoken strongly in this place to say that sexual violence in conflict will not be tolerated and that those who are found to have committed it will be punished.

The challenge for all of us in this place is that, to achieve this, survivors in Ukraine must come forward and we must have a co-ordinated international approach to collect the evidence. We all know that we have challenges domestically in encouraging women to come forward to be heard, but imagine the fear of coming forward for a woman who has not only been abused but whose country has been invaded—by Russia, which effectively decriminalised domestic violence in 2017.

We must now send a clear message to the women of Ukraine that they will be supported. Our actions must be stronger than just words: we must collate the evidence; we must engage with the International Criminal Court; and we must prosecute. None of us can allow this to pass us by. We all have a responsibility. On this International Women's Day we must say that sexual violence in conflict is not inevitable, and we must never allow it to be inevitable.

## 4.12pm

**Bell Ribeiro-Addy** >
(Streatham) (Lab)

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It is a pleasure to participate in this debate and to celebrate the trailblazers who made it possible for so many women to come through these doors and sit on these Benches: the women who fought, protested, sacrificed and put their lives on the line in their effort to secure gender equality and to grant women the right to go to school, to work, to vote, to open a bank account in our own name, which is such a simple thing, and so many other rights that we could not bear to live without. I argue those women would want us not just to celebrate but to continue agitating, because there is still a long way to go and more to be done if we are to get to a state where women can truly be considered equal to men.

This year, as on every International Women's Day, organisations have taken to social media to share their commitment to gender equality and to breaking the bias, which is this year's theme. In response, the "Gender Pay Gap Bot" Twitter account tweeted the pay gap of those organisations. Some organisations could hold their head high, such as Contact Company, Abbeycroft Leisure, St John Ambulance and a few others, but unfortunately these organisations were in the minority.

In 2022, we still live in a society in which 83% of the UK's most popular jobs have a gender pay gap. Recent Labour party analysis shows that, at the current rate of progression, the gender pay gap will not close until 2059. We need urgent action to change the system and address pay inequality, which is not just plain wrong but leaves so many women vulnerable to abuse.

The representation of women in senior positions, right across society, is still woefully low. I am proud to be part of a parliamentary Labour party that is 51% women. I will not pretend that that happened overnight, but when the time came, we did not wait for attitudes to change and we did not rest on platitudes. We took action to increase representation, and the result is someone like myself, who is the product of an all-women shortlist. This is a parliamentary party that reflects society not only in its make-up, but in the quality of debate and in the policies that are put forward.

So to all those in organisations across the country who are wringing their hands and saying, "Oh, it's so hard. What do we do on women's equality?", I say, "You are just making excuses". Change does not come just because time goes on; it is something that people have to make happen. Because of the work of women in this House and across society, enforcing equality has never been easier, as we have best practice, policy and legislation—all these different things—at our disposal.

In 2022 the under-representation of women in senior roles and a gender pay gap is a choice. So I will not applaud all the colourful social media bits that have been put up by different organisations, and the events and seminars for women that have gone by in past days. I will not applaud those organisations for saying that they are trying, because they are just failing. The ones that continue to preside over these situations have made a choice. Their choice has been to discriminate against women every single day, and they should be thoroughly ashamed of themselves.



It is right that we have discussed domestic gender inequality, as that is obviously extremely important, but we must remember that

we are celebrating International Women's Day, which is a day for all women, wherever they a
to the plight of women in Ukraine who are facing Putin's aggression: those women we all saw this morning in the maternity hospital; those left behind in the country, as so many women often are in this situation; and those who have fled and are currently being denied asylum by countries such as ours, alongside refugees from other countries who are also fleeing war and persecution. My hon. Friend the Member for Poplar and Limehouse (Apsana Begum) was right to say that no one could claim to support standing up for all women if we allow a heinous piece of legislation such as the Nationality and Borders Bill to go ahead, which will only worsen the situation for some of the most vulnerable women in the world.

Finally, I worry about a movement for women's equality and a feminism that does not represent all women, of all classes, nationalities and races. I was sad to hear black women speak of being feminists but not being able to call themselves such because they do not believe that movements for women's equality typically represent their experiences as black women. When the majority of women in the world are of colour, a women's movement that does not recognise the impact that racism plays, and the fundamental role it has in increasing inequality among women, is not truly a movement that represents all women, and it is not worth what it says it is worth. That is not acceptable. The idea that we should fight for women's equality but make concessions for a certain group of women first, and then later we can get to this other group of women, has been the bane of the women's equality movement, and that absolutely has to change. We have to demand equality for all women and we have to do it right now.

In this country at the moment the equality we seek for women does not have to be so hard. In 2022, if your organisation continues to preside over under-representation and a gender pay gap, it is simply just trash. If you are not actively a part of the solution to end gender inequality, you are simply just another part of the problem.

4.18pm

**Wera Hobhouse** ›

(Bath) (LD)

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I want to echo the opening remarks of the right hon. Member for Basingstoke (Mrs Miller). She is absolutely right: today we stand in solidarity with the women of Ukraine. Our hearts go out to them in their suffering, and we stand in awe of their bravery and resilience. Women are all too often the most vulnerable, and they are the real victims of war and conflict. The hon. Member for Sevenoaks (Laura Trott) has just made a passionate speech about that. Globally, an estimated 736 million women have experienced sexual violence—that is one in three of us. More than 80,000 women were murdered in 2020, most at the hands of a close relation. Violence extends to children, too; 60 million girls are being sexually assaulted on their way to school every year. Those are not just numbers—they are human beings who feel pain and fear, and are being traumatised throughout their lives.

UN Women notes that violence disproportionately affects low-income countries, but our country is no beacon when it comes to women's safety. Last week was the very sad first anniversary of Sarah Everard's horrific murder by a Metropolitan police officer. The police response to the Clapham Common vigil was violent, too. Today, we are still waiting to hear of serious steps to stamp out misogyny in the Met once and for all, but it is not just about police forces. Misogyny is deeply ingrained in our culture, being present everywhere from schools to nightclubs to the courts.

Drink spiking has received a lot of public attention recently. It is a particularly vile form of violence against women and girls. One third of women have been spiked or know someone who has been.

The Government's end-to-end rape review laid bare the failures of the criminal justice system. Last year, less than 2% of rape cases ended in conviction, adding insult to injury for survivors who find the strength to come forward and report rape—which only one in six women actually do, because they mistrust the system. No wonder they do.

What has been done in the past year to break the bias and to ensure that nobody is disadvantaged by their gender? Well, not enough. While racism and homophobia are considered hate crimes, misogyny is not, despite nearly every woman having experienced gender-based harassment. We have discussed it in the House, but I am still convinced that misogyny must become a hate crime. Although such a measure would not be a silver bullet, there are many reasons why it would mean progress: it would allow for the more accurate collection of data on harassment and make the collection of such data mandatory; it would set a precedent that such behaviour is unacceptable; it would curb the street harassment that 68% of all women experience on a near daily basis; and it would stamp out low-level behaviour based on misogyny so that it would not lead to much more serious offences based on misogyny.

Misogyny needs to be tackled in all settings. I have previously talked about the provision of age-appropriate education on consent in schools. The delivery of age-appropriate relationship education by experts in every school would be a very good start. It cannot be left to a postcode lottery. Some schools do it very well but, as I have said before, it cannot be for maths or language teachers to do such important work. It has to be delivered by experts.

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> It is not the full text of the charity's governing document.

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TO RELIEVE THE MENTAL AND EMOTIONAL STRESS OF ALL PERSONS AGED 19 YEARS AND UNDER WHO ARE IN ANY MANNER AFFECTED BY GENDER IDENTITY ISSUES, AND THEIR FAMILIES, AND TO ADVANCE PUBLIC EDUCATION IN THE SAME.

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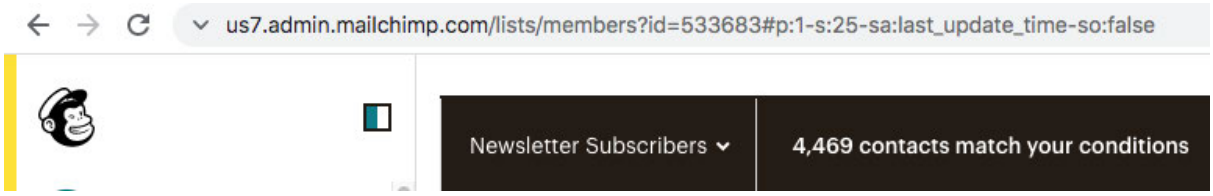
**Consortium of Lesbian, Gay, Bisexual and Transgender Voluntary and Community Organisations**
Company Number: **3534603**
Charity Number: **1105502**
**Registered Address:** Zone 5, Wrentham Business Centre, Prospect Park, Exeter, EX4 6NA

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LGB Alliance's Twitter account currently has over 48,000 Twitter followers and 8575 on Facebook, with 7315 page "likes". At present (Feb 2022), 4,487 people have signed up to our mailing list, and our first conference, at the QEII Centre in October 2021, was attended by just under 500 people and the recording made available free of charge online. We were showered with positive responses to this event.

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NEWS

10th June 2021

# Maya Forstater wins landmark employment case on gender critical beliefs



By Tom Gordon | @HTScotPol
Scottish Political Editor

UPDATED




Woman accused of transphobia wins landmark employment case

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**AN ally of JK Rowling who lost her job after tweeting that "male people are not women" has won a landmark employment case.**

The victory for Maya Forstater, who was also backed by SNP MP Joanna Cherry QC, means people with 'gender critical' beliefs must not be sacked simply for holding them.

However, they cannot express them in a way that discriminates against trans people.

The tribunal acknowledged "some trans people will be disappointed" by its

Ms Forstater said she was "delighted to have been vindicated", adding: "I'm proud of the role I've played in clarifying the **law** and encouraging more people to speak up".

However her former employer said the decision was "a step backwards for inclusivity and equality for all", and it was considering its legal options.

However Ms Cherry said the decision should end discrimination against academics, trade unionists and others like herself who had been bullied and threatened because of their beliefs.

Ms Rowling also retweeted Ms Forstater's response.

The decision comes just a day after student Lisa Keogh was cleared of wrongdoing for saying women have vaginas after an investigation by Abertay University.

**READ MORE: Abertay University student Lisa Keogh cleared after being investigated for saying women have vaginas**

Ms Forstater, 47, from St Albans in Hertfordshire, was a tax expert at the Centre for Gobal Deveolpment thinktank until losing her job in March 2019 after posting


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Appeal No. UKEAT/0105/20/JOJ

# EMPLOYMENT APPEAL TRIBUNAL

ROLLS BUILDING, 7 ROLLS BUILDINGS, FETTER LANE, LONDON, EC4A 1NL

At the Tribunal
on 27 & 28 April 2021
Handed down on 10 June 2021

**Before**

**THE HONOURABLE MR JUSTICE CHOUDHURY (PRESIDENT)**

**MR C EDWARDS**

**MRS M V MCARTHUR BA FCIPD**

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MAYA FORSTATER — APPELLANT

(1) CGD EUROPE
(2) CENTER FOR GLOBAL DEVELOPMENT
(3) MASOOD AHMED — RESPONDENTS

(1) INDEX ON CENSORSHIP
(2) EQUALITY AND HUMAN RIGHTS COMMISSION — INTERVENORS

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Transcript of Proceedings

JUDGMENT

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## APPEARANCES

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**SUMMARY**

**TOPIC NUMBER 26: RELIGION OR BELIEF DISCRIMINATION**

The Claimant holds gender-critical beliefs, which include the belief that sex is immutable and not to be conflated with gender identity. She engaged in debates on social media about gender identity issues, and in doing so made some remarks which some trans gender people found offensive and "transphobic". Some of her colleagues at work complained that they found her comments offensive, and, following an investigation, her visiting fellowship was not renewed. The Claimant complained that she was discriminated against because of her belief. There was a preliminary hearing to determine whether the Claimant's belief was a philosophical belief within the meaning of s.10 of the Equality Act 2010 (EqA). The Tribunal held that the belief, being absolutist in nature and whereby the Claimant would "refer to a person by the sex she considers appropriate even if it violates their dignity and/or creates an intimidating, hostile, degrading or offensive environment", was one that was "not worthy of respect in a democratic society". Accordingly, the Tribunal concluded that the belief did not satisfy the fifth criterion in **Grainger plc v Nicholson** [2010] ICR 360 ("Grainger V"). The Claimant appealed.

**Held**, **allowing the appeal**, that the Tribunal had erred in its application of Grainger V. A philosophical belief would only be excluded for failing to satisfy Grainger V if it was the kind of belief the expression of which would be akin to Nazism or totalitarianism and thereby liable to be excluded from the protection of rights under Articles 9 and 10 of the **European Convention of Human Rights** (ECHR) by virtue of Article 17 thereof. The Claimant's gender-critical beliefs, which were widely shared, and which did not seek to destroy the rights of trans persons, clearly did not fall into that category. The Claimant's belief, whilst offensive to some, and

notwithstanding its potential to result in the harassment of trans persons in some circumstances, fell within the protection under Article 9(1), ECHR and therefore within s.10, EqA.

However:

a. This judgment does **not** mean that the EAT has expressed any view on the merits of either side of the transgender debate and nothing in it should be regarded as so doing.

b. This judgment does **not** mean that those with gender-critical beliefs can 'misgender' trans persons with impunity. The Claimant, like everyone else, will continue to be subject to the prohibitions on discrimination and harassment that apply to everyone else. Whether or not conduct in a given situation does amount to harassment or discrimination within the meaning of EqA will be for a tribunal to determine in a given case.

c. This judgment does **not** mean that trans persons do not have the protections against discrimination and harassment conferred by the EqA. They do. Although the protected characteristic of gender reassignment under s.7, EqA would be likely to apply only to a proportion of trans persons, there are other protected characteristics that could potentially be relied upon in the face of such conduct.

d. This judgment does **not** mean that employers and service providers will not be able to provide a safe environment for trans persons. Employers would continue to be liable (subject to any defence under s.109(4), EqA) for acts of harassment and discrimination against trans persons committed in the course of employment.

**THE HONOURABLE MR JUSTICE CHOUDHURY**

**Introduction**

1. The Claimant holds the belief that biological sex is real, important, immutable and not to be conflated with gender identity. She considers that statements such as "woman means adult human female" or "trans women are male" are statements of neutral fact and are not expressions of antipathy towards trans people or "transphobic". Some of the Claimant's colleagues found the Claimant's statements on Twitter offensive and complained. When her consultancy contract was not renewed, she brought proceedings before the Central London Employment Tribunal ("the Tribunal") on the basis that, amongst other claims, she had been discriminated against because of her belief. After a six-day Preliminary Hearing, the Tribunal concluded that the Claimant's belief, having regard to its "absolutist" nature, whereby she would "refer to a person by the sex she considers appropriate even if it violates their dignity and/or creates an intimidating, hostile, degrading or offensive environment", was one that was "not worthy of respect in a democratic society". Accordingly, the Judge found that the Claimant's belief was not a "philosophical belief" within the meaning of section 10 of the **Equality Act 2010** ("EqA"). The sole issue in this appeal is whether the Tribunal erred in law in reaching that conclusion.

2. The issue is one that has generated strong feelings, with each side making dramatic claims as to the effect of upholding or reversing the Tribunal's judgment. The Claimant suggests that the effect of the Tribunal's conclusion is "Orwellian" in that it requires her to refer to a trans woman as a woman even though she does not believe that to be true; and the Respondents contend that to overturn the Tribunal's conclusion would mean that no trans person would be safe in any workplace from the harassment inherent in being "misgendered", that is to say being referred to by non-preferred pronouns or by a different gender to that in which they are living. Such positions

A are reflective of the debate in wider society about the rights of trans persons, which is often conducted in hyperbolic and intransigent terms. We wish to make clear at the outset that it is not the role of this Employment Appeal Tribunal to express any view as to the merits of either side of that debate (which we shall refer to as the "transgender debate"); its role is simply to determine whether, in reaching the conclusion that it did, the Tribunal erred in law. Our judgment should not therefore be read as providing support for or diminishing the views of either side in that debate.

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3. In taking that approach, we do not in any way seek to ignore or downplay the difficulties faced by trans persons seeking merely to live their lives peacefully in the gender with which they identify, irrespective of their natal sex. The regrettable reality for many trans persons, however, is that something which most take for granted - the sense of self and autonomy in identity – is under constant challenge and attack. As stated in the Equal Treatment Bench Book:

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> **"15. Awareness, knowledge and acceptance of gender-variant people such as those who are transgendered or gender-fluid has greatly increased over the last decade. Unfortunately, however, there remains a certain mistrust of non-conventional gender appearance and behaviour and many people experience social isolation and/or face prejudice, discrimination, harassment and violence in their daily lives – in schools and places of further education, in the workplace, and whilst being customers and service users. Some people experience rejection from families, work colleagues and friends. Some experience job or home loss, financial problems and difficulties in personal relationships.**
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> **16. Many trans people avoid being open about their gender identity for fear of a negative reaction from others. This applies in all contexts, but particularly when out in public because of safety issues. There is often concern about online privacy, perpetuated by a fear of being 'outed' online and having no control over the content shared.**
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> **17. A survey for the TUC of over 5,000 LGBT employees in the first half of 2017 found that almost half of transgender respondents had experienced bullying or harassment at work and that 30% had had their transgender status disclosed against their will. A 2017 ACAS research paper confirmed that workplace bullying is common and that many staff identified as transgendered experience it on a daily basis. The ACAS report also found that the level of bullying may be higher than other rates of bullying related to, for example, sexual orientation, and that transgender staff may look for another job rather than endure the costs and emotional labour of going to tribunal or court. The limited protection of the Equality Act 2010, which only covers those who are undergoing or have undergone (or who are perceived to be undergoing or to have undergone) gender reassignment, means non-transitioning, non-binary or otherwise gender non-conforming people are particularly vulnerable.**

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> **18. In a poll of 1,000 employers across a variety of industries in June 2018, one in three employers admitted they were less likely to hire a transgender person and 43% were unsure if they would.**
> **19. Social isolation, social stigma and transphobia can have serious effects on transgendered people's mental and physical health. Research shows that levels of self-harm and suicide ideation among young trans people and trans adults are much higher than for cisgender people (those whose gender identity corresponds to the gender assigned to them at birth).**
> **20. The coronavirus pandemic with its lockdown and periodic restrictions has had a particularly damaging effect on trans people. Research shows a high level of mental ill health, caused by increased discrimination and hate crime, isolation and reduction in peer group support, in some cases being required to stay at home with transphobic families, and reduction in access to specialised medical or advice services."**

4. The vulnerability of many trans persons is something we bear very much in mind. This case, however, is not about whether greater protection ought to be afforded to trans persons under the EqA, the Gender Recognition Act 2004 ("GRA") or otherwise; such legislative steps being a matter for Parliament and not for the Court. This appeal is about the much narrower issue of whether the Claimant's belief as to the immutability of sex is one that amounts to a philosophical belief under s.10, EqA. For the reasons we set out below, we have come to the conclusion that it does. That does not mean, however, that those with gender-critical beliefs can indiscriminately and gratuitously refer to trans persons in terms other than they would wish. Such conduct could, depending on the circumstances, amount to harassment of, or discrimination against, a trans person.

5. With those introductory remarks out of the way, we proceed with our judgment, which is structured as follows:

a. Background
b. The Tribunal's Judgment
c. The Legal Framework
d. The Grounds of Appeal
e. Parties' Outline Submissions
f. Discussion and Analysis

g. Conclusion

h. Note on Procedure.

6. The Claimant is represented in this appeal by Mr Ben Cooper QC and Ms Anya Palmer and the Respondents are represented by Ms Jane Russell. Ms Palmer and Ms Russell both appeared below. Permission to intervene was granted to Index on the Censorship ("IoC"), represented by Ms Aileen McColgan QC and Ms Katherine Taunton, and to the Commission for Equality and Human Rights ("the Commission"), represented by Ms Karon Monaghan QC. Ms Monaghan made it very clear that the Commission is not taking a position on any matter of controversy, its submissions being confined (like the decision of the EAT) to whether the Tribunal erred in law. We are grateful to all Counsel for their helpful and illuminating submissions.

**Background**

7. The Second Respondent is a not-for-profit think tank based in the US which focuses on international development. The First Respondent is a separate but closely linked organisation based in the UK. The Third Respondent is the President of the Second Respondent.

8. The Claimant is a researcher, writer and adviser on sustainable development. She was appointed a visiting fellow of the First Respondent in November 2016. That appointment was renewed in 2017. In that capacity, the Claimant carried out paid consultancy work on specific research projects.

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9. The Claimant has an active presence on social media and regularly posts comments relating to the transgender debate. In July 2018, the Government launched a consultation on proposed amendments to the GRA which would have made legal recognition of self-identified gender easier. The Claimant was concerned by the proposed amendments to the GRA, and from around August 2018, she began to express her beliefs about those issues and her views relating to the transgender debate generally on her personal Twitter account. It is not necessary to set out all of the relevant Tweets in detail in this judgment as they are set out in the judgment below. It suffices for present purposes to refer to the following extracts:

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a. On 2 September 2018, the Claimant tweeted about the GRA stating:

> **"I share the concerns of @fairplaywomen that radically expanding the legal definition of 'women' so that it can include both males and females makes it a meaningless concept, and will undermine women's rights and protection for vulnerable women and girls…**
> **Some transgender people have cosmetic surgery. But most retain their birth genitals. Everyone's equality and safety should be protected, but women and girls lose out on privacy, safety and fairness if males are allowed into changing rooms, dormitories, prisons, sports teams."**

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b. Later that month, the Claimant made a number of comments about Pips/Philip Bunce, who is a senior director at Credit Suisse and describes himself as being "gender fluid" and "non-binary". These included:

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> **"Bunce does not 'masquerade as female' he is a man who likes to express himself part of the week by wearing a dress"**
> **"Yes I think that male people are not woman. I don't think being a woman/female is a matter of identity or womanly feelings. It is biology"**
> **"Bunce is a white man who likes to dress in women's clothes".**

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c. Also in that month, when challenged about what she had said about Pips Bunce, the Claimant stated in a conversation on Slack (an online communication platform):

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> **"You are right on tone. I should be careful and not necessarily antagonistic. But if people find the basic biological truths that "women are adult human females" or "trans-women are male" or offensive, then they will be offended.**
> **Of course in social situations I would treat any trans-woman as an honorary female, and use whatever pronouns etc… I wouldn't try to hurt anyone's feelings but I don't think people should be compelled to play along with literal delusions like "trans-women are women"."**

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d. In a letter to Anne Main MP on 30 September 2018, the Claimant invited Ms Main MP not to support the proposed new GRA and said:

> **"Please stand up for the truth that it is not possible for someone who is male to become female. Trans-women are men, and should be respected and protected as men."**

10. In late September or early October 2018, some staff of the Second Respondent (and, later, some staff of the First Respondent) raised concerns about some of the Claimant's tweets, alleging that they were "trans-phobic", "exclusionary or offensive" and were making them feel "uncomfortable". An investigation into the Claimant's conduct followed, the end result of which was that the Claimant was not offered further consultancy work and her visiting fellowship was not renewed. The Claimant lodged proceedings in the Tribunal alleging, amongst other matters, direct discrimination because of her "gender-critical" beliefs and/or harassment related to those beliefs.

11. The Tribunal directed that there be a Preliminary Hearing to determine, amongst other matters, whether the belief relied upon by the Claimant amounts to a philosophical belief within the meaning of s.10, EqA, and whether she was in "employment" within the meaning of s.83(2)(a) EqA. Those issues came before the Tribunal between 13 and 21 November 2019, although, in the event, there was only time to consider the belief issue.

**The Tribunal's Judgment**

12. In what is (given the length of the hearing) an admirably concise and sensitively written judgment sent to the parties on 18 December 2019, the Tribunal concluded that the "specific belief that the Claimant holds as determined in the reasons, is not a philosophical belief protected by the Equality Act 2010."

13. At para 39 of the Judgment, the Tribunal set out the Claimant's evidence as to her belief:

**"39. In the Claimant witness statement she stated:**

**39.1 "I believe that people deserve respect, but ideas do not." Para 5**
**39.2 "I do not believe it is incompatible to recognise that human beings cannot change sex whilst also protecting the human rights of people who identify as transgender" Para 13**
**39.3 "I believe that there are only two sexes in human beings (and indeed in all mammals): male and female. This is fundamentally linked to reproductive biology. Males are people with the type of body which, if all things are working, are able to produce male gametes (sperm).**
**Females have the type of body which, if all things are working, is able to produce female gametes (ova), and gestate a pregnancy." Para 14**
**39.4 "Women are adult human females. Men are adult human males." Para 15**
**39.5 "Sex is determined at conception, through the inheritance (or not) of a working copy of a piece of genetic code which comes from the father (generally, apart from in very rare cases, carried on the Y chromosome)." Para 16**
**39.6 "Some women have conditions which mean that they do not produce ova or cannot conceive or sustain a pregnancy. Similarly, some men are unable to produce viable sperm. These people are still women and men." Para 17**
**39.7 "I believe that it is impossible to change sex or to lose your sex. Girls grow up to be women. Boys grow up to be men. No change of clothes or hairstyle, no plastic surgery, no accident or illness, no course of hormones, no force of will or social conditioning, no declaration can turn a female person into a male, or a male person into a female." Para 23**
**39.8 "Losing reproductive organs or hormone levels through illness or surgery does not stop someone being a woman or a man." Para 24**
**39.9 "A person may declare that they identify as (or even are) a member of the opposite sex (or both, or neither) and ask others to go along with this. This does not change their actual sex." Para 26**
**39.10 "There are still areas of scientific discovery about the pathways of sexual development, including chromosomal and other "disorders of sexual development" (so called "intersex" conditions), and about the psychological factors underlying transgender identification and gender dysphoria. However I do not believe that any such research will disprove the basic reality that there are two sexes" Para 60**
**39.11 "Under the Gender Recognition Act 2004, a person may change their legal sex. However this does not give them the right to access services and spaces intended for members of the opposite sex. It is an offence for a person who has acquired information in an official capacity about a person's GRC to disclose that information. However this situation where a person's sex is protected information relates to a minority of cases where a person has a GRC, is successfully "passing" in their new identity and is not open about being trans. In many cases people can identify a person's sex on sight, or they may have known the person before transition, or the person may have made it public information that they are trans. There is no general legal compulsion for people not to believe their own eyes or to forget, or pretend to forget, what they already know, or which is already in the public domain." Para 108**
**39.12 "In most social situations we treat people according to the sex they appear to be. And even when it is apparent that someone's sex is different from the gender they seek to portray through their clothing, hairstyle, voice and mannerisms, or the name, title and pronoun they ask to be referred to by, it may be polite or kind to pretend not to notice, or to go along with their wish to be referred to in a particular way. But there is no fundamental right to compel people to be polite or kind in every situation." Para 110**
**39.13 "In particular while it may be disappointing or upsetting to some male people who identify as women to be told that it is not appropriate for them to share female-only services and spaces, avoiding upsetting males is not a reason to compromise women's safety, dignity and ability to control their own boundaries as to who gets to see and touch their bodies."**

> **40. I accept that these passages reflect core aspects of the Claimant's belief.**
> **41. When questioned during live evidence the Claimant stated that biological males cannot be women. She considers that if a trans woman says she is a woman that is untrue, even if she has a Gender Recognition Certificate. On the totality of the Claimant's evidence it was clear that she considers there are two sexes, male and female, there is no spectrum in sex and there are no circumstances whatsoever in which a person can change from one sex to another, or to being of neither sex. She would generally seek to be polite to trans persons and would usually seek to respect their choice of pronoun but would not feel bound to; mainly if a trans person who was not assigned female at birth was in a "woman's space", but also more generally. If a person has a Gender Recognition Certificate this would not alter the Claimant's position. The Claimant made it clear that her view is that the words man and woman describe a person's sex and are immutable. A person is either one or the other, there is nothing in between and it is impossible to change form one sex to the other."**

14. At para 77, having considered the legal criteria for determining whether a belief is a philosophical belief, the Tribunal made the following findings as to the Claimant's belief:

> **"77. The core of the Claimant's belief is that sex is biologically immutable. There are only two sexes, male and female. She considers this is a material reality. Men are adult males. Women are adult females. There is no possibility of any sex in between male and female; or that is a person is neither male nor female. It is impossible to change sex. Males are people with the type of body which, if all things are working, are able to produce male gametes (sperm). Females have the type of body which, if all things are working, is able to produce female gametes (ova), and gestate a pregnancy. It is sex that is fundamentally important, rather than "gender", "gender identity" or "gender expression". She will not accept in any circumstances that a trans woman is in reality a woman or that a trans man is a man. That is the belief that the Claimant holds."**

15. We refer in this judgment to that belief as the "gender-critical belief" or "the Claimant's belief". It is necessary to set out the Tribunal's analysis of that belief in full:

> **"82. I accept that the Claimant genuinely holds the view that sex is biological and immutable. For her it is more that an opinion or viewpoint based on the present state of information available. Even though she has come to this belief recently she is fixed in it, and appears to be becoming more so. She is not prepared to consider the possibility that her belief may not be correct. I accept that the belief Claimant goes to substantial aspects of human life and behaviour.**
> **83. I next considered whether the Claimant's core belief that sex is immutable lacks a level of cogency and cohesion. It is avowedly not religious or metaphysical, but is said to be scientific. Her belief is that a man is a person who, if everything is working, can produce sperm and a woman a person who, if everything is working, can produce eggs. This does not sit easily with her view that even if everything is not, in her words, "working", and may never have done so, the person can still only be male or female. The Claimant largely ignores intersex conditions and the fact that biological opinion is increasingly moving away from an absolutist approach to there being genes the presence or absence of which determine specific attributes, to understanding that it is necessary to analyse which genes are present, which are switched on, the extent to which they are switched on and the way in which they interact with other genes. However, I bear in mind that "coherence" mainly requires that the belief can be understood**

**and that "not too much should be not expected". A "scientific" belief may not be based on very good science without it being so irrational that it unable to meet the relatively modest threshold of coherence. On balance, I do not consider that the Claimant's belief fails the test of being "attain a certain level of cogency, seriousness, cohesion and importance"; even though there is significant scientific evidence that it is wrong. I also cannot ignore that the Claimant's approach (save in respect of refusing to accept that a Gender Recognition Certificate changes a person's sex for all purposes) is largely that currently adopted by the law, which still treats sex as binary as defined on a birth certificate.**

**84. However, I consider that the Claimant's view, in its absolutist nature, is incompatible with human dignity and fundamental rights of others. She goes so far as to deny the right of a person with a Gender Recognition Certificate to be the sex to which they have transitioned. I do not accept the Claimant's contention that the Gender Recognition Act produces a mere legal fiction. It provides a right, based on the assessment of the various interrelated convention rights, for a person to transition, in certain circumstances, and thereafter to be treated for all purposes as the being of the sex to which they have transitioned. In Goodwin a fundamental aspect of the reasoning of the ECHR was that a person who has transitioned should not be forced to identify their gender assigned at birth. Such a person should be entitled to live as a person of the sex to which they have transitioned. That was recognised in the Gender Recognition Act which states that the change of sex applies for "all purposes". Therefore, if a person has transitioned from male to female and has a Gender Recognition Certificate that person is legally a woman. That is not something that the Claimant is entitled to ignore.**

**85. Many trans people are happy to discuss their trans status. Others are not and/or consider it of vital importance not to be misgendered. The Equal Treatment Bench Book notes the TUC survey that refers to people having their transgender status disclosed against their will. The Claimant does not accept that she should avoid the enormous pain that can be caused by misgendering a persons, even if that person has a Gender Recognition Certificate. In her statement she says of people with Gender Recognition Certificates "In many cases people can identify a person's sex on sight, or they may have known the person before transition.... There is no general legal compulsion for people not to believe their own eyes or to forget, or pretend to forget, what they already know, or which is already in the public domain." The Claimant's position is that even if a trans woman has a Gender Recognition Certificate, she cannot honestly describe herself as a woman. That belief is not worthy of respect in a democratic society. It is incompatible with the human rights of others that have been identified and defined by the ECHR and put into effect through the Gender Recognition Act.**

**86. There is nothing to stop the Claimant campaigning against the proposed revision to the Gender Recognition Act to be based more on self-identification. She is entitled to put forward her opinion that these should be some spaces that are limited to women assigned female at birth where it is a proportionate means of achieving a legitimate aim. However, that does not mean that her absolutist view that sex is immutable is a protected belief for the purposes of the EqA. The Claimant can legitimately put forward her arguments about the importance of some safe spaces that are only be available to women identified female at birth, without insisting on calling trans women men.**

**87. Human Rights law is developing. People are becoming more understanding of trans rights. It is obvious how important being accorded their preferred pronouns and being able to describe their gender is to many trans people. Calling a trans woman a man is likely to be profoundly distressing. It may be unlawful harassment. Even paying due regard to the qualified right to freedom of expression, people cannot expect to be protected if their core belief involves violating others dignity and/or creating an intimidating, hostile, degrading, humiliating or offensive environment for them.**

**88. As set out above, I draw a distinction between belief and separate action based on the belief that may constitute harassment. However, if part of the belief necessarily will result in the violation of the dignity of others, that is a component**

**of the belief, rather than something separate, and will be relevant to determining whether the belief is a protected philosophical belief. While the Claimant will as a matter of courtesy use preferred pronouns she will not as part of her belief ever accept that a trans woman is a woman or a trans man a man, however hurtful it is to others. In her response to the complaint made by her co-workers the Claimant sated "I have been told that it is offensive to say, "transwomen are men" or that women means "adult human female". However since these statements are true I will continue to say them".**

**89. When in an, admittedly very bitter, dispute with Gregor Murray, who alleged that they had been misgendered by the Claimant, rather than seeking to accommodate Gregor Murrays legitimate wishes she stated: "I had simply forgotten that this man demands to be referred to by the plural pronouns "they" and "them", "Murray also calls it "transphobic" that I recognise a man when I see one. I disagree", "In reality Murray is a man. It is Murray's right to believe that Murray is not a man, but Murray cannot compel others to believe this." And that "I reserve the right to use the pronouns "he" and "him" to refer to male people. While I may choose to use alternative pronouns as a courtesy, no one has the right to compel others to make statements they do not believe."**

**90. I conclude from this, and the totality of the evidence, that the Claimant is absolutist in her view of sex and it is a core component of her belief that she will refer to a person by the sex she considered appropriate even if it violates their dignity and/or creates an intimidating, hostile, degrading, humiliating or offensive environment. The approach is not worthy of respect in a democratic society.**

**91. I do not accept that this analysis is undermined by the decision of the Supreme Court in Lee v Ashers that persons should not be compelled to express a message with which they profoundly disagreed unless justification is shown. The Claimant could generally avoid the huge offense caused by calling a trans woman a man without having to refer to her as a woman, as it is often not necessary to refer to a person sex at all. However, where it is, I consider requiring the Claimant to refer to a trans woman as a woman is justified to avoid harassment of that person. Similarly, I do not accept that there is a failure to engage with the importance of the Claimant's qualified right to freedom of expression, as it is legitimate to exclude a belief that necessarily harms the rights of others through refusal to accept the full effect of a Gender Recognition Certificate or causing harassment to trans women by insisting they are men and trans men by insisting they are women. The human rights balancing exercise goes against the Claimant because of the absolutist approach she adopts.**

**92. In respect of the belief that the Claimant contends she does not hold, that everyone has a gender which may be different to their sex at birth and which effectively trumps sex so that trans men are men and transwomen are women. I consider that this is a good example of why, at least in certain circumstances, one needs to apply the Grainger criteria to the lack of belief, rather than the alternative belief. Believing that a trans woman is a woman does not conflict with the approach of the European Court of Human Rights in Goodwin, or the Gender Recognition Act, or involve harassment. It does not face the same issue of incompatibility with human dignity and fundamental rights of others as the lack of that belief does because that lack of belief necessarily involves the view that trans women are men. The lack of belief fails to meet the Grainger criteria.**

**93. It is also a slight of hand to suggest that the Claimant merely does not hold the belief that transwomen are women. She positively believes that they are men; and will say so whenever she wishes. Put either as a belief or lack of belief, the view held by the Claimant fails the Grainger criteria and so she does not have the protected characteristic of philosophical belief."**

**Legal Framework**

16. Section 4, EqA identifies the characteristics that are "protected characteristics". These are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Sections 5 to 12, EqA set out the circumstances in which a person "has" a protected characteristic.

17. Section 7 deals with gender reassignment. It provides:

> **"7 Gender reassignment**
> **(1) A person has the protected characteristic of gender reassignment if the person is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attributes of sex.**
> **(2) A reference to a transsexual person is a reference to a person who has the protected characteristic of gender reassignment.**
> **(3) In relation to the protected characteristic of gender reassignment—**
> **(a) a reference to a person who has a particular protected characteristic is a reference to a transsexual person;**
> **(b) a reference to persons who share a protected characteristic is a reference to transsexual persons."**

18. We acknowledge that the term "transsexual" has fallen into disfavour in recent years, and many consider it offensive. The Equal Treatment Bench Book states as follows at p.243:

> **"Despite its use in current legislation, the term 'transsexual' is dated and some people find it stigmatising. It is preferable to use the term transgender – if it is necessary to the legal proceedings to refer to a person as being transgender at all."**

19. We use the term "transgender" to refer to those persons whose gender identity does not correspond to their sex at birth and who identify with another gender.

20. Section 10, EqA deals with religion or belief. It provides:

> **"10 Religion or belief**
> **(1) Religion means any religion and a reference to religion includes a reference to a lack of religion.**
> **(2) Belief means any religious or philosophical belief and a reference to belief includes a reference to a lack of belief.**
> **(3) In relation to the protected characteristic of religion or belief—**

> **(a) a reference to a person who has a particular protected characteristic is a reference to a person of a particular religion or belief;**
> **(b) a reference to persons who share a protected characteristic is a reference to persons who are of the same religion or belief."**

21. The EAT in **Grainger plc & others v Nicholson** [2010] ICR reviewed the jurisprudence relating to belief in considering the materially similar predecessor provisions (contained in the **Employment Equality (Religion or Belief ) Regulations** 2003) and endeavoured to set out the criteria to be applied in determining whether a belief qualifies for protection. At para 24, Burton P held as follows:

> **"24 I do not doubt at all that there must be some limit placed upon the definition of "philosophical belief" for the purpose of the 2003 Regulations, but before I turn to consider Mr Bowers' suggested such limitations, I shall endeavour to set out the limitations, or criteria, which are to be implied or introduced by reference to the jurisprudence set out above. (i) The belief must be genuinely held. (ii) It must be a belief and not, as in McClintock v Department of Constitutional Affairs [2008] IRLR 29, an opinion or viewpoint based on the present state of information available. (iii) It must be a belief as to a weighty and substantial aspect of human life and behaviour. (iv) It must attain a certain level of cogency, seriousness, cohesion and importance. (v) It must be worthy of respect in a democratic society, be not incompatible with human dignity and not conflict with the fundamental rights of others (para 36 of Campbell v United Kingdom 4 EHRR 293 and para 23 of Williamson's case [2005] 2AC 246)."**

22. These five criteria, referred to here as "the Grainger Criteria", have since been applied in several cases and are reflected in the guidance on philosophical belief contained in the Commission's Code of Practice: see 2.59 of the Code. It is not in dispute that these are the appropriate criteria by which to assess whether a belief qualifies for protection under s.10, EqA.

23. The Tribunal in the present case found that the Claimant's belief only failed to satisfy the fifth Grainger Criterion, referred to here as "Grainger V". It is that criterion, namely that the belief must be "worthy of respect in a democratic society, be not incompatible with human dignity and not conflict with the fundamental rights of others", that is the focus of this appeal.

24. Section 11, EqA deals with sex. It provides:

> **"11 Sex**
> **In relation to the protected characteristic of sex—**

**(a) a reference to a person who has a particular protected characteristic is a reference to a man or to a woman;**
**(b) a reference to persons who share a protected characteristic is a reference to persons of the same sex."**

25. It is, in most cases, necessary for a person to fall within one or more of sections 5 to 12, EqA before any protection may arise under other parts of EqA. Thus, under s.13, EqA for example, "A person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourably than A treats or would treat others." In general, in a claim under the EqA, the first stage will be to identify whether a person has the protected characteristic being claimed. Some characteristics, e.g. age and race are universal: every person has those protected characteristics, and the analysis can quickly move to whether or not the relevant cause of action under the EqA is established. In the case of some other characteristics, e.g. disability or belief, it may be disputed that the person's condition or belief actually satisfies s.6 or s.10, EqA respectively. In such cases, there may be a preliminary issue (which may or may not be decided at preliminary hearing) as to whether the claimant has the relevant protected characteristic. In determining that issue, the Tribunal will generally not be required to consider whether any cause of action under EqA is established.

26. Given the requirement under s.3 of the **Human Rights Act** 1998 to read and give effect to statutory provisions in a way which is compatible with the rights conferred by the **European Convention on Human Rights** ("ECHR"), it is necessary to consider the following Articles of the ECHR which are relevant to the present appeal.

**"ARTICLE 8**
**Right to respect for private and family life**
**1. Everyone has the right to respect for his private and family life, his home and his correspondence.**
**2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.**

**ARTICLE 9**

**Freedom of thought, conscience and religion**
**1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.**
**2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.**

**ARTICLE 10**
**Freedom of expression**
**1. Everyone has the right to freedom of expression. This right shall include freedom to hold opinions and to receive and impart information and ideas without interference by public authority and regardless of frontiers. This Article shall not prevent States from requiring the licensing of broadcasting, television or cinema enterprises.**
**2. The exercise of these freedoms, since it carries with it duties and responsibilities, may be subject to such formalities, conditions, restrictions or penalties as are prescribed by law and are necessary in a democratic society, in the interests of national security, territorial integrity or public safety, for the prevention of disorder or crime, for the protection of health or morals, for the protection of the reputation or rights of others, for preventing the disclosure of information received in confidence, or for maintaining the authority and impartiality of the judiciary."**

27. Article 17, ECHR, which prohibits the abuse of Convention rights, is also important in this context. It provides:

**"ARTICLE 17**
**Prohibition of abuse of rights**
**Nothing in this Convention may be interpreted as implying for any State, group or person any right to engage in any activity or perform any act aimed at the destruction of any of the rights and freedoms set forth herein or at their limitation to a greater extent than is provided for in the Convention."**

## Grounds of Appeal

28. Whilst permission was granted on the sift to pursue six distinct grounds of appeal, the essential challenge to the Judgment is that the Tribunal erred in its approach to Grainger V, and that had it approached that criterion correctly, the inevitable conclusion would be that the Claimant's belief was protected. Neither Mr Cooper nor Ms Russell sought in their oral submissions to address the six grounds individually; instead, they sought respectively to attack or defend the Judgment on more general principles. We shall therefore approach our judgment in the appeal in the same way.

**Submissions**

*Outline of the Claimant's Submissions*

29. Mr Cooper submitted that the Claimant's beliefs do not deny the rights or status of trans persons, that her gender-critical beliefs are widely shared in society including, as the evidence before the Tribunal showed, by some trans persons. Her beliefs are similar to those of the claimant in **R (Miller) v College of Policing** [2020] 3 All ER 31 (Admin), whose beliefs were summarised at para 19 of Julian Knowles J's judgment as follows:

> **"19 In his first witness statement the Claimant says that over the years he has worked alongside many members of the lesbian, gay, bisexual and transgender (LGBT) community, and that prior to this case he had never been the subject of any complaints about transphobia. In [12], [17] and [18] he writes:**
> **"...**
> **17. I believe that trans women are men who have chosen to identify as women. I believe such persons have the right to present and perform in any way they choose, provided that such choices do not infringe upon the rights of women. I do not believe that presentation and performance equate to literally changing sex; I believe that conflating sex (a biological classification) with self-identified gender (a social construct) poses a risk to women's sex-based rights; I believe such concerns warrant vigorous discussion which is why I actively engage in the debate. The position I take is accurately described as gender critical.**
> **…"**

30. As Julian Knowles J found at para 250 of Miller, there is vigorous ongoing debate about trans rights:

> **"250. I take the following points from this evidence. First, there is a vigorous ongoing debate about trans rights. Professor Stock's evidence shows that some involved in the debate are readily willing to label those with different viewpoints as 'transphobic' or as displaying 'hatred' when they are not. It is clear that there are those on one side of the debate who simply will not tolerate different views, even when they are expressed by legitimate scholars whose views are not grounded in hatred, bigotry, prejudice or hostility, but are based on legitimately different value judgments, reasoning and analysis, and form part of mainstream academic research.**

31. Mr Cooper submits that it is clear from these passages in **Miller** that the Claimant's views cannot be regarded as inherently transphobic. Furthermore, whilst it is inherent in the Claimant's beliefs that she will *in some circumstances* refer to a trans woman as a man (or a trans man as a woman), she would not generally do so, or do so where it was not relevant to the context. Her

A complaint is that the Tribunal's judgment disregards this context and instead requires the Claimant to refrain from referring to what the Claimant considers to be a trans person's sex in any circumstances. That, submits Mr Cooper, has the effect that the Claimant must subordinate her language to reflect views that she does not hold, and is tantamount to state mandated - the Tribunal being the representative of the State in this context – adherence to a view she does not actually hold.

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32. Mr Cooper submits that, although, as held by the House of Lords in in **R (Williamson) V Secretary of State for Education and Employment** [2005] 2 AC 246, it is not for the Court to inquire into the validity of a belief, the Tribunal did just that, including by taking the view that the Claimant's beliefs were not supported by scientific evidence. What it ought to have done, submits Mr Cooper, is to consider whether the Claimant's belief was of the kind that would make Article 17, ECHR relevant. Had the Tribunal taken that approach, it could only have concluded that the belief was worthy of respect in a democratic society. Not only is it worthy of respect, but it is also one that is consistent with the common law under which sex is regarded as binary and fixed at birth for the purposes of all legal provisions which make a distinction between men and women: see **Corbett v Corbett** [1971] P 83, **Chief Constable of West Yorkshire v A** (No.2) [2005] 1 AC 51 HL at [30]. The coming into force of s.9, GRA, under which a person with a Gender Recognition Certificate ("GRC") "becomes for all purposes" the acquired gender, does not, as the Tribunal appears to have found, require the Claimant to disregard what she considers to be a material reality, namely that sex is immutable.

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33. Mr Cooper submits that the Tribunal went astray in engaging in a balancing of the Claimant's rights against those of others; at this stage of the analysis the only question was whether the belief was protected under s.10, EqA, read compatibly with Articles 9 and 10 of ECHR. By focusing on the way in which the Claimant manifested her belief in certain

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circumstances, the Tribunal was wrongly considering matters that would only become relevant at a later stage of the analysis in determining whether there was any cause of action and/or whether the Respondents' actions in restricting the manifestation of the Claimant's belief were justified.

*Outline of the Intervenors' submissions*

34. Ms Monaghan QC adopted Mr Cooper's submissions on the law and submitted that if the Tribunal had taken the correct approach, it would have been bound to conclude that the belief was protected. Like Mr Cooper, Ms Monaghan submitted that the Tribunal erred in considering manifestation of the beliefs at this preliminary stage, where the only question was whether the belief amounted to a philosophical belief and was therefore protected. The suggestion in my judgment in **Gray v Mulberry Co (Design) Ltd** [2019] ICR 175, (EAT) that in considering the Grainger Criteria, the focus should be on manifestation, is one that should be reconsidered. Where the Tribunal considered manifestation, it was wrong to do so and acted prematurely.

35. It was further submitted that although many might disagree with the proposition that sex is binary and that gender identity is a social construct, that is what the law of the land currently states: **Corbett v Corbett**; **Elan-Cane v Secretary of State for the Home Department** [2018] 1 WLR 5119. Even the operation of the GRA recognises that sex is immutable: see e.g. Sch 3, paragraph 24 to the EqA which provides that even where a person has a GRC, another person may lawfully refuse to validate a marriage if they hold a religious belief that sex is immutable.

36. Ms McColgan QC for IoC similarly agreed with Mr Cooper's submissions on the law. She concurred that the proper approach was to consider whether the very high threshold for invoking Article 17, ECHR had been crossed. Conversely, the Tribunal should have approached

Grainger V on the basis that the requirement to establish that a belief is worthy of respect in a democratic society presents a very low barrier, such that only the most extreme beliefs would be excluded. The barrier is especially low in cases where the belief engages a matter of ongoing political and/or public debate. IoC considered that the Tribunal gave little if any weight to the Claimant's Article 10, ECHR right to the freedom of expression. In any event, like Mr Cooper, she submits that the Tribunal erred in engaging in a balancing exercise between competing rights at this stage, where the only question is whether the belief falls within s.10, EqA.

*Outline of the Respondents' submissions*

37. Ms Russell submitted that the Claimant and Interveners had sought to present to the EAT a sanitised version of the Claimant's belief. In fact, she submits, a core component of that belief is to cause trans people enormous pain by misgendering them. This goes beyond causing mere offence; the belief is rooted in giving insult and slander, as shown by the Claimant's conduct towards people like Pips Bunce who have complex gender identities. The Tribunal took the Claimant's belief on its own terms and found that part of it – namely, her commitment to referring to a person by the sex she considers appropriate - was likely to give rise to harassment and create a hostile environment for others. Such conduct is not separable from her belief; it is "baked into" it. The Tribunal was correct to say that such a belief did not satisfy Grainger V.

38. Ms Russell further submits that the essential question for the Tribunal was whether the belief was protected under s.10, EqA and thus whether it was compatible with Grainger V. That analysis is not reducible to a consideration only of Articles 9 and 10, ECHR. In any event, the Claimant's contention that Grainger V should be reduced to a consideration of whether the belief is of a kind to engage the high threshold of Article 17, ECHR, is based on a misreading of **Campbell and Cosans v UK**. In that case, the European Court of Human Rights ("ECtHR")

said no more than that Article 17 was one of the factors to be taken into account, and it is clear from a proper reading of that case that other beliefs, not crossing the Article 17 threshold, could also be not worthy of respect in a democratic society. Were that not the case, then only a belief in Nazism or totalitarianism could fail Grainger V.

39. The Tribunal did not err in undertaking a balancing exercise between the Claimant's rights and the rights of others. Misgendering trans persons necessarily amounted to harassment and a violation of their Article 8 rights to "personal development and to physical and moral security", which can no longer be regarded as a matter of controversy: see **Goodwin v UK** [2002] IRLR 664 at para 90; Campbell and Cosans v UK (Application no.35968/97) at para 56 and **AP, Garçon and Niçot v France** (Application nos.79885/12, 52471/13 and 52596/13) at para 92. The Tribunal was not requiring the Claimant to refrain from expressing her beliefs, but merely to stop harassing trans persons by misgendering them. In reaching the conclusions that it did, the Tribunal achieved a fair balance between competing rights. The Supreme Court's decision in **Lee v Ashers Baking Co Ltd** [2020] AC 413, in which it was held that it was not unlawfully discriminatory for a bakery to refuse to supply a cake iced with the message "Support Gay Marriage" because of the belief of the owners that gay marriage is inconsistent with Biblical teaching, does not assist the Claimant, because the Claimant's objection is to trans persons and not merely to a message or a viewpoint with which she did not agree.

40. Whilst the Claimant's actions might not amount to the gravest forms of hate speech, it was within the lower category of hate speech identified by the ECtHR in **Lilliendahl v Iceland** (Application no. 29297/18), and which includes "serious, severely hurtful and prejudicial" comments that can justifiably be restricted by the State: **Lilliendahl** at para 45. The decision in **Miller** is not an answer in the present case because that was decided in the very different context of determining whether the police acted correctly in approaching Mr Miller's comments on the

basis that a criminal offence might have been committed. In any event, there was no suggestion of Mr Miller actively misgendering anyone whereas the Claimant has made it clear that she would do so.

41. Ms Russell also disagreed that the law of the land was that sex is immutable. **Corbett**, decided in 1971, was of its time and should no longer be considered good law. In any case, Parliament has decreed, by enacting s.9, GRA, that sex is not immutable and that a person does, upon obtaining a GRC, become 'for all purposes' a person of the acquired gender.

42. Finally, it was submitted that if the appeal is allowed, it would mean that no trans person would be safe from harassment in the workplace by a person holding gender-critical belief, and that no employer or service provided could take action against such a person to maintain a safe space for trans persons. It would also create a two-tier system with natal women having greater rights and protection that that afforded to trans women. That, submits Ms Russell, cannot be right.

**Discussion**

43. We begin by identifying the Claimant's belief.

*What is the Claimant's belief?*

44. Bean LJ in **Gray v Mulberry Co (Design) Ltd** [2020] ICR 715 (CA) held that:

> **"26. Precision in pleading is not equally important in every case heard by employment tribunals, but in our view it is essential, before considering whether a belief amounts to a "philosophical belief" protected under sections 4 and 10(2) of the 2010 Act, to define exactly what the belief is. In this case, as already noted the belief relied on is "the statutory human or moral right to own the copyright**

**and moral rights of her own creative works and output, except when that creative work or output is produced on behalf of an employer"."**

45. In that case, the belief relied upon was capable of being summed up in a single sentence. Most religious or philosophical beliefs will not be capable of such pithy encapsulation. Indeed, any belief that affects a number of aspects of a person's life and how they live it is likely to comprise a diffuse and diverse range of concepts and principles that would defy precise or concise definition. The Claimant's belief is a case in point. It was described across two detailed witness statements running to almost 50 pages. That evidence was supplemented by oral evidence which was subject to cross-examination. The Tribunal did not reject any part of that evidence. However, that did not mean that the Tribunal was obliged to set out the entirety of the Claimant's written and oral evidence in its reasons in order to satisfy the requirement to "define exactly" what the belief is. The standard of exactitude cannot mean, in our judgment, setting out a detailed treatise of a claimed philosophical belief in every case. A precise definition of those aspects of the belief that are relevant to the claims in question would, in our judgment, suffice. In this regard, we do not consider it incorrect for a tribunal to seek to identify the "core" elements of a belief in order to determine whether it falls within s.10, EqA. There may be aspects of a belief that are peripheral or merely practical instances of its main tenets, which need not form part of the definition of the belief that falls to be tested against the Grainger Criteria.

46. The Tribunal in this case summarised the passages in the Claimant's evidence as to her belief at para 39 of the Judgment (see para 13 above), and accepted (at para 40) that "these passages reflect core aspects of the Claimant's belief". It did not consider that the specific tweets that caused concern "represent the core" of that belief: para 76. It then went on at para 77 to define the Claimant's core belief as follows:

**"77. The core of the Claimant's belief is that sex is biologically immutable. There are only two sexes, male and female. She considers this is a material reality. Men are adult males. Women are adult females. There is no possibility of any sex in between male and female; or that is a person is neither male nor female. It is impossible to change sex. Males are people with the type of body which, if all**

**things are working, are able to produce male gametes (sperm). Females have the type of body which, if all things are working, is able to produce female gametes (ova), and gestate a pregnancy. It is sex that is fundamentally important, rather than "gender", "gender identity" or "gender expression". She will not accept in any circumstances that a trans woman is in reality a woman or that a trans man is a man. That is the belief that the Claimant holds."**

47. The concluding sentence of that passage might be interpreted as meaning that what precedes it is a summary of the entirety of the Claimant's "core beliefs". However, it would appear from subsequent paragraphs in the Judgment, that the Tribunal also considered it to be part of the Claimant's belief that she will refer to a person by the sex she considered appropriate even if it violates their dignity and/or creates an intimidating, hostile, degrading, humiliating or offensive environment: see para 90. Mr Cooper takes issue with that aspect of the Tribunal's judgment, which he submits mischaracterises the Claimant's belief and is inconsistent with the Tribunal's earlier acceptance of the Claimant's evidence. The Tribunal accepted the Claimant's evidence that "she would generally seek to be polite to trans persons and would usually seek to respect their choice of pronoun but would not feel bound to; mainly if a trans person who was not assigned female at birth was in a "woman's space", but also more generally". Mr Cooper also drew our attention to passages in the Claimant's statement that in accordance with her belief she considers "it is relevant and important in some circumstances to be able to acknowledge, describe or refer to a particular person's sex, even if that differs from his or her gender identity and even if that may cause that individual to be upset." However, as she also said in her statement, that "does not mean that it is any part of her belief that trans people should not generally be treated in accordance with their wishes or that she will not generally do so, let alone that [trans persons] should not be respected or protected from discrimination, or that they should be abused, disparaged or harassed".

48. Ms Russell submitted that Mr Cooper was seeking to sanitise the Tribunal's clear findings as to the nature of the Claimant's belief and that in the absence of a perversity appeal, those findings cannot be disturbed.

49. We do not agree with Ms Russell that Mr Cooper was seeking to sanitise the Tribunal's findings as to belief. We note that the Tribunal did not reject any of the Claimant's evidence and expressly included reference, at para 41, to the fact that the Claimant would 'generally' seek to be polite to trans persons and would 'usually' seek to respect their choice of pronoun. It also referred, at para 30, to the Claimant's evidence that she "would of course respect anyone's self-definition of their gender identity in any social and professional context"; and had "no desire or intention to be rude to people". In the light of those findings, it would be wrong, in our view to read the Tribunal's finding at para 90, as if it meant that the Claimant would in every circumstance seek to "misgender" trans persons, or cause them pain and thereby create a hostile etc. environment. That interpretation would be wholly inconsistent with what the Tribunal actually found to be the case. A person who "generally" and "usually" acts in a certain way, cannot simultaneously always or invariably act in the opposite way. On a proper reading of the Tribunal's findings, it seems to us that the most that can be said is that the Claimant will *sometimes* refuse to use preferred pronouns if she considered it relevant to do so, e.g. in a discussion about a trans woman being in what the Claimant considered to be a women-only space.

50. We proceed on the basis that the Claimant's belief is as summarised by the Tribunal at para 77 of the Judgment, read with the passages at paras 39 to 41.

51. The Claimant's gender-critical belief is not unique to her; it is a belief shared by others who consider that it is important to have an open debate about issues concerning sex and gender identity. To understand the nature of that debate, the Court in **Miller** considered the evidence of the gender-critical academic, Professor Kathleen Stock:

**"241. It is very important to recognise that the Claimant was not tweeting in a vacuum. He was contributing to an ongoing debate that is complex and multi-faceted. In order to understand the contours of that debate I have been assisted by the first witness statement of Professor Kathleen Stock, Professor of Philosophy at Sussex University. She researches and teaches the philosophy of fiction and feminist philosophy. Her intellectual pedigree is impeccable. She writes:**

**"4, In my work, among other things I argue that there's nothing wrong, either theoretically, linguistically, empirically, or politically, with the once-familiar idea that a woman is, definitionally, an adult human female. I also argue that the subjective notion of 'gender identity' is ill-conceived intrinsically, and a fortiori as a potential object of law or policy. In light of these and other views, I am intellectually 'gender-critical'; that is, critical of the influential societal role of sex-based stereotypes, generally, including the role of stereotypes in informing the dogmatic and, in my view, false assertion that – quite literally – 'trans women are women'. I am clear throughout my work that trans people are deserving of all human rights and dignity."**

**242. Professor Stock co-runs an informal network of around 100 gender-critical academics working in UK and overseas universities. Members of the network come from a wide variety of different disciplines including sociology, philosophy, law, psychology and medicine. She says that many members of the network 'research on the many rich theoretical and practical questions raised by current major social changes in the UK around sex and gender'.**

**243. Professor Stock then describes the 'hostile climate' facing gender-critical academics working in UK universities. She says that any research which threatens to produce conclusions or outcomes that influential trans-advocacy organisations would judge to be politically inexpedient, faces significant obstacles. These, broadly, are impediments to the generation of research and to its publication. She also explains how gender critical academics face constant student protests which hinder their work.**

**244. At [17] she says:**

**"As also indicative, since I began writing and speaking on gender-critical matters: the Sussex University Student Union Executive has put out a statement about me on their website, accusing me of 'transphobia' and 'hatred'; I've had my office door defaced twice with stickers saying that 'TERFS' are 'not welcome here' …"**

**245. I understand that 'TERF' is an acronym for 'trans-exclusionary radical feminist'. It is used to describe feminists who express ideas that other feminists consider transphobic, such as the claim that trans women are not women, opposition to transgender rights and exclusion of trans women from women's spaces and organisations. It can be a pejorative term.**

**246. She concludes at [22]:**

**"… there are also unfair obstacles to getting gender-critical research articles into academic publications, and in achieving grant funding. These stem from a dogmatic belief, widespread amongst those academics most likely to be asked to referee a project about sex or gender (e.g. those already established in Gender Studies; those in feminist philosophy) that trans women are literally women, that trans men are literally men, and that any dissent on this point must automatically be transphobic …"**

**247. Also in evidence is a statement from Jodie Ginsberg, the CEO of Index on Censorship. Index on Censorship is a non-profit organisation that campaigns for and defends free expression worldwide. It publishes work by censored writers and artists, promote debate, and monitor threats to free speech. She deals with a number of topics, including the Government Consultation on the GRA 2004. She explains at [10]-[11]:**

**"10. The proposed reforms to the Gender Recognition Act involve removing the gender recognition procedures described above and replacing them with a simple self-identification process (self-ID). Self-ID means the transitioner does not have to undergo medical or other assessment procedures.**

**11. Many in the UK are concerned that the proposed reforms for self-ID will erase 'sex' as protected characteristic in the Equality Act 2010 by conflating 'sex' and 'gender'. There are concerns that single sex spaces with important protective functions (women's prisons or women's refuse shelters for victims of domestic violence or rape) will be undermined. The UK government has said it does not plan to amend the existing protections in the Equality Act; however, this is not convincing to those who see self-ID in any form as fundamentally incompatible with legal protection for women and girls."**

**248. She goes on to address gender criticism and Twitter and explains that there is on-going concern that Twitter is stifling legitimate debate on this topic by its terms of service which apparently treat gender critical comment as hate speech. She then gives a number of examples where the police have taken action because of things people have posted on Twitter about transgender issues.**

**249. She concludes at [27]-[29]:**

**"27. Index is concerned by the apparent growing number of cases in which police are contacting individuals about online speech that is not illegal and sometimes asking for posts to be removed. This is creating confusion among the wider population about what is and is not legal speech, and - more significantly – further suppressing debate on an issue of public interest, given that the government invited comment on this issue as part of its review of the Gender Recognition Act.**

**28. The confusion of the public (and police) around what is, and what is not, illegal speech may be responsible for artificially inflating statistics on transgender hate crime … Police actions against those espousing lawful, gender critical views – including the recording of such views where reported as 'hate incidents' – create a hostile environment in which gender critical voices are silenced. This is at a time when the country is debating the limits and meaning of 'gender' as a legal category.**

**29. It has been reported that the hostile environment in which this debate is being conducted is preventing even members of parliament from expressing their opinions openly. The journalist James Kirkup said in a 2018 report for The Spectator: "I know MPs, in more than one party, who privately say they will not talk about this issue in public for fear of the responses that are likely to follow. The debate is currently conducted in terms that are not conducive to – and sometimes actively hostile to – free expression. As a result, it is very unlikely to lead to good and socially sustainable policy."**

**250. I take the following points from this evidence. First, there is a vigorous ongoing debate about trans rights. Professor Stock's evidence shows that some involved in the debate are readily willing to label those with different viewpoints as 'transphobic' or as displaying 'hatred' when they are not. It is clear that there are those on one side of the debate who simply will not tolerate different views, even when they are expressed by legitimate scholars whose views are not grounded in hatred, bigotry, prejudice or hostility, but are based on legitimately**

**different value judgments, reasoning and analysis, and form part of mainstream academic research.**

**251. The Claimant's tweets were, for the most part, either opaque, profane, or unsophisticated. That does not rob them of the protection of Article 10(1). I am quite clear that they were expressions of opinion on a topic of current controversy, namely gender recognition. Unsubtle though they were, the Claimant expressed views which are congruent with the views of a number of respected academics who hold gender-critical views and do so for profound socio-philosophical reasons. This conclusion is reinforced by Ms Ginsberg's evidence, which shows that many other people hold concerns similar to those held by the Claimant."**

52. As already stated above, it is not for the EAT to express any view as to merits of the transgender debate, but it is relevant to note, and it was not in dispute before us, that the Claimant's belief is shared by many others, including some trans persons. We were referred to the statement of Kristina Harrison, a trans woman who professes to hold gender-critical beliefs. That evidence was before the Tribunal and is referred to at para 16 of the Judgment.

*What approach should the Tribunal take in determining whether the Claimant's belief was a "philosophical belief" within the meaning of s.10, EqA?*

53. Having identified the belief in question, the next task of the Tribunal was to determine whether that belief amounted to a philosophical belief within the meaning of s.10, EqA. Given that domestic statutory provisions are to be read and understood conformably with the ECHR, it is appropriate to consider the effect of Articles 9 and 10, ECHR first, as that is likely to inform the analysis of s.10, EqA. We note, however, that there is no rule that the analysis should always follow this sequence: see **Page v NHS Trust Development Authority** [2021] EWCA Civ 255 at para 37.

54. Articles 9 and 10 are set out above. The rights protected by these articles have been described by the ECtHR as "closely linked" and the approach to be taken is to consider the case law in relation to the most directly applicable right, interpreted where appropriate in light of the

other: see **Ibragimov v Russia** 1413/08 & 28621/11, 4 February 2019 at para 78. It is not in dispute that the most directly applicable right here is the Article 9 right to freedom of belief.

55. We were referred to numerous authorities emphasising the high importance attached by the ECtHR to diversity or pluralism of thought, belief and expression and their foundational role in a liberal democracy. It is not necessary, in our view, to lengthen this judgment by setting out all of them. It is sufficient for present purposes to remind ourselves of the following principles:

a. Freedom of expression is one of the essential foundations of democratic society:

> **"The Court's supervisory functions oblige it to pay the utmost attention to the principles characterising a ' democratic society '. Freedom of expression constitutes one of the essential foundations of such a society. one of the basic conditions for its progress and for the development of every man. Subject to Article 10 (2), it is applicable not only to ' information ' or ' ideas ' that are favourably received or regarded as inoffensive or as a matter of indifference, but also to those that offend, shock or disturb the State or any sector of the population. Such are the demands of that pluralism, tolerance and broadmindedness without which there is no ' democratic society '. This means. amongst other things, that every ' formality ', ' condition ', ' restriction ' or ' penalty ' imposed in this sphere must be proportionate to the legitimate aim pursued." Handyside v UK (1979-80) 1 EHRR 737 at para 49.**

b. The paramount guiding principle in assessing any belief is that it is not for the Court to inquire into its validity:

> **"22. It is necessary first to clarify the court's role in identifying a religious belief calling for protection under article 9. When the genuineness of a claimant's professed belief is an issue in the proceedings the court will inquire into and decide this issue as a question of fact. This is a limited inquiry. The court is concerned to ensure an assertion of religious belief is made in good faith: "neither fictitious, nor capricious, and that it is not an artifice", to adopt the felicitous phrase of Iacobucci J in the decision of the Supreme Court of Canada in *Syndicat Northcrest v Amselem (2004) 241 DLR (4th) 1* , 27, para 52. <u>But, emphatically, it is not for the court to embark on an inquiry into the asserted belief and judge its "validity" by some objective standard such as the source material upon which the claimant founds his belief or the orthodox teaching of the religion in question or the extent to which the claimant's belief conforms to or differs from the views of others professing the same religion.</u> Freedom of religion protects the subjective belief of an individual. As Iaccobucci J also noted, at p 28, para 54, religious belief is intensely personal and can easily vary from one individual to another. <u>Each individual is at liberty to hold his own religious beliefs, however irrational or inconsistent they may seem to some, however surprising.</u> The European Court of Human Rights has rightly noted that "in principle, the right to freedom of religion as understood in the Convention rules out any appreciation by the state of the legitimacy of religious beliefs or of the manner in which these are expressed":**
> ***Metropolitan Church of Bessarabia v Moldova (2001) 35 EHRR 306* , 335, para 117. The relevance of objective factors such as source material is, at most, that they may throw light on whether the professed belief is genuinely held.**

> **23. Everyone, therefore, is entitled to hold whatever beliefs he wishes. But when questions of "manifestation" arise, as they usually do in this type of case, a belief must satisfy some modest, objective minimum requirements. These threshold requirements are implicit in article 9 of the European Convention and comparable guarantees in other human rights instruments. The belief must be consistent with basic standards of human dignity or integrity. Manifestation of a religious belief, for instance, which involved subjecting others to torture or inhuman punishment would not qualify for protection. The belief must relate to matters more than merely trivial. It must possess an adequate degree of seriousness and importance. As has been said, it must be a belief on a fundamental problem. With religious belief this requisite is readily satisfied. The belief must also be coherent in the sense of being intelligible and capable of being understood. But, again, too much should not be demanded in this regard. Typically, religion involves belief in the supernatural. It is not always susceptible to lucid exposition or, still less, rational justification. The language used is often the language of allegory, symbol and metaphor. Depending on the subject matter, individuals cannot always be expected to express themselves with cogency or precision. Nor are an individual's beliefs fixed and static. The beliefs of every individual are prone to change over his lifetime. Overall, these threshold requirements should not be set at a level which would deprive minority beliefs of the protection they are intended to have under the Convention: see Arden LJ *[2003] QB 1300* , 1371, para 258:** per Lord Nicholls in **R (Williamson) V Secretary of State for Education and Employment [2005] 2 AC 246.” (Emphasis added)**

c. The freedom to hold whatever belief one likes goes hand-in-hand with the State remaining neutral as between competing beliefs, refraining from expressing any judgment as to whether a particular belief is more acceptable than another, and ensuring that groups opposed to one another tolerate each other: **Metropolitan Church of Bessarabia v Moldova** (2002) 35 EHRR 13 at paras 115 and 116.

d. A belief that has the protection of Article 9 is one that only needs to satisfy very modest threshold requirements. As stated by Lord Nicholls in **R (Williamson)**, those threshold requirements “should not be set at a level which would deprive minority beliefs of the protection they are intended to have under the Convention.” In other words, the bar should not be set too high: see **Harron v Chief Constable of Dorset Police** [2016] IRLR 481 (EAT), per Langstaff P at para 34 and **Gray v Mulberry** at para 27.

56. The particular threshold requirement that is relevant for present purposes is that encapsulated in Grainger V, namely that the belief must be “worthy of respect in a democratic

society, not incompatible with human dignity and not conflict with the fundamental rights of others."

57. The question is what standard should the Court apply in determining whether a particular belief falls foul of that threshold requirement, bearing in mind that the bar is not to be set too high. It is clear from the passage in **Grainger** cited at para 21 above, that Burton P derived Grainger V from certain passages in two earlier decisions: the first is paragraph 36 of the decision of the ECtHR in **Campbell and Cosans v United Kingdom 4** EHRR 293. In that case, the issue was whether an objection to the use of corporal punishment in schools (when it was still permitted) amounted to a "philosophical conviction" within the meaning of Article 2 of the First Protocol to the European Convention on Human Rights (A2P1). A2P1 provides:

> **"No person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religious and philosophical convictions."**

58. In accepting that the applicants' views on corporal punishment did amount to philosophical convictions, the ECtHR said as follows at para 36 of its judgment:

> **"…Having regard to the Convention as a whole, including Article 17, the expression ' philosophical convictions ' in the present context denotes, in the Court's opinion, such convictions as are worthy of respect in a ' democratic society ' and are not incompatible with human dignity; in addition, they must not conflict with the fundamental right of the child to education, the whole of Article 2 being dominated by its first sentence. The applicants' views relate to a weighty and substantial aspect of human life and behaviour, namely the integrity of the person, the propriety or otherwise of the infliction of corporal punishment and the exclusion of the distress which the risk of such punishment entails. They are views which satisfy each of the various criteria listed above; it is this that distinguishes them from opinions that might be held on other methods of discipline or on discipline in general." (Emphasis added)**

59. The ECtHR's reference to Article 17, ECHR, is instructive. Article 17, ECHR, prohibits the use of the ECHR to destroy the rights of others. It becomes relevant where a State, group or person seeks to rely on Convention rights in a way that blatantly violates the rights and values protected by the Convention. One cannot, for example, rely on the right to freedom of expression to espouse hatred, violence or a totalitarian ideology that is wholly incompatible with the

principles of democracy: see the ECtHR's Guide on Article 17 of ECHR at para 26. The level at which Article 17 becomes relevant is clearly (and necessarily) a high one. The fundamental freedoms and rights conferred by the Convention would be seriously diminished if Article 17, and the effective denial of a Convention right, could be too readily invoked: see **Vajnai v Hungary** (2010) 50 EHRR 44 at paras 21 to 26. Thus, when the ECtHR refers to Article 17 (as it did in **Campbell and Cosans v UK** in considering whether a philosophical conviction is worthy of respect in a democratic society and not in conflict with the fundamental rights of others, it would have had in mind that it is only a conviction that e.g. challenges the very notion of democracy that would not command such respect. To maintain the plurality that is the hallmark of a functioning democracy, the range of beliefs and convictions that must be tolerated is very broad. It is not enough that a belief or a statement has the potential to "offend, shock or disturb" (see **Vajnai** at para 46) a section (or even most) of society that it should be deprived of protection under Articles 9 (freedom of thought conscience and belief) or Article 10 (freedom of expression). The stipulation that the conviction or belief must not be in conflict with the fundamental rights of others must also be viewed with regard to Article 17. The conflict between rights in this context of satisfying threshold requirements is not merely that which would arise in any case where the exercise of one right might have an impact on the ECHR rights of another; in order for a conviction or belief to satisfy threshold requirements to qualify for protection, it need only be established that it does not have the effect of destroying the rights of others.

60. The second passage to which Burton P referred was paragraph 23 of **Williamson**, where Lord Nicholls of Birkenhead said as follows:

> **"23. Everyone, therefore, is entitled to hold whatever beliefs he wishes. But when questions of "manifestation" arise, as they usually do in this type of case, a belief must satisfy some modest, objective minimum requirements. These threshold requirements are implicit in article 9 of the European Convention and comparable guarantees in other human rights instruments. The belief must be consistent with basic standards of human dignity or integrity. Manifestation of a religious belief, for instance, which involved subjecting others to torture or inhuman punishment would not qualify for protection. The belief must relate to matters more than merely trivial. It must possess an adequate degree of**

> **seriousness and importance. As has been said, it must be a belief on a fundamental problem. With religious belief this requisite is readily satisfied. The belief must also be coherent in the sense of being intelligible and capable of being understood. But, again, too much should not be demanded in this regard. Typically, religion involves belief in the supernatural. It is not always susceptible to lucid exposition or, still less, rational justification. The language used is often the language of allegory, symbol and metaphor. Depending on the subject matter, individuals cannot always be expected to express themselves with cogency or precision. Nor are an individual's beliefs fixed and static. The beliefs of every individual are prone to change over his lifetime. Overall, these threshold requirements should not be set at a level which would deprive minority beliefs of the protection they are intended to have under the Convention: see Arden LJ *[2003] QB 1300* , 1371, para 258." (Emphasis added)**

61. The reference there to a belief involving "torture or inhuman punishment" is consistent with the principle that only the gravest violations of Convention principles should be denied protection. Such violations go far beyond what might be regarded as potentially justifiable interference with a right: they seek to destroy such rights.

62. The two passages on which Burton P relied in formulating Grainger V clearly establish the extremely grave threat to Convention principles that would have to exist in order for a belief not to satisfy that criterion. We do not accept Ms Russell's submission that the Claimant has misconstrued these passages in pursuit of her submission that Article 17 provides the appropriate standard against which Grainger V is to be assessed. Far from being merely one of the factors to be taken into account, it appears to us that Article 17 was mentioned because that is the benchmark against which the belief is to be assessed; only if the belief involves a very grave violation of the rights of others, tantamount to the destruction of those rights, would it be one that was not worthy of respect in a democratic society. We do not consider that the ECtHR would have referred to Article 17, or the House of Lords to "torture and punishment", if a belief involving some lesser violation of others' rights - not sufficiently grave to engage Article 17 - was also capable of being not worthy of such respect.

63. Two recent decisions of the ECtHR provide further illustration of the kinds of views that must be espoused before Article 17 would apply so as to deprive a person of the protection under Article 10 of the Convention. The first is **Ibragimov**. In that case, publications by Muslim groups were banned by the State on the grounds that they were extremist and sought to incite religious discord. In response to an application to the ECtHR that rights under Article 10 (freedom of expression) had been infringed, the State contended that the Article 10 protection should be removed from the applicants by the operation of Article 17. The ECtHR rejected that contention stating:

> **"62. The Court reiterates that, as recently confirmed by the Court, Article 17 is only applicable on an exceptional basis and in extreme cases. Its effect is to negate the exercise of the Convention right that the applicant seeks to vindicate in the proceedings before the Court. In cases concerning Article 10 of the Convention, it should only be resorted to if it is immediately clear that the impugned statements sought to deflect this Article from its real purpose by employing the right to freedom of expression for ends clearly contrary to the values of the Convention (see Perinçek v. Switzerland [GC], no. 27510/08, § 114, ECHR 2015 (extracts)).**
> **63. Since the decisive point under Article 17 – whether the text in question sought to stir up hatred, violence or intolerance, and whether by publishing it the applicant attempted to rely on the Convention to engage in an activity or perform acts aimed at the destruction of the rights and freedoms laid down in it – overlaps with the question whether the interference with the applicant's rights to freedom of expression and freedom of religion was "necessary in a democratic society", the Court finds that the question whether Article 17 is to be applied must be joined to the merits of the applicant's complaints under Articles 9 and 10 of the Convention (see Perinçek, cited above, § 115).**
> **…**
>
> **123. Having regard to the above considerations and its case-law on the subject, the Court finds that the domestic courts did not apply standards which were in conformity with the principles embodied in Article 10 and did not provide "relevant and sufficient" reasons for the interference. In particular, it is unable to discern any element in the domestic courts' analysis which would allow it to conclude that the book in question incited violence, religious hatred or intolerance, that the context in which it had been published was marked by heightened tensions or special social or historical background in Russia or that its circulation had led or could lead to harmful consequences. The Court concludes that it was not necessary, in a democratic society, to ban the book in question.**
> **124. The Court therefore rejects the Government's preliminary objection under Article 17 and finds that there has been a violation of Article 10 of the Convention." (Emphasis added)**

64. **In Lilliendahl**, the applicant had been convicted under Iceland's General Penal Code for making derogatory remarks about homosexuals during a radio broadcast debating a local council proposal to strengthen education in schools on LGBT issues. The applicant had referred to

homosexuals as "sexual deviants" and used other highly offensive terminology. On the applicant's claim that his Article 10 (freedom of expression) rights had been infringed, the ECtHR considered whether the application should be dismissed pursuant to Article 17. It held:

> **"25. The decisive point under Article 17 is whether the applicant's statements sought to stir up hatred or violence and whether, by making them, he attempted to rely on the Convention to engage in an activity or perform acts aimed at the destruction of the rights and freedoms laid down in it (Perinçek v. Switzerland [GC], no. 27510/08, §§ 113-115, 15 October 2015). If applicable, Article 17's effect is to negate the exercise of the Convention right that the applicant seeks to vindicate in the proceedings before the Court. As the Court held in Perinçek, Article 17 is only applicable on an exceptional basis and in extreme cases. In cases concerning Article 10 of the Convention, it should only be resorted to if it is immediately clear that the impugned statements sought to deflect this Article from its real purpose by employing the right to freedom of expression for ends clearly contrary to the values of the Convention (ibid., § 114).**
>
> **26. The Court finds that the applicant's statement cannot be said to reach the high threshold for applicability of Article 17 as set out in the above-mentioned judgment in Perinçek (ibid.). Although the comments were highly prejudicial, as discussed further below, it is not immediately clear that they aimed at inciting violence and hatred or destroying the rights and freedoms protected by the Convention (compare Witzsch v. Germany (no. 1) (dec.), no. 41448/98, 20 April 1999; Schimanek v. Austria (dec.), no. 32307/96, 1 February 2000; Garaudy v. France (dec.), no. 65831/01, ECHR 2003-IX; Norwood v. the United Kingdom (dec.), no. 23131/03, 16 November 2004; Witzsch v. Germany (no. 2) (dec.), no. 7485/03, 13 December 2005; and Molnar v. Romania (dec.), no. 16637/06, 23 October 2012). The applicant is thus not barred from invoking his freedom of expression in this instance. What remains to be decided is whether his conviction complied with Article 10 of the Convention." (Emphasis added)**

65. The ECtHR went on to describe the two categories of "hate speech" considered by the Court's case-law under Article 10:

> **"33. 'Hate speech', as this concept has been construed in the Court's case-law, falls into two categories. As discussed above, the Supreme Court held that although the term 'hate speech' was not used in Article 233 (a) of the General Penal Code, it was clear from the provision's preparatory works and the international legal instruments by which it was inspired that the concept of 'hate speech' was simultaneously a synonym for the sort of expression which the provision penalized and a threshold for the severity which such expression had to reach in order to fall under the provision (see paragraph 13 above).**
>
> **34. The first category of the Court's case-law on 'hate speech' is comprised of the gravest forms of 'hate speech', which the Court has considered to fall under Article 17 and thus excluded entirely from the protection of Article 10 (see paragraphs 25-26 above and the cases cited therein). As explained above, the Court does not consider the applicant's comments to fall into this category (see paragraph 26 above).**
>
> **35. The second category is comprised of 'less grave' forms of 'hate speech' which the Court has not considered to fall entirely outside the protection of Article 10, but which it has considered permissible for the Contracting States to restrict (see, inter alia, Féret v. Belgium, no. 15615/07, §§ 54-92, 16 July 2009; Vejdeland and Others v. Sweden, cited above, §§ 47-60; Delfi AS v. Estonia, cited above, §§ 153 and 159; and Beizaras and Levickas v. Lithuania, cited above, § 125). In the last-mentioned case, the Court found a violation of Article 14 taken in conjunction**

**with Article 8, and of Article 13, on account of the authorities' refusal to prosecute authors of serious homophobic comments on Facebook, including undisguised calls for violence. In Delfi AS, the Court found no breach of Article 10 as regards the domestic courts' imposition of liability on the applicant company, notably due to the insufficiency of the measures taken by the applicant company to remove without delay after publication comments on its news portal amounting to hate speech and speech inciting violence and to ensure a realistic prospect of the authors of such comments being held liable.**

**36. Into this second category, the Court has not only put speech which explicitly calls for violence or other criminal acts, but has held that attacks on persons committed by insulting, holding up to ridicule or slandering specific groups of the population can be sufficient for allowing the authorities to favour combating prejudicial speech within the context of permitted restrictions on freedom of expression (see Beizaras and Levickas v. Lithuania, cited above, § 125; Vejdeland and Others v. Sweden, cited above, § 55, and Féret v. Belgium, cited above, § 73). In cases concerning speech which does not call for violence or other criminal acts, but which the Court has nevertheless considered to constitute 'hate speech', that conclusion has been based on an assessment of the content of the expression and the manner of its delivery.**

**37. Thus, for example, in Féret, the Court found no violation of Article 10 of the Convention in respect of the conviction of the applicant, chairman of the political party "Front National", for publicly inciting discrimination or hatred. The Court considered it significant that the applicant's racist statements had been made by him in his capacity as a politician during a political campaign, where they were bound to be received by a wide audience and have more impact than if they had been made by a member of the general public (Féret v. Belgium, cited above, § 75). Similarly, in Vejdeland and Others, the Court found no violation of Article 10 in respect of the applicants' conviction for distributing leaflets considered by the courts to be offensive to homosexual persons. It emphasized that the leaflets had been distributed in schools, left in the lockers of young people at an impressionable and sensitive age (Vejdeland and Others v. Sweden, cited above, § 56).**

**38. In the present case, the Court sees no reason to disagree with the Supreme Court's assessment that the applicant's comments were "serious, severely hurtful and prejudicial". As reasoned by the Supreme Court, the use of the terms kynvilla (sexual deviation) and kynvillingar (sexual deviants) to describe homosexual persons, especially when coupled with the clear expression of disgust, render the applicant's comments ones which promote intolerance and detestation of homosexual persons.**

**39. The Court has already found (see paragraph 26 above) that the comments in question did not constitute a manifestation of the gravest form of 'hate speech' thus falling outside the scope of protection of Article 10 of the Convention by virtue of Article 17. However, the Court considers it clear that the comments in issue, viewed on their face and in substance, fell under the second category of 'hate speech' (see paragraphs 35-36 above) falling to be examined under Article 10 of the Convention. The manner of delivery of the comments does not alter this conclusion, although it is true that the comments, which were made publicly, were expressed by the applicant as a member of the general public not expressing himself from a prominent platform likely to reach a wide audience. Moreover, viewing the severity of the comments, as correctly assessed by the Supreme Court, it does not detract from the Court's finding above that the comments were not directed, in particular, at vulnerable groups or persons (compare and contrast Vejdeland).**

**40. The Court finally notes that this conclusion, whilst relevant, is not, as such, conclusive for its assessment whether the applicant's conviction fulfilled the requirements of lawfulness, legitimate aim and necessity in a democratic society as required by Article 10 § 2 of the Convention." (Emphasis added)**

66. It is clear from these judgments that, in assessing whether a person's rights under Article 9 or Article 10 have been infringed, there is a preliminary question as to whether the person qualifies for protection at all, or, to use the ECtHR's terminology, as to whether the person "fall[s] outside the scope of protection of Article 10 of the Convention by virtue of Article 17": **Lilliendahl** at para 39. Where the expression amounts to the "gravest form of hate speech" then the protection would not apply, as Article 17 would operate to deprive the person of the protection that they seek to invoke. However, if the expression does not fall into that first category, then the question is whether the steps taken by the State to restrict such expression are justified within the meaning of Article 10(2). Thus even comments which are "serious, severely hurtful and prejudicial", or which promote intolerance and detestation of homosexuals would not fall outside the scope of Article 10 altogether. However, that does not mean that the individual making such comments has free rein to make them in any circumstance at all. The individual's freedom to express their views is limited to the extent provided for by Article 10(2) and it will then be for the Court to assess whether any limitation imposed by the State is justified.

67. In many Article 9 cases, that two-stage analysis will not arise because it will be obvious that the religion or belief is one which falls within scope of the protection afforded by that Article, and the analysis will move swiftly to whether there was an interference with the right and, if so, whether that was justified. However, where it does arise, it is important to bear in mind the extremely limited circumstances in which a belief would be considered so beyond the pale that it does not qualify for protection at all.

68. Of course, the architecture of the EqA does not precisely follow the structure of the ECHR. Section 10, EqA focuses on whether a person has the protected characteristic of belief. In determining whether a person falls within s.10, EqA, the Tribunal is essentially undertaking the 'first stage' analysis described above in relation to ECHR. That is to say, the Tribunal is

considering only whether the person falls within the scope of the relevant protection at all. At this stage, therefore, in order to ensure that s.10, EqA is applied compatibly with Article 9, ECHR, the question will be whether the belief meets the "modest threshold requirements" as established by the case law, and as encapsulated in the Grainger Criteria. In relation to Grainger V, that means that only those beliefs whose characteristics are such that they would fall outside the scope of Article 9, ECHR by virtue of Article 17 would fail to satisfy that criterion.

69. We do not accept Ms Russell's submission that taking that approach is to reduce the analysis under s.10 EqA only to a consideration of Articles 9 and 10, ECHR. It is the approach that is required having regard to the obligation under s.3, HRA to read and give effect to s.10, EqA compatibly with the Convention. In any event, it was not suggested that there were any residual or additional threshold conditions under s.10, EqA that would require a different approach to be taken. Instead, reliance is placed on Grainger V alone. However, Grainger V is, as we have seen, itself derived from case law concerned with Convention rights. Accordingly, it is correct, in our judgment, to apply s.10, EqA with Article 17, ECHR in mind.

70. Ms Russell's further objection to any approach based on Article 17 is that it would mean only beliefs akin to Nazism or espousing totalitarianism would fail to qualify for protection. However, it is clear from Convention case law that that is as it should be; a person is free in a democratic society to hold any belief they wish, subject only to "some modest, objective minimum requirements": per Lord Nicholls in **Williamson**. It is only in extreme cases involving the gravest violation of other Convention rights that the belief would fail to qualify for protection at all.

71. Ms Russell referred us to **Palomo Sánchez v Spain** [2011] IRLR 934, in which the ECtHR considered whether there had been a breach of Article 10 (and Article 11 (freedom of

association)) in circumstances where employees, who were on the executive of the relevant trade union, had been dismissed for publishing a newsletter containing a highly offensive cartoon depicting a manager and two co-workers in compromising positions. The Spanish courts dismissed their complaints based on a violation of the right to freedom of expression, considering the restriction of that right in the particular employment context concerned to be justified. The ECtHR held that the Spanish courts were required to balance the applicants' right to freedom of expression "against the right to honour and dignity" of the three impugned colleagues, and had, in the particular employment context concerned, reached decisions that did not amount to a violation of Article 10. We were not assisted by this case (a) because it was not concerned with Article 17 and the ouster of Article 10 protection; and (b) it appeared to us to be a straightforward application of Article 10(2) and the circumstances in which an interference with the right to freedom of expression may be justified. It did not, in our view, establish that qualification for protection under Article 9 or 10 would not be afforded to an individual in any case where their actions might impinge upon the "honour and dignity" of others.

*The Relevance of Manifestation*

72. Although Article 9(2) refers to the right to the freedom of thought, conscience and religion, it also refers to the freedom to manifest that religion or belief "in worship, teaching, practice and observance". Furthermore, it is the freedom to manifest religion or belief that is subject only to the limitations described in Article 9(2). Section 10, EqA makes no mention of manifestation. To what extent then, is manifestation relevant in applying s.10, EqA? Mr Cooper submits that manifestation may be taken into account but only for the purposes of determining whether the threshold requirements are met in general, rather than whether a particular expression or manifestation is protected.

73. In **Gray** (EAT), at paras 29 to 30, I said as follows in relation to the application of the Grainger Criteria and manifestation:

> **"29 However, it is important to remember that in an application of the Grainger criteria, and the fourth Grainger criterion in particular, the focus should be on the manifestation of the belief. As Lord Nicholls stated in Williamson, at para 23:**
>
> > **"Everyone, therefore, is entitled to hold whatever beliefs he wishes. But when questions of "manifestation" arise, as they usually do in this type of case, a belief must satisfy some modest, objective minimum requirements."**
>
> **30 Lord Walker of Gestingthorpe, at para 64 of Williamson, agreed with Lord Nicholls that a focus on manifestation was necessary "in order to prevent article 9 becoming unmanageably diffuse and unpredictable in its operation"" (see para 62):**
>
> > **"I am therefore in respectful agreement with Lord Nicholls that, at any rate by the time that the court has reached the stage of considering the *manifestation* of a belief, it must have regard to the implicit (and not over-demanding) threshold requirements of seriousness, coherence and consistency with human dignity which Lord Nicholls mentions." (Emphasis in original)"**

74. Although the Court of Appeal upheld the judgment in **Gray** (EAT), it did so on the basis that there was no causal link between the claimed belief and the detriment relied upon. The Court of Appeal went on to say:

> **"30 It is unnecessary in these circumstances for us to consider whether Choudhury J was right to require the focus to be on manifestation when determining whether there is a protected belief by reference to the Grainger criteria. Our judgment is not to be taken as endorsing this approach".**

75. Ms Monaghan submits that, although the Court of Appeal in **Gray** (CA) did not expressly overrule it, this aspect of my judgment in **Gray** (EAT) was wrong. She submits that manifestation is not a useful touchstone for determining whether a belief meets the Grainger Criteria, not least because a single belief may be manifested by different people in different ways, or may not be manifested at all. Furthermore, manifestation would be meaningless in relation to a lack of belief (which is also protected) since there would usually be no belief to manifest. Ms Monaghan submits that where, in **R (Williamson)**, Lord Nicholls and Lord Walker referred to a focus on manifestation being necessary, this meant no more than that the Court or Tribunal would probably

not be troubled with having to determine whether a belief met the threshold requirements unless and until manifestation becomes an issue.

76. Ms Russell submits that whether or not **Gray** (EAT) was wrong in this regard does not take the Claimant's appeal any further since the Tribunal considered that the manifestation in question was not separable from the belief itself.

77. We agree with Ms Monaghan that I was wrong to read the remarks of Lord Nicholls and Lord Walker in **R (Williamson)** as meaning that, at the stage of applying the Grainger Criteria, the *focus* should be on manifestation. Manifestation is not irrelevant: the belief may only come to the employer's attention because of some outward manifestation. The Claimant's tweets in this case are an example. Had she not sent those tweets or expressed her beliefs in any discernible way, then the issues giving rise to this appeal would not have arisen at all. Moreover, as I said in **Gray** (EAT) the manner in which a person manifests their belief might, in some cases, be relevant in determining whether the belief has the requisite degree of cogency or cohesion to satisfy Grainger IV. However, we accept Ms Monaghan's and Mr Cooper's submission that at this preliminary stage of assessing whether the belief even qualifies for protection, manifestation can be no more than a part of the analysis (assuming that there is any manifestation at all) and should be considered only in determining whether the belief meets the threshold requirements in general. It is also right to note that an approach that places the focus on manifestation might lead the Tribunal to consider whether a particular expression or mode of expression of the belief is protected, rather than concentrating on the belief in general and assessing whether it meets the Grainger Criteria.

78. That approach follows from the language of s.10, EqA which, as we have said, is concerned only with whether a person *has* the protected characteristic by being *of* the religion or belief in question, and not with whether a person *does* anything pursuant to that religion or belief.

79. In our judgment, it is important that in applying Grainger V, Tribunals bear in mind that it is only those beliefs that would be an affront to Convention principles in a manner akin to that of pursuing totalitarianism, or advocating Nazism, or espousing violence and hatred in the gravest of forms, that should be capable of being not worthy of respect in a democratic society. Beliefs that are offensive, shocking or even disturbing to others, and which fall into the less grave forms of hate speech would not be excluded from the protection. However, the manifestation of such beliefs may, depending on circumstances, justifiably be restricted under Article 9(2) or Article 10(2) as the case may be.

*Did the Tribunal err in its approach?*

80. The Tribunal was tasked with considering whether the Claimant's belief fell within s.10, EqA. In terms of Article 9 and Article 10 rights, the issue was simply whether the Claimant fell within the scope of the protection afforded by those Articles.

81. It was not the Tribunal's task to engage in any evaluation of the Claimant's beliefs by any objective standard. Instead, it was to assess that belief on its own terms.

82. In applying Grainger V, it was incumbent upon the Tribunal to bear in mind that only those beliefs or acts of expression that would fall to be excluded from protection by virtue of Article 17, ECHR would fall outside the scope of s.10, EqA. Thus, the Tribunal would, in order to exclude the protection, have to be satisfied that the belief in question or its expression gave

rise to the gravest form of hate speech, was inciting violence, or was as antithetical to Convention principles as Nazism or totalitarianism.

83. The Tribunal's application of the Grainger Criteria appears to commence at paras 79. There, the Tribunal states that:

> **"Many concerns that the Claimant has, such as ensuring protection of vulnerable women, do not, in fact, rest on holding a belief that biological sex is immutable."**

84. Similarly, at para 81, the Tribunal states that:

> **"Many of the illustrations the Claimant relies on do not, in fact, rely on the belief that men can never become women; but on the analysis that there may be limited circumstances in which it is relevant that a person is a trans woman or trans man, such as when ensuring appropriate medical care is provided, which takes proper account of trans status."**

85. The Tribunal appears here to be straying into an evaluation of the Claimant's belief. In our judgment, it is irrelevant in determining whether a belief qualifies for protection that some of its tenets are considered by the Tribunal to be unfounded, or that it might be possible for the Claimant's concerns to be allayed without adhering to or manifesting her belief. By expressing the view that it did and by proposing steps that the Claimant could take so as not to manifest her belief in a certain way, the Tribunal, was, it seems to us, implicitly making a value judgment based on its own view as to the legitimacy of the belief. In doing so, the Tribunal could be said to have failed to remain neutral and/or failed to abide by the cardinal principle that everyone is entitled to believe whatever they wish, subject only to a few modest, minimum requirements.

86. At para 82, the Tribunal comments that the Claimant is "not prepared to consider the possibility that her belief may not be correct". That too seems to us to be an irrelevant consideration. A person who is dogmatic in their belief, even in the face of overwhelming evidence tending to undermine it, is no less entitled to protection for their belief than a person

whose belief has the support, say, of the majority of the scientific community. Qualification for protection cannot depend on the quality of open-mindedness or a willingness to accept rational, but opposing, views. As stated in **Bessarabia**, the State (here represented by the Tribunal) must remain neutral; its role is "not to remove the cause of tensions by doing away with pluralism, but to ensure that groups opposed to one another tolerate each other." Even though this aspect of the Tribunal's judgment was concerned with Grainger III (i.e. whether the belief is as to a weighty and substantial aspect of human life and behaviour) on which the Claimant succeeded, the error in the Tribunal's approach is apparent.

87. We see this error of approach again at para 83, where the Tribunal considers whether the belief satisfies Grainger IV (by attaining a certain level of cogency, seriousness, cohesion and importance). Although, once again, the Tribunal finds in the Claimant's favour, it does so having expressed doubts as to the scientific basis for the Claimant's belief. The Tribunal refers to "the fact that biological opinion is increasingly moving away from an absolutist approach [to gender]…", despite there being little in the way of expert evidence about that issue and really little more than an article in the New York Times referred to at para 44 in support. It is irrelevant that the Tribunal might consider the scientific foundations of the Claimant's belief to be weak. The belief is to be assessed on its own terms against the very modest threshold requirements established by the case law. The requirement that a belief must attain a certain level of cogency or cohesion should not lead a Tribunal, using the tools of logic or science, to challenge the basis for a belief; were that not so then many might consider that no religious belief satisfies Grainger IV.

88. It is at para 84 that the Tribunal commences its analysis of the Claimant's belief by reference to Grainger V, and in respect of which the Tribunal found against the Claimant. The Tribunal considers that "the Claimant's view, in its absolutist nature, is incompatible with human

dignity and fundamental rights of others". It is not entirely clear from the Tribunal's judgment what is meant when it describes the Claimant's belief as "absolutist". If it meant "absolutist" in the sense that the Claimant has an unshakeable conviction that she is right that sex is immutable and that anyone who disagrees with her is wrong, then any person professing to hold a belief (whether religious or philosophical) with which others profoundly disagree or which others do not share could be said to be absolutist. However, as we have said already, the firmness with which one clings to a view (even one that others might consider offensive or irrational) is not a reason to deny that person the protection under s.10, EqA. If that were not so, then the more fervently held the belief, the less likely it is to qualify for protection. "Absolutism" in that sense cannot therefore be a valid criterion for determining whether or not a belief falls to be protected under s.10, EqA.

89. The other way in which the description "absolutist" appears to have been used is in relation to the Tribunal's finding at para 90 that "it is a core component of [the Claimant's] belief that she will refer to a person by the sex she considered appropriate even if it violates their dignity and/or creates an intimidating, hostile, degrading, humiliating or offensive environment." Insofar as the Tribunal is here suggesting that the Claimant would always, indiscriminately and gratuitously, "misgender" trans men and women, then that is, as we have said, inconsistent with the Tribunal's own earlier findings that the Claimant would "generally seek to be polite to trans persons and would usually seek to respect their choice of pronoun but would not feel bound to; mainly if a trans person who was not assigned female at birth was in a "woman's space" but also more generally." The evidence that we were taken to and which was before the Tribunal supported the Claimant's case that she would usually use preferred pronouns but reserved the right not to do so where she considered that to be relevant. The only evidence of "misgendering" appears to have been in relation to an incident described at para 89 of the Judgment and concerning Gregor Murray. The Claimant explains that her use of the male pronoun when

A referring to Gregor Murray instead of the preferred "they" and "them" was unintentional. There is nothing to suggest that the Tribunal rejected that evidence.

B 90. Reading the Tribunal's judgment as a whole, as we must, we do not read the Tribunal's conclusions at para 90 as meaning that the Claimant would always, indiscriminately and gratuitously use the wrong or non-preferred pronouns when referring to or communicating with trans persons. On a proper reading of the Judgment, the Tribunal was stating that the Claimant C would not use preferred pronouns whenever she considered it appropriate not to do so. That must mean that she would not use them where she considered it to be relevant. If that is correct, then the description "absolutist" would appear to be something of a misnomer as her position was D more nuanced and context dependent.

91. The Tribunal also relies, at paras 84, 85, 86 and 91 on the Claimant's refusal to E acknowledge the full effect of a GRC as evidence of the absolutist nature of her views, the Tribunal being of the view that the Claimant is not entitled to ignore the fact that a trans woman with a GRC is "legally a woman". The question is whether the Tribunal was correct to consider that the existence of a GRC means that the Claimant is not entitled in any circumstances to refer F to a trans woman holding such a certificate as a man.

92. The GRA was enacted following the decision of the ECtHR in **Goodwin**, in which the G Court considered whether the absence of any legal recognition of the acquired gender of those who had undergone gender reassignment surgery amounted to a violation of Article 8 (right to private and family life), ECHR. In holding that there was a violation of Article 8, the ECtHR held H as follows:

> **"77. It must also be recognised that serious interference with private life can arise where the state of domestic law conflicts with an important aspect of personal identity (see, mutatis mutandis, Dudgeon v the United Kingdom judgment of 22 October 1981, Series A no.45, paragraph 41). The stress and alienation arising**

> **from a discordance between the position in society assumed by a post-operative transsexual and the status imposed by law which =refuses to recognise the change of gender cannot, in the Court's view, be regarded as a minor inconvenience arising from a formality. A conflict between social reality and law arises which places the transsexual in an anomalous position, in which he or she may experience feelings of vulnerability, humiliation and anxiety.**
>
> **…**
> **90. Nonetheless, the very essence of the Convention is respect for human dignity and human freedom. Under Article 8 of the Convention in particular, where the notion of personal autonomy is an important principle underlying the interpretation of its guarantees, protection is given to the personal sphere of each individual, including the right to establish details of their identity as individual human beings (see, inter alia, Pretty v the United Kingdom, no.2346/02, judgment of 29 April 2002, paragraph 62, and Mikulic v Croatia, no.53176/99, judgment of 7 February 2002, paragraph 53, both to be published in ECHR 2002). In the 21st century the right of transsexuals to personal development and to physical and moral security in the full sense enjoyed by others in society cannot be regarded as a matter of controversy requiring the lapse of time to cast clearer light on the issues involved. In short, the unsatisfactory situation in which post-operative transsexuals live in an intermediate zone as not quite one gender or the other is no longer sustainable. Domestic recognition of this evaluation may be found in the report of the Interdepartmental Working Group and the Court of Appeal's judgment of Bellinger v Bellinger (see paragraphs 50, 52–53)." (Emphasis added)**

93. The ECtHR thus considered that it was an important aspect of their Article 8 rights that trans persons who had undergone gender reassignment surgery should be entitled to *legal* recognition of the acquired gender. The GRA was enacted to address the shortcomings in the law identified in **Goodwin**. Section 9, GRA so far as relevant provides:

> **"9 General**
> **(1) Where a full gender recognition certificate is issued to a person, the person's gender becomes for all purposes the acquired gender (so that, if the acquired gender is the male gender, the person's sex becomes that of a man and, if it is the female gender, the person's sex becomes that of a woman).**
> **…" (Emphasis added)**

94. The GRA provides for certain exceptions where, as a matter of law, a person's gender is not the acquired gender. For example, section 12 provides that the fact that a person's gender has become the acquired gender does not affect the status of that person as the father or mother of a child. Whilst the GRA makes it an offence to disclose information acquired in an official capacity as to a person's gender before it became the acquired gender (s.22, GRA), there is nothing in the Act that requires a person acting in any private capacity to refer to a person's

acquired gender or to refrain from referring to a person's gender before it became the acquired gender.

95. The GRA was considered by the House of Lords when it was still the Gender Recognition Bill in **Chief Constable of Yorkshire Police v A**. Baroness Hale referred to the Bill as follows:

> **"42. The Gender Recognition Bill is currently before Parliament. This lays down a comprehensive scheme for recognising the reassigned gender of a trans person in defined circumstances. There are wider than the postoperative conditions with which the domestic and European case law has been concerned. Once recognised, the reassigned gender is valid for all legal purposes unless specific exception is made. It will no longer be a genuine occupational qualification that the job may entail the carrying out even of intimate searches. In policy terms, therefore, the view has been taken that trans people properly belong to the gender in which they live." (Emphasis added)**

96. More recently, in **R (McConnell) v Registrar General for England and Wales (AIRE Centre intervening)** [2020] 3 WLR 683, the Court of Appeal stated that:

> **54 On that interpretation (which the High Court accepted and which we also would accept on the natural interpretation of the legislation) the general effect of section 9(1) of the GRA is displaced to the extent that an exception to it applies. For present purposes the relevant exception is contained in section 12. It follows that, although for most purposes a person must be regarded in law as being of their acquired gender after the certificate has been issued, where an exception applies, they are still to be treated as having their gender at birth. ..."**

97. Although s. 9, GRA refers to a person becoming "for all purposes" the acquired gender, it is clear from these references in decisions of the House of Lords and the Court of Appeal, that this means for all "legal purposes". That the effect of s.9, GRA is not to erase memories of a person's gender before the acquired gender or to impose recognition of the acquired gender in private, non-legal contexts is confirmed by the comments of Baroness Hale in **R (C) v Secretary of State for Work and Pensions** [2017] 1 WLR 4127 (SC). The issue in that case was whether the DWP had breached the GRA by keeping records of a trans person's gender before the acquired gender and operating a special customer records policy for customers seeking extra privacy, which had the effect of alerting front-line staff to the possibility that a customer had a GRC.

Baroness Hale begins her judgment with a powerful account of the traumas faced by trans persons and the importance to them of being acknowledged in their acquired gender:

> **"1 "We lead women's lives: we have no choice". Thus has the Chief Justice of Canada, the Rt Hon Beverley McLachlin, summed up the basic truth that women and men do indeed lead different lives. How much of this is down to unquestionable biological differences, how much to social conditioning, and how much to other people's views of what it means to be a woman or a man, is all debatable and the accepted wisdom is perpetually changing. But what does not change is the importance, even the centrality, of gender in any individual's sense of self. Over the centuries many people, but particularly women, have bitterly resented and fought against the roles which society has assigned to their gender. Genuine equality between the sexes is still a work in progress. But that does not mean that such women or men have not felt entirely confident that they are indeed a woman or a man. Gender dysphoria is something completely different - the overwhelming sense that one has been born into the wrong body, with the wrong anatomy and the wrong physiology. Those of us who, whatever our occasional frustrations with the expectations of society or our own biology, are nevertheless quite secure in the gender identities with which we were born, can scarcely begin to understand how it must be to grow up in the wrong body and then to go through the long and complex process of adapting that body to match the real self. But it does not take much imagination to understand that this is a deeply personal and private matter; that a person who has undergone gender reassignment will need the whole world to recognise and relate to her or to him in the reassigned gender; and will want to keep to an absolute minimum any unwanted disclosure of the history. This is not only because other people can be insensitive and even cruel; the evidence is that transphobic incidents are increasing and that transgender people experience high levels of anxiety about this. It is also because of their deep need to live successfully and peacefully in their reassigned gender, something which non-transgender people can take for granted."**

98. Baroness Hale went on to acknowledge, however, that the GRA does not erase history:

> **"22 The appellant accepts that section 9 "does not rewrite history". Thus, in J v C [2007] Fam 1 the issue of a full GRC in the male gender to a person who was previously female did not retrospectively validate his prior marriage to another female (at a time when the law did not provide for same sex marriages), with the result that he did not become the father of a child born to the other female as a result of artificial insemination by donor ("AID") (as would otherwise have been the case under section 27 of the Family Law Reform Act 1987, which provided that the husband of a woman who gives birth as a result of AID was to be treated for all purposes as the father of the child). But she argues that section 9(1) does require her now to be treated for all purposes as a woman and this includes how she is treated by the DWP for the purpose of claiming and receiving JSA. Section 22(1) is not an exception to the general principle in section 9(1). Rather it is an additional protection. It does not follow from the fact that no offence is committed under section 22 that a policy which is in breach of section 9(1) is lawful.**
>
> **23 The problem with this argument is that section 9(1) clearly contemplates a change in the state of affairs: before the issue of the GRC a person was of one gender and after the issue of the GRC that person "becomes" a person of another gender. The sections which follow section 9 are designed, in their different ways, to cater for the effect of that change. Thus, for example, section 12 provides that the acquisition of a new gender does not affect that person's status as the father or mother of a child; section 15 provides that it does not affect the disposal or devolution of property under a will or other instrument made before the**

**appointed day (thus section 9 will apply to dispositions made after that date); section 16 provides that the acquisition of a new gender does not affect the descent of any peerage or dignity or title of honour or property limited to descend with it (unless a contrary intention is expressed in the will or instrument).**
**24 <u>There is nothing in section 9 to require that the previous state of affairs be expunged from the records of officialdom. Nor could it eliminate it from the memories of family and friends who knew the person in another life.</u> Rather, sections 10 and 22 provide additional protection against inappropriate official disclosure of that prior history." (Emphasis added)**

99. The effect of a GRC, whilst broad as a matter of law, does not mean that a person who, like the Claimant, continues to believe that a trans woman with a GRC is still a man, is necessarily in breach of the GRA by doing so; the GRA does not compel a person to believe something that they do not, any more than the recognition by the State of Civil Partnerships can compel some persons of faith to believe that a marriage between anyone other than a man and a woman is acceptable. That is not to say, of course, that the Claimant can, as a result of her belief, disregard the GRC; clearly, she cannot do so in circumstances where the acquired gender is legally relevant, e.g. in a claim of sex discrimination or harassment. Referring to a trans person by their pre-GRC gender in any of the settings in which the EqA applies could amount to harassment related to one or more protected characteristics[1]; whether or not it does will depend, as in any claim of harassment, on a careful assessment of all relevant factors, including whether the conduct was unwanted, the perception of the trans person concerned and whether it is reasonable for the impugned conduct to have the effect of creating an intimidating, hostile, degrading, humiliating or offensive environment for the trans person. A simple example of a situation where referring to a trans person by their pre-GRC gender would probably not amount to harassment is where the trans person in question is happy to discuss their trans status or is sympathetic to or shares the Claimant's gender-critical belief. The Tribunal itself acknowledged that "Many trans people are happy to discuss their trans status", and had before it the uncontested evidence of Kristina

[1] A trans person could potentially bring a claim for harassment related to gender reassignment (where the definition under s.7(2) is satisfied), sex (see e.g. **P v S and Cornwall County Council** [1996] ICR 795 at paras 17 to 22), disability based on the conditions of Gender Dysphoria or Gender Identity Disorder (see EHRC Code at para 2.28), or even a philosophical belief that gender identity is paramount and that a trans woman is woman.

Harrison, a gender-critical trans woman, who, presumably, would not have felt harassed by being referred to as a man in some circumstances. It is difficult, therefore, to understand the Tribunal's conclusion that the Claimant's belief "necessarily harms the rights of others through her refusal to accept the full effect of a GRC…". Not only is this conclusion predicated on the incorrect assumption that the Claimant would always misgender trans persons, irrespective of the circumstances, and that the full effect of a GRC goes beyond legal purposes, but it also fails to recognise that whether there is harassment in a given situation is a highly fact-sensitive question.

100. Some beliefs, for example a belief that all non-white people should be forcibly deported for the good of the nation, are such that any manifestation of them would be highly likely to espouse hatred and incitement to violence. In such cases, it would be open to the Tribunal to say that the belief fails to satisfy Grainger V. However, the rationale for doing so would be that it is the kind of case to which Article 17 might be applied because of the inevitability that the rights of others would be destroyed. The Claimant's belief is not comparable.

101. At para 91, the Tribunal states:

> **"The Claimant could generally avoid the huge offense caused by calling a trans woman a man without having to refer to her as a woman, as it is often not necessary to refer to a person's sex at all. However, where it is, I consider requiring the Claimant to refer to a trans woman as a woman is justified to avoid harassment of that person. Similarly, I do not accept that there is a failure to engage with the importance of the Claimant's qualified right to freedom of expression, as it is legitimate to exclude a belief that necessarily harms the rights of others through refusal to accept the full effect of a Gender Recognition Certificate or causing harassment to trans women by insisting they are men and trans men by insisting they are women. The human rights balancing exercise goes against the Claimant because of the absolutist approach she adopts."**

102. In our judgment, the Tribunal fell into error in two respects here. First, the Tribunal's only task at this preliminary stage was to determine if the Claimant's belief fell within s.10, EqA. That analysis was confined, in Convention terms, to the first stage of determining whether the

belief qualified for protection under Article 9, ECHR at all. There is no balancing exercise between competing rights at this first stage, because it is only a belief that involves in effect the destruction of the rights of others that would fail to qualify. The balancing exercise only arises under the second stage of the analysis under Article 9(2) (or Article 10(2)) in determining whether any restriction on the exercise of the right is justified. That exercise is context specific.

103. The second error was in imposing a requirement on the Claimant to refer to a trans woman as a woman to avoid harassment. In the absence of any reference to specific circumstances in which harassment might arise, this is, in effect, a blanket restriction on the Claimant's right to freedom of expression insofar as they relate to her beliefs. However, that right applies to the expression of views that might "offend, shock or disturb". The extent to which the State can impose restrictions on the exercise of that right is determined by the factors set out in Article 10(2), i.e. restrictions that are "prescribed by law and are necessary in a democratic society … for the protection of the reputation or rights of others…" It seems that the Tribunal's justification for this blanket restriction was that the Claimant's belief "necessarily harms the rights of others". As discussed above, that is not correct: whilst the Claimant's belief, and her expression of them by refusing to refer to a trans person by their preferred pronoun, or by refusing to accept that a person is of the acquired gender stated on a GRC, could amount to unlawful harassment in some circumstances, it would not always have that effect: see para 99 above. In our judgment, it is not open to the Tribunal to impose in effect a blanket restriction on a person not to express those views irrespective of those circumstances.

104. That does not mean that in the absence of such a restriction the Claimant could go about indiscriminately "misgendering" trans persons with impunity. She cannot. The Claimant is subject to same prohibitions on discrimination, victimisation and harassment under the EqA as the rest of society. Should it be found that her misgendering on a particular occasion, because of

its gratuitous nature or otherwise, amounted to harassment of a trans person (or of anyone else for that matter), then she could be liable for such conduct under the EqA. The fact that the act of misgendering was a manifestation of a belief falling with s.10, EqA would not operate automatically to shield her from such liability. The Tribunal correctly acknowledged, at para 87 of the Judgment, that calling a trans woman a man "may" be unlawful harassment. However, it erred in concluding that that possibility deprived her of the right to do so in any situation.

105. At paras 58, 92 and 93 of the Judgment, the Tribunal analysed the position from the perspective of a "lack of belief" within the meaning of s.10(2), EqA. The Tribunal considered that the Grainger Criteria are to be applied to the lack of philosophical belief just as they would to a belief. At para 58, the Tribunal said as follows:

> **"While the position is reasonably clear for religion and lack of religion – as they are specifically provided for in section 10(1) EqA, I consider the position is less clear for lack of belief. Section 10(2) provides that "reference to belief includes a reference to a lack of belief". On that basis if one replaces the word "belief" with "lack of belief", sub-section 2 could be considered to protect any "religious or philosophical lack of belief" – i.e. the lack of belief must be religious or philosophical, rather than the protection applying to anyone who does not hold a particular religious or philosophical belief. On that analysis the Granger Criteria are to be applied to the lack of belief. I consider this is a more logical analysis, at least in some cases. A person might well hold a religious or philosophical belief that murder is wrong. It would be surprising if not holding that belief was also protected, so, in effect, believing there is nothing wrong with murder is a protected characteristic. On my suggested analysis such a lack of belief in murder being wrong would not comply with the Granger Criteria and so would not be protected. Similarly, atheism would be protected because it is a philosophical lack of belief that corresponds with the Granger Criteria rather than merely because atheist are not adherents of the large number of protected religions."**

106. In our judgment, the flaw in this analysis is that it assumes that the lack of belief necessarily denotes holding a positive view that is opposed to the belief in question. However, a lack of belief under s.10, EqA is merely the *absence* of belief: see **Grainger** at para 31. A lack of belief may arise from simply not having any view on the issue at all, either because of indifference, indecision or otherwise. It would also include a person who has some views on the issue but would not claim to have a developed philosophical belief to that effect. Thus, in the

example postulated by the Tribunal of a person having a belief that murder is wrong, the protection conferred on those who lack that belief would not mean that persons who positively believed that murder was not wrong would be protected under EqA. Those who held a positive belief to that effect would be deemed to have a belief, not a lack of belief. Those who had a lack of belief that murder is wrong would include those who had never given the matter any thought and those who think that there might be some situations in which murder is acceptable. That lack of belief is protected under s.10(2), EqA irrespective of whether the Grainger Criteria could be applied to it. Indeed, it is difficult to see how the Grainger Criteria could be applied to a person who held no view on an issue at all.

107. The Claimant had also put her claim in her ET1 on the alternative basis of a lack of belief. The belief that she did not subscribe to was described by the Tribunal as follows at para 92 of the Judgment:

> **"...everyone has a gender which may be different to their sex at birth and which effectively trumps sex so that trans men are men and transwomen are women"**

108. We refer to this as the "gender identity belief". The Claimant accepted that the gender identity belief was a philosophical belief qualifying for protection under s.10, EqA. However, instead of treating the Claimant's lack of the gender identity belief as also qualifying for protection, the Tribunal treated the Claimant's lack of that belief as necessarily equating to a positive belief that trans women are men (which the Tribunal considered to be a belief not worthy of protection). In our judgment, that approach was wrong. The fact that the Claimant did not share the gender identity belief is enough in itself to qualify for protection. If a person, A, is treated less favourably by her employer, B, because of A's failure to profess support for B's gender identity belief then that could amount to unlawful discrimination because of a lack of belief.

109. There was no "sleight of hand" here as suggested by the Tribunal in putting the claim on the basis of a lack of belief. That is a valid course open to putative claimants and its efficacy should not be undermined by treating any lack of belief as necessarily amounting to a positive opposing belief.

*Does the Claimant's belief fall within s.10 EqA?*

110. On a proper application of Grainger V, as analysed above, it seems to us that the only possible conclusion is that the Claimant's belief does fall within s.10, EqA.

111. Most fundamentally, the Claimant's belief does not get anywhere near to approaching the kind of belief akin to Nazism or totalitarianism that would warrant the application of Article 17. That is reason enough on its own to find that Grainger V is satisfied. The Claimant's belief might well be considered offensive and abhorrent to some, but the accepted evidence before the Tribunal was that she believed that it is not "incompatible to recognise that human beings cannot change sex whilst also protecting the human rights of people who identify as transgender": see para 39.2 of the Judgment. That is not, on any view, a statement of a belief that seeks to destroy the rights of trans persons. It is a belief that might in some circumstances cause offence to trans persons, but the potential for offence cannot be a reason to exclude a belief from protection altogether.

112. In the present case, there are two further factors which, upon analysis, are wholly at odds with the view that the belief is not one worthy of respect in a democratic society.

113. First, there is the evidence that the gender-critical belief is not unique to the Claimant, but is widely shared, including amongst respected academics. The popularity of a belief does not

necessarily insulate it from being one that gravely undermines the rights of others; history is replete with instances where large swathes of society have succumbed to philosophies that seek to destroy the rights of others. However, a widely shared belief demands particular care before it can be condemned as being not worthy of respect in a democratic society.

114. Second, the Claimant's belief that sex is immutable and binary is, as the Tribunal itself correctly concluded, consistent with the law: see para 83. The leading case is still **Corbett v Corbett** [1971] P 83 at 104D-G, 106B0D and 107A per Ormrod J. Its effect was considered by the House of Lords in **Chief Constable of West Yorkshire Police v A** (No.2) [2005] 1 AC 51:

> **"3. The advice given to the chief constable on English domestic law, summarised in (1) above, was correct. Such was the effect of *Corbett v Corbett (orse Ashley) [1971] P 83* . That case, it is true, concerned the capacity of a male-to-female transsexual to marry. But the Court of Appeal (Criminal Division) applied the same rule to gender-specific criminal offences in *R v Tan [1983] QB 1053* . Both decisions have been heavily criticised, and other jurisdictions have adopted other rules. But there was nothing in English domestic law to suggest that a person could be male for one purpose and female for another, and there was no rule other than that laid down in *Corbett* and *R v Tan* ." (per Lord Bingham)**
>
> **"19. In March 1998 the chief constable had been advised that, even though she had successfully undergone all the usual treatment, including surgery, in law Ms A's sex was still male. In my view that advice on the domestic law of the United Kingdom was, and remains, correct: Bellinger v Bellinger (Lord Chancellor intervening) [2003] 2 AC 467 , especially at p 480, para 45 per Lord Nicholls of Birkenhead. Section 54(9) of the Police and Criminal Evidence Act 1984 ("PACE") provides: "The constable carrying out a search shall be of the same sex as the person searched." Parliament's laudable aim is to afford protection to the dignity and privacy of those being searched in a situation where they may well be peculiarly vulnerable. While her application to join the force was pending, Ms A herself very properly drew attention to the possible problem posed by this provision. On the basis of the legal advice given to him, the chief constable considered that, because of section 54(9), Ms A could not lawfully search female suspects. And, in practice, she could not search male suspects. Nor could the chief constable arrange for Ms A not to have to carry out searches without it becoming known why he was doing so. Since he understood that she was not willing for this to happen, the chief constable decided that he could not accept her application to join the force." (Per Lord Rodger)**
>
> **"30. In the well known case of *Corbett v Corbett (orse Ashley)* [1971] P 83 , Ormrod J held that, for the purpose of the law of capacity to marry, the sex of a person was fixed at birth. Accordingly a purported marriage in 1963 between a man and a male to female trans person was void ab initio. Shortly after this, the Nullity of Marriage Act 1971 provided that a marriage taking place after 31 July 1971 is void on the ground "that the parties are not respectively male and female". This was later consolidated as section 11(c) of the Matrimonial Causes Act 1973 . The same approach was adopted by the Court of Appeal in R v Tan [1983] QB 1053 for the gender specific offences in the Sexual Offences Acts. The court considered that "both common sense and the desirability of certainty and consistency" demanded that the Corbett decision should apply in both contexts.**

> **Since then, it has been assumed that a person's gender is fixed at birth for the purpose of all legal provisions which make a distinction between men and women. Corbett was followed without challenge in S-T (formerly J) v J [1998] Fam 103 . (per Baroness Hale)"**

115. Where a belief or a major tenet of it appears to be in accordance with the law of the land, then it is all the more jarring that it should be declared as one not worthy of respect in a democratic society. Ms Russell sought to persuade us that the decision in **Corbett** is outdated and should not be followed, particularly in light of the GRA under which a person who obtains a GRC does "become for all purposes" the acquired gender. We cannot see any real basis on which this appeal tribunal could disregard **Corbett** especially given that the House of Lords' comments in **Chief Constable of Yorkshire v A** were made having regard to the Gender Recognition Bill: see para 42 of **Chief Constable of Yorkshire v A**. Society has, of course, moved on considerably since 1971, and, as stated in the Equal Treatment Bench Book, "awareness, knowledge and acceptance of transgender people has greatly increased over the last decade". However, the position under the common law as to the immutability of sex remains the same; and it would be a matter for Parliament, not a court or tribunal considering whether a belief is protected under s.10, EqA, to declare otherwise.

116. Just as the legal recognition of Civil Partnerships does not negate the right of a person to believe that marriage should only apply to heterosexual couples, becoming the acquired gender "for all purposes" within the meaning of GRA does not negate a person's right to believe, like the Claimant, that as a matter of biology a trans person is still their natal sex. Both beliefs may well be profoundly offensive and even distressing to many others, but they are beliefs that are and must be tolerated in a pluralist society.

**Conclusion**

A

117. For these reasons, and notwithstanding Ms Russell's powerful submissions to the contrary, it is our judgment that the Tribunal erred in law. In relation to the preliminary issue of whether the Claimant's belief falls within s.10, EqA, we substitute a finding that it does. The matter will now be remitted to a freshly constituted Tribunal to determine whether the treatment about which the Claimant complains was because of or related to that belief.

B

C

118. We acknowledge that some trans persons will be disappointed by this judgment. Ms Russell submitted that it would create a "two-tier" system between natal women and trans women, with some trans women fearing that it will give licence to people seeking to harass them. We do not agree that that is the effect of deciding that the Claimant's belief is a philosophical belief within the meaning of s.10, EqA. We take this opportunity to reiterate, once more, what this judgment does not mean:

D

a. This judgment does not mean that the EAT has expressed any view on the merits of either side of the transgender debate and nothing in it should be regarded as so doing.

E

b. This judgment does not mean that those with gender-critical beliefs can 'misgender' trans persons with impunity. The Claimant, like everyone else, will continue to be subject to the prohibitions on discrimination and harassment under the EqA. Whether or not conduct in a given situation does amount to harassment or discrimination within the meaning of EqA will be for a tribunal to determine in a given case.

F

c. This judgment does not mean that trans persons do not have the protections against discrimination and harassment conferred by the EqA. They do. Although the protected characteristic of gender reassignment under s.7, EqA would be likely to apply only to a proportion of trans persons, there are other protected characteristics that could potentially be relied upon in the face of such conduct: see footnote 1.

G

H

d. This judgment does not mean that employers and service providers will not be able to provide a safe environment for trans persons. Employers would be liable (subject to any defence under s.109(4), EqA) for acts of harassment and discrimination against trans persons committed in the course of employment.

**Note on Procedure**

119. Finally, we note that the Preliminary Hearing below took some six days to conclude with the Tribunal being presented with hundreds of pages of evidence as to the nature of the Claimant's belief and on the transgender debate more generally. It is perhaps unsurprising in these circumstances that the Tribunal was effectively drawn into an adjudication of the merits and validity of the Claimant's belief, rather than limiting itself to a determination of the question whether the belief fell within s.10, EqA. In our view, that question should not ordinarily take up more than a day of the Tribunal's time. Beliefs which appear trivial or flippant (i.e. not satisfying Grainger III or IV) for example ought to be capable of being dealt with fairly quickly. Given that Grainger V has now been clarified as being apt only to exclude the most extreme beliefs akin to Nazism or totalitarianism or which incite hatred or violence, very few beliefs will fall at that hurdle, and, once again, it should not take long to determine whether a belief falls into that category. It seems to us that it would only be in very rare cases that it would be necessary for there to be a hearing of several days' length to determine that preliminary issue. In most cases, the real issue will be whether there was discrimination because of the belief in question. Where it appears to the Tribunal that the analysis of any preliminary issue in this context is likely to take longer than a day or so, the better approach might be to consider whether all issues, including liability, should be determined together.

# Apply to register a charity

**Organisation names**

**Main name**
LGB ALLIANCE

**Other name or acronym**

**Application number**
5154625

**Submission date**
13/03/2020

**Special circumstances**
LGB Alliance's next public meeting is scheduled for Friday 12th June 2020, at the Queen Elizabeth II Centre in Westminster, London. The trustees are keen that the charity is registered in advance of this meeting to ensure that it will be able to give attendees the option of making a donation when purchasing their ticket or of making a donation to the charity on the day of the event.

**If we decide to register the organisation some of the information you have given in this form will be made publicly available in accordance with section 38(1) of the Charities Act 2011. We have marked on the online form which fields we will make public.**

**This form shows the information you have entered through the apply to register a charity service.**

**Your contact for this application**

**Your current contact is an**
Individual

**Role**
Solicitor

**Name**
Mr Philip Kirkpatrick

**Telephone number**
02075517762

**Email address**
p.kirkpatrick@bateswells.co.uk

## Governing document

**A governing document sets out a charity's rules; it's the key legal document that says what it is and how it will be run. Different charities have different governing documents.**

**Select the organisation's governing document type:**
Memorandum and Articles

**Has the governing document been issued by an organisation or umbrella body (often referred to as an approved governing document)?**

No

| File name |
| --- |
| Memorandum and Articles of Association |

## Replacement

**Are you replacing an existing registered charity?**

No

## Charity name

**This information will be made publicly available on the Charity Register.**

**The organisation's name:**

LGB ALLIANCE

**Is the organisation known by any other names?**

No

**This information will be made publicly available on the Charity Register.**

**Do any of the organisation's names contain acronyms, initials, made-up or non-English language words?**

Yes

**Please translate or explain each made up, non-English word, acronym or initial used:**

LGB - lesbian, gay, bisexual

**Do any names contain words that require consent from another body?**

No

## Structure and purposes

**This information will be made publicly available on the Charity Register.**

**Organisation's governing document:**

Memorandum and Articles

**This information will be made publicly available on the Charity Register.**

**Enter the date the organisation's governing document came into effect (dd/mm/yyyy).**

28/11/2019

**This information will be made publicly available on the Charity Register.**

**Enter the organisation's purposes (also known as 'objects') exactly as they are written in its governing document.**

2. Objects
The objects of the Company are:
2.1 To promote equality and diversity for the public benefit, in particular by:
2.1.1 the elimination of discrimination on the grounds of sexual orientation;
2.1.2 advancing education and raising awareness in equality and diversity in respect of lesbian, gay and bisexual people;
2.1.3 conducting or commissioning research on equality and diversity issues and publishing the useful results to the public; and
2.1.4 cultivating a sentiment in favour of equality and diversity for lesbian, gay and bisexual people.
2.2 To promote human rights (as set out in the Universal Declaration of Human Rights and subsequent United Nations conventions and declarations) and particularly the rights and freedoms of those who face discrimination on the grounds of sexual orientation, including by:
2.2.1 monitoring abuses of human rights;
2.2.2 obtaining redress for the victims of human rights abuses;
2.2.3 relieving need among the victims of human rights abuses;
2.2.4 research into human rights issues;
2.2.5 educating the public about human rights;
2.2.6 providing technical advice to government and others on human rights matters;
2.2.7 contributing to the sound administration of the law;
2.2.8 commenting on proposed human rights legislation;
2.2.9 raising awareness of human rights issues;
2.2.10 promoting public support for human rights;
2.2.11 promoting respect for human rights among individuals and corporations; and
2.2.12 eliminating infringements of human rights.
2.3 To promote any other purpose that is charitable under the law of England and Wales.

## Income

**Enter the organisation's gross annual income:**

£5,000

**What proof of income are you attaching?**

latest annual accounts

☒ Proof of income - LGB Alliance.pdf

## Classification: What

**Every charity on the Register of Charities has a classification. This is so that potential donors, beneficiaries and others who search the register can find types of charities they are interested in.**

**Our charity classification uses four headings. These describe WHAT a charity is set up to achieve, HOW it achieves it, WHO it helps and WHERE it operates.**

**Choose classifications that reflect your charity's purposes and how you currently achieve them.**

**What is the organisation set up to achieve? (select all that apply)**

**This information will be made publicly available on the Charity Register.**

☒ General charitable purposes

☒ Education/ Training/ Research

☒ Advancing education

☒ Academic research

☒ Human rights/ Religious or racial harmony/ Equality or diversity

☒ Human rights

☒ Equality or diversity

## Classification: How

**How does the organisation achieve it? (select all that apply)**

**This information will be made publicly available on the Charity Register.**

☒ Provides services

☒ Provides education/advocacy/advice/information

☒ Sponsors or undertakes research

☒ Acts as an umbrella or resource body

**Education/ Training/ Research**

☒ Workshops, conferences, seminars and/or lectures

## Classification: Who

**Who does the organisation help? (select all that apply)**

**This information will be made publicly available on the Charity Register.**

☒ Children/ Young people

☒ Elderly/ Old people

☒ People with disabilities

☒ People of a particular ethnic or racial origin

☒ Other charities or voluntary bodies

☒ Other defined groups

**Please specify**

The LGB community

☒ The general public/ Mankind

**Education/ Training/ Research**

## Where

**Where does the organisation operate? (select all that apply)**

**This information will be made publicly available on the Charity Register.**

☒ Throughout England

☒ Outside England & Wales

**Add all areas outside England and Wales**

**This information will be made publicly available on the Charity Register.**

| Area |
| --- |
| SCOTLAND |
| NORTHERN IRELAND |

## Education

**What does the organisation advance education in?**

LGB Alliance will advance education in the subjects of equality, diversity and on human rights, particularly rights of the LGB community and by doing this aims to encourage the public to better understand the issues that the LGB community faces and to raise public awareness about equality and diversity in respect of the LGB community.

LGB Alliance will collaborate with partner organisations, including charities and research bodies, to undertake and/or fund research into the rights of lesbian, gay and bisexual people. The results of this research will be published and accessible to the public online and free of charge. LGB Alliance will hold dissemination events (e.g. conferences) in relation to these areas of education and the results of its research will also be presented at the charity's meetings and events.

In the future, LGB Alliance also plans to provide guidance to the public and to public and private bodies about the correct implementation of the 2010 Equality Act. This guidance may include checklists and other helpful tools to support the LGB community and the public as a whole to better understand the rights of LGB people and to encourage public and private bodies to implement policies and behaviours that follow best practice and the law.

**How does the organisation select topics for research and what criteria are used for that.**

The trustees intend to commission a range of research, including policy based research and qualitative research involving interviews and case studies with individuals from the LGB community. The trustees will consult with subject matter experts in areas such as health, education, policy, and the law to identify topics of social interest and importance for research and will seek to engage expert academic researchers and to work with institutions like universities and think tanks to produce credible, peer-reviewed research. The trustees will consider whether a potential subject is of current relevance to LGB people, whether it needs further investigation and discussion and whether LGB Alliance is able to involve appropriate subject matter experts available to lead the research.

**Attach criteria**

☒ LGB Alliance - Research criteria.pdf

**Outline the typical structure and content of the workshops, conferences, seminars or lectures the organisation undertakes.**

LGB Alliance will organise a variety of events, including educational talks and seminars aimed at representatives from a variety of organisations with an interest in the promotion of equality and human rights of lesbian, gay and bisexual people.

These events will be hosted by LGB Alliance, and will include inviting experts in the field of international human rights to speak at events and run workshops. As an example, LGB Alliance will draw on the expertise of supporters in the field of psychiatry, the law and education.

The events will cover a wide range of topics related to equality and human rights in respect of the lesbian, gay and bisexual community. The aim of these events is to discuss challenging issues relating to this area. Examples of topics that the charity may discuss at its events are human rights issues, public funding available for LGB projects and to support initiatives relevant to the community and trans issues as they relate to the LGB community including transition and de-transition.

As set out above, LGB Alliance plans to hold two national meetings and four regional meetings planned each year. Typically, these will include:

- a talk from a keynote speaker;

- a panel discussion with a number of experts in relevant fields with a range of expertise and representing a range of perspectives on the topics for discussion; and

- a Q & A with the panel to ensure that attendees have the opportunity to engage in and contribute to the debate and to develop their own opinions on the matters discussed.

These meetings will be open to the general public and advertised via LGB Alliance's website and social media channels and on Eventbrite.

LGB Alliance also plans to hold smaller private meetings with policy makers, business leaders, the Police, NHS leaders and other public sector bodies and to join events hosted by broadcasters such as panel discussions and interview. These meetings will not be open to the general public but will fulfil LGB Alliance's aim of advancing education and raising awareness in equality and diversity in respect of lesbian, gay and bisexual people by targeting groups and individuals that have a particular ability to make a material difference to the lives of the LGB community, particularly in their role or profession.

**How are speakers and trainers chosen?**

The trustees will undertake due diligence to ensure that the speakers and trainers used for its events are appropriately qualified individuals in their respective fields.

In practice, the trustees will identify speakers through a combination of research and recommendation and approach them to invite them to be involved with LGB Alliance's events. There are also a number of experts working in the field of international human rights that have approached LGB Alliance and expressed a desire to work with us. These experts hold a range of views and some have been instrumental in drawing up existing international treaties and establishing case law affecting LGB people.

In conducting due diligence on speakers and trainers for events LGB Alliance will check CVs, ask for references and conduct interviews as appropriate before appointing of any potential speakers or trainers.

**How are the trustees satisfied that the subjects of study are of educational merit?**

The trustees choose the subjects for meetings based on the current environment for LGB people, following consultation with university academics, charities and other subject matter experts and supporters including in the fields of LGB rights, human rights in general, medicine, education and psychiatry.

In deciding the educational relevance of specific subjects for study, the trustees will be led by the considered opinion of subject matter experts and the views of LGB Alliance's supporters and beneficiaries. In determining whether LGB Alliance should engage with a particular subject, the trustees will consider whether a potential subject is of current relevance to LGB people, whether it needs further investigation and discussion and whether LGB Alliance is able to involved appropriate subject matter experts available to lead the discussion.

**How does the organisation advance education in a way that enables beneficiaries to make up their own minds on subjects rather than the organisation promoting a specific opinion or view?**

LGB Alliance aims to encourage respectful freedom of speech and informed dialogue and it will structure its events with this in mind and to support the public and politicians to make up their own minds on subjects of importance to the LGB Community, including in relation to matters of sex and gender, funding for LGB matters and policies and law.

With that in mind, it is important to LGB Alliance that its meetings will include panel discussion with specialists of varying backgrounds and views who will approach the topics covered at the charity's events from completely different starting points. LGB Alliance is also committed to ensuring that its meetings are open to the public and that Q&As are a staple of these meetings to engage with attendees and to invite a range of perspectives on the issues discussed. LGB Alliance considers the contribution of different views from experts and its beneficiaries to be invaluable to its approach to advancing education and discussion about LGB issues.

**How does the organisation advertise the events to the public?**

LGB Alliance will list upcoming events on its website which will be available to the public and will promote these events to the public through its social media channels. The tickets to LGB Alliance's meetings and workshops will be accessible to the public through Eventbrite.

**How do the trustees select the beneficiaries?**

There will be no criteria which must be met by attendees to events or callers to the helpline to qualify in order to engage with LGB Alliance.

The meetings of LGB Alliance will be open to the public and advertised publicly, and LGB Alliance will ensure that tickets are available at no cost to those on low incomes and that the cost for other attendees is no higher than is reasonable to ensure that no one is excluded from accessing LGB Alliance's activities. Tickets to LGB Alliance's events will be allocated on a first come first served basis and no other criteria will be applied.

## Carrying out the purpose

**The organisation's purposes are:**

2. Objects
The objects of the Company are:
2.1 To promote equality and diversity for the public benefit, in particular by:
2.1.1 the elimination of discrimination on the grounds of sexual orientation;
2.1.2 advancing education and raising awareness in equality and diversity in respect of lesbian, gay and bisexual people;
2.1.3 conducting or commissioning research on equality and diversity issues and publishing the useful results to the public; and
2.1.4 cultivating a sentiment in favour of equality and diversity for lesbian, gay and bisexual people.
2.2 To promote human rights (as set out in the Universal Declaration of Human Rights and subsequent United Nations conventions and declarations) and particularly the rights and freedoms of those who face discrimination on the grounds of sexual orientation, including by:
2.2.1 monitoring abuses of human rights;
2.2.2 obtaining redress for the victims of human rights abuses;
2.2.3 relieving need among the victims of human rights abuses;
2.2.4 research into human rights issues;
2.2.5 educating the public about human rights;
2.2.6 providing technical advice to government and others on human rights matters;
2.2.7 contributing to the sound administration of the law;
2.2.8 commenting on proposed human rights legislation;
2.2.9 raising awareness of human rights issues;
2.2.10 promoting public support for human rights;
2.2.11 promoting respect for human rights among individuals and corporations; and
2.2.12 eliminating infringements of human rights.
2.3 To promote any other purpose that is charitable under the law of England and Wales.

**Explain how the organisation carries out its purposes:**

LGB Alliance has been established to further the rights and interests of lesbians, gay men and bisexuals, and to campaign for respectful freedom of speech and informed dialogue on issues affecting the LGB community by educating the public and raising awareness and by highlighting the importance of these issues to the press and to Parliament.

LGB Alliance aims to carry out its purposes by:

- Commissioning and disseminating the useful results of research into human rights issues relevant to the LGB community in order to advance education about equality and diversity issues.

The trustees intend to commission a range of research, including policy based research and qualitative research involving interviews and case studies with individuals from the LGB community. The trustees will consult with subject matter experts in areas such as health, education, policy, and the law to identify topics of social interest and importance for research and will seek to engage expert academic researchers and to work with institutions like universities and think tanks to produce credible, peer-reviewed research.

LGB Alliance will distribute the vast majority of this research to the public free of charge via its website and social media channels and on the websites of its research partner organisations. LGB Alliance will also undertake research for the purposes of informing its interactions with government and to provide an evidential basis for the changes in policy it proposes to improve the lives of LGB people and relieve disadvantage.

- Giving public interviews to mainstream media to promote the findings of LGB Alliance's academic research and to raise awareness of the aims of LGB Alliance.

These interviews will be given by the academic research staff of the organisation that LGB Alliance had commissioned to conduct the research or an appropriately qualified member of LGB Alliance's board or

executive team. LGB Alliance is keen to use interviews to promote the protection of LGB rights and the need for respectful freedom of speech, informed dialogue and the need for diverse views in policy making on LGB issues. Links to interviews given by LGB Alliance or about research commissioned by LGB Alliance will be promoted to the public using LGB Alliance's website and social media channels in order to ensure that they can be read and watched by the general public.

• Organising public meetings to educate and inform the public about matters relating to LGB issues. LGB Alliance envisages having two national meetings a year (one in London and one in another major city in the UK) and quarterly regional meetings held in the South West, North East, North West and the Midlands to ensure its meetings will be accessible to all who wish to attend and that it can engage with the general public in a meaningful way. Events will be advertised publicly on LGB Alliance's website and social media channels and tickets will be available for purchase from Eventbrite to ensure that the meetings are accessible to all who are interested in attending.

Events will include presentations and panel discussions about topics such as sex and gender, new and proposed legislation, human rights issues and the findings from academic research commissioned by LGB Alliance. LGB Alliance will invite respected speakers from charities, corporations and government holding a wide range of opinions on a variety of topics relating to issues faced by LGB people to engage in an informed and respectful debate with the aim of developing thinking on the topics discussed and identifying improvements that can be made to better support LGB people.

It is the intention of LGB Alliance to record meetings and make these available on LGB Alliance's website and social media channels in order to reach the widest audience possible and have the greatest educational impact.

• Engaging with politicians, officials and others to promote the development of policy and practice that will help to overcome disadvantage faced by LGB people and to provide advice and guidance to the government on relevant issues, such as the treatment of sex and gender within the law. LGB Alliance will use its research findings in its discussions with decision makers on policy and funding to raise awareness and understanding of LGB issues and to put forward evidence of the need for changes in policy and the law to better protect LGB rights.

• Providing a helpline to offer advice and support to LGB people (with the aim of helping them to overcome disadvantage) and provide information to the general public.

The helpline will be available for anyone to call during working hours and will be free of charge to callers. It will offer essential support and information to LGB people by providing information about the existing legal protections available to them and will ensure that callers feel that they are not alone with the issues they are facing. LGB Alliance recognises the particular support required by young LGB people, who often experience discrimination or threatening behaviour from others.

The helpline will also offer information to parents, friends and other interested parties on all matters relating to the discrimination faced by LGB people and the legal redress that is available to them, with the aim of educating them and better equipping them to support LBG people.

The helpline will be staffed by qualified volunteers who have passed a DBS check. The Board will be responsible for ensuring that volunteers have received appropriate training from supervisory staff, and intends that this will be provided by individuals from an organisation with experience of running a similar helpline (such as Childline or The Samaritans). LGB Alliance will also ensure that ongoing training and supervision is provided. The Board will ensure that appropriate safeguarding procedures are put in place in setting up the helpline, including a robust safeguarding policy which will apply to the staff and volunteers of LGB Alliance and LGB Alliance's trustees.

**Attach any document (such as a business plan) which sets out how the organisation carries out its purposes:**

## Benefits

**What are the benefits of the organisation's purposes?**

LGB Alliance will benefit the public by advancing education and raising awareness of equality and diversity.

LGB Alliance will engage the general public through its educational events, workshops and by publishing interviews, press releases and other resources to raise the public's awareness about issues affecting the LGB community and to educate them about these issues. The charity will hold events regularly and will invite interested members of the public to join sessions to work together to further promote the rights of those who are lesbian, gay or bisexual.

LGB Alliance will work to offer the LGB community, particularly young people, an alternative and balanced narrative about LGB issues by having a particular focus on the rights of lesbians, gay men, and bisexuals rather than focusing on the "gender spectrum". In educating the public about human rights and equality issues relating to the LGB community, LGB Alliance's position will be there are only two sexes and gender is a social construct, and that this perspective should form part of the discussion about these issues. LGB Alliance understands that adolescence is a confusing time for young people and it will therefore work to benefit young people, both within and outside of the LGB community by supporting young people to be better informed about the rights of LGB people, sex, gender and the social constructs inherent in the discussions surrounding these topics so they can use this information as a basis for their decisions about their lives ahead of them.

LGB Alliance is planning to operate a telephone helpline which will be available to members of the LGB community to use to discuss the topics which they are confused about and the issues they are facing and to supporters of the LGB Community or the general public who would like more information about are struggling with how best to support a young person who is gay, lesbian or bisexual or any other concerns relating to LGB rights. This helpline will be operated by trained volunteers and will provide advice to members of the LGB community and the wider public about the legal and other support available to them. This helpline will be provided to callers free of charge during working hours in order to ensure that it is accessible as a source of support and information for the public.

LGB Alliance's campaigning activities will further its charitable purposes and the rights of the LGB community by providing advice to the government on human rights matters, particularly LGB issues, and thereby seeking to ensuring that the law appropriately addresses the needs of the LGB community and is administered soundly. The Trustees of LGB Alliance understand that their campaigning activities must be undertaken only in the context of supporting the delivery of LGB Alliance's charitable purposes and will have regard to the CC9 guidance of the Charity Commission on campaigning and political activity.

**Attach any document which shows how the organisation provides benefit:**

☐

**Who can benefit from the organisation's purposes?**

Available to everyone

## Carrying out the purpose for the public benefit

**What criteria do the trustees use to decide who the organisation benefits or what work it does or supports?**

LGB Alliance's primary beneficiaries will be lesbian, gay and bisexual people but LGB Alliance believes that its purposes also benefit the general public, because everyone benefits from a world in which human rights and equality for LGB people are promoted and protected. Additionally, the charity's educational activities such as the resources it produces, the publicly disseminated research it commissions and the majority of its talks and events, will be made available to the general public as well as the LGB community.

**Attach any document which explains how these decisions are made:**

## Grant making

**Is the organisation a grant maker?**

No

## Membership

**Do people or organisations have to be members of the organisation to benefit from its purpose?**

No

## Providing services or facilities

**Does the organisation provide public facilities or services as a way of carrying out its purpose?**

Yes

**What sort of facility or service does it provide?**

LGB Alliance is planning to operate a telephone helpline service available to LGB people who require advice and support, and believes that this will be particularly beneficial to young LGB people. The helpline will also be available to supporters of the LGB community from the general public who are struggling with how best to support a person who is gay, lesbian or bisexual. The helpline will provide advice to the LGB community and the general public about the rights of LGB people and the legal and other support available to them.

**When can the public access the facility or service?**

The helpline will be free of charge to callers and will available during normal working hours to ensure that it is accessible to the general public.

**Are there any restrictions on who can have access?**

No

**Are there any restrictions on what people can have access to?**

No

## Fees and charges

**Does the organisation charge people to be a member or to access its services or facilities?**

Yes

**What services or facilities does the organisation charge for and how much does it charge?**

The majority of LGB Alliance's services will be available free of charge to the public, but LGB Alliance will charge for attendance at its meetings and any other events it organises in order to cover the costs of running such events.

LGB Alliance will charge for tickets to such events on a sliding scale, in order to make attendance free of charge to those who cannot afford to pay and to offer the option of paying a higher price to those who can afford to do so by making a donation to LGB Alliance at the same time as buying their ticket. For example, for previous events LGB Alliance has made free tickets available to any person who self-selects as being on a low income, at £8 for a standard ticket and then at £20 and £50 for supporters who are able to pay more and who wish to include a donation to LGB Alliance with their ticket purchase. The decision to purchase a ticket at a price above the standard rate is entirely at the discretion of the purchaser.

Tickets to events will be made available on a first come first served basis and LGB Alliance does not intend to place any limit on the number of tickets that will be available free of charge to ensure that all those who wish to attend the event will be able to do so, subject to the availability of tickets.

**Do the trustees consider the charges to be more than the poor can afford?**

No

**How have you reached this view?**

The trustees have reached the view that the price of the tickets to its events are not more by researching the pricing of tickets for educational events and conferences run by similar organisations. The trustees have additionally taken advice from individuals involved in organising similar events run by charities and other organisations.

LGB Alliance has received positive feedback in relation to its approaching to pricing for tickets at the events that it has already run and has found that approximately 20% of tickets are purchased free of charge, 40% at the standard price of £8 and a further 40% of attendees have chosen to purchase their tickets at a higher price in order to support LGB Alliance. The trustees do not intend to place any limit on the number of tickets that are available to attendees free of charge and tickets will be allocated on a first come first served basis, having be advertised publicly on LGB Alliance's website and social media channels.

## Overseas aid

**As the organisation works outside England and Wales, please explain:**

**What needs will the organisation address in overseas locations?**

Based on the Charity Commission's Guidance on 'Charities working internationally', the questions in relation to overseas aid appear to be addressed to charities working in 'genuine third countries', rather than charities operating in countries within the United Kingdom. The questions in this section have therefore been answered on the basis that LGB Alliance will be addressing substantially the same needs, and carrying out substantially the same activities in Scotland and Northern Ireland as in England and Wales.

**How will the organisation address these needs?**

Please refer to the responses provided in relation to LGB Alliance's activities in England & Wales.

**How has the organisation identified those needs and what evidence or information it has used?**

Please refer to the responses provided in relation to LGB Alliance's activities in England & Wales.

**Does (or will) the organisation work with, or send funds to, local partner organisations or other delivery agents that operate overseas on its behalf?**

No

**Is the organisation carrying out its own operations in the locations you have named?**

Yes

**How does the organisation decide which activities to carry out overseas and how it will fund them?**

Please refer to the responses provided in relation to LGB Alliance's activities in England & Wales.

**How does the organisation select volunteers or staff to carry out activities overseas and how does it manage risks to them?**

Please refer to the responses provided in relation to LGB Alliance's activities in England & Wales.

## Property

**Does the organisation have use of land or property?**

No

## Contact for this application

**Who is the main contact for this application?**

**In what capacity are you submitting the application? (select one)**

Solicitor

**Is the contact for this application an individual or an organisation?**

Individual

**Title**

Mr

**Given names (First name(s))**

Philip

**Family name (Last name)**

Kirkpatrick

**Suffix (e.g. M.A.)**

**Date of birth (dd/mm/yyyy)**

## Organisation contact - Commission use only

**Please enter details of the charity contact the Commission can use to get in touch with the charity. The charity contact must be a named individual rather than an organisation.**

**Position in the organisation**

Trustee

**Title**

Ms

**Given names (First name(s))**

Katharine Rosemary

**Family name (Last name)**

Harris

**Suffix (e.g. M.A.)**

**Date of birth (dd/mm/yyyy)**

[redacted]

**Address line 1**

[redacted]

**Address line 2**

[redacted]

**Postcode**

[redacted]

**Telephone number**

[redacted]

**Email address**

[redacted]

## Organisation details

**Please enter the organisation's public contact details**

**This information will be made publicly available on the Charity Register.**

**Address line 1**

LGB Alliance

**This information will be made publicly available on the Charity Register.**

**Address line 2**

KEMP HOUSE

152-160 CITY ROAD

LONDON

**This information will be made publicly available on the Charity Register.**

**Postcode**

EC1V 2NX

**This information will be made publicly available on the Charity Register.**

**Organisation website**

lgballiance.org.uk

**This information will be made publicly available on the Charity Register.**

**Organisation Telephone number**

02039542540

**This information will be made publicly available on the Charity Register.**

**Organisation email address**

lgballiancefuture@gmail.com

**Does the organisation operate from this address?**

No

**Please provide the operating address**

**Address line 1**

[redacted]

**Address line 2**

[redacted]

**Postcode**

[redacted]

**Please explain why the organisation does not operate from the public address and why this address cannot be made public.**

LGB Alliance does not currently have any premises and the trustees intend to carry out their duties from their own homes and to meet at their homes and virtually. The address provided on the public register is the charity's registered office address from which its mail will be forwarded to the trustees. The operating address provided above is the home address of Katharine Harris, a trustee of LGB Alliance. We have therefore inserted a trustee's home address for the purpose of completing the question above, but this is not the address that members of the public should use to contact LGB Alliance. Rather, LGB Alliance's public address will be the best possible way to contact all or any of the trustees of LGB Alliance. If you disagree with this request, please let us know so we can consult with the trustees and find an alternative address for use on the public register.

## Other regulators

**Company number**

12338881

**Please attach your certificate of incorporation**

☒ Incorporation certificate.PDF

**Are you registered with any of the following regulators? (select all that apply)**

**Do you have a gift aid number from HMRC?**

No

## Income and bank details

**Please attach the organisation's latest accounts**

☐

**Estimated gross annual income**
£250,000

**Year to date income**
£42,000

**Does the organisation have a bank account?**
No

## Funding

**This information will be made publicly available on the Charity Register.**

**Next financial year end date (dd/mm/yyyy)**
30/11/2020

**Please explain how the organisation is or will be funded in the future (select all that apply) See guidance**

☒ Public donations

**Please tell us what procedures the trustees have put in place to identify and verify the donors and consider any conditions attached to any donations? See guidance.**
LGB Alliance has already received some donations for the establishment of the charity from members of the public using the crowd funding platform Just Giving.

LGB Alliance will continue to ask for and accept donations from the public and will put together an appropriate Donation Acceptance and Refusal Policy. LGB Alliance will not accept any conditional donations and its accountants will help with identifying and verifying the donors.

**Do you intend to claim Gift Aid on these?**
Yes

☒ Other trading activities

**Please give more details**
LGB Alliance intends to carry out some trading as part of its campaigning activities, which are likely to include selling merchandise such as t-shirts and badges aimed at raising awareness. LGB Alliance will have regard to the HMRC rules on trading and the Charity Commission guidance CC35 on Trustees Trading and Tax.

**Other than Public Donations that are eligible for Gift Aid, do the trustees intend that the proposed charity will take part in any other arrangement which might reduce the amount of tax payable by any other person?**

No

**Is it intended that the organisation will hold any funds or assets in overseas investment companies or trusts?**

No

## Employment

**Does or is it likely the organisation will employ:**

- **a trustee**
- **its founder**
- **a person related to a trustee**
- **a person related to the founder**
- **an organisation connected to a trustee**
- **an organisation connected to the founder**

No

## Goods or services

**Does or is it likely the organisation will buy goods or services from:**

- **a trustee**
- **its founder**
- **a person related to a trustee**
- **a person related to the founder**
- **an organisation connected to a trustee**
- **an organisation connected to the founder**

No

## Other personal benefits

**Are there any close links which the organisation has, or is likely to have, with any other person or body, which might be relevant to the work of the organisation?**

**This would include:**

- **Any contract or relationship with a value which represents a significant proportion of the organisation's income or expenditure;**
- **Any directorship, trusteeship, shareholding, membership interest or partnership held by the organisation or by any of the trustees;**
- **Any position of political or public authority held by any of the trustees;**
- **Any other arrangement or circumstance which might give rise to a conflict of interest for one or more of the trustees.**

No

## Connections

**Is the organisation linked to, or has it been established by a non-charitable organisation?**

No

## Managing risks

**Does the organisation work with children or vulnerable people?**

Yes

**Please confirm the trustees have read, understood and are following the Charity Commission's safeguarding guidance**

☒ Trustees have read, understood and are following the Charity Commission's safeguarding guidance.

## Trustee numbers

**How many trustees does the organisation currently have? (total)**

4

**What is the minimum number of trustees the organisation's governing document says it must have?**

3

**Are there any special circumstances for the organisation that require <u>all</u> the names of the trustees to be kept off the public register (please see guidance for examples)?**

No

## Trustees

**Add details for each trustee separately**

**Trustee details**

Fields prefixed with * will be made publicly available on the Charity Register

Individual Trustee
Title: Ms
Specify title:
* Given names (First name(s)): Beverley Ruth
* Family name (Last name): Jackson
Suffix (e.g. M.A.):

Date of appointment: 28/11/2019
* Trustee is a chair: F

Is this trustee a trustee of another registered charity? No

Individual Trustee
Title: Ms
Specify title:
* Given names (First name(s)): Ann Marie
* Family name (Last name): Sinnott
Suffix (e.g. M.A.):

Date of appointment: 28/11/2019
* Trustee is a chair: F

Is this trustee a trustee of another registered charity? No

Individual Trustee
Title: Ms
Specify title:
* Given names (First name(s)): Katharine Rosemary
* Family name (Last name): Harris
Suffix (e.g. M.A.):

Date of appointment: 28/11/2019
* Trustee is a chair: F

Is this trustee a trustee of another registered charity? No

Individual Trustee
Title: Mr
Specify title:
* Given names (First name(s)): Malcolm
* Family name (Last name): Clark
Suffix (e.g. M.A.):

Date of appointment: 28/11/2019
* Trustee is a chair: F

Is this trustee a trustee of another registered charity? No

**Attach your completed and signed trustee declaration. If you do not have one you can print a completed one here and get the trustees to sign it.**
☒ LGB Alliance - Trustee Eligibility Declaration Form.pdf

**You need to confirm that the details provided in this section are correct**

☒ I confirm that all details provided in this section are correct

## Attached documents

1. **Governing Document 1**
2. **Certificate of Incorporation**
3. **Trustee Declaration**
4. **Proof of Income**
5. **Academic Criteria**

## Data protection

**Any information you give us will be held securely and processed only in accordance with the rules on data protection. We will not disclose your personal details to anyone unconnected to the Charity Commission unless:**

- **you have consented to their release; or**
- **we are legally obliged to disclose them; or**
- **we regard disclosure as necessary so that we can properly carry out our statutory functions.**

**We may share and disclose information about you with relevant public authorities, regulatory bodies and agencies, outside the Charity Commission but only if:**

- **we can lawfully do so; and**
- **we decide that disclosure is necessary for national security, crime detection, prevention, and law enforcement, or other issues in the public interest**

**Information we collect about you**

**We will use this information:**

**To enable us to carry out our statutory functions and duties;**

**This will include the following actions:**

**(a) update, consolidate, and improve the accuracy of our records;**

**(b) undertake crime detection and prevention and law enforcement and assist the third parties specified above to investigate or prevent crime and carry out law enforcement;**

**(c) data analysis, testing, research, statistical and survey purposes**

**Information we receive from other sources.**

**Information we receive from other sources**

**We may combine this information with information you give to us and information we collect about you. We may use this information and the combined information for the purposes set out above (depending on the types of information we receive).**

**We will ensure that any such disclosure and use is proportionate; considers your right to respect for your private life; and is done fairly and lawfully in accordance with the data protection principles of the Data Protection Act 2018/GDPR.**

**The Data Protection Act 2018/GDPR regulates the use of 'personal data', which is essentially any information, however stored, about identifiable living individuals. As a 'data controller' under the Act, the Charity Commission must comply with it.**

**You can view our full privacy notice detailing how we process your personal data as part of the charity registration process at www.gov.uk/government/publications/register-a-charity-privacy-notice**

## Declaration

**Do you want to attach any supplementary documentation?**

No

**Is there any additional information that the Charity Commission should take into account?**

Yes

**Please provide any additional information here:**

LGB Alliance's next public meeting is scheduled for Friday 12th June 2020, at the Queen Elizabeth II Centre in Westminster, London. The trustees are keen that the charity is registered in advance of this meeting to ensure that it will be able to give attendees the option of making a donation when purchasing their ticket or of making a donation to the charity on the day of the event.

**Submitting your application for charity registration**

☒ I certify that:

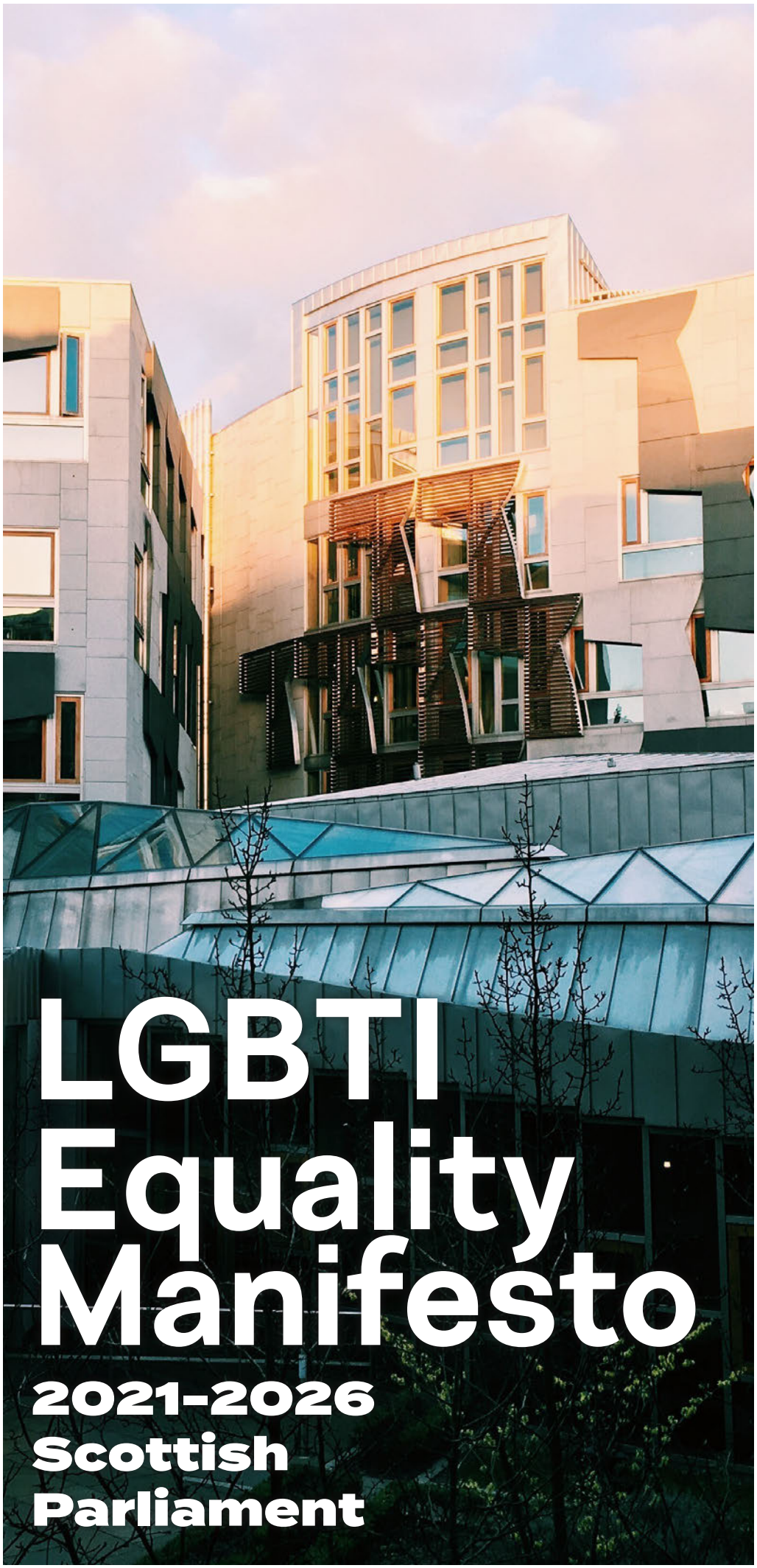
- all information provided has been checked by the trustees and is correct and complete to the best of my knowledge
- all trustees agree to this submission and have read and accept the commission's privacy notice

**Application reference number**

**Your application reference number is:**

5154625

**Please quote this in all correspondence.**



# LGBTI Equality Manifesto

## 2021-2026 Scottish Parliament

**Developed by:**

Stonewall Scotland

Equality Network

Scottish Trans

LGBT Youth Scotland

**Endorsed by:**

ICON UK

LEAP sports

LGBT Health & Wellbeing

# LGBTI Equality Manifesto

## 2021-2026 Scottish Parliament

## Our approach to developing this manifesto

This manifesto has been co-developed by national LGBTI organisations Stonewall Scotland, Equality Network, Scottish Trans Alliance, and LGBT Youth Scotland. It sets out our joint priorities for delivering equality for lesbian, gay, bi and trans people, and people with a variation in sex characteristics or who are intersex (I/VSC) in the 2021-2026 parliamentary term. It is further endorsed by our partners at LGBT Health and Wellbeing, LEAP Sports Scotland, Time for Inclusive Education, and iCON UK.

Our organisations work to achieve equality for LGBTI people. There are important differences in the experiences, needs and marginalisations of these groups of people. Experiences of discrimination and marginalisation due to sexual orientation, trans status or variations in sex characteristics can vary widely, and thus require different and multi-faceted solutions. Some of our calls in this manifesto are specific to particular groups – such as bisexual people, or non-binary people. Some of our calls will be specific to LGBTI people who are marginalised in multiple ways – such as LGBTI refugees, or older LGBTI people.

We have grouped our calls for commitments from the Scottish Government, MSPs and their parties into the following sections:


- **Ensure Gender Identity Services are fit for purpose** p4
- **Protect and progress LGBTI rights** p6
- **Support LGBT mental health** p8
- **Ensure fair treatment in Health and Social care for LGBTI people** p10
- **Implement LGBT-inclusive education** p12
- **Improve community safety and inclusion** p14
- **Support LGBTI rights abroad** p16




## A note on I/VSC equality

Throughout this manifesto, we refer to 'LGBT' in some contexts, and 'LGBTI' in others. We refer to 'LGBTI' when there is existing research highlighting inequalities and human rights concerns for people with a variation in sex characteristics or who are intersex (I/VSC), or where tangible work is underway, or is needed, to further I/VSC equality. We recognise that not all individuals with I/VSCs would consider themselves as a part of the LGBTI acronym.

There has been limited progress so far in Scotland in tackling the inequalities and barriers that people with I/VSCs experience. It is important that the Scottish Government and Scottish Parliament engage with people with I/VSCs to review the inequalities they experience, identify their needs and priorities for national law and policy, and, in light of this, take action to further I/VSC equality.

## Foreword

There has been significant progress on LGBT equality in the first two decades of the Scottish Parliament, from the repeal of Section 28 to the introduction of equal marriage. In the five years since the 2016 election, positive steps have been taken to build upon this progress, including world-leading work towards LGBT-inclusive education in Scotland's schools, the pardon for historical 'homosexual offences', and equal civil partnerships.

But the last five years have also been challenging for many LGBTI people – in Scotland and around the world. Hate crimes based on sexual orientation and transgender identity are on the rise, waiting times for gender identity services have continued to increase alarmingly, LGBT mental health inequalities continue, toxic debates about LGBT identities are ongoing, and many trans people still do not have access to full legal recognition of their gender. Scotland is falling down the ILGA Europe Rainbow Index and must take action to continue to uphold its international reputation as a leading voice on LGBT equality.

The world has also changed considerably since the last election. The COVID-19 pandemic and the public health measures taken in response to it have affected everyone, but have exacerbated existing inequalities faced by marginalised communities. These include LGBTI people, particularly LGBTI people of colour, disabled people, younger and older people, and those living rurally.

In this LGBTI equality manifesto, we set out the concrete steps that the next Scottish Government and Scottish Parliament can take, over the next five years, to improve the lives of LGBTI people living in Scotland. This includes improving public services, delivering legal equality, tackling discrimination, promoting wellbeing, and building a more equal Scotland.

# 1. Ensure Gender Identity Services are fit for purpose

## We're calling on MSPs and their parties to support and commit to:

**Ensuring NHS gender identity services are fit for purpose – now, and in the future. Take action to substantially reduce the waiting times for first appointments as a matter of urgency, by providing centralised crisis funding and piloting new ways of delivering these services to realise their long-term sustainability.**

The number of people on waiting lists for first appointments at a Gender Identity Clinic has continually risen over recent years, and demand for services is outstripping the capacity of under-resourced clinics. Unlike other NHS Scotland services, the 18-week Referral to Treatment standard does not apply to gender identity care. Currently, many people have been waiting more than two years to be seen for their first appointment. With waiting lists growing and services unable to meet demand, people joining the waiting list now can expect to wait even longer. It is feared that the impacts of COVID-19 on the health service will further exacerbate the already grave problem of access to gender identity services, with some clinics now forecasting 35-40 month waits[1].

Clinicians recognise that longer waiting times have a detrimental effect on the physical and mental health of their patients, with many identifying the period of waiting for a first appointment as a time when trans people are more likely to experience high levels of distress, self-harm, and suicidal ideation[2].

There are systemic issues with NHS gender identity services in Scotland which urgently need to be redressed at a national level, through Scottish Government intervention. The current structure of gender identity services does not provide sufficient capacity or efficiency to provide an adequate service. Outdated service delivery, which is overly reliant on Consultant Psychiatrists and Psychologists, contributes to recruitment problems for unfilled staff posts. Internationally, modernised models of gender identity service provision utilise multidisciplinary teams primarily staffed by specialist nurse practitioners, sexual health doctors, GPs with special interest in gender identity, and counsellors, supported by local endocrinology and mental health services. This recognises that the majority of trans people do not have any complex physical or mental health problems.

It is crucial to understand that simply increasing funding for existing gender identity services, though important, will not be sufficient in and of itself to provide long-term solutions to the waiting list crisis or the harm it causes. It is vital that new models of service delivery that take a person-centred, multi-disciplinary approach are piloted in Scotland.

*1 All figures from National Gender Identity Clinical Network Scotland (NGICNS) Waiting List and Workload Quarterly Reports*
*2 https://www.scotphn.net/wp-content/uploads/2017/04/2018_05_16-HCNA-of-Gender-Identity-Services-1.pdf*

## We're calling on the Scottish Government to:

- Take action to substantially reduce the lengthy waiting times for first appointments at NHS gender identity services as a matter of urgency.
- Introduce the national waiting time standards for accessing first appointments at NHS gender identity services, and ensure they are adhered to.
- Provide centralised crisis intervention funding to pilot new models of service delivery outside of the existing Gender Identity Clinics, which take a person-centred, multi-disciplinary approach.
- Revise the NHS Scotland Gender Reassignment Protocol to reflect the need for new models of service delivery which take a person-centred, multi-disciplinary approach, and to allow for greater flexibility in treatment pathways.
- Undertake work to ensure services have sufficient funding and staffing capacity to meet levels of demand going forward.

# 2. Protect and progress LGBTI rights

## We're calling on MSPs and their parties to support and commit to:

**Protecting and progressing LGBTI rights, including through enshrining LGBTI human rights in Scots law; taking measures to end 'conversion therapy'; improving trans equality, including through reforming the Gender Recognition Act; and taking action to further I/VSC equality.**

There has been significant progress on LGBT equality in the first two decades of the Scottish Parliament, from the repeal of Section 28 to the introduction of equal marriage. But there is more to be done, and it is crucial that this progress does not stall. In a global environment where some LGBTI people have seen their rights removed or rolled back, our hard-won rights and protections must be maintained.

In recent years, Scotland's trans communities have experienced their lives and rights being debated in the public domain without witnessing any material improvements in law or policy on trans equality. It is vital that the unfinished business of reforming the Gender Recognition Act is taken forward in the next parliament, and other steps are taken to improve the lived experience of trans people, including non-binary people.

The practice of 'conversion therapy', which seven per cent of LGBT people (rising to13 per cent of trans people) in the UK have undergone or been offered[3], is still legal in Scotland. With the UN Independent Expert[4] calling for a global ban, steps must be taken in the 2021-26 parliamentary term to end this practice once and for all in Scotland.

*3 UK Government Equalities Office National LGBT Survey Research Report (July 2018)*

*4 https://www.ohchr.org/EN/Issues/SexualOrientationGender/Pages/ReportOnConversiontherapy.aspx*



## We're calling on the Scottish Government to:

Improve laws on gender recognition in line with international best practice, to allow trans people to change the sex on their birth certificate with a simple administrative process based on the principle of statutory declaration, and without intrusive medical diagnosis requirements. This process should be available from the age of 16 (and under 16 for those with parental/carer consent) and include the recognition of non-binary people.

End the harmful practice of sexual orientation and gender identity 'conversion therapy', including through introducing a comprehensive legal ban, working with the UK Government where necessary.

Introduce an Act of the Scottish Parliament to incorporate international human rights into Scots law, and ensure this explicitly includes rights for LGBTI communities.

Engage with people with I/VSCs to review the inequalities they experience, identify their needs and priorities for national law and policy, and, in light of this, take action to further I/VSC equality.

Commit to improving non-binary inclusion in public life and access to public services. Work with the UK Government to introduce 'X' gender markers in official documents to enable non-binary people to be legally recognised.

Work with the UK Government to update reserved surrogacy law to accurately reflect societal change and meet the needs of surrogates and prospective parents, including LGBT people.

Encourage public authorities to use 2022 Census data on sexual orientation and trans status to inform their service planning and delivery for LGBT people and equality outcomes under the Public Sector Equality Duty.

Ensure no retrograde steps are taken on LGBT equality at Holyrood, by the Scottish Government, or by Scottish public bodies.

Oppose any attempts to roll back LGBT rights at Westminster, either through changes to the Equality Act, or as a result of Brexit.

# 3. Support LGBT Mental Health

## We're calling on MSPs and their parties to support and commit to:

**Tackling LGBT mental health inequalities by taking forward targeted work on mental health improvement and prevention, and ensuring mental health services are equipped to support LGBT people.**

There is substantial evidence[5] that LGBT people are an at-risk group for poor mental health, and that they experience depression, anxiety, self-harm, and suicidal ideation at a significantly higher level than the general population. This is commonly recognised as being linked to experiences of prejudice and 'minority stress'[6]. These mental health inequalities are felt more acutely by different parts of the LGBT community: for example, trans people and bi people face particularly high rates of poor mental health[7].

LGBT people can often be deterred from accessing services, including mental health services, if they do not think it will be safe to 'come out' or that their identity will be respected. It is crucial that mental health professionals and other frontline health and social care staff understand LGBT identities and the associated risk factors for poor mental health so that LGBT people can confidently access the services they need.

The needs of LGBT people, as an at-risk group for experiencing poor mental health, must also be incorporated into wider work on improving mental health and wellbeing, alongside targeted prevention and intervention approaches.

## We're calling on the Scottish Government to:

Ensure that LGBT people's needs are embedded throughout the implementation of the Mental Health Strategy (2017-2027), the development of any revised strategy, and the implementation of the Suicide Prevention Action Plan (2018).

In line with the actions of the Mental Health Transition and Recovery Plan (2020), act on and address the causes of LGBT mental health inequalities at a structural and individual level.

Include targeted work concerning LGBT populations within Scottish Government funded mental health improvement and suicide prevention programmes. This must adequately reflect the differing risks and needs of particular groups, such as bi and trans communities.

Fund mandatory training for mental health professionals, including frontline Child and Adolescent Mental Health Services (CAMHS) staff, on supporting LGBT people, and ensure that mental health and suicide prevention training delivered to NHS staff is LGBT inclusive.

Ensure LGBT and mental health inclusion in national strategies, policies and action plans related to wider mental health risk factors such as bullying, hate crime, lack of employment, equalities, and social isolation.

Support public bodies and mental health services to routinely monitor the sexual orientation and trans status of service users, in order to identify inequalities in access, experience and outcomes.

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*5 https://www.lgbthealth.org.uk/wp-content/uploads/2018/08/LGBTI-Populations-and-Mental-Health-Inequality-May-2018.pdf*

*6 'Minority stress' recognises that LGBT people's experiences of stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems and poor mental health is not an intrinsic part of being LGBT.*

*7 https://www.stonewallscotland.org.uk/sites/default/files/lgbt_in_scotland_-_health_report.pdf*

# 4. Ensure fair treatment in Health and Social Care for LGBTI people

## We're calling on MSPs and their parties to support and commit to:

**Ensuring that LGBTI people experience fair treatment when accessing all health and social care services, including equal access to reproductive and fertility services, with staff trained to effectively support LGBTI patients and service users.**

Now more than ever, it is important that people feel safe and comfortable when accessing health and social care services. However, many LGBT people have experiences or expectations of facing discrimination in these settings due to their sexual orientation or trans status.

In fact, almost two in five trans people (37 per cent) have avoided healthcare treatment for fear of discrimination[8]. Many older LGBT people fear that, if they need to enter a residential care setting or receive care in their own homes, carers may not acknowledge and support their LGBT identity. Reproductive and fertility services are another area where LGBT people report poorer experiences, and can encounter inequalities in access to funded NHS treatment.

## We're calling on the Scottish Government to:

Ensure that all health and social care professionals are able to meet the needs of their LGBTI service users by incorporating training on LGBTI identities for staff at all levels and across all services, that addresses barriers faced due to sexual orientation, trans status and having an I/VSC.

Ensure that LGBTI people, including older LGBTI people, are able to access welcoming and inclusive social care services, by providing targeted training for staff working across residential and at-home care services.

Undertake a review to ensure that LGBTI people have fair and equal access to NHS reproductive and fertility services, and that these services recognise, and address, the different barriers and health inequalities faced by lesbian and bi women, trans people, and gay and bi men.

Engage with people with I/VSCs to identify understand their needs and priorities, and, in light of this, take action to further I/VSC equality and inclusion across health and social care.

8 *https://www.stonewallscotland.org.uk/sites/default/files/lgbt_in_scotland_-_health_report.pdf*

# 5. Implement LGBT-inclusive education

## We're calling on MSPs and their parties to support and commit to:

**The continued implementation of LGBT-inclusive education, ensuring all of the recommendations from the Report to the Scottish Ministers (2018) are fully realised, and that the progress made so far in the implementation pathway is further built upon in the 2021-26 parliamentary term.**

LGBT young people are now more likely to experience inclusive school environments and to be taught about LGBT issues – but this is not yet a consistent picture across all schools in Scotland, and many LGBT young people still face discrimination and prejudice. Research conducted in the last five years has shown that nine in ten LGBT young people (92 per cent) experience homophobic, biphobic or transphobic bullying in education, including nearly all trans young people (96 per cent)[9], while two in five LGBT young people (41 per cent) are never taught anything about LGBT issues[10].

In 2018, following the campaigning efforts of Time for Inclusive Education (TIE) and others, the Scottish Government agreed to implement a series of recommendations from the LGBTI Inclusive Education Working Group[11] in full, with Scotland set to become the first country in the world to have LGBT inclusive education embedded throughout the curriculum. This received the support of all parties.

Significant progress has been made on LGBT inclusion in schools over the 2016-21 parliamentary term, including work on taking forward the recommendations.

However, it is important that this crucial work to implement the recommendations continues, and is completed, after the Scottish Parliament election in 2021. Importantly, all recommendations must be fully implemented, with impact robustly evaluated. This includes aspects of the implementation pathway due to be completed after the current parliamentary term, including publishing the new LGBT inclusive Statutory Guidance on the Conduct of Relationships, Sexual Health and Parenthood (RSHP) education; and that specific LGBT Experiences and Outcomes are developed at the next review of Curriculum for Excellence. We know that schools are a place where too many trans young people do not feel safe, secure, or valued for who they are. We also know that teachers and schools can feel unsure of how to best provide a welcoming learning environment for their trans pupils. This is why we welcomed the Scottish Government announcement that it would update existing guidance on supporting trans young people in school. However, its publication has subsequently been delayed due to COVID-19. It is therefore essential that the next Scottish Government publishes the 'Supporting Trans Young People' guidance for schools as a matter of urgency.

Furthermore, it is vital that the widespread commitment to LGBTI-inclusive education does not waver in the 2021-26 parliamentary term, and that this momentum is harnessed to consider where further progress could be made on LGBTI inclusive education.

*9 Lough Dennell, B.L., Anderson, G. and McDonnell, D. (2018) Life in Scotland for LGBT Young People. LGBT Youth Scotland. Available online: www.lgbtyouth.org.uk/media/1354/life-in-scotland-for-lgbt-young-people.pdf*

*10 https://www.stonewallscotland.org.uk/system/files/school_report_scotland_2017.pdf*

*11 https://www.gov.scot/publications/lgbti-inclusive-education-working-group-report/*



## We're calling on the Scottish Government to:

- Continue to fully implement and resource the recommendations of the LGBT Inclusive Education Working Group as a key priority. Opportunities for where further progress could be made, beyond the scope of the recommendations, should be identified where necessary through robust evaluation.
- In line with the recommendations, pursue further measures, including legislative options, if there is insufficient progress in local delivery of LGBT-inclusive education.
- Fund and resource LGBT-inclusive inputs for Initial Teacher Education and Career-Long Professional Learning to ensure that the implementation of inclusive education is effective and is sustained beyond 2021.
- Provide necessary funding for long-term commitment, and sustainability of, LGBT-inclusive education.
- At the next review of the Education Scotland school evaluation framework, 'How Good Is Our School', incorporate and include LGBT indicators and themes to ensure that LGBT inclusion is fully embedded into school inspections.
- Publish the updated Scottish Government guidance on 'Supporting Trans Young People' for schools as a matter of urgency.
- Engage with people with I/VSCs to further consider and identify how to incorporate issues around variations in sex characteristics into work on inclusive education.

# 6. Improve Community Safety and Inclusion for LGBTI People

## We're calling on MSPs and their parties to support and commit to:

**Improving community safety and inclusion for LGBTI people by funding LGBTI services and community groups, and ensuring that work on tackling issues such as hate crime, homelessness, and social isolation includes LGBTI-focused measures.**

For many LGBTI people, concerns about discrimination, harassment, and safety within their communities are part of their day-to-day lives. Some LGBTI people, particularly younger LGBTI people living with unsupportive family members, or those experiencing domestic abuse, do not feel safe in their own homes.

Many LGBTI people have experienced hate crime based on their sexual orientation, trans status, or variation in sex characteristics. Hate crimes against trans people recorded by Police Scotland have doubled since 2015[12], while in 2019-20, charges reported to the Procurator Fiscal of hate crime on the grounds of sexual orientation rose by a quarter[13].

LGBTI refugees and people in the asylum system can face extreme difficulties in accessing public services due to the No Recourse to Public Funds policy. They can also face homophobic, biphobic or transphobic discrimination on arrival in Scotland, in either immigration detention or accommodation, including when they have fled their country of origin as a result of such persecution and discrimination.

Many of these problems are hard for the Scottish Government to address, as matters relating to immigration are reserved to Westminster. This needs to change so that LGBTI refugees and people in the asylum system are treated with dignity and respect.

LGBT populations experience relatively high levels of homelessness, domestic abuse, and social isolation. Research has found that one in three LGBT people (33 per cent) feel isolated where they live because they are LGBT, including almost half of those living in rural Scotland[14]. It is likely this will have been further compounded by COVID-19. LGBTI-specific and inclusive services are essential to ensuring that LGBTI people undergoing hardship are supported. Local LGBTI community infrastructure, including support services and social groups, Prides, and inclusive sports clubs, are vital in building strong local communities that celebrate diversity and inclusion and promote positive wellbeing for LGBTI people.

*12 A Study into the Characteristics of Police Recorded Hate Crime in Scotland. Justice Analytical Services, Scottish Government (February 2021)*

*13 https://www.copfs.gov.uk/images/Documents/Statistics/Hate%20Crime%20in%20Scotland%202019-20/Hate%20Crime%20in%20Scotland%202019-20.pdf*

*14 https://www.equality-network.org/wp-content/uploads/2015/07/The-Scottish-LGBT-Equality-Report.pdf*



## We're calling on the Scottish Government to:

- Take forward a programme of work to raise awareness and encourage the reporting of anti-LGBTI hate crimes, and to build LGBTI people's trust and confidence in Police Scotland and other criminal justice agencies.
- Ensure frontline police officers and staff receive training on LGBTI issues to enable them to support LGBTI people, and understand and accurately record cases of anti-LGBTI hate crime.
- Ensure that gender-based violence services are adequately funded so that they have the resources necessary to support LGBTI survivors, and can address the differing needs and experiences of gay and bi men, lesbian and bi women, and trans people.
- Review the impact of the No Recourse to Public Funds regime in Scotland, and campaign for the UK Government to end this policy. Take all steps possible in the meantime to support LGBTI refugees settling in Scotland, including helping them to understand their rights and protections from discrimination, and to access support and relevant services.
- Seek devolution of the asylum support and accommodation system, in part to ensure that LGBTI refugees and people in the asylum system who may have fled their country of origin due to homophobic, biphobic or transphobic persecution do not continue to face such persecution or discrimination on arrival in Scotland.
- Ensure that LGBTI support services and community groups across Scotland, including in rural and island areas, have the funding and resources they need to effectively support LGBTI people, and improve inclusion and challenge prejudice in their local communities.
- Work with Sport Scotland and other governing bodies to end LGBTI discrimination in sport, supported by strategic investment to ensure that LGBTI people can fully participate in grassroots and community sport.
- Ensure there is LGBT inclusion in national strategies, policies and action plans related to tackling homelessness, recognising LGBT young people in particular as an at-risk group.
- Ensure the needs of LGBTI people, including LGBTI older people and those living in rural communities, are included in national strategies, policies and action plans related to tackling social isolation and digital poverty in light of the COVID-19 pandemic.
- Show public leadership on equality for LGBTI people, including through effective media campaigns, and researching public attitudes on discrimination to measure progress.

# 7. Support LGBTI Rights Abroad

## We're calling on MSPs and their parties to support and commit to:

**Showing leadership in advancing LGBTI equality and the protection of LGBTI rights abroad, including through delivering LGBTI-inclusive and LGBTI-specific international development work.**

The Scottish Government must show leadership in advancing LGBTI equality and the protection of LGBTI rights abroad, including through its work on international development. In many countries across the world, LGBTI people face criminalisation, ostracism, and harassment that can prevent them from accessing vital services, including through international development programmes. Where development programmes are not targeted at redressing these inequalities, LGBTI people can be left behind.

## We're calling on the Scottish Government to:

Work with partner countries to advance LGBTI equality and protect LGBTI rights abroad.

Where appropriate, raise concerns about LGBTI equality with governments and international bodies around the world, in consultation with LGBTI human rights defenders in those countries.

Ensure all international development and small grants programmes reach LGBTI people in partner countries, and ensure that LGBTI people are supported as part of wider health, anti-poverty, and education programmes. Fund LGBTI-specific international development programmes, where possible.

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## Published March 2021

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# Scottish LGBTI Equality Pledge




See who has signed the pledge | Contact your candidates
Candidates: Click here to contact us

Read our LGBTI Equality Manifesto '21-'26
Read what the parties are saying about LGBTI issues

The Scottish LGBTI Equality Pledge has been developed by the Equality Network, Scottish Trans Alliance, Stonewall Scotland and LGBT Youth Scotland, national charities working for LGBTI equality and human rights in Scotland. It calls for candidates to commit to:

- Promote positive mental wellbeing for LGBTI people, ensuring that actions to improve Scotland's mental health specifically address the inequalities LGBTI people face.
- Support LGBTI people to have equal access to health and social care services, including by reforming NHS gender identity services to be fit-for-purpose.
- Improve LGBTI rights and protections in the law, including by reforming laws on gender recognition and ending conversion therapy.
- Support LGBTI young people to flourish in schools through the continued implementation of inclusive education.
- Stand up for all LGBTI people, including the most marginalised – LGBTI people of colour, refugees, disabled people, older people, and trans people.

We want to see as many MSPs committed to LGBTI equality in the next Scottish Parliament as possible. Please take the time to email your candidates to let them know this matters to you, and ask them to sign our LGBTI pledge. It can make a real difference!

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2022 is a historic moment for the counting of LGBT+ in Scotland 🌈

It was a pleasure to work with @ScottishTrans, @addyknight and brilliant interviewees to produce four short videos on #ScotlandsCensus 📺 https://twitter.com/ScottishTrans/status/1502251489489739788

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# Trans Activists Greet Women's Meeting With Masked Protests, Smoke Grenades and Flashing Penis

By **Tiffany Cowen** - March 11, 2020




*Cruel: masked protesters intimidated women and let off smoke flares at the site of a memorial to 72 people killed in a fire*

UK — London, England. Women arriving for a rally in London Monday night were greeted by masked protesters shouting abuse, letting off smoke flares and – in one case – flashing his penis.

There was a minimal police presence for the meeting of the Labour Women's Declaration, which was calling on contenders for the leadership of the Labour Party to "defend me or expel me" over attempts to defend sex-based legal protections for women.



*Protester with penis displayed outside London women's rally*

The location of the rally was kept secret until just hours before its start, but this failed to foil transgender activists, who turned up in number to threaten and intimidate those who attended. Wearing balaclava helmets, they filmed women entering the meeting, demanding to know names and addresses.

Smoke flares were let off outside the venue, which is just a few hundred yards from the site of the Grenfell Tower fire, in which 72 people died in June 2017. This prompted a backlash from onlookers and on social media. A transgender rights group, London Bi Pandas later apologised.




*Witnesses to smoke grenades Tweet from the event*

*Grenfell community responds with disgust to smoke bombs from thrown by transactivists*

Inside, journalist Julie Bindel, trans woman Debbie Hayton, and academic Selina Todd were among those who spoke in defence of Woman's Place UK and LGB Alliance – organisations branded 'hate groups' in a pledge signed by Rebecca Long-Bailey and Lisa Nandy, two contendors in the contest to be the next leader of the opposition Labour Party.

*Julie Bindel and speakers at the London rally*

**Read more on this story**

Transgender rights protestors are branded as 'thugs' for 'setting off smoke grenades' in the shadow of Grenfell Tower

DAILY MAIL

Activists cover their faces with scarves and chant: 'Trans women are women' amid puffs of smoke outside a meeting in Kensington, West London, close to the site of the 2017 blaze, which killed 72 people.

#Expel me

MEDIUM

Former Labour Party policy advisor Lachlan Stuart recounts how a Labour manifesto commitment to age-appropriate sex education was hi-jacked by transgender ideology.

**Tiffany Cowen**

UK-based writer and campaigner. Donate to this writer.

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Women Are Human is dedicated to exploring the impact of the modern gender identity ideology movement on society, particularly on women and girls, from legal identity, legal rights, safety, health, sexuality, participation in sports, politics, careers and more. Do you have a story you'd like us to cover? Have you spotted an error or omission? Would you like to submit an article?

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# Speech by Bev Jackson, of LGB Alliance at Labour Women's Declaration #ExpelMe Rally London, 9th March 2020

First: thank you very much to Labour Women's Declaration for organizing this rally. I'd also like to thank the impromptu choir outside for demonstrating rather graphically that there is something of a misunderstanding here: we are not against trans rights. We are for women's rights and the rights of LGB people.

Everyone in this room – well actually, every single person on the planet – was born from an egg from a female and a sperm from a male. Biological sex is binary, it's immutable, and it's the basis on which women and LGB people worldwide are oppressed.

Sex – not gender. When I moved from London to Amsterdam, I became a professional translator. I deal with language. So I've watched with interest as more and more people have taken to using the word 'gender', partly to avoid the unwanted associations of the word 'sex'. Now this has spun out of control until it reaches everywhere, even influencing children's views of their own bodies, and the lessons they are taught at school. Let's be clear: Sex is biology. Gender is about social stereotypes.

When the candidates for Labour leadership and deputy leadership signed up to a pledge that defamed my organization, LGB Alliance, clearly showing that they knew nothing about us, we were proud to be linked with Woman's Place UK, which is a fantastic organization.

LGB Alliance and Woman's Place UK both insist on the importance of biological sex. And when women's sex-based rights are at issue, lesbian rights are doubly impacted. Women who make love – and make their lives – with other women have always been seen as a threat within patriarchal society. LGB Alliance is an organization that supports the rights of lesbians, gay men and bisexuals to define ourselves as same-sex attracted. Sexual orientation is protected by the Equality Act. More and more gay men and bisexuals are protesting against the insistence on gender identity. But we are a lesbian-led organization, and that is no accident. Because what we're seeing now is the worst attack on lesbian rights in my lifetime. Let me give you a few examples:

● Young women visiting 'lesbian' dating sites report that some 40% of the people who sign up have male bodies.

● There's been an almost 4000% increase in the number of girls going to gender clinics and self-IDing as boys in the UK over the past decade. The government has commissioned research into this huge increase, but says it's not in the public interest to tell us who is carrying it out or what the terms of reference are. Meanwhile, hundreds of young women in their twenties now regret transitioning. You can go online and hear their stories – brave young women like Benji from Canada, like Sinead Watson, and like Keira Bell, who is now challenging the NHS gender clinic in a landmark legal case. They and hundreds like them question why the medical profession went along with transitioning them instead of giving them the care they needed. They were sure they were trans. Now they know they're lesbians.

● And lesbians are no longer welcome within what some people still refer to as the LGBT 'community'. Community! When Lesbians assert their sexual orientation at Pride events, they are jeered at and shouted down by activists. When this happened at Lancaster Pride last year, the activists were praised on Twitter. Who by? By the chair of Stonewall. It's the upside down. Stonewall – that once proud organization, which helped to defeat the infamous Section 28 legislation and helped to achieve same-sex marriage –

Stonewall no longer represents us. It has signed up to gender identity theory. Gender identity theory says that males who 'identify' as women can call themselves lesbians. This is a kind of theft -- stealing our word for ourselves -- and we will not, do not accept it.

We are LGB but we have many allies: straight women and men and trans people too – trans people who are appalled at the attacks on the rights of women and on those of LGB people. When they speak out, they often find themselves caught in crossfire. I'm happy that one of our strongest trans allies will be speaking here today. We value all those who support us in our work.

What is that work? Right now we have four priorities:

Our first priority is to 'Press Pause' on the Gender Recognition Reform Bill in Scotland. The Bill is described as a minor administrative change that will help a small group of people and leave existing rights intact. That is completely false. Please fill in the consultation: there's just one week left! There are guidelines on our website and on the website of For Women Scotland.

Second: We will stop the rollout of Stonewall's 'LGBT-inclusive curriculum' for primary schools. Although schools can choose which curriculum they use, Stonewall's is the only one shown on the DfE website resources page – no sign of the resource produced by the group Transgender Trend, for instance. Stonewall's curriculum focuses on gender identity, and suggests to kids that they may have been born in the wrong body. It does not belong in any classroom.

Third: our battle to end the rule of what we call 'Stonewall Law'. We sent a letter to the EHRC in the autumn, asking for an inquiry into whether Stonewall is in breach of the Equality Act. The EHRC wrote back saying there was nothing to worry about. Funnily enough, this did not reassure us. Our lawyer has now sent the EHRC a killer letter, detailing the damage Stonewall is wreaking across the public and private sectors - with no Parliamentary authority whatsoever. We're expecting the reply next week.

Fourth, we demand a seat at the table everywhere where decisions are made about LGB issues. For example, the government's LGBT advisory panel consists of 12 people – all twelve of whom support self ID. No diversity of thought at all. We are in talks with the Government Equalities Office and have requested a meeting with Liz Truss.

On top of all this, we've been building a brand new organisation. Believe me, it's detailed, boring, tiring but it has to be done. We're applying for charitable status and building an organization to challenge the dominance of those who promote the damaging theory of gender identity.

We're a grassroots organization trying to engage with people who hold different views. And to the Labour candidates who know so little about us, I have two things to say:

• First, stop pretending that there is no conflict between the demands of transactivists, especially self-ID, and the rights of women and LGB people.

• And second, talk to us! Where there are problems and clashes, let us sit down and talk about them. We've been arguing for months now for fact-based, respectful discussions in which we can work towards finding solutions that are fair for everyone: for women, for LGB people, for trans people, and for children. As Kate Harris, co-founder of LGB Alliance, likes to say: "Our door is always open."

Let me close with the words of the late Magdalen Berns: "It is not hate to defend your rights. And it's not hate to speak the truth." So: when we leave here today: let's try to cast off the fear. Let's go out, stand up, and talk in public about sex and gender! Thank you very much.

# investigates: Stonewall. Episode 1: The brief

19th October 2021

The Nolan team based in Belfast are a group of BBC journalists well used to asking awkward questions. Nolan looks at the influence Stonewall has in public institutions across the UK. This 18-month investigation has already had significant impact behind the scenes in major public institutions. The podcast is the story of how it all unfolded. A team of volunteers at Fair Play For Women have transcribed the main content from each of the ten episodes spanning over 6 hours of audio content. You can listen to the full audio

here (https://www.bbc.co.uk/sounds/play/p09yk1fy)

## Episode 1: The brief

How the investigation began.

“I can sum up why this story is important to the audience in a nutshell. If you have any organisation that becomes so powerful that it has penetrated the thinking of many of our public institutions, then there needs to be a lot of transparency around that. The public need to be able to look at that power and scrutinise it and ask these big public, that’s the key word, public, organisations. Sorry, how much are you influenced by this group? What about other groups that oppose Stonewall? Are they allowed to influence your policy? This is critically important to the public. That’s why we’re spending months investigating this”.

“It’s not about the rights and wrongs of what Stonewall are doing. They’re entitled to lobby. It’s about the process. And is it right that in a democracy, a lobby group can have so much influence within government on government policy. And if Stonewall can have it, who else can have it?”

[00:02:12.170] – David Thompson

This story came to me in 2018 when I was looking at how the BBC had described a comment on the BBC staff page, I wondered how the BBC stood on it because it seemed to me it didn’t really stack up. And I asked them and he said, well, it came from Stonewall, and Stonewall said it’s correct, so they’re the experts, and I kind of thought well, that’s odd for the BBC to be taking an outside lobby group’s position, as a matter of fact, on anything. That’s kind of how it started. And I’ve been asking questions about it for a couple of years. I’m kind of working on it more intensely in the past, sort of six months or so.

[00:02:58.890] – Stephen Nolan

But a recurring theme that you will hear throughout this podcast is that some people from all different sides of this debate either don't want to or because of that backlash are too afraid to ask or even answer questions about sex, gender, self ID and trans issues.

[00:03:18.930] – David Thompson

I think most people probably associate Stonewall with the gay rights movement in sort of80s and 90s, the campaign for same sex marriage as advocates of gay rights.

[00:03:41.790] – David Thompson

Where Stonewall's views are quite controversial at the moment, is around gender. Historically, sex and gender were essentially the same thing, but it meant, are you male or female?

What Stonewall would argue for is that there are a multiplicity of genders, and it's about how you feel as a person so you could be in a male body, but you could be a woman.

And it's about how you self-identify. And there are other genders, people who identify as nonbinary, neither male nor female. There's genderqueer, genderfluid. Lots of different ways that people can identify. What Stonewall essentially are arguing for is a change to legislation to protect having a different gender identity, to give a legislative basis for that, which there isn't currently. Some feminist groups feel that by doing this, it does start to impinge on sex-based rights, and that's where the conflict comes. So, for example, if you're looking at women's changing rooms, a lot of feminists argue that they should be based solely on sex. But if you change the law to allow people to self-identify their gender, and there's a concern that undermines safe spaces for women and girls in sports, another area where it's become really contentious. Obviously, there are physical differences between males and females and should trans women be allowed to compete in women's sport.

[00:05:41.230] – David Thompson

This is all new territory. The gender debate is a debate that's been happening for just a few years. And some of the changes that Stonewall want to bring in are pretty radical in terms of how we perceive gender and how fluid your gender can be and how easily that can change.

[00:05:55.870] – Stephen Nolan

But just to be clear, we are not, nor are we allowed to, within the BBC, attack Stonewall. In fact, if anything, what this journalism might do is show how effective

Stonewall are at what they're supposed to be, which is a lobbying group; they lobby incredibly well. What this journalism is about is all of the public institutions that should have their own thought of mind should be standing back and should be saying to themselves, is this in line with our ethos, our policies and we've big questions around some of that.

[00:06:37.990] – David Thompson

It's institutions like the Scottish government, the Welsh government, Whitehall, Police, NHS, all of these organisations have brought Stonewall in, presumably aware that Stonewall hold some controversial views.

So why did they bring them in and allow them to influence their own policies? And can they then say that they are truly independent?

[00:07:24.870] – David Thompson

When you consider how controversial some of these issues are, Stonewall's position of often not debating them has just meant that the potential policies that Stonewall are advocating for can't be scrutinised and can't be debated.

[00:08:42.570] – David Thompson

Where the conflict comes is how you legislate for this and how as a society, we lay down the law in a way that allows people to be themselves but doesn't infringe other people's rights.

[00:09:09.450] – David Thompson

So far, we've gone to the Scottish government, the Welsh government, the Northern Irish government, to the Whitehall departments of the UK government. We've gone to NHS Trusts, the police, universities and the BBC. So these are all big public sector organisations who already have a relationship with Stonewall. So unless we want to see how governments across the UK and public bodies across the UK have interacted with Stonewall because we know there's a relationship there. We know monies paid, but we want to see exactly what these governments and institutions have got for their money. What were Stonewall asking for and what policies changed because of this relationship, if any?

So that's what we're trying to find out how much influence of Stonewall has over public policy.

[00:10:28.170] – David Thompson

I think there's just a principle here about how government works. We do this day and day out in the radio about how government works and making sure that government is transparent and open. And as a journalist, everything is about public debate and some of these issues that Stonewall lobby on in terms of self ID, gender; these issues are not settled issues they're contested. The government has rejected proposals for self-identification. But yet Stonewall has this influential position within these organisations, which is filtering that down through them. So to me, there's a really important principle there as to whether that influence within government means the democratic process could be undermined. And that might sound quite dry. But it's important because if we don't scrutinise these types of issues.

It's not about the rights and wrongs of what Stonewall are doing. They're entitled to lobby. It's about the process. And is it right that in a democracy, a lobby group can have so much influence within government on government policy. And if Stonewall can have it, who else can have it?

[00:13:21.010] – Stephen Nolan

I can sum up why this story is important to the audience in a nutshell.
If you have any organisation that becomes so powerful that it has penetrated the thinking of many of our public institutions, then there needs to be a lot of transparency around that.

The public need to be able to look at that power and scrutinise it and ask these big public, that's the key word, public, organisations. Sorry, how much are you influenced by this group? What about other groups that oppose Stonewall? Are they allowed to influence your policy? This is critically important to the public. That's why we're spending months investigating this.

[00:14:10.430] – Stephen Nolan

And yes, we are asking questions too of the BBC. We will be looking at many organisations. But the first couple of episodes of this podcast is looking at the BBC. Tim Davie is Director General of the BBC.

[00:14:34.550] – David Thompson

I think where it becomes a problem for the BBC is that Stonewall obviously have a set of views and we, as an organisation, pride ourselves in independence and impartiality and being separate from groups and it's very difficult to have any relationship with any charity or any group, if you work for the BBC. Particularly charities who are lobbying on sensitive areas.

[00:15:10.370] – David Thompson

There's a lot of criticism about how the BBC provides educational material for young children, about there being 100 and more genders, which most people probably won't have heard of. So lots of people were very angry about that. And it's that type of thing that we want to find out.

Is that the BBC's position or is that Stonewall's position
and did Stonewall influence the BBC and say, look, this is where you've got to go to. You have to teach kids about this. We know that Stonewall wants to influence the education system on matters around sex and gender. Like, why wouldn't they? But if you're a member of the public who doesn't agree with Stonewall and you see Stonewall and the BBC have a relationship and that Stonewall provide advice to the BBC, you'd be questioning: is the BBC really impartial on these issues? The BBC will say there's like a Chinese wall between their diversity and inclusion people and the journalism and the independence of the BBC as a broadcaster. But if there's a perception out there that the BBC has taken a position on allot these issues around gender and people will argue that by saying there are 100 genders, they have taken a position, is that because Stonewall have asked them to? And is there apolitical pressure for a public service broadcaster to push the agenda of a lobby group? And that's what we're trying to get an answer to.

# BBC pulls out of Stonewall diversity scheme

10 November 2021




PA MEDIA

**The BBC has withdrawn from a workplace equality scheme run by LGBTQ+ charity Stonewall.**

The broadcaster said its participation in Stonewall's Diversity Champions scheme had raised questions about whether it could be impartial on issues that the charity was campaigning about.

A number of other bodies and government departments have previously pulled out.

Stonewall said organisations were being "pressured into rolling back support for LGBTQ+ employees".

The BBC said it was committed to inclusion and may work with the charity in the future.

316

1678

Last month, **BBC Radio 5 Live presenter Stephen Nolan's podcast** considered whether the BBC and other public bodies were too close to the charity, such as by allowing its stance on gender identity to influence the BBC's training and style guide.

The BBC started a review of its membership before the podcast.

**A statement from the corporation** on Wednesday said: "We are proud of our lesbian, gay, bisexual and trans colleagues and we support them to have fulfilling careers at the BBC.

"Along with many other UK employers, the BBC has participated in Stonewall's Diversity Champions Programme to support our objective to create a fully inclusive workplace. However, over time our participation in the Programme has led some to question whether the BBC can be impartial when reporting on public policy debates where Stonewall is taking an active role.

"After careful consideration, we believe it is time to step back from the Diversity Champions Programme and will also no longer participate in Stonewall's Workplace Equality Index.

"Being a part of the Diversity Champions Programme has never required the BBC to support the campaigns of Stonewall, nor its policy positions. As a broadcaster, we have our own values and editorial standards - these are clearly set out and published in our Editorial Guidelines. We are also governed by the Royal Charter and the Ofcom Broadcasting Code. Our journalists continue, as ever, to report a full range of perspectives on stories.

"Although the BBC will not be renewing its participation in the Diversity Champions Programme, in the future we will continue to work with a range of external organisations, including Stonewall, on relevant projects to support our LGBTQ+ staff."

- **BBC unveils 'significant' impartiality plan**
- **Stonewall's influence on BBC and Ofcom revealed**
- **Harder to be impartial amid culture wars - BBC boss**

Stonewall said it was "a shame" that the BBC had decided not to renew its membership.

"We will continue to engage with the BBC on a number of fronts to champion support for LGBTQ+ colleagues and to represent our communities through their reporting," **a statement said.**

It added: "It is shocking that organisations are being pressured into rolling back support for LGBTQ+ employees."

Stonewall says more than 900 organisations in the UK have signed up to the Diversity Champions scheme, which aims to promote inclusion in the workplace.

It is described by Stonewall as "the leading employers' programme for ensuring all LGBTQ+ staff are free to be themselves in the workplace".

Media watchdog Ofcom, the Equality Human Rights Commission and the government's Cabinet Office, Equalities Office and Ministry of Justice are among the other bodies to have pulled out.

The BBC's decision comes almost two weeks after director general **Tim Davie unveiled a new 10-point impartiality plan**.

## More on this story



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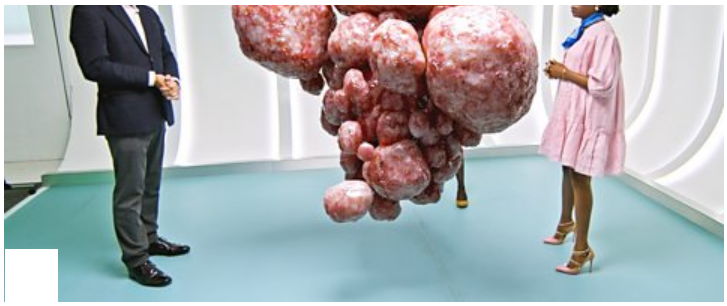


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Rainbow pedestrian crossing in support of LGBTQ. The broadcaster said it would continue to work with Stonewall
AURORA GIAMPAOLI / GETTY IMAGES

# Channel 4 quits Stonewall scheme amid legal advice scandal

Ben Ellery

Saturday June 05 2021, 12.01am, The Times

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Channel 4 has become the latest organisation to pull out of the diversity scheme run by the charity Stonewall.

The broadcaster, which has been praised for its programmes highlighting LGBTQ issues, said it was withdrawing from the "diversity champions" scheme.

A host of organisations have pulled out of the programme after the charity was criticised for providing inaccurate advice regarding transgender people.

Liz Truss, the women and equalities minister, told officials this week that she did not think that Whitehall departments should be signed up to the scheme amid concerns it may not provide value for money.

Yesterday Moon Beever, a law firm, severed its ties with the charity. The Equality and Human Rights Commission and the employment dispute service Acas have withdrawn for "cost reasons", and the DVLA and the housing department have also pulled out.

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A spokesman for Channel 4 said: "We have worked with Stonewall for many years and will continue to do so. Last year was the first time we'd entered its index in order to benchmark our progress as a supportive LGBT+ employer – it was a resource intensive, costly but extremely valuable exercise and something we might undertake again in the future.

"We need to invest in different partnerships each year and no doubt that will involve Stonewall again but not every year – in this Paralympic year our focus is on disability."

Frances Coulson, senior partner at Moon Beever, told the legal blog RollOnFriday: “After some disquiet about recent actions of Stonewall we have decided to exit the Stonewall Diversity Programme.”

Last month the charity was accused of misrepresenting the law in its advice to Essex University, which failed to uphold free speech when it dropped speakers accused of transphobia.

Akua Reindorf, a barrister, warned of “potential illegalities” and said the university should reconsider its ties to the campaigning group. Her report was commissioned by Essex after two professors were disinvited from events. The report has been accepted by the university, which promised to act on its recommendations.

Stonewall provides advice to hundreds of organisations, including businesses, schools, universities and police forces. Membership of the scheme costs about £2,500 a year.

A Stonewall spokesman said: “As with every membership programme, organisations come and go depending on what works best for them at the time.”

Television | Liz Truss

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# EXCLUSIVE Law firm quits Stonewall over its 'disquieting recent actions' (/news-content/exclusive-law-firm-quits-stonewall-over-its-disquieting-recent-actions)

By Jamie Hamilton (/readcontent/710489)
04 June 2021




*not the new logo.

A law firm has ended its membership of a diversity scheme run by Stonewall citing concerns over its recent actions, saying it can no longer support the LGBTQ+ charity.

Moon Beever, based in Gray's Inn and specialising in insolvency work, was one of 77 firms signed up to Stonewall's Diversity Champions scheme.

But Frances Coulson, the firm's Senior Partner, told RollOnFriday that Moon Beever had relinquished its membership.

"After some disquiet about recent actions of Stonewall we have decided to exit the Stonewall Diversity Programme", she said.

"This in no way detracts from our commitment to diversity and equality, but in common with the Equality and Human Rights Commission and Government Departments we no longer feel that we can support Stonewall", said Coulson.

Public bodies including the EHRC, the DVLA, the Ministry of Housing and Acas have all pulled out of the scheme, and Equalities Minister Liz Truss has recommended that all Government departments should withdraw.

At least one other firm has also pulled out of the Diversity Champion programme, RollOnFriday understands, however it did not respond to a request for comment.

Concerns from erstwhile supporters over Stonewall's direction have grown since it pivoted to encompass transgender issues in 2015, when it began campaigning for male-bodied people to be able to self-identify as women, and for the abolition of exemptions (https://www.rollonfriday.com/news-content/exclusive-firms-should-abolish-single-sex-spaces-help-staff-feel-comfortable-says-law) which can currently prevent males from using single sex female spaces such as women's changing rooms, refuges, hostels and prisons.

The charity's position has faced opposition from 'gender critical' feminists and their allies who argue that biological sex should take precedence over people's self-determined 'gender identity', and that women should be able to define and organise themselves based on their sex.

Two of Stonewall's founders, Simon Fanshawe and Matthew Parris, this week accused the charity of losing its way. "The lesbians, gays and bisexuals (it used, after all, to be just ‘LGB’ before it became ‘LGBTQ+’) that Stonewall was set up to defend have been all but abandoned by an organisation now pushing a divisive dogma", said (https://www.dailymail.co.uk/news/article-9638119/amp/Stonewalled-aggressive-new-leaders-gay-rights-group-helped-launch.html?__twitter_impression=true)Fanshawe.

"Gathering all of us under one big ‘LGBT’ umbrella failed to recognise that sexual orientation and gender identity are two entirely different things - and that unlike the battles we fought 30 years ago, in this instance the rights of one section of this community can directly impact on the rights of another", he said.

Parris said (https://www.thetimes.co.uk/article/stonewall-should-stay-out-of-trans-rights-war-xcz25nhdt)Stonewall had become "tangled up in the trans issue" and "cornered into an extremist stance".

Critics accuse the charity of seeking to go beyond statute and impose 'Stonewall Law' by influencing Diversity Champions' internal policies, which they say could create legal issues.

Essex University apologised in May for cancelling speaking invitations for two lecturers accused of being transphobic due to their gender critical views. An independent report produced for the Diversity Champion by barrister Akua Reindorf found that the university's transgender policy was "misleading", "founded on an erroneous understanding of the law" and "states the law as Stonewall would prefer it to be, rather than the law as it is". Reindorf advised the university to reconsider its relationship with Stonewall.

And a lesbian barrister, Allison Bailey, is suing Stonewall for allegedly putting pressure on her chambers to sanction her after she expressed misgivings about Stonewall's aims and influence. In March, a judge rejected Stonewall's application to throw out the case (https://www.rollonfriday.com/news-content/stonewall-urged-chambers-remove-lesbian-barrister-who-criticised-it) and concluded that it had urged Garden Court Chambers, a Diversity Champion, to take punitive action against Bailey for her views.

But in an interview (https://www.bbc.co.uk/news/uk-57281448)with the BBC, Stonewall head Nancy Kelley defended the charity against accusations that it facilitated an atmosphere in which women were stigmatised or risked losing their jobs for questioning transgender issues. Stating that freedom of speech was "not without limit", she compared gender critical beliefs to anti-Semitism.

"With all beliefs including controversial beliefs there is a right to express those beliefs publicly and where they're harmful or damaging - whether it's anti-Semitic beliefs, gender critical beliefs, beliefs about disability - we have legal systems that are put in place for people who are harmed by that", said Kelley.

Amid increasing scrutiny of the benefits of participation, at the time of going to press 24 of the 77 Diversity Champion law firms contacted by RollOnFriday confirmed that they remained members of the scheme, while nine, including Travers Smith, Pinsent Masons, Gateley, Cleary Gottlieb, and Baker McKenzie, said they intended to renew their memberships.

A spokesperson for Simmons & Simmons voiced its approval of the charity's work, stating said, "as a longstanding Stonewall Diversity Champion, we have received valuable support from Stonewall in advancing some of our LGBT+ initiatives".

The Solicitors Regulation Authority declined to clarify whether or not it was still a Diversity Champion. A Law Society spokesperson said, “Like most organisations the Law Society regularly reviews its memberships as they come up for renewal and we will do this with Stonewall as usual”.

A Stonewall spokesperson said, "As with every membership programme, organisations come and go depending on what works best for them at the time, and it’s great that organisations can continue this important work on their own".

"We are pleased to say that our Diversity Champions programme is continuing to grow and take on new members. This year alone, from 1 June 2020 to 1 June 2021, our membership grew by thirty organisations in total", they said. "We are very proud of the work we’re doing with more than 850 organisations to help create inclusive working environments for their lesbian, gay, bi, trans and queer staff".

Note: An earlier version of the story stated that the Law Society declined to comment, when in fact its spokesperson was out of the office and did not receive the request.

Tags
Transgender (/taxonomy/term/516)
Stonewall (/taxonomy/term/1159)
Moon Beever (/taxonomy/term/1309)

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## Comments

**Anon 04 June 21 09:57**

From my expereince of being on the committee of the LGBT+ staff network at a large city firm, there's an element of hysteria when it comes to trying to get onto Stonewall's top 100 list and being a diversity champion. Firms want to be SEEN to be doing the right thing, and getting recognised by Stonewall is viewed as the only way to achieve that goal. Whether or not firms actually support the campaigns that Stonewall runs is something I am less convinced by.

433 122 (/vote/comment/token=token0SZ cbiQxPa7UAMj

**Harold the Heron 04 June 21 10:11**

Interesting to see that it's a smaller firm that had the guts and integrity to speak up.

I comment as a long time supporter of stonewall who believes it's lost its way. I hope it can recover and start representing gays, lesbians and bisexuals wholeheartedly again.

544 154 (/vote/comment/token=token KhQQ7Np4leg)

**Anonymous 04 June 21 10:14**

How can so many law firms continue to support a group that has misrepresented the law, and much worse?

The demands of trans lobby come into hard conflict with women's rights; predictable that law firms, who have long had a 'women problem', seem to be prioritizing the former.

561 136 (/vote/comment/token=token tuPxkqV

**Unwalt 04 June 21 10:16**

It's just business. Compare the logos of major companies' western branches with those of their middle-eastern branches during "pride month". Tells you all you need to know.

375 130 (/vote/comment/token=token=i2 _Qi_a5

**Anon 04 June 21 10:22**

Hats off to ROF for the most succinct summary of the trans debate I’ve ever read

465 103 (/vote/comment/token=token rlnq9ehwrsvDl

**Anon 04 June 21 10:28**

No firm with a high profile wants to be the first to go. It's a recipe for spending the rest of the year being screeched at on the internet. Maybe the firms that continue to be members will keep shelling out their annual £3k, but will quietly shelve the misrepresentations of the law that they get in return.

320 127 (/vote/comment/token=token 8gUV3Rd_S1TB

**TERF Wars 04 June 21 10:34**

So many TERFs here.

330

158 695 (/vote/comment/token=token=VI CoCsAUROoCd

**Anonymous 04 June 21 10:35**

Harold the Heron has got this one right.

Stonewall has walked itself down a dead-end with its current approach to trans issues. I can't see it surviving continued contact with reality for many more years. It's just g… accruing more and more bad press (which, for an organisation that trades on being able to grant good press to people who pay it money, is a poor strategy).

406 128 (/vote/…token=…)

Either it will find its way to intellectual renewal and deal with the issue in a more inclusive way, or it will gradually tarnish its own brand to the point that larger firms consider it safe to move to an alternative provider of PR-friendly certificates and rosettes.

One hopes for the former, but fears that the kind of ideologues who now run Stonewall may not be for turning.

**Anonymous 04 June 21 10:51**

Succint? Biased & unbalanced with critical comments routinely censored is more truthful.

190 544 (/vote/…token=…)

Take the reference to founder members of Stonewall. It's just two of them. One of whom happens to also be a Tory journalist with an interest in pushing his party & paper's editorial l… line. RoF news, in order to peddle a misleading narrative, fails to mention that the majority of Stonewall founders support its current policy.

**Anonymous 04 June 21 10:55**

@10:28 - that's exactly it.

351 135 (/vote/…token=…)

Big firms don't want the PR hit of being first to go, which right now they would certainly get. But the intensity of that hit reduces each time another smaller firm leaves, so they'll eventually shift (a) when enough smaller firms have taken the flak first, making leaving commonplace and unremarkable, or (b) after Stonewall sufficiently toxifies its own brand, at which point several large firms would probably move at the same time.

You can see it coming as Stonewall increasingly makes itself the story (in a bad way). It'll take a few years still, but the above is inevitable without a change of course from the divisive approach to trans issues.

The only thing that will come as a surprise is how quickly the migration will happen when that tipping point is reached. Which is why I hope that Stonewall changes course beforehand, because it will be too late once the moment comes.

**Anonymous 04 June 21 11:01**

@10:51 - describing the objections to the narratives about trans issues currently in vogue at Stonewall is not 'bias'.

459 125 (/vote/…token=…)

It is a contentious issue on which there are at least two valid points of view. Giving a fair hearing to more than one of those viewpoints does not represent 'bias', it represents an adult discussion that hasn't caved in to demands for censorship.

One of the problems that Stonewall and its fellow travellers have at the moment is that they have painted themselves into a corner whereby they consider even the voicing of polite, logical disagreement with their own opinions as being a crime in and of itself. It's a totalitarian approach which is doomed to failure on that basis alone.

hth

**Anonymous 04 June 21 11:01**

10:51 -

345 118 (/vote/…token=…F8)

Rof also quotes stonewall, who were presumably given the chance to comment too. It quotes a happy champion too (Simmons).

If a firm says it's quitting over issues with stonewall's direction, papers surely have to explain what those issues are.

You seem to just want no criticisms and an article blasting the firm for leaving by citing how much support stonewall has. This is why I worry about the measures being demanded by lobby groups like stonewall these days. It ends up with little authoritarians whipping anyone who steps out of line and doesn't provide unfettered adulation for the cause.

**Anonymous 04 June 21 11:11**

Transpeople really are the canaries in the coalmine when it comes to human rights.

181 534 (/vote/…token=…)

**Anon 04 June 21 11:12**

I find Simon Fanshawe and Matthew Parris' claim that "it used, after all, to be just 'LGB' before it became 'LGBTQ+" very strange given that Stonewall is named from the 1969 riots in… which a significant number of trans people participated and, arguably, led.

143 511 (/vote/…token=…)

Trans people have always been part of of the LGBTQ+ community and I'm glad that Stonewall continues to advocate on its behalf.

**Warren 04 June 21 11:17**

Nothing is quite so disgusting as people who were part of previously discriminated against groups who, now they have reached their goal, turning around and pulling up the… drawbridge to prevent another marginalised group (and a group that had stood shoulder to shoulder with them through their own struggle) realising it's own asperations.

181 498 (/vote/…token=…)

Matthew Parris etc used to argue for gay rights on the basis of fairness and equality. So did many feminists, and they were 100% right. Turns out for many of them it was just a tool for them they cynically used to advance their self interest, rather than an actual principal they believed in.

**anon 04 June 21 11:21**

Good for Moon Beever,

-the way Stonewall have bullied Allison Bailey is a disgrace. Hopefully my firm will also drop out but I won't hold my breath.

562 116 (/vote/comment/token=kW3lFH_lOvIxpoPh2SLEY)

**Mercedes Driver 04 June 21 11:23**

The real point to take away from this article is that there exists a firm called Moon Beever.

282 126 (/vote/comment/token=5qEJvOX_akBZfjZZnQ62

**LGBTQI+ 04 June 21 11:26**

Completely agree 11:12. Although the official records claim the stonewall riots were led by gays and lesbians, famously it was a Demi-romantic asexual non-binary queer person who actually threw the first brick at stonewall, leading a chant of 'they/them' at the cops before dousing themselves in purple hair dye.
As a gay man, I for one am glad that stonewall has finally rediscovered its roots. It's high time I was accused of transphobia for requiring my lover to have male genitals.

462 124 (/vote/comment/token=sBrC9

**Anonymous 04 June 21 11:28**

The lack of generosity of spirit towards the quite small number of people who are transsexual and resistance to any small accommodation of their needs - when the rates of self-harm and suicide among trans people is so high - is really disheartening. Well done, Stonewall, for standing up for this vulnerable group and shame on the idiots who make it all about women's toilets...

142 529 (/vote/comment/token=

**Lydia 04 June 21 11:31**

That is a good summary in the article and Stonewall have lost their way over this issue., Most of us want to treat trans, gay/lesbian and all the others equally and well but there are ways to do it which do not damage women or lesbians and ways that hurt vast numbers of women (50% of the UK) are the expense of a tiny number of trans people. Apparently there are FOIA requests going into universities and schools about what has been paid to Stonewall so at least people are starting to realise the damage that has been done.

340 120 (/vote/comment/token=WE4)

I am also taken back to the bible on these issues - treat people equally -

"**There** is neither Jew nor Greek, **slave** nor **free**, male nor **female**, for you are all one in Christ Jesus" and

"Take heed that ye do not your alms before men, to be seen of them: otherwise ye have no reward of your Father which is in heaven.". There is a very public form of virtue signalling going on at present which feels morally wrong to me. Do not shout it from the rooftops that you treat black lesbian women well - just treat them well and hire them. Do not have them on every last video (not least because they need a break from constantly being dragged out on every PR exercise). Just quietly go about being fair, even if the lack of shouting about how good you are means you do not win some silly reward.

**Clive 04 June 21 11:38**

Trans people had nothing to do with Stonewall (the riot). That's a piece of historical revisionism peddled by the likes of Stonewall (the organisation). The only trans person (self-identified as such much later) associated with the riot was Sylvia Riveira and she wasn't there until the second night. The riot was led by gay men and lesbians. That's it.

And no, Marsha P Johnson was not trans. Never identified himself as such. Always said he was a gay man.

479 134 (/vote/comment/token=6uNL-H6Odxa0cj64)

**Anonymous 04 June 21 11:40**

The appeal to 'be kind' won't wash anymore. We all sympathise with trans people struggling with dysphoria, but how about you display some generosity to women who want to organise by sex, because they are oppressed on the basis of their sex? What about gays and lesbians who want to be able to define their sexuality as same sex attraction? Where is your recognition that this is very different to gay rights and impacts upon other groups in a seismic way?
We are all expected to make way and 'be kind' to those you support - how come you are not prepared to be kind and recognise the issues that this creates for others? 'No debate', that was the mantra, wasn't it?

497 137 (/vote/comment/token=Uw)

**Anon 04 June 21 11:53**

Anonymous @11.28

We are far beyond making a "small accommodation" here. Stonewall is campaigning to remove the concept of single-sex exemptions in the Equality Act. That's not a "small accommodation" by any stretch of the imagination.

456 140 (/vote/comment/token=F3F8D0

**Paul 04 June 21 12:19**

The problem for Stonewall is that it has to adopt an ever more extreme position in order to justify its continued existence.

At some point firms will start to find that being a 'diversity champion' puts off as many potential recruits as it attracts. We are probably getting close to that point already.

Then, if someone created an alternative, more moderate, more straightforward scheme (which doesn't call for an annual 100 page submission), everyone could jump ship without being accused of having become bigots overnight.

Maybe that is what the newly formed LGB Alliance have in mind.

Maybe that is why certain other organisations are trying to strangle it at birth.

351 126 (/vote/comment/token=8)

**Anonymous 04 June 21 12:24**

The Stonewall Champions scheme is a protection racket, in my opinion, used by companies to get their diversity brownie points with the public and a sticker to put on their website and promotional leaflets. Look at all the Rainbows on UK company sites for Pride month, eg BMW - noticeably absent from their Saudi and Middle East sites.

After the right to gay marriage was won, what was left to achieve for Stonewall? Not much, so in order to keep the money coming trans rights became the new mantra in 2015. It's true what they say; all good causes start as a movement, become a business, then degenerate into a racket. Stonewall have given years of inaccurate advice on the law and hopefully more companies will realise and find the courage to leave this scheme.

I would ask anyone interested in the conflict between trans activism and women's rights to read up on the case of Marion Millar in Scotland. Arrested this week for, it seems, offending trans activists on Twitter. Perhaps RoF could look at how the new Hate Crime legislation in Scotland is being used, in my view, to frighten women into silence on trans issues? The legislation seems to cover hate crimes against trans people but not hate crimes against women.

444 138 (/vote/comment/token=...)

**Anon 04 June 21 12:28**

@ 11.40 - Exactly

also the classic argument that we should give the trans lobby what they want because “look at all the suicides and mental health troubles trans people go through”. They’re suffering because of the dysphoria they are going through, not because people won’t let them use the toilets they want.

Our profession isn’t helped either when we have practitioners like Jolyolyolyoln trying to force through the trans lobby’s demands by (il)legal means.....

354 143 (/vote/comment/token=...)

**Anonymous 04 June 21 12:31**

"*if someone created an alternative, more moderate, more straightforward scheme (which doesn't call for an annual 100 page submission), everyone could jump ship without being accused of having become bigots overnight*"

That is exactly what will happen without a change of course from Stonewall.

At the moment it is the UK's 'Premier' brand for awarding D&I certificates - but that hard won position isn't unassailable. Many other charities would happily take its place and money.

The more Stonewall tarnishes its once strong brand by pushing a viewpoint that isn't logically sustainable and which alienates many of the minority groups it alleges to be in the business of protecting, the more likely it becomes that some other charity will leapfrog by offering an alternative product which takes exactly the form you describe.

One can only survive on dewy eyed nostalgia about a riot in 1969 for so long - *especially* once you start watering that story down by revising and reinventing it to put the latest diversity trend at its forefront.

286 148 (/vote/comment/token=...)

**Anonymous 04 June 21 12:52**

How do you go about getting a list of who continue to pay Stonewall? I would be interested so I know who NOT to give my business to.

243 134 (/vote/comment/token=...)

**Eilee 04 June 21 13:01**

The Stonewall riots were started by a lesbian called Storme de laverie.
Stonewall is a protection racket that wants to remove the single sex services exemption from the EQ2010 and even wants to erase the word mother!
‘Being kind’ has led to rapists like Karen white being allowed to identify into female prisons and rape the female inmates, it has led to Philip Bunce winning business woman of the year, and to children being chemically castrated and becoming lifelong medical patients.
Stick a fork in it, it’s done.

370 114 (/vote/comment/token=...)

**Anonymous 04 June 21 13:17**

*Our profession isn’t helped either when we have practitioners like Jolyolyolyoln trying to force through the trans lobby’s demands by (il)legal means.....*

That preening fool, and the kind of practice he represents, is a far wider problem for the profession.

The approach of going to court to make new law, then calling that outcome 'justice', genuinely undermines the public's faith in the courts and their collective sense that their elected representatives have the will to actually represent them. Never mind the fact that it effectively allows activists to legislate for extreme outcomes that Parliament would have recognised lacked democratic support.

It's always for a supposedly good cause, and the people involved inevitably feel like good eggs for 'taking the fight to the government' on an issue they deem personally important - but the more ubiquitous it becomes the angrier the public gets that new law seems to be getting made in London courtrooms by wealthy lawyers who self-describe as 'progressive', rather than in Parliament by the people they voted for.

City dwelling progressives feel like doing it over and over again is 'winning' and assume these small victories will all add up (and they'll swear blind that it's all "interpretation not legislation") - but then they scratch their heads at election time and wonder why the dreadful oiks keep voting for the Tories, cheering for legal aid cuts, and applauding the Home Secretary's proposals to cut back the powers of the Courts and the HRA.

Spoiler: This is one of the key reasons why. So stop bloody doing it.

342 95 (/vote/comment/token=...)

**Kitty 04 June 21 13:23**

Hehe, Moon Beever. Hehe.

165 137 (/vote/comment/token=...)

**Lesbian, female homosexual, same-sex attracted. 04 June 21 13:37**

Lesbians do **not** have a penis. Gay men do **not** have a vagina. Stonewall has not represented me or my gay family for many years. I am labelled as "transphobic" for wanting to only date other women, i.e. adult human females. I am **NOT** cis. I was not assigned a sex at birth. I have lost all my lesbian only safe spaces due to men, who identify as women, attending. **P. S.** Seeing as it is Pride time, I am really annoyed at the transing of a black butch lesbian, Storme de Laverie and Martha P Johnson, a gay man who was not trans.

400 133 (/vote/comment/token=VNebdw0A0Lk)

**Anon 04 June 21 13:45**

The Law Society ARE currently Stonewall Diversity Champions and have been for years. Their membership renewal is due on 31st August.

In a response to an FOI request submitted on 4th Feb 2021 they confirmed that in 2019 and 2020 they paid a total of £6000 inc VAT ( £3000 annual membership fee).

So years of spending our fees to join and promote the Stonewall protection racket that misrepresents the law.

Sure as hell they don't want to 'clarify' whether they are still members. Cowards.

https://www.whatdotheyknow.com/request/information_about_your_dealings_5?utm_campaign=alaveteli-experiments-87&utm_content=sidebar_similar_requests&utm_medium=link&utm_source=whatdotheyknow

296 119 (/vote/comment/token=A8Q)

**Anon 04 June 21 13:49**

Anonymous @ 12.52

Here's a list of the diversity champions: https://sex-matters.org/stonewall-champions-list/

Stonewall did publish this list on its website but took it down recently, presumably to protect the nice revenue stream it gets from this racket.

224 126 (/vote/comment/token=RBJsv_QUAXWS)

**fre 04 June 21 14:23**

Everyone knows transmen are biological females, and that transwomen are biological males.

People accept gender dysmorphia since everyone has some form of body or identity glitch.

Who wants to be a working class, average/ugly looking person in a low paid job - for example ? Most people fit this bracket. They can't just demand access to being tret as sex gods or goddess, or demand the same lived experience as popstars or a billionaire.

I want to be a 6ft gorgeous Nordic blonde, to match my inner soul however, the reflection in the mirror dictates my reality, wether I like it or not. There is only so much we can do to blur the stark reality of our visual and biological lack of bullshit detector. We can be kind and polite but biology speaks its truth one way or the other and shafts everyone, not just transgender souls.

293 128 (/vote/comment/token=)

**Assignee 04 June 21 15:09**

Just following on from Lesbian, female homosexual, same-sex attracted at 13:37, does anyone else find the use of the phrase "assigned a sex at birth" strange?

It's clearly become part of the Trans lobby's verbal armory, and is trotted out a lot, but seems to assume that, so far as I can tell, babies are born without any genitalia, and a doctor / midwife or nurse either says "Hmmm.... we're out of penii... better make this one a female" or "we're low on the male quote this week. Next 4 to be male, please everyone".

I'm sure it's me being insensitive or not reading into the issue, but in what was is a sex "assigned", and by whom?

289 119 (/vote/comment/token=)

**Paul 04 June 21 15:22**

How to get the law changed in favour of your preferred minority group:

Become an 'expert' on certain minority rights.

Get everyone to subscribe to your scheme to protect those rights.

Encourage your subscribers to favour your preferred minority group illegally, by misrepresenting to them what the law says.

Lobby government to change the law to favour your preferred minority group because it's what employers are already doing in practice anyway.

229 131 (/vote/comment/token=)

**Bjorn McBjornsson 04 June 21 15:39**

"*I want to be a 6ft gorgeous Nordic blonde, to match my inner soul however, the reflection in the mirror dictates my reality, wether I like it or not.*"

Well then all that you need to do is buy a pair of stripper heels, dye your hair platinum-blonde, put on a bit of a generic euro accent, and call yourself Ulrika and/or Freya.

Congratulations, you have successfully transitioned to Swedish.

Next stop the sauna.

171 138 (/vote/comment/token=wJmPdWGbUw)

**Mum 04 June 21 16:33**

Even juicy sex stories do not even come near the clicks that comments get on trans related stories. Are the lawyers so trans-phobic? I just don't understand. Literally one of the most marginalised minorities and lawyers 'yeah, kick them hard'.

151 280 (/vote/comment/token=y4OdE2X-WamOwxMiYY)

**@Mum 04 June 21 19:51**

Lawyers deal in facts rather than feelings. As a result, trans issues perhaps get tougher handling than we are used to seeing in the press and polite conversation.

242 114 (/vote/comment/token=)

**Richard England 04 June 21 20:45**

Although Stonewall has stopped publishing its list of 'Diversity Champions' online, since just last week, the last iteration of the list has been archived on the Wayback Machine facility. Note that some organisations and companies listed have left since the snapshot was taken. Scroll down for the law firms signed-up;

https://web.archive.org/web/20210514165034/https://www.stonewall.org.uk/diversity-champions-members (https://web.archive.org/web/20210514165034/https://www.stonewall.org.uk/diversity-champions-members)

186 118 (/vote/

**Anonymous 04 June 21 20:56**

"The lawyers" are engaging critical thinking faculties, not swallowing the lobbyists bullsh1t and being aware of where rights are being eroded. You should take a leaf from their book.

235 120 (/vote/

**Anonymous 04 June 21 22:06**

“Most marginalised” minorities - I’m sorry but this is just bullshit. There are more transwomen murderers in the UK, than transwomen murder victims - this kind of rhetoric always harks back to the USA where the murder rate is higher for every group and completely ignores the fact that between 1-3 women a week are murdered by a current or former partner, 1 in 4 women is a victim of rape, 1 in 3 is a victim of domestic violence - that’s your marginalised group right there!

258 132 (/vote/

So so glad that pp mentions Marion Millar and the hideous mess that is the Scottish Hate Crime Act 2021 and the treatment of Allison Bailey. Stonewall has long ago lost its way and is now actively misrepresenting the law and incorrectly claiming “gender” is a protected characteristic under the Equalities Act. Nancy Kelley has openly admitted that they no longer represent all sections of LGBTQ.There is a really grim undercurrent of misogyny and homophobia running through a lot of transactivism now.

**Anonymous 04 June 21 23:10**

@15:09 "I'm sure it's me being insensitive or not reading into the issue, but in what was is a sex "assigned", and by whom?"

177 134 (/vote/

Most humans are "Sex observed at birth".
"Sex assigned at birth" is the phrase used to describe how a baby with indeterminate genitalia is assessed and assigned to the most likely sex. It's unusual and apparently (I have only read descriptions) it's a difficult and delicate task for those who undertake it because their call will influence much of that person's life. Often but not always people with indeterminate genitalia are intersex, which means (in a tiny nutshell) they have a chromosomal irregularity that prevents them developing into a fully functioning male or female.

'Assigned at birth', 'AFAB' [assigned female at birth], 'AMAB' [assigned male at birth] have become code phrases for people who believe themselves to be something other than the sex they were (probably) observed to be. Sometimes sex is conflated with gender, too (sex is biological, gender is performative, as in following gender stereotypes). It's a mess. I'm just really, really glad that the wheels are falling off the Stonewall bandwagon because lesbian, gay and bisexual people deserve better.

**Viktoria 05 June 21 02:37**

Isn’t Marion Millar the lady in Scotland who is presently facing trial for posting a photo of a suffragette ribbon tied to a fence? Meanwhile, some lovely he/him student posted about shooting ‘TERFS’ along with pictures of his gun collection and was clapped on the back by his university! Strange times indeed.

234 115 (/vote/

**Delia Morris 05 June 21 02:48**

Yep trans can defend their rights and 'terfs' as everyday women are now described by some can defend ours.

172 124 (/vote/

**Garet M 05 June 21 04:01**

Never had a problem with Stonewall campaigning for gender reassignment to have protected status but any NGO ‘selling’ a misrepresentation of the law is a problem for public and educational bodies. Blurring the distinction between sex, sexual orientation and gender reassignment is not inclusion. It elevates the status of an ill-defined ‘trans’ identity group as it actively excludes other protected groups. Demanding censure and launching libellous attacks on individuals (mainly women) for challenging this subversion of the law has a chilling effect on freedom of expression and has no place in a democracy that demands only that interference in this right is proportionate and legitimate.

195 128 (/vote/

**They Came For Trans People, LGB will be next 05 June 21 08:28**

Yeah, fuck Stonewall. I am a silenced Lesbian women. Let's get rid of trans people, the the White Gay partners, allow me to thrive. Then we can removed a few of the other minorities we hate!!! Wooheee, I am so happy to remove the rights of a small group of people that do absolutely no harm.

144 226 (/vote/

Wait a minute, why does every one hate Lesbians, now??? Oh god why are my rights being questioned!!! Help!!! They are banging on the door!!! Oh god, forgive me, I didn't realize that take one groups small rights that they would all topple!! How did we go so right wing Nazi in the UK. They are here, goodbye, remember m.....

**Anonymous 05 June 21 12:38**

A lesson in accurate professional journalism that RoF might want to take note of.

https://www.theguardian.com/society/2021/jun/05/stonewall-trans-debate-toxic-gender-identity

130 161 (/vote/

**Clive 05 June 21 14:26**

335

*"Yeah, fuck Stonewall.  I am a silenced Lesbian women.  Let's get rid of trans people, the the White Gay partners, allow me to thrive.  Then we can removed a few of the other minorities we hate!!! Wooheee, I am so happy to remove the rights of a small group of people that do absolutely no harm."*

The fantasy dribblings of a disordered mind. I don't know anyone gender-critical who thinks like this. Grow up, put your battered old victimhood violin away and stop trying to silence women.

217 123 (/vote/comment/token=[illegible]9C85pjKDMYDXtN1DsJvXxYkXiF[illegible])

**Anonymous 05 June 21 18:00**

That guardian piece rather undoes itself by representing Peter tatchell as an unbiased voice of reason asking 'why can't we all just get along?' This is a disingenuous formulation of the familiar invocation for women to just 'be kind'. Getting along and being kind in effect means, 'move over and shut up, women'.

He knows the trans policies he advocates for mean any male can self ID as a woman, but he implies in the piece that only transwomen would use self-ID. That's not the case - we know male predators will take advantage of self-ID to gain access to women and children in vulnerable situations.

This unfortunate fact is constantly presented by the trans lobby as if we are claiming, transphobically, that transwomen are a danger. We are not - they are no more or less a danger than any other subset of males, but those other males can and will take advantage of the access rights which trans activists want us to give to transwomen to enable them to be validated.

Tatchell at least recognises the existence of 'a few bad apples' who are trans, but then, outrageously, dismisses the impact of them as negligible and not something trans policies should take into account. It is of course exactly what trans polices should take into account, as should all safeguarding polices. By his logic we should not carry out CRB checks, because only a few men are child predators.

This is, though, the same campaigner who once wrote "Whilst it may be impossible to condone paedophilia it is time society acknowledged the truth that not all sex involving children is unwanted, abusive and harmful" (https://gript.ie/peter_tatchell_see_no_evil/#Jump-response) so I'm not sure, despite all the good work he has indisputably done, he's the best guy to listen to on balancing the rights of the vulnerable when those groups include women and children. He has an expert area, and this isn't it.

So I suppose you're right, that guardian piece is a very illuminating read if you didn't appreciate that the other side both knows there are safeguarding issues, and is worryingly happy to casually dismiss them.

232 118 (/vote/comment/token=[illegible]B8g)

**Lilly 05 June 21 19:21**

As a gay woman I have witnessed other guy women being called TERFs because they have said they would not engage in a sexual relationship with a transwoman (in particular one surgery).

As a woman I have witnessed women being called TERFs because they query the inclusion of transwomen in elite sport.

As a member of society I have witnessed intelligent women such as JK Rowling being hunted down as a TERF for eloquently stating her concerns with regard to potential changes in the law whilst detailing why she holds their concerns.

This does not, in my opinion, bode well for the future. There appears to be little room for people to question, debate, hold valid opinions without being hunted down by Stonewall and their supporters.

226 124 (/vote/comment/token=[illegible]bqh4HLaIMg)

**Anonymous 05 June 21 20:11**

"*guy women*"

Steady now, you can't say that anymore.

124 166 (/vote/comment/token=[illegible]L7-UvAcMztFkn-Xh4o)

**Anon 06 June 21 03:05**

I work in the legal sector and now choose not to work at any legal firm which is listed on the Stonewall Champions list - yes that's limiting, but i just can't sign up to this. I am a lesbian. Coincidentally, a magic circle firm I also worked at wondered why they had so few out lesbians. Go figure

173 130 (/vote/comment/token=[illegible]wpSU[illegible])

**Anonymous 06 June 21 08:16**

I am straight.

I care that any gay person is being told someone whom has different genitals to themselves should be classed as their sex, and being called transphobic because of this.

We care that women's sports will be ravaged by Transwoman and records will be broken, that no born female will ever be able to beat.

As in "The Emperor's New Clothes" a child would once have been able to scream a truth, now though schools and law will force a child to lie. How legally can that be right?

171 138 (/vote/comment/token=[illegible]k)

**Nonokimono 06 June 21 12:10**

I read an interesting comment in The Times the other day. They said the last thing they would do is hire a law firm with connections to Stonewall.

When paying for legal advice they want expertise in the law as it actually is, not the law as Stonewall wants it to be.

169 134 (/vote/comment/token=[illegible]3hpJK[illegible])

**Anonymous 06 June 21 18:58**

https://www.stonewall.org.uk/about-us/news/stonewall-statement-misinformation-about-diversity-champions-programme

124 132 (/vote/comment/token=[illegible]ma471l2yPpcXcb4



**Anonymous 07 June 21 07:49**

Trans people are some of the most marginalised people in society and suffer terrible prejudice and often violence so though Stonewall may be misguided or even just plain wrong we still have to find a way to resolve the difficulties trans people face.

Where should trans people try on clothes, change or use toilets?

How can people tell if a trans person using a women's changing room is a danger to women?

If trans people are forced to use changing rooms of their biological gender will women accept being joined by trans men on testosterone with beards and penises?

Stonewall's stance is at least highlighting the problems trans people face and society's failure to solve them. If we don't solve them we condemn trans people to a half life, at risk of prejudice and violence themselves.

140 165 (/vote/comment/ token=tokd3=Y AJxeBVev 0RDAfNt

**Anonymous 07 June 21 10:58**

@7.49 assuming you are genuine..... why not a third, gender neutral space for trans people ? In reality most women have no issue with trans men using their toilets, changing rooms etc as they are biologically women and therefore present very little danger to them. The issue is trans women, who are biologically male, and may retain their original anatomy and who provide cover for the worst kind of predators. As men they present the greatest risk of harm to women of any section of society (in fact the greatest danger to trans women is from other men, something that gets ignored time and time again). This is really the issue - it's a hugely asymmetric position. Men know they have nothing to fear from trans men using their toilets, facilities or trying to compete against them in sports (ha!). There is also no discernible attempt to erase them from the discussion. I don't see any trans activists complaining about the use of the word "man" or men's working clubs, or demanding that Cancer Research refer to "prostate havers" rather than men, in the way they do with women, insisting that they be reduced to their anatomy as "menstruators" or "uterus havers".

158 138 (/vote/comment/ token=token=iU zfRFE2b6pbEx GoQqLc7xidQL

"How can people tell if a trans person using a women's changing room is a danger to women?"

Well, we can't can we? So we unfortunately have to assume that all men, including trans women are a danger and exclude them from our safe spaces for our own protection. But even if you came up with a 100% accurate way of determining this - I still don't want trans women in women only spaces or women's sports or in roles such as a "woman" police officer or "woman" probation officer (with their ability to conduct intimate searches). We are entitled to our privacy and our dignity as women without having to allow access to trans women simply because they demand it for their own validation.

What about the "half life" of prejudice and violence faced by women across the world?!

**Anonymous 07 June 21 11:58**

"Stonewall's stance is at least highlighting the problems trans people face and society's failure to solve them. If we don't solve them we condemn trans people to a half life, at risk of prejudice and violence themselves."

153 141 (/vote/comment/ token=tWEuFHg zOvg- lxkNBu0GO_hF

No. Don't try to deploy that well-worn rhetorical device.

Stonewall is not just 'highlighting' the problem, they're calling for a solution which actively prejudices and undermines the rights of several other groups.

Stonewall's proposed course of action is not the only way to 'solve' the issue and thereby rid ourselves of 'prejudice' (and/or the nonspecific 'violence' which we're repeatedly warned of but which never really seems to materialise in the UK). There are other solutions available which aren't as divisive, don't prejudice other groups, and which don't rely on obliging everyone in society to pretend they believe that men can literally turn into women by the power of positive thinking alone.

Everybody here would like to find a way to 'resolve the difficulties trans people face'. So don't try to pretend that giving Stonewall's useless suggestions the treatment they deserve somehow means that we're rejecting any and all other reasonable options.

**Anonymous 07 June 21 21:05**

*Everybody here would like to find a way to 'resolve the difficulties trans people face'.*

153 142 (/vote/comment/ token=G2hYE _F6pqZ1

Would they? Really?

Seems to me it's being made into an "either / or" situation. The reason Stonewall have taken the position they have is because no-one is trying to find a way to resolve the difficulties trans people face.

They might be misguided. They might be plain wrong. But if they weren't doing what they are doing no-one would be doing anything for trans people.

We can get hung up on Stonewall's position if you like (or rather you can - I'll pass) but it'd be better if you can find some helpful answers to the three questions I posed in my 07:49. I don't know what the answers are but I think the only way people can move beyond their entrenched positions is finding solutions.

*Where should trans people try on clothes, change or use toilets?*

*How can people tell if a trans person using a women's changing room is a danger to women?*

*If trans people are forced to use changing rooms of their biological gender will women accept being joined by trans men on testosterone with beards and penises?*

And if there are no obvious answers that fit in our current systems then perhaps we have to find you systems and ways of doing things - which may, of course, create new problems and pushback. People are resistant to change. But the way things are currently is not working for anyone.

**Anonymous 07 June 21 23:19**

typo:

perhaps we have to find ***new*** systems and ways of doing things

124 120 (/vote/comment/ token=tkqqlf2i RRtnpSi

**Anonymous 08 June 21 10:15**

337

*What about the "half life" of prejudice and violence faced by women across the world?!*

111 168 (/vote/comment/ token=tkYpN4M

While I absolutely agree that women tend to experience prejudice and violence, blaming that on trans people is a bit like blaming the budget deficit on too many public libraries in Wolverhampton.

Trans people are not the cause of women's oppression.  They are victims of gender stereotyping and patriarchy just as much as (and probably more than) women.

**Anonymous 08 June 21 11:37**

Prior to going into law I worked for a very large private healthcare company, I was reasonably high up in the marketing department and I have seen first hand the thought process that goes into seeking stonewall accreditation. It is viewed as a shield, something which the businesses or organisation can use to protect them when they do something wrong.

The focus is never on avoiding doing things wrong, and I recall with some shame that I sat across a table from a young man who was only in his early 20's, who pointed out it that if we want to be seen as supporting gay people, perhaps we should stop doing business with certain prominent organisations in the middle east who supported regimes that were openly hostile to homosexuality.

'm sorry to say I didn't do anything to defend the young man when he was told his ideas were idiotic and bigoted because I was in the running for a step up on a career I left later that year anyway. Maybe if all of us middle managers would have put our foot down 10 years ago we wouldn't have the issues with identity politics we have now.

Stonewall has lost its way, pride month is a corporate money spinner and the trans lobby is terrifying in both its reach and vindictiveness to those who oppose it.

**Anonymous 08 June 21 12:03**

"*Seems to me it's being made into an "either / or" situation.  The reason Stonewall have taken the position they have is because no-one is trying to find a way to resolve the difficulties trans people face.*"

That's so divorced from reality that it's hard to believe you're saying it in good faith.

There have been a multitude of potential solutions offered to resolve these difficulties, both by private groups and by the UK Government itself. Stonewall et all's approach is to declare those efforts to be 'insufficient' at best or 'transphobic' at worst; then to demand a solution which actively prejudices the rights of others.

Stonewall et al did not begin doing that because "no-one else is trying to find a way", they did it because they wanted their own extreme way at any cost.

If you don't believe me about the existence of these solutions, then go look up the Gender Recognition Act. I'm staggered you hadn't appreciated it's existence.

Or, alternatively, you know all of this already and are just trying to paint yourself/Stonewall as victims, when in fact you're the ones actively pushing an approach that will prejudice others, undermine their rights, and create safeguarding issues - all for the sake of feeling personal validation.

"*I don't know what the answers are but I think the only way people can move beyond their entrenched positions is finding solutions.*"

... and yet you think anyone pointing out that Stonewall's solution isn't the right one should then be able to do more than you can? That they should know what the answers are and be obliged to answer your arbitrary questions to your satisfaction?

Again, if I didn't know better I'd suggest that you're just falsely pretending concern and neutrality, while you try to paint anyone who doesn't agree with your preferred proposal as being a 'transphobe' who is actively trying to prevent any kind of solution being found.

Please put that overused rhetorical device back on the shelf - nobody is buying the idea that the people seeking to implement oppressive changes to the law (which would actively take away other peoples' freedom of belief and conscience) are actually the victims here.

"*the way things are currently is not working for anyone*"

...bar the 99.9% of the population that are not trans and/or who don't sign up to the mad suggestion that the right answer is At Will Self-ID with enforced acceptance.

With no disrespect intended to them, the only people for whom the current solution "isn't working" are the sub-set of the trans community who advocate the Stonewall endorsed solution. That's a sub-set of an already very tiny minority.

They don't get to dictate public policy any more than the tiny sub-set of Muslims who think Sharia Law is the right answer. That fact does not mean that they are being 'oppressed' as a result of being unable to impose their far-out views on everyone else.

"*women tend to experience prejudice and violence, blaming that on trans people is a bit like blaming the budget deficit on too many public libraries in Wolverhampton*"

What, in the sense that nobody except you is doing it?

**Bob The Builder 08 June 21 14:07**

Moon Beever - Fnnar

**Anonymous 09 June 21 06:49**

*bar the 99.9% of the population*

Well if minorities and the marginalised don't matter then women will just have to take what they're given until they can make it stop.

**Anonymous 09 June 21 07:08**

@ Anonymous 08 June 21 12:03

So you've had a nice long rant.

Now let's get back to the practical stuff.

*Where should trans people try on clothes, change or use toilets?*

*How can people tell if a trans person using a women's changing room is a danger to women?*

*If trans people are forced to use changing rooms of their biological gender will women accept being joined by trans men on testosterone with beards and penises?*

Anonymous 09 June 21 18:23

134 124 (/vote/comment/token/ApCClCeCKYs)

"*So you've had a nice long rant.*

*Now let's get back to the practical stuff.*"

What an astoundingly pathetic whimper of a response.

I didn't expect much, but I did expect better.

Anonymous 10 June 21 16:02

156 113 (/vote/comment/token/2tZfOHHmIMFe)

@10.15

“Trans people are not the cause of women's oppression.  They are victims of gender stereotyping and patriarchy just as much as (and probably more than) women.”

Yeah this is really up for debate, given that transwomen benefit from being male for a large portion of their lives until they decide that they identify as a marginalised and oppressed group (and that discrimination and oppression against them is so much worse than that experienced by any other group - spoiler, it isn’t!). Transwomen then further benefit by having access to enhanced opportunities to participate in women’s sports (taking away opportunities from natal women, see for example Laurel Hubbard, the New Zealand weightlifter and oldest “female” weightlifter at the Tokyo olympics. Plus increasing the rate and severity of injuries suffered by natal women in contact sports), women’s prizes and positions reserved exclusively for women (like heading up Edinburgh Rape Crisis - see Mridul Wadhwa (who is a man - doesn’t have a GRC and hasn’t had surgery to correct their gender dysphoria btw). Their identification as women also seems to hang on really reductive, regressive ideas about gender and what women are - liking the colour pink, feminine things, makeup etc.

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(/news-content/exclusive-linkedin-lawyer-recommends-starting-nuclear-war-russia)

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**Trinity College barrister charged with murder (/news-content/trinity-college-barrister-charged-murder)**



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# Human rights body leaves Stonewall diversity scheme

By John McManus
BBC News

23 May 2021



GETTY IMAGES

**Britain's human rights watchdog has not renewed its membership of a diversity scheme run by LGBT group Stonewall.**

The Equality and Human Rights Commission says it told Stonewall it would be leaving **the Diversity Champions scheme** in March.

Members pay Stonewall a fee and allow it to vet their internal policies, such as who can use their toilets and changing facilities.

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But the EHRC says it "did not constitute best value for money"

But the EHRC says it "did not constitute best value for money".

Nancy Kelley, Stonewall's chief executive, said the charity was proud of its work supporting organisations to create inclusive working environments, but added that it was "up to individual employers how they meet their statutory requirements".

Hundreds of private and public bodies are members of Stonewall's scheme.

But the scheme is not without controversy - earlier this week **an independent report commissioned by the University of Essex** found that Stonewall gave it incorrect and potentially illegal advice on transgender issues.

News that the EHRC left the scheme in March comes just days after Stonewall and several other LGBT groups **criticised the organisation in an open letter**, saying it was not doing enough to champion LGBT rights.

The letter followed **a Times interview in May** in which Lady Falkner, who was appointed head of the EHRC in December, said that women must have the right to question transgender identity without being abused, stigmatised or risking losing their job.

A spokesman for the EHRC said: "We remain committed to creating an inclusive workplace that will attract people from all backgrounds, where all of our colleagues will thrive and where all LGBT employees are accepted without exception."

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# Ministry of Justice not renewing membership of Stonewall diversity scheme, ITV News understands

POLITICS LGBT+ STONEWALL Tuesday 8 June 2021, 10:36pm




**ITV News Political Correspondent Shehab Khan has the details**

ITV News understands the Ministry of Justice (MoJ) will not be renewing its membership of Stonewall's 'diversity champions' scheme when it expires next month.

Following a review, the department concluded membership no longer represents good value for money for the MoJ.

Stonewall, the country's leading LGBT+ charity, describes the scheme as "the leading employers' programme for ensuring all LGBTQ+ staff are free to be themselves in the workplace."

It follows a report in The Times that equalities minister, Liz Truss, was encouraging government departments to withdraw from the scheme. Stonewall says the claim is untrue.






*Credit: PA Archive/PA Images*

The Equality and Human Rights Commission (EHRC) recently dropped its membership of the scheme too, citing "value for money".

Organisations pay Stonewall an annual fee to join the scheme and they are then helped to review, build and fine tune their internal policies on LGBT issues.

On the news the MoJ would not be renewing its membership, a spokesperson for Stonewall said: "As with every membership programme, organisations come and go depending on what works best for them at the time, and it's great that some organisations feel that they can continue this important work on their own.

"Since we set up the Diversity Champions programme in 2001, many large employers have developed major internal programmes to promote diversity and inclusion across their staff and make the workplace better for LGBTQ+ people."

ITV News understands the MoJ will continue to work with other external organisations to ensure LGBT+ inclusion across the organisation.

*People take part at a Black Trans Lives Matter march on the day Pride in London was due to take place in June 2020. Credit: PA*

It comes as the charity has received criticism from some groups and figures for its position on the rights of transgender people.

Co-founder and former Conservative MP Matthew Parris wrote in the Sunday Times that Stonewall had become "tangled up in the trans issue".

But Stonewall's chief executive Nancy Kelley said she was "really comfortable with the decision that we made years ago to become trans-inclusive."

She added that the amount of media focus on trans rights could prevent members of the public from seeing how much work Stonewall does for lesbian, gay and bisexual people.

*The transgender flag where the colours represent blue (boys) pink (girls) and white for those transitioning or intersex. Credit: Pride Cymru*

It comes after the Women and Equalities Committee earlier this month heard trans people had been "systematically discriminated against" in gender identity services and the current "gatekeeper-based system" should be scrapped.

Stonewall's statement on the MoJ's decision not to renew continued: "While there have been attempts by campaign groups to claim that the government is mandating that all government departments withdraw from the Diversity Champions programme, an **Equalities Minister has confirmed** that these decisions are delegated to individual departments."

people is free to be themselves, wherever they are."

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POLITICS LGBT+ STONEWALL

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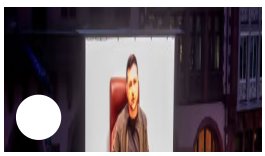
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UCL (University College London)

# UCL becomes first university to formally cut ties with Stonewall

**University says membership of LGBTQ+ charity's programmes may inhibit academic freedom**

**Richard Adams** *Education editor*

Tue 21 Dec 2021 19.48 GMT

University College London has become the first university to formally cut ties to the LGBTQ+ charity Stonewall, saying its membership of Stonewall's programmes could inhibit academic freedom and discussion around sex and gender.

UCL announced that it would end its involvement with Stonewall's workplace equality index, which rates employers on their policies, and its diversity schemes, following a recommendation from the university's most senior academics.

"Following a period of debate within our community and careful consideration of the issues, UCL has now taken the decision that we will not re-join Stonewall's diversity champions programme or make a submission to the workplace equality index," UCL said in a statement.

The university said its discussions had been "informed by thoughtful and respectful debates" at its equality, diversity and inclusion (EDI) committee and its academic board, with the EDI committee voting to retain involvement with Stonewall.

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But UCL's management instead sided with the academic board, which voted against retaining links after an anonymous ballot.

"In weighing up all opinions in this debate, UCL's senior leadership team has accepted the academic board's advice about the fundamental need to uphold academic freedom and freedom of speech in an academic context, recognising that a formal institutional commitment to Stonewall may have the effect of inhibiting academic work and discussion within UCL about sex and gender identity," the university said.

A spokesperson for UCL said the university had "an unwavering commitment" to upholding the rights of LGBTQ+ staff and students. UCL's senior management plans to establish an LGBTQ+ equality group "to tackle all forms of inequality, marginalisation, and discrimination experienced by LGBTQ+ colleagues and students" and develop an action plan.

A Stonewall spokesperson said: "UCL decided not to renew their membership to the diversity champions programme almost two years ago in February 2020. Our work with organisations in no way impacts their ability to uphold free speech, it simply creates welcoming working environments for LGBTQ+ people - which in 2021, should not be a controversial act."

UCL - the largest campus university in the UK - was ranked 98th out of the more than 400 employers who submitted entries to Stonewall's workplace equality index in 2018. In 2014 it had been the first university to join Stonewall's global diversity champions programme.

But it emerged earlier this year that UCL had withdrawn from the diversity champion's programme in 2020, which it said it was a temporary decision taken as a result of a cost-cutting review during the Covid pandemic. Under the scheme, members paid fees for Stonewall to assess and advise on their internal equality policies.

UCL's move comes as Stonewall has seen several high-profile organisations, including the BBC and Ofcom, withdraw from its diversity champions programme in recent months. The University of Winchester has also previously withdrawn.

This article was amended on 27 January 2022. The picture caption in an earlier version said UCL was "the first university to leave Stonewall's diversity programme". As the article makes clear, UCL is the first to "formally cut ties"; Winchester, for example, said it left for cost reasons.



# BREAKING: Sweden drastically changes protocol, prioritizes psychotherapy

By Guest Author

*Genspect has quickly translated the following article from the Swedish publication Lakartidningen.se, which was published February 22, 2022. Please also read SEGM's quick analysis of this ground-breaking change here, with a more thorough assessment coming soon.*

**The National Board of Health and Welfare: Young people should only be given hormone treatment in exceptional cases**

*The National Board of Health and Welfare is now calling for restraint when it comes to hormone treatment in minors with gender dysphoria. According to the authority, treatment should be offered only in exceptional cases outside the framework of research.*

By Katrin Trysell

katrin.trysell@lakartidningen.se

The National Board of Health and Welfare is currently working to update the knowledge support for care of young people with gender dysphoria that was established in 2015. This is happening in stages and now the authority comes with new recommendations regarding puberty blocking  and cross-sex hormone treatment in this group.

The National Board of Health and Welfare therefore calls for restraint with treatment in persons under 18 years of age. According to the authority, the risks of hormone treatment currently outweigh the possible benefits for the group as a whole.

The National Board of Health and Welfare relies, among other things, on a review of relevant studies on the effect and safety of hormone treatment carried out by the Swedish Agency for Medical and Social Evaluation (SBU). In the report, which is published today, the SBU concludes that it is not yet possible to draw any definite conclusions regarding this.

Hormone treatment should henceforth be given within the framework of research, according to Thomas Lindén, head of department at the National Board of Health and Welfare.

“While waiting for a research study to be put in place, our assessment is that the treatments can be given in exceptional cases,” he says in a press release.

According to SBU, based on current evidence, it is also not possible to determine how common it is for people who undergo gender-confirming treatment to later change their perception of their gender identity, interrupt treatment or in some aspect regret it. At the same time, it has been documented that detransition occurs, and there may also be an unknown figure, the National Board of Health and Welfare states.

For the group that regrets or interrupts an initiated treatment, there may be a risk that the treatment has led to poorer health or quality of life, says Thomas Lindén.

According to the National Board of Health and Welfare, puberty blocking or cross-sex hormone treatment should therefore only be offered in exceptional cases outside the framework of studies. The authority has developed criteria that care can be based on in the clinical assessment.

According to the authority, the clinical assessments should be in line with the criteria in the ‘Dutch protocol’. Central to this is that gender incongruity debuted during childhood, persisted over time, and that the development of puberty led to clear suffering.

The National Board of Health and Welfare also writes that these complex multidisciplinary assessments must be made under “an overall operational responsibility within the units that receive a permit to conduct national highly specialized care.”

SBU’S CONCLUSIONS:

The scientific evidence is not sufficient to assess the effects on gender dysphoria, psychosocial conditions, cognitive function, body size, body composition or metabolism of puberty blocking or cross sex-hormone treatment in children and adolescents with gender dysphoria.

There is some support at the group level for the fact that puberty blockers (GnRH) slows down the bone building that can be expected to occur during the following puberty (low reliability) but that the bone density achieved at the start of treatment is maintained (low reliability).

There is some support at the group level for young people who have received puberty blockers, during a cross sex hormone treatment with estrogen or testosterone, to recover bone density (low reliability), but it is not possible to determine whether bone density will eventually reach the level of young people in the surrounding population.

The scientific evidence is not sufficient to assess how often young people after the psychological / psychiatric and medical investigation has been initiated due to psychosocial problems that are considered to be due to gender dysphoria, choose not to start or to voluntarily discontinue puberty or cross sex hormone treatment.

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March 3, 2022

# National Academy of Medicine in France Advises Caution in Pediatric Gender Transition

*Medical care of children and adolescents with transgender identity*

The National Academy of Medicine in France has issued a press release in which it cautions medical practitioners that the growing cases of transgender identity in young people are often socially-mediated and that great caution in treatment is needed. The Academy draws attention to the fact that hormonal and surgical treatments carry health risks and have permanent effects, and that it is not possible to distinguish a durable trans identity from a passing phase of an adolescent's development.

SEGM has translated the press release, which is provided in full below. Both the original press release in French, and its unofficial SEGM translation are appended.

## National Academy of Medicine, France

***Press Release***

## Medical Care of Children and Adolescents with Transgender Identity

*This press release was adopted by the National Academy of Medicine, France on February 25, 2022, with 59 votes in favor, 20 votes against, and 13 abstaining. It was approved in its revised version by the Administrative Council on February 28, 2022.*

Transgender identity is a feeling of identifying as a gender different from that assigned at birth, which is persistent and lasts more than 6 months. This experience can cause significant and prolonged distress, which can contribute to an increased risk of suicide [a].

No genetic predisposition has been found.

While this condition has been long recognized, a sharp increase in demand for medical interventions has been observed (1,2) first in North America, then in Northern Europe, and, more recently, in France, particularly among children and adolescents. A recent study of a number of high schools in Pittsburgh revealed a prevalence that is clearly higher than previously estimated in the United States (3): 10% of students declared themselves to be transgender or non-binary or were unsure of their gender [b]. In 2003, the Royal Children's Hospital in Melbourne diagnosed only one child with gender dysphoria, whereas today it treats nearly 200.

Whatever the mechanisms involved in adolescents - excessive engagement with social media,  greater social acceptability, or influence by those in one's social circle - this epidemic-like phenomenon manifests itself in the emergence of cases or even clusters of cases in the adolescents' immediate surroundings (4). This primarily social problem is due, in part, to the questioning of an overly dichotomous view of gender identity by some young people.

The demand for medical interventions, due to the distress that this condition (which is not a mental illness per se) causes, leads to a growing supply of care in the form of consultations or care in specialized clinics. This involves many pediatric subspecialties. The psychiatric consultations are utilized first, and if the identity is authentic and the discomfort persists, endocrinology, gynecology and, ultimately, surgery become involved.

However, great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects and even serious complications that can be caused by some of the therapies available. In this regard, it is important to recall the recent decision (May 2021) of the Karolinska University Hospital in Stockholm to prohibit the use of puberty blockers.

If France allows the use of puberty blockers or cross-sex hormones with parental authorization and no age limitations, the greatest caution is needed in their use, taking into account the side-effects such as the impact on growth, bone weakening, risk of sterility, emotional and intellectual consequences and, for girls, menopause-like symptoms.

As for surgical treatments, specifically mastectomy, which is allowed in France at the age of 14, and surgeries relating to the external genitalia (vulva, penis), it must be emphasized that these procedures are irreversible.

When medical care is provided for this reason, it is essential to ensure medical and psychological support, first for the affected children and adolescents, but also for their parents, especially since there is no test to distinguish between persisting gender dysphoria and transient adolescent dysphoria. Moreover, the risk of over-diagnosis is real, as evidenced by the growing number of young adults wishing to detransition [c]. It is, therefore, appropriate to extend the phase of psychological care as much as possible.

**The National Academy of Medicine draws the medical community's attention to the growing demand for care in the context of transgender identity in children and adolescents, and recommends the following:**

Children and adolescents expressing a desire to transition, as well as their families, should receive extended psychological support;
Should the desire to transition persist, the decision to treat with puberty blockers or cross sex-hormones must be considered carefully and within the framework of multidisciplinary consultations;
Medical studies should include clinical information specifically adapted for informing and guiding young people and their families;
Continued research into both, clinical and biological, as well as ethical aspects of this matter, still lacking in France, is needed;
Parents addressing their children's questions about transgender identity or associated distress should remain vigilant regarding the addictive role of excessive engagement with social media, which is both harmful to the psychological development of young people and is responsible for a very significant part of the growing sense of gender incongruence.

Glossary:

a. Gender dysphoria is the medical term used to describe the distress resulting from the incongruence between the experienced gender and the gender assigned at birth (5).

b. A non-binary person is a person whose gender identity is neither male nor female.

c. A transgender person adopts the appearance and lifestyle of a sex different from that assigned at birth. Whether born a man or a woman, the transgender person modifies, or even rejects, his or her original sexual identity. The sex registered on their official documents  does not match the appearance presented. This does not necessarily involve medical interventions.

References:


1. NHS, The Tavistock and Portman, Referrals to the Gender Identity Development Services (GIDS) for children and adolescents level off in 2018-19, 28 June 2019 (https://tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/
2. Swedish national health Council, Report on the prevalence of persons diagnosed with gender dysphoria since 1998 among registered citizens of Sweden, 2020, www.socialstyrelsen.se
3. Kidd K.M., Sequeira G.M., Douglas C. et al, Prevalence of gender diverse youth in an urban school district, Pediatrics, 2021, vol 147, issue 6
4. Littman, L., Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS ONE, 2018, 13(8), e0202330. https://doi.org/10.1371/journal.pone. 0202330; Correction: PLoS ONE 2019; 14(3): e0214157. Published online 2019 Mar 19. doi:10.1371/journal.pone.0214157
5. Martinerie L., Condat A., Bargiacchi A., et al., Management of endocrine disease. Approach to the management of children and adolescents with gender dysphoria, European Journal of Endocrinology, 2018, 179, p. 1219-1237


Attachments
22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf
English Translation_22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf




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July 2, 2021

# One Year Since Finland Broke with WPATH "Standards of Care"

*Finland prioritizes psychotherapy over hormones, and rejects surgeries for gender-dysphoric minors*

A year ago, the Finnish Health Authority (PALKO/COHERE) deviated from WPATH's "Standards of Care 7," by issuing new guidelines that state that psychotherapy, rather than puberty blockers and cross-sex hormones, should be the first-line treatment for gender-dysphoric youth. This change occurred following a systematic evidence review, which found the body of evidence for pediatric transition inconclusive.

Although pediatric medical transition is still allowed in Finland, the guidelines urge caution given the unclear nature of the benefits of these interventions, largely reserving puberty blocker and cross-sex hormones for minors with early-childhood onset of gender dysphoria and no co-occurring mental health conditions. Surgery is not offered to those <18. Eligibility for pediatric gender reassignment is being determined on a "case-by-case basis" in two centralized gender dysphoria research clinics.

The qualifying criteria for gender reassignment of youth, articulated in the 2020 Finnish treatment guidelines, are consistent with the original Dutch protocol, but represent a significant tightening of the more recent practices promoted by WPATH. WPATH Standards of Care 7 (SOC7) allows for hormones and surgery to be offered to youth with a pubertal-onset of gender dysphoria which is frequently complicated by mental health problems or neurocognitive comorbidities (such as ADHD and autism-spectrum disorders), following only a cursory assessment. Assessments by mental health professionals can be bypassed altogether according to the "informed consent model" of care endorsed by WPATH SOC7.

The Finnish guidelines warn of the uncertainty of providing any irreversible "gender-affirming" interventions for those 25 and under, due to the lack of neurological maturity. The guidelines also raise the concern that puberty blockers may negatively impact brain maturity and impair the young person's ability to provide informed consent to the subsequent and more irreversible parts of the Dutch protocol: cross-sex hormones and surgeries.

The Finnish guidelines reflect the growing international concern about the unexplained sharp rise in adolescents presenting with gender dysphoria, which is occurring in increasingly complex developmental and mental health contexts, and often without a childhood history of gender-related distress. There are significant questions as to whether the Dutch protocol (hormonal and surgical interventions for youth), designed for a distinctly different population of high-functioning teens with childhood-onset cross-sex identification and with no significant mental health comorbidites, is appropriate for this novel population.

The guidelines reference a recent Finnish study, which noted that adolescents who were high functioning before cross-sex hormones continued to do well after, but those who had "*psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems.*" The study concluded that *"medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities*."

The guidelines also mentioned that a key study on puberty blockers, which utilized a comparison group of waitlisted adolescents, failed to show a statistically significant difference between the treated and waitlisted groups at the study end-period at 18 months. Although in the abstract of that study, the authors chose to highlight the small improvements in the puberty-blocked group at 12 months, the actual study conclusion – which remains behind a paywall and hidden to most readers – showed that by 18 months, no significant differences could be found.

The Finnish Health Authority states that the guidelines will not be further revised until research is able to: explain the recent sharp rise in adolescents presenting with gender dysphoria; determine whether transgender identities in this population are stable or will evolve; assess whether gender-affirming treatments are able to improve health outcomes of those who present with co-occurring mental health problems, including improvements in depression and suicide; and quantify the rate of regret.

The Finnish gender identity services program is a worldwide leader in pediatric gender medicine. The 2020 Finnish guidelines represent a strong signal that the pioneers of pediatric medical transition are concerned about unintended harm to the growing number of gender dysphoric adolescents presenting for care. The guidelines echo the concerns voiced by the principal investigator of the Dutch protocol, who warned the medical community in a commentary published in *Pediatrics* in 2020 that a "*new developmental pathway"* of gender dysphoria has emerged, including patients with "*postpuberty adolescent-onset transgender histories*" and "*more mental health challenges*," adding, "*these youth did not yet participate in the early evaluation studies. This raises the question whether the positive outcomes of early medical interventions also apply to adolescents who more recently present in overwhelming large numbers for transgender care*."

While the official summary of the guidelines has been available on the Finnish Health Authority's site for a year (see June 2020), SEGM has just completed the translation of the full text of the Finnish guidelines for minors. **It is an unofficial translation**. The original and the translated versions of the guidelines are attached below.

Attachments
Finnish_Guidelines_2020_Minors_Unofficial Translation.pdf
Finnish_Guidelines_2020_Minors_Original.pdf


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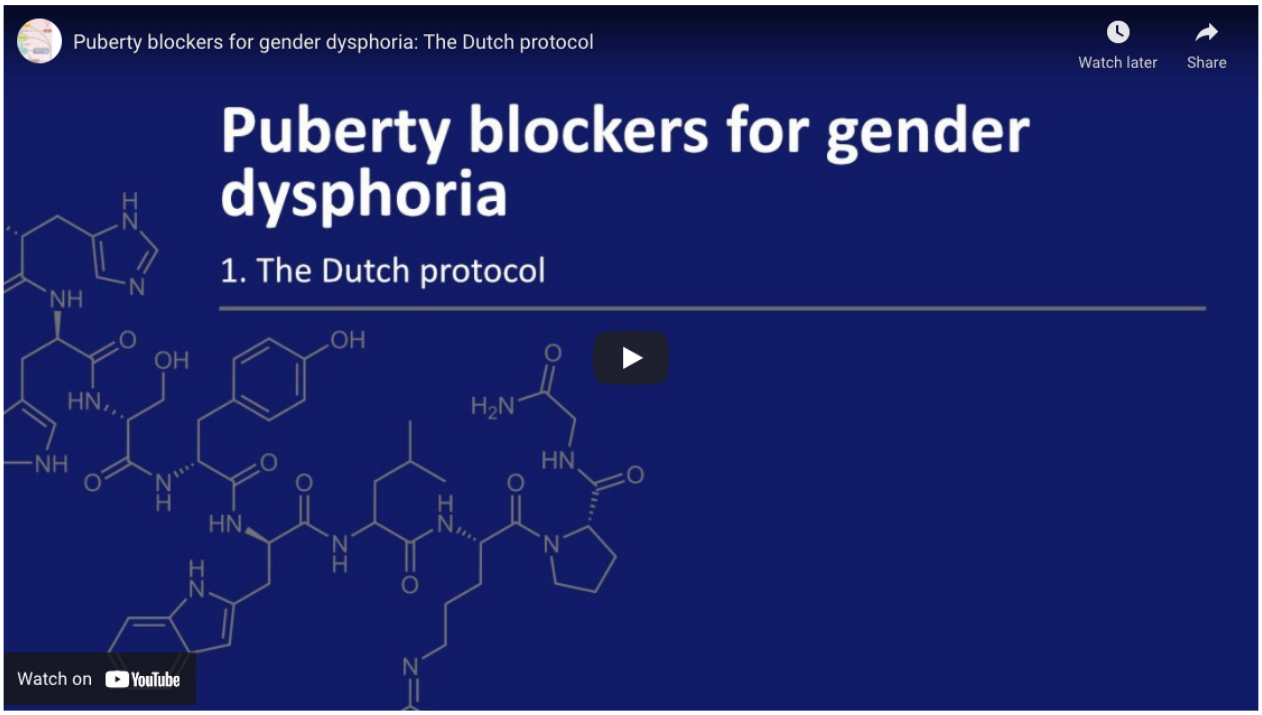

GAY TEENS AREN'T SICK
GAY TEENS AREN'T SICK

# Puberty blockers



**Video: Puberty blockers for gender dysphoria: The Dutch protocol**

**Dr. Michael Biggs**




**In the UK on December 1st 2020 the High Court handed down judgment on the use of puberty blockers for the treatment of children under the age of eighteen.**



The judicial review was brought by former Tavistock psychiatrist Susan Evans against the Tavistock & Portman NHS Trust. The claimants were Keira Bell, a 23 year-old lesbian who regretted the medical intervention she underwent at the Tavistock Gender Identity Development Service, and Mrs A, the mother of an autistic 15 year-old girl who was waiting for treatment. The claim brought before the court was that a child under the age of eighteen cannot give informed consent to treatment with puberty blockers.

This was the court's conclusion.

*OVERALL CONCLUSION*

151. A child under 16 may only consent to the use of medication intended to suppress puberty where he or she is competent to understand the nature of the treatment. That includes an understanding of the immediate and long-term consequences of the treatment, the limited evidence available as to its efficacy or purpose, the fact that the vast majority of patients proceed to the use of cross-sex hormones, and its potential life changing consequences for a child. There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication. It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers.

152. In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment. 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, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.

The full court judgment can be read here.

Puberty blockers are a class of synthetic gonadotrophin-releasing hormone (GnRH) analogues. By acting on the pituitary gland, these drugs prevent the release of chemical signals which stimulate the production of estrogen and testosterone, halting the changes of puberty caused by these sex hormones.

The Tavistock GIDS began an 'Early Intervention study' in 2011. Previous to this, puberty blockers were offered as a treatment only to children from the age of sixteen. The trial lowered the age to twelve, and subsequently, by 2014, to any child who had reached Tanner Stage 2 of puberty. This meant that now children as young as ten could be given blockers. No final results of this trial have as yet been published. To date GIDS has treated over a thousand children with puberty blockers, with about 230 of these children under the age of 14, the youngest child being 10 years old.

The claimed therapeutic benefit is to allow more time for children to consider whether they want to continue transitioning via cross-sex hormones and surgery, without the stress of ongoing unwanted pubertal development. Those who choose not to transition can stop taking blockers, and it is claimed that their original puberty will resume and progress normally. **It was claimed that the drugs are effective, safe and fully reversible.**

Is there any evidence to back up this claim?

The NHS changed their guidance on puberty blockers this year. From previously claiming that blockers "are considered to be fully reversible" the NHS webpage now states:

> ***"Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria.***
>
> ***Although the Gender Identity Development Service (GIDS) advises this is a physically reversible treatment if stopped, it is not known what the psychological effects may be.***
>
> ***It's also not known whether hormone blockers affect the development of the teenage brain or children's bones. Side effects may also include hot flushes, fatigue and mood alterations."***
>
> *https://www.nhs.uk/conditions/gender-dysphoria/treatment/*

All the available evidence to support their defence was presented to the court by the Tavistock. This is what the court found:




**Side effects of puberty blockers**

GnRH analogues were first licensed for use as **end-stage prostate cancer drugs** in 1985 and are still in widespread use today. They are also prescribed to chemically castrate sex offenders in Broadmoor. They have since been used in other indications and are most recently being used 'off-label' to delay puberty in children with gender dysphoria. They are also used by transgender adults on cross-sex hormone therapy to suppress the production of their natural sex hormones.

In the US, a GnRH analogue drug with the tradename Lupron was licensed in 1993 for use in children with precocious puberty. It was also commonly used off-label to help children who needed to grow taller. There is now a growing number of women who used Lupron in childhood who are reporting serious issues with bone and blood disorders and joint problems in adulthood. This information is reviewed here.

It has long been known that mechanistically GnRH analogues can cause bone thinning. The reduction of estrogen levels in girls can induce a temporary osteopenia (similar to what's seen in menopause when estrogen levels naturally fall). A 2009 study showed that Lupron caused bone thinning in girls treated although bone density was seen to return to normal levels within 10 years after treatment. There is also a large 2005 study in men treated for prostate cancer in which a significantly increased risk of bone fractures was observed. The bone thinning effects are also mentioned in the 'Important safety information' leaflets that accompany Lupron and extended use is not recommended in people with pre-existing bone thinning conditions.

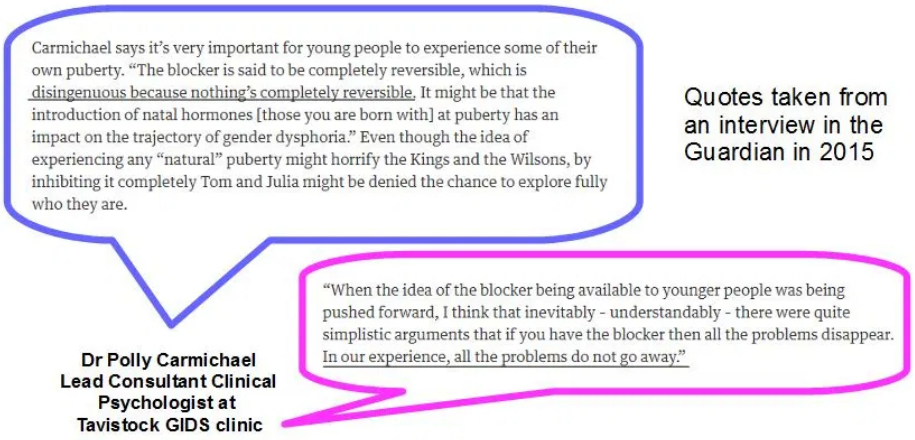
> ***The FDA considers the drug's impact on children's bones an unanswered question, according to a statement: "The effects of bone density in children whose central precocious puberty is arrested with a GnRH agonist are considered 'unknown' as they have not been studied"***

The UK endocrinologists at GIDS used the GnRH analog called Triptorelin. Although slightly different to Lupron all these drugs are in the same class of GnRH analogs and all have the same mechanism of action. The mechanistic safety issues will most likely apply to the whole class of drugs.

Triprorelin is manufactured by two different companies under the tradenames Gonapeptyl Depot and Decapeptyl SR. This drug has been approved by NICE for use in children with precocious puberty, although it should be noted that it is being used 'off label' for children with gender dysphoria. This means its use by the NHS does not come with regulatory approval because the appropriate safety studies are not available.

Leuprorelin (Lupron) has not been approved by NICE for use in children. This is only prescribed if adverse reactions are observed with Triptorelin. GIDS prescribing information was made available under a freedom of information request here.

**What is the longer term impact on gender identity?**




Although blocking the progression of puberty can in some cases relieve the immediate distressing symptoms suffered by children with gender dysphoria, the evidence is mixed. The long term effects are unknown. There have been no long term studies on the effectiveness of puberty blockers and it is unknown whether interrupting natural puberty alters the natural trajectory and perhaps resolution of gender dysphoria in children.

Gender identity is shaped during puberty and adolescence as young people's bodies become more sexually differentiated and mature. Given how little we understand about gender identity and how it is formed and consolidated, we should be cautious about interfering with the normal process of sexual maturation.

What we do know however is that virtually all the children who start on puberty blockers eventually go onto cross-sex hormones suggesting that changing their minds is rare once natural puberty is interrupted.

The Health Research Authority, in its investigation into the Tavistock's Early Intervention study, questioned the stated purpose of puberty suppression as providing children with 'space to decide'. The HRA report suggested that blockers were in fact used as a first step towards further medical intervention in the form of cross-sex hormones:

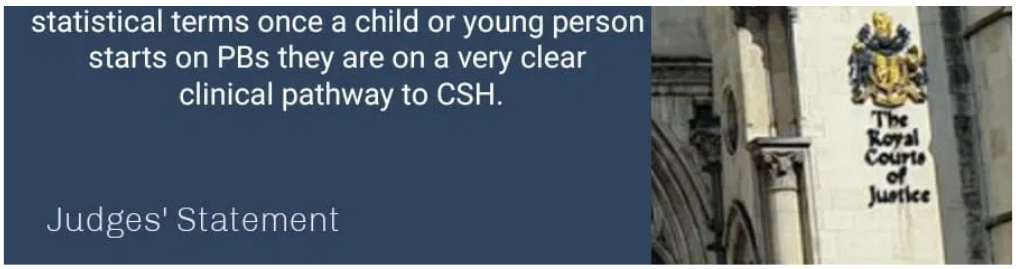
> ***It would have reduced confusion if the purpose of the treatment had been described as being offered specifically to children demonstrating a strong and persistent gender identity dysphoria at an early stage in puberty, such that the suppression of puberty would allow subsequent cross-sex hormone treatment without the need to surgically reverse or otherwise mask the unwanted physical effects of puberty in the birth gender.***
>
> *https://www.hra.nhs.uk/about-us/governance/feedback-raising-concerns/investigation-study-early-pubertal-suppression-carefully-selected-group-adolescents-gender-identity-disorders/*

Cross-sex hormones have serious lifelong effects which cannot be 'reversed' if treatment is discontinued. If a child takes puberty blockers at Tanner stage 2 of puberty followed by cross-sex hormones at age 16 they will be sterilised as gametes have not developed.

The court found:




375




**Are the effects on puberty really reversible?**

Since its rare for children with gender issues to stop taking puberty blockers this also means there have been no long term studies to show that normal puberty will resume in these children. The evidence of 'reversibility' is from studies in a different set of children; namely children with precocious puberty (a puberty disorder in which puberty commences very early. Technically this is before the age of 8 in girls but could be as young as pre-school age). In these children puberty blocking drugs are normally withdrawn around the age of 12 and menstruation in girls commences about 1 year later. In this respect the resumption of puberty occurs around the 'expected age' in children and will be in line with other aspects of physiological and psychological adolescent development.

This is very different from the approach in children with gender dysphoria. Normal puberty is postponed while the normal ageing process proceeds. Restarting natural puberty (or inducing cross-sex puberty artificially at 16) would therefore be out of step with other development processes. It should also be noted that virtually all cases of precocious puberty occur in girls so there is extremely little evidence of the restarting of puberty in boys. For these reasons the true reversibility of blocking puberty in children with gender issues is currently unknown.

The court found:




**What are the implications of preventing a natural puberty?**

Proponents of the use of puberty blockers say that not only do these drugs relieve the distressing symptoms of 'the wrong puberty' in childhood but also prevent the body from undergoing irreversible changes which then have to be modified surgically during adulthood. For example, permanent growth of breasts in females which may necessitate a double mastectomy in the future. Alternatively, permanent facial hair growth in males which may necessitate its removal in the future. However, what is rarely discussed is the effect on the reproductive and sexual development of the child.

Puberty blockers followed by opposite sex hormones cannot create 'opposite sex puberty', only secondary sex characteristics of the opposite sex. However, normal sexual or reproductive development will not occur. Girls will not begin menstruation and so will be infertile. Boys testes will not grow and develop and will impact on fertility. The change therefore is only cosmetic. A boy's penis will remain immature and remain the size of a child's into adulthood. This will cause problems sexually if the penis is retained, both

functionally and in terms of sexual arousal. It is also problematic if gender reassignment surgery is later chosen since there is too little material to use from the penis and testicles.

When a child's natural puberty is blocked we can expect to see effects not only on the body but on the developing brain. It is the surge of sex hormones at puberty which triggers the important changes in the adolescent brain which only reach completion in the mid-twenties. Hormonal changes at puberty are thought to influence the development of both brain structure and function.

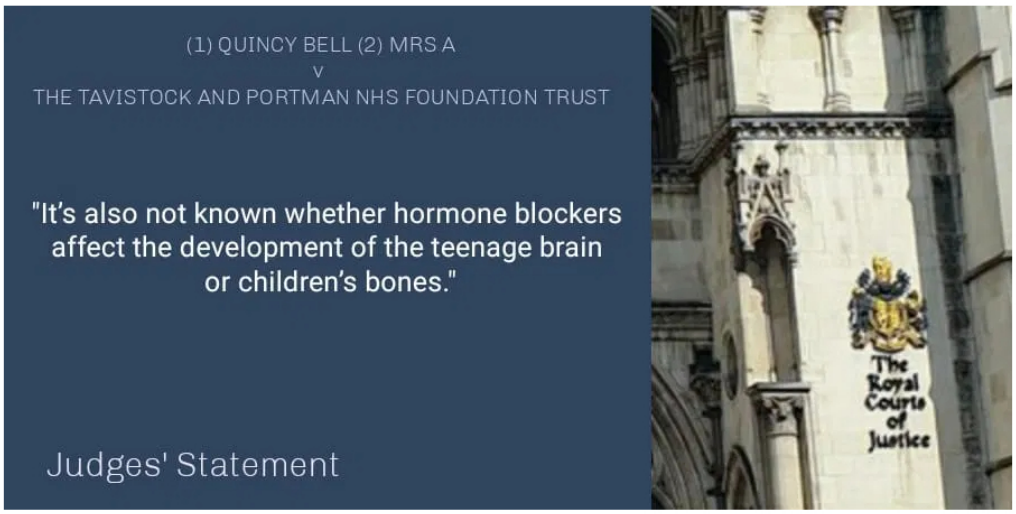
Recent research indicates that there is a window of development for some cognitive functions, and if this window is missed, cognitive development does not resume later even if blockers are discontinued. A reduction in long-term spatial memory was found to persist after discontinuation of blockers in a recent study on sheep, which concluded:

> ***This result suggests that the time at which puberty normally occurs may represent a critical period of hippocampal plasticity. Perturbing normal hippocampal formation in this peripubertal period may also have long lasting effects on other brain areas and aspects of cognitive function.***

Two previous studies which analysed IQ performance in girls taking puberty blockers for central precocious puberty also suggest the possibility that GnRHa treatment may have an adverse impact on cognitive functioning in children. The first study of 25 children in 2001 found a drop of 7 IQ points after two years on blockers. The second study in 2016 found a drop of 8 IQ points in 15 girls compared to a matched control group. An analysis of these studies is here.

A study in 2017 of men with late stage prostate cancer found that treatment with GnRH analogs affects cognitive functions such as language ability, short-term memory capacity, mental flexibility, and inhibitory control.

The court found:




A recent analysis of evidence by Professor Michael Biggs, who researched the Tavistock GIDS ongoing Early Intervention study, indicated some significant and worrying emotional/behavioural effects reported after children had taken puberty blockers for a year:

> ***'Natal girls showed a significant increase in behavioural and emotional problems', according to their parents (also from the Child Behavior Checklist, contradicting the only positive result). One dimension of the Health Related Quality of Life scale, completed by parents, 'showed a significant decrease in Physical well-being of their child'. What is most disturbing is that after a year on blockers, 'a significant increase was found in the first item "I deliberately try to hurt or kill self"' (in the Youth Self Report questionnaire).***
>
> *https://www.transgendertrend.com/tavistock-experiment-puberty-blockers/*

In a review of all recent published research studies, Professor Carl Heneghan highlighted the very low quality of evidence for the benefits of blockers:

> ***Problems within these studies, however, make it difficult to assess whether early pubertal changes regress under GnRHa treatment and whether prolonged puberty suppression is safe. For example, there is a lack of controls, and in one study that included controls, these were inadequate as relatives and friends of the participants were asked to participate, serving as age-matched controls. A lack of blinding was also problematic.***

The conclusion on the evidence for all 'gender affirming' treatment for children and young people was this:

> ***Treatments for under 18 gender dysphoric children and adolescents remain largely experimental. There are a large number of unanswered questions that include the age at start, reversibility; adverse events, long term effects on mental health, quality of life, bone mineral density, osteoporosis in later life and cognition.***

**Conclusion**

It is often said that the use of puberty blockers in children is completely safe and irreversible. This claim however has never been tested in long term studies and its use for gender dysphoria is experimental. What the evidence does show is that blockers may simply lock children into a medical pathway resulting in sterility and potential loss of sexual function.

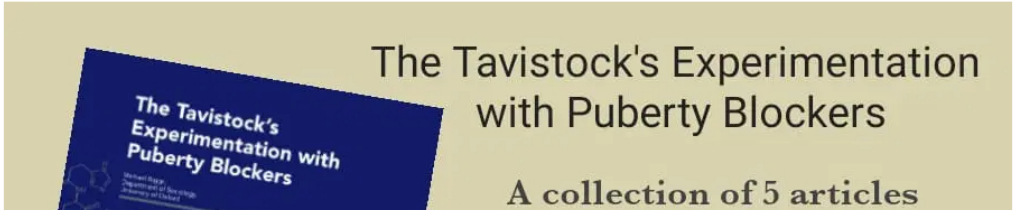
Now the evidence has been examined in a court of law. All the evidence presented in support of the use of blockers by the one provider of this treatment in England, the Tavistock GIDS, was read by three High Court judges, and the Tavistock's lawyer presented their case over a two day hearing. On the basis of all the evidence the court has judged that children under the age of eighteen in most cases are not able to give informed consent to take puberty blockers without application to the court.

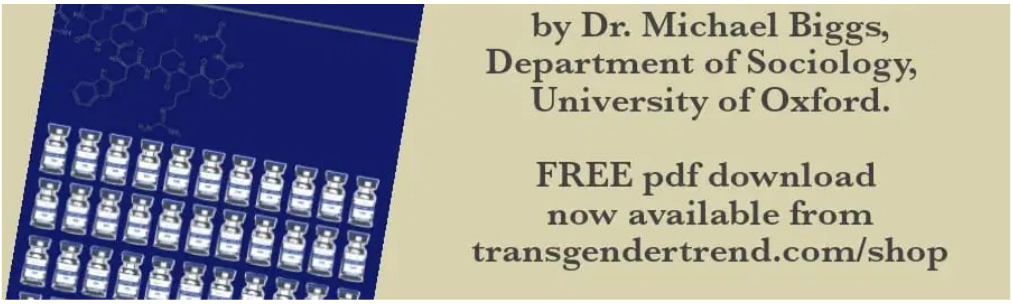



The long-awaited study results of the Tavistock's puberty blockers trial were finally published the day after the court judgment. The results of the study serve to reinforce the judgment and the court's reasons for the ruling. The full study can be read here.

An analysis of the study results by Michael Biggs can be read here.

For the full story of the Tavistock's Experimentation with Puberty Blockers, download our free pdf of all five of Michael Biggs' articles written for Transgender Trend. From the scandal of unpublished negative results to the Keira Bell victory in court and the finally published study, read the full shocking story here.






There are a number of recent 'studies' which purport to show that puberty blockers 'cure' suicidality. The most recent has been widely publicised. Read Michael Biggs' analysis to see how the study results do not back up the claims of the authors.

Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria

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# The Tavistock's Experimentation with Puberty Blockers

Dr. Michael Biggs,
Department of Sociology,
University of Oxford





# Part 1: Scrutinizing the Evidence

**2 March 2019**


NHS transgender clinic accused of covering up negative impacts of puberty blockers on children by Oxford professor

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The Tavistock & Portman NHS NHS Foundation Trust

The Tavistock Centre

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The Tavistock ccentre is an NHS specialised clinic for transgender children in London CREDIT: JEFF BLACKLER/REX SHUTTERSCOCK

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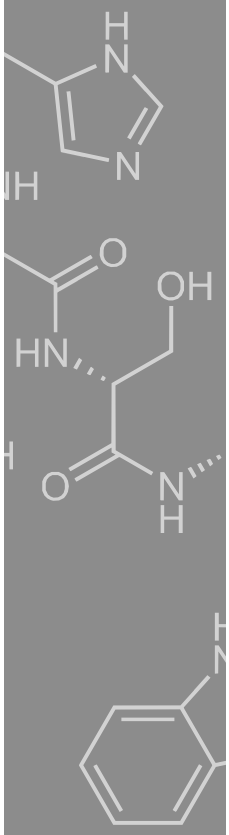
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In 2010, Tavistock and Portman NHS Trust's Gender Identity Development Service (GIDS) launched a trial of puberty blockers for children in their early teens with gender dysphoria. This was—and remains—an experimental treatment. These drugs, Gonadotropin-Releasing Hormone agonists (GnRHa), have not been certified as a safe or effective treatment for gender dysphoria by their manufacturers, nor by the National Institute for Clinical Excellence.

The Director of GIDS, Polly Carmichael, was keenly aware of the controversy over these drugs. 'The question is, if you halt your own sex hormones so that your brain is not experiencing puberty, are you in some way altering the course of nature?' (Guardian, 14 August 2008). '[T]he debate revolves around the reversibility of this intervention—physical and also psychological, in terms of the possible influence of sex hormones on brain and identity development' (Carmichael and Davidson 2009). Before 2010, GIDS administered blockers to children only when they reached 16; this is the age at which young people have the presumptive capacity to consent to medical treatment.

This cautious approach was vociferously opposed by two organizations devoted to transgendering of children, Mermaids and the Gender Identity Research and Education Society. As Carmichael later recounted: 'There was a lot of pressure coming from certain group [sic] to introduce it—families were travelling abroad because they knew it was available in Holland and America. As a service, we didn't have the evidence one way or the other, so the best way to do it was as part of a research study' (Vice, 16 November 2016).

Tavistock Trust announced the study on its website in April 2011. It stated that GnRHa treatment 'is deemed reversible'. This assertion contradicted the study's own research protocol (which I obtained under Freedom of Information from the NHS Health Research Authority). *'It is not clear* [my emphasis] what the long term effects of early suppression may be on bone development, height, sex organ development, and body shape and their reversibility if treatment is stopped during pubertal development' (Early Pubertal Suppression in a Carefully Selected Group of Adolescents with Gender Identity Disorder, 4 November 2010, Research Ethics Committee number 10/H0713/79). A paediatrician on the study team, Russell Viner, frankly acknowledged the risks. 'If you suppress puberty for three years the bones do not get any stronger at a time when they should be, and we really don't know what suppressing puberty does to your brain development. We are dealing with unknowns' (Daily Mail, 25 February 2012).



The study received considerable publicity, being reported in the *Mirror*, the *Daily Telegraph*, and the *Times*. As Carmichael observed, 'as professionals we need to be looking at the long term and making sure this treatment is safe' (Daily Telegraph, 15 April 2011). The bare outlines of the study can be gleaned from a conference presentation and a half-page published abstract (Gunn et al. 2015a; Gunn et al. 2015b). From 2010 to 2014, 61 children aged between 12 and 15 were recruited; puberty blockers were administered to 44 of them.

Even before the final patient was enrolled, Carmichael announced success to the tabloid press. 'Now we've done the study and the results thus far have been positive we've decided to continue with it' (Daily Mail, 17 May 2014). In fact the decision had already been made, at least six months earlier (Daily Mail, 17 November 2013). Tavistock Trust then embraced the drug regime with enthusiasm. Three years later, GIDS (and its satellite operation in Leeds) had prescribed puberty blockers for a total of 800 adolescents under 18, including 230 children under 14 (Daily Mail, 30 July 2017). By 2018, new prescriptions were running at 300 per year (BBC News, 2 July 2018). Freedom of Information requests have failed to elicit more recent figures because GIDS does not collate basic data on this experimental treatment—and neither does the University College London Hospitals NHS Foundation Trust, which provides its endocrinology services.

Over a thousand adolescents have been given puberty blockers on the basis that the 2010–14 study yielded 'positive' results. Tavistock is surprisingly reticent to share these results with the scientific community. GIDS has a webpage on the evidence base for puberty blockers. It notes that 'research evidence for the effectiveness of any particular treatment offered is still limited.' There is no mention of its own study; it cites only research from the Netherlands. The former director of GIDS stated last year that the 'project is ongoing and the results are yet to be published' (De Ceglie 2018).

Diligent searching does, however, uncover some unpublished results. Most revealing is an appendix within a report to Tavistock's Board of Directors (Carmichael 2015). It tracks the first 30 children on GnRHa, measuring changes after one year of the drug regime. The text is sometimes internally inconsistent and occasionally contradicts the tabulated figures, suggesting that it was prepared in haste. But we can summarize those changes that were reported as statistically significant ($p$-value < .05). Only one change was positive: 'according to their parents, the young people experience less internalizing behavioural problems' (as measured by the Child Behavior Checklist). There were three negative changes. 'Natal girls showed a significant increase in behavioural and emotional problems', according to their parents (also from the Child Behavior Checklist, contradicting the only positive result). One dimension of the Health Related Quality of Life scale, completed by parents, 'showed a significant decrease in Physical well-being of their child'. What is most disturbing is that after a year on blockers, 'a significant increase was found in the first item "I deliberately try to hurt or kill self"' (in the Youth Self Report questionnaire). Astonishingly, the increased risk of self-harm attracted no comment in Carmichael's report. Given that puberty blockers are prescribed to treat gender dysphoria, it is paradoxical that 'the suppression of puberty does not impact positively on the experience of gender dysphoria' (measured by the Body Image Scale). When differentiated by sex, the impact was positive for boys on one aspect of body image, but negative for girls on two aspects.

Preliminary results (44 children after one year on GnRHa) were also presented at a symposium at the World Professional Association for Transgender Health (Carmichael et al. 2016). Only the abstract is available. 'For the children who commenced the blocker, feeling happier and more confident with their gender identity was a dominant theme that emerged during the semi-structured interviews at 6 months. However, the quantitative outcomes for these children at 1 years time suggest that they also continue to report an *increase in internalising problems and body dissatisfaction* [my emphasis], especially natal girls.' Why were these negative results never published?

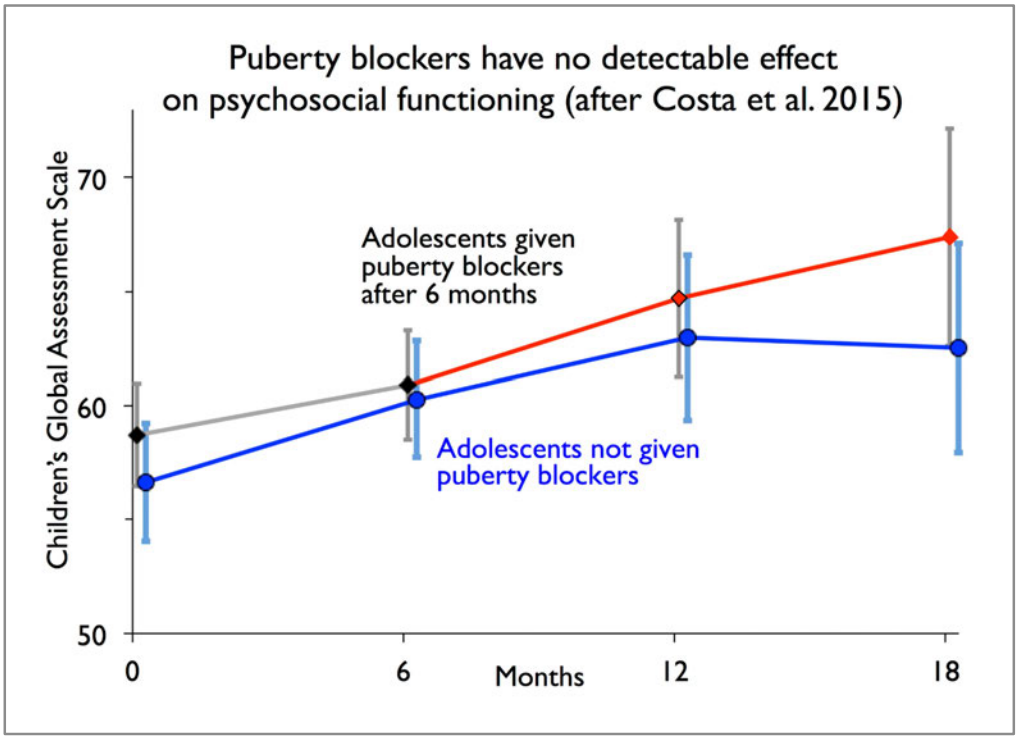
The study apparently contributed data on outcomes to one publication, coauthored by Carmichael (Costa et al. 2015). The abstract proclaims that 'adolescents receiving also

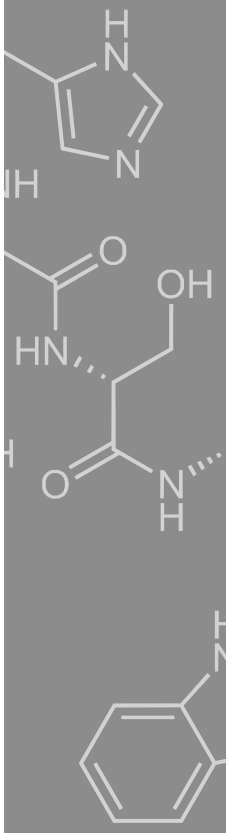
puberty suppression had significantly better psychosocial functioning after 12 months of GnRHa … compared with when they had received only psychological support'. The article is treated in the literature (e.g. Heneghan and Jefferson 2019) as providing evidence in favour of puberty blockers. But the abstract is misleading: the analysis actually *failed to detect any difference* between children who were given blockers and those who were not. To understand this, we need to scrutinize the article in detail. (Statistically minded readers will recognize the fallacy described by Gelman and Stern 2006.)

The analysis starts with 201 adolescents diagnosed with gender dysphoria. The children were divided into two groups: those deemed eligible for puberty blockers immediately, and those who needed more time due to 'comorbid psychiatric problems and/or psychological difficulties'. This second group did not receive any physical intervention during the time of this analysis, and so serves as a control group. Both groups received psychological support. The article chooses one outcome, psychosocial functioning as measured by the Children's Global Assessment Scale (CGAS). This scale was administered at the outset, and then after six, twelve, and eighteen months. It is intriguing that the article omits the outcomes that were negative in the preliminary results: the Child Behavior Checklist, the Youth Self Report Questionnaire, the Health Related Quality of Life scale, and the Body Image Scale.

The authors graph the CGAS results, but without confidence intervals—which indicate the extent of random statistical variation or noise. The smaller the sample, the greater this noise. These samples shrank over time: after eighteen months, the group getting puberty blockers numbered only 35, and the control group 36. The article does not explain why two thirds of the subjects disappeared. Presumably they did not stop the medication, because all 44 children given blockers in the 2010–14 study continued the drug regime for two years (Gunn et al. 2015b).

My graph plots the results with standard 95% confidence intervals. The group given puberty blockers from six months onwards showed improvement at eighteenth months: the average CGAS score had increased from 61 to 67 (coloured red on the graph). This improvement is statistically significant, and it is the one that the authors chose to highlight.





However, these children also received psychological support, and so attributing this improvement to medical intervention is unjustified. The crucial comparison is between the group receiving blockers and the control group. The latter's average CGAS score (coloured blue) after eighteen months was lower, 63 compared to 67. But this difference is *not statistically significant*; the 95% confidence intervals substantially overlap. (For statistically minded readers, a two-tailed *t*-test for the difference between group means yields a *p*-value of .14, far beyond the conventional .05 threshold.) In other words, the samples were so small, and there was such wide variation in scores within each group, that we can draw *no conclusions*. There is no evidence that puberty blockers improve psychosocial functioning. Presumably this is why GIDS omits the article from its own evidence base.

The abstract describing the baseline characteristics of the children in the 2010–14 study concluded: 'Assessment of growth, bone health and psychological outcomes *will* [my emphasis] be important to assess the medium and long-term safety and effectiveness of early intervention' (Gunn et al. 2015b). However, GIDS apparently failed to collect any data on its experimental subjects after they turned 18. In a startling admission, Carmichael and coauthors blame 'the frequent change in nominal and legal identity, including NHS number in those referred on to adult services'—'to date they have not been able to be followed up' (Butler et al. 2018). (Transgender activists successfully lobbied the NHS to provide new numbers to patients as well as to change the 'gender' on their medical records.)

To summarize, GIDS launched a study to administer experimental drugs to children suffering from gender dysphoria. Between 2010 and 2014, puberty blockers were given to 44 children. This study yielded only one published scientific article on outcomes. It showed no evidence for the effectiveness of GnRHa: there was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on GnRHa children reported greater self-harm, and that girls experienced more behavioural and emotional problems and expressed greater dissatisfaction with their body—so puberty blockers exacerbated gender dysphoria. Yet the study has been used to justify rolling out this drug regime to several hundred children aged under 16. Almost five years after the last patient was enrolled in the experiment, there is no evidence to substantiate Carmichael's claim 'that the results thus far have been positive'.

*The Director of GIDS needs to answer these questions about the 2010–14 experimentation with puberty blockers:*

- *On what evidence did you claim in 2014 that 'the results thus far have been positive'?*
- *When preliminary results in 2015 showed that children after a year on blockers showed a statistically significant increase in reported self-harm, was this ever investigated?*
- *Why did you never publish the negative results reported to Tavistock's Board of Directors in 2015 and to WPATH in 2016?*
- *Why did your only published article (Costa et al. 2015) using data from the study omit all the outcomes that were negative in the preliminary results (Child Behavior Checklist, Youth Self Report questionnaire, Health Related Quality of Life scale, and Body Image Scale)?*
- *In your article, why did the abstract and conclusion not report the finding that there was no statistically significant difference between the group given GnRHa and the control group?*
- *In your article, what accounts for the reduction in the number of subjects from 201 to 71 over eighteen months?*
- *What steps have you taken to monitor the 'long-term safety and effectiveness of early intervention', as these experimental subjects become adults?*

**Note**

How many subjects from the 2010–14 study are included in Costa et al. (2015) is unclear. The 2010–14 study gave GnRHa to 44 adolescents, referred at ages from 10 to 15. (Gunn et al. 2015a, 2015b). One would expect all of them to be included in the 'immediately eligible' group in Costa et al. (2015), along with some older adolescents to boost the sample size. The article counts 101 children in this group at 6 months when GnRHa commenced (Table 2), starting at ages from 13 to 17 (Table 1). The age range indicates the exclusion of some children from the 2010–14 study: those who commenced GnRHa from ages 10 to 12. Why? Another puzzle is worth noting. When I requested the Research Ethics Committee number from Tavistock and

Portland NHS Trust under Freedom of Information, it provided the number 10/H0718/62. According to the NHS Health Research Authority, however, this number refers to a study that was given an 'unfavourable opinion' and therefore could not proceed.

**References to the 2010–14 GIDS Study**

Carmichael, Polly, 2015, 'Preliminary Results from the Early Intervention Research', Appendix 7 in 'Service Line Report: Gender Identity Development Service (GIDS)', Tavistock and Portman NHS Trust, *Board of Directors Part One: Agenda and Papers … 23rd June 2015*, pp. 50–55.

Carmichael, Polly, Sally Phillott, Michael Dunsford, Amelia Taylor, and Nastasja de Graaf, 2016, 'Gender Dysphoria in Younger Children: Support and Care in an Evolving Context', World Professional Association for Transgender Health 24th Scientific Symposium.

Costa, Rosalia, Michael Dunsford, Elin Skagerberg, Victoria Holt, Polly Carmichael, and Marco Colizzi, 2015, 'Psychological Support, Puberty Suppression, and Psychosocial Functioning in Adolescents with Gender Dysphoria', *Journal of Sexual Medicine*, vol. 12, pp. 2206–14.

Gunn, H.M., C. Goedhart, G. Butler, S.N. Khadr, P.A. Carmichael, R.M. Viner, 2015a, 'Gender Dysphoria: Baseline Characteristics of a UK Cohort Beginning Early Intervention', presented to the Youth Health Conference, Australia.

Gunn, H.M., C. Goedhart, G. Butler, S.N. Khadr, P.A. Carmichael, R.M. Viner, 2015b, 'Early Medical Treatment of Gender Dysphoria: Baseline Characteristics of a UK Cohort Beginning Early Intervention', *Archives of Disease in Childhood*, vol. 100, supp. 3, p. A198.



# Part 2: An Update

**22 July 2019**

Tavistock and Portman NHS Trust started an experiment in 2011, using Gonadotropin-Releasing Hormone agonist (GnRHa) to block puberty in children suffering gender dysphoria. My original investigation for Transgender Trend (posted on 5 March 2019) raised serious questions about this experiment. The outcomes were never published in a scientific journal. And I discovered unpublished evidence that initial results, after the drugs had been administered for one year, were predominantly negative.

My research was reported by the Daily Telegraph. It is elaborated in a chapter in Inventing Transgender Children and Young People, edited by Michele Moore and Heather Brunskell-Evans. It has just featured on BBC Newsnight, broadcast on 22 July.




Following my original investigation, I wrote to Professor Russell Viner at University College London (UCL), the experiment's principal investigator, and Dr Polly Carmichael, Director of the Tavistock's Gender Identity Development Service (GIDS), asking why they failed to publish results. I also contacted the Research Ethics Committee which originally granted permission, pointing out that the researchers consistently failed to provide annual progress reports. Another researcher working with Transgender Trend submitted a Freedom of Information request for further details of the experiment, and this apparently prompted GIDS to post a webpage entitled 'A statement and update on the Early Intervention Study by the Tavistock and Portman NHS Foundation Trust' at the end of June. The statement first came to notice in the *Sunday Times* on 7 July.

The statement runs to more than 4,600 words. The first 3,600 detail the origins of the experiment, emphasizing two points. First, in the years before 2011, families and transgendering organizations like Mermaids lobbied vigorously to lower the age at which GnRHa drugs were administered to children, and the Tavistock could not resist this pressure. Second, the researchers could not employ the standard randomized trial to assess the effects of blocking puberty. Both points have some justification, but one wonders why such a lengthy apologia would be necessary if the experiment's outcomes have been favourable.

The Tavistock now claims 'The study concluded in February 2019 when the last cohort member began the next stage of therapy (cross-sex hormones) at age 17 years'. When the *Daily Telegraph* asked GIDS to respond to my questions (before publication on 6 March), its spokesman did not mention that the study had just concluded. Similarly, on 26 March, Viner replied to my letter, stating 'The early intervention study cohort *remain under study*

as some of the last recruited young people have still not completed the treatment pathway' (italics added). Carmichael's reply on the same date also said nothing about the study having been concluded in February. The webpage on GIDS' *research* still describes it as 'a study that is currently underway'.

When *Lord Lucas* kindly followed my suggestion to ask a parliamentary question, he was told on 22 May that the Tavistock 'plans to publish the data once all of the young people in the study have reached the stage when a clinical decision is made about moving from pubertal suppressants to cross-sex hormones, which the Trust expects to occur in the next 12 months'. Did the Tavistock mislead the Parliamentary Under-Secretary for the Department of Health and Social Care, who answered the question? The earliest indication that the experiment had terminated came from the NHS Research Ethics Committee, which informed me on 25 June that a final report is now being drafted by the chief investigator, Viner. One suspects that this precipitous ending – which has apparently been backdated to February – was forced by Transgender Trend's scrutiny.

Whenever the study formally ended, the researchers have been collecting data for eight years. The first subject consented to GnRHa drugs in June 2011. All 44 subjects enrolled in the experiment had completed one year on the drugs by mid 2015, two years by mid 2016, and three years by mid 2017. The results should have been closely monitored and the outcomes published in a scientific journal. After all, GnRHa has never been licensed for treating gender dysphoria, not just in the United Kingdom but anywhere in the world.

Five years ago, in 2014, Carmichael told the *Mail on Sunday* that the study demonstrated favourable outcomes: 'Now we've *done* the study and the results thus far have been *positive* we've decided to continue with it' (italics added). She even appeared in a BBC television programme – 'I Am Leo', aimed at audiences aged 6 to 12 – to promote the benefits of GnRHa drugs. (*See our analysis of the programme here*).

A video clip can be found here




Credit: @STILLtish

The Tavistock's statement says remarkably little about the experiment's outcomes. It cites Carmichael and Viner's presentation to the 2014 World Professional Association for Transgender Health (WPATH) conference showing 'there was *no overall improvement* in mood or psychological wellbeing using standardized psychological measures' (italics added). This finding was presented in February 2014, but just four months later Carmichael claimed 'the results thus far have been positive'. I cannot find slides from this 2014 presentation, but Carmichael's presentation to the 2016 WPATH conference apparently recycles the same finding. It also acknowledges that 'Natal girls showed an *increase in internalising problems* from t0 to t1 [after 12 months on GnRHa] as reported by their parents' (italics added). This negative outcome is omitted from the Tavistock's statement.

The statement also omits two other statistically significant negative outcomes that I discovered buried in an appendix submitted to the Tavistock's Board of Directors in 2015. Most seriously, after a year on GnRHa, 'a significant increase was found in the first item "I deliberately try to hurt or kill self"'. Evidence that an experimental treatment raised the risk of self-harm should be a major concern, but GIDS have never addressed this finding.

There is a backhanded admission in a presentation given by the GIDS endocrinologist, Professor Gary Butler, to the 2016 WPATH conference (only the abstract is available). 'Partial suppression [of sex hormones by GnRHa] may produce more side effects due to hormone swings, and also a lowering in mood leading to clinical depression. Expectations of improvement in functioning and relief of the dysphoria are not as extensive as anticipated, and psychometric indices do not always improve nor does the prevalence of measures of disturbance such as deliberate self harm improve.' Butler's presentation is, curiously enough, not cited in the Tavistock's statement.

The Tavistock's statement also fails to mention an article coauthored by Carmichael (Costa et al. 2016), which includes data from some subjects in the Early Intervention Study. This article purported to show beneficial outcomes from GnRHa, but I have demonstrated that the authors made an elementary statistical error. The analysis actually failed to detect any difference between children who were administered GnRHa and those who were not.

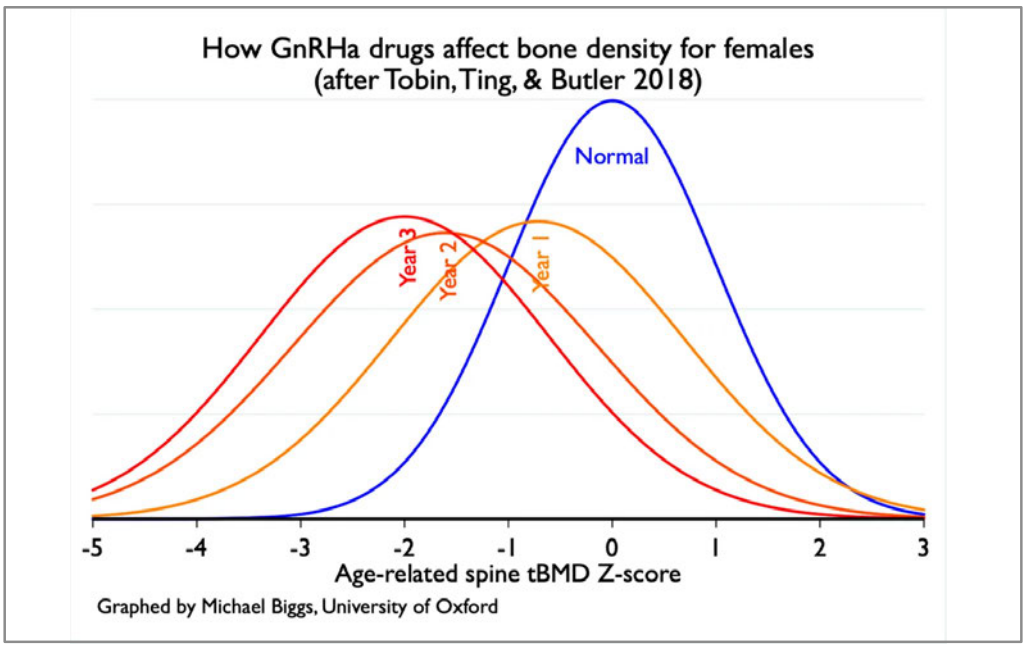
Finally, the Tavistock's statement cites a recent article on bone density, coauthored by Butler (Tobin, Ting, and Butler 2018). The article – a one-page abstract – emphasizes that bone density did not decline, in absolute terms, after GnRHa was administered. This is extremely misleading, as pointed out by Dr Michael Laidlaw and reiterated by Dr William J. Malone, both endocrinologists.

Growing children need bone density to *increase*. The article admits that the children did experience a decline relative to the normal standard for their age group, and this decline was especially marked for girls. My graph shows the distributions implied by the article's figures.

It is obvious that a substantial minority of the girls on GnRHa suffered from abnormally low bone density.

In sum, the Tavistock's statement continues the sorry record of prevarication and obfuscation that has dogged the experiment for several years. GIDS is clearly incapable of undertaking rigorous scientific research, perhaps because it has been swamped by exponentially increasing caseloads. There is no such excuse for the failure of UCL's Institute of Child Health, the experiment's lead sponsor. Neither organization can be trusted to objectively analyze the 2011 experiment.

We demand that a team of independent researchers be given access to all the data from the experiment. They will need expertise in statistics, psychiatry, and endocrinology; most importantly, they must have no vested interests in the promotion of GnRHa drugs. Given that this experiment has been used since 2014 to justify the provision of these drugs to children under the NHS, the outcomes of this experiment – on all the physical, psychological, and behavioural measures that were collected – must be published urgently.



# Part 3: The Health Research Authority report

**17 October 2019**




The Health Research Authority (HRA) has just published its investigation into the 2010 experiment with puberty blockers, or more precisely its role in giving ethical approval and oversight. The investigation was prompted by research published on Transgender Trend in March 2019, with an update in July (the full paper is here). The HRA report's conclusions are predictably bland. Firstly, 'the research team involved in the design and delivery of the study … worked in accordance with recognised practice for health research, and in some areas such as patient involvement and transparency were ahead of normal practice at the time' (p. 11). Secondly, 'The HRA has acted within its Standard Operating Procedures and its normal practice in relation to this study' (p. 10).

On close reading, however, the report contains an astonishing admission. The paragraph deserves to be quoted in full:

> It would have reduced confusion if the purpose of the treatment had been described as being offered specifically to children demonstrating a strong and persistent gender identity dysphoria at an early stage in puberty, such that the suppression of puberty ***would allow subsequent cross-sex hormone treatment*** without the need to surgically reverse or otherwise mask the unwanted physical effects of puberty in the birth gender. The present study was ***not designed to investigate the implications on persistence or desistence of offering puberty suppression*** to a wider range of patients, it was limited to a group that had already demonstrated persistence and were actively requesting puberty blockers.
>
> *(p.5, my own emphasis added in bold).*

In fact the 2010 research protocol declared that one of its three aims was '[t]o *evaluate persistence and desistence* of the gender identity disorder and the continued wish for gender reassignment' (Early pubertal suppression in a carefully selected group of adolescents with gender identity disorder, proposal submitted to Central London REC 2, November 2010, obtained under Freedom of Information from the HRA; italics added). History is being rewritten to alter the rationale

for the experiment. It is not clear whether this revisionist history originates with the HRA, or whether the HRA is conveying the current views of the experiment's chief investigator, Professor Russell Viner (Professor in Adolescent Health at University College London) or his co-investigator, Dr Polly Carmichael (Director of the Gender Identity Development Service, GIDS).

Whatever the source, this is a clear admission that puberty blockers were the first stage on the predestined path to cross-sex hormones. After four assessment interviews, a child of 12 would be consenting in effect to a lifetime of drug dependence and the loss of fertility and the probable loss of sexual functioning. Because the "treatment" was intended to enhance the child's desire to change sex, it naturally exacerbated her or his gender dysphoria. 'Worsening behavioural and emotional symptoms of dysphoria', the HRA notes cheerily, 'would therefore not in itself be unexpected' (p. 6).

While the HRA is quite clear that puberty blockers were supposed to set the child on a course for full medical transition, it ignores one gruesome irony. For a boy who wishes to resemble a woman, puberty blockers will indeed prevent 'the unwanted physical effects of puberty' such as voice deepening. But they also leave the adolescent with the genitalia of a prepubescent boy. If he subsequently chooses (after the age of 18) to undergo genital surgery, there is insufficient for a vaginoplasty and so a piece of his bowel will have to be used. This point was underlined at a conference organized by the Gender Identity Research and Education Society in 2005:

> 'Although there are surgical means to deal [with] this difficulty, the patient and her parents or guardians should be fully informed about its implications.'

The conference was attended by Viner and Carmichael. Unaccountably they forgot to mention these implications on the Patient Information Sheet they gave to children and carers in their experiment.

Following from the HRA's admission that puberty blockers are really the start of irreversible physical transition, it makes one valuable recommendation. 'Researchers and clinical staff should consider carefully the terms that they use in describing treatments e.g. avoid referring to puberty suppression as providing a "breathing space", to avoid risk of misunderstanding.'

That phrase is common. According to Dr Gordon Wilkinson at the Young People's Gender Clinic in Glasgow—the Scottish equivalent of GIDS—GnRHa drugs 'provide breathing space to explore options'. Gendered Intelligence, a charity which trains staff in many universities, describes puberty blockers as giving 'young trans people appropriate time and breathing space to ensure that they are sure about the permanent effects of cross-sex hormones, without the adverse effects of an incorrect [sic] puberty'. (The phrase is also widely used in the USA and New Zealand.)

It is not the only misleading phrase. Carmichael went on BBC children's television in 2014 to tell one of the children in the experiment and the audience (aged 6 to 12) that puberty blockers merely pressed a pause button. We can only hope that the HRA's report will stop clinicians and charities from misleading the public—and more importantly the children and carers who are making life-changing decisions.

The HRA's investigation repeats a familiar misconception: because Gonadotropin-Releasing Hormone agonist (GnRHa) drugs are licensed for the postponement of central precocious puberty, therefore 'the treatment was licensed for the purpose of blocking progression of puberty' (p. 4). In the case of precocious puberty, a child starts to go through puberty at an abnormally young age—a girl starts menstruating at five, for example. This condition has an objective physical diagnosis. GnRHa drugs are then prescribed in order to *postpone* puberty until the normal age of puberty is reached, when the drugs are stopped and puberty resumes normally. There is no similarity at all for the case of a child with gender dysphoria. This condition has no objective physical diagnosis. GnRHa drugs are prescribed in order to prevent the child from ever experiencing puberty. The adolescent never develops the ability to conceive a baby and might never develop the capacity to orgasm.

When it comes to the HRA's own ethical

procedures, its investigation throws some intriguing findings. The experiment was first rejected by one Research Ethics Committee (REC 1), and was then submitted to another Committee (REC 2). 'A number of members' on the latter 'had connections with University College London', which by coincidence was Viner's own institution. The committee also co-opted a member who had co-authored with Viner. 'It is not clear whether the potential conflict of interest was declared, whether this committee discussed this potential conflict of interests and agreed that it was not a concern, or whether the other members agreed that the individual concerned could contribute but that they would ensure that it did not influence their decision-making' (p. 9). It is unfortunate that the minutes provide no information.

The Research Ethics Committee made the submission of annual progress reports 'a condition of the favourable ethical opinion', as it stressed in its letters (e.g. letter of 29 April 2013, obtained under Freedom of Information from the HRA). Viner failed to submit such reports in 2013, 2014, and 2015. The HRA reassures us that 'it is common for researchers not to supply annual progress reports' (p. 10). Rules, after all, are made to be broken.

After 2015, the Research Ethics Committee forgot about the experiment, as apparently did Viner and Carmichael. It had served its purpose, for what had been 'research' now became policy at GIDS: puberty blockers are routinely given to children from the age of 12, and in some cases as to children as young as 10.

Let us leave the last word to Viner, who spoke with remarkable candour in 2012:

> If you suppress puberty for three years the bones do not get any stronger at a time when they should be, and we really don't know what suppressing puberty does to your brain development. We are dealing with unknowns. (Daily Mail, 25 February 2012)

We know no more now than we did then.

The HRA should review how effectively declarations of interest by REC members are managed, and seen to be managed.

The Tavistock and Portman NHS Trust should provide greater clarity both internally and externally about the boundaries between research and clinical service.

Researchers and clinical staff working in gender identity development should consider carefully the terms that they use in describing treatments e.g. avoid referring to puberty suppression as providing a 'breathing space', to avoid risk of misunderstanding.

UCL should ensure it has mechanisms to oversee version labeling of documents used in research.

NHS England should provide guidance to NHS organisations on appropriate and transparent oversight and governance of innovative practice undertaken outside research.

From: Investigation into the study 'Early pubertal suppression in a carefully selected group of adolescents with gender identity disorders'

NHS Health Research Authority

# Part 4: The Judicial Review

**3 December 2020**

Keira Bell's and Mrs A's claim against the Tavistock and Portman NHS Foundation Trust led to a momentous judgment on 1 December 2020. The judgment places significant constraints on the use of GnRHa (Gonadotropin-Releasing Hormone agonist) to suppress puberty in children suffering from gender dysphoria, as adopted by the Tavistock's Gender Identity Development Service (GIDS) in 2011.

## 1. Puberty suppression is an experimental treatment

The judgment is unequivocal that puberty suppression for gender dysphoria is an experiment: 'it is right to call the treatment experimental or innovative in the sense that there are currently limited studies/evidence of the efficacy or long-term effects of the treatment' (para 148). This finding should finally dispose of the claim—frequently made by the GIDS—that the treatment is not experimental because GnRHa drugs are licensed for precocious puberty. Treating a child whose puberty arrives abnormally early (under the age of 8) so that he or she can experience puberty at a normal age cannot be compared to stopping puberty at the normal age so that a child can proceed to cross-sex hormones at the age of 16.

Puberty suppression is an experiment whose aims are ambiguous. The judgment highlights the 'lack of clarity over the purpose of the treatment: in particular, whether it provides a "pause to think" in a "hormone neutral" state or is a treatment to limit the effects of puberty, and thus the need for greater surgical and chemical intervention later' (para 134).

## 2. GIDS fails to collect basic data and to report outcomes

At several points the judges express surprise at the failure of the GIDS to provide data to the court. The GIDS could not provide comprehensive figures on the ages at which children have been prescribed GnRHa (para 28). It had no information on how many were diagnosed with Autism Spectrum Disorder (para 35). It could not say how many proceeded from GnRHa to cross-sex hormones (paras 59). This failure—or perhaps reluctance—to collect basic data has been highlighted by Transgender Trend.



During the proceedings, the judges asked the GIDS to produce results from their initial experiment with puberty blockers on 44 children from 2011 to 2014. This initial experiment had been conveniently forgotten by GIDS—and even by the Principal Investigator, Professor Russell Viner—until it was brought to light by Transgender Trend in March 2019. We called then for the outcomes of the treatment on all 44 subjects to be published immediately.

When the judges asked for these results during the hearing, the GIDS refused. As the judges explain, 'we note that though this research study was commenced some 9 years ago, at the time of the hearing before us the results of this research had yet to be published. Dr Carmichael says in her witness statement dated 2 February 2020 that a paper is now being finalised for publication. At the hearing we were told that that this paper had been submitted for peer-review but that Professor Viner, one of the authors of it, had yet to respond to issues raised by the reviewers, as he has been otherwise engaged in working on issues relating to the coronavirus pandemic' (para 24).

Using the pandemic as an excuse is not plausible given that Professor Viner and Dr Carmichael promised (in their protocol given ethical approval in 2010) to provide outcomes after the patients had been on GnRHa for two years, which would have been in 2016. (The only peer-reviewed publication on the experiment's outcomes for psychological functioning and gender dysphoria is my letter in Archives of Sexual Behavior.) If the longer-term outcomes of the 2011-14 experiment were positive, why would Dr Carmichael and Professor Viner refuse to produce this evidence for the judges?

The failure to publish cannot be blamed on lack of resources. In 2019 the GIDS won a £1.3 million grant to research outcomes for children treated for gender dysphoria.

## 3. Puberty suppression inexorably leads to cross-sex hormones

The judgment should finally dispose of the illusion that puberty suppression simply provides a "breathing space" or pushes a "pause" button (as Dr Carmichael claimed on BBC Children's Television in 2014). As I have said, it is more like pressing fast forward into cross-sex hormones and ultimately surgery. The Health Research Authority has acknowledged that the rationale for puberty suppression is lifelong physical transition. The judges emphasized that 'the vast majority of children who take PBs [puberty blockers] move on to take cross-sex hormones, that Stages 1 and 2 are two stages of one clinical pathway and once on that pathway it is extremely rare for a child to get off it' (para 136).

Therefore for a child to actually consent, he or she 'would have to understand, retain and weigh up' the following information: '(i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH [cross-sex hormones] and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain' (para 138).

## 4. Can children consent to sterility and potentially losing sexual function?

The judges remarked on the curious fact that the GIDS could not recall any child ever being considered to lack "Gillick competence" to consent to GnRHa drugs (para 44). Gillick competence requires the child to have 'sufficient maturity and intelligence to understand the nature and implications of the proposed treatment' (para 105). Even when treating children as young as 10, the GIDS invariably assessed them as having the ability to consent, 'on the assumption that if they give enough information and discuss it sufficiently often with the children, they will be able to achieve Gillick competency'. The judges concluded laconically, 'we do not think that this assumption is correct' (para 150).

One of the GIDS' witnesses, "J" embarked on puberty suppression at the age of 12. According to J's recollection of the consent process: "We discussed sex and I told them the idea of it disgusted me. I knew I would be unable to consider having a sexual relationship as an adult with my body so wrongly formed' (para 86). Such testimony heightened the judges' concerns about consent. 'Some of the children and young people who have been treated at GIDS say in their witness statements that the thought of sex disgusted them, or they did not really think about fertility. These normal reactions do not detract from the difficulties surrounding consent and treatment with PBs. That adolescents find it difficult to contemplate or comprehend what their life will be like as adults and that they do not always consider the longer-term consequences of their actions is perhaps a statement of the obvious.' (para 141).

Remarkably little is known about the effect of puberty suppression on the development of sexual desire and the capacity to orgasm. This was revealed in the proceedings, when the judges asked for evidence that the development of sexuality was unimpaired by GnRHa. The question stumped the barrister for University College London Hospitals NHS Foundation Trust, which prescribes the drugs on behalf of the GIDS. One clue is that GnRHa is prescribed to chemically castrate sex offenders in Broadmoor—a use for which it is licensed, unlike for gender dysphoria. It seems implausible that an adolescent's sexuality would be unaffected by several years of chemical castration.

## 5. Who can consent to puberty suppression?

The judges concluded by emphasizing the 'enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication' (para 150). Therefore GIDS—and private clinicians who wish to prescribe GnRHa for treating gender dysphoria—will have to seek a court order for each individual patient. The judgment sets a high bar for meeting Gillick competence: for a child aged 13 or under, this would be 'highly unlikely'; for a child aged 14 or 15, it would be 'very doubtful'. Even for a child aged 16 or 17, for whom there is a presumption of consent, the judges recommend that clinicians 'may well regard these as cases where the authorisation of the court should be sought' (para 151). The judgment closes the era of unconstrained experimentation on children suffering from gender dysphoria, when the GIDS could flout ethical rules and ignore scientific principles.



# Part 5: The belated results

**18 December 2020**

The Tavistock's Gender Identity Development Service (GIDS) and University College London have finally released the results of their experiment on puberty blockers, albeit not in a scientific journal. The timing is curious. The paper's first author, Dr Polly Carmichael (Director of GIDS) refused to provide it to the judicial review brought by Keira Bell and Mrs A, on a flimsy pretext. On the day after the judgement was handed down, the paper appeared on a preprint server, medRxiv (Carmichael et al., 2020). It was not discovered for some days because the authors were too modest to seek publicity. The event has not been mentioned on the website of the Tavistock and Portman NHS Foundation Trust, which had originally announced the experiment in 2011 with some fanfare: 'It is hoped that the results of this study will contribute to improving the standards of care offered to this group of young people and their families.'

The fact that the Carmichael et al. have only now published results that were available in 2016—for outcomes after one year—and in 2017—after two years—shows their lack of concern for the standards of care offered to this group of young people. Indeed, it is almost certain that the experiment would have been conveniently forgotten without Transgender Trend's sustained scrutiny. This website first called on the Tavistock to publish the results of its 'Early Intervention Study' in March 2019. I made a formal complaint to the Health Research Authority, which oversees the Research Ethics Committee that had approved this experiment. The report of its investigation was sent to me (embargoed before publication) on 11 October 2019. Carmichael et al.'s statistical analysis plan was 'lodged with the Research Ethics Committee of the Health Research Authority on 9 October 2019' (Appendix S2, p. 1).

The long-delayed paper provides results for 44 subjects—aged 12 to 15—who were prescribed Gonadotropin-releasing Hormone agonist (GnRHa). They were followed up at three time points: after one year, two years, and three years. Because the subjects could progress to cross-sex hormones soon after their sixteenth birthday, only 24 remained on GnRHa after two years, and only 14 at three years.

## Managing expectations

The authors' statistical analysis plan, written in 2019 after they had come under scrutiny from Transgender Trend, is remarkable for its low expectations. It is far more pessimistic than the original research protocol from 2010.

- *2010:* 'Going through puberty in what is perceived to be the wrong body can be very distressing and in some cases contribute to self-harm and suicide attempts …. It is important to evaluate whether intervention early in puberty reduces self harm and suicide attempts' (Viner et al., 2010, p. 15).
- *2019:* 'We hypothesise no change in self-harm across the study' (Carmichael et al., 2020, S2, p. 9).
- *2010:* 'Early intervention is also associated with a reduction in the gender dysphoria experienced by these adolescents …' (Viner et al., 2010, p. 15).
- *2019:* 'It is therefore unlikely that GnRHa treatment will result in significant reduction in body dissatisfaction' (Carmichael et al., 2020, S2, pp. 12-13).

The authors have provided a perfect illustration of what psychologists call 'HARKing': hypothesizing after the results are known (Kerr, 1998). Aside from this being a questionable research practice, one wonders how it could be ethical to give an experimental treatment to children if the experimenters themselves expect the treatment not to lead to any improvement.

## Psychological functioning does not change

The paper's headline finding is that 'GnRHa treatment brought no measurable benefit nor harm to psychological function in these young people with GD [gender dysphoria]' (p. 45). This seems reassuring given that the first 30 subjects enrolled in the GIDS experiment reported more negative than positive effects after one year (GIDS, 2015; Biggs, 2020).

The paper's findings might partly reflect the authors' choice to present results only for girls and boys combined, and to test sex differences (Table 6) for only 2 measures out of 26. 'Our statistical analysis plan restricted testing all outcomes for differences by sex due to the type 1 error risk', they explain (p. 46). This risk is a legitimate concern, which will be discussed below. There is no justification, however, for not tabulating the results disaggregated by sex, as done by the landmark Dutch study on which the Tavistock's experiment was modelled (de Vries et al., 2011), and by Carmichael's presentation of the preliminary results (GIDS, 2015). My article (Biggs, 2020) shows that the measures for boys and for girls are uncorrelated, in the preliminary GIDS results and likewise in the Dutch study. In both data sets, to take the clearest example, girls' body image worsened following GnRHa, while boys' body image improved. By combining both sexes, the authors make it impossible to discern such patterns.

The authors also provide frustratingly little information on self-harm. There are two indexes, one created from the child's answers and one from the parent's. Each index sums two questions, each scored as 0, 1, or 2. The authors report only the median and the interquartile range (Table 4). The median is always 0 because most children do not harm themselves. The lower quartile is 0, of course; the upper quartile is 1 in every measure except the index for Youth Self Report after twelve months, when it is 2. (The difference between this measure at baseline and at one year is apparently not statistically significant; $p = .4$.) Why not report the mean, as they had previously (GIDS, 2015)? Or tabulate the frequency? Disaggregating by sex would also be informative, because their own preliminary results for the first 30 subjects showed that the increase in self-harm—on the question 'I deliberately try to hurt or kill myself'—was greater for girls than for boys (the sex difference was statistically significant, $p = .014$).

The lack of discernible improvement is quite surprising because children and their parents must have been enthusiastic about puberty blockers and would have considered themselves fortunate to be in the first group of British adolescents to receive them. After all, this treatment had been demanded for years by Mermaids and GIRES, as a lifesaving elixir for children who identify as transgender (Biggs, 2019). This context should have created a powerful placebo response, even if the specific physical effects of GnRHa were minimal. We know that almost all or all the benefit of anti-depressants comes from placebo response (Kirsch, 2019).

## The sample is too small

The authors are right to be wary of conducting too many statistical tests on a small sample, comprising only 44 individuals. I will try to explain this simply. Let us say we find a sample statistic—like the average change in one measure after these particular patients have been treated for a year—to be statistically significant at the .05 level. This means that if the population parameter were truly zero—if there were really no effect—we would then have only a 5% probability of getting a statistic of that magnitude in a sample of that size, simply due to random variability. In other words, the probability of a 'Type I error' is 5%. The more measures we test, however, the greater the probability of finding one to be statistically significant. If we were to carry out 20 statistical tests on completely random variables, on average 1 in 20 would be statistically significant at the .05 level.

The authors point out that my analysis (Biggs, 2020) of their preliminary results does not adjust for the number of statistical tests. I replicated the procedure used in the Dutch article (de Vries et al., 2011) which provides the only significant evidence for the benefits of puberty blockers. The authors' critique therefore applies equally to that article, whose sample was almost as small, ranging from 41 to 57 (depending on the measure). Statistical tests were conducted on 14 measures. Applying the Bonferroni correction, as the authors advocate (Carmichael et al., 2020, p. 18), would also eliminate 3 out 8 of the positive Dutch findings. Most importantly, the improvement in overall psychological functioning (captured the Children's Global Adjustment Scale) and the reduction in depression would no longer be statistically significant ($p > .05 / 14$).

The authors make a convincing argument that their sample was too small to really detect changes in so many measures. Why did they not realize this earlier? When the experiment was designed, the GIDS had a caseload of only 29 teenagers aged between 12 and 15 (Viner et al., 2010, pp. 8–9), and so they planned to enrol 30–45 patients over three years. Referrals subsequently grew exponentially, perhaps helped by Dr Carmichael's promotion of puberty blockers in newspaper interviews and on BBC Children's Television. In 2014/15, the final year of enrolment on to the experiment, the GIDS received referrals for 282 teenagers in the 12-15 age bracket. In other words, the *annual increase* was by then ten times greater than the *total* number of patients just four years earlier. After enrolment in the experiment finished, the GIDS recruited over 50 children aged 10-14 each year to its GnRHa programme. The GIDS therefore should now possess data on the effect of puberty suppression—after one year—on at least 250 more children (counting those referred to the endocrine clinic from January 2015 to December 2018). A sample size of around 300 would provide sufficient statistical power to really test whether adolescents undergoing puberty suppression improve or deteriorate. Unfortunately, the GIDS chose either not to collect or not to report these data, despite winning £1.3 million in research funding. Why?

## No information on autism

In the case brought by Keira Bell and Mrs A, the judges asked for the number of children on the autism spectrum who were administered puberty blockers. They were told that these data could not be obtained. The judgment 'found this lack of data analysis—and the apparent lack of investigation of this issue—surprising' (para 35). The authors mention that they used the Social Responsiveness Scale to assess autism but simply promise that 'these data will be analysed in the future' (Carmichael et al., 2020, p. 17). We know only that out of the first 30 experimental subjects, 16 were in the normal range, 10 had 'mid to moderate' Autism Spectrum Disorder traits, and 5 had 'severe' traits as measured by SRS-2 (GIDS, 2015, p. 50).

## Bone density

An American endocrinologist, Dr Michael Laidlaw, raised the alarm about the effects of GnRHa on bone density, which must accrue rapidly during puberty to avoid osteoporosis later in life. This paper confirms his fears. At baseline the subjects were already half a standard deviation below the norm for their age and sex (Table 3). After one year, they were one standard deviation below the norm; at two years, more than one standard deviation below. (The authors chose not to statistically test these changes in *Z*-scores, for reasons which are unclear.) The paper omits the range of bone density, which is crucial: given that after one year the *average* was a standard deviation below the norm, many of the subjects would fall more than two standard deviations below the norm—which is a warning sign 'that your bone density is lower than it should be for someone of your age' (NHS, 2020). In the overall population, only 2% of individuals will experience such low bone density to meet this warning threshold (*Z*-score < -2). After two years on GnRHa, perhaps 30% of those with puberty suppression could meet this threshold for spine bone density, even adjusting for height. (My calculation assumes the Normal distribution and necessarily estimates the standard deviation of the *Z*-score from the authors' confidence intervals.)

Whether the failure to accrue bone density increases the risk of fractures is unclear. The authors collected data on various 'adverse events', but these did not include broken bones.

## Puberty blockers lead inexorably to cross-sex hormones

The most important outcome—but the least surprising—is that 43 out of 44 subjects continued to cross-sex hormones. Although puberty blockers are promoted as a diagnostic aid, since 2006 (if not before) we have known that in almost every case they lead to cross-sex hormones and eventually surgery. It is therefore astonishing that the authors continue to claim that 'pubertal suppression may be both a treatment in its own right and also an intermediate step' (p. 48).

Considered as a treatment in its own right, the suppression of puberty with GnRHa might be the only treatment provided by the NHS for which the costs clearly exceed the benefits. The sole justification for GnRHa is to prepare a child for lifelong medicalization with cross-sex hormones and surgeries, with irreversible consequences for sexuality and fertility. After all, the paper that introduced puberty suppression was entitled 'The Feasibility of Endocrine Interventions in Juvenile Transsexuals' (Gooren & Delemarre-van de Waal, 1996). The question is whether the GIDS has the moral authority and scientific expertise to designate children as young as 10 as juvenile transsexuals. As the judges ruled in the case of Keira Bell and Mrs A, 'Apart perhaps from life-saving treatment, there will be no more profound medical decisions for children than whether to start on this treatment pathway' (para 149).



**References**

Biggs, M. (2019). *The Tavistock's experiment with puberty blockers*. https://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf

Biggs, M. (2020). Gender dysphoria and psychological functioning in adolescents treated with gnrha: comparing Dutch and English prospective studies. *Archives of Sexual Behavior*, 49, 2231–2236. https://doi.org/10.1007/s10508-020-01764-1

Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., & Viner, R. (2020). *Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK*. https://doi.org/10.1101/2020.12.01.20241653

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen- Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *Journal of Sexual Medicine*, 8, 2276–2283. https://doi.org/10.1111/j.1743-6109.2010.01943.x

Gender Identity Development Service. (2015). Preliminary results from the early intervention research. Tavistock and Portman NHS Foundation Trust, Board of Directors, *Part One: Agenda and Papers ... 23rd June* 2015, 50–55. https://tavistockandportman.nhs.uk/documents/142/board-papers-2015-06.pdf

Gooren, L., & Delemarre-van de Waal, H. (1996). The feasibility of endocrine interventions in juvenile transsexuals. *Journal of Psychology & Human Sexuality*, 8, 69–74. https://doi.org/10.1300/J056v08n04_05

Kerr, N. L. (1998). HARKing: Hypothesizing after the results are known. *Personality and Social Psychology Review*, 2, 196–217. https://doi.org/10.1207/s15327957pspr0203_4

Kirsch, I. (2019). Placebo effect in the treatment of depression and anxiety. *Frontiers in Psychiatry*, 10. https://doi.org/10.3389/fpsyt .2019.00407

NHS (2019). *Bone density scan (DEXA scan): How it is performed*. https://www.nhs.uk/conditions/dexa-scan/what-happens/

Viner, R., Carmichael, P., Di Ceglie, D., Butler, G., Brain, C., Holt, V., Khadr, S., & Skagerberg, E. (2010). A*n evaluation of early pubertal suppression in a carefully selected group of adolescents with gender identity disorder (v1.0*, 6 October 2010). Obtained from the Health Research Authority under Freedom of Information.

# Part 6: The effects on bone density

**3 May 2021**

Transgender Trend first examined the effects of Gonadotropin-Releasing Hormone agonist (GnRHa) on bone density in 2019. This was prompted by a study co-authored by Professor Gary Butler, the lead clinical endocrinologist for the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust (Joseph, Ting, and Butler 2018; Joseph, Ting, and Butler 2019).

The authors emphasized that adolescents administered with GnRHa had not experienced any decline in absolute bone density. As endocrinologists Dr William J. Malone and Dr Michael Laidlaw pointed out on Twitter, however, adolescence is a period of increasing bone density—this is the developmental stage when an individual lays down the bone mass that will last them the rest of their life. What matters, then, is the individual's bone density relative to the norm for their age and sex, which is measured by the Z-score (standardized deviation from the population mean). The Z-scores of the patients at the GIDS had fallen significantly. Spurred by Laidlaw's and Malone's comments, I produced a graph to illustrate how these Z-scores had declined (the graph was crude because it had to be derived from the mean and standard deviation of Z-scores alone, because nothing more was reported by Butle's study). My conclusion: 'It is obvious that a substantial minority of the girls on GnRHa suffered from abnormally low bone density.'

This claim can be vindicated now that the Tavistock finally released a subset of data from their experiment with GnRHa on children aged 12 to 15. The data were released following Transgender Trend's lengthy campaign to disclose the outcomes of the experiment, which included a formal complaint to the Health Research Authority. My reanalysis of these data is now published by the Journal of Paediatric Endocrinology and Metabolism. I find that after two years on GnRHa, the Z-scores for up to a third of the children had declined to below -2. Only about 2% of the population fall below this threshold, and this is the threshold of clinical concern. Indeed, the Tavistock's 2011 experimental protocol initially excluded any child with a Z-score below -2. This restriction was subsequently relaxed, with the stipulation that the patient must understand the 'risks of later osteoporosis' (Amendment 1.2, 3 July 2012). The Patient Information Sheet, however, never mentioned osteoporosis; it stated merely 'We do not know how blocker treatment in early puberty will affect bone strength …'. The experimental protocol provides evidence that Butler—one of the investigators in the project, led by Professor Russell Viner and Dr Polly Carmichael—understood that such low bone density indicates a risk of osteoporosis.

The graphs show my results in detail. The blue line shows the normal distribution of bone density in the population. For hip bone mineral density, the Z-scores of one third of the patients had fallen below -2. For spine bone mineral density, over a quarter of Z-scores had declined below this threshold. Some had even fallen below  3; such low bone density is extremely rare, found in only 0.13% of the population. Adjusting for height—bone mineral apparent density—does not attenuate the lowest values.

Does such abnormally low bone density increase the risk of bone fractures? One of the Tavistock's patients who started GnRHa at age 12 then experienced four broken bones by the age of 16. We have no idea whether this was unusual because Butler and the other researchers collected no data on fractures. Dutch studies show that the accrual of bone density recommences when cross-sex hormones are taken from age 16, and so Z-scores increase (Klink et al 2015; Stoffers et al. 2019).

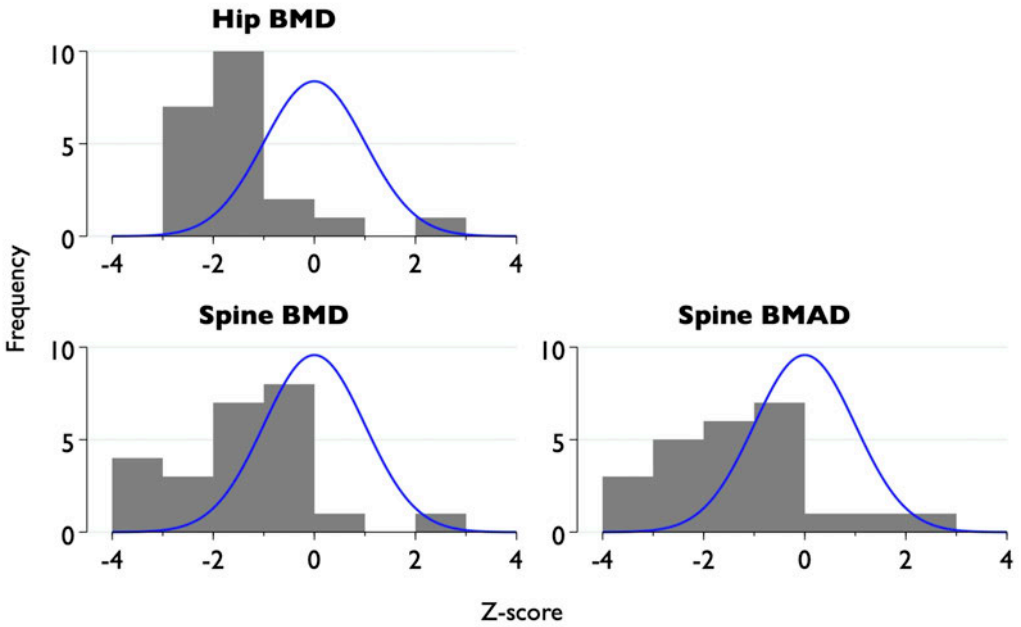
But in many cases the recovery is partial, and the Z-scores do not return to the level registered at the onset of GnRHa. The Tavistock has given GnRHa to a child as young as 10 years old, and so the failure to accrue bone mass could last up to five years. The Tavistock never follow up GIDS patients once they turn 18—not even those who graduate to the adult Gender Identity Clinic in the Tavistock Trust itself—and so there is no way of knowing whether patients who experience abnormally low Z-scores for years in adolescence have experienced osteoporosis as dults.

The fact that adolescents undergoing puberty suppression failed to accrue bone mass—to the point where a significant minority ended up with abnormally low bone density—inspired Butler and his coauthors to make two recommendations (Joseph, Ting, and Butler 2019). One is to reduce the monitoring of bone density, which has 'significant financial implications for healthcare providers'. The other is to change the computation of Z-scores; 'reference ranges may need to be re-defined for this select patient cohort'. When a measure provides inconvenient results, stop measuring or choose another scale: that is how transgender medicine is practiced at the Tavistock.

The Tavistock's Dutch counterparts at least provide practical advice: 'Adolescents should be counseled on the importance of weight-bearing exercise, an adequate dietary calcium intake, sufficient sunlight exposure to ensure adequate vitamin D levels, or vitamin D supplementation' (Schagen et al. 2020). But the Dutch researchers also apparently omitted to collect data on fractures. Their latest article (which acknowledges a research grant from Ferring Pharmaceuticals, the manufacturer of the GnRHa drug used in the Netherlands and Britain) suggests that future studies should 'investigate clinically important outcomes such as fracture risk' (Schagen et al. 2020).

Fifteen years ago the exponents of the Dutch protocol for transgendering children admitted that their patients could 'end with a decreased bone density, which is associated with a high risk of osteoporosis' (Delemarre-van de Waal & Cohen-Kettenis 2006). It is remarkable that the proponents of puberty suppression are only now contemplating collecting evidence on this key clinical outcome at some future date.

**Fig. 1.** Bone density after 24 months of puberty suppression




N = 24 for spine, 21 for hip. BMD, bone mineral density; BMAD, bone mineral apparent density.

# Acknowledgements

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# Further reading

*The Tavistock's experiment with puberty blockers*. 2019. 1 http://users.ox.ac.uk/~sfos0060/Biggs_ExperimentPubertyBlockers.pdf

Britain's experiment with puberty blockers. In M. Moore & H. Brunskell-Evans (Eds.), *Inventing transgender children and young people* (pp. 40–55). Newcastle, England: Cambridge Scholars Press, 2019.

Puberty blockers for gender dysphoria: The Dutch protocol, YouTube, 2020 https://www.youtube.com/watch?v=9VHlkE40cFk

A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine, 16*, 2019, p. 2043. https://doi.org/10.1016/j.jsxm.2019.09.002

Gender dysphoria and psychological functioning in adolescents treated with GnRHa: comparing Dutch and English prospective studies. *Archives of Sexual Behavior, 49*, 2020, pp. 2231–2236. https://doi.org/10.1007/s10508-020-01764-1

A collection of articles by Dr. Michael Biggs for

# Transgender TREND

Questioning the trans narrative



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Tavistock and Portman NHS Foundation Trust

# Gender identity services

## Inspection report

The Tavistock Centre
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Date of inspection visit: 14 October 2020 to 6 November 2020
Date of publication: 20/01/2021

## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Are services safe? | **Requires Improvement** |
| Are services effective? | **Requires Improvement** |
| Are services caring? | **Good** |
| Are services responsive to people's needs? | **Inadequate** |
| Are services well-led? | **Inadequate** |

# Our findings

## Gender identity services

**Inadequate** 

This was an announced, focused inspection of the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust.

The Gender Identity and Development Service (GIDS) is provided by the Tavistock and Portman NHS Foundation Trust. In October 2020, the service was working with 2093 young people. The service is based at the Tavistock Centre in London. The service has a regional centre in Leeds and satellite clinics in Exeter, Bristol and Birmingham. Most of the referrals to the service are from GPs and child and adolescent mental health services. The service also accepts referrals from other health, social care and education professionals and from voluntary organisations. Referrals are made for people under the age of 18 with features of gender dysphoria. Gender dysphoria describes a sense of unease that a person may have because of a mismatch between their assigned sex at birth and their gender identity. The gender dysphoria leads to clinically significant distress and/or social occupational and other functioning impairment. There may be an increased risk of suffering distress or disability.

The service is commissioned by NHS England. The service is commissioned to provide assessments of young people, refer young people for medical treatment when appropriate and provide some continuing support when this is required. It is a national specialist service and is the only service available in England for children and young people with gender dysphoria. The service also treats children and young people from Wales.

The Tavistock and Portman NHS Foundation Trust provide outpatient psychosocial services only, and GIDS provides outpatient services for gender dysphoria. Any medical treatment is provided by other acute healthcare providers and the Tavistock and Portman NHS Foundation Trust refer into these as required. Medical treatment involves the prescribing of medicines that pause the physical changes of puberty and hormones that alter characteristics of gender. This medical treatment is provided by the endocrinology departments at University College Hospital London and Leeds General Infirmary. The CQC inspected and published reports on these services at the same time as the inspection and publication of GIDS.

Our last inspection of GIDS was in 2016. This took place as part of an overall inspection of the Tavistock and Portman NHS Trust. Following the inspection, we rated the trust as good overall. The domains of effective, caring, responsive and well-led were rated as good. The domain of safe was rated as requires improvement, although the improvements we said the trust must make related to a different service within the trust.

We undertook this inspection due to concerns reported to the CQC by healthcare professionals and the Children's Commissioner for England. Concerns related to clinical practice, safeguarding procedures and assessments of capacity to consent to treatment. This inspection focused on the Gender Identity Development Service (GIDS) only.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent at the service to prevent cross infection. Four inspectors and a CQC specialist advisor visited the service at the Tavistock Centre on 14 and 15 October 2020 to review patients' records and complete essential checks. Two inspectors visited the service

# Our findings

in Leeds on 20 October 2020. Whilst on site we wore appropriate personal protective equipment (PPE) and followed local infection control procedures. The remainder of our inspection activity was conducted off-site. This included interviews by telephone, the use of video conferencing facilities and analysis of evidence and documents. Our final staff interview was completed on the 6 November 2020.

Separate from our inspection the High Court made a ruling on the 1 December 2020 around capacity and consent of children receiving hormone intervention for gender dysphoria. This ruling has not impacted on our findings. Our findings and judgements are based on the legal position at the time of our inspection.

Prior to, and during, the inspection we received intelligence from former members of staff and healthcare professionals not directly associated with the service. During the inspection visit, the inspection team:

- visited the service to look at the quality of the environments
- spoke with 22 young people who were using the service
- spoke with 13 parents of young people using the service
- reviewed information from 23 people who contacted the CQC through our website to share their experience of using the service
- reviewed information from six people on the waiting list who contacted the CQC through our website
- reviewed information from six service users and parents who wanted to share their experience via an independent organisation
- spoke with four members of the GIDS clinical executive team, the GIDS safeguarding lead, the GIDS service manager, the divisional director for gender service, the medical director, human resources director and a staff governor.
- spoke with 30 other staff members across the multidisciplinary team
- looked at 35 patients' records
- looked at a range of policies, procedures and other documents relating to the running of the service.

**Overall summary**

Our rating of this service went down. We rated it as inadequate because:

- The service was difficult to access. There were over 4600 young people on the waiting list. Young people waited over two years for their first appointment.
- Staff did not always assess and manage risk well. Many of the young people waiting for or receiving a service were vulnerable and at risk of self-harm. The size of the waiting list meant that staff were unable to proactively manage the risks to patients waiting for a first appointment. For those young people receiving a service, individual risk assessments were not always in place with plans for how to manage these risks. The number of patients on the caseload of the teams, and of individual members of staff, were high making caseloads difficult to manage and placing pressure on staff.
- Staff did not develop holistic care plans for young people. Records of clinical sessions did not include any structured plans for care or further action. Staff did not sufficiently record the reasons for their clinical decisions in case notes. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made.

# Our findings

- Staff had not consistently recorded the competency, capacity and consent of patients referred for medical treatment before January 2020. However, since this date these decisions had been recorded.
- The teams did not always include the full range of specialists required to meet the individual needs of the patients. Staff did not always work well together as a multidisciplinary team.
- Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution.
- The service was not consistently well-led. Whilst areas for improvement had been identified and some areas improved, the improvements had not been implemented fully and consistently where needed.

However:

- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. Feedback from young people and families currently being seen at the service was overwhelmingly positive about the care and support staff had provided.
- Staff referred young people to other providers for medical treatments that were consistent with good practice.
- Managers ensured that staff received training, supervision and appraisal. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Clinical premises where patients were seen were safe and clean.

Following the inspection, we took enforcement action against this provider under the Health and Social Care Act 2008 by imposing a condition upon their registration. This requires the trust to report to us on a monthly basis so we can monitor their progress with improving their waiting times.

## Is the service safe?

**Requires Improvement** ↓

Our rating of safe went down. We rated it as requires improvement because:

- Many of the young people waiting for or receiving a service were very vulnerable and at risk of self-harm. Despite this staff often did not assess the risks presented by young people and their families. Staff did not create plans to manage risks. The size of the waiting list meant that staff could not proactively monitor the risks to all patients waiting for their first appointment. However, in a few cases, where patients presented a particularly high risk, staff worked effectively with child and adolescent mental health services and children's social care services to ensure that young people were safe.
- Staff did not always work well with other agencies to safeguard young people. Most records did not include plans, agreed with other agencies, on sharing information and protecting young people.
- Not all staff had completed an appropriate level of training in safeguarding adults.
- The number of young people on the caseload of the teams, and of individual members of staff, was high and varied considerably between different members of staff, causing caseloads to be stressful and difficult to manage.

However:

# Our findings

- Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Clinical premises where patients were seen were safe and clean.

Detailed Findings

**Safe and clean environment**

Interview rooms were not fitted with alarms. Staff considered that the risk presented by interviews was low and did not require alarms to be installed.

The waiting area provided a comfortable space for young people to wait for appointments. There were four chairs in the waiting room all suitably distanced from each other.

All areas were clean, had good furnishings and were well-maintained. Interview rooms were bright with comfortable chairs.

Staff adhered to infection control principles, including handwashing. Between the onset of the Covid-19 pandemic in March 2020 and October 2020, the service conducted 6360 consultations. Only 7% had involved face-to-face meetings. Forty-one percent had been carried out by telephone. Fifty two percent had been carried out using video call facilities. Face-to-face consultations were only arranged for specific reasons, such as if a patient was particularly vulnerable. The service did not refer young people to the endocrinology service unless the young person had met a therapist in person. Therefore, some young people needed to attend the service in order for a referral to be made. When staff, young people and visitors attended the service, they were required to wear a face mask at all times. Hand sanitising gel was provided at the entrance to the building, at the entrance to all the corridors and in the toilets.

**Safe staffing**

The established number of clinical psychologists and psychotherapists for the service was 66.3 whole time equivalents (WTE). The established number of assistant psychologists was 6.6 WTE. The service employed 15 administrators, 1.8 consultant psychiatrists and 1.8 specialist nurses. The service also received support from service managers, project managers, research assistants and divisional level staff. The vacancy rate for the service was 17%. This included vacancies for 9.2 psychologists or psychotherapists, six administrators and three assistant psychologists.

During 2019/20, the staff turnover for the service was 23.5%. This is very similar to the total turnover for the trust which was 23.68%. During the same period, the sickness rate for the service was 2.19%. This is very similar to the overall rate for the trust of 2.5%.

The provider had determined safe staffing levels by calculating the number and grade of members of the multidisciplinary team required using a systematic approach. The level of staffing was based on the budget for the service agreed with the commissioners. The staffing allocation had been calculated to take account of the waiting list and the current caseload for staff.

# Our findings

The caseload for each member of staff varied considerably. Ten members of staff had a caseload of less than 10 young people. One member of staff had a caseload of over 100. Sixty-five percent of staff had a caseload over 40, including 34% of staff who had a caseload over 60. The overall average was 45.53. This increased to 52.5 when staff with a caseload under ten were removed from the calculation. This meant that staff were working with high numbers of clients which could be stressful and difficult to manage.

Cover arrangements for sickness, leave and vacant posts ensured patient safety. Staff worked on each case in partnership with a colleague. If a member of staff was off work due to leave or sickness, the case would be covered by their partner.

The service used bank and agency staff appropriately. Between April and June 2020, the service had not used any agency staff. The service had used bank staff to deliver 2% of the service during this time, meaning that permanent staff had provided 98% of the service.

The service had rapid access to a psychiatrist when needed. The service had an urgent concerns protocol. This protocol included arrangements for an on-call rota for psychiatrists who could see young people urgently.

Staff were not up-to-date with all appropriate mandatory training. The trust had designated 17 courses as mandatory for some or all their staff. Overall compliance with mandatory training was 86%. The service achieved compliance of over 90% for courses on equality, diversity and human rights (95%), infection prevention and control (96%) and safeguarding children level 3 (95%). However, compliance fell below 75% for training on preventing radicalisation (74%), resuscitation (70.21%), and adult basic life support (54%).

**Assessing and managing risk to young people and staff**

We reviewed the assessment and management of risk in 29 care records. Twenty-eight of these records included details of risks that were relevant to the young person. However, the recording of risk and of plans to manage these risks varied considerably. Some records demonstrated good practice, such as completing risk assessments jointly with child and adolescent mental health services. Others had limited information. For example, one record had very little information about risks, despite the referral letter stating that the young person had frequent suicidal thoughts and had previously harmed themselves by cutting.

**Assessment of patient risk**

Staff recorded the risks presented by the young person at the initial appointment, either in the record of the appointment or on a standard form. Staff had identified many young people as being vulnerable to specific risks. We found examples of young people who had made suicide attempts, young people who were vulnerable to sexual exploitation and young people who had a history of inappropriate or high-risk sexual behaviour. Records of risks were based on information provided by young people, parents and the person making the referral. Staff did not routinely update the risk assessment form, although updated information relating to risks was recorded in the notes of meetings with young people.

Staff used a recognised risk assessment tool. The service had introduced a standard risk assessment form in April 2020. This form had been completed on most of the records we reviewed. However, on some records, staff only completed very brief details. The risks were not always assessed by staff in relation to the impact of the risk and the likelihood of risk incidents occurring. On some risk assessment forms, staff had not recorded all the risks discussed in the notes of meetings. This meant that someone unfamiliar with the patient may find it difficult to identify the risks quickly.

# Our findings

Staff did not create crisis plans for young people. However, both young people and their parents said they would contact their counsellor if they had any problems or their situation deteriorated.

**Management of risk**

Staff usually managed significant risks appropriately, although their approach was not always structured or consistent. The primary approach for managing risk was known as the 'network model'. Through this model, clinicians liaised with the young peoples' local services, including child and adolescent mental health services (CAMHS), children's social services, GP and special needs co-ordinators in schools, to ensure that risks were being appropriately managed. We saw some evidence of this model working well. For example, one record showed evidence of joint working with the patient's CAMHS and voluntary sector organisations. This included sharing information in accordance with an agreed protocol. Another record included a joint assessment by GIDS and CAMHS. When young people were subject to high levels of risk, several other agencies were involved in supporting and protecting them However, the approach was not always consistent. On some records, the management of risk was poorly documented. Some records did not include a risk management plan to show how risks were being managed and which agencies were responsible. Two records for patients presenting a high level of risk did not include evidence to demonstrate that GIDS staff were fully involved in multi-agency meetings.

The service did not have the resources to sufficiently address risks associated with gender dysphoria of young people on the waiting list. The service had introduced an 'enquiries line' that young people on the waiting list or their parents could use to contact the service whilst waiting. This was to address the fact that the service could not proactively assess and manage all risks for the young person whilst they were waiting. The service relied on the child's local support agencies, such as CAMHS or the GP, to address serious risk issues that arose whilst the patient was waiting. However, some parents we spoke with said the support they had received from CAMHS was not relevant to their child's needs associated with gender dysphoria. Staff also said that the threshold to access CAMHS had increased, making it difficult for young people to access these services. The service had also carried out a pilot study to work with CAMHS to support young people on the waiting list, although this pilot had not demonstrated a significant impact. This meant that whilst serious risks to young people on the waiting list were managed by local services, who were in themselves stretched, young people's needs associated with gender dysphoria were often not being met and less serious risks were not addressed.

The service had developed good personal safety protocols, including lone working practices, and there was evidence that staff followed them. The trust had a policy for lone working. This included guidance for staff working in isolation. Staff usually worked in pairs and met with young people and parents either at the trust's offices or using video conferencing facilities. None of the staff raised any concerns about working alone.

**Safeguarding**

Clinical staff were trained in safeguarding young people. Ninety-four percent of staff who were required to do so had completed level three training in safeguarding children. Three out of the four staff who had not completed this training had recently joined the service. However, non-clinical staff said they would find it helpful to have safeguarding training above the basic, level one training in order to become more confident in dealing with situations of possible abuse that had arisen through their daily contact with vulnerable young people.

# Our findings

Safeguarding adults training was completed at level 2 for 68% of staff required to do so. This did not reach the trust target of 80% compliance. Records showed that some work with families involved supporting vulnerable adults at risk of abuse. This meant that staff may not be able to identify and respond to safeguarding matters relating to the parents they worked with. Staff providing safeguarding supervision had not received specialist safeguarding supervision training.

The trust had produced a standard operating procedure specifically for the Gender Identity and Development Service. Staff were required to report any safeguarding concerns to a supervisor, regional lead or senior clinician. The matter would then be reviewed by the trust's safeguarding team or the GIDS safeguarding lead and referred to the relevant multi-agency safeguarding hub if necessary. The GIDS safeguarding lead said that this procedure would be reviewed in November 2020. Most staff we spoke with gave examples of safeguarding concerns they had raised. For example, a clinician referred a patient to the multi-agency safeguarding hub following concerns about parental neglect and sexual abuse. Another clinician made a referral about a 17-year-old young person who was living independently in inappropriate housing, experiencing poor physical health and was not receiving any support.

Staff could give examples of how to protect young people from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, one clinician gave an example of how they had worked with families that had held homophobic or transphobic attitudes. They explained that if this presented a risk to the young person, they would make a referral to children's social care services.

Staff knew how to identify young people at risk of, or suffering, significant harm. The service carried out work to support and protect young people in partnership with other agencies, such as CAMHS and children's social care services. We reviewed the records in relation to safeguarding young people for a sample of 22 patients. On 13 of these records, 60%, we found that there had been effective joint working with local agencies to support the young person. However, on three records we found insufficient evidence of multi-agency work. Two of these records involved patients who were at significant risk. The other six records showed some good practice and some areas for improvement. Clinicians said that the scope and quality of information sharing with multi-agency partners varied hugely depending on the local authority. Most records did not include any formal information sharing agreements with local services. This meant that whilst, in most cases, the structures and processes in place to safeguard young people worked well, there remained some risk that young people may not have been appropriately protected.

**Staff access to essential information**

Staff recorded all information on an electronic patient record system. Administrators scanned paper correspondence and uploaded this to the electronic record.

Information needed to deliver patient care was available to all relevant staff, although we found that staff kept records in an unstructured and poorly organised manner. This meant that it could be difficult to find important information quickly. For example, records did not include documents giving all the key information about young people such as details of the person or people with parental responsibility or professional contacts in other agencies such as schools and CAMHS. Records did not include care plans. Risk assessments did not include comprehensive risk management plans and some were not completed fully. Assessments were not recorded in a structured manner. This meant it would be difficult for someone unfamiliar with the young person to understand the work that had been carried out.

**Track record on safety**

# Our findings

Between April 2019 and March 2020, there had been two serious incidents. Both of these incidents occurred in June 2019. In addition, there had been 64 reported incidents during this period. Between January and March 2020, there were 14 recorded incidents. One of these involved harm to a young person. This incident involved a young person taking an overdose of over-the-counter medicines after their therapeutic session evoked traumatic memories. One incident involved a member of the public posting abusive messages about the service on social media and one involved a member of the public leaving an abusive message on the service's voicemail. Other incidents related to information governance, communication and facilities.

**Reporting incidents and learning from when things go wrong**

All staff knew what incidents to report and how to report them. Staff recorded incidents on an electronic incident record. Staff received training and information on incident reporting at a team meeting in July 2020.

Staff reported most incidents that should be reported. However, we found that some incidents identified during audits were not recorded in the electronic incident record. For example, an audit of capacity, competency and consent was carried out in March 2020. This audit found that assessments of capacity, competency and consent had not been recorded in accordance with the established procedures in eight of the 11 records reviewed. The absence of a structured assessment had not been recorded as an incident for any of these records, despite the absence of a formal record of assessment potentially leading to a risk of medicines being administered unlawfully.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if and when something went wrong. For example, a member of staff described an incident involving the young person's preferred name being written on a letter but their given name, which they did not like to use, was written on the envelope. The service sent the young person a formal apology for this.

Staff met to discuss feedback. For example, staff discussed cases where there were safeguarding concerns at regular case discussion forums, the monthly psychoanalytic forum, team meetings and reflective practice sessions. Staff discussed the suicide of a former patient and an information governance incident at a clinical governance meeting in July 2020.

## Is the service effective?

**Requires Improvement** ↓↓

Our rating of effective went down. We rated it as requires improvement because:

- Staff's assessments of patients were unstructured, inconsistent and poorly recorded. Staff did not sufficiently record their reasoning in reaching clinical decisions. There were significant variations in the clinical approach of professionals in the team and it was not possible to clearly understand from the records why these decisions had been made.
- Staff did not develop care plans for young people. Many records provided insufficient evidence of staff considering the specific needs of young people, such as autistic spectrum disorders.
- Staff had only recently begun to record consent and capacity or competence clearly for young people who might have impaired mental capacity or competence. The records of young people who began medical treatment before January 2020 did not include a record of their capacity, competency and consent. When staff identified records without a

written capacity assessment, they did not seek to address this or record it as an incident. However, staff had supported patients to make decisions on their care for themselves proportionate to their competence. They understood how the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to people under 16.

- Staff did not consistently assess the physical healthcare needs of patients and how they could support them to access external services.
- The multi-disciplinary teams supporting the young people did not always include the specialists required to meet all the individual needs of patients under their care.
- Whilst staff were supported with ongoing supervision and appraisals it was not possible to see how these identified whether individual staff were performing in terms of meeting the requirements of the service and the young people they support.
- Whilst staff participated in clinical audit, they did not always act on the findings of audits to make improvements where needed.

However:

- Staff used some recognised rating scales to measure the impact of the service. They also participated in quality improvement projects.
- Managers provided an induction programme for new staff and there was access to ongoing specialist training.

Detailed findings

**Assessment of needs and planning of care**

We reviewed 35 care records. We found these records to be unstructured. Records did not provide evidence to show what staff were assessing. There was no clear rationale for clinical decision making.

Staff completed an assessment of each patient, although these assessments were completely unstructured. The specification for the service states that clinicians would assess young people during a course of between three and six sessions. Data from the trust shows that young people attended, on average, 10 assessment sessions. Eighteen percent of young people referred to an endocrinology service between March 2019 and March 2020 attended 25 or more assessment sessions. Although the trust had produced this data, it had not carried out any analysis to understand why there was such a high variation in the number of assessment sessions for each patient. Furthermore, there was no clearly defined assessment process. For example, there were no standard questions for staff to explore with young people at each session. Most records of assessment sessions were simply descriptions of conversations that had taken place between the clinician, the young person and their parents. None of the records included a clear statement of what the service was assessing. Whilst the criteria for considering referring young people for administration of hormone blockers was set out in the service specification, we saw no reference to this on any patient records. Although decisions about referrals to endocrinology were taken by at least two clinicians, it would be very difficult for the service to assess whether clinicians had made the correct decision in making a referral.

Although staff did not provide interventions for physical ill health, we did not see consistent evidence that staff routinely asked young people about their physical health, in order to refer them to external services if needed. We reviewed

physical health monitoring on 24 records. On 18 records (75%) there was no mention of physical health. Four records (16%) included a discussion of physical health at the initial meeting. This meant that staff were not consistently screening for physical health problems, unless these were included in the referral from the young person's GP or local CAMHS.

Staff did not develop care plans that met the needs identified during assessment. Some records included a short care plan in letters to the young person's GP, but these were usually very brief. For example, one of these letters simply stated that GIDS would continue to support the patient and refer to the adult service when the patient reached the age of 18. Records did not include plans for assessment and care that were specific to needs or circumstances of the young person. This meant that it would be difficult to someone unfamiliar with the young person to understand what assessments had been carried out or what the plans were for further assessment and treatment.

**Best practice in treatment and care**

We reviewed 35 care records. These records were not completed in a consistent or structured manner. This meant that many records did not demonstrate good practice.

Staff provided a range of care and treatment interventions suitable for the patient group. Care and treatment consisted of an assessment by clinicians followed by ongoing occasional contact with the service, more frequent input from the service approximately every three months or a referral to the endocrinology clinic with ongoing input from the service. The endocrinology clinic prescribed medicines used to block hormones and, therefore, inhibit hormonal changes that take place in puberty. The aim of this model was to provide support, advice and treatment to assist young people experiencing features of gender dysphoria in reducing behavioural, emotional and relationship difficulties. Twenty-eight percent of young people assessed by the service were referred to endocrine clinics for medical treatment. The decision to refer young people to endocrine clinics was taken by at least two clinicians and reviewed at a meeting of senior staff. However, records we reviewed did not sufficiently record the needs of patients with autistic spectrum disorders. The service did not record how many patients had a diagnosis, or suspected diagnosis, of an autistic spectrum disorder. We reviewed a sample of 22 records, more than half of which referred to autistic spectrum disorder or attention deficit hyperactivity disorder (ADHD). Discussions with staff about autistic spectrum disorders focused on the communication needs of these patients. Records we reviewed did not record consideration of the relationship between autistic spectrum disorder and gender dysphoria.

Staff used recognised rating scales and other approaches to rate the extent of young peoples' needs and to monitor outcomes. For example, the service used the Children's Global Assessment Scale to assess adolescent global functioning after psychological support and physical treatment. The service also used Patient Rated Outcome Measures to assess the progress each patient felt they had made as a result of interventions by the service. This included specific measures for gender dysphoria and a self-harm questionnaire.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. For example, the service carried out an audit to see how many young people had received an assessment using the Children's Global Assessment Scale (CGAS). The audit found that 97% of young people who had been discharged between April and June 2020 had received an assessment using this tool. The audit showed a small increase in the average CGAS score from 63.1 at the initial assessment to 66.4 at a pre-discharge assessment. This meant there was, on average, a small increase in patient's global functioning during their treatment, although this did not indicate a significant change. In addition, the service completed quarterly audits of the completion of 'Safeguarding and Risk Forms' and the completion of safeguarding supervision forms to check that these forms were completed correctly. The service had begun work on a quality improvement initiative to improve consistency in managing waiting times.

# Our findings

**Skilled staff to deliver care**

The staff team included clinical psychologists, psychotherapists, family therapists, specialist social workers and a counselling psychologist and assistant psychologists. The service also employed two psychiatrists, two specialist nurses and a large team of administrators.

Staff were experienced and qualified and had the right skills and knowledge to meet the primary needs of the patient group. However, staff did not necessarily have the skills or experience to meet the needs of young people with complex needs. For example, whilst some staff had previous experience of working with patients with autistic spectrum disorders, the service did not employ a specialist to focus on this area of clinical practice. This meant the service may not be sufficiently able to assess the needs of young people with complex needs.

Managers provided new staff with appropriate induction. The induction period for new staff was six months, although this could be extended to ten months if necessary. Clinical staff primarily learned from working alongside experienced colleagues. New staff received supervision once a week. The service had introduced an electronic platform where staff could access teaching materials, text and academic papers that new staff were required to read as part of their induction.

Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to regular team meetings. Data from the trust showed that clinical staff within the service had received supervision in accordance with the trust's policy. The service in Leeds had recently reintroduced supervision for administrative staff. Staff said that supervision was helpful, providing the opportunity to discuss complex cases and safeguarding matters. However, records of supervision sessions were held confidentially between the supervisor and supervisee. This meant that these discussions lacked transparency and made it difficult for senior staff to monitor the quality of line management. Managers conducted appraisals using a standard development and appraisal form. Completion of this form involved a discussion with the member of staff about their work over the past year, a review of their performance against objectives and a review of their personal development plan. Appraisals also involved agreeing objectives for the year ahead. The trust had developed a training presentation for staff and managers to help them conduct effective appraisals. The service also held discussion forums for staff including weekly team meetings, clinical discussion forums and complex case panels.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. Managers created continuing professional development plans collaborative with staff at annual appraisals.

Managers ensured that staff received the training for their roles. The service provided staff with training sessions at regular team meetings. For example, staff had received training sessions on autistic spectrum disorders, sexual abuse, gender presentation and the Mental Capacity Act.

There was variation in how managers dealt with staff performance. Concerns about poor performance could be identified through supervision or joint working with colleagues. Systems were in place for managers to work with staff to identify and address their development needs by creating an action plan. Managers could be supported by the trust human resources department when necessary. However, staff told us that performance varied enormously. For example, staff said that one member of staff worked with two young people each week whilst other staff worked with 17. They said these types of discrepancies in performance were not addressed.

**Multidisciplinary and interagency teamwork**

# Our findings

Staff held regular and effective multidisciplinary team meetings within the service. Staff held regional team meetings each week and meetings for all staff once a month. At regional team meetings staff discussed practical matters, such as leave and rotas, and complex cases. At meetings for all staff, there were discussions about waiting times, referrals, complaints, patient satisfaction surveys and patient involvement.

Staff usually shared information about young people although they did not always provide effective handover notes. Young people were assigned to a new clinician when the clinician they had been working with left the service. On one patient record, we found that the outgoing clinician had prepared comprehensive handover notes. However, on another record we found there were no handover notes. This meant it could be difficult for the new clinician to provide a consistent service.

The teams did not always have good working links with primary care, social services, and other teams external to the organisation. The service did have good relationships and regular meetings with the endocrinology departments that provided medical interventions. We also found some good practice, including an example of joint assessments with the young person's CAMHS. However, in some cases, work with other agencies was unstructured, inconsistent and poorly recorded. Two records showed that staff from GIDS were not fully involved in multi-agency meetings.

**Good practice in applying the Mental Capacity Act**

Staff had received training in the Mental Capacity Act 2005. This training included details of the five statutory principles of the Act. The service had provided training on the Mental Capacity Act to over 50 staff at a team meeting in July 2020. A further training session for staff on assessing competency in children under the age of 16 was held at the team meeting in October 2020.

The provider had a policy on the Mental Capacity Act. Staff were aware of the policy and had access to it.

Staff knew where to get advice from within the provider regarding the Mental Capacity Act. When staff had any concerns about a patient's competency or capacity, they could discuss the matter with senior colleagues at the complex cases panel. If the staff required further advice, they could contact an independent legal service.

For young people who might have impaired mental capacity, staff had not always assessed and recorded competency or, capacity to consent appropriately, although the service had recently made some improvements. We reviewed 16 records of young people the service had referred to endocrinology services for hormone blockers. On six of these records where the patient had been referred for treatment before January 2020, there was no evidence of an assessment of the patient's capacity or competency. Some records showed that staff had discussed the effects of hormone treatment with the young people and recorded that the patient demonstrated an understanding of the potential benefits and side-effects, although these records still lacked a comprehensive, structured approach to the assessment of the patient's mental capacity. Since the introduction of a standard operating procedure for consent, capacity and competency, in January 2020 there had been improvements. This procedure had introduced a form for staff, young people and parents to sign confirming their consent to treatment. The procedure also introduced a checklist for staff to complete confirming that they have provided necessary information to young people and assessed all the components of young people' capacity, such as the ability to understand, retain and weigh up information, as well as being able to communicate their views. However, the absence of structured assessments prior to staff implementing the standard operating procedure in January 2020 meant that the service has not fully assessed the competency and capacity of some young people who were still receiving hormone blockers. At the time of the inspection we asked the trust to review this.

# Our findings

Staff's approach to enabling young people to make their own decisions was unstructured and inconsistent although there was some evidence of good practice. Some records included very little information about the work carried out to help the young person make decisions. For example, on one record the evidence of capacity was limited to a statement that the young person was able to think about the pros and cons of treatment. Another simply said that the young person appeared to understand everything and is able to communicate their wishes. There were also some examples of good practice. For example, one record noted observations of family involvement. Also, in this record staff encouraged the young person to have a 'cooling off' period before proceeding with treatment to allow time for them to reflect on their decision. The service had produced a pictorial guide to the effects of hormone blockers. This had been designed for young people with autism or learning difficulties. Many young people said that staff had talked to them about their consent to treatment. Parents also said that decisions about treatment had been discussed at a number of sessions. This helped staff to assess young people's understanding and retention of the information provided. However, whilst staff demonstrated their work on helping young people to understand information about treatment, there were very few details on the records of staff engaging in the more difficult task of supporting young people weigh-up the foreseeable risks and consequences.

Staff audited the application of the Mental Capacity Act but did not always take action to address any learning that resulted from it. The service carried out audits of compliance with the standard operating procedure for consent, capacity and competency in March and September 2020. In the audit in March 2020, the service reviewed ten records of young people who had been referred to endocrinology for hormone blockers. Of these, only three contained a completed consent form and checklist for referral. Staff completing the audit had not recorded the absence of a structured assessment of capacity, competency and consent as a recordable incident. During our review of records, we found no evidence that staff had completed an assessment after the documentation was found to be missing. Again, this meant that staff had still not assessed the capacity and competency of young people receiving treatment, despite being aware that they had not done so. However, the audit carried out in September 2020 showed there had been improvements. This audit found that only three out of 29 referrals to endocrinology did not have a complete set of referral documents.

## Is the service caring?

**Good** ➔➔

Our rating of caring stayed the same. We rated it as good because:

- Staff treated young people with compassion and kindness. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition.
- Staff involved young people in their care and actively sought their feedback on the quality of care provided. They provided young people with details of organisations that could provide independent support and information.
- When appropriate, staff involved families and carers in assessment, treatment and care.
- Young people and parents could be involved in the design and delivery of the service.

Detailed findings

# Our findings

During this inspection, we interviewed 22 young people receiving care and treatment from GIDS. We interviewed the parents of 13 young people using the service. Twenty-three people contacted the CQC through our website to share their experience of using the service. Feedback from these people was overwhelmingly positive. Six people on the waiting list for the service contacted us through the CQC website. These people were concerned about the length of time they had to wait.

**Kindness, privacy, dignity, respect, compassion and support**

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Throughout our interviews with staff they demonstrated a caring, supportive and understanding approach to patients. Clinicians talked about the importance of listening, engaging and understanding young people and families. Records showed examples of clinicians speaking with patients in a way that was supportive and appropriate to their age. Young people said that their clinicians always responded quickly if they contacted them between appointments.

Staff supported patients to understand and manage their care, treatment or condition. Throughout consultations, clinicians, young people and parents talked about how to manage the young person's situation. This involved, for example, discussion about problems at school as well as discussions about treatment.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. For example, staff provided details of organisations that provided support and information to young people with gender dysphoria.

Patients said staff treated them well and behaved appropriately towards them. Feedback from young people about the staff was overwhelmingly positive. Young people described staff as knowledgeable, caring and understanding. Patients said they felt very safe with their clinicians and valued their non-judgemental approach.

Staff understood the individual needs of patients. However, there was no evidence of the service responding to young people's cultural and religious needs.

Staff maintained the confidentiality of information about patients. For example, clinicians routinely had consultations with young people and parents both jointly and on their own. This provided the opportunity for young people to discuss matters they may not have been comfortable discussing with their parents.

**Involvement in care**

**Involvement of patients**

Staff involved patients in discussions about their care and treatment. This included detailed discussions about possible medical interventions.

Staff communicated with young people so that they understood their care and treatment, including finding effective ways to communicate with young people with communication difficulties. Records showed that clinicians spoke with young people in a way that was supportive and appropriate to their age. The service had also provided an illustrated guide to puberty and hormone blockers for young people who may have found it difficult to read detailed text.

# Our findings

Staff involved young people when appropriate in decisions about the service. The service had appointed a member of the executive team to be the lead in patient and public involvement. The service provided opportunities to train young people to sit on interview panels for the recruitment of new staff. There were also opportunities for young people to give feedback, to be involved in media activities, to take part in research and to be involved in other training and service development opportunities. At the time of the inspection, take up of these opportunities was low but staff were working to increase involvement.

Staff enabled young people to give feedback on the service they received. Young people and care givers were encouraged to complete an 'Experience of Service Questionnaire'. The questionnaire included 12 questions. This included questions about whether they felt listened to, were their views taken seriously and whether staff sufficiently explained the help available. Between January and March 2020, 44 young people and six parents had completed this questionnaire. The responses they provided were mostly positive. In response to the statement "Overall, the help I received here was good", 88% of young people and 86% of parents said this was certainly true. Respondents were also able to record comments. One young person said that staff were kind and listened to them. A parent said they trust the people they were working with and believed they had the child's best interests at heart. However, another young person said they found the process invasive and they felt staff had misunderstood what they were saying. A parent said they felt like they were being pushed into doing things they didn't want to do.

Young people could not access advocacy through this service. However, the service did give young people details of organisations that provided independent support and information.

**Involvement of families and carers**

Staff informed and involved families and carers appropriately and provided them with support when needed. The service worked closely with the parents of young people using the service. Parents attended appointment with young people and were able to see clinicians in private. Feedback from parents was positive. Some parents described the service as being a 'life saver' and that they found a lot of the work to be family focused. Parents said that they were able to build positive relationships with their clinicians and that they trusted the staff to provide the right care, support and treatment for their child. The service also invited parents and siblings to 'Family Days' where families could meet with clinicians to learn more about the service. However, some parents said that they had had to wait a long time for an appointment and they did not receive any support whilst they were on the waiting list.

Staff enabled families and carers to give feedback on the service they received. Parents completed the 'Experience of Service Questionnaire'. Responses to this questionnaire were collated and reviewed by the trust.

## Is the service responsive?

**Inadequate** ↓↓

Our rating of responsive went down. We rated it as inadequate because:

- The service was difficult to access. There were over 4500 young people on the waiting list for the service. Young people often waited over two years for a first appointment.



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# Our findings

- The service did not have specific regard to the needs of all patients including those with a protected characteristic. Staff only completed ethnicity data for half the patients referred to the service. Work with young people did not include cultural and spiritual support.

However:

- Staff offered flexibility in appointment times and followed up patients who missed appointments.
- The service ensured that patients, who would benefit from care from another agency, made a smooth transition. This included facilitating transitions to adult gender identity services.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- The service had a website that provided clear information to young people and parents and carers about the service. It had links to helpful information and resources and contact details for the service.

Detailed findings

The number of referrals to the service had increased from 77 in 2009/10 to over 2700 in 2019/20. Between 2010 and 2017, the number of referrals had, on average, increased by well over 50% each year. However, the rate of increase had slowed to 6% in both 2018/19 and 2019/20. During the year from April 2019 to March 2020, the service received 2736 referrals. The covid-19 pandemic had caused a reduction in referrals. Between January and March 2020, there was a small reduction from an average quarterly rate of 701 between April and December 2019, to 632. There was a more significant reduction between April and June 2020, with the number of referrals falling to 339. The service expected the number of referrals to increase as referral agencies adapt to covid-19 arrangements.

There was a long waiting list for the service. The service was commissioned as a single national provider and the growth in referrals had exceeded the capacity of the service. On 30 June 2020, there were 4509 patients on the waiting list for the service. This had risen to 4677 in October 2020. The service had introduced some initiatives to reduce the waiting list. For example, the service in Leeds had worked collaboratively with a local voluntary organisation to provide sessions on gender identity for young people on the waiting list. The service encouraged patients over 17 years and six months to be referred to the adult service. The service had also carried out work with child and adolescent mental health services to support patients on the waiting list. However, none of these initiatives had had a significant impact. There were not enough new patient appointments available to reduce the number of patients on the waiting list. The numbers of patients who were discharged or referred on from the service was consistently less than the number accepted on to the waiting list. For example, between January and March 2020, the service accepted 456 new patients onto the waiting list but only discharged 128. This meant the service continued to be unable to meet the needs of those young people waiting.

The service had clear criteria for which patients would be offered a service. The service accepted referrals from GPs, CAMHS, other health, social care and education professionals and from voluntary organisations for children and adolescents with features of gender dysphoria. The criteria did not exclude patients who needed treatment and would benefit from it. Between April 2019 and March 2020, the service accepted 90% of referrals made to the service. However, data from the trust showed that 33% of young person only attend one session.

# Our findings

The provider did not meet its target for the time from referral to triage/assessment. The service aimed to see patients within 18 weeks from the date of referral. An 18 week wait target is set out in the NHS standard contract. Out of 1089 patients being seen by the service, only 13% were seen within 18 weeks. In total 64% of patients waited more than 66 weeks to be seen, including 26% who waited two or more years. Once patients had been seen at their initial appointment, their second appointment usually took place within the next 11 weeks.

It was possible for the team to see urgent referrals quickly, although regional teams took different approaches to the waiting list. Overall, the service did not provide urgent interventions for young people although it did provide support to local services if that was required.

Where possible, staff offered patients flexibility in the times of appointments. Since March 2020, the service had offered appointments to young people and their parents by telephone or using video conferencing facilities. This had increased the flexibility for appointment times and addressed the concerns of many families who had previously travelled long distances to appointments.

Since the start of the Covid-19 pandemic, staff have conducted appointments with patients using telephone and video facilities. This has led to an increase in the number of appointments provided by staff from 3519 between January and March 2020 to 4032 between April and June 2020.

Staff cancelled appointments only when necessary and when they did, they explained why and helped patients to access treatment as soon as possible. Between April and June 2020, staff cancelled 2% of appointments. Staff rearranged these appointments as soon as possible.

**Facilities that promote comfort, dignity and privacy**

The service had a range of rooms and equipment to support treatment and care. The waiting room had chairs for up to six people. Interview rooms had comfortable furniture and adequate soundproofing. Toilets at the London service were gender neutral. The service did not have facilities to carry out physical examinations.

**Patients' engagement with the wider community**

When appropriate, staff ensured that patients had access to education opportunities. Staff talked to young people about how to manage difficult situations at school to help them maintain a positive experience of education. The service provided information for schools on how to support young people with gender dysphoria. The service contacted the special needs co-ordinator at the young person's school if the young person was having specific difficulties, such as bullying or disengaging from education. One young person told us that the liaison between the school and the service had been very helpful and had led to staff and pupils having a better understanding of gender dysphoria.

**Meeting the needs of all people who use the service**

Of the 339 referrals made to the service between April and June 2020, 71% were from natal female patients. Staff had recorded the ethnicity of only 51% of patients. Of these, 89% were recorded as being 'White-British'. Only one patient was recorded as being 'Asian or Asian British' and one patient was recorded as being 'Black or Black British'. We reviewed the records of two young people from black or minority ethnic groups. There was no evidence to show that the service had explored the cultural context of these young people.

# Our findings

The service made adjustments for disabled people. There was step free access to the service in London and accessible bathrooms available on the site.

Staff ensured that young people could obtain information on treatments, local services and patients' rights. The service provided information about treatments such as hormone blockers.

The information provided was in a form accessible to the particular patient group. For example, the service provided an illustrated guide to puberty and hormone blockers for young people who may find it difficult to read detailed text. This included information on the negative side effects of hormone blockers, such as low mood, fatigue, weight gain and reduced activity. The service had a website that young people who used the internet could access and read all about the service and find links to further information. Information was clear, young person friendly and up-to-date.

Managers could provide staff and patients with interpreters and make information leaflets available in languages spoken by patients. However, the service had not needed to do so. The service provided therapy and support in English.

**Listening to and learning from concerns and complaints**

Between April 2019 and March 2020, the service had received 17 complaints. Three complaints were upheld. Three complaints were partly upheld. Four complaints were not upheld. Seven complaints were still being investigated. There had been three complaints in September 2020. These related to the waiting time for a first appointment, concerns from a parent about their child's ability to give consent to treatment and concern from a young person about their treatment after their clinician had left.

Some young people and parents we spoke with did not know how to make a complaint, but they all said that if they had any concerns they would feel comfortable speaking to the clinician. Parents said they were confident they would be able to find out how to complain if they needed to. Information about making a complaint was available on the website for the service.

When young people complained or raised concerns, they received feedback. Complainants received a final letter from the Chief Executive setting out the outcomes of the complaint and findings of the investigation.

Staff knew how to handle complaints appropriately. The process for handling complaints was set out in the trust's complaints procedure. This included performance standards such as acknowledging complaints within three days and responding to complaints within 25 days. If the investigation lasted longer than 25 days, young people where kept informed of the progress of the complaint.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Staff discussed complaints at Clinical Quality and Governance meetings.

## Is the service well-led?

**Inadequate** 

Our rating of well-led went down. We rated it as inadequate because:



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# Our findings

- The service was not consistently well-led. Whilst areas for improvement had been identified and some areas improved, the improvements had not been implemented fully and consistently where needed.
- Staff did not always feel respected, supported and valued. Some said they felt unable to raise concerns without fear of retribution.
- Managers were not always able to deal effectively with professional disagreement amongst team members.

However:

- Leaders had a good understanding of the young people who used the service and were visible in the service. There were initiatives for young people to give feedback on care and be involved in service development.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Young people we spoke with said those values came across in how staff interacted with them.

Detailed findings

**Leadership**

The service was led by a service director along with senior clinicians who formed the Gender Identity Development Service (GIDs) executive team. All staff on the GIDs executive team had relevant qualifications and many years' experience of working within the service. Leaders recognised that demands on the service and the leadership team had increased considerably in recent years due to increase in the number of young people referred to the service.

Leaders had a good understanding of the services they managed and identified the challenges the service faced. They could explain clearly how the teams worked to provide the service. Leaders were fully aware of the many challenges, such as the substantial rise in demand, very long waiting lists and high levels of external scrutiny, particularly within the national media. They also highlighted some improvements such as introducing standard operating procedures for safeguarding and consent to treatment. All of the GIDS executive team continued to have a caseload of young people and engaged in the casework discussion forums. Members of the GIDS executive team also participated in complex case reviews.

Leaders were visible in the service and young people and staff knew who they were. The executive team led the clinical quality and governance meeting with all the staff once a month. The service director welcomed discussions and feedback from young people and parents.

**Vision and strategy**

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The values and ethos of the service focused on promoting non-judgemental acceptance of gender identities, taking a holistic approach and providing support to both young people and their families. Staff demonstrated these values throughout the inspection. Young people and parents told us that they valued and appreciated the supportive, non-judgemental approach taken by staff.

**Culture**

# Our findings

Clinicians said they had developed collaborative and supportive relationships with their colleagues through supervision and staff forums. Staff also felt proud of the way service supported the young people they worked with. However, non-clinical staff did not always feel valued. These staff were often frustrated at being unable to make simple decisions without going through many layers of approval. This meant that it was difficult to make simple improvements to the service and have their voice heard.

Staff said they felt positive and proud about working for the provider and their team. Many staff said that they loved their work. However, some staff said high caseloads and constant external scrutiny meant they worked under relentless pressure. The service was subject to frequent media interest. The service had been subject to a judicial review in the High Court in October 2020. The service was also preparing for a thorough review by its commissioner, NHS England. Some staff said there was a sense of the team being 'under siege' from external pressures. Some staff also commented that although staff turnover was consistent with the average for the trust, it was still high at 24%. This turnover created pressure on long-standing members of staff to support new employees.

Staff did not always feel able to raise concerns without fear of retribution. Some staff, particularly those in non-clinical roles, said there was a fear of blame within the service. This meant they were reluctant to raise concerns.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The Speak Up Guardian presented an annual report to the trust board. In their report in May 2019, the Speak Up Guardian stated that staff at GIDS had raised concerns and that many of these staff felt worried about speaking in open groups.

Managers could deal with poor staff performance when needed, although there were examples of inconsistencies in performance that had not been addressed. Managers explained that when they identified poor performance, they agreed an action plan for improvement with the member of staff.

Teams worked well together although, when difficulties arose, managers did not always deal with them appropriately. Senior managers explained that there were a number of staff forums where clinicians had the opportunity to discuss concerns and differences of opinions. Some staff said that their team was good at challenging each other's clinical opinions. However, during the inspection, staff told us about situations involving differences of opinions between staff. These situations had led to a clinician resigning, a formal grievance, and a situation where staff felt it was difficult to engage with a senior member of staff.

Staff appraisals included conversations about career development and how it could be supported. At each appraisal, staff agreed their objectives and personal development plan for the year ahead.

The service did not provide any initiatives to promote equality and diversity in its day-to-day work. The trust's policy on equality, diversity and inclusion stated the trust's commitment and intent to creating an organisation that diverse, inclusive and provide opportunities for all. However, in relation to race equality, staff commented that the service predominantly employed white people. The workforce race equality standard report for the trust for 2019 showed that over 80% of staff were white.

The service's staff sickness and absence rates were similar to the average for the provider. During 2019/20, the turnover rate of 23.5% was the same as the turnover rate for the trust. The sickness rate of 2.19% was slightly below the sickness rate for the trust.

# Our findings

Staff had access to support for their own physical and emotional health needs through an occupational health service. Staff could access the trust's 'Staff Advice and Consultation Service'. This service could give support to staff in coping with crises such as bereavement, relationship breakdown or experience of trauma.

The provider recognised staff success within the service. For example, at the regional team meeting in Leeds, staff reviewed compliments and thank-you cards that had been sent to the service. A member of staff was awarded the 'Star of the Month' award. At the meeting in September 2020, staff thanked a colleague for completing a particularly difficult piece of administrative work.

**Governance**

Our findings from the other key questions demonstrated that governance processes did not operate effectively to ensure that the needs of patients were met in a safe, structured and systematic manner. The GIDS service had a comprehensive action plan to address issues identified by the trust and improve service performance. This was written in March 2019. It contained seven areas of recommendation and over 55 specific actions. These covered areas of concern focused on during this inspection. While improvements were seen in some areas, such as introducing standard documentation for assessments of consent and capacity, there were still many areas where improvements had not been consistent. For example, actions to minimise variation in practice had not been fully achieved. There continued to be a wide variation in the number of sessions young people received, from two or three sessions to over 25 sessions, with some young people receiving more than 50 sessions. There also remained variation in assessments which were unstructured. Assessments did not demonstrate what staff were assessing or demonstrate clear criteria for decision making. There appeared to be no framework for discharge other than young people reaching the age of 18. Actions to manage the waiting list had not reduced the time young people waited, with current waits at 24 to 26 months. Record keeping was also poorly organised and it could be difficult to find important information.

There was a clear framework of what must be discussed at a team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The service had an established structure for executive team meetings, meetings for senior staff, clinical quality and governance meetings and regional team meetings. Each meeting had a standard agenda of items that were discussed. For example, at clinical quality and governance meetings staff discussed waiting times, complaints, feedback from young people and opportunities for young people to be involved in the service. At regional team meetings, staff discussed practical arrangements, such as leave and rotas, and casework. These meetings also provided opportunities for staff to discuss any concerns.

Staff undertook or participated in clinical audits. In most cases the audits were sufficient to provide assurance and staff acted on the results when needed. One exception we found was that staff had not taken sufficient action after an audit on consent and capacity found cases were missing necessary paperwork.

The service did not have consistent arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients. For example, records did not include risk management plans to show which agencies were responsible for or involved in managing the risks to young people. However, the service did have well-established arrangements for supporting young people to be transferred to the service for adults. The service also had regular meetings with endocrinology services.

**Management of risk, issues and performance**

# Our findings

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level. Two entries on the trust's risk register related specifically to GIDS. The risk register included details of the risk, a risk score and details of action being taken to mitigate the risk.

Staff concerns matched those on the risk register. Entries on the risk register related to stress placed on staff due to the level of internal and external scrutiny and the length of waiting times. Both these risks were assessed as being high.

The service had plans for emergencies, for example, adverse weather or a flu outbreak. The trust had developed a business continuity plan that provided details of what the trust would do in the event of a major incident.

**Information management**

The recording of information was insufficient to ensure safe and effective professional practice. Records of sessions with young people and their parents were often simply descriptions of discussions that had taken place. They did not include any analysis, structured assessment, professional curiosity or clinical decision making. One member of staff commented that clinicians often said they were too busy with direct patient work to complete records. Supervision notes were also held in confidence by the supervisor and supervisee. This meant the service did not have access to fundamental information about the competence of staff in respect of both work with young people and the provision of supervision.

The service used systems to collect data that could be over-burdensome for frontline staff and administrative support was not working efficiently. The service employed 15 administrators to support 66 clinical staff. Many staff said there was too much administrative work. One member of staff said the service would be improved if there was more time to think and less administrative work.

Information governance systems included confidentiality of patient records. Breaches of patient confidentiality were record as information governance incidents.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. This information was prepared by non-clinical staff and accessed by the executive team in the form of a monthly dashboard. However, there were concerns that the executive were reluctant to engage in discussions about data.

Staff who left the service were routinely offered an exit interview with a line manager or executive team member. They could make a specific request for exit interview with a member of staff from trust human resources department if they preferred.

**Engagement**

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. For example, the service provided updates and information in the 'News' section of its website.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Staff encouraged young people and their parents to give feedback by completing the 'Experience of Service Questionnaire'.

# Our findings

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. The service collated reviewed feedback. Staff discussed this feedback at clinical quality and governance meetings. Collated feedback was included in the quarterly report to commissioners.

Directorate leaders engaged with external stakeholders. The service provided comprehensive reports to commissioners every three months.

**Learning, continuous improvement and innovation**

Some staff said they were given the time and support to consider opportunities for improvements and innovation. For example, staff had explored initiatives to reduce the waiting list. These initiatives had involved collaboration with CAMHS and voluntary sector organisations. Other staff said it could be difficult to embed improvements across the whole service and it was done at a local team level. They said it could be difficult to embed consistently and have their ideas considered by senior staff in other teams.

Staff used quality improvement methods and knew how to apply them. The service had provided training in quality improvement methods for non-clinical staff. The service was carrying out a quality improvement project to review the parity of waiting times in the different regional teams.

# Our findings

## Areas for improvement

**Action the provider MUST take to improve**

The service must ensure that it meets the needs of young people who are referred to the service. Regulation 9(1)(b)

The service must ensure that young people referred to the service do not have to wait unacceptable lengths of time for a first appointment. Regulation 9(1)(b)

The service must ensure that plans for care and treatment are established and clearly recorded on care records. Regulation 9(1)(b)

The service must ensure that appropriate staff with specialist skills are available to meet the needs of young people and that records of assessments include details of how care and treatment is planned in relation to those complex needs. Regulation 9(1)(b)

The service should ensure that it records the details of ethnicity for all young people and that it responds to young peoples' cultural needs. Regulation 9(1)(b)

The service must continue its work to ensure that assessments of capacity, competency and consent are recorded for all patients referred for medical treatment, including young people currently receiving treatment who were referred before January 2020. Regulation 11(1)

The service must ensure that staff assess the risks to all young people and record these risks appropriately. Regulation 12(1)(2)(a)(b)

The service must ensure that systems or processes are established and operated effectively to ensure compliance with regulations. The service must maintain securely an accurate, complete and contemporaneous record in respect of each young person, including a record of the care and treatment provided to the young person and of decisions taken in relation to the care and treatment provided. This includes ensuring that assessments and clinical decisions are structured and clearly recorded. Regulation 17(1)(2)(c)

The service must ensure that systems are in place so all staff are able to contribute to discussions about the service and that staff do not feel fearful that they will be blamed when they raise concerns. Regulation 17(1)(2)(e)

**Action the provider SHOULD take to improve**

The service should have effective systems in place to ensure that staff caseloads are kept to an equitable and reasonable level and to ensure that staff feel they have a manageable workload.

The service should ensure that staff are aware of young peoples' holistic needs including their physical health needs.

The service should continue its work with individual clinicians to review their competency and performance in terms of meeting the requirements of the service and the young people they support.

# Our findings

The service should ensure that non-clinical staff have sufficient training to ensure they are confident in responding appropriately to potential safeguarding risks they encounter through their contact with young people using the service.

The service should ensure that all staff have completed an appropriate level of training in safeguarding adults.

The service should ensure that it continues to develop its multi-agency support and protection for young people, including the development of joint protocols and information sharing agreements.

# Our inspection team

The team that inspected the service comprised of eight CQC inspectors, an assistant inspector, two inspection managers, two specialist inspectors of children's services, a head of hospital inspection and two specialist advisors with professional backgrounds in gender identity services. The lead of a current independent review of gender identity services for children and young people, commissioned by NHS England, attended all the interviews with the executive team, interviews with some other members of staff and participated in meetings to review the evidence collated during this inspection.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 11 HSCA (RA) Regulations 2014 Need for consent |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
| --- | --- |
| Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care |



The Observer

# Tavistock trust whistleblower David Bell: 'I believed I was doing the right thing'

The psychiatrist behind a critical report on the gender identity unit at the NHS trust on the efforts to silence him and his concerns about children's access to treatment



**Rachel Cooke**

@msrachelcooke

Sun 2 May 2021 10.00 BST

To talk to David Bell is to have some small sense of what it might be like to be his patient. At 70, his energy puts mine to shame. He cycles everywhere. His diary is full. I've rarely interviewed someone so engaged (there are days when he emails me several times, each message more exacting than the last). But ask him a question and he's unlikely to rush in. Certainty is not a given. His open-mindedness belongs to someone far younger. Above all, he is so calm: a reassuring presence. There are times during our conversation when it's hard to believe we're discussing experiences that must have caused him so much anxiety and even, at moments, some fear.

Bell, a distinguished psychiatrist and practising psychoanalyst, is the doctor who in 2018 wrote a controversial report about the activities of the gender identity development service (GIDS), a clinic at the Tavistock and Portman NHS foundation trust in north London, where he worked in adult services from 1995 until his retirement earlier this year. GIDS, the only clinic of its kind in England, specialises in treating children with gender identity issues and in

recent months has been in the news even more than usual. Last December, a judgment by the high court ruled that those under the age of 16 were unlikely to be mature enough to give informed consent to the prescription of puberty blockers (such drugs delay the development of secondary sex characteristics in patients, in theory enabling children more easily to transition into their desired gender identity as an adult). This ruling, the result of a judicial review brought by 23-year-old Keira Bell - born female, she was prescribed blockers by GIDS at 16 and now regrets her transition - has effectively curtailed medical intervention for children with gender dysphoria. (The Tavistock is to appeal; the case will be heard in June. David Bell will be what is technically called an intervenor in the appeal, which means he can give evidence.)

Bell's report anticipated the concerns of the high court and he feels vindicated by its judgment. "It was jaw-dropping," he says. "Because it was very strong." As he read it, he was struck by details that have not been widely reported, particularly those involving a lack of data, a problem he had raised himself (GIDS was unable to produce for the court any data relating to outcomes and effects, whether desirable or adverse, in children who had been prescribed puberty blockers; nor could it provide details of the number and ages of children who had been given them). But the experience was painful, too: "I felt concerned that we'd moved away from the values [of care] the trust has embodied for so long." He is astonished the judgment seems to have had so little effect on the organisation of GIDS. "Ordinarily, heads would roll," he says. "The management structure has changed slightly, but it feels like window-dressing."



Keira Bell outside the high court after its recent ruling on puberty blockers. Photograph: Facundo Arrizabalaga/EPA

But whatever the court's verdict, it cannot change the fact that the organisation to which Bell devoted the greater part of his working life did not respect his rights as a whistleblower. Nor

has it taken the heat out of the debate about the medical treatment of trans children - if anything, the discourse has only grown more entrenched - which is why he's talking to me now. This is the first time he has spoken in detail about his experiences: about how he came to write his report and the grave consequences that doing so had for him. His retirement means that the threats of disciplinary action against him are over. He is free, at last, to say what he likes.

Writing the report was, he says, a matter of conscience. In 2018, 10 GIDS staff brought their worries to him unsolicited, a figure he estimates to be around a third of those then working there. He had no choice but to act and would do the same again. Nevertheless, it was not easy. Far from being grateful to him for alerting it to a potentially dangerous situation, the trust's position appeared defensive - having read the correspondence involved, perhaps aggressively so - almost from the start. It tried to silence him and instituted proceedings against him. Was he frightened? Yes and no. "I believed I was doing the right thing," he says. "I never doubted that, and most of my colleagues in the adult department supported me, so when I went up to my floor at the Tavistock, I could be oblivious and get on with my work. The real betrayal wasn't of me personally, but of the trust's duty to whistleblowers and to its wider mission [since 1920, the Tavistock has specialised in talking cures]. But the thing that enables you to sleep at night is a good lawyer." To pay for this lawyer, he launched two crowdfunding appeals.

How, exactly, did the trust attempt to silence him? The trust told the *Observer* that it is proud of the GIDS service, which is committed to providing high-quality support and care for young people experiencing issues with gender dysphoria, and that the claims made by Dr Bell are historical and were dealt with following proper processes at the time. It vigorously denies that any steps were taken against Bell for being a whistleblower. It says that it has a duty to safeguard its staff, who have faced intense, personalised and upsetting harassment, and has taken a series of actions, following proper processes, to do this.

By Bell's telling, its approach was at once Kafkaesque and cack-handed. In the months after he delivered his report, a book to which he had written an introduction was removed from the Tavistock's library. When he spoke at a conference about de-transition in Manchester, a member of GIDS' staff travelled there, he says to spy on him. "They wrote it up very accurately," he says, with a laugh. Finally, he was told that he was not allowed to write about, or to talk in public about, anything that wasn't directly connected to his NHS employment, "which sounded odd to me... was it the case that if I was going to write a paper about the psychology of *King Lear*, I'd have to ask permission?" (As his lawyer informed him, this was against the terms of his contract.)

The story begins in February 2018, with a knock on Bell's office door. "I was often the person people came to when they had problems," he says. Having worked as a consultant at the Tavistock for more than 25 years, he was one of its most senior doctors: for 10 years, he was in charge of its scientific programme; in 2018, he was also an elected staff governor of the trust, for the second time. Of the 10 GIDS staff who would talk to him over the course of the next seven months, only the first saw Bell at the Tavistock; the others, who spoke of intimidation,

worried about being seen. What did he make of what they told him? “My blood ran cold. Their concerns were similar, but not in a choreographed way. One or two were severely troubled.”




The Tavistock Centre in north London. Photograph: Alamy

Among these concerns were the fact that children attending GIDS often seemed to be rehearsed and sometimes did not share their parents’ sense of urgency; that senior staff spoke of “straightforward cases” in terms of children who were to be put on puberty blockers (no case of gender dysphoria, notes Bell, can be said to be straightforward); that some were recommended for treatment after just two appointments and seen only infrequently thereafter; some felt that GIDS employed too many inexperienced (and inexpensive) psychologists; that clinicians who’d spoken of homophobia in the unit were told they had “personal issues”. One told Bell that a child as young as eight had been referred to an endocrinologist for treatment. “I could not go on like this… I could not live with myself given the poor treatment the children were obtaining,” said another.

Was he surprised? How much did he know about GIDS before these conversations? (The clinic, which was established in 1989, had grown hugely during his time. In 2009, it saw 80 patients. By 2019, this figure had risen to 2,700.) “That’s a good question. It started as a small service, then it became nationally funded; a contract with NHS England meant a guaranteed income. It was peculiar. You could see that everyone knew about it and yet no one wanted to know about it. In the adult department, there was a sense that we didn’t want to find out what went on there, because we might not have liked it if we did.”

Bell wondered what he should do. “In July, I met with hospital management. I told them I would write a report. They said: OK. While I was writing it, I contacted GIDS. I needed to know some basic stuff: the number of patients they’d seen; their gender; what psychiatric

problems they may have had." He received no answers. "I then got a rather unpleasant letter from Paul Jenkins, the trust's chief executive. It said that GIDS was very busy and that its staff were not obliged to answer me." Was it that GIDS didn't have the data or that it didn't want Bell to have it? "Both."

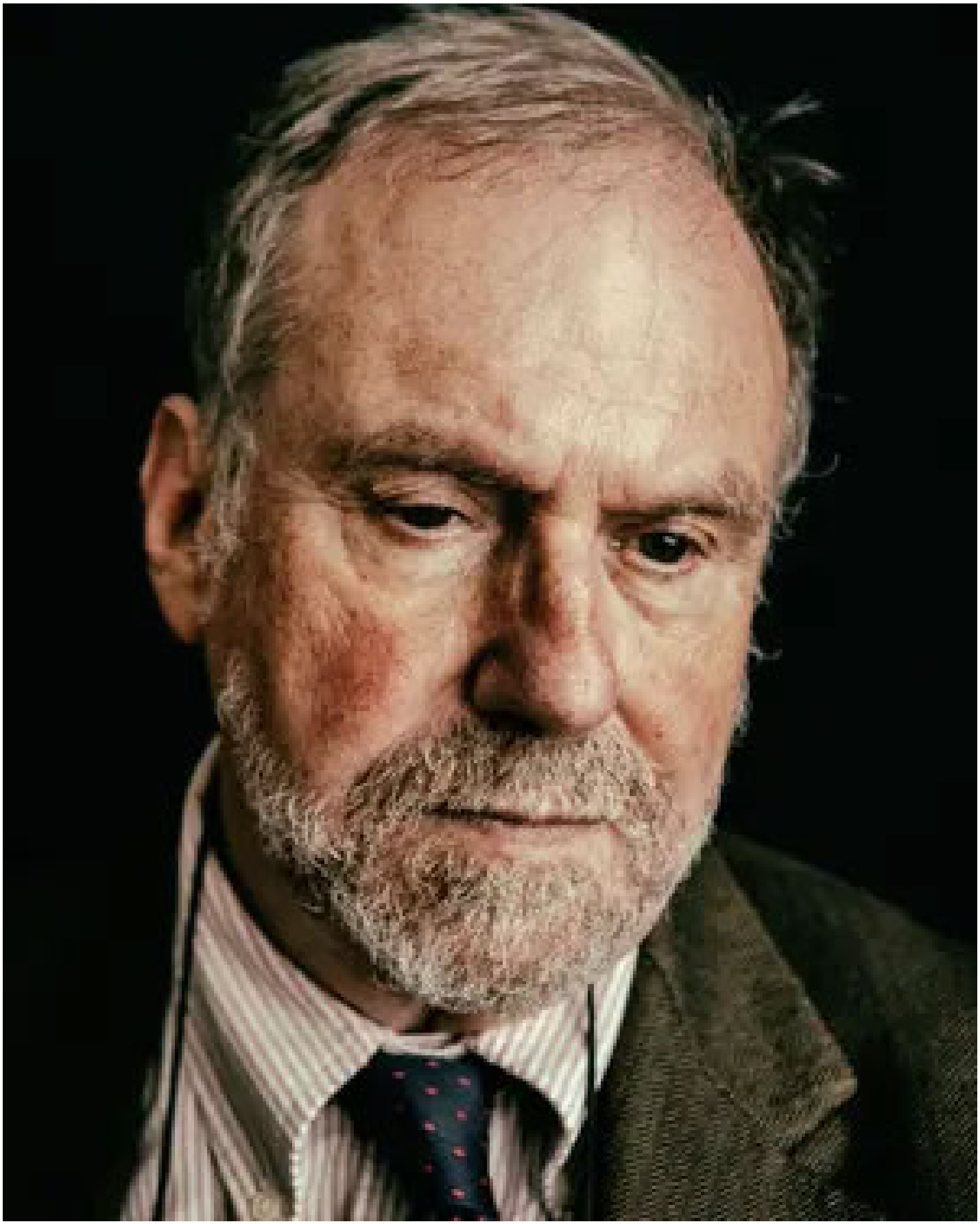
In September, Bell sent his report to Jenkins and to Paul Burstow, the chairman of the board. For unspecified legal reasons, he says, they forbade him to send it to the council of governors, which oversees the board. "That was when I got myself a lawyer," says Bell. His lawyer told him that, on the contrary, a failure to send it out might make him culpable in the event of any future legal case taken against the trust. When he did so, however, he received what felt like a "very hostile and threatening" note from Burstow. Nevertheless, the report was discussed at the next council, where it was agreed that a review of GIDS would be led by Dinesh Sinha, the trust's medical director. In spite of this, in November 2018, Bell received two letters threatening disciplinary action. One of the grounds was "bullying". He was not told whom he had bullied. He was also asked to agree not to speak any further to Sonia Appleby, the trust's director of child safeguarding. (Appleby is bringing a whistleblowing claim against the trust in which she alleges that when she made "protected disclosures" regarding concerns raised by GIDS staff over patient safety, she was subjected to detriments.)

While Sinha's review was taking place, Bell asked for its terms of reference. He wanted to ensure that those who'd talked to him could speak to the review safely, that their anonymity would be protected. He says he got no response. Bell wrote to staff at GIDS, reminding them of their right, as NHS workers, to speak confidentially. At this point, he says, the trust "went ballistic… they interfered with my emails so I couldn't write to them again". The trust's review delivered its report in February 2019. Initially, Bell was not allowed to see it. He was then given 30 minutes to read its 70 pages (it was later leaked to him in full). "There was still no data. It mentioned intimidation, but no action was [to be] taken. However, it did acknowledge the inappropriate involvement of trans ideology groups in the work of the service." The report was approved by the board and the council of governors, although one consultant psychotherapist, Marcus Evans, accused the trust of having an "overvalued belief" in GIDS expertise and resigned. Soon after this, Bell's report was leaked to the press. "That disturbed me, until I read [the article]," he says. "The reporting was accurate. I started to think it was a good thing." He says the trust began to suggest that Bell was unqualified to write such a report and to suggest that the cases in it were hypothetical. (They were not.)

In early 2020, procedures were set up for disciplinary action to be taken against Bell. "All the grounds were in connection with my activities as a whistleblower," he says. In the meantime, Bell announced that he would retire, as he'd always planned to, in June 2020. But then the pandemic hit; wanting to see his unit through it, he decided to delay his departure until January 2021. The trust attempted more than once to set a date for the hearing, but these were always dropped. Bell felt all this was just for show.

His retirement was only weeks away.

Last January, he retired as planned, only a month after the Keira Bell judgment. He had long believed a case would be brought against the trust, though he thought the most likely scenario was that a former patient would sue for damages (Keira Bell instigated a judicial review). “It was inevitable,” he says. “I warned the trust of this.” But the Keira Bell judgment has done little to alleviate his concerns. Whatever the outcome of the appeal, he believes more questions must be asked, particularly about the rise in the number of girls presenting at the clinic (three-quarters of patients are now girls; the gender balance used to be closer to 50:50). “We do not know why this is happening.” He worries that too much emphasis is placed on gender and not enough on sexuality - “the children are often gay” - and he continues to be anxious about co-morbidities such as anorexia, autism and history of trauma in its patients. “Some of the children are depressed. It’s said that it’s their gender that is the cause of this, but how do we know? And why don’t we try to treat that first?”



'Consent is the issue here, nothing else,' says Bell. Photograph: Antonio Olmos/The Observer

Bell is not against puberty blockers per se - "a doctor should never say never" - but he believes that halting puberty only makes it more frightening to the child: "The child will never want to come off the hormones and 98% do now stay on them. This could be a dangerous collusion on the part of the doctor. The body is not a video machine. You can't just press a pause button. You have to ask what it really means to stop puberty." It should be

possible, he believes, to manage the distress of a child who is suffering gender dysphoria in a less interventionist way, until he or she is an adult and can make a decision: “Consent is the issue here, nothing else.” He does not doubt that some patients will want, and need, to transition in the future. But, he says, not all children with gender dysphoria are trans. The two have been elided. More work needs to be done locally. “Gender dysphoria clinics should be part of child and adolescent mental health services (CAMHS) and available nationwide,” he says. “At the moment, children who are suffering extreme distress in relation to their bodies are sent to the Tavistock and the problem then goes away at local level, where psychotherapy services are on their knees.”

There is anger on both sides of the debate. But given his politics - Bell describes himself to me as a “Corbyn-supporting Jew” - he has been most shocked by the reluctance of the left to engage with the issues. “They think this is to do with being liberal, rather than with concerns about the care of children. Mermaids and Stonewall [the charities for trans children and LGBTQ+ rights] have made people afraid even of listening to another view.” It surprises him that the left is unwilling to consider the role played by big pharma. In the US, a journal that published a paper about the effect of puberty blockers on suicide risk recently had to disclose that one of its co-authors received a stipend from the manufacturer of another drug.

When he appeared on *Channel 4 News* earlier this year, Bell was asked if he feared being on the wrong side of history. “I’ve often thought about that question,” he says. “It’s a good one. Psychiatry has a sad past. Homosexual men were given behavioural therapies and so on. But history isn’t always right. What matters is the truth. I hate the weaponisation of victimhood, the fact that the fear of being seen to be transphobic now overrides everything.” The current campaign to ban so-called gay conversion therapy is, he believes, likely to become a Trojan horse for trans activists who will use it to put pressure on any clinician who does not immediately affirm a young person’s statement about their identity, decrying this, too, as a form of “conversion”. For Bell, the prospect of not being able to talk openly about such things is a tyranny: just another form of repression. “This is about light and air,” he says. “It’s about free thinking, the kind that will result in better outcomes for all young people, whether transgender or not.”

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‘The transcripts detail a range of worries about the service. Homophobia in families attending GIDS is mentioned in all the transcripts Newsnight has seen.

As well as seeing young people struggling with their sexuality, staff say some parents appeared to prefer their children to be transgender and straight, rather than gay.
In one example, a GIDS clinician describes a young person who had come out as a lesbian and faced homophobic bullying, "within the family and quite openly in school".

"Suddenly the young person changed their mind and they started identifying as trans."
In some of these cases, clinicians thought that it wouldn't be appropriate for the patient to be referred for puberty blockers, with one child apparently saying: 'My mum wants the hormone more than I do.'"

**NHS child gender clinic: Staff welfare concerns ‘shut down’**
**BBC Newsnight**
**Jun 19, 2020**

# Does Tavistock GIDS fast-track 16+ referrals of adolescents with gender dysphoria?

Transgender Trend - August 4, 2019 - Health Professionals and Organisations - 2 Comments

*by Susan Matthews, academic and contributor to the book Transgender Children and Young People: Born in Your Own Body and the follow-up book Inventing Transgender Children and Young People, available to pre-order now. Susan Matthews writes on gender ideology and campaigns for better NHS treatment for young people with gender dysphoria.*

## Does Tavistock GIDS fast-track 16 + referrals of adolescents with gender dysphoria?

In November 2018 the Observer reported the claim that the Tavistock Gender Identity Development Service was 'fast-tracking young adults'. In response the Tavistock said:

> *'We do not limit or curtail assessments because of pressure to move swiftly to medical interventions. With complex cases, rather than truncating assessments, we will often extend the time given to trying understand what may be going on.'*

In a private email that has been shared with us, Paul Jenkins, CEO of the Tavistock, wrote to some concerned parents and explained that the Leeds branch of GIDS did offer a pathway for older adolescents but denied that this could be described as 'fast-tracking':

> *In Leeds referrals of older adolescents are carefully screened; some attend a one-off group session. Others who are not considered suitable– usually on the basis of the complexity of their presentation – are not offered this. This approach offers young people who have been on our waiting list a chance to think with us about their options from a balanced GIDS perspective: it is not fast-tracking. (Email 2/10/2018)*

This reply left us with more questions that it answered. What does 'carefully screened' mean in practice? Can a desire to be the other sex ever be straightforward? We got in touch with a clinician who had worked at the Leeds clinic. Their view is that: 'The service did not have agreed criteria for how to rate the complexity of a case (despite the intake form requiring clinicians to pick a severity rating).'

Writing from their own experience, this clinician described the process as a 'fast-track assessment' which 'encapsulates well what GIDS assessments often are: an extended

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information-giving process so that the NHS can say that the young person provided informed consent to physical intervention.'

A different clinician who also worked at Leeds GIDS, Dr Kirsty Entwistle, has written of her concerns at the lack of differential diagnosis:

> *'I think there are others, like me, who went to work at GIDS expecting to do complex assessments and differential diagnosis but the reality is that you run the risk of being called transphobic if you propose that, say, a child might have Body Dysmorphia rather than Gender Dysphoria.'*

We feel that the situation of older adolescents and young adults is particularly dangerous. This is the age group amongst which gender dysphoria has soared. The years from 17 to 25 are also an age group in which mental health problems can appear for the first time.

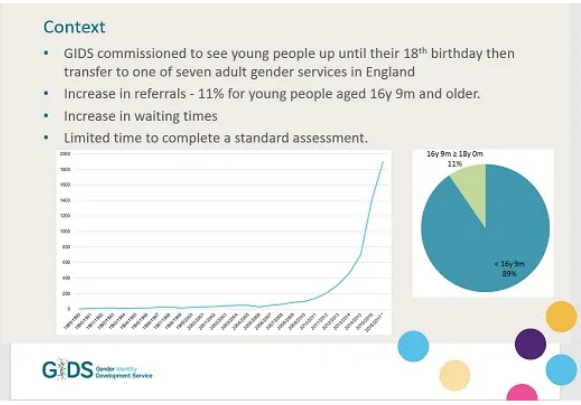
This post is an attempt to work out just what an adolescent on the 16 + pathway at Leeds GIDS might experience in terms of assessment. It draws on three sources:

1. a 2017 presentation to the Belgrade EPATH conference by two GIDS clinicians, Laura Charlton and Jo Charsley.
2. a video diary (four short Youtube videos) by a 17-year-old natal female who attended the Leeds adolescent pathway and was then referred on to the Nottingham GIC. These are no longer available on the web but have been archived.
3. comments from a clinician (not Dr Entwistle) who was previously employed at GIDS Leeds. All quotations that follow, unless specifically attributed to Dr Entwistle are authorised quotations from this clinician.

We are very grateful to the clinician who has shared their experience with us.

## The rationale for the pathway

According to the EPATH presentation, the pathway was designed to deal with the 11% of the referrals aged between 16 years 9 months and 18 for whom there was a 'limited time to complete a standard assessment' in the context of the sudden increase in referrals evident in the graph shown.



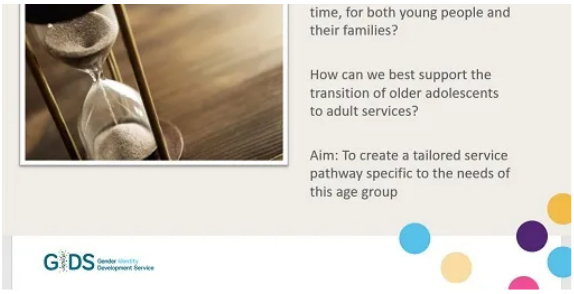

Time was clearly of the essence – as the next slide revealed.




Transgender Organisations and Activists
Uncategorised

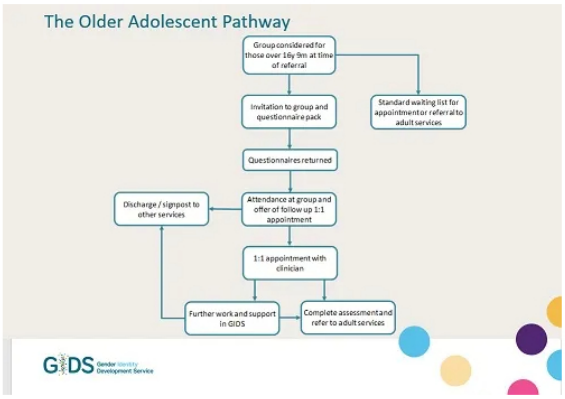
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The view of the Leeds clinician was that 'GIDS were trying to find a way to get older teenagers through the service quickly.' This was partly a funding issue, 'an artefact of an NHS England decision not to fund any sessions at GIDS beyond the age of 18, even by one day. The endocrine clinic at Leeds General Infirmary was also unhappy if older adolescents were referred for the blocker as it meant they would have to hold on to them until the adult service took over clinical responsibility.' The drivers for the new pathway were financial and organisational, it seems.

The pathway involved three elements: a questionnaire sent to the young person to complete at home, a group meeting for young people and their parents or carers, and a single one to one meeting with a clinician (though further meetings were available if requested). The clinician commented: 'In my experience as a clinician, important information often only started to emerge after a number of sessions. It takes time to build a relationship with someone so they feel able to share more difficult or complicated feelings, or to trust telling a professional about experiences of abuse. It would therefore not be contained in a GP referral and not captured by this fast-track assessment.'

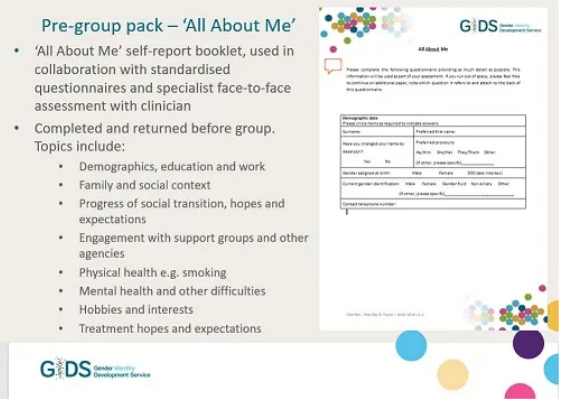



## The Questionnaire

According to the conference presentation, the questionnaire is 'An efficient way of gathering rich, client-centred, contemporaneous information as an adjunct to referral information' which also 'Saves face-to face clinician time'. It allows 'Co-construction of gender narrative using client's own words which they can complete in the comfort of their own homes and at their own pace'. We can get a glimpse of a young person's response to this questionnaire from the online video diary. The young person complains that the questions were 'quite triggering' because they used biological terms for the female body like 'breasts'. She believes that her body is not female ('I was like, really no it is not female'). The assessment process offers no resistance to this belief apart from the questionnaire.

The Leeds clinic, it seems, reinforces this belief which is common in youth online culture. In *Trans* (2018), Psychiatrist Az Hakeem argues that trans people are generally not delusional

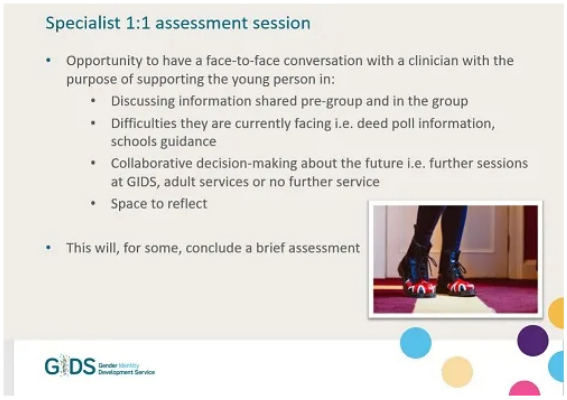
because they don't believe they are '*already* the preferred gender'. (183) 'They believe that they *should be*, or *would like* to be the preferred gender.' This young person manifests the stronger claim now common in online communities: that breasts and vagina do not define a body as female. The GIDS questionnaire challenges this belief but this challenge can be handled 'in the comfort of their own homes and at their own pace.'




## The Group meeting

The second element is the group meeting. The young person describes a presentation for about 15 seventeen-year olds and their parents and carers on 'gender identity, gender expression, sexual and romantic attraction' which outlines the NHS pathway for transition: 'To be honest the presentation was basically for the parents – it was stuff we all know'. This is an opportunity for the clinicians to demonstrate that they understand online trans culture. After a mini break, parents and carers go off into a room where 'they just sat round in a circle and told their stories, everyone went round, a couple of people were crying and all that.' The separate group session for the 'kids' was 'funny': the convenor talked 'about the 'stress bucket', what stresses us, how we deal with dysphoria. What upsets us.' 'It was a bit awkward, only about three people spoke'. At the break the young people were given appointments if they wanted them.

## The 1:1 assessment




There is just one '1:1 assessment session' and that's it. The young person reports being complimented on how well she passes. Then they talk through the answers on the questionnaire in more detail. But then 'Something just hit me, I felt myself welling up. I was gone, absolutely gone.' The teenager breaks down and cries but time is up (the sessions, apparently, run exactly to time). She has talked in some detail about self-harm and worries this might slow the process but the clinicians reassure her that she fits all the criteria and can now choose which adult clinic to be referred to. Another appointment is offered but the

young person does not want any more potentially embarrassing conversation and instead confirms by phone.

That this assessment session provides little scope for a differential diagnosis is not surprising given the comment from the clinician that: 'There are staff at GIDS who believe that even suggesting that a gender presentation may be an expression of other difficulties is tantamount to transphobia. Those staff believe that any difficulties are almost always the result of gender dysphoria and transphobia and that therefore the answer is to remove barriers to both social and physical transition.'

From the point of view of GIDS, the pathway is a success. Feedback from the young people reported in the EPATH presentation is positive. 'Having all my questions answered so I could make more important decisions', said one. 'Being able to meet more trans people' said another. The trans youtuber likes it because there is as little embarrassing contact with professionals as possible.

It's interesting to compare what this self-harming 17-year-old might have encountered had they accessed dialectical behaviour therapy (DBT) on the NHS at the Maudsley in London. In June 2019, Dr Troy Tranah described the experience of using DBT with a 'small group of young people […] who identify as transgender' (ACAMH Jack Tizard lecture 14th June 2019). The group were 'not referred in relation to transgender but generally due to a combination of self-harm, aggression, trauma and CSE'. Nevertheless, 'several were on the waiting list for Gender Identity Development Service.' The difference in provision is striking: DBT practitioners work with around six patients whereas GIDS clinicians may have up to 120 patients at any one time (and according to the Bell report have reported difficulty in remembering individual cases).

Before a young person is accepted onto the Maudsley DBT course they must undertake up to six individual pre DBT sessions to 'orientate them to DBT, assess and strengthen motivation, clarify goals of treatment and for the young person to decide whether they wish to commit to engaging in DBT.' They will then be asked to sign a contract before entering a year of therapy which requires weekly individual therapy sessions plus for the first six months, a compulsory skills training group. Telephone skills support and crisis management are available if needed. Their parents and carers are offered, in parallel, a six-month skills training course so that they can support their young people together with their own telephone support.

## On to Adult Services

Given the sketchy nature of the GIDS brief assessment, we might assume that the real work takes place at the adult service. But this is not necessarily the case – indeed all the information we have suggests that once within adult services there is little in the way of careful psycho-social assessment. A young natal female who transferred from GIDS to the London GIC claimed at the GIDS 'Science of Gender' conference on Thursday 18th October 2018 that 'Assessment at adult services felt perfunctory, like a box ticking exercise.' She had experienced sexual abuse as a child and told how her belief that she was male came on suddenly after the abuse: 'like a switch flicked'. She had struggled with self harm and dissociation. Nevertheless, the adult GIC required no further exploration before putting her on to testosterone and offering a mastectomy.

We know that the various NHS clinics work to different protocols and we also know that if a

young person decides to use the private gender clinic GenderCare they can access hormones after a one hour assessment with a single clinician followed by a one hour endocrinology assessment some months after starting on cross sex hormones.

In the case of our trans YouTuber on the 'Older Adolescent Pathway', the 'Mini assessment' was forwarded by Tavistock GIDS to the Nottingham gender clinic with 'a little bit of information but not too much'. The questions at the first adult appointment were 'really easy, easiest I've had it so far.' According to the teenager, they 'really only skimmed the surface… there's a lot deeper that I feel I go'. The adult service second appointment was a 'kind of just a mish mash of different things, there wasn't any huge big questions.' It seems as if it was mostly a discussion about effects of testosterone.

In this case it appears that self-harm and distress served to speed up the process and remove the need for any deep exploration. The young person's verdict: 'It was really easy, honestly'. Thinking about the Older Adolescent Pathway in general, the clinician comments: 'It isn't a psychosocial assessment, it is a tick-box exercise to ensure that the young person has correctly learnt from the Internet about how to self-diagnose as meeting the criteria for gender dysphoria.' In 2011, James Barrett, lead clinician at the Charing Cross GIC wrote this:

> *'The least certain diagnosis is that made by the patient, made as it is without any training or objectivity. This uncertainty is not lessened by the patient's frequently high degree of conviction. Neither does the support of others with gender dysphoria help, since conviction leads people to associate with the like-minded and to discount or fail to seek out disharmonious views.'*

In place of what could be seen as the hubris of the medical professional exemplified by Barrett in 2011 we now have professionals who have given up their ability to diagnose altogether: in the case of transgender identity the patient's word, aided by the internet, is enough. Our concern is that the 'Older Adolescent Pathway' fails to offer a chance to explore the complex psychosocial context in which gender dysphoria develops in this age group, effectively discouraging self-reflection and preventing differential diagnosis. The result is a complete failure in normal duty of care for those vulnerable young people who self-diagnose as transgender.

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September 19, 2017

## THIS POST HAS 2 COMMENTS



**Sarah Read**

5 AUG 2019 REPLY

I find these assessments so scarily superficial. I work with vulnerable children and their families within an attachment-focused model (DDP and Theraplay). I have a colleague who reported to me that a youngster – a 13 year-old, I think – had self-assessed gender issues and was being treated by family and professionals as if she/he were the opposite gender. Even so, the young person was becoming increasingly unwell having gained a massive amount of weight due to retreating to bed and refusing to go to school. All this was being seen as due to gender dysphoria, but my colleague was beginning to wonder, surely there must be more to it as the young person was clearly increasingly unwell. i feel like a voice crying in the wilderness with all this!



**Gender Critical Dad**

7 AUG 2019 REPLY

My kid was young-adult when she got caught up in trans. My gut instinct – not to let her near GIDS. All I could see was a ratchet towards trans, a fish trap I called it as I tried to explain to people who thought I'd gone off the rails. I was right.

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0770 702 6595
info@transgendertrend.com

The Tavistock and Portman NHS
NHS Foundation Trust

# Freedom of Information Act 2000 disclosure log entry

## Reference

18-19333

## Date sent

25/03/2019

## Subject

Gender Dysphoria Referrals 2012-2018

## Details of enquiry

For each of the years between 2012 and 2018, could you please provide me with the number of

1. Patients with gender dysphoria under 16 who have been referred to specialist services, excluding hormone blockers (e.g. counselling, psychotherapy, reviews to monitor gender identity development) with or without parental consent
2. The number of patients with gender dysphoria under 16 who have been referred to specialist services, excluding hormone blockers (e.g. counselling, psychotherapy, reviews to monitor gender identity development) WITHOUT parental consent
3. The number of patients with gender dysphoria under 16 who have been given hormone therapy (hormone blockers) with or without parental consent
4. The number of patients with gender dysphoria under 16 who have been given hormone therapy (hormone blockers) with or without parental consent
5. The number of patients with gender dysphoria under 16 who have been given hormone therapy (hormone blockers) WITHOUT parental consent

Also, can you please tell me under what circumstances treatment for a patient under 16 can be given without parental consent?

## Response Sent

For each of the years between 2012 and 2018, could you please provide me with the number of

1. Patients with gender dysphoria under 16 who have been referred to specialist services, excluding hormone blockers (e.g. counselling, psychotherapy, reviews to monitor gender identity development) with or without parental consent

Please see below a table showing accepted referrals to the service for each year from 2012 to 2018 for ages under 16. These figures do not include young people who have been referred, but are not accepted, as they are not appropriate for the service, i.e., fall outside the age range of the service, do not have an issue around gender.

| Year | Accepted referrals to GIDS service |
|---|---|
| 2012 | 182 |
| 2013 | 251 |

| | |
|---|---|
| **2014** | 323 |
| **2015** | 761 |
| **2016** | 1,272 |
| **2017** | 1,570 |
| **2018** | 1,451 |

These figures are the number of young people referred to the service. Not all of these young people will fulfil the criteria for a diagnosis of gender dysphoria. All referrals to the GIDS complete a comprehensive assessment in the first instance, this includes assessment of gender dysphoria and general psychosocial wellbeing.

2. The number of patients with gender dysphoria under 16 who have been referred to specialist services, excluding hormone blockers (e.g. counselling, psychotherapy, reviews to monitor gender identity development) WITHOUT parental consent

We have this data on a case by case basis but not in a collectable form. Referral to the service without parental consent would be highly unusual. We encourage referrers to work with young people to involve parents and most often this is achieved.

3. The number of patients with gender dysphoria under 16 who have been given hormone therapy (hormone blockers) with or without parental consent

We have collated data for young people under 15 years olds referred to the endocrine clinic and who have provided consent for hormone blocking treatment as part of that referral. We assume that these young people have gone on to receive hormone blocking treatment. We do not have collated data for young people referred for blockers aged between 15 and 16 years old.

Our data suggests that in total we have had 267 young people accessing hormone blocking treatment under the age of 15 through the Early Intervention treatment pathway between 2012-2018. Please see below for a breakdown of this number per calendar year:

| Calendar Year | Number accessing Hormone blocking Treatment |
|---|---|
| 1st Jan 2012 – 31st Dec 2012 | n=9 |
| 1st Jan 2013 – 31st Dec 2013 | n=10 |
| 1st Jan 2014 – 31st Dec 2014 | n=27 |
| 1st Jan 2015 – 31st Dec 2015 | n=51 |
| 1st Jan 2016 – 31st Dec 2016 | n=51 |
| 1st Jan 2017 – 31st Dec 2017 | n=66 |
| 1st Jan 2018 – 31st Dec 2018 | n=53 |

4. The number of patients with gender dysphoria under 16 who have been given hormone therapy (hormone blockers) with or without parental consent

   This is a repeated question

5. The number of patients with gender dysphoria under 16 who have been given hormone therapy (hormone blockers) WITHOUT parental consent

   None of the young people under the age of 15 years old have needed to access blockers without parental consent.

Also, can you please tell me under what circumstances treatment for a patient under 16 can be given without parental consent?
In theory if a child is looked after by the local authority and they are the corporate parent they could be referred for blockers without consent of the biological parents. Again we would always try to work with parents to address their concerns and most often it is possible to get parental agreement.

The Tavistock and Portman NHS
NHS Foundation Trust

# Freedom of Information Act 2000 disclosure log entry

## Reference
19-20426

## Date sent
16/06/20

## Subject
GIDS Referrals to Endocrinology Clinics 2019
& Consent for Hormone Blockers

## Details of enquiry
How many young people under 15 years' old have been referred to the endocrine clinic and have provided consent for hormone blocking treatment as part of that referral, in the calendar year from 1 January to 31 December 2019?

Please ensure that this figure is comparable to the information provided in the request numbered FOI 18-19333, which covered the calendar years from 2012 to 2018.

## Response Sent
The number of young people who we referred to the endocrinology clinics at UCLH (University College London Hospitals NHS Foundation Trust) and LGI (Leeds General Infirmary, Leeds Teaching Hospitals NHS Trust ) for consideration of treatment (which may or may not result in hormone blocking treatment being prescribed) in 2019 under the age of 15 was 48.

The data was captured on 2nd April and is subject to change.

# EMPLOYMENT TRIBUNALS

**Claimant:** Ms. S. Appleby
**Respondents:** Tavistock and Portman NHS Foundation Trust

**London Central Remote Hearing (CVP)** **14-18, 21-24 June 2021**
**in chambers 25 June 2021**

**Employment Judge Goodman**
**Ms. H.C. Mclellan**
**Mr. R. Miller**

**Representation:**
**Claimant:** Ms. Anya Palmer, counsel
**Respondent:** Ms. Yvette Genn, counsel

# RESERVED JUDGMENT

1. The respondent subjected the claimant to detriment on grounds of protected disclosures.

**2.** The respondent is ordered to pay the claimant £20,000 as compensation for injury to feelings**.**

# REASONS

1. This is a claim of detriment for whistleblowing. The claimant, still employed, is one of three members of the Trust's central Safeguarding team, which oversees safeguarding across number of divisions within the Trust. The respondent admits she made protected disclosures (that is, blew the whistle) on matters of public interest. This tribunal must decide whether she has suffered detriment because she had blown the whistle.

2. The context of the claim is work of one of those divisions, the Gender Identity Development Service (GIDS). Their work is controversial. This tribunal is not required to make findings on the rights and wrongs of that treatment, only on the rights and wrongs of how the claimant has been

treated.

**The Issues for the Tribunal**

3. By the end of the first day the parties had been able to agree a list of issues. The full list is appended to this judgment.

4. The claimant made six disclosures. They concerned the reporting of safeguarding issues within GIDS. The respondent agrees that they are protected under the legislation. The real dispute in this case is whether the respondent was subjected to detriment on grounds of these disclosures. Twelve detriments are listed, but they can be arranged in two groups. Those in first group are about an interview with Dr Sinha, the claimant's line manager, in July 2019; in the other group, are what was being said about the claimant to GIDS staff in 2018-9.

5. The respondent also argues that some of the claims for detriment are brought out of time.

**Conduct of the Hearing**

6. The remote hearing was open to the public, and members of the press and public attended from time to time. The pleadings, witness statements, and documents bundles (redacted to exclude medical information) were available on a website hosted by the respondent's solicitors, who sent a link for access to participants who requested one. Communication was adequate, although on day five the claimant lost her internet connection for the first hour or so and gave part of her evidence by a telephone link, and counsel for the respondent had a poor quality connection for much of the hearing. These difficulties slowed down the taking of evidence, but despite that, and losing a hearing day due to listing error, we were able to complete in time and then reserve judgment.

7. We received written submissions, and each side was also able to make a short oral submission. Counsel prepared these under some time pressure and we are grateful to them for doing so, enabling the panel to deliberate without going part-heard.

**Anonymity**

8. Much of the first morning of hearing was taken up hearing applications by the claimant, first to know the identity of individuals who had made statements to Dr Sinha for his report under a promise of anonymity, and secondly to see the unredacted texts, the redactions being considerable. After hearing from each side, the tribunal directed that the respondent should identify the makers of statements where they were due to give evidence to the tribunal in any event, but (after delay to read in and assess context) not otherwise, as they had spoken on a promise of anonymity, and, given the number of witnesses already being called on detriment,

identifying the speakers was not proportionate. On redaction, counsel were directed to review the unredacted material together, counsel for the claimant having undertaken to preserve confidentiality. When this was done, a further five pages were added to the bundle as being necessary to understand the context.

9. On day five there was a further application from the claimant for more documents, resulting in some additions to the bundle (especially on when Mr Richardson assumed his safeguarding lead duties) but no further removal of anonymity.

10. On the first morning the respondent asked, without detailed argument, for an order anonymising all names from the documents bundle except for those giving evidence, advancing the Convention right to privacy of all non-witnesses in it, as some staff had received "abuse, some of it quite scary" when there was earlier publicity of GIDS activity. No order was made. The tribunal in preparing written reasons would exercise the usual restraint in identifying individuals who had not given evidence, so far as compatible with public understanding of the judicial process and reasoning, but it was too late to start the lengthy process of encoding individual identity in such a large hearing bundle. No reason was given why the application was only made on the first morning when the level of public interest was predictable and both sides knew there must be public access to statements and documents. It would delay the start of a nine day hearing with a tight timetable. The same considerations would have applied had this been an in person hearing, or had public access for the remote hearing been to a hard copy bundle under the supervision of a clerk at the Employment Tribunal's premises.

**Evidence**

11. In order to decide the issues the tribunal heard live evidence from:

**Anastasis Spiliadis**, Systemic and Family Psychotherapist, employed in GIDS 2015-19
**David Bell**, adult psychiatrist, formerly staff governor of the Trust.
**Sonia Appleby**, the claimant
**Anna Churcher Clarke,** psychologist, formerly employed in GIDS
**Polly Carmichael**, psychologist, Director of GIDS from 2009
**Dinesh Sinha**, psychiatrist, and the Trust's Medical Director from August 2018
**Garry Richardson,** senior social worker in GIDS
**Craig de Sousa**, the Trust's Director of Human Resources and Corporate Governance

12. The following were called to confirm their witness statements, but were not questioned by the respondent:

**Kirsty Entwhistle**, clinical psychologist employed in GIDS 2017-18

**Matt Bristow**, clinical psychologist employed in GIDS 2014-18
**Anna Hutchinson**, clinical psychologist employed in GIDS 2013-19.

13. There was a main documents bundle of 1,500 pages, and another 240 pages in a supplementary bundle. Up to 200 others were added in the course of the hearing. We read those to which we were directed.

**Findings of Fact**

14. The respondent is a small NHS Trust, employing around 800 people. It specialises in talking therapies for mental health. It has grown from a tradition of psychoanalytic and psychotherapeutic work at the Tavistock clinic, which has always included child and adolescent mental health.

15. GIDS is a service within the Trust. It was established in 1989 to support young people experiencing difficulty with gender identity development, and commissioned as a specialised service within the NHS from 2009. From 2016 it became a national service, the only NHS service of its kind for children under 18. There are clinics in London and Leeds, and outreach centres in three other cities.

16. Gender dysphoria is a complex condition, where is there is distress caused by incongruence between a person's perceived gender identity and the gender assigned at birth or their biological sex. GIDS aims to assess young people referred to them by doctors and mental health services. Assessment is conducted by two people from a multi- disciplinary team of around 100 clinicians, and a care plan is then made.

17. Decisions about assessment are rarely straightforward. For example, some patients referred are autistic, and some come from backgrounds of neglect or abuse. Clinicians from a psychoanalytic background may want to consider whether gender dysphoria is a symptom of some other problem which merits treatment. Some clinicians are concerned that young people who might be homosexual presented as misgendered, or are unduly influenced by social media campaigning on trans identity. Others hold that in general young people should be taken at their word on identity, and allowed to make their own choices. Until recently there was no model to follow, and decisions were left to clinical judgment and discussion on a case by case basis. This complexity is an important part of the background to the claimant's disclosures.

18. Treatment may be by discussion but, controversially, distressed young people may also be referred to other hospitals for treatment with puberty blocking drugs, for the stated purpose of giving them more time to reflect on their gender identity. A young person may then decide to proceed to cross-sex hormone treatment to start a transition from their natal gender. In October 2019 judicial review proceedings on whether young people could validly consent to hormone treatment were begun by a former GIDS patient, Keira Bell. The resulting judgment of the Divisional Court of

December 2020 was that they could not. The judgment sets out some of the treatment issues that are the background to this claim. It has been appealed, and the decision of the Court of Appeal is awaited. The pending litigation will have added to existing tensions in the service at the time when the claimant was making the protected disclosures.

19. Becoming a national service led to a vast increase in referrals to GIDS. From 2009 it went up 50% each year, then increased by 100% in 2016/17, by which time there were 1,408 referrals. By 2019/20 it was 2,728. Individual caseloads have risen, putting staff under considerable pressure. There has been greater turnover, especially among junior staff. The rise in referrals has also put patients under pressure: in 2018 the waiting time for a first appointment had risen to 14 months (the NHS standard being 18 weeks), and currently it is 3 years.

20. There was a change, over the period, in the balance of the sexes being referred. Initially natal males predominated. By 2011 it had moved closer to 50:50. By 2019, 76% of referrals were of natal females. This has raised added questions on diagnosis, for example, whether social pressure on young women is playing a part in their thinking about gender identity, or whether the change reflects increasing recognition of the condition, and past underdiagnosis.

21. In the background was an increased politicisation of the issue, amplified by both social and traditional media, as trans people asserted their rights, feminists responded defending women-only spaces, and gays expressed concern that sexual orientation was being mistaken for gender identity. External pressure from campaigners (including a group called Mermaids) and some parents made difficult clinical decisions more difficult, and in consequence there were staff who sometimes found detachment difficult. Accusations of transphobia and homophobia were made.

The Claimant's Role

22. The claimant, Sonia Appleby, is a social worker and psychoanalytical psychotherapist. She has long social work experience. From 1987 to 2009 she was also a children's guardian (guardian ad litem). From 2009-2013 she was concurrently service manager in the CAMHS (Child and Adult Mental Health Service) of another Trust, and she has been a CAMHS team leader within the respondent Trust. She has been employed by the Trust from 2004 onwards on 20 sessions ( 3 days) a week) as senior social worker and as named Safeguarding Lead for Children.

23. The named Safeguarding Lead for children is a statutory post. Safeguarding children means protecting children at risk from maltreatment, and preventing impairment of children's health or development. Naming a lead means there is someone in an institution whose job it is to see that information on children at risk is shared between local authorities, schools, and health providers. Within the NHS:

"The Designated Professionals Safeguarding Children role in the Clinical Commissioning Groups (CCGs) is as professional advisors and strategic leaders for safeguarding. Their role is to advise on strategic planning, commissioning and hold health organisations in their area to account for the quality of the safeguarding services, ensuring that they are meeting the safeguarding responsibilities. They also provide advice for monitoring contracts and commissioned services. They can lead on innovation and change across health to improve safeguarding and provide expert advice on quality productivity, improving health outcomes for vulnerable children including those identified with safeguarding concerns".

24. Within the respondent Trust, the claimant is the named lead for Children, and Dr Caroline McKenna is the named lead for Adults. Both report to the Trust's Medical Director, although until Dr McKenna's appointment in mid-2018, the Medical Director was also the Adult lead.

25. The claimant is responsible for ensuring safeguarding of children in all the Trust's divisions, including GIDS. She prepares an annual safeguarding report for the Board. Her duties included supporting and advising the Trust board on child protection, both strategically and on day-to-day management, working with other designated professionals in the geographical area, ensuring there are appropriate child protection policies and procedures, and that staff understand and implement them, being actively involved in the delivery of training to Trust staff and other groups, advising on effective systems and audits, monitoring agreed local child protection policies and procedures, assisting with collecting data, and monitoring the quality, acceptability and effectiveness of service provision and training. She has to advise board members to ensure that performance indicators on child protection are set. She has also to provide child protection supervision of staff, and support their safeguarding skills.

Events leading up to the Protetced Disclosures

26. In June 2016, the claimant stated in her report to the Trust Board that the increasing pressure of rising referral numbers had an impact that was distressing and even traumatic. She noted deficiencies in reporting on cases, in particular on Safeguarding, in Care Notes, the patient records software used by the Trust.

27. During 2016 and 2017 there was a particular and growing concern among some GIDS staff about a private GP, Dr Webberley, who was, on her own initiative, issuing private prescriptions for puberty blocking drugs to young people being assessed by GIDS, or who were on the waiting list for assessment. Staff were uncertain how to deal with this. Concerned that taking hormones before assessment could pose a risk to children, some approached the claimant, as the Safeguarding lead. She raised with the issue with the then medical director, Dr Rob Senior, who in turn convened a meeting in June 2107 between her and Dr Polly Carmichael, Director of GIDS. The claimant said that in her view staff needed to have some kind

of manual, or standard operating procedure, on how to approach assessment difficulties. It was agreed that an individual within GIDS should be nominated to monitor Safeguarding, and provide a link to the claimant in the central Safeguarding team. Dr Carmichael identified Garry Richardson, a GIDS social worker, for this. She then emailed the claimant saying that Safeguarding issues in GIDS were "not straightforward and would require careful thought", leaving it to the claimant and Mr Richardson to agree with each other what to do.

28. The follow-up is interesting. The same day, the claimant emailed Garry Richardson thanking him for agreeing to be the lead and inviting him to the safeguarding SSF on 26 June. She added that she, Dr Carmichael and Dr Senior would discuss how to take forward his role. Mr Richardson was not available on the date in question and suggested another meeting, but at the same time he forwarded this exchange to his boss, Dr Carmichael, who in tun asked the claimant what discussion she meant - she was "unsure of the agenda here". Dr Senior, the claimant's line manager, replied on the claimant's behalf, saying: "I don't think there is an agenda here. I think the question is what he can realistically expected to do?" He suggested he might be able to do some of the consultation and safeguarding supervision, or with his help, they could make safeguarding practice: "an everyday integral part of the team rather than a bureaucratic burden". Like Dr Senior, the tribunal panel understood Dr Carmichael to have used "agenda" in the sense of an ulterior purpose; Dr Carmichael told us she just wanted to know the agenda for the proposed meeting, but when viewed in the light of other events, we are unconvinced.

29. There was another meeting of some kind, and besides Mr Richardson, a psychiatrist, Dr Rebecca McLaren, and another psychologist, Mattei Dudu, entered the discussion with suggestions on improving GIDS' understanding of Safeguarding. In practice however Mr Richardson was already very busy with his existing job, and little or nothing changed until March 2018.

**First Protected Disclosure**

30. In October 2017 the claimant was again approached by some concerned GIDS staff. She reported this to Dr Senior, her line manager, on 30 October 2017 in the following terms:

> "a number of GIDS staff have brought some concerns to my attention of late.
>
> Predictably, there are challenges regarding Mermaids, rogue medics and the political expectations of the national service.
>
> Perhaps more worrying are the manifestations of a number of splits within the team (not unusual) but I have been reported is quite potent:
>
> (a) team members feel they are coerced into not reporting safeguarding issues,

and to do so is "trans phobic";
(b) lack of confidence in Children's Social Care
(c) an unhelpful development regarding the linking of the politics of sexuality and gender issues.

I think I was most concerned that some team members reported the tensions around political conformity within and beyond the Trust, the lack of a team position regarding the clinical management of gender issues and what to do when there are safeguarding concerns whatever the genesis".

She was trying to arrange a meeting with him, and would also talk with some workers who had invited her to a meeting they had convened to discuss it. She referred to the need to follow up on the June meetings they had had with Dr Carmichael.

**Second Protected Disclosure**

31. After meeting the workers, she emailed Dr Senior again on 13 November 2017, saying that they were all reporting the same concerns, and she listed them:

"(i) Dr W is still prescribing despite being apparently suspended by the GMC
(ii) the culture within the service has created a dynamic, which makes it hard for staff to raise safeguarding concerns and this is compounded by staff being referred to as being trans phobic
(iii) the model of service delivery is not properly take into account that some children are referred within the context of significant familial adversity
(iv) a worry that some young children are being actively encouraged to be transgender without effective scrutiny of their circumstances
(v) some staff have raised concerns the service, which now has a referral rate of nearly 2000 referrals annually is bound to be seeing some children, who falsely protect presenting as being transgender as a less oppressive option than acknowledging they are gay. There is apparently no acceptable mechanism for discussing these phenomena within the team
(vi) the challenge of working within a sector where other agencies are oppositional
(vii) the team meetings are fraught events and there are specific allegations that Polly is unwilling to listen to these concerns (as above) and demonstrates this by being on her phone and leaving meetings before the end
(viii) there are worries that the current challenge at GOSH regarding the "intersex" complaint, will have implications for GIDS because Polly is allegedly heavily implicated in this historical issue."

32. She went on: "I discussed some of these matters with you several weeks ago. You advised you would advise Sally. I am writing to you today because a fourth staff member has approach me. Please advise".

33. Regrettably, Dr Senior did not advise, or reply at all. The claimant thought he was going to talk to Sally Hodges, Dr Carmichael's manager, about it.

34. Soon after this the claimant had to cease work through ill health, and did not return until mid- January 2018. On her return to work she chased it up, forwarding both messages to Dr Senior on 19 January 2018, saying

"FYI – please advise".

**The Third and Fourth Protected Disclosures**

35. A few days later, on 23 January 2018, Frank Lowe, the Trust's Head of Social Work, emailed the claimant and Dr Senior, copying Garry Richardson, about a recent meeting of GIDS social workers he had attended, discussing Safeguarding in the context of increased referrals, and the need to "increase space for and dialogue about safeguarding issues to improve awareness and responsiveness in this highly specialised service". They would be contacting her for advice and support.

36. The claimant replied all, that she was already aware of "explicit concerns", which she had twice escalated the previous year, and had chased on 19 January. This was meant for Dr Senior of course, but Garry Richardson did not know that, and wondering if it meant people in GIDS, he forwarded this to Polly Carmichael and two executive members asking who the claimant was awaiting a response from. He also sent it to Dr Senior, who still did not reply. In the email traffic Dr Carmichael, thinking it was being suggested *she* had not responded, complained to Garry Richardson that she had not heard from the claimant about this since their meetings the previous June, and: "it is somewhat unhelpful that she is writing emails suggesting she has not had a response especially as there is implied criticism of the team".

37. The claimant says she did not consider she could approach Dr Carmichael, GIDS head of service, without first clearing it with her own line manager, Dr Senior. She had thought he was speaking to Sally Hodges, and only learned from this flurry of emails that he had not.

38. The upshot was that Sally Hodges asked the claimant and Polly Carmichael to meet to discuss it. The claimant fixed a meeting on 5 February 2018. There the claimant read out her earlier disclosures to Dr Senior, and they discussed them. The claimant explained she had understood from Dr Senior he would be discussing them with Sally Hodges; it was awkward that he had not. The discussion at this meeting is the third protected disclosure.

39. On 8 February 2018 the claimant emailed Dr Carmichael her record of their meeting and the action they proposed. This is the fourth protected disclosure. She recorded the detail of earlier disclosures and meetings, that they had agreed that staff might be "acting out some of the predictable tractions within the service", and that "the challenge was responding to the meaning of these communications". She noted some staff did not feel "safe", and that Dr Carmichael regretted not having been aware of staff concerns earlier. The claimant apologised for that. In conclusion they had agreed that the claimant would talk to Garry Richardson on strengthening Safeguarding leadership in GIDS, Dr

Carmichael would discuss it with Sally Hodges and her executive team, and the claimant would in future alert her direct about any concerns. She asked Dr Carmichael to correct any errors in her record of their discussion (the claimant makes a similar invitation in all her records of meetings).

40. Dr Carmichael did not reply.

**"Jimmy Savile"**

41. The claimant followed on by arranging a meeting with Garry Richardson. She wanted to establish a relationship, knowing as she now did that Dr Carmichael resented her staff having reported concerns behind her back. At the beginning of March 2018 they discussed how to get Safeguarding more embedded in GIDS. The claimant explained her view of the need for a manual, supplemented by professional judgement, the need for staff to feel supported and safe, and the scenario of affirmative parents, children's capacity, and whether a child was likely to be at risk of significant harm. They planned a further meeting in the summer. From this point on, Garry Richardson took an active role as safeguarding lead in GIDS.

42. Gary Richardson told the tribunal he was shocked and confused by something Ms Appleby said at this meeting. She remarked that if they were not careful a Jimmy Savile type situation could arise, adding, when he looked upset, that she did not mean there was child abuse, but rather, an institution turning a blind eye to what was in front of them. He did not discuss this remark with her further, then or later, but he was upset that she seemed to think his professional colleagues in GIDS were aware children were not safe and wilfully ignoring it.

43. The claimant's explanation is that when delivering training to staff about Safeguarding, she routinely included a reference to Jimmy Savile, (who had been found in the Lampard report to have abused children over many years under the noses of NHS staff, some of whom knew about it, or ought to have noted warning signs, but brushed them off), having been involved with 44 NHS organisations, to illustrate how vigilant staff should be about Safeguarding. It was her shorthand reminder. She did not mean staff were consciously complicit, only that they did not see the risk having been dazzled by celebrity. We have the evidence of this reference in context in the comprehensive notes made by Kirsty Entwistle of a training session the claimant delivered in Leeds later that month.

**Further Concerns about Safeguarding**

44. Early in 2018 ten concerned GIDS staff had also approached Dr David Bell, the staff representative on the Trust's Board of Governors, and in April 2018 he and the claimant exchanged information about the concerns

raised with each.

45. On 15 May 2018, the claimant was approached by another worried GIDS staff member. The claimant reported their concerns to Dr Senior, listing patients' limited understanding, the premature use of blockers, failure to address the fact that some children lived in homophobic environments, that some staff felt themselves unsafe in the group and were afraid to report these issues within the Trust, high caseloads, staff with anxiety symptoms, and concerns that the GIDS manager had no helpful model for the complexities of the work, nor understood the culture of discontent among the staff group. In terms of action, she advocated a whole service intervention, so that those who complained got a formal response. She discussed this with Dr Senior on 18 May, reporting back to Garry Richardson. Her view was that there should be a document pulling together the concerns and institutional responses. Over the next few weeks she took more steps to act on what had been reported.

46. She met Garry Richardson about it on 21 May. Summarising discussion in an email later that day, she expressed surprise that he had not been briefed about the concerns staff had raised in the autumn. He responded that he had *not* been briefed, and had never seen anything in writing on what they were.

47. Next, on 24 May the claimant reported to Sally Hodges that a GIDS worker she had not seen before had approached her with concerns about children being given medication when they were unable to give informed consent, and when caseloads were very high. She reported the worker's concern about children not having access to local mental health services, being exposed to abuse, that some may be gay, and that the challenges were not being thought about consistently.

48. Sally Hodges said the Trust management group had discussed it, and hoped to develop a clear action plan, and she asked the claimant for more detail. Next day therefore the claimant did a quick audit of Safeguarding referrals from the various divisions within the Trust, using records from the patient records system, and sent it to Sally Hodges. She compared numbers of referrals accepted by five Trust services (I.e. GIDS and 4 others), and the numbers referred to mental health services and local authorities. GIDS had vastly more referrals to it than any other service, and had the lowest rate of referrals to other services. She considered some reasons for disparity, including that possibly GIDS referrals out were underreported by the software, compared to anecdotal evidence, and might simply not being recorded. (The tribunal adds that later it became clear that she was right about this, and one reason was that the Safeguarding form for the system had never been sent to GIDS, who were using their own form).

49. The claimant had another meeting with Sally Hodges, who fed back what was being done to reconfigure job descriptions and strengthen leadership,

and reiterated that decisions were made on a case-by-case basis. The claimant responded on 18 June that the service needed a documented model of criteria for decision-making, especially as some children could not be Gillick competent, and caseloads were too high; she cushioned this message in elaborate and respectful language. She ended by restating her intention to help, even though she had been cast in the role of someone asking the awkward questions. She was also conducting a further audit of case discussions and safeguarding supervisions as shown on case files in 2017/18. This showed that in the entire service in 2017 there had been one record of safeguarding supervision, and only 11 recorded case discussions. This showed urgent action was needed to ensure decision-making events were captured on the records. After further work on the figures confirmed a very low level of recording and supervision, she arranged to meet Garry Richardson to discuss this.

50. All this was now in the context of an impending CQC inspection. Polly Carmichael then cancelled the meeting with Garry Richardson about safeguarding reporting. She said she was on leave and wanted to be involved, at which the claimant protested that it was arranged to discuss gaps in reporting, and had been supported by Sally Hodges. The meeting did then go ahead; examining the Safeguarding risk assessment form, the clinical risk form, crisis planning and the Safeguarding supervision form, and concluded that the claimant and Garry Richardson should continue to meet to discuss informatics.

51. The relationship between the claimant and Dr Carmichael and Garry Richardson was strained, as shown by the claimant having to explain in detail to Dr Carmichael, who had challenged her about it, why she had spoken directly to a Cambridgeshire Designated Nurse about Safeguarding in a GIDS case.

**The Bell Report. Fourth Protected Disclosure**

52. Meanwhile, the claimant and Rob Senior met Dr Bell, the staff governor, to discuss his concerns. David Bell was to write a report for the governors, and Rob Senior would have another meeting with Sally Hodges about Safeguarding. He also agreed (according to Andrew Hodge, investigating later) the claimant could assist Dr Bell on Safeguarding issues. David Bell told Polly Carmichael and Sally Hodges, the GIDS managers, that he would be writing a full report, and arranged to meet them. Unknown to the managers, he also arranged to interview a number of GIDS staff. He asked the claimant for figures about referrals, which she provided. This provision of information is the fourth protected disclosure.

53. The claimant saw a draft of the Bell report on 11 August, and knowing he intended to submit it at the governors meeting in September, she marked it up for him with her editing suggestions, principally that it needed to be shorter. She also asked him to take out the opening passage which said:

"This report is signed by David Bell but Sonia Appleby has been closely involved throughout preparation and has read and discuss with me this final version to which she has made a number of very important contributions". She learned however, after sending these on 18 August, that he had already submitted his report.

54. The claimant is concerned that his statement exaggerated her input, and led colleagues to suppose that she adopted his views. The tenor of her evidence was that although she agreed that Safeguarding was not being properly handled in GIDS, she was not in agreement with the tone of his report, which came across as an attack on the management of the service.

55. The report, entitled "Serious Concerns Regarding The Gender Identity Service", sets out in detail the concerns reported, and concludes that the whole approach to assessment needed to be rethought, as " the service as it now functions and children's needs are being met in a woeful (sic) inadequate manner and some will live on with the damaging consequences". The service had adopted "an excessively affirmative attitude associated with an inability to stand up to the pressure of a highly publicised external world". There were "serious ethical concerns" and "inadequacy of consent", and systemic homophobia, meaning homophobia was not being identified in children and families, and led to gay and lesbian staff being subject to persecution.

56. Dr Carmichael was certainly troubled by its "divisive tone". In her view the Bell report was "not constructive or balanced". More than that, she felt deceived that Dr Bell had interviewed her staff "in the guise of taking an interest", and then written a hatchet job.

**The Sinha Enquiry. Fifth Protected Disclosure**

57. In March 2018 Dr Rob Senior had announced he was retiring, and he left in September 2018. His replacement as Medical Director was Dr Dinesh Sinha. He was new to the Trust. As a newcomer he was commissioned to conduct a review of GIDS. Terms of reference were agreed on 25 September and he got to work at the beginning of October. In all he interviewed 31 staff members, with the aid of set questions.

58. The claimant and Dr Sinha did not have a comfortable working relationship. He told the tribunal that he been warned by Dr Senior on handover that the claimant was resistant to management and liked to work autonomously. He added that his initial interaction with the claimant confirmed this view, although he was unable to give us any examples of what she had said or done that led him to this conclusion. He described her as argumentative, and he objected to her habit of summarising discussion and action points by email after meetings, as frequently it "did not accurately reflect my own recollection". His statement of how he formed his assessment of her character so soon after he had started in

post is puzzling, because on the annual appraisal form completed by the claimant a year later, in August 2019, she stated she had not have any one to one meeting or supervision to discuss her work with Dr Sinha from August 2018 (when he started) to January 2019, when she went sick, only returning in May 2019.

59. An example of the difficult relationship is that in mid-October 2018 the claimant asked Garry Richardson for some data on Safeguarding in GIDS As to the purpose of the request for data, the claimant says this was about her quarterly report to the board; the tribunal notes that a quarterly report on Safeguarding reports is mentioned in the CQC inspection report. Garry Richardson forwarded this to Sally Hodges, who then asked the claimant for "some context for this request", saying they were very busy with the CQC audit, copying in Dr Carmichael, Garry Richardson and Dr Sinha. Their inclusion indicates to us this was about more than workload – there was concern within GIDS following the Bell report that she was gathering more adverse material for an attack. The claimant replied that it was only follow-up on the earlier discussion about recording on Case Notes (the records software), and that she would ask the administrator to get the figures. Dr Sinha then immediately wrote to the claimant asking for background about why they needed to submit this information about GIDS, and who had requested it. This shows that he too was suspicious. Sally Hodges asked the claimant, copying interested others, to keep the agenda for her meeting with Garry Richardson "within operational aspects of safeguarding and governance", and said that their meeting must be minuted by a third party. Requiring independent minutes does show suspicion. The claimant replied to Sally Hodges, copying everyone else, which included Dr Sinha, explaining the meeting was about how staff were putting information onto Case Notes. Just 50 minutes later Dr Senior emailed the claimant, copying Sally Hodges: "I note that you have not responded to my message. Please cancel the planned meeting with GIDS until we have met and discussed the current context of service". He explained to the tribunal that he regarded it as insubordination that she had not replied direct to his enquiry on why she wanted the information, and that this was an example of her autonomous working, which he wanted to rein back. We were surprised: he had a detailed answer in the message to Sally Hodges, copied to him. The charitable view is that he had not actually read the message to Sally Hodges. If he had read it, then he comes across as petulant. Moreover, if he did think she had an attitude problem, it might have been better to discuss it face-to-face rather than issue an order about not meeting a Safeguarding colleague about getting accurate statistics. These exchanges show how in the wake of the Bell report the claimant was being regarded with suspicion by both GIDS and Dr Sinha.

60. The claimant was interviewed by Dr Sinha, as part of his GIDS review, on 25 October 2018. She prepared a six page written statement of her views, with eight appendices. One of the appendices is a recent exit interview with Matt Bristow, and providing this exit interview to Dr Sinha is the fifth

protected disclosure. The text is extensive, but incudes that there was homophobia in GIDS, that staff worked in a "climate of fear", and referral outside the service (such as a Safeguarding report) was the last resort. When she handed the statement to Dr Sinha at the start of the meeting, he handed it unread to the note taker, and proceeded with his set questions. The claimant found this discouraging. It is interesting that Dr Sinha says that he learnt for the first time in this meeting that the claimant had raised concerns about GIDS with his predecessor a year earlier. He also says he was not aware that the Bell report had been leaked until early 2019, but he did ask questions about her involvement in it, and she told him that she had neither co-authored nor approved the report, as Dr Bell had seemed to suggest.

61. Dr Carmichael saw the exit interview independently of the claimant's disclosure to Dr Sinha. She said on 8 October: "I do not recognise some of the things attributed … and as with David Bell's report feel strongly that whatever I may have said it is not what is reported".

62. After the interview Dr Sinha emailed tersely instructing her not to interrogate *any* service for additional data or information without discussing it with him first, nor to take any part in the ongoing board review of the GIDS service, and to have no contact with David Bell except with respect his clinical practice.

63. In February 2019 the Bell report was leaked to the press, increasing public pressure in the service, and it seems it was the first draft, identifying the claimant as co-author. At the time many people speculated that the leak came from Dr Bell or the claimant, though current Trust thinking is that it was in fact leaked by another governor. The media publicity only increased ill feeling.

64. In the spring of 2019 Dr Sinha presented his review report to the board. It was published in March 2019 with an action plan. This included having a Safeguarding lead within each division, as GIDS already did in Garry Richardson.

**The first group of detriments**

65. The first five detriments listed for this claim revolve around Dr Sinha's handling, in July 2019, of a remark or remarks made to him about the claimant in the course of his confidential interviews for his enquiry. A number of matters had come to light in the course of his interviews which were not directly relevant to his review of GIDS, but which he wanted to follow up as matters of individual conduct. He discussed with HR what action was appropriate in these cases. At least one of his concerns resulted in disciplinary action of another staff member.

66. In the claimant's case, he learned from two of his interviews that she had "allegedly made comments indicating a comparison between GIDS and "a

Jimmy Savile type situation" , indicating that she was not objective in her view of GIDS work.

67. The first of these two interviews was on 8 October 2018, with an unknown member of senior staff. Discussing the safeguarding process within GIDS, he or she said:

> "the issues of the ethics of this work and the young people doing what they are doing, some coming to the service, grooming, parents pushing the young person down to this path is detrimental to their welfare. Sonia said there will be another Jimmy Savile. With the Jimmy Savile case it was clear that there was blatant harm being done and there was a massive cover-up by the senior people, which is not the case in GIDS. It was upsetting to hear that from Sonia as we take our work very seriously and we do the best we can to ensure that the young person is safe".

Discussion then moved to another topic, and there is no context for the remark. Dr Sinha did not ask the claimant about it when he interviewed her later that month.

68. The second such interview was with Garry Richardson, on 10 December 2018. He complained to Dr Sinha that at times the Safeguarding advice from the claimant was: "less of a collaborative process or collaborative conversation and much more directive". He went on that the claimant had seemed to endorse the contents of Dr Bell's report, and he worried that if she took a particular position about their work, her advice might not be balanced. During the conversation about Safeguarding and GIDS:

> "and in the context that people simply were coming forward and raising their concerns, she made a comment about we need to be careful that the Jimmy Savile type situation does not happen here… then added that she did not mean child abuse but something in terms of your service being a cash cow for the Tavi and the Tavi turning a blind eye to something that is not right. So I think that is what she meant".

He said that later he had interpreted this as the Tavistock trying to close down Safeguarding concerns :

> "because we bring in a lot of money for the Trust, but you know the team works exceptionally hard and have something like that, you know to have our own work referenced in that way, I personally found that quite disrespectful and really difficult to take from the safeguarding lead".

He next volunteered the episode about the Cambridgeshire enquiry which the claimant had handled directly, and from which she had felt excluded:

> "It is just situations like that which make me feel a bit uncomfortable, make me wonder what Sonia's motives are, especially given her involvement (in) David Bell's report; it almost felt like there was some sort of information gathering process happening alongside the concerns about the child".

69. Dr Sinha discussed this complaint about the Jimmy Savile remark with a member of the HR staff, SM, at the beginning of April, once his review and action plan was complete. He says: “she (SM) advised that the concerns are too general to be the subject of further investigation but that there was sufficient information/concern to warrant me having a conversation with Ms Appleby to explore it”.

70. At this point the claimant was away from work. After a period of ill health in the late autumn, on 25 January 2019 she had had to take leave for unplanned major surgery at short notice. Her return to work was delayed by wound infections. It is worth mentioning that the way this was handled reflects Dr Sinha’s unsympathetic, almost hostile, relationship with the claimant. She had notified HR and supplied them with fit notes. He took objection to her not informing him directly (the policy on this had recently changed) and insisted on an explanation of the cause. The tribunal could understand that when things are difficult at work and an employee goes sick for some time a manager may want to find out whether work-related stress is the reason for absence, but this was much more than that. Even when he was satisfied on that score, he seems to have viewed her approach to reporting sick leave as insubordination.

71. At the beginning of May 2019 the claimant returned to full duties, phased in, as recommended in an occupational health report.

72. On 16 July 2019 the claimant was asked to attend “an informal meeting to discuss recent events regarding the GIDS”, with Dr Sinha, with a member of HR staff in attendance. The message was recalled, but then the claimant was asked to attend on 22 July anyway. She speculated it had to do with her recent request for voluntary redundancy - in fact the scheme was no longer open). When the claimant arrived, and found an HR staff member attending what was said to be an informal discussion, she was concerned, and asked what it was about. Dr Sinha told her it was about an alleged comment on GIDS, reported during the review, “about something like a Jimmy Savile type situation”. Dr Sinha did not explain more; he felt he could not give her context, because the remarks had been made in confidence. The claimant explained that she did make reference to Jimmy Savile in Safeguarding training, as an “attention grabber”. She could not recall in what circumstances she might have said anything else about it to GIDS staff. He then told her she would be receiving a letter about it, which would be kept on her file.

73. The claimant was very upset. Later that day she emailed saying she understood that if a letter was going on her file there should be an investigative process. Other than when delivering training she would only have said it to those who approached her direct; without context she could not say more. She also emailed an account of the meeting to her union representative, emphasising that it was scheduled as an informal meeting, with no notice of the topic, or mention of bringing a companion, but the outcome ( a letter being kept on her file) was as if it was the conclusion of

a disciplinary process.

74. Two days later Dr Sinha sent the claimant the promised letter. He recited the brief allegation and her response, and that he had told her the member of staff concerned felt "very disrespected"; her role was to facilitate good practice in Safeguarding in a supportive way. "I further suggested that you should ensure you are mindful of any further statements made in the future in relation to this matter or any other that may cause offence to other colleagues". It had not been a formal proceeding because he was not giving her context for the alleged comment. He concluded:

> "finally, I confirmed that although this matter will not be taken further, this meeting would be documented and remain on your file. I may need to investigate the matter formally, if there are further reports of this type of incident".

**The Claimant's Grievance**

75. Soon after this July 2019 episode the claimant, through solicitors, lodged a grievance about it, and then presented this claim to the tribunal.

76. The Trust's HR department asked an independent investigator, Andrew Hodge, to interview staff and report back. He did so in February 2020. As an outsider and non-specialist, he noted that Trust clinicians were divided between those who considered the Bell report an overreaction to the inherent complexity of GIDS work, and those concerned about the increase in natal females identifying as male, that gender identity may be a proxy for same-sex orientation, and that there is no thorough exploration of the issues. He concluded that most saw the claimant as a concerned professional, not someone out to make trouble.

**The Second Group of Detriments**

77. In January 2019 the claimant was contacted by Matt Bristow (who had left a few months before), and told that, within GIDS, staff were being told not to take concerns to her direct. It was second-hand, and a few days later she stopped work for urgent surgery, so she did not pay it much attention at the time.

78. The claimant later learned from past and present colleagues about matters which - by amendment of proceedings on 20 February and 19 March 2020 - form the second group of detriments, which could collectively be characterised as disparagement of her as Safeguarding lead. Specifically, it is alleged that Dr Carmichael put in place an unwritten but mandated directive that Safeguarding concerns in GIDS should not be brought to the claimant's attention, that reporting of Safeguarding to her was discouraged, that Garry Richardson tended not to refer Safeguarding concerns to her and discouraged others from doing this, that the Trust and Dr Carmichael excluded and denigrated the claimant by remarking that she had a negative stance about GIDS and was "not on side" , so underlining and marginalising her, that she was viewed negatively by Trust

management and some GIDS staff by reason of perceived involvement or collaboration with Dr Bell, or had conspired with Dr Bell to damage GIDS, or mobilise complainants. It is alleged to be a continuing state of affairs that she was regarded as adverse to GIDS.

79. Nothing was ever put in writing to GIDS staff about reporting or not Safeguarding concern. In fact they were not even told in writing that Garry Richardson was the Safeguarding lead within GIDS, so the lack of writing does not mean of itself that this was not said.

80. Reviewing the evidence we heard on this, we note that Anna Hutchinson had said to Dr Senior in the course of the GIDS review in October 2018, that there was no explicit instruction, but active discouragement of raising Safeguarding issues, and gave as example that in discussion a manager had said to her that prescription of puberty blockers by the private GP (Dr W) to a child was not something which should be referred to social services. In the course of the interview she also said "what is interesting is, since the review was started… they are bringing Safeguarding in-house now, which means that they are stopping taking cases to Sonia Appleby because they think she is "bad", part of the review, and they're trying to get the social worker to deal with it in-house". In evidence she recalled an episode where Dr Carmichael said of a case where she had consulted the claimant, "oh you're not taking it to Sonia are you?", her tone suggesting this was the wrong thing to do.

81. Anastasis Spiliadis told Dr Sinha at the review interview in January 2019 that until Garry Richardson was appointed a safeguarding lead (which he dated to September 2018): "there was a very clear message actually from senior management about being being really cautious about how we talked to the Safeguarding team at the Tavi and specifically Sonia Appleby", and that Dr Carmichael thought the claimant "had a very clear agenda about GIDS, and she thinks we are not on top of the safeguarding concerns in GIDS and, especially in the last how many months until the announcement of the review, there was a message actually towards the clinicians, at least to people who were talking to Polly directly about having to really cautious about how we talk to Sonia about safeguarding issues". He had in fact spoken to the claimant about a case without going to Dr Carmichael first, because he feared that she would think he was "deep into this agenda that Sonia might have the GIDS". In his evidence to the tribunal he reported attending a large team meeting of both London and Leeds teams (in December 2018) when Dr Carmichael said on Safeguarding issues: "that Sonia clearly had an agenda, and that she was making all our lives difficult". At the same meeting Dr Carmichael had mentioned that the claimant said clinicians needed smaller caseloads, as they were overstretched. He did not understand what he meant by her "having an agenda". He also recalled an episode where the claimant had enquired about a case of his with domestic violence and emotional abuse in the background, and Dr Carmichael had told him: "you should not just take cases to Sonia… You should discuss things internally and avoid talking to

Sonia …I don't know what her issues with GIDS are". Despite that he had called the claimant (whom he had never met) as Safeguarding and found her helpful, this led to social care workers being involved.

82. Dr Carmichael later told Andrew Hodge, when he was investigating the claimant's grievance, that the claimant "seems to be on a fishing expedition" to show that Safeguarding was defective, but was providing no real support. Safeguarding was meant was go to Garry Richardson in the first instance.

83. There is some support for this understanding in emails from Anna Churcher Clarke about a Safeguarding case: she had approached Sonia Appleby for advice, and copied Garry Richardson into her emails, explaining that he had been away on the day in question. That she needed to explain why she had gone to the claimant is significant.

84. Pulling this together, we understand that having Garry Richardson to assist the claimant in strengthening Safeguarding came out of the claimant's discussions with Polly Carmichael on Safeguarding back in June 2017, (though nothing was done to implement that until March 2018), and that an instruction to GIDS staff to take Safeguarding issues to Garry Richardson in the first instance could well have been intended to make sure that this system worked. This message could well have been understood by some as meaning not to take cases to the claimant at all. Whether Dr Carmichael's message to staff was being understood or misunderstood by them is hard to say, because nothing was ever put in writing, and both in emails, and in answers to questions in the tribunal, Dr Carmichael was often both verbose and imprecise. Undoubtedly her message could have been extended and amplified in third party discussion. The tribunal has considered the evidence of witnesses such as Mr Spiliadis and Ms Churcher Clarke carefully, in particular, whether it has been contaminated, noting that a number of staff had met up after the meeting, or after they had left employment, to discuss what they had heard. We concluded nevertheless that there *was* a message being communicated to GIDS staff by Dr Carmichael , at the time of the Sinha review, that they should not take Safeguarding issues to the claimant, not because she was not a clinician familiar with the complexities (as had been suggested to some staff when they took concerns to the speak up champion) but because she was hostile to GIDS.. What had been said in the December 2018 team meeting went beyond a mere statement of Safeguarding protocol. It was clear from Dr Carmichael's discussion after the event with Andrew Hodge that she *did* doubt the claimant's good faith and neutrality in what GIDS were doing (attributing it to her psychoanalytic background). This reinforces the earlier indicators of suspicion of the claimant (for example, that she had an agenda when she communicated staff concerns brought to her) and lends credence to the perception of those working in the team that they were being told that the claimant was to be regarded as hostile to their work.

85. It was plain that Garry Richardson himself resented the claimant, as far back as September 2017. That may only have been an understandable resentment that he was being expected to do more work without additional resource when he was already overstretched; possibly too because Dr Carmichael had volunteered him without discussion. But he did not give the claimant the benefit of the doubt as a fellow professional who was the Safeguarding lead. He reported to his own managers whenever the claimant sought to involve him, which indicates that he understood that they saw her as a hostile outsider, and probably held this view himself. He heard her Jimmy Savile remark as an attack on his colleagues complicit in abuse, not as a discussion between Safeguarding personnel about the need to be vigilant on behalf of vulnerable children.

86. It is less clear how this impacted on the claimant herself, whose communication with others is notable as always scrupulously correct, and who stepping carefully, no doubt aware of the difficult politics and boundaries of expertise. It is said Safeguarding referrals to her from GIDS fell dramatically. It is hard to say whether this is what happened. There were already very few Safeguarding referrals from GIDS - that was her concern. It is agreed that many GIDS staff with concerns would go to Dr Senior, a familiar figure, while the claimant, whose daily work did not involve her in GIDS, was more remote. It is a matter of impression, and there are no figures. Garry Richardson, however, told Andrew Hodge he was more likely to go to Caroline McKenna for support and to discuss Safeguarding than to the claimant. This is surprising, as she is the adult Safeguarding lead. Whether the claimant's work was impaired by this, but her reputation was damaged by what was said to people who themselves had little day to day contact with her.

87. One result of these proceedings is that since they began. the claimant and Garry Richardson have had little contact on Safeguarding at all.

**Relevant Law**

88. By law, in whistleblowing, what is protected is:

"any disclosure of information which, in the reasonable belief of the worker making the disclosure, is made in the public interest and tends to show one or more of the following—

(d) that the health or safety of any individual has been, is being or is likely to be endangered - (section 43B Employment Rights Act), and qualifies for protection if made to the employer (among others) - section 43C.

89. By section 47B(1)A:

" a worker has the right not to be subjected to any detriment by any act, or any deliberate failure to act, by his employer done on the ground that the worker has made a protected disclosure.

90. This includes acts done

"by another worker of W's employer in the course of that other worker's employment" - section 47B (1A).

91. Detriment means being put at a disadvantage. The test of whether someone has been disadvantaged is set out in **Shamoon v Chief Constable of RUC (2003) UKHL 11:** it is whether a reasonable worker would or might take the view that the treatment accorded to them had in all the circumstances been to their detriment. **Jesudason v Alder Hey Children's NHS Foundation Trust (2020) IRLR 37** shows that whether it is detriment depends on the worker's reasonable perception, not on the employer's intention or motive- though of course the employer's state of mind that may be relevant to the grounds on which detriment occurred**.** In **Garry v London Borough of Ealing (2001) IRLR 681** the claimant was unaware of the detriment (an investigation) at the time, but had nevertheless been disadvantaged by what was going on.

92. The test of whether any detriment was "on the ground that" she had made protected disclosures is whether they were materially influenced by disclosures, rather than that disclosures were the sole or principal reason for the treatment – **NHS Manchester v Fecitt (2012) ICR 372**. Tribunals must look for the reasons why an employer acted as he did.

93. A reason is a set of facts and beliefs known to the respondent - **Abernethy v Mott, Hay and Anderson 1974 ICR 323 CA**, and **Kuzel v Roche Products Ltd (2008) IRLR 530, CA.**

94. In assessing reasons, tribunals must be careful to avoid "but for" causation: see for example the discussion in **Chief Constable of Manchester v Bailey (2017) EWCA Civ 425 (**a victimisation claim). However, it is not necessary to show that the employer acted through conscious motivation – just that a protected disclosure was the reason for the dismissal (or grounds for detriment)– **Nagarajan v London Regional Transport (1999) ITLR 574**. These cases concern the Equality Act, but the same considerations apply to analysing why the employer acted as it did in the context of a protected disclosure.

95. There may of course be more than one reason why something occurred, and there have been cases where a tribunal finds that although the disclosure was the occasion of detriment, it is not the disclosure itself, but some feature of the way it was made that is the reason for the unfavourable treatment. An employer may be able to say that the fact that the employee disclosed particular information played no part in a decision to subject the employee to the detriment, for example, but the offensive or abusive way in which the employee conveyed the information was considered to be unacceptable. Similarly, it is also possible, depending on the circumstances, for a distinction to be drawn between the disclosure of the information and the steps taken by the employee in relation to the information disclosed. Tribunals must however take care not to diminish statutory protection for whistleblowers by accepting arguments about there being a different reason. For example, in **Aziz v Trinity Street Taxis, (1988) ICR 134,** making covert recordings was held to be the reason for expulsion, not that they were intended for use in tribunal proceedings**,** and in **Bolton School v Evans (2017) IRLR 140** an IT technician was dismissed for hacking into the school IT system to prove a point he had been making (the protected disclosures) that the

system was insecure, and it was held he was dismissed for hacking, not for his disclosures insisting it was insecure. In **Martin v Devonshires (2011) ICR 352** (a victimisation case) the person making extravagant allegations was ill, and it was held her difficult behaviour was the reason for dismissal, not making the allegations themselves. In **Panayiotou v Hampshire Police (2014) IRLR 500,** a police officer who had made a series of disclosures (which were heeded and investigated) was eventually dismissed because he persisted because the outcome of his complaints was not as he wished, and his complaints took up too much management time. While the employer's decision was upheld, in so doing the EAT drew attention to a passage in **Martin** as a warning:

"Of course such a line of argument is capable of abuse. Employees who bring complaints often do in ways that are, viewed objectively, unreasonable. It would certainly be contrary to the policy of the anti-victimisation provisions if employers were able to take steps against employees simply because in making a complaint they had, say, used intemperate language or made inaccurate statements. An employer who purposes to object to "ordinary" unreasonable behaviour of that kind should be treated as objecting to the complaint itself, and we would expect tribunals to be slow to recognise a distinction between the complaint and the way it is made save in clear cases. But the fact that the distinction may be illegitimately made in some cases does not mean that it is wrong in principle."

In **Beatt v Croydon Health Services NHSTrust (2017) EWCA Civ 401**, the Court of Appeal said:

" it is all too easy for an employer to allow its view of a whistleblower as a difficult colleague or an awkward personality (as whistleblowers sometimes are) to cloud its judgement about whether the disclosures in question do in fact have a reasonable basis or are made (under the old law) in good faith or (under the new law) in the public interest."

**Discussion and Conclusion**

96. Was the meeting between the claimant and Dr Sinha in July 2019, and the letter he sent her afterwards, a detriment? The Trust argues it was not disciplinary action, but a discussion about being more respectful to colleagues, which a line manager is entitled to have. Dr Sinha said he was following HR advice, and he wanted HR there because the claimant's record of what was said at the meeting would not be accurate. At this stage we leave aside his intention, and assess whether the claimant was reasonable in her apprehension that this was in practice a disciplinary warning, even though not labelled as such.

97. In our finding, any employee who goes into a meeting and finds a member of HR staff there, is right to apprehend that this is part of a process, whether on capability or on her conduct. The outcome, a letter being placed on file indefinitely, to be used if there was any recurrence of "this type of incident", is clearly in the nature of a warning that it will be taken into account at some later date if there is a similar event. The obvious unfairness of this is that the claimant was given no context as to when or

to whom she may have said it, which might have prompted her memory and enabled her to explain, nor any notice, which might have helped her to recall it. Further, there was no investigation. Had there been, Dr Sinha would have learned that this was indeed part of her standard training presentation, as we can see from Kirsty Entwistle's notes. In some ways the outcome was worse than a disciplinary warning. A warning would have remained on her file only for a set period. She would also have had a chance to appeal. The injustice was obvious and the claimant's upset entirely understandable. She was nearing the end of a long and blameless career, and as far as we can see had always tried to act responsibly over the Safeguarding concerns of GIDS staff.

98. We now assess the reasons why Dr Sinha acted as he did. He says he was following HR advice, and that this was to the effect that the reported remark was too vague to merit investigation but might be worth a conversation. Dr Sinha may have been justified in thinking that the claimant and Garry Richardson had fences to mend and bridges to build in their working relationship, but as far as we could see this was no way to achieve it. She did not know that Garry Richardson found her directive and not collaborative, or that he thought she was condemning hard-working GIDS staff, so she was unable to take steps to improve relations. Nor did Dr Sinha do anything to mend relationships. He was judgemental and punitive; he believed Garry Richardson and not her. It is possible that was because their own relationship had been difficult right from the start because of his perception of her. He attributes this to handover from Dr Senior and his own experience. We do not know what Dr Senior made of the claimant, but as far as we know, they had worked well together; he had come to her defence in October 2017 when suspected of an agenda. The handover may not have been very detailed, given that Dr Sinha was unaware of the claimant's disclosures to Dr Senior. As noted, Dr Sinha seems to have had almost no contact with the claimant than by email, and there were no 1:1 meetings other than when she returned to work in May 2019. There was an interesting comment in his interview with Andrew Hodge that some people in this small Trust were very self-important. We were driven to the conclusion that the only explanation for his stern, arm's-length approach to the claimant, his direct report, was that he thought she was raising concern about Safeguarding in particular, and the GIDS model in general, in bad faith. He therefore banned her from continuing the work getting accurate records for statistics on Safeguarding because he suspected she was digging for dirt to attack the service, when, as far as we can see, her actions were dedicated to finding out why the level of referrals from GIDS was so low, which might have been thought a legitimate activity on the part of the Safeguarding lead for children. The claimant's disclosures to Dr Carmichael in February 2018, and her contributions to Dr Bell's report, led to her being positioned as hostile to the service model, and having an ulterior motive. We found it hard to credit that the only reason Dr Sinha treated her in this way was because he thought she was resistant to line management and needed to be brought into line. By July 2019 extensive press coverage of the matters she had

raised, given the leaking Dr Bell's report, had contributed to a febrile 'them and us' mentality.

99. The respondent has argued that a number of features of the claimant's disclosures and the way she made them that explain why she was treated as she was, which do not concern the content of the protected disclosures. These include that she was not really concerned about Safeguarding, or about service delivery, that she was associated with Dr Bell, and that she was perceived as more accusatory in approach, leading Dr Sinha to raise the Jimmy Savile remark with her. In our finding, she was associated with Dr Bell, but that was because she had already raised in her disclosures the issues that GIDS staff later took to Dr Bell. The fact that she questioned not just record-keeping, but the lack of rigour in the service model for making judgements about whether there was background abuse requiring consideration of Safeguarding, meant that she was seen as hostile to a service already under external pressure from politicised groups, and the internal pressure of sometimes acrimonious splits between clinicians. In our view these cannot be separated from the fact that the claimant had made disclosures about concerns on young people needing more consideration of whether there were Safeguarding issues, and staff being too overworked to deal with them properly. Stating that a manual or standard operating procedure or model was a suggestion to assist clear thinking about a child's case and whether a Safeguarding issue was shown by the particular circumstances. Dr Sinha's quasi-disciplinary treatment of her can only be explained as materially influenced by her disclosures, which were viewed by him (and others) as unwarranted interference, overstepping her proper role.

**The second group of detriments**

100. It is harder to grasp here the extent of disadvantage to the claimant. It had been agreed Garry Richardson would lead within GIDS. If staff were told to take difficult cases to him first, that was as planned and agreed. As discussed, the comments about the claimant having an agenda ring true. Those who did approach her comment on how clear and practical she was in her advice. Many staff in GIDS did not know her however, and it must have done her some harm in the way staff who did not know her thought about her. It damaged her professional reputation, and her ability to do her job, even if she did not find out until later. Andrew Hodge noted that the Jimmy Savile remark had become well known within GIDS. That must have come either from Garry Richardson, or the other senior person who spoke about it to Dr Sinha, so that she was seen by them as hostile. Garry Richardson did not want to work with her because he saw her as critical of GIDS work. This too will have prevented her from proper work on Safeguarding in GIDS, and continues to do so.

101. We concluded that Dr Carmichael was long suspicious that the claimant was undermining her and her work. In her view, the claimant should have gone to her first, in 2017, not Dr Senior or Sally Hodges,

when she heard about it in January and February 2018. She resented being, as she saw it, undermined, and this was amplified when Dr Bell made his report at the end of August 2018. She also put her in the hostile camp because of her psychoanalytic background. She held the claimant was against the service model, not just concerned that Safeguarding was weak. But she held these views principally because the claimant had raised concerns. We cannot sever her sense of being undermined from the claimant making the disclosures, which she did, in the first instance, and properly, to her line manager. We do not consider that the making of disclosures about GIDS work and Safeguarding can be severed from the way the claimant handled the information. She was subjected to the second group of detriments because she made them.

**Time**

102. The respondent argues that the addition of the second group of detriments was out of time, and that it came to the claimant's attention much earlier, perhaps as much as a year before the amendments in February or March 2020, proceedings having been started in July 2019. The directions to GIDS staff about the claimant were made in the autumn of 2018, and on the face of it time starts to run then. The test under the Employment Rights Act is whether it was not reasonably practicable for the claimant to present a claim within 3 months of the act complained, and if so, whether it was presented within a reasonable time thereafter. 'Practicable' means whether there was some factor, physical or mental, which prevented the claim being presented in time. We noted that by its nature, it was something which came to the claimant's attention late and indirectly, and she was not fully aware of what had been said until disclosure of documents, after starting proceedings, or speaking to witnesses. As of January 2019, she had only Matt Bristow's hearsay. She was then very ill until May 2019. There is no reason to believe she had any idea of what had been said at that time, or indeed at any time until disclosure of documents, after proceedings began. She may have sensed hostility, or may have felt there were reduced referrals, but as noted there were and are no figures and it is not clear they did fall. If fewer came to her, then from her point of view it was because Garry Richardson now fielded them first, and after she started proceedings, relations between them became more difficult. It is doubtful that any reasonable person would present a complaint based on impression and hearsay; in our view it was not practicable. It was reasonable not to press a claim for which she had no evidence other than. When the documents were disclosed, she amended in a reasonable time thereafter.

**Remedy**

103. The claimant has continued to work, and the remedy sought is compensation for injury to feelings. Awards were standardised in the guidelines of **Vento v Chief Constable for West Yorkshire (2002) EWCA**

**Civ 1871**, and have been updated from time to time for inflation. For claims begun between April 2019 and April 2020 the middle band range is £8,800 to £26,300.

104. We assessed the injury to feelings from July 2019 as significant. The claimant was reaching the end of her hitherto blameless professional career in a senior position. She was being blamed for offending unknown persons by unknown words. Her explanation that referring to Jimmy Savile was shorthand for being careful that harm was not overlooked and was something she routinely stated in training was rejected without investigation. The letter on her file contained an explicit threat that it would be taken into account later if there was a recurrence of an obscure event. She had no opportunity to clear her name or get another view, as would happen if there was an appeal, and it was to remain on her file indefinitely, and it still is on her file. The resulting sense of injustice is obvious. Anyone would lose sleep over this.

105. We assessed the injury from that date at £12,500.

106. As for learning in December 2019 that (in summary) staff were being discouraged from referring Safeguarding matters to her because she had "issues" with GIDS, that must have been hurtful, and must have made carrying on with her duties painful and difficult, especially when the Trust denied that had occurred, and was asserting that she bore the responsibility for any difficulty. As an added hurt, we assess it in the round at £7,500.

107. Taking the two together, the award is £20,000. That is a little above the mid-point of the middle band. Both senses of injury are likely to resolve on receipt of this judgment vindicating her position. Looked at in the round that seemed to us a fair figure.

Employment Judge Goodman
03/09/21

JUDGMENT and REASONS SENT to the PARTIES ON

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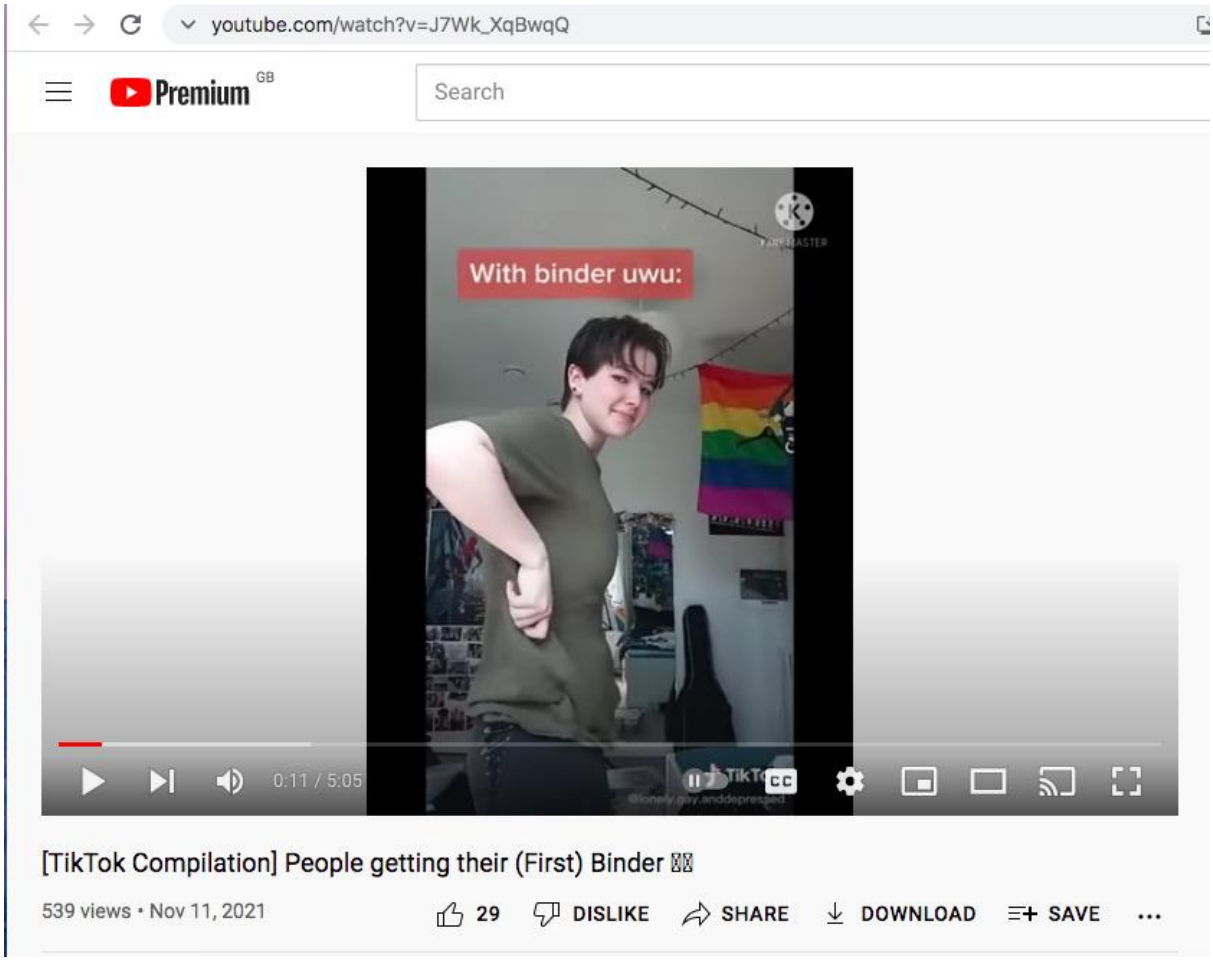
FOR THE TRIBUNAL OFFICE



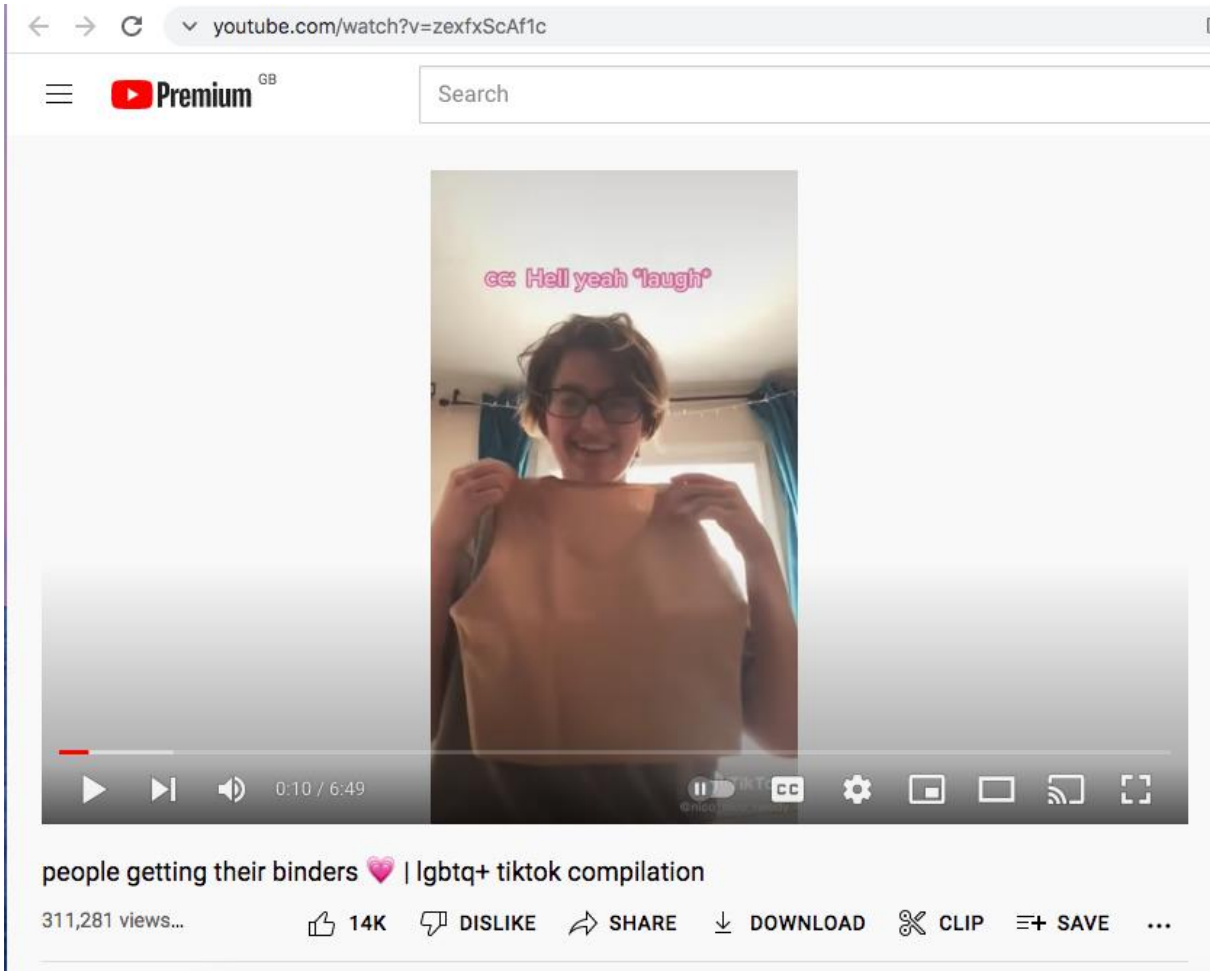
**Benjamin Cohen** @benjaminco... · 7h

Young trans and non-binary people find a media that is often hostile to their identity, so @PinkNews has partnered with @Snapchat to launch Pure Trans Joy. The first episode demystifies top surgery in an accessible style for audiences discovering their place in the world 🏳️‍⚧️🏳️‍⚧️🏳️‍⚧️

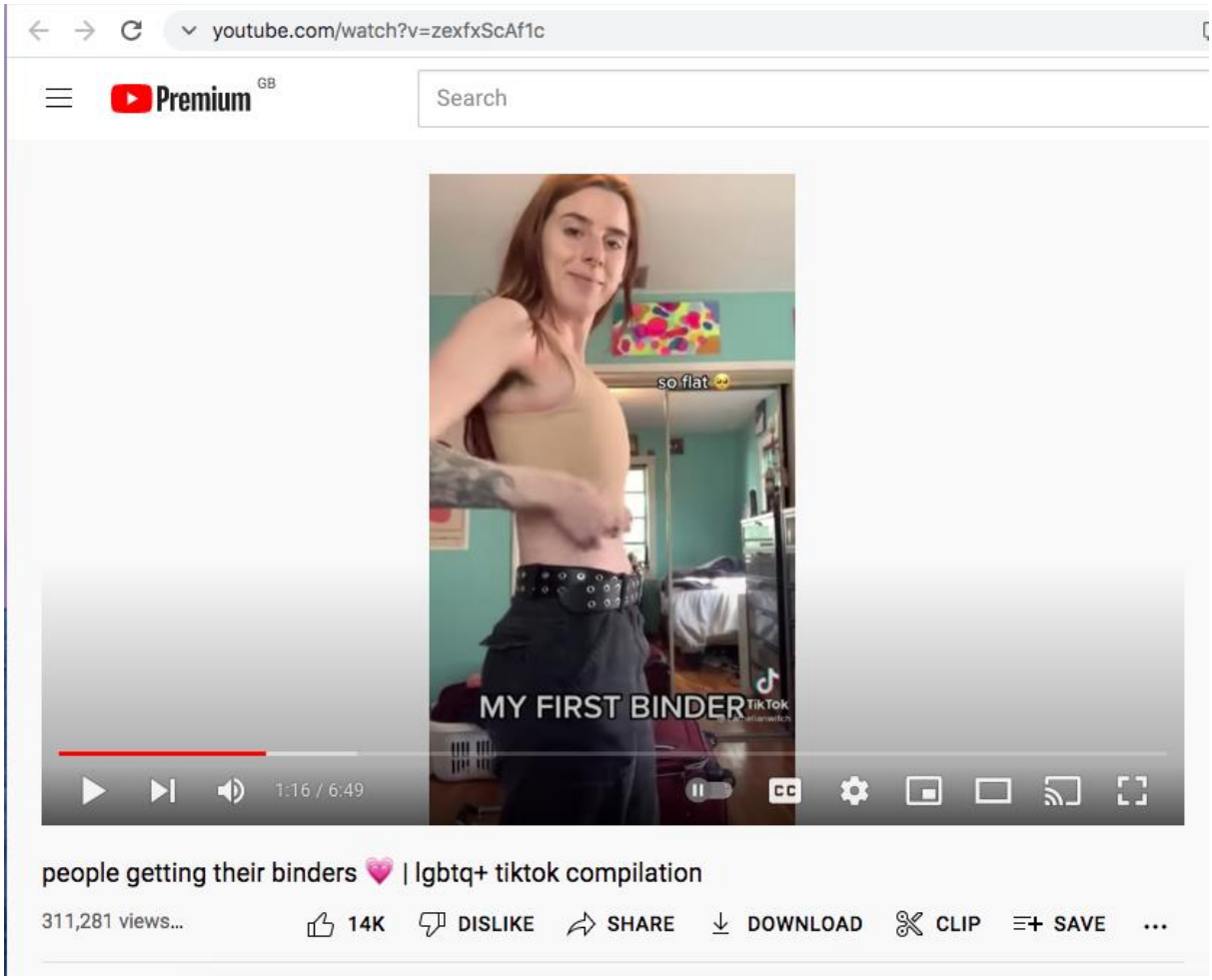





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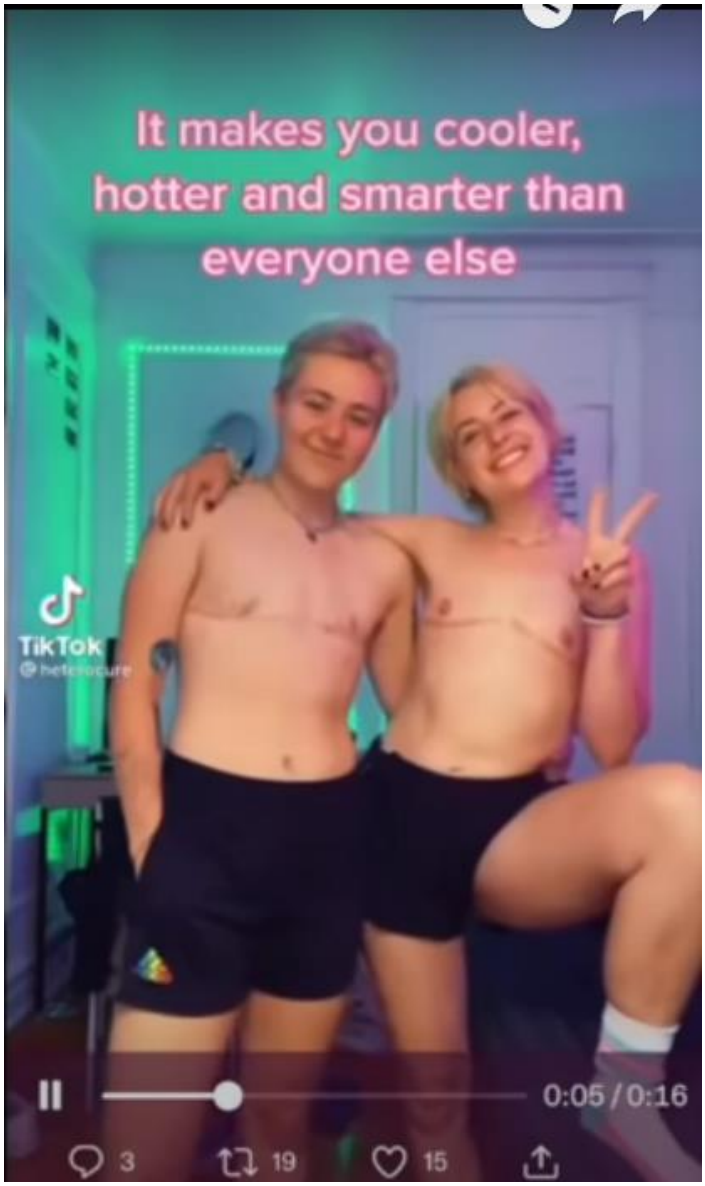



https://www.youtube.com/watch?v=zexfxScAf1c




https://www.youtube.com/watch?v=zexfxScAf1c


What I wish I knew before
Top Surgery
TikTok
@heterocure
0:00 / 0:16
3
19
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It makes you cooler, hotter and smarter than everyone else
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← **Tweet**



**🌎Local Area Man🌎**
@cloud2014

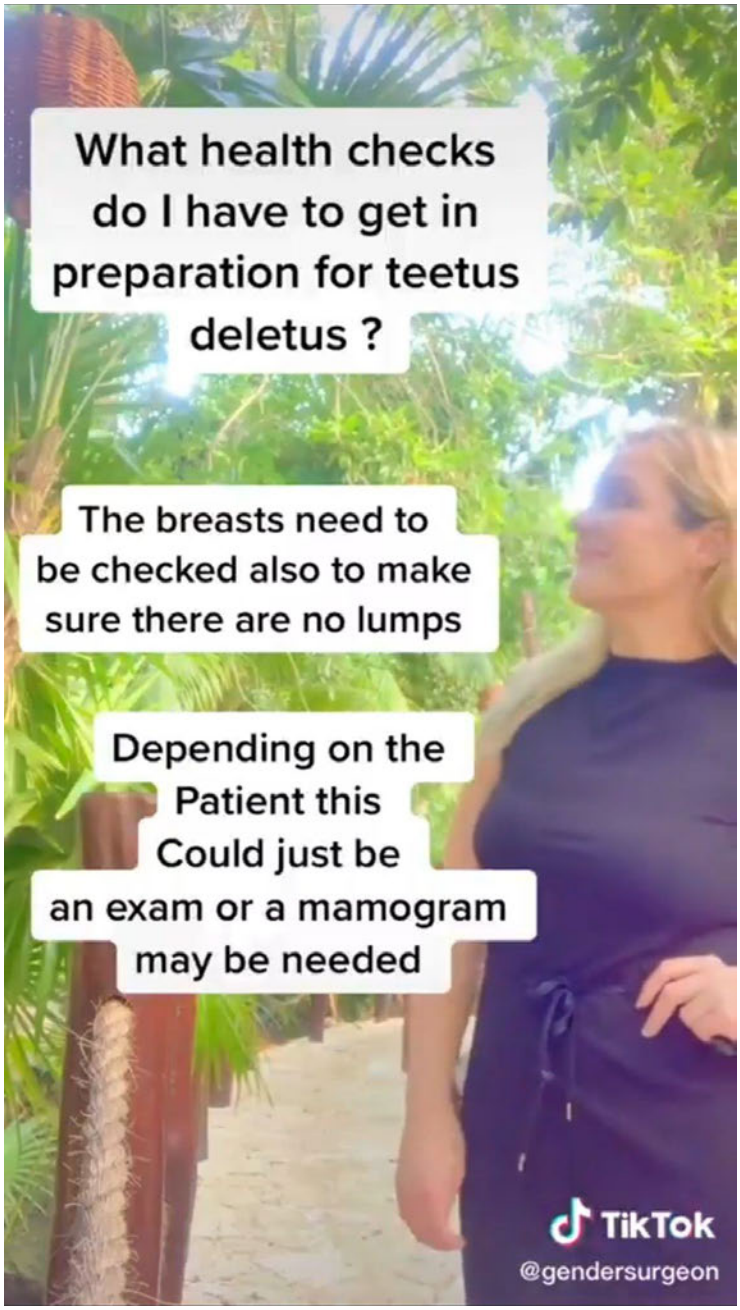
Replying to @HormoneHangover

I wonder how the good doctor feels about the term "teetus deletus"?

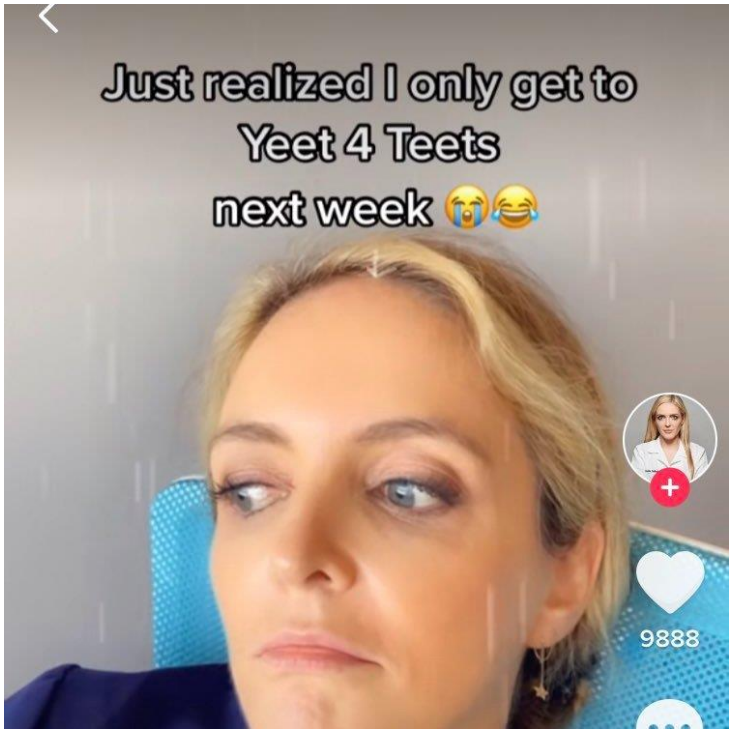
**🌎Local Area Man🌎** @cloud2014 · Sep 22, 2021

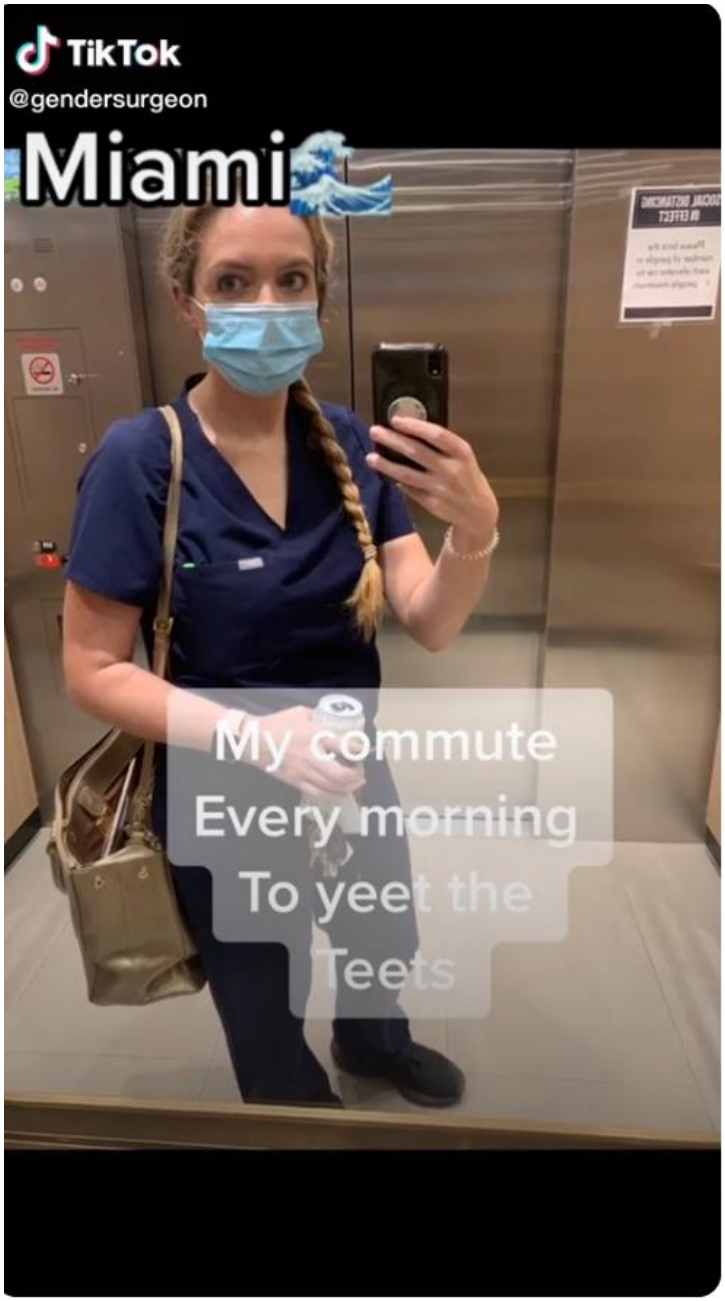



3:01 AM · Sep 22, 2021 · Twitter for Android


What health checks do I have to get in preparation for teetus deletus ?
The breasts need to be checked also to make sure there are no lumps
Depending on the Patient this Could just be an exam or a mamogram may be needed
TikTok
@gendersurgeon

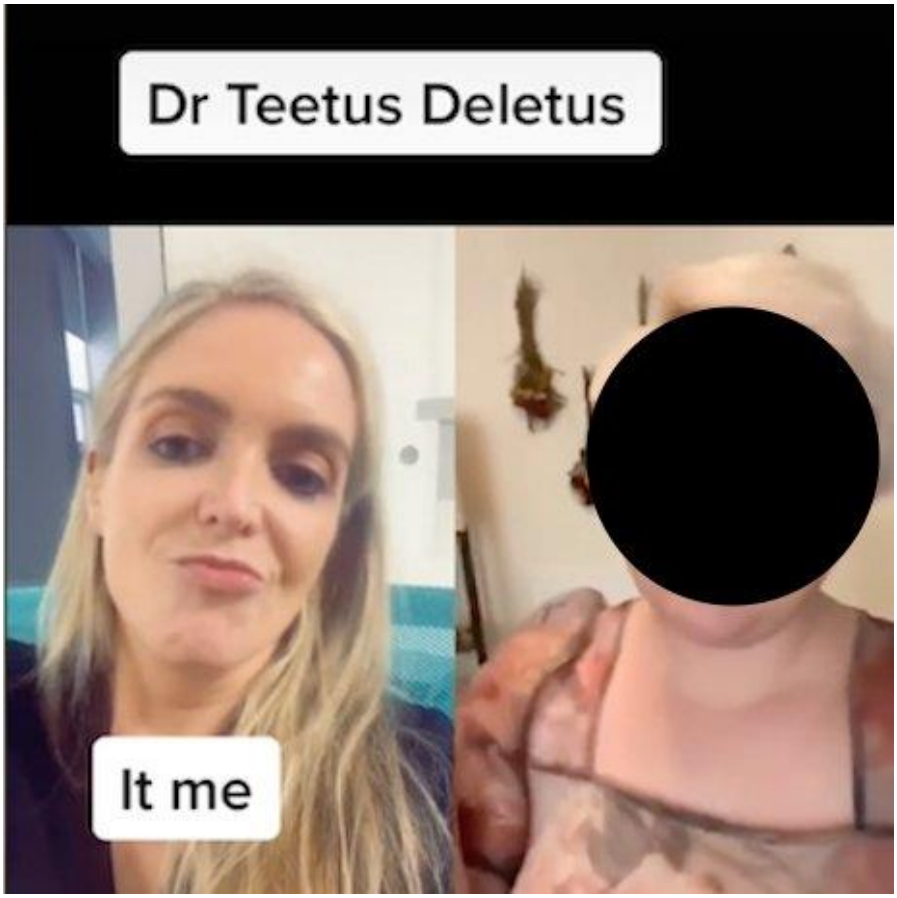

Dr Sidhbh Gallagher is in Miami, Florida.
Dec 18 ·
Congrats on the teetus DELETUS 🥰 all the way from North Carolina ☺️

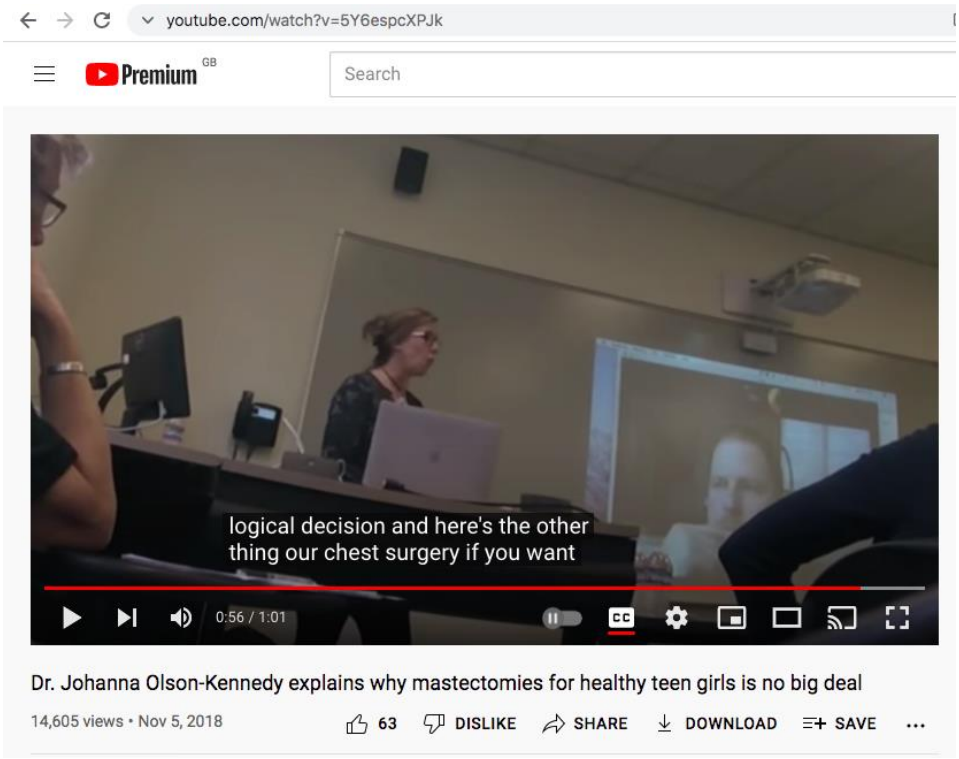

Just realized I only get to Yeet 4 Teets next week 😭😂
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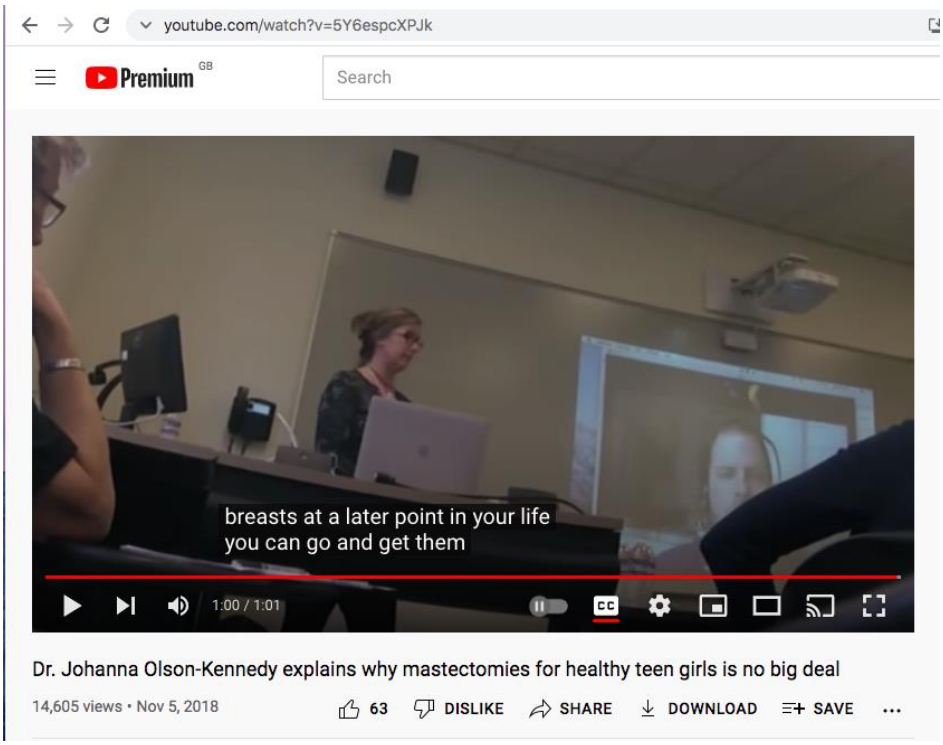

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Toronto & GTA / Ontario

# MANDEL: Decision upheld against surgeon's social media posts on transgender top surgery

Michele Mandel
Nov 11, 2021 • November 11, 2021 • 3 minute read • 21 Comments




Dr. Giancarlo McEvenue, a plastic surgeon who performed female-to-male chest surgeries at McLean Clinic in Mississauga, holds two medical waste buckets labelled "breast tissue" while dressed in a Santa hat in a photo that was posted on social media. PHOTO BY SOCIAL MEDIA POST

Holding two medical waste buckets labelled “breast tissue” while dressed in a Santa hat was probably not the most tasteful move by a doctor who performed female-to-male chest surgeries at a Mississauga clinic.

STORY CONTINUES BELOW

“For all you good boys,” read the message posted on Instagram by the McLean Clinic, “Dr. McEvenue is not bringing gifts, he’s taking them away.”

The plastic surgeon insisted the post was intended to be “light-hearted” to celebrate the many patients who had surgeries over the Christmas holidays and any way, there was no real breast tissue in the photo.

But in a recent ruling, Ontario’s health review board upheld the decision of a College of Physicians and Surgeons of Ontario committee to provide “advice” to Giancarlo McEvenue that he should better follow the profession’s advertising regulations.

Under the Medicine Act, any advertising by a doctor “must not be false, misleading or deceptive; must not contain a testimonial; and must be readily comprehensible, dignified and in good taste.”

495

STORY CONTINUES BELOW

1860

This one definitely violated the latter category.

“The photograph showing (McEvenue) holding up buckets labelled breast tissue is not dignified or in good taste, regardless of whether the clinic has received positive feedback about it,” the committee wrote.

In addition to the Santa post, the Inquiries, Complaints and Reports Committee of the CPSO took issue with some of the clinic’s other promotional material online that it said violated advertising regulations. It found that before-and-after photos amounted to testimonials and a photo of an

regulations. It found that before-and-after photos amounted to testimonials and a photo of an "ideal" male chest was "misleading in that the results depicted are impossible to achieve using female to male top reconstruction surgery."

The committee also found telling patients in posts that they'll have an improved relationship following top surgery was a "false claim" since there was no evidence to back that up.

STORY CONTINUES BELOW

McEvenue appealed the "advice" decision to the Health Professions Appeal and Review Board, which found it was "reasonable."

The McLean Clinic publishes information about its gender-confirming surgical services and post-surgery pictures on its Facebook, Instagram and YouTube pages.

"Chest masculinization is requested by those who find that feminine breasts do not suit their perception of themselves," the clinic explains on its website. "If you are transgender, gender fluid, or identify elsewhere in the spectrum of those who are uncomfortable with their breasts, you may want to consider top surgery."

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The complaint was filed in 2020 by Pamela Buffone, who in reality appears to be worried about more than a tasteless Santa shot. She's the founder of Canadian Gender Report, which believes

"vulnerable youth are being fast-tracked down an irreversible medical pathway" and complains there is no minimum age for gender reassignment surgery in Ontario.

STORY CONTINUES BELOW

"I filed the complaint," she explained by email, "on behalf of a coalition of concerned groups, including detransitioners, some of whom had surgery at the McLean clinic while they were teenagers and now regret it."

She claimed the clinic's social media posts not only violated the Medicine Act's advertising regulations but were targeting teenage girls confused about their gender identity. The committee disagreed, finding the clinic's advertising wasn't directed at minors nor was it trying to entice minors to have surgery.

According to the decision, McEvenue told the CPSO that the LGBTQ+ community has historically suffered from a great deal of discrimination, "not only from society at large but from within the medical community," and the clinic's positive social media accounts gave transgender patients quality information that "not only normalize the procedures, but also advocate for its safe performance in a gender-affirming manner."

After the CPSO committee decision, Buffone said the clinic's @topsurgery Instagram account went private.

And as for McEvenue, "Dr. G" has decamped to Miami where advertising knows no bounds.

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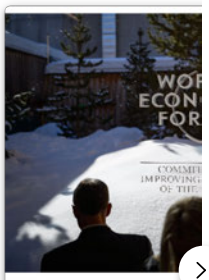

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# The Cass Review

## Independent review of gender identity services for children and young people: Interim report

February 2022



1868

# Independent review of gender identity services for children and young people: Interim report

February 2022

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# About this report

This interim report represents the work of the independent review of gender identity services for children and young people to date. It reflects a point in time. It does not set out final recommendations; these will be developed over the coming months, informed by our formal research programme.

This Review is forward looking. Its role is to consider how to improve and develop the future clinical approach and service model. However, in order to do this, it is first necessary to understand the current landscape and the reasons why change is needed, so that any future model addresses existing challenges, whilst retaining those features that service users and the professionals supporting them most value.

This report is primarily for the commissioners and providers of services for children and young people needing support around their gender. However, because of the wide interest in this topic, we have included some explanations about how clinical service development routinely takes place in the NHS, which sets the context for some of our interim advice.

The care of this group of children and young people is everyone's business. We therefore encourage the wider clinical community to take note of our work and consider their own roles in providing the best holistic support to this population.

Since the Review began, it has focused on hearing a wide range of perspectives to better understand the challenges within the current system and aspirations for how these could be addressed. This report does not contain all that we have heard during our listening sessions but summarises consistent themes. These conversations will continue throughout the course of the Review and there will be further opportunities for stakeholders to engage and contribute.

It is important to note that the references cited in this report do not constitute a comprehensive literature review and are included only to clarify why specific lines of enquiry are being pursued, and where there are unanswered questions that will be addressed more fully during the life of the Review. A formal literature review is one strand of the Review's commissioned work, and this will be reported in full when complete.

## A note about language

There is sometimes no consensus on the best language to use relating to this subject. The language surrounding this area has also changed rapidly and young people have developed varied ways of describing their experiences using different terms and constructs that are relevant to them.

The Review tries as far as possible to use language and terms that are respectful and acknowledge diversity, but that also accurately illustrate the complexity of what we are trying to describe and articulate.

The terms we have used may not always feel right to some; nevertheless, it is important to emphasise that the language used is not an indication of a position being taken by the Review. A glossary of terms is included.

The Review is cognisant of the broader cultural and societal debates relating to the rights of transgender adults. It is not the role of the Review to take any position on the beliefs that underpin these debates. Rather, this Review is strictly focused on the clinical services provided to children and young people who seek help from the NHS to resolve their gender-related distress.

# A letter to children and young people

**Children and young people accessing the NHS deserve safe, timely and supportive services, and clinical staff with the training and expertise to meet their healthcare needs.**



**Dr Hilary Cass**

I understand that as you read this letter some of you may be anxious because you are waiting to access support from the NHS around your gender identity. Maybe you have tried to get help from your local services, or from the Gender Identity Development Service (GIDS), and because of the long waiting lists they have not yet been able to see you. I hope that some of you have had help – maybe from a supportive GP, a local Child and Adolescent Mental Health Service (CAMHS), or from GIDS.

I have heard that young service users are particularly worried that I will suggest that services should be reduced or stopped. I want to assure you that this is absolutely not the case – the reverse is true. I think that more services are needed for you, closer to where you live. The GIDS staff are working incredibly hard and doing their very best to see you as quickly as possible but providing supportive care is not something that can be rushed – each young person needs enough time and space for their personal needs to be met. So, with the best will in the world, one service is not going to be able to respond to the growing demand in a timely way.

I am advising that more services are made available to support you. But I must be honest; this is not something that can happen overnight, and I can't come up with a solution that will fix the problems immediately. However, we do need to start now.

The other topic that I know is worrying some of you is whether I will suggest that hormone treatments should be stopped. On this issue, I have to share my thoughts as a doctor. We know quite a bit about hormone treatments, but there is still a lot we don't know about the long-term effects.

Whenever doctors prescribe a treatment, they want to be as certain as possible that the benefits will outweigh any adverse effects so that when you are older you don't end up saying 'Why did no-one tell me that that might happen?' This includes understanding both the risks and benefits of having treatment and not having treatment.

Therefore, what we will be doing over the next few months is trying to make sense of all the information that is available, as well as seeing if we can plug any of the gaps in the research. I am currently emphasising the importance of making decisions about prescribing as safe as possible. This means making sure you have all the information you need – about what we do know and what we don't know.

Finally, some of you may want the chance to talk to me and share your thoughts about how services should look in the future. Over the coming months we will need your help and there will be opportunities to get involved with the Review, so please keep an eye on our website (www.cass.independent-review.uk), where we will provide updates on our work.



**Dr Hilary Cass, OBE**

# Introduction from the Chair

Anyone with an interest in the care of gender-questioning children and young people, as well as those with lived experience, may have wondered what qualifies me to take on this Review, and whether I have a pre-existing position on this subject.

I am a paediatrician who was in clinical practice until 2018, my area of specialism being children and young people with disability. I have also held many management and policy roles throughout my career, most notably as President of the Royal College of Paediatrics and Child Health (RCPCH) from 2012-15.

Children's services are often at a disadvantage in healthcare because health services are usually designed around the needs of adults. As President of RCPCH, a key part of my role was to advocate for services to be planned with children and families at their heart.

I have not worked in gender services during my career, but my strong focus on hearing the voice of service users, supporting vulnerable young people, equity of access, and strong clinical standards applies in this area as much as in my other work.

With this in mind, the aim of the Review is to ensure that children and young people who are experiencing gender incongruence or gender-related distress receive a high standard of NHS care that meets their needs and is safe, holistic and effective.

I have previously set out the principles governing this Review process, namely that:

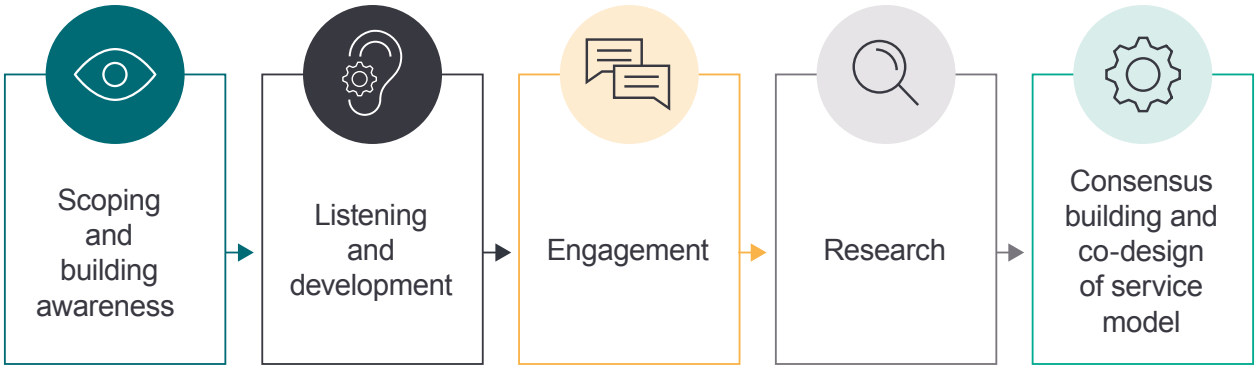
- The welfare of the child and young person will be paramount in all considerations.
- Children and young people must receive a high standard of care that meets their needs.
- There will be extensive and purposeful stakeholder engagement, including ensuring that children and young people can express their own views through a supportive process.
- The Review will be underpinned by research and evidence, including international models of good practice where available.
- There will be transparency in how the Review is conducted and how recommendations are made.
- There are no pre-determined outcomes with regards to the recommendations the Review will make.

The Review's terms of reference (**Appendix 1**) are wide ranging in scope, looking at different aspects of gender identity services across the whole pathway through primary, secondary and specialist services, up to the point of transition to adult services. This includes consideration of referral pathways, assessment, appropriate clinical management and workforce recommendations.

I have also been asked to explore the reasons for the considerable increase in the number of referrals, which have had a significant impact on waiting times, as well as the changing case-mix of gender-questioning children and young people presenting to clinical services.

The Review is taking an investigative approach to understanding what the future service model should look like for children and young people. This means that its outcomes are not being developed in isolation or by committee but rather through an ongoing dialogue aimed at building a shared understanding of the current situation and how it can and should be improved.

## The key aspects of the approach to the Review are:




My starting point has been to hear from a variety of experts with relevant expertise and those with lived experience to understand as many perspectives as possible. To date, this has included hearing directly from those with lived experience, from professionals and support and advocacy groups. This listening process will continue.

We have been very fortunate in the generosity of all those who have been prepared to talk to the Review and share their experiences. In addition to some divergent opinions, there are also some themes and views which seem to be widely shared. The commitment of professionals at all levels is striking and I genuinely believe that with collective effort we can improve services for the children and young people who are at the heart of this Review.

These discussions have been valuable to get an in-depth sense of the current situation and different viewpoints on how it may be improved. However, it is essential that this initial understanding is underpinned by more detailed data and an enhanced evidence base, which is being delivered through the Review's academic research programme.

Providing this evidence base for the Review is going to take some time. I recognise there is a pressing need to enhance the services currently available for children, young people, their

parents and carers, some of whom are experiencing considerable distress. Clinicians providing their treatment and care are also under pressure and cannot sustain the current workload. As such, I know the time I am taking to complete this Review and make recommendations will be difficult for some, but it is necessary.

I wrote to NHS England in May 2021 (**Appendix 2**) setting out some more immediate considerations whilst awaiting my full recommendations. This report builds on that letter and looks to provide some further interim advice.

Through our research programme, the Review team will continue to examine the literature and, where possible, will fill gaps in the existing evidence base. However, there will be persisting evidence gaps and areas of uncertainty. We need the engagement of service users, support and advocacy groups, and professionals across the wider workforce to work with us in the coming months in a collaborative and open-minded manner in order to reach a shared understanding of the problems and an agreed way forward that is in the best interests of children and young people.

My measure of success for this Review will be that this group of children and young people receive timely, appropriate and excellent care, not just from specialists but from every healthcare professional they encounter as they take the difficult journey from childhood to adulthood.

# 1. Summary and interim advice



# Summary

1.1. In recent years, there has been a significant increase in the number of referrals to the Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust. This has contributed to long waiting lists and growing concern about how the NHS should most appropriately assess, diagnose and care for this population of children and young people.

1.2. Within the UK, the single specialist service has developed organically, and the clinical approach has not been subjected to some of the usual control measures that are typically applied when new or innovative treatments are introduced. Many of the challenges and knowledge gaps that we face in the UK are echoed internationally,[1] and there are significant gaps in the research and evidence base.

1.3. This Review was commissioned by NHS England to make recommendations on how to improve services provided by the NHS to children and young people who are questioning their gender identity or experiencing gender incongruence and ensure that the best model for safe and effective services is commissioned (**Appendix 1**).

1.4. This interim report represents the Review's work to date. It sets out what we have heard so far and the approach we are taking moving forward. There is still much evidence to be gathered, questions to be answered, and voices to be heard, and our perspective will evolve as more evidence comes to light. However, there is sufficient clarity on several areas for the Review to be able to offer advice at this stage so that action can be taken more quickly.

1.5. The Review is not able to provide definitive advice on the use of puberty blockers and feminising/masculinising hormones at this stage, due to gaps in the evidence base; however, recommendations will be developed as our research programme progresses.

Every gender-questioning child or young person who seeks help from the NHS must receive the support they need to get on the appropriate pathway for them as an individual.

Children and young people with gender incongruence or dysphoria must receive the same standards of clinical care, assessment and treatment as every other child or young person accessing health services.

[1] Vrouenraets LJ, Fredriks AM, Hannema SE, Cohen-Kettenis PT, de Vries MC (2015). Early medical treatment of children and adolescents with gender dysphoria: an empirical ethical study. J Adolesc Health 57(4): 367-73. DOI: 10.1016/.2015.04.004.

## Conceptual understanding and consensus about the meaning of gender dysphoria

1.6. In clinical practice, a diagnosis of gender dysphoria is currently based on an operational definition, using the criteria set out in DSM-5 (**Appendix 3**). Some of these criteria are seen by some as outdated in the context of current understanding about the flexibility of gender expression.

1.7. At primary, secondary and specialist level, there is a lack of agreement, and in many instances a lack of open discussion, about the extent to which gender incongruence in childhood and adolescence can be an inherent and immutable phenomenon for which transition is the best option for the individual. Professionals' experience and position on this spectrum may determine their clinical approach.

1.8. Children and young people can experience this as a 'clinician lottery', and failure to have an open discussion about this issue is impeding the development of clear guidelines about their care.

## Service capacity and delivery

1.9. A rapid change in epidemiology and an increase in referrals means that the number of children seeking help from the NHS is now outstripping the capacity of the single national specialist service, the Gender Identity Development Service (GIDS) at The Tavistock and Portman NHS Foundation Trust.

1.10. The mix of young people presenting to the service is more complex than seen previously, with many being neurodiverse and/or having a wide range of psychosocial and mental health needs. The largest group currently comprises birth-registered females first presenting in adolescence with gender-related distress.

1.11. Until very recently, any local professional, including non-health professionals, could refer to GIDS, which has meant that the quality and appropriateness of referrals lacks consistency, and local service provision has remained patchy and scarce.

1.12. The staff working within the specialist service demonstrate a high level of commitment to the population they serve. However, the waiting list pressure and lack of consensus development on the clinical approach, combined with criticism of the service, have all resulted in rapid turnover of staff and inadequate capacity to deal with the increasing workload. Capacity constraints cannot be addressed through financial investment alone; there are some complex workforce (recruitment; retention; and training) and cultural issues to address.

1.13. Our initial work has indicated that many professionals working at primary and secondary level feel that they have the transferable skills and the commitment to offer more robust support to this group of children and young people, but are nervous about doing so, partly because of the lack of formal clinical guidance, and partly due to the broader societal context.

1.14. Primary and secondary care staff have told us that they feel under pressure to adopt an unquestioning affirmative approach and that this is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters.

1.15. Children and young people are waiting lengthy periods to access GIDS, during which time some may be at considerable risk. By the time they are seen, their distress may have worsened, and their mental health may have deteriorated.

1.16. Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be overlooked.

1.17. The current move to adult services at age 17-18 may fall at a critical time in the young person's gender management. In contrast, young people with neurodiversity often remain under children's services until age 19 and some other clinical services continue to mid-20s. Further consideration will be needed regarding the age of transfer to adult services.

## Service standards

1.18. The Multi-Professional Review Group (MPRG), set up by NHS England to ensure that procedures for assessment and for informed consent have been properly followed, has stated that the following areas require consideration:

- From the point of entry to GIDS there appears to be predominantly an affirmative, non-exploratory approach, often driven by child and parent expectations and the extent of social transition that has developed due to the delay in service provision.
- From documentation provided to the MPRG, there does not appear to be a standardised approach to assessment or progression through the process, which leads to potential gaps in necessary evidence and a lack of clarity.
- There is limited evidence of mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic or psychological formulation.
- Of 44 submissions received by the MPRG, 31% were not initially assured due to lack of safeguarding information. And in a number of cases there were specific safeguarding concerns. There do not appear to be consistent processes in place to work with other agencies to identify children and young people and families who may be vulnerable, at risk and require safeguarding.

- Appropriate clinical experts need to be involved in informing decision making.

1.19. Many of these issues were also highlighted by the Care Quality Commission (CQC) in 2020.[2]

## International comparisons

1.20. The Netherlands was the first country to provide early endocrine interventions (now known internationally as the Dutch Approach). Although GIDS initially reported its approach to early endocrine intervention as being based on the Dutch Approach,[3] there are significant differences in the NHS approach. Within the Dutch Approach, children and young people with neurodiversity and/or complex mental health problems are routinely given therapeutic support in advance of, or when considered appropriate, instead of early hormone intervention. Whereas criteria to have accessed therapeutic support prior to starting hormone blocking treatment do not appear to be integral to the current NHS process.

1.21. NHS endocrinologists do not systematically attend the multi-disciplinary meetings where the complex cases that may be referred to them are discussed, and until very recently did not routinely have direct contact with the clinical staff member who had assessed the child or young person. This is not consistent with some international approaches for this group of children and young people, or in other multi-disciplinary models of care across paediatrics and adult medicine where challenging decisions about life-changing interventions are made.[4,5]

1.22. In the NHS, once young people are started on hormone treatment, the frequency of appointments drops off rather than intensifies, and review usually takes place quarterly. Again, this is different to the Dutch Approach.[6] GIDS staff would recommend more frequent contact during this period, but the fall-off in appointments reflects a lack of service capacity, with the aspiration being for more staff time to remedy this situation.

## Existing evidence base

1.23. Evidence on the appropriate management of children and young people with gender incongruence and dysphoria is inconclusive both nationally and internationally.

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[2] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.
[3] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.
[4] Ibid.
[5] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.
[6] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

1.24. A lack of a conceptual agreement about the meaning of gender dysphoria hampers research, as well as NHS clinical service provision.

1.25. There has not been routine and consistent data collection within GIDS, which means it is not possible to accurately track the outcomes and pathways that children and young people take through the service.

1.26. Internationally as well as nationally, longer-term follow-up data on children and young people who have been seen by gender identity services is limited, including for those who have received physical interventions; who were transferred to adult services and/or accessed private services; or who desisted, experienced regret or detransitioned.

1.27. There has been research on the short-term mental health outcomes and physical side effects of puberty blockers for this cohort, but very limited research on the sexual, cognitive or broader developmental outcomes.[7]

1.28. Much of the existing literature about natural history and treatment outcomes for gender dysphoria in childhood is based on a case-mix of predominantly birth-registered males presenting in early childhood. There is much less data on the more recent case-mix of predominantly birth-registered females presenting in early teens, particularly in relation to treatment and outcomes.

1.29. Aspects of the literature are open to interpretation in multiple ways, and there is a risk that some authors interpret their data from a particular ideological and/or theoretical standpoint.

## The mismatch between service user expectations and clinical standards

1.30. By the time children and young people reach GIDS, they have usually had to experience increasingly long, challenging waits to be seen.[8] Consequently, some feel they want rapid access to physical interventions and find having a detailed assessment distressing.

1.31. Clinical staff are governed by professional, legal and ethical guidance which demands that certain standards are met before a treatment can be provided. Clinicians carry responsibility for their assessment and recommendations, and any harm that might be caused to a patient under their care. This can create a tension between the aspirations of the young person and the responsibilities of the clinician.

[7] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[8] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

# Interim advice

1.32. The Review considers that there are some areas where there is sufficient clarity about the way forward and we are therefore offering some specific observations and interim advice. The Review will work with NHS England, providers and the broader stakeholder community to progress action in these areas.

## Service model

1.33. It has become increasingly clear that a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand.

1.34. Additionally, children and young people with gender-related distress have been inadvertently disadvantaged because local services have not felt adequately equipped to see them. It is essential that they can access the same level of psychological and social support as any other child or young person in distress, from their first encounter with the NHS and at every level within the service.

1.35. A fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity. This must include support for any other clinical presentations that they may have.

1.36. The Review supports NHS England's plan to establish regional services, and welcomes the move from a single highly specialist service to regional hubs.

1.37. Expanding the number of providers will have the advantages of:

- creating networks within each area to improve early access and support;
- reducing waiting times for specialist care;
- building capacity and training opportunities within the workforce;
- developing a specialist network to ensure peer review and shared standards of care; and
- providing opportunities to establish a more formalised service improvement strategy.

### Service provision

1.38. The primary remit of NHS England's proposed model is for the regional hubs to provide support and advice to referrers and professionals. However, it includes limited provision for direct contact with children and young people and their families.

**1:** The Review advises that the regional centres should be developed, as soon as feasibly possible, to become direct service providers, assessing and treating children and young people who may need specialist care, as part of a wider pathway. The Review team will work with NHS England and stakeholders to further define the proposed model and workforce implications.

**2:** Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children and young people who are in early stages of experiencing gender distress.

**3:** Clear criteria will be needed for referral to services along the pathway from primary to tertiary care so that gender-questioning children and young people who seek help from the NHS have equitable access to services.

**4:** Regional training programmes should be run for clinical practitioners at all levels, alongside the online training modules developed by Health Education England (HEE). In the longer-term, clearer mapping of the required workforce, and a series of competency frameworks will need to be developed in collaboration with relevant professional organisations.

## Data, audit and research

1.39. A lack of routine and consistent data collection means that it is not possible to accurately track the outcomes and pathways children and young people take through the service. Standardised data collection is required in order to audit service standards and inform understanding of the epidemiology, assessment and treatment of this group. This, alongside a national network which brings providers together, will help build knowledge and improve outcomes through shared clinical standards and systematic data collection. In the longer-term, formalisation of such a network into a learning health system[9] with an academic host would mean that there was systematised use of data to produce a continuing research programme with rapid translation into clinical practice and a focus on training.

[9] Scobie S, Castle-Clarke S (2019). Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

**5:** The regional services should have regular co-ordinated national provider meetings and operate to shared standards and operating procedures with a view to establishing a formal learning health system.

**6:** Existing and future services should have standardised data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.

**7:** Prospective consent of children and young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children and young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.

## Clinical approach

### Assessment processes

1.40. We have heard that there are inconsistencies and gaps in the assessment process. Our work to date has also demonstrated that clinical staff have different views about the purpose of assessment and where responsibility lies for different components of the process within the pathway of care. The Review team has commenced discussions with clinical staff across primary, secondary and tertiary care to develop a framework for these processes.

**8:** There needs to be agreement and guidance about the appropriate clinical assessment processes that should take place at primary, secondary and tertiary level.

**9:** Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiverse children and young people.

## Hormone treatment

1.41. The issues raised by the Multi-Professional Review Group echo several of the problems highlighted by the CQC. It is essential that principles of the General Medical Council's Good Practice in Prescribing and Managing Medicine's and Devices[10] are closely followed, particularly given the gaps in the evidence base regarding hormone treatment. Standards for decision making regarding endocrine treatment should also be consistent with international best practice.[11,12,13]

**10:** Any child or young person being considered for hormone treatment should have a formal diagnosis and formulation, which addresses the full range of factors affecting their physical, mental, developmental and psychosocial wellbeing. This formulation should then inform what options for support and intervention might be helpful for that child or young person.

**11:** Currently paediatric endocrinologists have sole responsibility for treatment, but where a life-changing intervention is given there should also be additional medical responsibility for the differential diagnosis leading up to the treatment decision.

1.42. Paediatric endocrinologists develop a wide range of knowledge within their paediatric training, including safeguarding, child mental health, and adolescent development. Being party to the discussions and deliberations that have led up to the decision for medical intervention supports them in carrying out their legal responsibility for consent to treatment and the prescription of hormones.

**12:** Paediatric endocrinologists should become active partners in the decision making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.

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[10] General Medical Council (2021). Good practice in prescribing and managing medicines and devices (76-78).
[11] Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.
[12] Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.
[13] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

1.43. Given the uncertainties regarding puberty blockers, it is particularly important to demonstrate that consent under this circumstance has been fully informed and to follow GMC guidance[14] by keeping an accurate record of the exchange of information leading to a decision in order to inform their future care and to help explain and justify the clinician's decisions and actions.

**13:** Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer-term outcomes.

**14:** In the immediate term the Multi-Professional Review Group (MPRG) established by NHS England should continue to review cases being referred by GIDS to endocrine services.

[14] General Medical Council (2020). Decision making and consent.

# 2. Context





1891

## Transgender, non-binary and gender fluid adults

2.1. NHS clinical services to support transgender adults with hormone treatment and subsequent surgery began in 1966.

2.2. Services were initially established within a mental health model, in conjunction with endocrinology and surgical services.

2.3. Currently, NHS services for transgender adults do not have adequate capacity to cope with demand.[15] In addition, the broader healthcare needs of this group are not well met. This is important in the context of the current generation of gender-questioning children and young people in that there are now two inflows into adult services – individuals transitioning in adulthood, and those moving through from children's services.

2.4. Legal rights and protections for transgender people lagged behind the provision of medical services, with the Gender Recognition Act 2004 coming into force in April 2005. Over the last few years, broader discussions about transgender issues have been played out in public, with discussions becoming increasingly polarised and adversarial. This polarisation is such that it undermines safe debate and creates difficulties in building consensus.

2.5. It is not the role of this Review to take any position on the cultural and societal debates relating to transgender adults. However, in achieving its objectives there is a need to consider the information and support that children and young people access from whatever source, as well as any pressures that they are subject to, before they access clinical services.

## Terminology and diagnostic frameworks

2.6. The Office for National Statistics defines sex as "referring to the biological aspects of an individual as determined by their anatomy, which is produced by their chromosomes, hormones and their interactions; generally male or female; something that is assigned at birth".[16]

2.7. The Office for National Statistics defines gender as "a social construction relating to behaviours and attributes based on labels of masculinity and femininity; gender identity is a personal, internal perception of oneself and so the gender category someone identifies with may not match the sex they were assigned at birth".[17]

2.8. Societal attitudes towards gender roles and gender expression are changing. Children, teenagers and younger adults may more commonly see gender as a fluid, multi-faceted phenomenon which

[15] Gender Identity Clinic, The Tavistock and Portman NHS Foundation Trust. Waiting times.
[16] Office for National Statistics (2019). What is the difference between sex and gender?
[17] Ibid.

does not have to be binary, whereas older generations have tended to see gender as binary and fixed. It is not unusual for young people to explore both their sexuality and gender as they go through adolescence and early adulthood before developing a more settled identity. Many achieve this without experiencing significant distress or requiring support from the NHS, but this is not the case for all.

2.9. For those who require support from the NHS, there are two widely used frameworks which provide diagnostic criteria. The International Classification of Diseases (ICD), which is the World Health Organization (WHO) mandated health data standard, and the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the classification system for mental health disorders produced by the American Psychiatric Association. The current editions of these manuals – ICD-11 and DSM-5 – came into effect in January 2022 and 2013 respectively.

2.10. ICD-11[18] has attempted to depathologise gender diversity, removing the term 'gender identity disorders' from its mental health section and creating a new section for gender incongruence and transgender identities in a chapter on sexual health. These changes are part of a much broader societal drive to remove the stigma previously associated with transgender healthcare. ICD-11 defines gender incongruence as being "characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex." Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis. The full criteria for gender incongruence of childhood and gender incongruence of adolescence or adulthood are listed in **Appendix 3**.

2.11. DSM-5[19] is currently the framework used to diagnose gender dysphoria. This diagnostic category describes gender dysphoria as "the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender". A diagnosis of gender dysphoria is usually deemed necessary before a young person can access hormone treatment, and criteria are listed in **Appendix 3**.

## Conceptual understanding of gender incongruence in children and young people

2.12. Children and young people presenting to gender identity services are not a homogeneous group. They vary in their age at presentation, their cultural background, whether they identify as binary, non-binary, or gender fluid, whether they are neurodiverse and in a host of other ways.

[18] World Health Organization (2022). International Classification of Diseases Eleventh Revision.
[19] American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5™, 5th ed.

2.13. Some children and young people may thrive during a period of gender-questioning whilst for others it can be accompanied with a level of distress that can have a significant impact on their functioning and development.

2.14. Alongside these very varied presentations, it is highly unlikely that a single cause for gender incongruence will be found. Many authors view gender expression as a result of a complex interaction between biological, cultural, social and psychological factors.

2.15. Despite a high level of agreement about these points, there are widely divergent and, in some instances, quite polarised views among service users, parents, clinical staff and the wider public about how gender incongruence and gender-related distress in children and young people should be interpreted, and this has a bearing on expectations about clinical management.

2.16. These views will be influenced by how each individual weighs the balance of factors that may lead to gender incongruence, and the distress that may accompany it. Beliefs about whether it might be inherent and/or immutable, whether it might be a transient response to adverse experiences, whether it might be highly fluid and/or likely to change in later adolescence/early adulthood, etc will have a profound influence on expectations about treatment options.[20]

2.17. All of these views may be overlaid with strongly held concerns about children's and young people's rights, autonomy, and/or protection.

2.18. The disagreement and polarisation is heightened when potentially irreversible treatments are given to children and young people, when the evidence base underlying the treatments is inconclusive, and when there is uncertainty about whether, for any particular child or young person, medical intervention is the best way of resolving gender-related distress.

2.19. As with many other contemporary polarised disagreements, the situation is exacerbated when there is no space to have open, non-judgemental discussions about these differing perspectives. A key aim of this review process will be to encourage such discussions in a safe and respectful manner so that progress can be made in finding solutions.

[20] Wren B (2019). Notes on a crisis of meaning in the care of gender-diverse children. In: Hertzmann L, Newbigin J (eds) Sexuality and Gender Now: Moving Beyond Heteronormativity. Routledge.

# 3. Current services



# Current service model for gender-questioning children and young people

3.1. Currently there are no locally or regionally commissioned services for children and young people who seek help from the NHS in managing their gender-related distress. Within primary and secondary care, some clinical staff have more interest and expertise in initial management of this group of young people, but such individuals are few and far between.

3.2. The pathway for NHS support around gender identity for children and young people is designated as a highly specialised service.[21] The Gender Identity Development Service (GIDS) at the Tavistock and Portman NHS Foundation Trust is commissioned by NHS England to provide specialist assessment, support and, where appropriate, hormone intervention for children and young people with gender dysphoria. It is the only NHS provider of specialist gender services for children and young people in England. The Trust runs satellite bases in Leeds and Bristol. Until recently GIDS accepted referrals from multiple sources, for example, GPs, secondary care, social care, schools, and support and advocacy groups, which is unusual for a specialist service.

3.3. Children and young people are assessed by two members of the GIDS team who may be any combination of psychologists, psychotherapists, family therapists, or social workers. If there is uncertainty about the right approach, individual cases may be discussed in a complex case meeting. Those deemed appropriate for physical interventions are referred on to the endocrine team; under the current Standard Operating Procedure (SOP), this decision requires a multi-disciplinary team (MDT) discussion within GIDS. A member of the GIDS team attends new appointments in the endocrine clinic, but they will not routinely be the member of staff who saw the young person for assessment. However, very recently a triage meeting has been piloted to enable endocrinologists to discuss upcoming appointments with the clinician who saw the young person for assessment. The young person then attends an education session prior to their endocrine appointment. The endocrinologist will assess any medical contraindications prior to seeking consent from the patient for any hormone treatments.

3.4. For many years, the GIDS approach was to offer assessment and support, and to only start puberty blockers when children reached sexual maturity at about age 15 (Tanner Stage 5) as the first step in the treatment process to feminise or masculinise the young person, with

[21] National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

oestrogen or testosterone given from age 16. Feminising/masculinising hormones are not given at an earlier stage because of the irreversibility of some of their actions in developing secondary sex characteristics of the acquired gender.[22,23]

3.5. In 1998, a new protocol was published by the Amsterdam gender identity clinic.[24] It was subsequently named the Dutch Approach.[25] This involved giving puberty blockers much earlier, from the time that children showed the early signs of puberty (Tanner Stage 2), to pause further pubertal changes of the sex at birth. This stage of pubertal development was chosen because it was felt that although many younger children experienced gender incongruence as a transient developmental phenomenon, those who expressed early gender incongruence which continued into puberty were unlikely to desist at that stage.

3.6. It was felt that blocking puberty would buy time for children and young people to fully explore their gender identity and help with the distress caused by the development of their secondary sexual characteristics. The Dutch criteria for treating children with early puberty blockers were: (i) a presence of gender dysphoria from early childhood; (ii) an increase of the gender dysphoria after the first pubertal changes; (iii) an absence of psychiatric comorbidity that interferes with the diagnostic work-up or treatment; (iv) adequate psychological and social support during treatment; and (v) a demonstration of knowledge and understanding of the effects of gonadotropin-releasing hormones (puberty blockers), feminising/masculinising hormones, surgery, and the social consequences of sex reassignment.[26]

3.7. Under the Dutch Approach, feminising/masculinising hormones were started at age 16 and surgery was permitted to be undertaken from age 18, as in England.

3.8. From 2011, early administration of puberty blockers was started in England under a research protocol, which partially paralleled the Dutch Approach (the Early Intervention Study). From 2014, this protocol was adopted by GIDS as routine clinical practice. Results of the Early Intervention Study were published in December 2021.[27]

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[22] Delemarre-van de Wall HA, Cohen-Kettinis PT (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol 155 (Suppl 1): S131–7. DOI: 10.1530/eje.1.02231.
[23] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.
[24] Cohen-Kettenis PT, Van Goozen S (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. Eur Child Adolesc Psychiatry 7: 246–8. DOI: 10.1007/s007870050073.
[25] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.
[26] Ibid.
[27] Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.

3.9. However, the Dutch Approach differs from the GIDS approach in having stricter requirements about provision of psychological interventions. For example, under the Dutch Approach, if young people have gender confusion, aversion towards their sexed body parts, psychiatric comorbidities or Autism Spectrum Disorder (ASD) related diagnostic difficulties, they may receive psychological interventions only, or before, or in combination with medical intervention. Of note, in 2011, the Amsterdam team were reporting that up to 10% of their referral base were young people with ASD.[28]

## Changing epidemiology

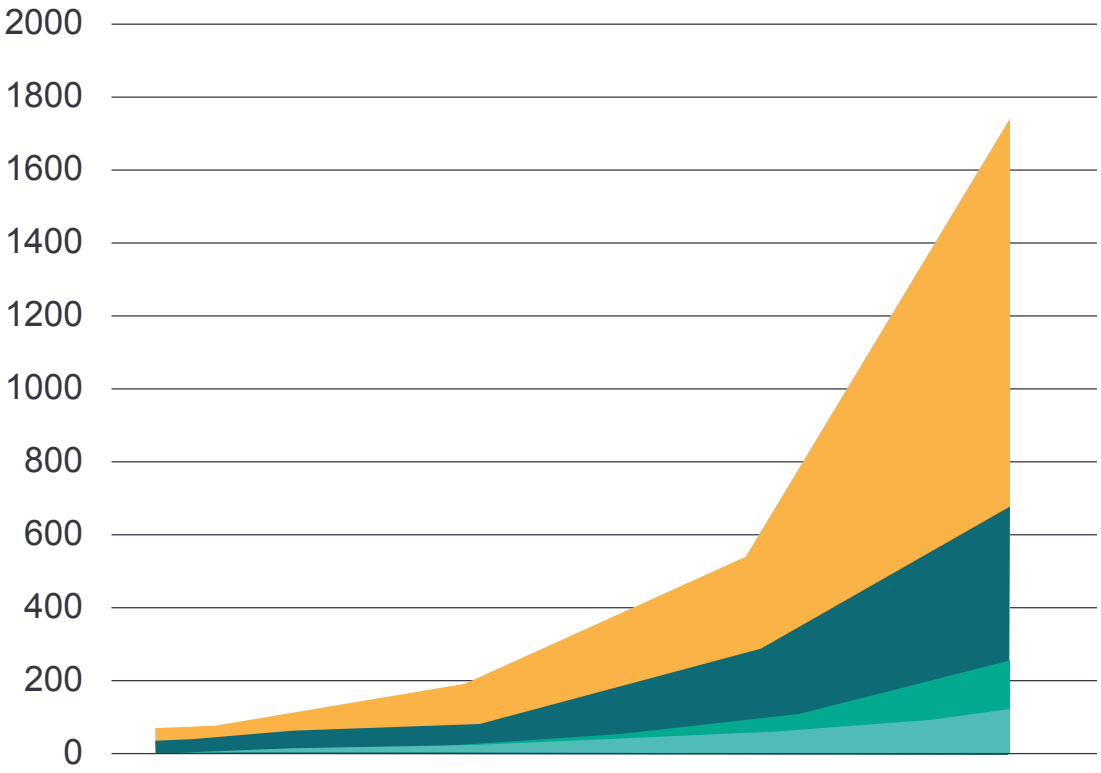
3.10. In the last few years, there has been a significant change in the numbers and case-mix of children and young people being referred to GIDS.[29] From a baseline of approximately 50 referrals per annum in 2009, there was a steep increase from 2014-15, and at the time of the CQC inspection of the Tavistock and Portman NHS Foundation Trust in October 2020 there were 2,500 children and young people being referred per annum, 4,600 children and young people on the waiting list, and a waiting time of over two years to first appointment.[30] This has severely impacted on the capacity of the existing service to manage referrals in the safe and responsive way that they aspire to and has led to considerable distress for those on the waiting list.

3.11. This increase in referrals has been accompanied by a change in the case-mix from predominantly birth-registered males presenting with gender incongruence from an early age, to predominantly birth-registered females presenting with later onset of reported gender incongruence in early teen years. In addition, approximately one third of children and young people referred to GIDS have autism or other types of neurodiversity. There is also an over-representation percentage wise (compared to the national percentage) of looked after children.[31]

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[28] Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.
[29] de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.
[30] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.
[31] Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

**Figure 1: Sex ratio in children and adolescents referred to GIDS in the UK (2009-16)**




| | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|---|---|
| Adolescents F | 15 | 48* | 78* | 141* | 221* | 314* | 689* | 1071* |
| Adolescents M | 24 | 44* | 41 | 77* | 120* | 185* | 293* | 426* |
| Children F | 2 | 7 | 12 | 17 | 22 | 36 | 77* | 138* |
| Children M | 10 | 19 | 29 | 30 | 31 | 55* | 103* | 131 |

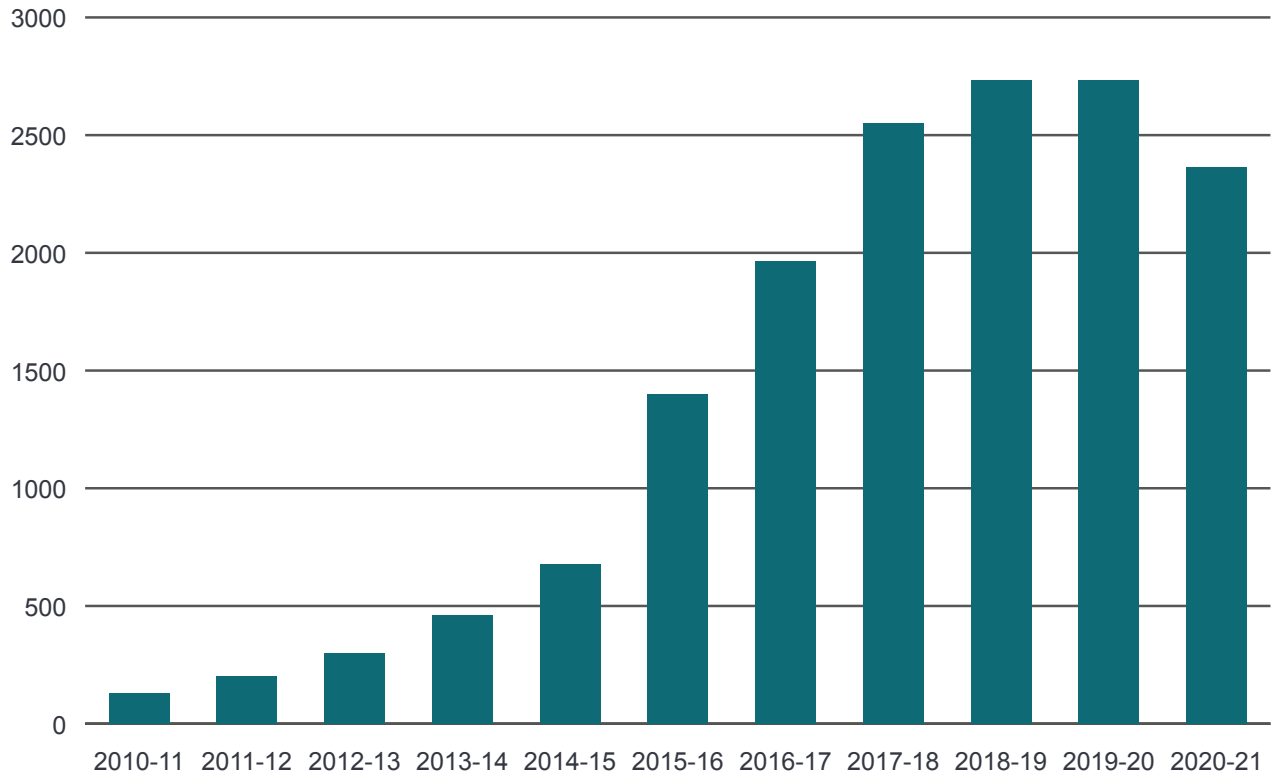
**AFAB** = assigned female at birth; AMAB = assigned male at birth

***Indicates** p<.05 which shows a significant increase of referrals compared to the previous year

**Source: de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018).**[32]

[32] de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.

**Figure 2: Referrals to GIDS, 2010-11 to 2020-21**




**Source: Gender Identity Development Service.**[33]

3.12. In 2019, GIDS reported that about 200 children and young people from a referral base of 2,500 were referred on to the endocrine pathway. There is no published data on how the other children and young people from this referral baseline were managed, for example if: their gender dysphoria was resolved; they were still being assessed or receiving ongoing psychological support and input; they were not eligible for puberty blockers due to age; they were referred to endocrine services at a later stage; they were transferred to adult services; or they accessed private services.

## Challenges to the service model and clinical approach

3.13. Over a number of years, in parallel with the increasing numbers of referrals, GIDS faced increasing challenges, both internally and externally. There were different views held within the staff group about the appropriate clinical approach, with some more strongly affirmative and some more cautious and concerned about the use of physical intervention. The complexity of the cases had also increased, so clinical decision making had become more difficult. There was also a high staff

[33] Gender Identity Development Service. Referrals to GIDS, financial years 2010-11 to 2020-21.

turnover, and accounts from staff concerned about the clinical care, which were picked up in both mainstream and social media. This culminated in 2018 with an internal report by a staff governor.

3.14. Following that report, a review was carried out in 2019 by the Trust's medical director. This set out the need for clearer processes for the service's referral management, safeguarding, consent, and clinical approach, and an examination of staff workload and support, and a new Standard Operating Procedure (SOP) was put in place.

## NHS England Policy Working Group

3.15. In January 2020, a Policy Working Group (PWG) was established by NHS England to undertake a review of the published evidence on the use of puberty blockers and feminising/masculinising hormones in children and young people with gender dysphoria to inform a policy position on their future use. Given the increasingly evident polarisation among clinical professionals, Dr Cass was asked to chair the group as a senior clinician with no prior involvement or fixed views in this area. The PWG comprised an expert group including endocrinologists, child and adolescent psychiatrists and paediatricians representing their respective Royal Colleges, an ethicist, a GP, senior clinicians from the NHS GIDS, a transgender adult and parents of gender-questioning young people. The process was supported by a public health consultant and policy, pharmacy and safeguarding staff from NHS England.

3.16. NHS England uses a standardised protocol for developing clinical policies. The first step of this involves defining the PICO (the Population being treated, the Intervention, a Comparator treatment, and the intended Outcomes). This of itself was challenging, with a particular difficulty being definition of the intended outcomes of puberty blockers, and suitable comparators for both hormone interventions. However, agreement was reached on what should be included in the PICO and subsequently the National Institute for Health and Care Excellence (NICE) was commissioned to review the published evidence,[34,35] again following a standardised protocol which has strict criteria about the quality of studies that can be included.

3.17. Unfortunately, the available evidence was not strong enough to form the basis of a policy position. Some of the challenges and outstanding uncertainties are summarised as follows.

[34] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[35] National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

## Feminising/masculinising hormones

3.18. Sex hormones have been prescribed for transgender adults for several decades, and the long-term risks and side effects are well understood. These include increased cardiovascular risk, osteoporosis, and hormone-dependent cancers.

3.19. In young people, consideration also needs to be given to the impact on fertility, with the need for fertility counselling and preservation.

3.20. The additional physical risk of starting these treatments at age 16+ rather than age 18+ is unlikely to add significantly to the total lifetime risk, although data on this will not be available for many years. However, as evidenced by take-up of treatment with feminising/masculinising hormones, where there is a high level of certainty that physical transition is the right option, the child or young person may be more accepting of these risks, which can seem remote from the immediate gender distress.

3.21. The most difficult question in relation to feminising/masculinising hormones therefore is not about long-term physical risk which is tangible and easier to understand. Rather, given the irreversible nature of many of the changes, the greatest difficulty centres on the decision to proceed to physical transition; this relies on the effectiveness of the assessment, support and counselling processes, and ultimately the shared decision making between clinicians and patients. Decisions need to be informed by long-term data on the range of outcomes, from satisfaction with transition, through a range of positive and negative mental health outcomes, through to regret and/or a decision to detransition. The NICE evidence review demonstrates the poor quality of these data, both nationally and internationally.

3.22. Regardless of the nature of the assessment process, some children and young people will remain fluid in their gender identity up to early to mid-20s, so there is a limit as to how much certainty one can achieve in late teens. This is a risk that needs to be understood during the shared decision making process with the young person.

3.23. It is also important to note that any data that are available do not relate to the current predominant cohort of later-presenting birth-registered female teenagers. This is because the rapid increase in this subgroup only began from around 2014-15. Since young people may not reach a settled gender expression until their mid-20s, it is too early to assess the longer-term outcomes of this group.

## Puberty blockers

3.24. The administration of puberty blockers is arguably more controversial than administration of the feminising/masculinising hormones, because there are more uncertainties associated with their use.

3.25. There has been considerable discussion about whether the treatment is 'experimental'; strictly speaking an experimental treatment is one that is being given as part of a research protocol, and this is not the case with puberty blockers, because the GIDS research protocol was stopped in 2014. At that time, the treatment was experimental and innovative, because the drug was licensed for use in children, but specifically for children with precocious puberty. This was therefore the first time it was used 'off-label' in the UK for children with gender dysphoria. If a drug is used 'off-label' it means it is being used for a condition that is different from the one for which it was licensed. The many uncertainties around the 'off-label' use were recognised, but given that this was not a new drug, it did not need Medicines and Healthcare products Regulatory Agency (MHRA) approval at that time.

3.26. The important question now, as with any treatment, is whether the evidence for the use and safety of the medication is strong enough as judged by reasonable clinical standards.

3.27. One of the challenges that NHS England's PWG faced in considering this question was the lack of clarity about intended outcomes, several of which have been proposed including:

- providing time/space for the young person to make a decision about continuing with transition;
- reducing or preventing worsening of distress;
- improving mental health; and
- stopping potentially irreversible pubertal changes which might later make it difficult for the young person to 'pass' in their intended gender role.

3.28. Proponents for the use of puberty blockers highlight the distress that young people experience through puberty and the risk of self-harm or suicide.[36] However, some clinicians do not feel that distress is actually alleviated until children and young people are able to start feminising/masculinising hormones. The Review will seek to gain a better understanding of suicide data and the impact of puberty blockers through its research programme.

3.29. On the other hand, it has been asserted that starting puberty blockers at an older age provides children and young people with more time to achieve fertility preservation. In the case of birth-registered males, there is an argument that it also

[36] Turban JL, King D, Carswell JM, et al (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. Pediatrics 145 (2): e20191725. DOI: 10.1542/peds.2019-1725.

allows more time to achieve adequate penile growth for successful vaginoplasty.

3.30. In the short-term, puberty blockers may have a range of side effects such as headaches, hot flushes, weight gain, tiredness, low mood and anxiety, all of which may make day-to-day functioning more difficult for a child or young person who is already experiencing distress. Short-term reduction in bone density is a well-recognised side effect, but data is weak and inconclusive regarding the long-term musculoskeletal impact.[37]

3.31. The most difficult question is whether puberty blockers do indeed provide valuable time for children and young people to consider their options, or whether they effectively 'lock in' children and young people to a treatment pathway which culminates in progression to feminising/masculinising hormones by impeding the usual process of sexual orientation and gender identity development. Data from both the Netherlands[38] and the study conducted by GIDS[39] demonstrated that almost all children and young people who are put on puberty blockers go on to sex hormone treatment (96.5% and 98% respectively). The reasons for this need to be better understood.

3.32. A closely linked concern is the unknown impacts on development, maturation and cognition if a child or young person is not exposed to the physical, psychological, physiological, neurochemical and sexual changes that accompany adolescent hormone surges. It is known that adolescence is a period of significant changes in brain structure, function and connectivity.[40] During this period, the brain strengthens some connections (myelination) and cuts back on others (synaptic pruning). There is maturation and development of frontal lobe functions which control decision making, emotional regulation, judgement and planning ability. Animal research suggests that this development is partially driven by the pubertal sex hormones, but it is unclear whether the same is true in humans.[41] If pubertal sex hormones are essential to these brain maturation processes, this raises a secondary question of whether there is a critical time window for the processes to take place, or whether catch up is possible when oestrogen or testosterone is introduced later.

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[37] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[38] Brik T, Vrouenraets LJJJ, de Vries MC, Hannema SE (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. Arch Sex Behav 49: 2611–8. DOI: 10.1007/s10508-020-01660-8.
[39] Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.
[40] Delevichab K, Klinger M, Nana OJ, Wilbrecht L (2021). Coming of age in the frontal cortex: The role of puberty in cortical maturation. Semin Cell Dev Biol 118: 64–72. DOI: 10.1016/j.semcdb.2021.04.021.
[41] Goddings A-L, Beltz A, Jiska S, Crone EA, Braams BR (2019). Understanding the role of puberty in structural and functional development of the adolescent brain. J Res Adolesc 29(1): 32–53. DOI: 10.1111/jora.12408.

3.33. An international interdisciplinary panel[42] has highlighted the importance of understanding the neurodevelopmental outcomes of pubertal suppression and defined an appropriate approach for investigating this further. However, this work has not yet been undertaken.

## Initiation of Cass Review

3.34. Dr Cass' own reflections on the PWG process, the available literature, and the issues it highlighted were as follows:

- Firstly, that hormone treatment is just one possible outcome for gender-questioning children and young people. A much better understanding is needed about: the increasing numbers of children and young people with gender-related distress presenting for help; the appropriate clinical pathway for each individual; their support needs; and the full range of potential treatment options.
- Secondly, there is very limited follow-up of the subset of children and young people who receive hormone treatment, which limits our understanding about the long-term outcomes of these treatments and this lack of follow up data should be corrected.
- Thirdly, the assessment process is inconsistent across the published literature. The outcome of hormone treatment is highly influenced by whether the assessment process accurately selects those children and young people most likely to benefit from medical treatment. This makes it difficult to draw conclusions from published studies.

3.35. In light of the above, NHS England commissioned this independent review to make recommendations on how the clinical management and service provision for children and young people who are experiencing gender incongruence or gender-related distress can be improved.

## CQC inspection

3.36. In October and November 2020, the Care Quality Commission (CQC) inspectors carried out an announced, focused inspection of GIDS due to concerns reported to them by healthcare professionals and the Children's Commissioner for England. Concerns related to clinical practice, safeguarding procedures, and assessments of capacity and consent to treatment.

[42] Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, et al (2020). Consensus parameter: research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. Transgender Health 5(4). DOI: 10.1089/trgh.2020.0006.

3.37. The CQC report, published in January 2021,[43] gave the service an overall rating of inadequate. The report noted the high level of commitment and caring approach of the staff but identified a series of issues that needed improvement. In addition to the growing waiting list pressures, the CQC identified problems in several other areas including: the assessment and management of risk; the variations in clinical approach; the lack of clarity and consistency of care plans; the lack of any clear written rationale for decision making in individual cases; and shortfalls in the multidisciplinary mix required for some patient groups. Recording of capacity, competency and consent had improved since the new SOP in January 2020; however, there remained a culture in which staff reported feeling unable to raise concerns.

3.38. The CQC reported that when it inspected GIDS, there did not appear to be a formalised assessment process, or standard questions to explore at each session, and it was not possible to tell from the notes why an individual child might have been referred to endocrinology whilst another had not. Current GIDS data demonstrate that a majority of children and young people seen by the service do not get referred for endocrine treatment, but there is no clear information about what other diagnoses they receive, and what help or support they might need.

3.39. Since the CQC report, NHS England and The Tavistock and Portman NHS Foundation Trust management team have been working to address the issues raised. However, whilst some problems require a focused Trust response, the waiting list requires a system-wide response. This was noted in the letter from the Review to NHS England in May 2021 (**Appendix 2**).

## Legal background

3.40. This section sets out the chronology of recent case law. In October 2019, a claim for Judicial Review was brought against The Tavistock and Portman NHS Foundation Trust. The claimants' case was summarised by the High Court as follows: "The claimants' case is that children and young persons under 18 are not competent to give consent to the administration of puberty blocking drugs. Further, they contend that the information given to those under 18 by the defendant [GIDS] is misleading and insufficient to ensure such children or young persons are able to give informed consent. They further contend that the absence of procedural safeguards, and the inadequacy of the information provided, results in an infringement of the rights of such children and young persons under Article 8 of the European Convention

[43] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

for the Protection of Human Rights and Fundamental Freedoms."[44]

3.41. In December 2020, three judges in the High Court of England and Wales handed down judgment in *Bell v Tavistock.*[45] (Most cases in the High Court are heard by a single judge sitting alone, and when a case is heard by more than one judge in the High Court, it is described as the Divisional Court.) The Divisional Court recognised that the Tavistock's policies and practices as set out in the service specification were not unlawful. However, the Court made a declaration that set out in detail a series of implications of treatment that a child would need to understand to be *Gillick* competent[46] to consent to puberty blockers. Specifically, because most children put on puberty blockers go on to have feminising/masculinising hormones, the judgment said a child would need to understand not only the full implications of puberty blocking drugs, but also the implications of the full pathway of medical and surgical transition. The judges concluded that it will be "very doubtful" that 14-15 year-olds have such competence, and "highly unlikely" that children aged 13 or under have competence for that decision. Under the Mental Capacity Act 2005, 16-17 year-olds are presumed to have capacity, and they are effectively treated as adults for consent to medical treatment under the Family Law Reform Act 1969 section 8, but the judges suggested that it would be appropriate for clinicians to involve the court in any case where there were doubts as to whether the proposed treatment would be in the long term best interests of a 16-17 year-old.

3.42. Following the Divisional Court judgment in *Bell v Tavistock*, a claim was brought against the Tavistock in the High Court Family Division by the mother of a child for a declaration that she and the child's father had the ability in law to consent on behalf of their child to the administration of puberty blockers *(AB v CD)*.[47] The Court concluded that "the parents' right to consent to treatment on behalf of the child continues even when the child is *Gillick* competent to make the decision, save where the parents are seeking to override the decision of the child" [para 114] and that there is no "general rule that puberty blockers should be placed in a special category by which parents are unable in law to give consent" [para 128].

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[44] Bell v Tavistock. [2020] EWHC 3274 (Admin).
[45] Ibid.
[46] Gillick v West Norfolk and Wisbech AHA [1986] AC 112.
[47] AB v CD & Ors [2021] EWHC 741.

3.43. Subsequently, the Tavistock appealed the Divisional Court's earlier decision in *Bell v Tavistock* and was successful.[48] The Court of Appeal held that it was not appropriate for the Divisional Court to provide the guidance about the likelihood of having *Gillick* competence at particular ages, or about the need for court approval [para 91]. The Court of Appeal went on to say "The Divisional Court concluded that Tavistock's policies and practices (as expressed in the service specification and the SOP) were not unlawful and rejected the legal criticism of its materials. In those circumstances, the claim for judicial review is dismissed." [para 91]. However, clinicians should "take great care before recommending treatment to a child and be astute to ensure that the consent obtained from both child and parents is properly informed" [para 92].

3.44. The Court of Appeal in *Bell v Tavistock* recognised the lawfulness of treating children for gender dysphoria in this jurisdiction. Recognising the divergences in medical opinion, morality and ethics, it indicated that the question of whether treatment should be made available is a matter of policy "for the National Health Service, the medical profession and its regulators and Government and Parliament" [para 3].

3.45. Following the Divisional Court decision in *Bell v Tavistock*, new referrals for puberty blockers were suspended and a requirement was put in place that children currently on puberty blockers were reviewed with a view to court proceedings for a judge to determine the best interests for children in whom these medications were considered essential. This requirement was changed following *AB v CD*, with the reinstatement of the hormone pathway in March 2021. However, an external panel, the Multi Professional Review Group (MPRG), was established to ensure that procedures for assessment and for informed consent had been properly followed. The outcome of the *Bell* appeal has not changed this requirement, which is contingent not just on the legal processes but on the concerns raised by CQC regarding consent, documentation and clarity about decision making within the service.[49]

[48] EWCA [2021] Civ 1363.
[49] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

## The Multi-Professional Review Group

3.46. NHS England has established a Multi-Professional Review Group (MPRG) to review whether the agreed process has been followed for a child to be referred into the endocrinology clinic and to be prescribed treatment. The Review has spoken directly to the MPRG, which has reported its observations of current practice.

3.47. The MPRG has stated that its work has been impeded by delays in the provision of clinical information, the lack of structure in the documentation received, and gaps in the necessary evidence. This means that when reviewing the documents provided it is not always easy to determine if the process for referral for endocrine treatment has been fully or safely followed for a particular child or young person.

3.48. The MPRG indicates that there does not appear to be a standardised approach to assessment. They are particularly concerned about safeguarding shortfalls within the assessment process. There is also limited evidence of systematic, formal mental health or neurodevelopmental assessments being routinely documented, or of a discipline of formal diagnostic formulation in relation to co-occurring mental health difficulties. This issue was also highlighted by the Care Quality Commission (CQC).[50]

3.49. Additionally, there is concern that communications to GPs and parents regarding prescribed treatment with puberty blockers sometimes come from non-medical staff.

[50] Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

# 4. What the review has heard so far



# Listening sessions

4.1. Since its establishment, the Review has met with an extensive range of stakeholders, including professionals, their respective governing organisations and those with lived experience, both directly and through support and advocacy groups, to understand the broad range of views and experiences surrounding the delivery of gender identity services.

## What we have heard from service users, their families and support and advocacy groups

### Issues for children and young people

4.2. What we understand most clearly from all we have heard is that at the centre of a difficult and complex debate are children, young people and families in great distress. We have heard concerns about children and young people facing the stress of being on a prolonged waiting list with limited support available from statutory services, lack of certainty about when and if they might reach the top of that list and subsequent impacts on mental health. Also, the particular issues that have followed the *Bell v Tavistock* litigation.

4.3. We have heard about the anxiety that birth-registered males face as they come closer to the point where they will grow facial hair and their voice drops, and the fear that it will make it harder for them to pass as a transgender woman in later life. We have also heard about the distress experienced by birth-registered females as they reach puberty, including the use of painful, and potentially harmful, binding processes to conceal their breasts.

4.4. When children and young people are able to access the service, there is often a sense of frustration with what several describe as the "gatekeeping" medical model and a "clinician lottery". This can feel like a series of barriers and hurdles designed to add to, rather than alleviate, distress. Most children and young people seeking help do not see themselves as having a medical condition; yet to achieve their desired intervention they need to engage with clinical services and receive a medical diagnosis of gender dysphoria. By the time they are seen in the GIDS clinic, they may feel very certain of their gender identity and be anxious to start hormone treatment as quickly as possible. However, they can then face a period of what can seem like intrusive, repetitive and unnecessary questioning. Some feel that this undermines their autonomy and right to self-determination.

4.5. We have heard that some young people learn through peers and social media what they should and should not say to therapy staff in order to access hormone treatment; for example, that they are advised not to admit to previous abuse or trauma, or uncertainty about their sexual orientation. We have also heard that many of those seeking NHS support identify as non-binary, gender non-conforming, or gender fluid. We understand that some

young people who identify as non-binary feel their needs are not met by clinical services unless they give a binary narrative about their gender preferences.

### Issues for parents

4.6. We have also heard about the distress parents may feel as they try to work out how best to support their children and how tensions and conflict may arise where parents and their children have different views. For example, some parents have highlighted the importance of ensuring that children and young people are able to keep their options fluid until such time as it becomes essential to commit to a hormonal course of action, whilst their children may want more rapid hormone intervention.

4.7. We have heard about families trying to balance the risks of obtaining unregulated and potentially dangerous hormone supplies over the internet or from private providers versus the ongoing trauma of prolonged waits for assessment.

4.8. Parents have also raised concerns about the vulnerability of neurodiverse children and young people and expressed that the communication needs of these children and young people are not adequately reflected during assessment processes or treatment planning.

4.9. GIDS has always required consent/assent from both the child and parents/carers and has sought ways to resolve family conflict, which in the worst-case scenario can lead to family breakdown. It has been highlighted to us that the future service model should provide more targeted support for parents and carers.

### Service issues

4.10. Another significant issue raised with us is one of diagnostic overshadowing – many of the children and young people presenting have complex needs, but once they are identified as having gender-related distress, other important healthcare issues that would normally be managed by local services can sometimes be subsumed by the label of gender dysphoria. This issue is compounded by the waiting list, which means that there can be a significant period of time without appropriate assessment, treatment or care.

4.11. Stakeholders have spoken of the need for appropriate assessment when first accessing NHS services to aid both the exploration of the child or young person's wellbeing and gender distress and any other challenges they may be facing.

### Information

4.12. We have also heard about the lack of access to accurate, balanced information upon which children, young people and their families/carers can inform their decisions.

4.13. We have heard that distress may be exacerbated by pressure to identify with societal stereotyping and concerns over the influence of social media, which can be seen to perpetuate unrealistic images of gender and set unhealthy expectations, especially given how long

children and young people are waiting to access services.

### Other issues

4.14. Several issues that were raised with us are not explored further in this interim report, but we have taken note of them. These will be considered further during the lifetime of the Review and include:

- The important role of schools and the challenges they face in responding appropriately to gender-questioning children and young people.
- The complex interaction between sexuality and gender identity, and societal responses to both; for example, we have heard from young lesbians who felt pressured to identify as transgender male, and conversely transgender males who felt pressured to come out as gay rather than transgender. We have also heard from adults who identified as transgender through childhood, and then reverted to their birth-registered gender in teen years.
- The issues faced by detransitioners highlight the need for better services and pathways for this group, many of whom are living with irreversible effects of transition but for whom there is no clear access to services as they fall outside the responsibility of NHS gender identity services.
- The age at which adult gender identity clinics can receive referrals, with concerns about the inclusion of 17-year-olds. The service offer in adult services is perceived to be quite different from that of GIDS, and young people presenting later may therefore not be afforded the same level of therapeutic input under the adult service model. There is also concern about the impact on the young person of changing clinicians at a crucial point in their care. The movement of young people with special educational needs between children's and adult services raises particular concerns.

## What we have heard from healthcare professionals

### Lack of professional consensus

4.15. Clinicians and associated professionals we have spoken to have highlighted the lack of an agreed consensus on the different possible implications of gender-related distress – whether it may be an indication that the child or young person is likely to grow up to be a transgender adult and would benefit from physical intervention, or whether it may be a manifestation of other causes of distress. Following directly from this is a spectrum of opinion about the correct clinical approach, ranging broadly between those who take a more gender-affirmative approach to those who take a more cautious, developmentally-informed approach.

4.16. Speaking to current and ex-GIDS staff, we have heard about the pressure on GIDS clinicians, many of whom feel overwhelmed by the numbers of children and young people being referred and who are demoralised by the media coverage of their service. Although the clinical team attempt to manage risk on the waiting list by engaging with local services, there is limited capacity and/or capability to respond appropriately to the needs of this group in primary and secondary care. The Review has already referred to this issue as the most pressing priority in its letter to NHS England (**Appendix 2**), alongside potential risks relating to safeguarding and/or mental health issues, and diagnostic overshadowing.

4.17. With respect to GIDS, we have been told that although there are forums for staff to discuss difficult cases with senior colleagues, it is still difficult for staff to raise concerns about the clinical approach. Also that many individuals who are more cautious and advocate the need for an exploratory approach have left the service.

## Consistency and standards

4.18. GIDS staff have confirmed that judgements are very individual, with some clinicians taking a more gender-affirmative approach and others emphasising the need for caution and for careful exploration of broader issues. The Review has been told that there is considerable variation in the approach taken between the London, Leeds and Bristol teams.

4.19. Speaking to professionals outside GIDS, we have heard widespread concern about the lack of guidance and evidence on how to manage this group of young people.

4.20. Some secondary care providers told us that their training and professional standards dictate that when working with a child or young person they should be taking a mental health approach to formulating a differential diagnosis of the child or young person's problems. However, they are afraid of the consequences of doing so in relation to gender distress because of the pressure to take a purely affirmative approach. Some clinicians feel that they are not supported by their professional body on this matter. Hence the practice of passing referrals straight through to GIDS is not just a reflection of local service capacity problems, but also of professionals' practical concerns about the appropriate clinical management of this group of children and young people.

4.21. GPs have expressed concern about being pressurised to prescribe puberty blockers or feminising/masculinising hormones after these have been initiated by private providers.

4.22. This also links to professional concerns about parents being anxious for hormone treatment to be initiated when the child or young person does not seem ready.

## Other issues

4.23. We have also heard that parents and carers play a huge role and are instrumental in helping young people

to keep open their developmental opportunities. In discussion with social workers, we heard concerns about how looked after children are supported in getting the help and support they need.

4.24. Therapists who work with detransitioners and people with regret have highlighted a lack of services and pathways and a need for services to support this population. There is also the need for more research to understand what factors contribute to the decision to detransition.

4.25. The importance of broad holistic interventions to help reduce distress has been emphasised to the Review, with therapists and other clinicians advocating the importance of careful developmentally informed assessment and of showing children and young people a range of different narratives, experiences and outcomes.

4.26. Clinicians have raised concerns about children and young people's NHS numbers being changed inconsistently, as there is no specific guidance for GPs and others as to when this should be done for this population and under what consent. This has implications for safeguarding and clinical management of these children and young people and it also makes it difficult to do research exploring long-term outcomes.

4.27. As with the comments made by service users, their families and support and advocacy groups, we have heard similar views from professionals about the transition from children's to adult services, and the role of schools.

## Structured engagement with primary, secondary and specialist clinicians

4.28. The Review's letter to NHS England (**Appendix 2**) set out some of the immediate issues with the current provision of gender identity services for children and young people and suggested how its work might help with the challenging problem of establishing an infrastructure outside GIDS. This included looking at the capacity, capability and confidence of the wider workforce and how this could be built and sustained, and the establishment of potential assessment frameworks for use in primary and/or secondary care.

### Professional panel – primary and secondary care

4.29. In order to understand the challenges and establish a picture of current competency, capacity and confidence among the workforce outside the specialist gender development service, an online professional panel was established to explore issues around gender identity services for children and young people. The role of the panel was aimed at better comprehending how it looks and feels for clinicians and other professionals working with these young people, as well as any broader thoughts about the work, and to start exploring how the care of these

children and young people can be better managed in the future.

4.30. The project was designed to capture a broad mix of professional views and experiences, recruiting from the professional groups that are most likely to have a role in the care pathway – GPs, paediatricians, child psychiatrists, child psychologists and child psychotherapists, nurses and social workers.

4.31. A total of 102 clinicians and other professionals were involved in the panel. The panel represented a balanced professional mix, and participant ages and gender were broadly representative of the overall sector workforce. Participants were self-selecting and were recruited via healthcare professional networks and Royal Colleges.

4.32. Each week the panel was set an independent activity comprised of two or more tasks. Additionally, a sub-set of the panel was invited to participate in focus groups at the midway and endpoint of the project. Activities were designed to capture an understanding of:

- experiences of working with gender-questioning children and young people and panel members' confidence and competence to manage their care;
- changes they may have experienced in the presentation of children and young people with gender-related distress;
- areas where professionals feel they require more information in order to support gender-questioning children and young people;
- where professionals currently go to find that information;
- the role of different professions in the care pathway;
- the role of professionals in the assessment framework; and
- what participants felt should be included in an assessment framework across the whole service pathway.

## Gender specialist questionnaire

4.33. Having concluded the professional panel exercise, we wanted to triangulate what we had heard with the thoughts and views of professionals working predominantly or exclusively with gender-questioning children and young people.

4.34. To do this in a systematic way, we conducted an online survey which contained some service-specific questions, but also reflected and sought to test some of what we had heard from primary and secondary care professionals.

## Findings

4.35. This structured engagement has yielded valuable insights from clinicians and professionals with experience working with gender-questioning children and young people both within and outside the specialist gender service. It has contributed to the thinking of the Review and informed some of the interim advice set out in this report.

4.36. There are a number of consistent messages arising from these activities:

- The current long waiting lists that gender-questioning children and young people and their families/carers face are unacceptable for all parties involved, including professionals.
- Many professionals in our sample said that not only are gender-questioning children and young people having to wait a long time before receiving treatment, but they also do not receive appropriate support during this waiting period.
- Another impact of the long wait that clinicians reported is that when a child or young person is seen at GIDS, they may have a more fixed view of what they need and are looking for action to be taken quickly. This reportedly can lead to frustration with the assessment process.
- When considering the more holistic support that children and young people may need, gender specialists further highlighted the difficulties that children and young people face accessing local support, for example, from CAMHS, whilst being seen at GIDS.
- It is clear from the professionals who took part in these activities that there is a strong professional commitment to provide quality care to gender-questioning children and young people and their families/carers. However, this research indicates that levels of confidence and competence do vary among primary and secondary care professionals in our sample.
- Concerns were expressed by professionals who took part in this research about the lack of consensus among the clinical community on the right clinical approach to take when working with a gender-questioning child or young person and their families/carers.
- In order to support clinicians and professionals more widely, participants felt there is a need for a robust evidence base, consistent legal framework and clinical guidelines, a stronger assessment process and different pathway options that holistically meet the needs of each gender-questioning child or young person and their families/carers.

4.37. There are also several areas where further discussion and consensus is needed:

- There is not a consistent view among the professionals participating in the panel and questionnaire about the nature of gender dysphoria and therefore the role of assessment for children and young people experiencing gender dysphoria.

- Some clinicians felt that assessment should be focused on whether medical interventions are an appropriate course of action for the individual. Other clinicians believe that assessment should seek to make a differential diagnosis, ruling out other potential causes of the child or young person's distress.
- There are different perspectives on the roles of primary, secondary and specialist services in the care pathway(s) and what support or action might best be provided at different levels.
- While there was general consensus that diagnostic or psychological formulation needs to form part of the assessment process, there were differing views as to whether a mental state assessment is needed, and should it be, where in the pathway and by whom this should be done.

4.38. It is important to note that the information gathered represents the views and insights of the panel participants and survey respondents at a moment in time and findings should be read in the context of a developing narrative on the subject, where perspectives may evolve. This relates to both the experiences of professionals, but also the extent to which this subject matter is discussed in the public sphere.

4.39. The Review is grateful to all the participants for their time and high level of engagement. The Review will build on the work we have undertaken and, alongside our academic research, will continue with a programme of engagement with professionals, service users and their families, which will help to further develop the evidence base.

The full reports from the professional panel and gender specialist questionnaire are on the Review's website (https://cass.independent-review.uk/).

# 5. Principles of evidence based service development



# Evidence based service development

5.1. This chapter integrates the information regarding the development of the current service (see Chapter 3) with the views we have heard to date (see Chapter 4) and sets this in the context of how evidence is routinely used to develop and improve services in the NHS.

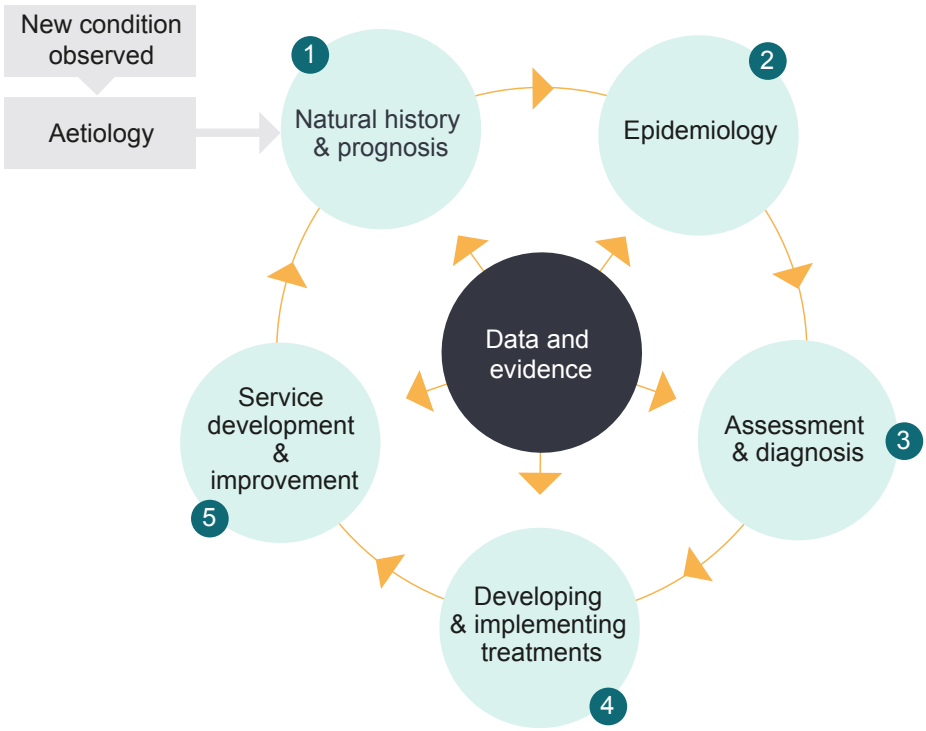
5.2. Some earlier information is necessarily repeated here, but this is with the intention of providing a more accessible explanation of the standards and processes which govern clinical service development. This is essential to an understanding of the rationale for the Review's recommendations.

5.3. Because the specialist service has evolved rapidly and organically in response to demand, the clinical approach and overall service design has not been subjected to some of the normal quality controls that are typically applied when new or innovative treatments are introduced. This Review now affords everyone concerned the opportunity to step back and consider from first principles what this cohort of children and young people now need from NHS services, based on the evidence that exists, or additional evidence that the Review hopes to collect.

5.4. In **Appendix 4** we have described the service development process for three different conditions which may help to illustrate what would be expected to happen at each different stage of developing a clinical service. The steps may proceed in a different sequence for different conditions, but each step is important in the development of evidence based care.

5.5. We recognise that for some of those reading this report it may feel wrong to compare gender incongruence or dysphoria to clinical conditions, and indeed this approach would not be justified if individuals presenting with these conditions did not require clinician intervention. However, where a clinical intervention is given, the same ethical, professional and scientific standards have to be applied as to any other clinical condition.

## Key stages of service development




**New condition observed:** This often begins with a few case reports and then clinicians begin to recognise a recurring pattern and key clinical features, and to develop fuller descriptions of the condition.

**Aetiology:** Clinicians and scientists try to work out the cause of the condition or the underlying physical or biological basis. Sometimes the answers to this are never found.

**Natural history and prognosis:** It is important to understand how a condition usually evolves over time, with or without treatment. The latter is important if treatment has limited efficacy and the condition is 'self-limiting' (that is, it resolves without treatment), because otherwise there is a risk that treatments create more difficulties than the condition itself.

5.6. The first UK service for gender-questioning children and young people was established in 1989. At that time there were very few children and young people being seen by medical services internationally. The most common presentation in the early years of the service was of birth-registered

boys who had demonstrated gender incongruence from an early age.[51,52,53]

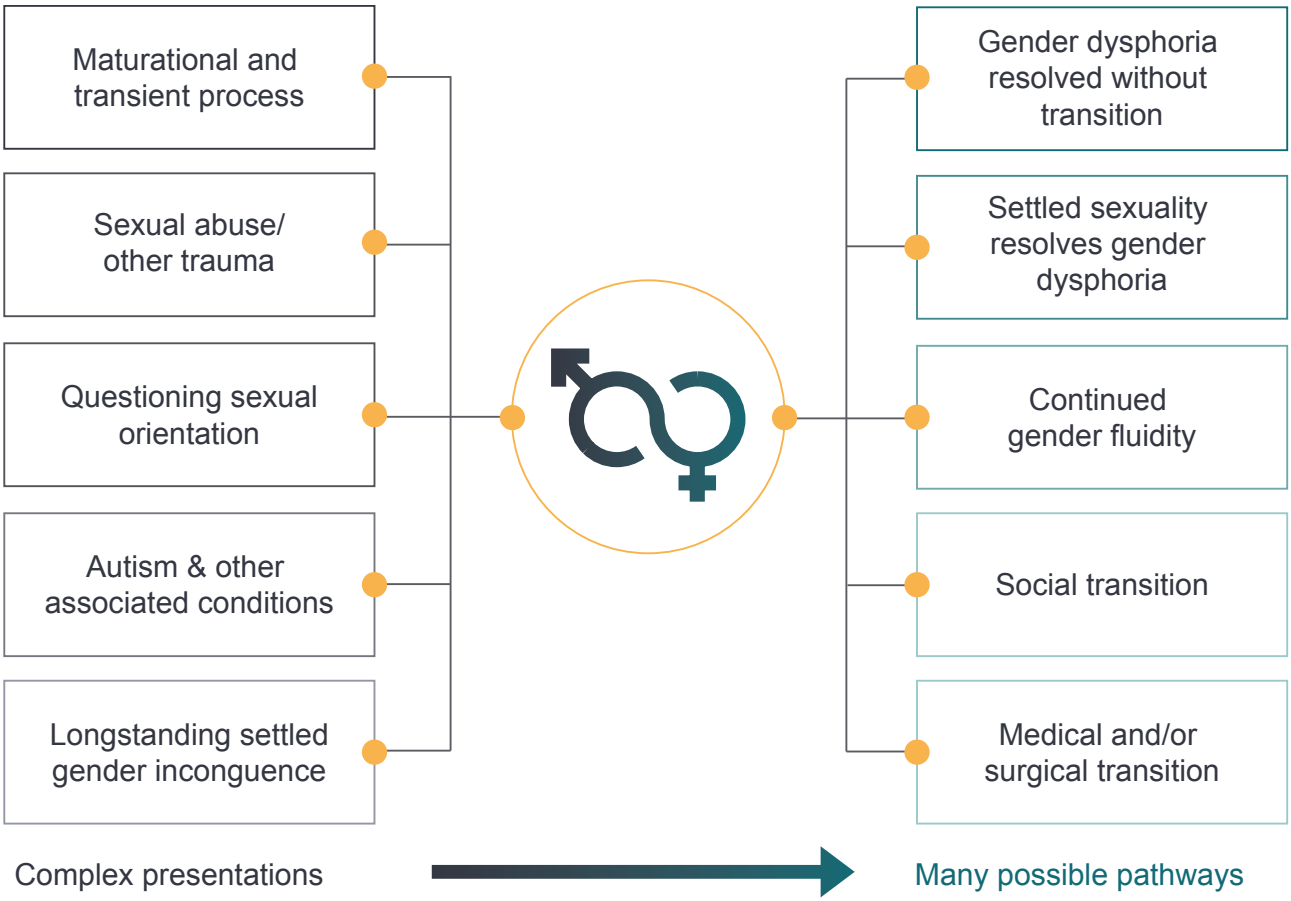
5.7. There is extensive literature discussing the possible aetiology of gender incongruence. Based on the available evidence, many authors would suggest that it is likely that biological, cultural, social and psychological factors all contribute. The examples in **Appendix 4** show that this is not an uncommon situation; many conditions do not have a single clear causation – they are in other words 'multifactorial'.

5.8. Regardless of aetiology, the more contentious and important question is how fixed or fluid gender incongruence is at different ages and stages of development, and whether, regardless of aetiology, can be an inherent characteristic of the individual concerned. There is a spectrum of academic, clinical and societal opinion on this. At one end are those who believe that gender identity can fluctuate over time and be highly mutable and that, because gender incongruence or gender-related distress may be a response to many psychosocial factors, identity may sometimes change or the distress may resolve in later adolescence or early adulthood, even in those whose early incongruence or distress was quite marked. At the other end are those who believe that gender incongruence or dysphoria in childhood or adolescence is generally a clear indicator of that child or young person being transgender and question the methodology of some of the desistance studies. Previous literature has indicated that if gender incongruence continues into puberty, desistance is unlikely.[54,55] However, it should be noted that these older studies were not based on the current changed case-mix or the different socio-cultural climate of recent years, which may have led to different outcomes. Having an open discussion about these questions is essential if a shared understanding of how to provide appropriate assessment and treatment is to be reached.

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[51] Zucker KJ (2017). Epidemiology of gender dysphoria and transgender identity. Sex Health 14(5): 404–11. DOI:10.1071/SH1.
[52] Zucker KJ, Lawrence AA (2009). Epidemiology of gender identity disorder: recommendations for the Standards of Care of the World Professional Association for Transgender Health. Int J Transgend 11(1): 8-18. DOI: 10.1080/15532730902799946.
[53] de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.
[54] Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry 16(4): 485-97. DOI: 10.1177/135910451037803.
[55] Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry 52: 582-590. DOI: 10.1016/j.jaac.2013.03.016.

**Complex presentations and complex pathways – exemplars, not comprehensive lists**




**Epidemiology:** Epidemiologists collect data to find out how common a condition is, who is most likely to be affected, what the age distribution is and so on. This allows health service planners to work out how many services are needed, where they should be established, and what staff are needed.

They also report on changes in who is most affected, which may mean that either the disease is changing, or the susceptibility of the population is changing.

5.9. As previously indicated, the epidemiology of gender dysphoria is changing, with an increase in the numbers of birth-registered females presenting in early teens.[56,57] In addition, the majority of children and young people presenting to GIDS have other complex mental health issues and/or neurodiversity.[58] There is also an over-representation of looked after children.[59]

5.10. There are several implications arising from the change in epidemiology:

- Firstly, the speed of change in the numbers presenting means that services have not kept pace with demand.
- Secondly, the cohort that the original Dutch Approach was based on is different from the current more complex NHS cohort, and also from the current case-mix internationally, and therefore it is difficult to extrapolate from older literature to this current group.
- Thirdly, different subgroups may have quite different needs and outcomes, and these must be built into any service design, so that it works for all children and young people.

5.11. At present we have the least information for the largest group of patients – birth-registered females first presenting in early teen years. Since the rapid increase in this group began around 2015, they will not reach late 20s for another 5+ years, which would be the best time to assess longer-term wellbeing.

[56] Steensma TD, Cohen-Kettenis PT, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988-2016). Journal of Sex & Marital Therapy 44(7): 713–5. DOI: 10.1080/0092623X.2018.1437580.
[57] de Graaf NM, Carmichael P, Steensma TD, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for Gender Dysphoria: Data from the Gender Identity Development Service in London (2000–2017). J Sex Med 15(10): 1381–3. DOI: 10.1016/j.jsxm.2018.08.002.
[58] Van Der Miesen AIR, Hurley H, De Vries ALC (2016). Gender dysphoria and autism spectrum disorder: A narrative review. Int Rev Psychiatry 28: 70-80. DOI: 10.3109/09540261.2015.1111199.
[59] Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

**Assessment and diagnosis:** Clinicians will usually take a history from (that is, of their symptoms) and examine the patient (that is, for signs and symptoms), and where appropriate undertake a series of investigations or tests, to help them reach an accurate diagnosis.

Sometimes the whole process of making a diagnosis through talking to the patient and asking them to complete formal questionnaires, examining them and/or undertaking investigations is called 'clinical assessment'.

As well as diagnosing and ruling out a particular condition, clinicians often need to consider and exclude other, sometimes more serious, conditions that present in a similar way but may need quite different treatment – this process is called 'differential diagnosis'.

5.12. For children and young people with gender-related distress, many people would dispute the notion that 'making a diagnosis' is a meaningful concept, arguing that gender identity is a personal, internal perception of oneself. However, there are several reasons to why a diagnostic framework is used:

- Firstly, the clinician will seek to determine whether the child or young person has a stable transgender identity, or whether there might be other causes for the gender-related distress.
- Secondly, the clinician will determine whether there are other issues or diagnoses that might be having an impact on the young person's mental health. The Dutch Approach suggesting that these should be addressed prior to or alongside initiation of any medical treatments.
- Thirdly, in any situation where life-altering treatments are being administered, the clinician holds the responsibility for ensuring that they are being administered based on an appropriate decision making process. Therefore, it is usual practice for a diagnosis of gender dysphoria to be made prior to referring for any physical treatments.

5.13. When the word 'diagnosis' is used, people often associate this with the use of blood tests, X-rays, or other laboratory tests. As set out in the **Appendix 4**, the public is very familiar with diagnosis of Covid-19 and understands that there need to be tests that give a high degree of certainty about whether an individual is Covid-19 positive or not. False positive lateral flow tests are rare, but caused problems for schools, while PCR has been treated as the 'gold standard' test for accuracy.

5.14. When it comes to gender dysphoria, there are no blood tests or other laboratory tests, so assessment and diagnosis in children and young people with gender-related distress is reliant on the judgements of experienced clinicians. Because medical, and subsequently possibly surgical treatments will follow, it may be argued that a highly sensitive and specific assessment process is required. The assessment should be able to accurately identify those children or young people for whom physical intervention is going to be the best course of action, but it is equally important that it identifies those who need an alternative pathway or treatment.

5.15. The formal criteria for diagnosing gender dysphoria (DSM-5) are listed in **Appendix 3**. However, there are two problems associated with the use of these criteria:

- Firstly, several of the criteria are based on gender stereotyping which may not be deemed relevant in current society, although the core criteria remain valid.
- Secondly, and more importantly, these criteria give a basis on which to make a diagnosis that a young person is clinically distressed by the incongruence between their birth-registered and their experienced gender, but they do not help in determining which factors may have led to this distress and how they might best be resolved.

5.16. At present, the assessment process varies considerably, dependent on the perceptions, experience and beliefs of different clinicians. There are some existing measurement tools, but it is suggested that these have substantial limitations.[60]

5.17. The challenges are similar to the early difficulties in diagnosing autism, as set out in **Appendix 4**. As with autism, the framework for assessment needs to become formalised so there are clearer criteria for diagnosis and treatment pathways which are shared more widely. These should incorporate not just whether the child or young person meets DSM-5 criteria for gender dysphoria, but how a broader psychosocial assessment should be conducted and evaluated, and what other factors need to be considered to gain a holistic understanding of the child or young person's experience. Professional judgement and experience will still be important, but if the frameworks and criteria for assessment and diagnosis were more consistent and reproducible, there would be a greater likelihood that two different people seeing the same child or young person would come to the same conclusion. This would also mean that any research on interventions or long-term outcomes would be more reliable because the criteria on which a diagnosis was made, and hence the patients within the sample, would have the same characteristics.

[60] Bloom TM, Nguyen TP, Lami F, Pace CC, Poulakis Z, Telfer N (2021). Measurement tools for gender identity, gender expression, and gender dysphoria in transgender and gender-diverse children and adolescents: a systematic review. Lancet Child Adolescent Health. 5: 582-588. DOI: 10.1016/s2352-4642(21)00098-5.

5.18. As outlined above, it is standard clinical practice to undertake a process called differential diagnosis. This involves summarising the main points of the clinical assessment, the most likely diagnosis, other possible diagnoses and the reasons for including or excluding them, as well as any further assessments that may be required to clarify the diagnosis and the treatment options and plan. This is important when a medical intervention is being provided on the basis of the assessment, so the process is robust, explicit and reproducible. These considerations need to be applied to the assessment of children and young people presenting with gender-related distress. In mental health services, practitioners may also undertake a diagnostic or psychological formulation, which is a holistic summary of how the patient is feeling and why, and how to make sense of it, and a plan for moving forward with management or treatment.

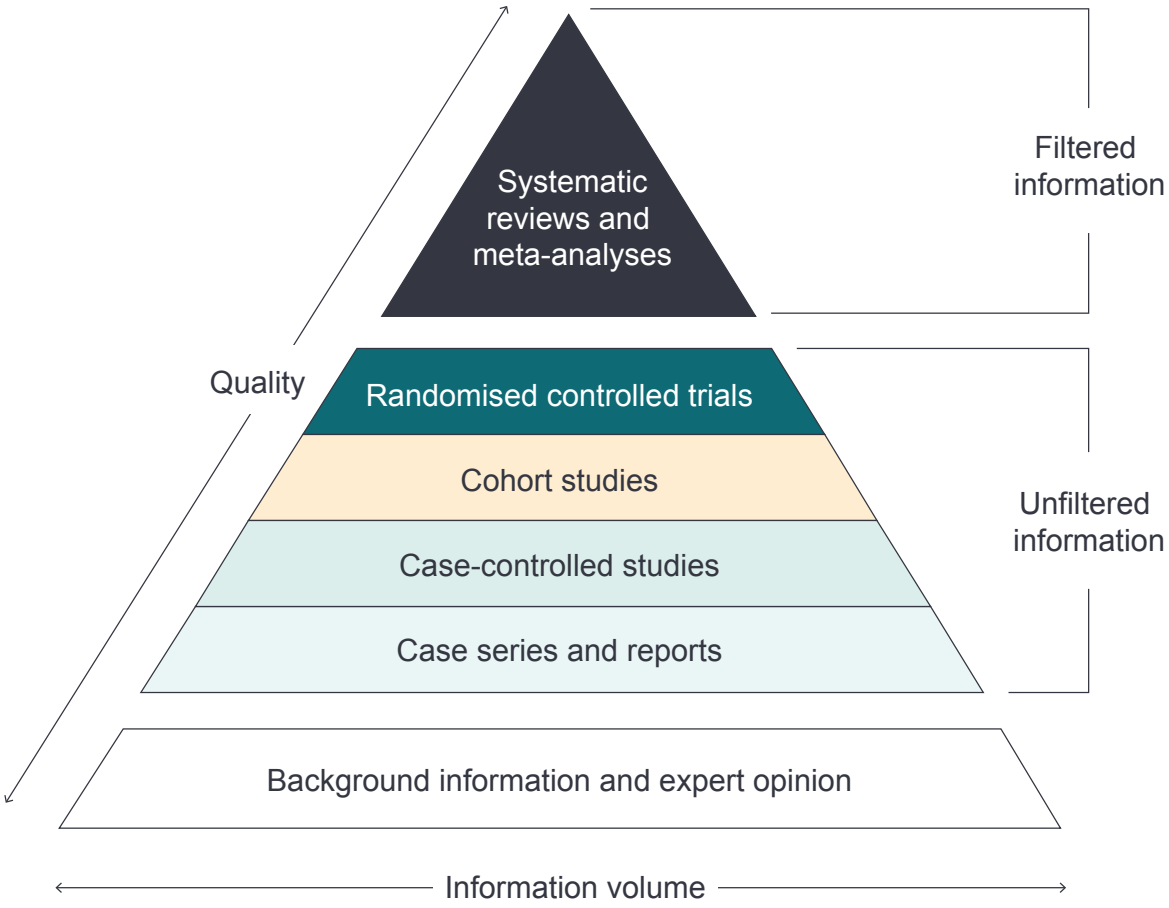
**Developing and implementing new treatments:** Clinicians and scientists work on developing treatments. This involves clinical trials and, where there are new treatments, comparing them to any existing treatments. Questions include: What are the intended outcomes or benefits of treatment? What are the complications or side effects? What are the costs? To initiate a new treatment, it must be both safe and effective. Questions of affordability can sometimes become controversial.

The best type of single study is considered to be the randomised controlled trial (RCT), but sometimes this is not feasible. Even where RCTs are not available, it is usual to at least have data on the outcomes of sufficient cases or cohorts to understand the risk/benefit of the treatment under consideration. As demonstrated in Fig. 4, the highest level of evidence is when the results of several different studies are pooled, but this is only useful if the individual studies themselves are of high quality.

In many instances, evidence is not perfect and difficult decisions have to be made. Where treatments are innovative or life-changing, the whole multi-disciplinary team will usually meet to consider the available options, and how to advise the child or young person and family so that a shared decision can be made. Sometimes an ethics committee is involved. This is one of the most challenging areas of medicine and is underpinned by GMC guidance.[61,62]

[61] General Medical Council (2020). Decision making and consent.
[62] National Institute for Health and Care Excellence (2021). Shared decision making.

**Figure 3: Pyramid of standards of evidence**




**Source: Levels of evidence pyramid, OpenMD. Reproduced with permission[63]**

5.19. There are three types of intervention or treatment for children and young people with gender-related distress, which may be introduced individually or in combination with one another:

- **Social transition** – this may not be thought of as an intervention or treatment, because it is not something that happens within health services. However, it is important to view it as an active intervention because it may have significant effects on the child or young person in terms of their psychological functioning.[64,65] There are different views on the benefits versus the harms of early social transition. Whatever position one

[63] OpenMD (2021). New Evidence in Medical Research.
[64] Sievert EDC, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I (2020). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria.Clin Child Psychol Psychiatry 26(1): 79–95. DOI: 10.1177/1359104520964530
[65] Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

takes, it is important to acknowledge that it is not a neutral act, and better information is needed about outcomes.

- **Counselling, social or psychological interventions** – these may be offered before, instead of, or alongside physical interventions. Again, they should be viewed as active interventions which require robust evaluation in their own right.
- **Physical treatments** – these comprise puberty blockers and feminising/masculinising hormones (administered by endocrinologists) and surgery. The latter is not considered as part of this Review since it is not available to those under age 18.

5.20. It should also be recognised that 'doing nothing' cannot be considered a neutral act.

5.21. The lack of available high-level evidence was reflected in the recent NICE review into the use of puberty blockers and feminising/masculinising hormones commissioned by NHS England, with the evidence being too inconclusive to form the basis of a policy position.[66,67] Assessing treatments for gender dysphoria has many of the same problems as assessing treatment for children with autism – it can take many years to get a full appreciation of outcomes and there may be other complicating factors in the child or young person's life during this period. However, this of itself is not an adequate reason for the major gaps in the international literature.

5.22. It is still common that drugs are not specifically licensed for children because the trials have only taken place on adults. This does not preclude their use or make their use inherently unsafe, particularly if they are used very commonly in children. However, where their use is innovative, patients receiving the drug should ideally do so under trial conditions.

5.23. The same considerations apply to 'off-label' drugs, where the drug is used for a condition different to the one for which it was licensed. This is the case for puberty blockers, which are licensed for use in precocious puberty, but not for puberty suppression in gender dysphoria. Again, it is important that it is not assumed that outcomes for, and side effects in, children treated for precocious puberty will necessarily be the same in children or young people with gender dysphoria.

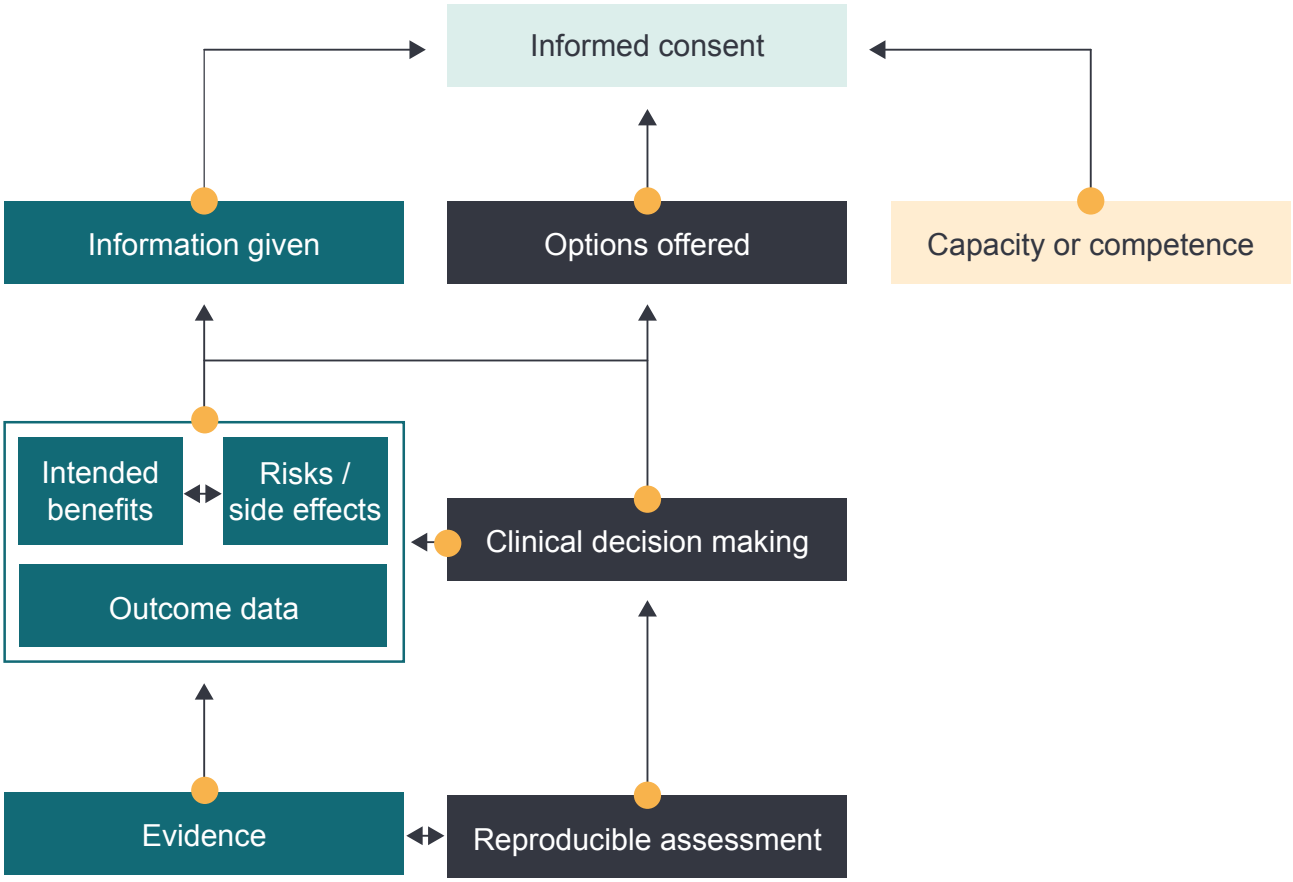
5.24. As outlined above, in other areas of practice where complex or potentially life-altering treatment is being considered for a child or young person, it is usual for the case to be discussed by an MDT including all professionals involved in their care. In gender services for children and young people in the Netherlands, as well as a number of other countries, there are full

[66] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria
[67] National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

MDT meetings, including psychiatrists and endocrinologists, to make decisions about suitability for hormone intervention and to review progress.[68,69]

5.25. Recent legal proceedings have examined the question of the competence and capacity of children and young people to consent to hormone treatment. However, there are some essential components that underpin informed consent; the robustness of the options offered to the patient, the information provided to them about those options, and their competence and capacity to consider them. The courts have given consideration to competence and capacity, and it is incumbent on this Review to consider the soundness of the decision making which underpins the options offered, and the quality and accuracy of the information provided about those options.

**Elements of informed consent**




[68] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.
[69] Cohen-Kettenis PT, Steensma TD, de Vries ALC. Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20. 689–700. 2001. DOI: 10.1016/j.chc.2011.08.001.

**Service development and service improvement:** Central to any service improvement is the systematic and consistent collection of data on outcomes of treatment. There is a process of continuous service improvement as new presentations or variations on the original condition are recognised, diagnosis or screening improves and/or trials on new treatments or variations on existing treatments are ongoing.

There should be consistent treatment protocols or guidelines in place, in order to make sense of variations in outcomes. Where possible, these should be compared between and across multiple different centres.

As time passes, services need to be changed or extended based on patient need, and on what resources are needed to deliver the available treatments. They need to be accessible where the prevalence of the condition is highest. The relevant workforce to deliver the service needs to be recruited and trained, contingent on the type of treatments or therapy that is required.

5.26. When a pioneering treatment or specialist service starts, it is often delivered in a single centre. Thereafter, additional centres take on the work as increasing numbers of patients need to access the treatment. Current provision of NHS specialist gender identity services for children and young people has remained concentrated within a single organisation, but demand has grown dramatically.

5.27. The situation has been exacerbated because there are not many local services seeing gender-questioning children at an earlier stage in their journey, which means that GIDS is carrying an unsustainable workload of increasingly complex young people.

5.28. As a condition evolves, rigorous data collection and quantitative research is an essential prerequisite to refining understanding and treatment. Historically, The Tavistock and Portman NHS Foundation Trust built its international reputation as the home of psychoanalysis, psychotherapy and family therapy, with a strong track record of publishing qualitative rather than quantitative research; consequently its approach to quantitative data collection about this important group of children and young people has been weak.

5.29. A further anomaly is a public perception that The Tavistock and Portman NHS Foundation Trust is the responsible organisation for leading the management of children receiving hormone treatment for their gender dysphoria. In reality, the hormone treatment is delivered by paediatric services in University College London Hospitals NHS Foundation Trust and The Leeds Teaching Hospitals NHS Trust.

5.30. In practice, it is important that for children and young people who need physical intervention, paediatric and mental health services are seen as equal partners, with seamless joint working and shared responsibility. When there were very small numbers of patients, it was easier for this to be achieved, but cross-site working with a very large caseload has made this more difficult to achieve, despite the best intentions of the staff.

5.31. Over the last two years there have been strong efforts on the part of The Tavistock and Portman NHS Foundation Trust to make practice within GIDS more consistent, with tighter procedures for case management, consent, and safeguarding. However, although this has resulted in better documentation, variations and inconsistencies in clinical decision making remain. In responding to a changing legal framework, some processes have become more cumbersome and complex, and the team are working hard to streamline the process.

5.32. Overall, GIDS faces a daunting task as a single provider in managing risk on the waiting list, seeing new referrals, reviewing and supporting those on hormone treatment, undertaking an ongoing transformation programme, recruiting and training new staff and trying to retain existing staff. This suggests that the current model is not sustainable and that another model is needed.

# 6. Interim advice, research programme and next steps



## Dealing with uncertainty

6.1. As outlined throughout this report, there are major gaps in the research base underpinning the clinical management of children and young people with gender incongruence and gender dysphoria, including the appropriate approaches to assessment and treatment.

6.2. As with any other area of medicine, where there are gaps in the evidence base and uncertainties about the correct clinical approach, three tasks must be undertaken:

- Clinical services must be run as safely and effectively as possible, within the constraints of current knowledge; treatment options must be weighed carefully; and treatment decisions must be made in partnership between the clinicians and the children, young people and their families and carers, based on our current understanding about outcomes.
- Consistent data must be collected by clinical services, for both audit and research purposes so that knowledge gaps can be filled, alongside an active research programme.
- Where there is not an immediate prospect of filling research gaps, professional consensus should be developed on the correct way to proceed pending clearer research evidence, supported by input from service users.

6.3. The additional problem with the current service model is that safety and access are further compromised by the pace at which referrals have grown and outstripped capacity at tertiary level, and the lack of service availability at local level.

6.4. The Review's approach to these tasks is as follows:

- Our **interim advice** focuses on the issues of capacity, safety, and standards around treatment decisions, as well as data and audit.
- Our **research streams** will provide the Review with an independent collation of published evidence relevant to epidemiology, clinical management, models of care, and outcomes, as well as delivering qualitative and quantitative research relevant to the Terms of Reference of the Review. This offers a real opportunity to contribute to the international evidence base for this service area.
- There will be an ongoing and wide-ranging **programme of engagement** to address areas on which we will not be able to obtain definitive evidence during the lifetime of the Review.

# Interim advice

6.5. The Review considers that there are some areas where there is sufficient clarity about the way forward and we are therefore offering some specific observations and interim advice. The Review will work with NHS England, providers and the broader stakeholder community to progress action in these areas.

## Service model

6.6. It has become increasingly clear that a single specialist provider model is not a safe or viable long-term option in view of concerns about lack of peer review and the ability to respond to the increasing demand.

6.7. Additionally, children and young people with gender-related distress have been inadvertently disadvantaged because local services have not felt adequately equipped to see them. It is essential that they can access the same level of psychological and social support as any other child or young person in distress, from their first encounter with the NHS and at every level within the service.

6.8. A fundamentally different service model is needed which is more in line with other paediatric provision, to provide timely and appropriate care for children and young people needing support around their gender identity. This must include support for any other clinical presentations that they may have.

6.9. The Review supports NHS England's plan to establish regional services, and welcomes the move from a single highly specialist service to regional hubs.

6.10. Expanding the number of providers will have the advantages of:

- creating networks within each area to improve early access and support;
- reducing waiting times for specialist care;
- building capacity and training opportunities within the workforce;
- developing a specialist network to ensure peer review and shared standards of care; and
- providing opportunities to establish a more formalised service improvement strategy.

### Service provision

6.11. The primary remit of NHS England's proposed model is for the regional hubs to provide support and advice to referrers and professionals. However, it includes limited provision for direct contact with children and young people and their families.

**1:** The Review advises that the regional centres should be developed, as soon as feasibly possible, to become direct service providers, assessing and treating children and young people who may need specialist care, as part of a wider pathway. The Review team will work with NHS England and stakeholders to further define the proposed model and workforce implications.

**2:** Each regional centre will need to develop links and work collaboratively with a range of local services within their geography to ensure that appropriate clinical, psychological and social support is made available to children and young people who are in early stages of experiencing gender distress.

**3:** Clear criteria will be needed for referral to services along the pathway from primary to tertiary care so that gender-questioning children and young people who seek help from the NHS have equitable access to services.

**4:** Regional training programmes should be run for clinical practitioners at all levels, alongside the online training modules developed by Health Education England (HEE). In the longer-term, clearer mapping of the required workforce, and a series of competency frameworks will need to be developed in collaboration with relevant professional organisations.

## Data, audit and research

6.12. A lack of routine and consistent data collection means that it is not possible to accurately track the outcomes and pathways children and young people take through the service. Standardised data collection is required in order to audit service standards and inform understanding of the epidemiology, assessment and treatment of this group. This, alongside a national network which brings providers together, will help build knowledge and improve outcomes through shared clinical standards and systematic data collection. In the longer-term, formalisation of such a network into a learning health system[70] with an academic host would mean that there was systematised use of data to produce a continuing research programme with rapid translation into clinical practice and a focus on training.

**5:** The regional services should have regular co-ordinated national provider meetings and operate to shared standards and operating procedures with a view to establishing a formal learning health system.

**6:** Existing and future services should have standardised data collection in order to audit standards and inform understanding of the epidemiology, assessment and treatment of this group of children and young people.

[70] Scobie S, Castle-Clarke S (2019). Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

**7:** Prospective consent of children and young people should be sought for their data to be used for continuous service development, to track outcomes, and for research purposes. Within this model, children and young people put on hormone treatment should be formally followed up into adult services, ideally as part of an agreed research protocol, to improve outcome data.

## Clinical approach

### Assessment processes

6.13. We have heard that there are inconsistencies and gaps in the assessment process. Our work to date has also demonstrated that clinical staff have different views about the purpose of assessment and where responsibility lies for different components of the process within the pathway of care. The Review team has commenced discussions with clinical staff across primary, secondary and tertiary care to develop a framework for these processes.

**8:** There needs to be agreement and guidance about the appropriate clinical assessment processes that should take place at primary, secondary and tertiary level.

**9:** Assessments should be respectful of the experience of the child or young person and be developmentally informed. Clinicians should remain open and explore the patient's experience and the range of support and treatment options that may best address their needs, including any specific needs of neurodiverse children and young people.

### Hormone treatment

6.14. The issues raised by the Multi-Professional Review Group echo several of the problems highlighted by the CQC. It is essential that principles of the General Medical Council's Good Practice in Prescribing and Managing Medicine's and Devices[71] are closely followed, particularly given the gaps in the evidence base regarding hormone treatment. Standards for decision making regarding endocrine treatment should also be consistent with international best practice.[72,73,74]

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[71] General Medical Council (2021). Good practice in prescribing and managing medicines and devices (76-78).
[72] Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.
[73] Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.
[74] Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

**10:** Any child or young person being considered for hormone treatment should have a formal diagnosis and formulation, which addresses the full range of factors affecting their physical, mental, developmental and psychosocial wellbeing. This formulation should then inform what options for support and intervention might be helpful for that child or young person.

**11:** Currently paediatric endocrinologists have sole responsibility for treatment, but where a life-changing intervention is given there should also be additional medical responsibility for the differential diagnosis leading up to the treatment decision.

6.15. Paediatric endocrinologists develop a wide range of knowledge within their paediatric training, including safeguarding, child mental health, and adolescent development. Being party to the discussions and deliberations that have led up to the decision for medical intervention supports them in carrying out their legal responsibility for consent to treatment and the prescription of hormones.

**12:** Paediatric endocrinologists should become active partners in the decision making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.

6.16. Given the uncertainties regarding puberty blockers, it is particularly important to demonstrate that consent under this circumstance has been fully informed and to follow GMC guidance[75] by keeping an accurate record of the exchange of information leading to a decision in order to inform their future care and to help explain and justify the clinician's decisions and actions.

**13:** Within clinical notes, the stated purpose of puberty blockers as explained to the child or young person and parent should be made clear. There should be clear documentation of what information has been provided to each child or young person on likely outcomes and side effects of all hormone treatment, as well as uncertainties about longer-term outcomes.

[75] General Medical Council (2020). Decision making and consent.

**14:** In the immediate term the Multi-Professional Review Group (MPRG) established by NHS England should continue to review cases being referred by GIDS to endocrine services.

# Research programme

6.17. The Review's formal academic research programme, comprising a literature review, quantitative analysis and primary qualitative research, has been based on the identified gaps in the evidence and the feasibility of filling them within the lifetime of the Review.

6.18. Initial work has identified the existing evidence base on epidemiology, natural history, and the treatment and outcomes of children and young people with gender dysphoria/gender-related distress. It has also assessed the feasibility of linking data between local, regional or national datasets in order to assess intermediate and longer-term outcomes.

## Literature review

6.19. A literature review is being undertaken, which will interface with evidence gathering from the professional community (see qualitative research section below). Its aim is to systematically identify, collate and synthesise the existing evidence on the changing epidemiology of gender-related distress in children and young people and the appropriate social, clinical, psychological and medical management of that distress.

6.20. The literature review will capture primary studies of any design, including experimental, observational, survey and qualitative, and is looking to answer the following questions:

1. How has the population of children and young people presenting with gender dysphoria and/or gender-related distress changed over time?
2. What are the appropriate referral, assessment and treatment pathways for children and young people with gender dysphoria and/or gender-related distress?
3. What are the short-, medium- and long-term outcomes for children and young people with gender dysphoria and/or gender-related distress?
4. How do children and young people and their families negotiate distress, present this distress to services, and what are their expectations, following presentation?
5. How do children, young people and their families/carers experience referral, assessment and treatment? And how are these negotiated among children and young people, parents/carers, families and healthcare professionals?

6.21. A separate synthesis for each question will be undertaken. The systematic review has been registered on PROSPERO [ID:289659].

## Quantitative research

6.22. The National Institute for Health and Care Excellence (NICE) recently published two evidence reviews.[76,77] These highlight shortcomings in the follow-up data collected about children and young people, when they are referred to a specialist gender identity service. The quantitative research will therefore focus on the collection and analysis of data to uncover patterns and quantify problems, thereby helping the Review to address some of these shortcomings.

6.23. The aim of the quantitative study is to supplement the material collected by the literature review, further examining the changing epidemiology of gender-related distress in children and young people, in addition to exploring the appropriate social, clinical, psychological and medical management. Its objectives are to:

a) describe the clinical and demographic characteristics of this population of children and young people and their clinical management in the GIDS service; and

b) assess the intermediate and longer-term outcomes of this population of children and young people utilising national healthcare data.

6.24. This research will provide an evidence base to facilitate informed decision making among children and young people and their families. It will also provide an evidence base for those responsible for commissioning, delivering and managing services.

## Qualitative research

6.25. The qualitative research will capture a diverse range of trajectories experienced by gender-questioning children and young people, exploring a range of different experiences and outcomes. This will include talking to children and young people and their families/carers who are currently negotiating gender-related distress, young adults who have gone through the process of resolving their distress and care professionals.

[76] National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.
[77] National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

## The objectives of the qualitative research are to:

1. Explore how children and young people understand, respond and negotiate gender-related distress within the context of their social networks, alongside the perspectives of young adults who experienced gender distress as children.
2. Examine the perspectives, understandings and responses of parents (or carers), including how they support their child.
3. Investigate how children, young people, young adults and their families experience(d) and negotiate(d) referral, assessment and possible treatment and intervention options.
4. Understand the role and experiences of care professionals who offer support, including identifying shared and potentially divergent views among care professionals, children and young people, and parents of what constitutes optimal care.

## Progress

6.26. The literature review is already underway and is identifying relevant studies. Initial meetings have also taken place with voluntary organisations and other researchers working in the area to ensure there is no duplication and in recognition of research fatigue among this population.

6.27. Children and young people and young adults who have experienced gender-related distress are involved in the research programme. Their advice has been, and will continue to be, sought throughout this work, including in relation to the focus of the research and interpretation of findings and the design and content of dissemination materials.

6.28. Three research protocols have been produced setting out how the research will be undertaken, and the research team is currently gaining the necessary ethical and governance approvals to progress the study. The systematic review is published on the PROSPERO website and will be published on the Review website in due course, along with the qualitative and quantitative research proposals once ethical and governance approvals have been received.

6.29. The research findings will be subject to peer review through the publication process and various summaries, aimed at different audiences, will be available on the project website and distributed via support organisations. These summaries will also be made available on the Review website.

## Ongoing engagement

6.30. In recognition that not all the published evidence is likely to be of high enough quality to form the sole basis for our recommendations, a consensus development approach will be used to synthesise the published evidence and research outputs of the academic work with stakeholder submissions and expert opinion.

6.31. Over the coming months, the Review will build on its engagement to date and, alongside the academic research programme, will continue informal and structured engagement with service users, their families, support and advocacy groups and professionals to test emerging thinking, provide opportunities for challenge and further develop the evidence base.

6.32. This review is an iterative process and we will share important findings when they become available. For the latest updates, please visit our website: https://cass.independent-review.uk/

6.33. We thank those who have participated in the Review to date and welcome engagement with us as work progresses towards final recommendations.

# Glossary





1943

# Glossary

There is sometimes no consensus on the best language to use relating to this subject. The language surrounding this area has also changed rapidly and young people have developed varied ways of describing their experiences using different terms and constructs that are relevant to them.

The Review tries as far as possible to use language and terms that are respectful and acknowledge diversity, but that also accurately illustrate the complexity of what we are trying to describe and articulate.

The terms we have used may not always feel right to some; nevertheless, it is important to emphasise that the language used is not an indication of a position being taken by the Review. The glossary below sets out a description of some of the terms we have used in the Review.

| Term | | Description |
|---|---|---|
| Affirmative model | | A model of gender healthcare that originated in the USA[78,79,80,81] which affirms a young person's subjective gender experience while remaining open to fluidity and changes over time. This approach is used in some key child and adolescent clinics across the Western world. |
| Assent | | To agree to or approve of something (idea, plan or request), especially after thoughtful consideration. |
| Autonomy | | Personal autonomy is the ability of a person to make their own decisions. In health this refers specifically to decisions about their care. |

[78] Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, et al (2013). The gender affirmative model: What we know and what we aim to learn [Editorial]. Human Dev 56(5): 285–290. DOI:10.1159/000355235.
[79] Chen D, Abrams M, Clark L, Ehrensaft D, Tishelman AC, Chan YM, et al (2021). Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: baseline findings from the trans youth care study. J Adol Health 68(6): 1104–11.
[80] Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, et al (2019). Creating the Trans Youth Research Network: A collaborative research endeavor. Transgend Health 4(12): 304–12. DOI: 10.1089/trgh.2019.0024.
[81] Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

| Term | | Description |
|---|---|---|
| Best interests | | Clinicians and the courts seek to act in the best interests of children and young people. For the Mental Capacity Act (MCA) 2005, decisions for someone who cannot decide for themselves must be made in their best interests. Under the Children Act 1989, in any decision of the court about a child (under 18), the welfare of the child must be paramount. For these purposes, there is little or no material difference between the welfare and best interests, and we have used "best interests" throughout the report.<br><br>Although there is no standard definition of "best interests of the child," the General Medical Council advises that an assessment of best interests will include what is clinically indicated as well as additional factors such as the child or young person's views, the views of parents and others close to the child or young person and cultural, religious and other beliefs and values of the child or young person.[82] |
| | | The MCA s4,[83] and extensive Court of Protection case law, deals with the approach to best interests under that legislation. Whether in the Court of Protection or the High Court, when the court is asked to make an assessment of a child or young person's best interests, it will consider their welfare/best interests in the widest sense. This will include not just medical factors but also social and psychological factors. |
| Case-mix | | The mix of patients within a particular group. |
| Child and adolescent mental health services | CAMHS | NHS children and young people's mental health services.[84] |

[82] General Medical Council (2018). 0-18 years – guidance for all doctors.
[83] Mental Health Law Online. MCA 2005 s4.
[84] Young Minds. Guide to CAMHS: a guide for young people.

| Term | | Description |
|---|---|---|
| Child and/or young person | | In law, everyone under 18 years of age is a child (Children Act 1989) but we recognise that it may be more appropriate to refer to those approaching the age of 18 as a young person, and that such young people may not recognise themselves as a "child".<br>In places, we have referred only to "young person", or only to "child", for example where treatment in question is only given towards the later stages of childhood, closer to the age of 18, or in reference to the parent/child relationship, in which they remain the parents' child, regardless of their age.<br>Otherwise, we have used the phrase "child and/or young person" throughout the report for this reason only, and do not intend there to be a material difference between them other than that. |
| Cognitive | | Relating to, or involving, the process of thinking and reasoning. |
| Consent | | Permission for a clinical intervention (such as an examination, test or treatment) to happen. For consent to be 'informed', information must be disclosed to the person about relevant risks, benefits and alternatives (including the option to take no action), and efforts made to ensure that the information is understood.<br>In legal terms, consent is seen as needing:<br>1 – capacity (or *Gillick* competence under 16) to make the relevant decision;<br>2 – to be fully informed (ie the information provided about the available options, the material risks and benefits of each option, and of doing nothing, "material" meaning (per the Montgomery Supreme Court judgment in 2015) what a reasonable patient would want to know, and what this patient actually wants to know, NOT what a reasonable doctor would tell them); and<br>3 – to be freely given (that is,without coercion). |
| Contraindications | | A condition or circumstance that suggests or indicates that a particular technique or drug should not be used in the case in question. |

| Term | | Description |
|---|---|---|
| Court of Appeal | | (England and Wales) The Court of Appeal hears appeals against both civil and criminal judgments from the Crown Courts, High Court and County Court. It is second only to the Supreme Court. |
| Detransition/ detransitioners | | Population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both.[85] |
| Diagnostic and Statistical Manual of Mental Disorders Fifth edition | DSM-5 | The American diagnostic manual used to diagnose mental health disorders, and commonly used in UK practice. See **Appendix 3**. |
| Diagnostic formulation | | The comprehensive assessment that includes a patient's history, results of psychological tests, and diagnosis of mental health difficulties. |
| Divisional Court | | (England and Wales) When the High Court of Justice of England and Wales hears a case with at least two judges sitting, it is referred to as the Divisional Court. This is typically the case for certain judicial review cases (as well as some criminal cases). |
| Dutch Approach | | Protocol published in 1998 by the Amsterdam child and adolescent gender identity clinic.[86] |
| Endocrine treatment | | In relation to this clinical area, this term is used to describe the use of gonadotropin-releasing hormones (see below) and feminising and masculinising hormones (see below). |
| Endocrinologist | | An endocrinologist is a medical doctor specialising in diagnosing and treating disorders relating to problems with the body's hormones. |
| Endocrinology | | The study of hormones. |

[85] Littman L (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch Sex Abuse 50: 3353–69. DOI: 10.1007/s10508-021-02163-w

[86] de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. J Homosex 59: 301-320. DOI: 10.1080/00918369.2012.653300.

| Term | | Description |
|---|---|---|
| Epidemiology | | Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.[87] |
| Exploratory approaches | | Therapeutic approaches that acknowledge the young person's subjective gender experience, whilst also engaging in an open, curious, non-directive exploration of the meaning of a range of experiences that may connect to gender and broader self-identity.[88,89,90,91] |
| Feminising and masculinising hormones (also known as cross-sex hormones, and gender affirming hormones). | | Hormones given as part of a medical transition for gender dysphoric individuals, where sex hormones (testosterone for transgender males and oestrogen for transgender females). |
| Gender dysphoria | | Diagnostic term used in DSM-5.[92] Gender dysphoria describes "a marked incongruence between one's experienced/expressed gender and assigned gender of at least 6 months duration" which must be manifested by a number of criterion – see **Appendix 3** for further detail. |
| Gender fluid | | An experience of gender that is not fixed, but changes between two or more identities. |
| Gender identity | | This term is used to describe an individual's internal sense of being male or female or something else. |
| Gender identity development | | The developmental experience of a child or young person in seeking to understand their gender identity over time. |
| Gender Identity Development Service | GIDS | The service that NHS England commissions for children and adolescents with gender dysphoria. |

[87] Centers for Disease Control and Prevention (2012). Principles of Epidemiology in Public Health Practice: An introduction to Applied Epidemiology and Biostatistics, 3rd ed.
[88] Di Ceglie D (2009). Engaging young people with atypical gender identity development in therapeutic work: A developmental approach. J Child Psychother 35(1): 3–12. DOI: 10.1080/00754170902764868.
[89] Spiliadis A (2019). Towards a gender exploratory model: Slowing things down, opening things up and exploring identity development. Metalogos Systemic Ther J 35: 1–9.
[90] Churcher Clarke A, Spiliadis A (2019). 'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties. Clin Child Psychol Psychiatry 24(2): 338–52. DOI:10.1177/1359104518825288.
[91] Bonfatto M, Crasnow E (2018). Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service. J Child Psychother 44(1): 29–46. DOI:10.1080/007541 7X.2018.1443150.
[92] American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5™, 5th ed.

| Term | | Description |
|---|---|---|
| Gender incongruence | | Diagnostic term used in ICD-11.[93] Gender incongruence is characterised by "a marked and persistent incongruence between an individual's experienced gender and the assigned sex". See **Appendix 3** for further detail. |
| Gender-questioning | | A broader term that might describe children and young people who are in a process of working out how they want to present in relation to their gender. |
| Gender-related distress | | A way of describing distress that may arise from a broad range of experiences connected to a child or young person's gender identity development. Often used for young people whereby any formal diagnosis of gender dysphoria has not yet been made. |
| Gillick competence/ Fraser guidelines | | A term derived from *Gillick v West Norfolk And Wisbech AHA*, 1984 that is used to decide whether a child or young person up to the age of 16 years is able to consent to their own medical treatment, without the need for parental permission or knowledge. A child or young person will be 'Gillick competent' for that decision if they have the necessary maturity and understanding to make the decision. |
| Gonadotropin-releasing hormone analogues (also known as the hormone blocker/s and puberty blocker/s) | GnRH | GnRH analogues competitively block GnRH receptors to prevent the spontaneous release of two gonadotropin hormones, Follicular Stimulating Hormone (FSH) and Luteinising Hormone (LH) from the pituitary gland. This arrests the progress of puberty. |
| General Practitioner | GP | GPs deal with a whole range of health problems and manage the care of their patients, referring onto specialists as appropriate.[94] |
| High Court | | The third highest court in the UK. It deals with all high value and high importance civil law (non-criminal) cases and appeals of decisions made in lower courts. When the High Court sits with more than one judge, as required for certain kinds of cases, it is called the Divisional Court. |
| International Classification of Diseases, Version 11 | ICD-11 | ICD-11[95] is the World Health Organization (WHO) mandated health data standard used for medical diagnosis. |

[93] World Health Organization (2022). International Classification of Diseases Eleventh Revision.
[94] NHS. GP services.
[95] World Health Organization (2022). International Classification of Diseases Eleventh Revision.

| Term | | Description |
|---|---|---|
| Looked after children | | Children who are in the care of their Local Authority who may be living with foster parents or in a residential care setting. |
| Multi-disciplinary-team | MDT | The identified group of professional staff who provide a clinical service. |
| Neurodiverse | | Displaying or characterised by autistic or other neurologically atypical patterns of thought or behaviour; not neurotypical. |
| Non-binary | | A gender identity that does not fit into the traditional gender binary of male and female.[96] |
| Paediatrics | | The branch of medicine dealing with children and their medical conditions. |
| Pass/passing | | A person's gender being seen and read in the way they identify. |
| Precocious puberty | | This is when a child's body begins changing into that of an adult (puberty) too soon – before age 8 in girls and before age 9 in boys. |
| Primary care | | Primary care includes general practice, community pharmacy, dental and optometry (eye health) services. This tends to be the first point of access to healthcare. |
| Psychological formulation | | A structured approach to understanding the factors underlying distressing states in a way that informs the changes needed and the therapeutic intervention for these changes to occur. |
| Psychosocial | | Describes the psychological and social factors that encompass broader wellbeing. |
| Puberty blockers | | See gonadotropin-releasing hormone above. |
| Secondary care | | Hospital and community health care services that do not provide specialist care and are usually relatively close to the patient. For children this will include Child and Adolescent Mental Health Services (CAMHS), child development and general paediatric services. |
| Tanner Stage | | Classification of puberty by stage of development. This ranges from Stage 1, before physical signs of puberty appear, to Stage 5 at full maturity. |

[96] Twist J, de Graaf NM (2019). Gender diversity and non-binary presentations in young people attending the United Kingdom's National Gender Identity Development Service. Clin Child Psychol Psychiatry 24(2): 277–90. DOI: 10.1177/1359104518804311.

| Term | | Description |
|---|---|---|
| Tertiary care | | Tertiary care is the specialist end of the NHS. These services relate to complex or rare conditions. Services are usually delivered in a number of hospitals/centres. |
| Transgender | trans | This is an umbrella term that includes a range of people whose gender identity is different from the sex they were registered at birth. |
| Transition | | These are the steps a person may take to live in the gender in which they identify. This may involve different things, such as changing elements of social presentation and role and/or medical intervention for some. |

# Appendix 1

## Terms of reference



**TERMS OF REFERENCE FOR REVIEW OF GENDER IDENTITY DEVELOPMENT SERVICE FOR CHILDREN AND ADOLESCENTS**

**INTRODUCTION**

1. NHS England is the responsible commissioner for specialised gender identity services for children and adolescents. The Gender Identity Development Service for children and adolescents is currently managed by the Tavistock and Portman NHS Foundation Trust.

2. In recent years there has been a significant increase in the number of referrals to the Gender Identity Development Service, and this has occurred at a time when the service has moved from a psychosocial and psychotherapeutic model to one that also prescribes medical interventions by way of hormone drugs. This has contributed to growing interest in how the NHS should most appropriately assess, diagnose and care for children and young people who present with gender incongruence and gender identity issues.

3. It is in this context that NHS England and NHS Improvement's Quality and Innovation Committee has asked Dr Hilary Cass to chair an independent review, and to make recommendations on how to improve services for children and young people experiencing issues with their gender identity or gender incongruence, and ensure that the best model/s for safe and effective services are commissioned.

**REVIEW SCOPE**

**The independent review, led by Dr Cass, will be wide ranging in scope and will conduct extensive engagement with all interested stakeholders. The review is expected to set out findings and make recommendations in relation to:**

**i.** Pathways of care into local services, including clinical management approaches for individuals with less complex expressions of gender incongruence who do not need specialist gender identity services;
**ii.** Pathways of care into specialist gender identity services, including referral criteria into a specialist gender identity service; and referral criteria into other appropriate specialist services;
**iii.** Clinical models and clinical management approaches at each point of the specialised pathway of care from assessment to discharge, including a description of objectives, expected benefits and expected outcomes for each clinical intervention in the pathway;
**iv.** Best clinical approach for individuals with other complex presentations.
**v.** The use of gonadotropin-releasing hormone analogues and gender affirming drugs, supported by a review of the available evidence by the National Institute for Health and Care Excellence; any treatment recommendations will include a description of treatment objectives, expected benefits and expected outcomes, and potential risks, harms and effects to the individual;
**vi.** Ongoing clinical audit, long term follow-up, data reporting and future research priorities;
**vii.** Current and future workforce requirements;
**viii.** Exploration of the reasons for the increase in referrals and why the increase has disproportionately been of natal females, and the implications of these matters; and,

**TERMS OF REFERENCE FOR REVIEW OF GENDER IDENTITY DEVELOPMENT SERVICE FOR CHILDREN AND ADOLESCENTS**

**ix.** Any other relevant matters that arise during the course of the review

4. In addition, and with support from the Royal College of Paediatrics and Child Health and other relevant professional associations, the Chair will review current clinical practice concerning individuals referred to the specialist endocrine service. It is expected that findings and any recommendations on this aspect of the review will be reported early in 2021 with the review's wider findings and recommendations delivered later in 2021.

5. The review will not immediately consider issues around informed consent as these are the subject of an ongoing judicial review. However, any implications that might arise from the legal ruling could be considered by the review if appropriate or necessary.

# Appendix 2

## Letter to NHS England from Dr Cass – May 2021






Dr Hilary Cass
Chair
Review of GIDS for Children and Young People

John Stewart
National Director
Specialised Commissioning
NHS England and NHS Improvement

Sent by email

10 May 2021

Dear John

**INDEPENDENT REVIEW INTO GENDER IDENTITY SERVICES FOR CHILDREN AND YOUNG PEOPLE**

I am writing to update you on my current approach to the work of the independent review into gender identity services for children and young people. However, the most pressing issue is how we augment the immediate support for children and young people currently needing assessment and treatment, some of whom have already been waiting for an extended period for an appointment. I will therefore also make some suggestions about interim arrangements and ways in which the review team could help to support and strengthen these.

**Commissioned research programme**

As you know, a key principle of the review is that it should be evidence-based, and that final conclusions will be developed through a consensus development process contingent on the synthesised evidence.

I am pleased to see that the National Institute for Health and Care Excellence (NICE) evidence reviews of gonadotrophin releasing hormone analogues and gender affirming hormones for children and adolescents with gender dysphoria have now been published. Although this is a helpful starting point, despite following a standard and robust process the NICE review findings are not conclusive enough to inform policy decisions. As part of my review, I am therefore exploring other methodologies to give increased confidence and clarity about the optimal treatment approaches.

My team is commissioning a broader literature review of the existing evidence base on the epidemiology, management and outcomes of children with gender dysphoria. We are also commissioning qualitative and quantitative research, including considering other approaches which might be employed to understand the intermediate and longer-term outcomes of children with gender dysphoria. We intend to include a review of international models and data in this programme of work.

**Addressing the immediate situation**

Recognising that the outcome of the review is going to take some time, I have been reflecting on the recent court rulings on puberty blockers and consent and the Care Quality Commission (CQC) report on the Gender Identity Development Service (GIDS) run by the Tavistock and Portman NHS Foundation Trust. These significant developments have changed the context in which the review is taking place, and further added to the service pressures.

I note the proposal to establish an independent multidisciplinary professional review group to confirm decision-making has followed a robust process, which seems an appropriate interim measure pending further clarification of the legal situation.

I know that everyone concerned with the delivery of services – both commissioners and providers – are worried about the increasing number of children on the waiting list for assessment by the GIDS service and the resulting distress for the children and young people and their families. The difficulty in managing risk for those on the waiting list is exacerbated by the staff vacancies at GIDS, the increasing volume of new referrals, and the fact that the support and engagement from local services is highly variable and, in some cases, very limited.

Having a single provider may have been a logical position when the GIDS service was first set up, given that this is a highly specialised service that was seeing a relatively small number of cases each year. As the epidemiology has changed and there has been an exponential increase in numbers of children with gender incongruence or dysphoria, concentration of expertise within a single service has become unsustainable. At the same time, local services have not developed the skills and competencies to provide support for children on the waiting list and those with lesser degrees of gender incongruence who may not wish to pursue specialist medical intervention, and / or to provide help for children with additional complex needs.

I know from discussions we have had that your team is working hard to find some practical alternative arrangements, and that you have been in discussion with relevant professional bodies to come up with creative interim solutions while awaiting the outcome of my review.

The review team has also been in discussion with CQC, with the Tavistock and Portman NHS Foundation Trust and with colleagues within and external to NHS England and NHS Improvement to consider which aspects of this situation we can help with in the short to medium term, whilst keeping our focus on the longer-term questions of the appropriate clinical management and whole care pathway for these children and young people. In the past months I have also met with many groups and individuals with expertise and lived experience relevant to the review, including charities and support groups, Royal Colleges and healthcare professionals.

**Recommendations to NHS England and NHS Improvement**

I would encourage you to consider the following when developing an interim pathway for children and young people experiencing gender dysphoria:

- **Access and referral:** Children and young people need ready access to services. However, it is unusual for a specialist service to take direct referrals. The risk of having a national service as the first point of access is that assessment and treatment of children and young people who have the greatest need for specialist care is delayed because of the lack of differentiation of those on the waiting list. In addition, many children and

young people have complex needs, but once they are identified as having gender dysphoria, other important healthcare issues which would normally be managed by local services can sometimes be overlooked.

- **Assessment and management:** All children and young people who are referred to specialist services should have a competent local multi-disciplinary assessment and should remain under active holistic local management until they are seen at a specialist centre.

  I recognise that developing capacity and capability outside of the existing GIDS service to provide such initial assessment and support will be difficult to achieve at speed and will be incremental. This means that there will likely be a range of different models and options around the country, dependent on local resources, with some of the work being delivered through existing secondary service teams, and some being delivered at regional level. The support of wider services is vital.

- **Data:** The lack of systematic data collection is a significant issue. Therefore, when employing interim measures, I would suggest that particular attention is paid to the gathering of good quality data, which can then be used to inform the evidence base and future model of provision.

**Actions for the review team**

I would like to suggest how the review team might help with the challenging problem of growing an infrastructure outside of GIDS. From my conversations to date, I believe there are three barriers to the involvement of local services:

- **Capacity** – the staff most appropriately trained to be involved in initial assessment are those who are already most stretched within Child and Adolescent Mental Health Services (CAMHS) and paediatric services, and this situation has been significantly worsened through the impact of the Covid-19 pandemic on children's mental health. However, I know that there is substantial investment in CAMHS services, so close engagement with the relevant national policy teams at NHS England and NHS Improvement and at Health Education England (HEE) will be crucial.

- **Capability and confidence** – clinical teams outside of GIDS do not feel confident in initial assessment and support of children and young people with gender incongruence and dysphoria, in large part because they have not had the necessary training and experience, but also because of the societal polarisation and tensions surrounding the management of this group.

- **Lack of an explicit assessment framework** – currently expertise in assessment of children and young people presenting to GIDS is held in a small body of clinicians and their assessment processes have not been made explicit. The CQC report drew attention to the lack of structured assessment in the GIDS notes, and this is something that the Tavistock and Portman NHS Foundation Trust is already working to address internally. However, it is equally important to develop an initial assessment approach that can be used by first contact professionals, not just those working in the specialist service.

In the first instance, it is important that we test these assumptions with a range of clinical staff and ascertain whether there are other barriers that are preventing local engagement in this work. Then we would plan to prioritise a series of workshops, in collaboration with relevant professional groups, service users and close engagement with HEE. The purpose of these workshops would be to address identified barriers and develop:

- A framework for initial assessment of children and young people presenting with gender dysphoria.

- An approach to training for professionals at local and regional level.

- Some preliminary workforce recommendations, which will be particularly important in meeting the timelines of the three-year Comprehensive Spending Review.

These workshops will serve multiple purposes – firstly to support NHS England and NHS Improvement in the establishment of local and / or regional teams; secondly as an essential component of the work needed to inform the questions that the review is tackling; and thirdly to form the professional networks that will be needed to underpin future service and research networks.

**Timelines**

As you will recognise, setting up a complex national review is difficult and time consuming at the best of times. It requires a team to support the work and mechanisms for stakeholders to engage safely and with confidence. Starting a review in the midst of a pandemic is even more challenging.

I have committed to a review approach which is participative, consensus-based, evidence-based, transparent, and informed by lived and professional experience. This requires extensive engagement. Pending the appointment of our research team, the review has now launched its website and I have been proactively engaging with the stakeholder community.

It is critical that we get the approach right, particularly the engagement, the evidence review and the quantitative research given the gaps in the evidence highlighted through the NICE review, and this will take time.

My intention is that an interim report will be delivered in the summer, with a report next year setting out my final recommendations.

Yours sincerely



**Dr Hilary Cass**
**Chair, Independent Review into Gender Identity Services for Children and Young People**

Cc: Care Quality Commission
Health Education England
Tavistock and Portman NHS Foundation Trust

# Appendix 3

## Diagnostic criteria for gender dysphoria



# DSM-5 diagnostic criteria for gender dysphoria

## Gender Dysphoria in Children

**A.** A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following (one of which must be Criterion A1):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

**B.** The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome).

## Gender Dysphoria in Adolescents and Adults

**A.** A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).

3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

**B**. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

With a disorder of sex development (e.g., a congenital adrenogenital disorder such as congenital adrenal hyperplasia or androgen insensitivity syndrome).

Specify if:

Post transition: the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one cross-sex medical procedure or treatment regimen – namely, regular cross-sex hormone treatment or gender reassignment surgery confirming the desired gender (e.g., penectomy, vaginoplasty in a natal male; mastectomy or phalloplasty in a natal female).

## ICD-11: HA60 Gender incongruence of adolescence or adulthood

Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions:

Paraphilic disorders.

# ICD-11: HA61 Gender incongruence of childhood

Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about 2 years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis.

Exclusions:

Paraphilic disorders.

# Appendix 4

## The standard approach to clinical service development



# The standard approach to clinical service development

The three examples below illustrate the usual process of developing a clinical service: Covid-19 is included because this is a new condition that everyone is familiar with; childhood epilepsy because it is a complex condition with physical manifestations; and autism because it is a condition with neuro-behavioural manifestations.

By comparing these examples of clinical service development, it is possible to demonstrate some of the challenges in developing services for children and young people with gender incongruence or dysphoria, and to identify where there are gaps and questions that need to be addressed for this population, in order to ensure any future service model delivers the highest possible standards of care.

The stages below may proceed in a different sequence for different conditions, but each stage is important in the development of evidence based care.

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| **New condition is observed**<br>This often begins with a few case reports and then clinicians begin to recognise a recurring pattern and key clinical features, and to develop fuller descriptions of the condition. | Covid-19 is an example of a recent new condition that we all recognise, and this started with a few unusual cases of respiratory illness being described in Wuhan. | Childhood epilepsy has been recognised for centuries, but over the last century there has been growing understanding of the many different subtypes. | Individuals with autism have probably also existed for an indefinite period, but it wasn't until 1943 and 1944 that Leo Kanner and Hans Asperger wrote the first scientific accounts about the condition. |

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| **Aetiology**<br>Clinicians and scientists try to work out the cause of the condition or the underlying physical or biological basis. Sometimes the answers to this are never found. | The cause of Covid-19 was identified at a very early stage as being due to a novel coronavirus, although it remains unclear where and how this originated. | It is now known that there are numerous different types of epilepsy, with many different causes – for example, epilepsy can be caused by specific epilepsy genes, by birth trauma, by metabolic conditions, by brain tumours and many other mechanisms. Epilepsies due to a change in the brain structure which occur after birth are called 'symptomatic' – they are a symptom of something else. Epilepsies for which there is no identified cause are called 'idiopathic'. | The first theory about the aetiology of autism was that it was caused by so called 'refrigerator parents'. This was inaccurate and damaging. It has subsequently been shown that there are many complex genetic and physical or chemical brain changes underpinning this condition. |
| **Natural history and prognosis**<br>It is important to understand how a condition usually evolves over time, with or without treatment. The latter is important if treatment has limited efficacy and the condition is 'self-limiting' (that is, it resolves without treatment), because otherwise there is a risk that treatments create more difficulties than the condition itself. | Covid-19 is an example of a condition where there are quite polarised views about management based on its prognosis and natural history. A relatively small proportion of people are seriously affected and need treatment, and for the majority the natural history is that it will get better by itself.<br>This has led some people to question the need for lockdowns, vaccinations and other measures which they see as impacting personal freedoms. | In epilepsy the natural history is very important. Some epilepsies get better through puberty and into adulthood, and some can get worse with hormonal changes. This is important to know when monitoring and reviewing drug treatment. | |

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| **Epidemiology**<br>Epidemiologists collect data to find out how common a condition is, who is most likely to be affected, what the age distribution is and so on. This allows health service planners to work out how many services are needed, where they should be established, and what staff are needed.<br>They also report on changes in who is most affected, which may mean that either the disease is changing, or the susceptibility of the population is changing. | Epidemiologists have been crucial in supporting the management of Covid-19 because they have extracted and analysed the data on which patients are at greater risk from the virus. This has been fundamental to planning a vaccination strategy and other protective measures. | | The epidemiology of autism has changed considerably, with a dramatic increase in the numbers of children diagnosed over the last 20 years. This has had major implications for service provision. There is ongoing debate about the cause of the increase – whether it is because of greater awareness and better diagnosis, or because there are more children with autism. Current opinion favours the first option. |

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| **Assessment and diagnosis**<br>Clinicians will usually take a history from (that is, of their symptoms) and examine the patient (that is, for signs and symptoms), and where appropriate undertake a series of investigations or tests, to help them reach an accurate diagnosis.<br>Sometimes the whole process of making a diagnosis through talking to the patient and asking them to complete formal questionnaires, examining them and/or undertaking investigations is called 'clinical assessment'.<br>As well as diagnosing and ruling out a particular condition, clinicians often need to consider and exclude other, sometimes more serious, conditions that present in a similar way but may need quite different treatment – this process is called 'differential diagnosis'. | PCR has been used as a 'gold standard' test for diagnosis of Covid-19 since the beginning of the pandemic. Lateral flow testing was developed to provide a quicker and cheaper option, but it demonstrates the limitations of testing; it is 99.68% specific, which is a very high specificity. This means there are only a tiny number of false positives. It has lower sensitivity at 76.8%, which means it will miss about a quarter of all cases, so giving many more false negatives, BUT it will only miss 5% of cases with high viral load. | Epilepsy can only be definitively diagnosed by either getting a really clear description of the events from a parent or carer, or seeing the child or young person having a seizure on a video. An EEG (brain wave tracing) and other tests can provide information about the type of epilepsy, but unless a seizure happens during the recording, it does not demonstrate that they actually have seizures – only that they may be susceptible to seizures. | In autism there are no blood tests or X-rays to make the diagnosis. It is a 'clinical' diagnosis, which means it is dependent on taking a standardised history from the parents, and performing standardised assessments on the child or young person to distinguish between autism and other possible diagnoses (for example, language disorder, social anxiety). In the early days, these standardised measures did not exist; the diagnosis was very dependent on experts who were used to diagnosing autism by making a clinical judgement about each child. This made it difficult to teach new people how to do this without a long apprenticeship, and also made it difficult to know whether two different experts would come to the same conclusion about the same child or young person. Standardisation of the questions and process made diagnosis more reliable and consistent, as did an improved evidence base.<br>At the same time, because children with autism all present differently, the assessment had to be flexible enough to accommodate, for example, non-verbal children with severe learning disability, as well as high-functioning children with strong verbal skills. |

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| **Differential diagnosis**<br>As well as making a positive diagnosis, clinicians often need to exclude other, sometimes more serious conditions that present in a similar way, but may need quite different treatment. | | There are conditions that can be mistaken for epilepsy, so it is important to accurately diagnose whether seizures are happening and exclude other conditions (differential diagnoses) by carrying out relevant tests. | There are many conditions that may be mistaken for autism – for example, children who have language disorders, learning disability, severe social anxiety for other reasons, or ADHD can all appear to have autism. It is important to exclude these other conditions as well as making a positive diagnosis of autism. Sometimes these conditions can exist alongside autism, and management must then be planned to address all the child's difficulties. |

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| **Developing and implementing new treatments**<br>Clinicians and scientists work on developing treatments. This involves clinical trials and, where there are new treatments, comparing them to any existing treatments. Questions include: What are the intended outcomes or benefits of treatment? What are the complications or side effects? What are the costs? To initiate a new treatment, it must be both safe and effective. Questions of affordability can sometimes become controversial.<br>The best type of single study is considered to be the randomised controlled trial (RCT), but sometimes this is not feasible. Even where RCTs are not available, it is usual to at least have data on the outcomes of sufficient cases or cohorts to understand the risk/benefit of the treatment under consideration. As demonstrated in Fig. 3, the highest level of evidence is when the results of several different studies are pooled, but this is only useful if the individual studies themselves are of high quality. | Developing treatments for Covid-19 has been possible at speed because of the large numbers of patients, and the fact that outcomes can be observed on each patient within a matter of days to weeks. Because Covid-19 was a new condition, clinicians also started in a position of 'equipoise' which means that they did not have reason to believe any one treatment might be more effective than another; this made it ethical to have one group having a treatment and another group having a different treatment or a placebo. There are also really clear outcome measures, such as whether or not patients survive or need hospitalisation. This has facilitated a high level of evidence through randomised controlled trials (see diagram below). | Similar considerations apply to the treatment of epilepsy in that there are 'hard' outcome measures (for example, frequency of seizures), but it can take several months to determine whether a new drug is better than an existing one for any one patient, and some side effects may be longer-term, so trials can take several years. In addition, children with epilepsy may have very different conditions causing their seizures which can also make trials more challenging.<br>In the most severe cases of epilepsy, surgery may be the best option for controlling seizures. This can be very radical in certain cases and have lifelong implications for how they function. These options, which have a cost as well as a benefit to the child, will only be offered after a multi-disciplinary team meeting, including the paediatricians, therapists, neuropsychologists, radiologists, neurophysiologists and neurosurgeons have all discussed whether the benefits will outweigh the costs. | Evaluating interventions for autism is the most difficult of these three examples. This is because it can take many years to see developmental outcomes; it is hard to get uniform groups of children; outcomes are extremely sensitive to the social (and historical) response of others; and many other things happen in children's lives (such as changes of school, other medications, new diets). Isolating the effect of the target treatment is therefore challenging. |

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| In many instances, evidence is not perfect and difficult decisions have to be made. Where treatments are innovative or life-changing, the whole multi-disciplinary team will usually meet to consider the available options, and how to advise the child or young person and family so that a shared decision can be made. Sometimes an ethics committee is involved. This is one of the most challenging areas of medicine and is underpinned by GMC guidance.[97, 98] | The UK has been internationally recognised for its Recovery Trial, led by Oxford University. This has recruited over 46,000 participants, and resulted in several treatments being approved. A key factor in this success was the willingness of patients to participate in these studies – with over 46,000 being recruited and consented. | | |

[97] General Medical Council (2020). Decision making and consent.
[98] National Institute for Health and Care Excellence (2021). Shared decision making.

| Stage | Covid-19 | Childhood Epilepsy | Autism |
|---|---|---|---|
| **Service development and service improvement**<br>Central to any service improvement is the systematic and consistent collection of data on outcomes of treatment. There is a process of continuous service improvement as new presentations or variations on the original condition are recognised, diagnosis or screening improves and/or trials on new treatments or variations on existing treatments are ongoing.<br>There should be consistent treatment protocols or guidelines in place, in order to make sense of variations in outcomes. Where possible, these should be compared between and across multiple different centres.<br>As time passes, services need to be changed or extended based on patient need, and on what resources are needed to deliver the available treatments. They need to be accessible where the prevalence of the condition is highest. The relevant workforce to deliver the service needs to be recruited and trained, contingent on the type of treatments or therapy that is required. | Service development to manage Covid-19 has been on a scale unlike any normal new service development ever experienced. It has also demonstrated how other non-Covid services have had to evolve alongside, including the need for isolation, and/or PCR testing prior to routine clinical appointments, use of remote consultation and an array of other changes across the NHS. Continuous audit and monitoring of outcomes has resulted in major improvements in survival – for example, changing ventilation approach to include 'proning' (putting patients on their front while on the ventilator) and delaying fully intubated ventilation by giving mask ventilation for as long as possible. | Paediatric epilepsy is a good example of how a national approach can be taken to service improvement through the Epilepy12 programme.[99] This is a nationally co-ordinated audit which collects a standardised dataset, incorporating NICE standards, and is used to drive up standards of care for children and young people with epilepsy. | Improvement in autism services has been driven by the changing epidemiology, NICE standards, extensive training of the workforce and attempts to improve public understanding. Where previously diagnosis was undertaken in a few specialist centres, the rising waiting times and NICE standards on access, assessment and appropriate multi-professional provision have led to almost every community child development service having an autism assessment clinic or team. Services are able to self-assess against national standards to inform local improvement strategies. |

[99] Royal College of Paediatrics and Child Health (2021). Epilepsy 12 – national organisational audit and clinical audit.

# References


AB v CD & Ors [2021] EWHC 741.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Health Disorders: DSM-5TM, 5th ed.

Bell v Tavistock [2020] EWHC 3274 (Admin).

Bloom TM, Nguyen TP, Lami F, Pace CC, Poulakis Z, Telfer N (2021). Measurement tools for gender identity, gender expression, and gender dysphoria in transgender and gender-diverse children and adolescents: a systematic review. Lancet Child Adolescent Health. 5: 582-588. DOI: 10.1016/s2352-4642(21)00098-5.

Bonfatto M, Crasnow E (2018). Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service. J Child Psychother 44(1): 29–46. DOI:10.1080/0075417X.2018.1443150.

Brik T, Vrouenraets LJJJ, de Vries MC, Hannema SE (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. Arch Sex Behav 49: 2611–8. DOI: 10.1007/s10508-020-01660-8.

Care Quality Commission (2021). The Tavistock and Portman NHS Foundation Trust Gender Identity Service Inspection Report. London: CQC.

Carmichael P, Butler G, Masic U, Cole TJ, De Stavola BL, Davidson S, et al (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLoS One. 16(2):e0243894. DOI:10.1371/journal.pone.0243894.

Centers for Disease Control and Prevention (2012). Principles of Epidemiology in Public Health Practice: An introduction to Applied Epidemiology and Biostatistics, 3rd ed.

Chen D, Abrams M, Clark L, Ehrensaft D, Tishelman AC, Chan YM, et al (2021). Psychosocial characteristics of transgender youth seeking gender-affirming medical treatment: baseline findings from the trans youth care study. J Adol Health 68(6): 1104–11.

Chen D, Strang JF, Kolbuck VD, Rosenthal SM, Wallen K, Waber DP, et al (2020). Consensus parameter: research methodologies to evaluate neurodevelopmental effects of pubertal suppression in transgender youth. Transgender Health 5(4). DOI: 10.1089/trgh.2020.0006.

Churcher Clarke A, Spiliadis A (2019). 'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties. Clin Child Psychol Psychiatry 24(2): 338–52. DOI:10.1177/1359104518825288.

Cohen-Kettenis PT, Steensma TD, de Vries ALC (2001). Treatment of adolescents with gender dysphoria in the Netherlands. Child Adolesc Psychiatr Clin N Am 20: 689–700. DOI: 10.1016/j.chc.2011.08.001.

Cohen-Kettenis PT, Van Goozen S (1998). Pubertal delay as an aid in diagnosis and treatment of a transsexual adolescent. Eur Child Adolesc Psychiatry 7: 246–8. DOI: 10.1007/s007870050073.

de Graaf NM, Carmichael P, Steensma TD, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for Gender Dysphoria: Data from the Gender Identity Development Service in London (2000–2017). J Sex Med 15(10): 1381–3. DOI: 10.1016/j.jsxm.2018.08.002.

de Graaf NM, Giovanardi G, Zitz C, Carmichael P (2018). Sex ratio in children and adolescents referred to the gender identity development service in the UK (2009-2016). Arch Sex Behav 47(5): 1301–4.

de Vries ALC, Cohen-Kettenis PT (2012). Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex 59: 301–320. DOI: 10.1080/00918369.2012.653300.

Delemarre-van de Wall HA, Cohen-Kettinis PT (2006). Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. Eur J Endocrinol 155 (Suppl 1): S131–7. DOI: 10.1530/eje.1.02231.

Delevichab K, Klinger M, Nana OJ, Wilbrecht L (2021). Coming of age in the frontal cortex: The role of puberty in cortical maturation. Semin Cell Dev Biol 118: 64–72. DOI: 10.1016/j.semcdb.2021.04.021.

Di Ceglie D (2009). Engaging young people with atypical gender identity development in therapeutic work: A developmental approach. J Child Psychother 35(1): 3–12. DOI: 10.1080/00754170902764868.

Ehrensaft D, Giammattei SV, Storck K, Tishelman AC, Colton K-M (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. Int J Transgend 19(2): 251–68. DOI: 10.1080/15532739.2017.1414649.

EWCA [2021] Civ 1363.

Gender Identity Clinic, The Tavistock and Portman NHS Foundation Trust. Waiting times.

Gender Identity Development Service. Referrals to GIDS, financial years 2010-11 to 2020-21.

General Medical Council (2018). 0-18 years – guidance for all doctors.

General Medical Council (2020). Decision making and consent.

General Medical Council (2021). Good practice in prescribing and managing medicines and devices (76-78).

Gillick v West Norfolk and Wisbech AHA [1986] AC 112.

Goddings A-L, Beltz A, Jiska S, Crone EA, Braams BR (2019). Understanding the role of puberty in structural and functional development of the adolescent brain. J Res Adolesc 29(1): 32–53. DOI: 10.1111/jora.12408.

Hembree WC, Cohen-Kettenis PT, Gooren L, Hannema SE, Meyer WJ, Murad MH, et al (2017). Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab 102(11): 3869–903. DOI: 10.1210/jc.2017-01658.

Hidalgo MA, Ehrensaft D, Tishelman AC, Clark LF, Garofalo R, Rosenthal SM, et al (2013). The gender affirmative model: What we know and what we aim to learn [Editorial]. Human Dev 56(5): 285–290. DOI:10.1159/000355235.

Kyriakou A, Nicolaides NC, Skordis N (2020). Current approach to the clinical care of adolescents with gender dysphoria. Acta Biomed 91(1): 165–75. DOI: 10.23750/abm.v91i1.9244.

Littman L (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch Sex Abuse 50: 3353–69. DOI: 10.1007/s10508-021-02163-w

Matthews T, Holt V, Sahin S, Taylor A, Griksaitis (2019). Gender Dysphoria in looked-after and adopted young people in a gender identity development service. Clinical Child Psychol Psychiatry 24: 112-128. DOI: 10.1177/1359104518791657.

Mental Health Law Online. MCA 2005 s4.

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

National Institute for Health and Care Excellence (2020). Evidence Review: Gonadotrophin Releasing Hormone Analogues for Children and Adolescents with Gender Dysphoria.

National Institute for Health and Care Excellence (2020). Evidence review: gender-affirming hormones for children and adolescents with gender dysphoria.

National Institute for Health and Care Excellence (2021). Shared decision making.

NHS. GP services.

Office for National Statistics (2019). What is the difference between sex and gender?

Olson-Kennedy J, Chan YM, Rosenthal S, Hidalgo MA, Chen D, Clark L, et al (2019). Creating the Trans Youth Research Network: A collaborative research endeavor. Transgend Health 4(12): 304–12. DOI: 10.1089/trgh.2019.0024.

OpenMD (2021). New Evidence in Medical Research.

Royal College of Paediatrics and Child Health (2021). Epilepsy 12 – national organisational audit and clinical audit – 2021.

Scobie S, Castle-Clarke S (2019). Implementing learning health systems in the UK NHS: Policy actions to improve collaboration and transparency and support innovation and better use of analytics. Learning Health Systems 4(1): e10209. DOI:10.1002/lrh2.10209.

Sievert EDC, Schweizer K, Barkmann C, Fahrenkrug S, Becker-Hebly I (2020). Not social transition status, but peer relations and family functioning predict psychological functioning in a German clinical sample of children with Gender Dysphoria.Clin Child Psychol Psychiatry 26(1): 79–95. DOI: 10.1177/1359104520964530

Spiliadis A (2019). Towards a gender exploratory model: Slowing things down, opening things up and exploring identity development. Metalogos Systemic Ther J 35: 1–9.

Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT (2011). Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry 16(4): 485-97. DOI: 10.1177/135910451037803.

Steensma TD, Cohen-Kettenis PT, Zucker KJ (2018). Evidence for a change in the sex ratio of children referred for gender dysphoria: Data from the Center of Expertise on Gender Dysphoria in Amsterdam (1988-2016). Journal of Sex & Marital Therapy 44(7): 713–5. DOI: 10.1080/0092623X.2018.1437580.

Steensma TD, McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. J Am Acad Child Adolesc Psychiatry 52: 582-590. DOI: 10.1016/j.jaac.2013.03.016.

Turban JL, King D, Carswell JM, et al (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. Pediatrics 145 (2): e20191725. DOI: 10.1542/peds.2019-1725.

Twist J, de Graaf NM (2019). Gender diversity and non-binary presentations in young people attending the United Kingdom's National Gender Identity Development Service. Clin Child Psychol Psychiatry 24(2): 277–90. DOI: 10.1177/1359104518804311.

Van Der Miesen AIR, Hurley H, De Vries ALC (2016). Gender dysphoria and autism spectrum disorder: A narrative review. Int Rev Psychiatry 28: 70-80. DOI: 10.3109/09540261.2015.1111199.

Vrouenraets LJ, Fredriks AM, Hannema SE, Cohen-Kettenis PT, de Vries MC (2015). Early medical treatment of children and adolescents with gender dysphoria: an empirical ethical study. J Adolesc Health 57(4): 367-73. DOI: 10.1016/.2015.04.004.

World Health Organization (2022). International Classification of Diseases Eleventh Revision.

Wren B (2019). Notes on a crisis of meaning in the care of gender-diverse children. In: Hertzmann L, Newbigin J (eds) Sexuality and Gender Now: Moving Beyond Heteronormativity. Routledge.

Young Minds. Guide to CAMHS: a guide for young people.

Zucker KJ (2017). Epidemiology of gender dysphoria and transgender identity. Sex Health 14(5): 404–11. DOI:10.1071/SH1.

Zucker KJ, Lawrence AA (2009). Epidemiology of gender identity disorder: recommendations for the Standards of Care of the World Professional Association for Transgender Health. Int J Transgend 11(1): 8-18. DOI: 10.1080/15532730902799946.

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Closed petition

# Safeguard evidence-based therapy for children struggling with gender dysphoria

We are deeply concerned by the possibility of normal therapeutic practices being banned alongside conversion therapy.

We ask the government not to criminalise essential, explorative therapy. Such well-meaning legislation might ironically deny vulnerable children the help they need.

More details

**This petition is closed**
**All petitions run for 6 months**

## 11,119 signatures

Show on a map 100,000

## Government responded

This response was given on 5 July 2021

> Government will ban conversion therapy, maintain safeguards for young people from inappropriate interventions and uphold the independence of clinicians supporting those experiencing gender dysphoria.

Read the response in full

Conversion therapy is an abhorrent practice that this government will ban.

We will ensure that any action we take will be proportionate and effective and does not have unintended consequences.

We will protect free speech, uphold the individual freedoms we all hold dear and protect under-18s from irreversible decisions.

We will ensure parents, teachers and medical professionals are able to safeguard young people from inappropriate interventions and are clear that this ban must not impact on the independence and confidence of clinicians to support those who may be experiencing gender dysphoria. We will be working with stakeholders, including medical experts, to ensure we do not inhibit people seeking support.

We will be launching a consultation, which will provide experts and those impacted by conversion therapy with a formal opportunity to feed in views.

We are proud that the UK is a leader on LGBT equality at home and abroad, having legalised same-sex marriage and introduced one of the world's most comprehensive legislative frameworks for protecting LGBT people from violence and discrimination.

We want to ensure everybody can live their lives free from discrimination and violence and prosper in a modern Britain and banning conversion therapy is the next step in ensuring this.

Government Equalities Office

## Other parliamentary business

Government launches consultation on banning conversion therapy

MPs announce evidence sessions on the Government's consultation on conversion therapy

Date closed
**14 October 2021**

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# LGB Alliance's Response to the Government Consultation on Banning Conversion Therapy

Consultation




**Here are our answers to the Consultation on the Government's proposals for a Bill to Ban Conversion Therapy, which may serve as guidance.**

**We encourage all our supporters to read our guidance and respond to the Consultation. We recommend you respond in your own words.**

**Not all the questions allow for explanatory comments. We suggest adding explanations to the replies to the following questions where needed.**

**When you have read our guidance, you can respond to the Consultation HERE.**

615

1980

*Do you agree or disagree that the Government should intervene to end conversion therapy in principle?*

**We responded:** Somewhat agree

**Explanation**

LGB Alliance welcomes the fact that the UK government intends to ban so-called "gay conversion therapy". However, the inclusion in the proposals of "transgender conversion" threatens to amplify what we consider to be the greatest risk to young LGB people today: the promotion of the notion that children who have gender dysphoria can change their sex, or should begin to do so, before they are fully adult. We're concerned that, by a tragic irony, the government's proposals could lead to thousands of children, most of whom would have gone on to become LGB, having their puberty blocked by experimental drugs and pushed into life-long medical treatment. In other words, these proposals would promote, not stop, gay conversion therapy.

We recommend separating sexual orientation and transgender identity into two different bills. A bill on "transgender conversion therapy" needs much better research than the extremely poor Coventry University Report cited by the government. It also needs detailed pre-legislative scrutiny. There is a place for a bill that focuses solely on conversion therapy for sexual orientation, which would send a clear message to religious institutions and schools, and would empower children to reject attempts to psychologically demean them. Such a bill would also deal with the very few remaining loopholes that permit organisations to promote and recruit people for "conversion therapy". However, the need for such a bill is neither so urgent nor so extensive that it could justify supporting the government's confused, contradictory and dangerous proposals.

Any legislation to ban "transgender conversion therapy" will need more time and scrutiny in our view, because of the many problems surrounding this issue:

- A lack of clear definitions
- A lack of robust evidence

- Grave risks that the proposed legislation could cause more harm than good
- Concerning gaps that need to be researched and closed
- The Cass Review, which is studying these very problems, will not be delivering its findings until the second half of 2022

Given these concerns, we recommend that the Government focus on drafting legislation to ban gay conversion therapy, ensuring that the ban can be implemented effectively. In the case of "transgender conversion therapy" we recommend separating this out into a separate bill that is subjected to its own process of pre-legislative scrutiny, the gathering of fresh and robust evidence, and above all awaiting the results of the Cass Review before drafting any legislation.

**Question 1**

*To what extent do you support, or not support, the government's proposal for addressing physical acts of conversion therapy? Why do you think this?*

**We responded:** Strongly Support

While all acts of physical "*conversion therapy*" (that is violence, any acts of physical punishment or deprivation, corrective rape or any other cruel and coercive physical acts intended to change a person's sexual orientation or gender identity) are fortunately already illegal under existing law, the proposed Bill could underline and highlight the unlawfulness of such acts. It may also help to identify any gaps in the prohibition of acts of physical conversion practices.

Although we want sexual orientation and gender identity to be separated into two different bills, we want to make it clear that we utterly oppose all attempts to try to change any personal belief or sense of self, including gender identity, that involves anything that's bullying, demeaning or humiliating. There are some children who will never desist from the conviction they are trans and they must be respected and given care that allows them to prosper. It is in their interests to be given time to experience their adolescent body. We agree with the prominent

trans rights activist Jack Halberstam, who has spoken out against rushing to medicate young people who believe they are trans.
Source: https://youtu.be/quvWUlus6ao at 1.11.52

**Question 2**

*The government considers that delivering talking conversion therapy with the intention of changing a person's sexual orientation or changing them from being transgender or to being transgender either to someone who is under 18, or to someone who is 18 or over and who has not consented or lacks the capacity to do so should be considered a criminal offence. The consultation document describes proposals to introduce new criminal law that will capture this. How far do you agree or disagree with this?*

**We responded**: Strongly Disagree

There are many problems with this question:

- It fails to define what "conversion therapy" means in the context of "talking", so this point is left open to misinterpretation.
- It mixes up sexual orientation with "transgenderism", which is not a sexual orientation but a "gender identity"; which is very different and in some ways the opposite.
- It also fails to define what "transgender" means. "Trans" is often described as an umbrella term covering many different issues.
- It fails to distinguish between psychotherapy and religious practices.

Here are some things to consider:

**Sexual orientation:** Under current law, any licensed therapist would lose their license if they tried to practise "conversion therapy", in the sense of applying pressure of any kind in an attempt to change a person's sexual orientation. However, where evidence reveals loopholes, and new legislation could close them, this would be welcome.

**"Transgender"**: "conversion therapy" in this regard is a controversial subject with polarised views. Of course, all people who are "gender non-conforming" should be treated with dignity and respect and be free to be

themselves and dress as they please. So what is “conversion therapy” when it comes to people self-defining as transgender?

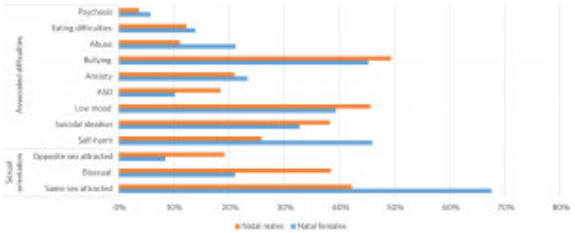
Some people say that if a child has gender dysphoria and is certain they are transgender, any attempt to explore their reasons for believing this should be labelled “conversion therapy”. We reject that view. Homophobia is still so rife in our society that many LGB young people are left confused and full of shame and risk being sucked into seeing their bodies as somehow “wrong”. We know from experience that many teens who are labelled “butch” (girls) or “effeminate” (boys) need time to work out what they really are.

Research suggests – and is confirmed by growing numbers of detransitioners – that many can be convinced they are the opposite sex because of homophobic parents, sexual abuse in the family or internalised fear of being thought gay. Autistic spectrum disorder and a range of mental health issues may also play a role. Banning therapists from exploring what’s going on in a young person’s mind could unintentionally promote conversion therapy: lesbian and gay young people might become convinced they’re trans when they’re not.

We believe the most pressing example of “conversion therapy” currently practised in the UK is the widespread prescription of puberty blockers to teens claiming to be the opposite sex

Please consider the four crucial points below:

- Around 74% of teens referred to the Tavistock GIDS clinic are girls. Only 8.5% of these girls say they are exclusively attracted to boys: almost 70% are attracted only to other girls and over 20% to both sexes. In other words, the vast majority are lesbian or bisexual.
  Source: https://www.cambridge.org/core/journals/bjpsych-bulletin/article/sex-gender-and-gender-identity-a-reevaluation-of-the-evidence/76A3DC54F3BD91E8D631B93397698B1A



- Research shows that 85% of children who are not medicalised for gender dysphoria "desist" with puberty, that is, become comfortable with their sexed body and no longer wish to change it.
  Source: Cantor, J. (2016) "Do trans kids stay trans when they grow up?"SexologyToday http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html
- Of those who are prescribed puberty blockers, 98% go on to take cross-sex hormones. Source: https://www.thetimes.co.uk/article/tavistock-clinic-treats-girls-who-dont-like-dolls-as-transgender-ffdz7kc00
- What is often referred to as "gender-affirming health care" (puberty blockers, cross-sex-hormones and surgery) can leave the young person with permanently impaired sexual function.
  Source: https://www.genderhq.org/trans-youth-side-effects-hormone-blockers-surgery

**Consider this example**

> If a 14-year-old girl referred to a gender clinic says she is certain she is a boy, what is an ethical psychotherapist to say? Under the proposals, psychotherapists will be afraid to ask exploratory questions. Fearing prosecution, they may affirm the girl's identity as a boy without exploring all the other issues that may be relevant (internalized homophobia, autism spectrum disorder, past trauma, depression, anxiety, eating disorders etc.).

Some therapists may decline to see such patients altogether, for fear of falling foul of the law, thereby increasing the length of already long waiting lists and leaving these vulnerable young people without support. This is harmful for the young people concerned and puts therapists in an impossible position. Furthermore, in the case of "affirmative" interventions that are later regretted, multiple lawsuits for medical malpractice are likely in the medium to long term.

Are our concerns justified? Consider the grave errors made in similar legislation introduced in Victoria, Australia – legislation that has astonishingly been praised by MPs in the UK House of Commons as "best practice". This Victoria Bill, the Change or Suppression (Conversion) Practices Prohibition Bill 2020, makes it illegal to provide

talking therapy or psychiatric support to any young people convinced that they have been born in the wrong bodies.

**To put it plainly: under the law in Victoria, if a girl says she is a boy, this must be affirmed and not questioned or explored: otherwise the therapist risks imprisonment.**

**Do you really think this should be described as best practice?**

On religion: We find it abhorrent that some religions classify homosexuality as sinful and set out to "cure" people of it. It is disheartening that some adults feel distressed by their homosexuality and seek out religious help because of it. However, we do not believe it is the role of the state to say some forms of religious belief are valid and others are invalid, or that some religious rituals are acceptable and others are unacceptable.

**Question 3**

How far do you agree or disagree with the penalties being proposed?

**We answered:** Neither agree nor disagree

We cannot answer the question on penalties, since there is no coherent definition of "conversion therapy" and confusing sexual orientation with "gender identity" risks causing real harm. As far as gay conversion therapy is considered, we would cautiously agree. As far as "transgender conversion therapy" is concerned, given all the risks we have identified, we strongly reject the idea of introducing any penalties for "talking therapy" in relation to children with gender dysphoria who self-identify as "transgender".

**Question 4**

*Do you think that these proposals miss anything? If yes, can you tell us what you think we have missed?*

**We answered:** YES

*This is an opportunity to share what you think is missing from the UK Government's proposals*

Please consider the following crucial points in your response:

We are surprised and concerned that the Government is seeking to draft legislation about two very different issues – sexual orientation and gender identity – at the same time. Introducing a ban on gay conversion would command universal support. But "transgender conversion therapy" is a completely different matter and any legislation covering it will require far more time and scrutiny:

- There is a body of evidence, going back decades, to show that gay conversion therapy is a cruel and furthermore wholly ineffective practice. Although most people think of practices that ceased in the UK some 50 years ago, there are undoubtedly cruel practices going on today, largely in religious settings, and if the government can close these loopholes we would applaud it.
- Where "transgender conversion therapy" is concerned, it is unclear what is meant, the evidence is very thin and very recent, and getting it wrong would be enormously harmful. The UK Government surely doesn't want to make the same mistakes as were made in Victoria, Australia. That would risk sending children down a path towards lifelong medicalisation with irreversible effects that some will regret, and criminalizing decent therapists who want to help them.
- The proposals provide insufficient protection to young people with gender dysphoria and insufficient protection to therapists wanting to work with patients who are convinced they are the opposite sex. The proposals refer to children who are "questioning" their gender identity. But many young people are – apparently – not questioning at all. They are certain they are transgender. We know from the soaring numbers of detransitioners that their certainty is often based on a misunderstanding.
- The UK Government should make clear, either directly in legislation or in guidance accompanying a Bill, that exploratory psychotherapy given to young people who assert that they are the opposite sex (or "transgender") does not qualify as conversion therapy and would therefore not be an offence under its proposals.

- Conversely, the prescription of puberty blockers to minors who claim to be the opposite sex (or "transgender") without extensive psychotherapy (to be further defined in guidance) to ascertain the presence of comorbidities and/or the existence of environmental factors such as homophobia in the family circle should be explicitly classified as conversion therapy and constitute an offence under the government's proposals.
- It is our hope that The Cass Review will clarify the appropriate approaches to children referred to gender clinics once it has reviewed the evidence. We therefore feel introducing any legislation on this issue before Hilary Cass has announced the findings of her team's review would be entirely wrong.
- It is our position that the main victims of conversion therapy are detransitioners. These are young people who were convinced they were the opposite sex and underwent hormone treatment and in many cases surgery in an attempt to change sex and who later regretted these interventions and are sad or indeed angry that they did not receive better care. There are no funded support services for these people; the government has failed to address this.
- We hope that detransitioners, and others with direct experience of this issue, will respond to the consultation and make their views known.
- It is also a real problem that these proposals do not clarify whether detransitioners could receive help. Would therapists be criminalised for exploring patients' certainty that they are transgender, or – at a later stage – their certainty that they made a mistake and are not transgender after all?
- As the example in the reply to Question 2 shows, the proposals will scare therapists so much – fearing false accusations of "conversion therapy" and criminal charges – that fewer will agree to see such clients. This will exacerbate the already serious shortage of care for all gender-distressed children.

**Question 5**

*The government considers that Ofcom's Broadcasting Code already provides measures against the broadcast and promotion of conversion therapy. How far do you agree or disagree with this? Why do you think this?*

**We answered:** SOMEWHAT DISAGREE

This is sadly of little relevance. The main promotion of "conversion therapy" occurs on social media, through platforms such as TikTok, YouTube and reddit. There, girls are encouraged to wear binders, and images of girls who have had their breasts removed are posted in a celebratory manner. This material, in our view, is profoundly homophobic and seeks in many cases to "trans the gay away". We urge the government to consider separate regulatory action to curb this harmful material, similar to curbs on material promoting suicide or self-harming.

**Question 6**

*Do you know of any examples of broadcasting that you consider to be endorsing or promoting conversion therapy? If yes, can you tell us what these examples are?*

**We answered:** YES

BBC dramas such as "First Day" (CBBC, 2021) and the ITV's "Butterfly" (2017) not only promote the fiction that some children are "born in the wrong body" and require drugs and surgery, but depict those who disagree as nasty bigots. TV documentaries on trans issues frequently present false statistics on suicide and detransitioning, and falsely state that puberty blockers are harmless and provide a "pause" during which teens can "make up their minds" whether to transition or not (e.g. Victoria Derbyshire series, "Transgender Children" (2017), and "Transitioning Teens" (BBC3, 2021))

All this material is profoundly misleading and we believe it is also homophobic. It amounts to "conversion therapy" targeting gender non-conforming children, most of whom would grow up gay, lesbian or bisexual if not medicalised. The belief that one has been "born in the wrong body" leads in many cases to lifelong medicalisation, absence of sexual feeling, a wealth of medical complications including incontinence and sterilization, in young people who later profoundly regret having

undergone this treatment. It is frankly shocking that these interventions are celebrated in BBC broadcasts.

**Question 7**

*The government considers that the existing codes set out by the Advertising Standards Authority and the Committee of Advertising Practice already prohibits the advertisement of conversion therapy. How far do you agree or disagree with this?*

**We answered:** DISAGREE

The definition of "conversion therapy" should include the promotion of harmful products such as binders and harmful surgeries such as double mastectomies. In our view, the Government has failed to realize that such products – which target children who do not conform to gender stereotypes – are part of an online "conversion therapy" encouraging them to believe they need to change their bodies to become the opposite sex – something that is neither desirable nor possible.

**Question 8**

*Do you know of any examples of advertisements that you consider to be endorsing or promoting conversion therapy? If yes, can you tell us what these examples are?*

**We answered:** YES

There are hundreds of examples. Here are just two. Below is a link to an advert on TikTok, a social media platform popular with young people, by Dr Sidhbh Gallagher. She stands and sways amid palm trees, with a cheerful musical accompaniment, for her sales pitch on double mastectomies, which she calls "Teetus Deletus". Such videos are viewed many thousands of times. We are referring to this as an advertisement

promoting conversion therapy since many of the girls who want their breasts removed are lesbians and are hoping to be “converted” into boys.

https://twitter.com/ALLIANCELGB/status/1379540567579893760?s=20

The same applies to the company Lush, which advertised a campaign to provide binders to girls seeking to flatten their breasts. Binders are harmful products that cause a number of health problems. Again, we see them as a kind of conversion therapy for young lesbians.

**Question 9**

*The consultation document describes proposals to introduce conversion therapy protection orders to tackle a gap in provision for victims of the practice. To what extent do you agree or disagree that there is a gap in the provision for victims of conversion therapy?*

**We answered:** STRONGLY AGREE

Although we agree there is a gap in provision for victims of the practice, we believe the Government has failed to address what we see as the primary gap. As explained above, we believe the main victims of “conversion therapy” are detransitioners. The document completely fails to address this issue. Since these patients have been so woefully failed by the NHS, it is the responsibility of the NHS to urgently establish a dedicated unit to address these patients’ complex needs.

**Question 10**

*To what extent do you agree or disagree with our proposals for addressing the gap we have identified? Why do you think this?*

**We answered:** STRONGLY DISAGREE

Given the Government’s failure to identify what we see as the primary gap in provision for victims of the practice, we find the proposals

inadequate. The Government has made no proposals to remedy the current lack of any provision to provide care to detransitioners, who we see as currently the primary victims of gay conversion therapy in the UK.

We do not object to the proposals to introduce Conversion Therapy Protection Orders in the case of gay conversion therapy, but as we have said, we strongly advise against introducing any legislation at this stage in relation to "gender identity conversion therapy", since the definitions and evidence have not yet been established.

**Question 11**

*Charity trustees are the people who are responsible for governing a charity and directing how it is managed and run. The consultation document describes proposals whereby anyone found guilty of carrying out conversion therapy will have the case against them for being disqualified from serving as a trustee at any charity strengthened. To what extent do you agree or disagree with this approach? Why do you think this?*

**We answered:** NEITHER AGREE NOR DISAGREE

Where gay "conversion therapy" is concerned – practices seeking to change a person's sexual orientation – we certainly agree. However, in the case of "transgender conversion therapy", we do not consider the Government has provided any evidentiary basis for this proposal. Given the above arguments, such as the failure to provide clear definitions and the complete failure to understand the homophobia underlying the drive to promote puberty blockers, we consider this approach misguided in relation to "transgender conversion therapy". The proposals risk disqualifying persons who have a genuine desire to ensure safeguarding principles are upheld.

**Question 12**

*To what extent do you agree or disagree that the following organisations are providing adequate action against people who might already be carrying out conversion therapy? (Police; Crown Prosecution Service; OTHER statutory service)? Why do you think this?*

**We answered:** Neither agree nor disagree

The Government has failed to provide any evidence on which to answer this question. Given the failure to provide clear definitions of "conversion therapy", "transgender", and "gender identity", this question is impossible to answer.

**Question 13**

*To what extent do you agree or disagree that the following organisations are providing adequate support for victims of conversion therapy? (Police; Crown Prosecution Service; OTHER statutory service)? Why do you think this?*

**We answered:** Strongly disagree.

Our answer relates to the NHS. As explained in our answer to question 4, the main victims of conversion therapy, in our view, are detransitioners. The NHS urgently needs to set up a specialist unit for detransitioners, whose lives have been severely impacted by interventions carried out by the NHS itself.

**Question 14**

*Do you think that these services can do more to support victims of conversion therapy? If yes, what more do you think they could do?*

**We answered:** Yes

At present the NHS is doing nothing at all to support the main victims of conversion therapy: detransitioners. This is a national scandal. See our answer to question 4.

## Economic appraisal

**Question 15**

*Do you have any evidence on the economic or financial costs or benefits of any of the proposals set out in the consultation? If yes, please can you provide us with details of this evidence, including where possible, any references to publications?*

**We answered:** YES

Once the medicalisation of children with gender dysphoria is halted, there is a danger that these children will be left without care. There is a need for a major investment in mental health services to provide these distressed young people with decent care. This subject needs to be properly researched.

If talking therapy is criminalised and more children are led down a path towards sterilisation and numerous other health risks, the NHS can expect a plethora of lawsuits alleging clinical negligence. These are likely to be extremely expensive for the NHS. This projection is based on the growing number of young detransitioners who feel their medical care was negligent.

## Equalities impacts appraisal

**Question 16**

*There is a duty on public authorities to consider or think about how their policies or decisions affect people who are protected under the Equality Act 2010. Do you have any evidence of the equalities impacts of any proposals set out in the consultation?*

**We responded:** YES

As argued above, the main "conversion therapy" taking place in the UK today (misleadingly known as "gender-affirming care") impacts disproportionately on young people who are attracted to others of the

same sex – those with the protected characteristic of sexual orientation. This is in our view by far the most important issue to be addressed.

Meanwhile, those who realise they received completely inappropriate care – detransitioners, many of whom are lesbians and therefore have the protected characteristic of sexual orientation – are being failed a second time by the health service that failed them by being completely abandoned.

## Questions related to privacy

### Question 17

*Would you like your response to be treated as confidential?*

**We responded**: No

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# A rapid review of the Coventry University research on “gender identity conversion therapy”



Is there evidence to support the proposal to criminalise people who engage in talking therapies “aiming to change someone from being transgender”?

**November 2021**

**Sex Matters is a human rights organisation campaigning for clarity about sex in law, policy and language**

**sex-matters.org | info@sex-matters.org**

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## Executive summary

*This paper reviews the evidence presented in the Coventry University research commissioned by the Government Equality Office (GEO) to make the case for banning "gender identity conversion therapy".*

The Coventry study sets out to show that "conversion therapy" in relation to gender identity is similar to religiously motivated attempts to "pray the gay away" or to pseudo-scientific therapies.

1. **No robust evidence is presented for this.** The entirety of the evidence presented consists of four articles based on three datasets, and limited highlights from six one-hour interviews with individuals. The studies are weak, and the report relies heavily on a single question in a self-selected survey run by a US transgender advocacy organisation.

   **The three datasets:**



A single question from a self-selected US online survey associated with incidence symptoms of serious mental disorder.



A study involving 400 people in the US watching a 6 minute video



4 published papers covering 10 patients in total

2. **In mapping legislation in other countries** the report does not distinguish between sexual orientation and gender identity legislation.
3. **The report is strongly embedded in transgender orthodoxy to the exclusion of other perspectives and principles of evidence.** This can be seen for example in its glossary, the wider references that it includes (and excludes), and its ignoring of people who have desisted from cross-sex identity. Based on the doctrine of self-identity the study concludes that two people interviewed who had serious mental health issues were the victims of "conversion therapy" because they report that their psychiatrists explored other potential causes and course of action than transition.

4. **The review misrepresents the findings of the research.** The high-level conclusions do not reflect the underlying evidence considered. In particular, the report states that "there is increasing evidence that attempts to change a person's [..] gender identity can cause serious harms."

   This is a misrepresentation of the findings of the underlying survey from the US, which did not demonstrate causality and could equally well indicate that individuals presenting with serious mental illness are not suitable subjects for medical intervention based on gender medicine. Moreover, the research ignored the harm inflicted on individuals given interventions who regret or detransition.

5. **What this study demonstrates is that the framework of "conversion therapy" is ill-suited to understanding the complexity of questions concerning the treatment of people with gender dysphoria, particularly the rapidly growing cohort of young people.** In contrast, the ongoing Cass Review on Gender Identity Services for Children and Young People is taking an approach without pre-determined outcome and is undertaking a much more intensive and wide-ranging evidence review.
6. **Based on our rapid review of the Coventry studies we conclude:**
   - **It provides no evidence for banning what it terms "conversion therapy"** in relation to transgender identity. The concept and the practice remain poorly defined.
   - **Writing the simplistic 'affirmation' versus 'conversion' binary into criminal and civil law risks doing harm** to children and parents, vulnerable people, therapists and other professionals, and to the relationship between them, without any evidence of the harm it purports to be addressing.
   - **Rushing through any legislation concerning children and young people before the Cass Review is published would be irresponsible** and counterproductive to evidence-based policy making.
7. **It is concerning that the Government Equalities Office would commission such a biased piece of work, and then hold it from publication for four months before releasing it just in time for a rushed six-week consultation.**

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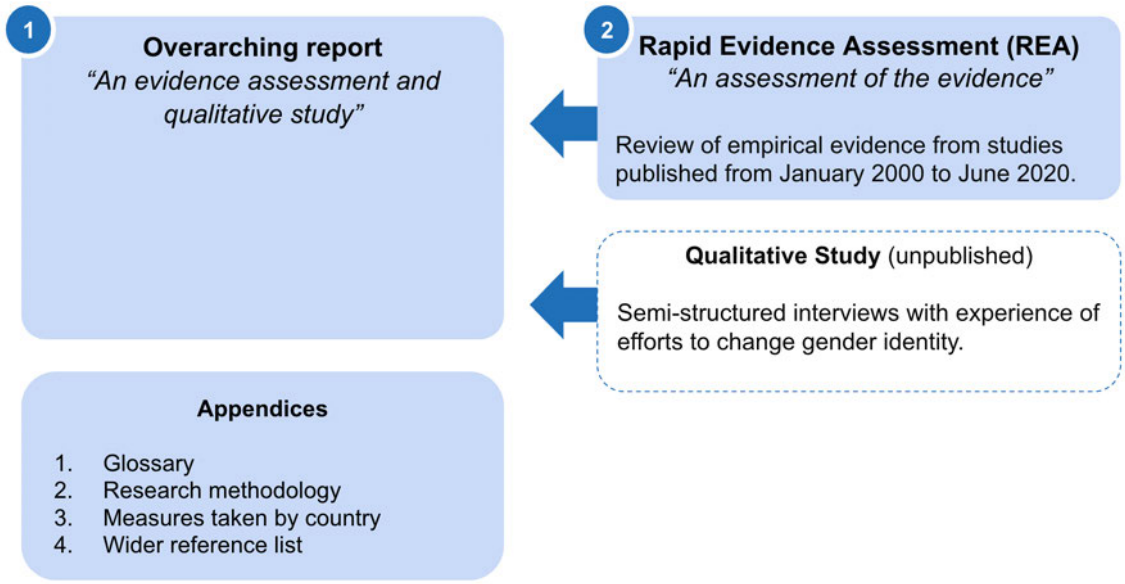
# 1. Introduction

The UK government recently published a consultation document on the proposal to criminalise 'conversion therapy' and launched a six-week consultation on it.[1] At the same time it published a pair of research publications: *Conversion therapy: an evidence assessment and qualitative study*[2] and *An assessment of the evidence on conversion therapy for sexual orientation and gender identity*.[3]

The studies were commissioned by the Government Equalities Office (GEO) and delivered by a team at Coventry University made up of Adam Jowett, Geraldine Brady, Simon Goodman, Claire Pillinger and Louise Bradley. They are dated June 2021.

The papers have similar names which is somewhat confusing. The first is an **Overarching Report** which draws on and includes the findings of the second, which is a **Rapid Evidence Assessment** (REA). We will refer to them collectively as the 'Coventry University studies' and individually as the overarching report and the REA.

*Figure 1: The Coventry University research papers for GEO*




[1] https://www.gov.uk/government/consultations/banning-conversion-therapy

[2] https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/conversion-therapy-an-evidence-assessment-and-qualitative-study

[3] https://www.gov.uk/government/publications/an-assessment-of-the-evidence-on-conversion-therapy-for-sexual-orientation-and-gender-identity

The reports define "conversion therapy" as

> "any efforts to change, modify or suppress a person's sexual orientation or gender identity regardless of whether it takes place in a healthcare, religious or other setting."

The stated aim of the research was to answer four questions:

1. What forms does conversion therapy take?
2. Who experiences conversion therapy and why?
3. What are the outcomes of conversion therapy?
4. What measures have been taken to end conversion therapy around the world?

The reports are based on a conceptual framework, as set out in the glossary in which gender identity is fixed and self-identified at any age and people are either *cis* or *trans*. Being homosexual (gay or lesbian) is defined as having "an emotional, romantic or sexual attraction towards someone of the same sex or gender."[4]

The research views any therapy which does not affirm a person's transgender identity as "conversion therapy". It frames any treatment for gender dysphoria that does not immediately affirm a transgender identity – and support endocrinological and surgical interventions if desired – as a direct parallel with religiously motivated or pseudoscientific attempts to change a person's sexual orientation. This approach is also reflected in the selection of wider literature referenced.[5]

While the report sets out findings relating to sexual orientation separately from those relating to transgender identity, it often recombines the two into generalised conclusions, suggesting that patterns of observations relating to attempts to alter sexual orientation (on which there is significant research) can be read across to attempts to explore the reasons why an individual feels distress about his or her body and the gender stereotypes associated with their sex (where there is little research).

There is no empirical or therapeutic justification for this approach.

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[4] https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/appendix-1-glossary

[5] https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/appendix-4-references

The broader context for this is a political organising tactic which has linked sexual orientation and gender identity into "the LGBT[QI+] community". This movement calls for same sex-attracted (LGB) people to stand in solidarity with people who identify as transgender, as expressed in slogans such as "No LGB without the T" and "L with the T". The characterisation of people as "LGBT" and talk of "LGBT conversion therapy" reflects this political coaltion.

While solidarity between groups is legitimate as a political axis for organising, it is not a defensible approach to analyse evidence about people with different characteristics, experiencing different phenomena.

This paper, therefore, reviews the evidence presented in the Coventry University reports ***only in relation to gender identity / transgender***. It is concerned with the first three research questions which make the case for banning "conversion therapy".

The aim is to scrutinise the evidence and the way the conclusions are presented, in order to support evidence-based debate (including media debate) of the current proposal in relation to criminalising "gender identity conversion therapy".

## 1.1 How was the Coventry research carried out?

To answer questions 1 to 3, a 'rapid evidence assessment' (REA) of research was carried out. This is a standard methodology for identifying, assessing, and distilling findings from existing research to answer a question for public policy makers.

The research team carried out a search of empirical research papers published in academic journals or by professional organisations or government bodies from January 2000 to June 2020. A standard framework (the Mixed Methods Appraisal Tool) was used to rate the quality of the articles.[6]

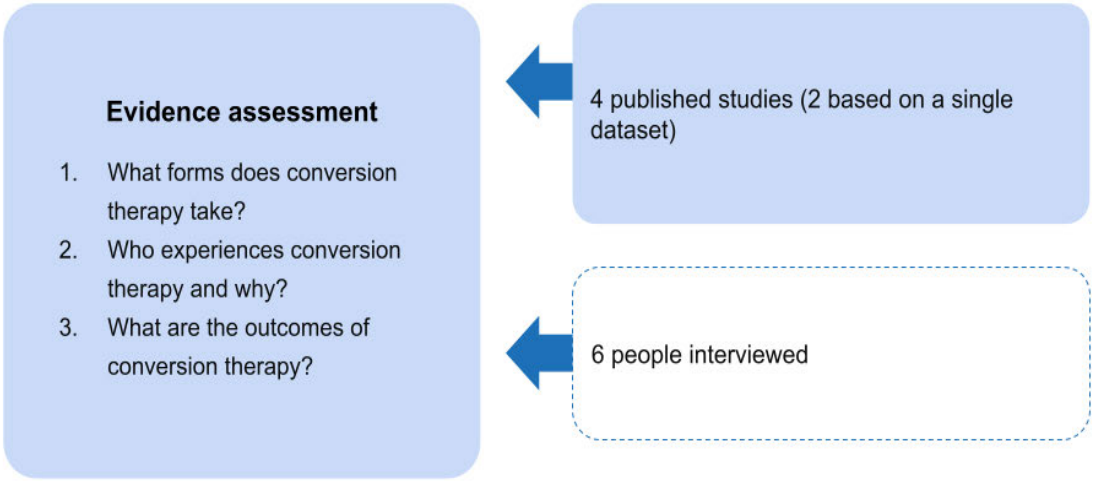
Only five articles were found that specifically addressed "conversion therapy" to change gender identity. Only four of these articles were identified as providing useful evidence for the review. Of these four, two were based on the same underlying dataset. The REA judges these four studies to be "above average quality" while recognising that the conclusions that can be drawn from them are limited.

[6] https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/appendix-2-research-method

In addition, six individuals were interviewed who said they had experienced efforts to change their gender identity. The interviews lasted about an hour each.

**This is the entirety of the evidence presented in support of the proposed ban: four articles based on three datasets, and interviews with six individuals.**

*Figure 2: Overview of the Coventry University evidence*



# 2. Assessing the evidence

## 2.1 The US National Transgender Survey

Two of the cited articles analysed data from the US Transgender Survey 2015, both produced by the same research team led by Dr Jack Turban.

> Turban J L, Beckwith N, Reisner S L, and Keuroghlian, A S (2019). 'Psychological attempts to change a person's gender identity from transgender to cisgender: Estimated prevalence across US States, 2015'. *American Journal of Public Health,* 109(10), 1452-1454. Available at: https://doi.org/10.2105/AJPH.2019.305237
>
> Turban J L, Beckwith N, Reisner S L, and Keuroghlian, A S (2020). 'Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults'. *Jama Psychiatry,* 77(1), 68-76. Available at: https://doi.org/10.1001/jamapsychiatry.2019.2285

The underlying dataset is the 2015 US Transgender Survey which was conducted by US transgender advocacy organisation the National Center for Transgender Equality. This was a "convenience survey" where participants were recruited through organisations, and subjects were asked to "pledge" to promote the survey among friends and family.[7] It yielded a large but unrepresentative sample of 27,715 respondents. The population it captured is skewed towards respondents who are young, non-binary and politically engaged with the transgender movement. Desisters and detransitioners (those who change their mind before, during or after transition) were disqualified from completing the survey.[8]

The population captured by the study was highly distressed: 39% of respondents said they had experienced serious psychological distress in the month prior to completing the survey, compared with only 5% of the US population. 40% of respondents have attempted suicide in their lifetime – nearly nine times the attempted suicide rate in the US population.

[7] https://www.ustranssurvey.org/

[8] https://link.springer.com/article/10.1007/s10508-020-01844-2

A single question was asked about what was termed "gender identity conversion experience" (GICE):

> "Did any professional (such as a psychologist, counsellor, or religious advisor) try to make you identify only with your sex assigned at birth (in other words, try to stop you being trans)?"

The headline finding is that survey participants who responded affirmatively to this question (around 14% of the total) tended to report poorer mental health than those who responded negatively to the question.

While the Coventry research team assess this study to be of "above average quality" it has already attracted severe criticism published in an academic journal. Roberto D'Angelo, Ema Syrulnik, Sasha Ayad, Lisa Marchiano, Dianna Theadora Kenny and Patrick Clarke in the *Archives of Sexual Behaviour* (2021) argue that it is compromised by serious methodological flaws, including the use of a biased data sample, reliance on survey questions with poor validity, and the omission of a key control variable, namely subjects' baseline mental health status.[9] They say:

> "While they claim to have found evidence that GICE is associated with psychological distress, what they actually found was that those recalling GICE were more likely to be suffering from serious mental illness. Further, Turban et al's choice to interpret the said association as evidence of harms of GICE disregards the fact that neither the presence nor the direction of causation can be discerned from this study due to its cross-sectional design. In fact, an alternative explanation for the found association – that individuals with poor underlying mental health were less likely to be affirmed by their therapist as transgender – is just as likely, based on the data presented."

They argue that failure to include detransitioned and desisted individuals in research regarding psychological interventions for gender dysphoria is a serious oversight.

> "These individuals, whose transgender identification was transient, may have been hurt by therapies that affirmed them as transgender, and may

[9] https://link.springer.com/article/10.1007/s10508-020-01844-2

> have benefitted from therapies that helped them successfully ameliorate their GD [gender dysphoria]."

D'Angelo et al note that the scoring tool used to assess psychological distress is designed to be predictive of having a diagnosis of schizophrenia, bipolar disorder or other serious mental disorders. Thus any claim of causation implies that exposure to GICE caused serious mental illness, in previously mentally well populations. They conclude:

> "This is a highly speculative and implausible hypothesis, which further challenges their claims."

The Turban paper (2020) is cited several times in the Coventry research.

> **Is this research fairly represented by the Coventry University team?**
> The Turban paper has severe flaws but was judged as "above average". The research review recognises that the study lacks data regarding the degree to which "conversion therapy" occurred (for example, the duration, frequency and forcefulness) or what techniques were used and that it a self-selecting sample.
>
> It is hard to see how they justified scoring this study as above average quality using the scoring framework. (Is the sampling strategy relevant to address the research question? Is the sample representative of the target population? Are the measurements appropriate? Is the risk of nonresponse bias low? Is the statistical analysis appropriate to answer the research question?)
>
> The findings are presented in a way that inflates their perceived validity and the scale of impacts, for example:
>
> *"A growing number of studies are finding that exposure to conversion therapies is associated with multiple indicators of poor health for both sexual orientation and gender identity change efforts (Blosnich and others, 2020, Dehlin and others, 2015, Meanley and others, 2020, Ryan and others, 2018, Salway and others, 2020, Turban and others, 2020)."*
>
> This is misleading. Only the Turban paper relates to gender identity change. There is no "growing number" of papers on gender identity change.

The research review also presents the Turban et al findings alongside those from a study on sexual orientation conversion therapy which finds that those who had gone through this experience were twice as likely to have suicidal thoughts, had 75% increased odds of planning to attempt suicide, 88% increased odds of attempting suicide resulting in minor injury and 67% increased odds of attempting suicide resulting in moderate or severe injury (Blosnich and others, 2020). It goes on to say: "There is also recent evidence that gender identity change efforts are associated with similar negative health outcomes," and outlines the Turban et al (2020) article. In fact that study was based on a much weaker methodology and reports increases in odds that are lower at 44%, 42%, 49%, 62% respectively.

## 2.2 The video study

The other empirical study cited is one which tested perceptions of different therapies among 400 transgender participants.

Bettergarcia J N and Israel T (2018). 'Therapist reactions to transgender identity exploration: Effects on the therapeutic relationship in an analogue study.' *Psychology of Sexual Orientation and Gender Diversity*, 5(4), 423.

This study shows participants a video clip of a therapy session, played by actors and asks questions about their perceptions.

409 participants were recruited via online lists and Amazon Mechanical Turk. After an initial online survey participants were randomly assigned to view a six-minute video showing actors playing the role of therapist and client showing one of three scenarios:

- **Transition affirming** – the therapist explains the process of transitioning to the client with no details for other options.
- **Non-binary affirming** – the therapist affirms the client's exploration of their gender identity and gender fluidity without assuming the client is interested in transitioning.
- **Non-affirming** – the therapist tries to help the client identify with their sex assigned at birth, for example with statements such as "It sounds like you're really pretty confused about your manhood... Just so you know, I have worked with people who don't feel normal and helped them get in touch with their masculinity again."

After viewing the video, the participants were asked to complete a series of questions which assessed their perception of the therapist such as attractiveness, therapist trustworthiness, expertise, session depth and smoothness.

The study found that there were less positive perceptions of the scene involving actors playing the non-affirming therapist who were judged to be less trustworthy, less of an expert, and less likable, with the session judged as being less smooth, less deep, and less positive.

The study's authors claim:

> "These findings empirically support the various books, articles, recommendations, guidelines, and transgender advocates who voice the importance and need for affirming therapeutic approaches for transgender and gender questioning individuals. These results are important because they show how the therapeutic relationship might be strengthened or harmed when therapists use an affirming versus non-affirming approach with clients who are questioning their gender identity."

Using an online perception survey based on a six-minute fictional video clip to make clinical recommendations about the efficacy of therapeutic approaches is absurd.

> **Is this research fairly represented by the Coventry University team?**
> The Coventry University review assesses this study as "above average".
>
> The study is not cited by the GEO review. It would seem that the authors judge it to be irrelevant to the policy making question in the UK. We agree.

## 2.3 The systematic review

The final study is a systematic review which is presented as "a robust study of the available evidence on conversion therapy for gender identity, and access to transition-related healthcare in transgender people." However, as Jowett et al note, it is limited by a dearth of studies in this area to review.

Wright T, Candy B, and King M (2018). 'Conversion therapies and access to transition-related healthcare in transgender people: a narrative systematic review'. *BMJ Open*, 8(12), e022425. https://doi.org//10.1136/bmjopen-2018-022425

Wright et al searched databases for work since 1990, identifying 117 papers considered potentially relevant. Most were discarded as not containing evidence but four "psychotherapeutic conversion therapy" studies were identified. Three of these studies cover one individual each, one covers a group of seven. In total ten individuals are covered by these four studies.

Of these only one, from 1997, was UK based. It was a study of just one trans person who was treated for OCD. The other study of note was by one of the leading psychologists specialising in gender dysphoria, Professor Ken Zucker, in which seven children under ten years of age were given open-ended play psychotherapy. The result was that a majority desisted in their cross-sex identities. Wright et al claim this is an example of 'conversion therapy'.

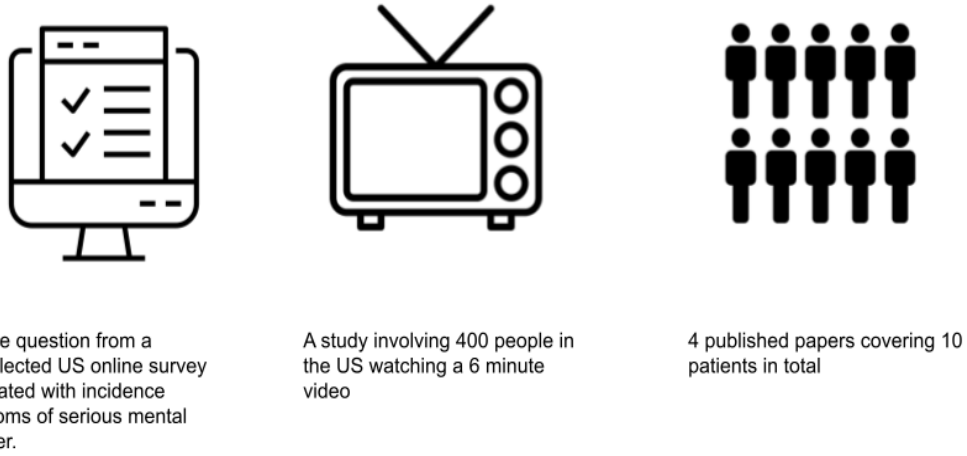
The systematic study concludes "We found limited published evidence on use, nature, structure and/or health consequences of conversion therapies".

**Is this research fairly represented by the Coventry University team?**
The Coventry review states: "There is very limited evidence about the methods used to change gender identity. A systematic review by Wright, Candy and King (2018) found only four relevant studies. The study concluded that treatment for modifying gender identity and changing sexual orientation appeared to be similar, and that they both adopted psychoanalytic and behavioural techniques."

The Coventry study does not make clear that only ten individuals are covered by the systemic review. The vague, generalised conclusion that treatments in relation to sexual orientation and gender identity "appeared to be similar" is not robust.

This finding is used to underpin the approach taken throughout the rest of the report of grouping sexual orientation and gender identity together and carrying conclusions over from one to the other.

*Figure 3: The three datasets*




## 2.4 Are the findings and conclusions of the REA supported?

The overarching report by the Coventry University team summarises the findings from the rapid evidence assessment as:

> Studies relating to conversion therapy for gender identity and transgender participants show that:
>
> - there is no robust evidence that conversion therapy can change gender identity
> - the types of practices used tend to be similar to those for conversion therapy for sexual orientation
> - there was some robust evidence of self-reported harms (such as negative mental health effects like depression and feeling suicidal)
> - there was indicative evidence that transgender respondents were as likely or more likely to be offered and receive conversion therapy than non-transgender respondents

It also states that "there is increasing evidence that attempts to change a person's sexual orientation or gender identity can cause serious harm".

In fact what the REA evidence finds is there is **no robust evidence** of any sort on the impact of "conversion therapy" from these studies ("No studies which examined the effectiveness of conversion therapy aimed at changing gender identity were identified during the search period (2000 to 2020)"). There is **no agreed definition of** "conversion

therapy", and no reason to assume that gender identity is stable in children and young adults.

The conclusion that the types of practices tend to be similar for gender identity and sexual orientation is vague and based on four studies covering ten individuals. This is **no basis for pronouncing similarity with therapy designed to change sexual orientation.**

The claim of "self-reported harms" is a **completely unsupported causal inference.**

The statement that "transgender respondents are more likely to be offered and receive conversion therapy than non-transgender respondents" (which is based on the UK Government's LGBT Survey[10]) is not meaningful. Using ***"more likely"*** suggests that the study can be used to infer prevalence in the wider population beyond those who were sampled in the survey. No such inference can be made from the non-representative sample of respondents.

*Figure 4: Summary assessment of conclusions*




**A robust assessment of the paucity of evidence found through this research review suggests that "banning gender identity conversion therapy" is a solution looking for a problem. There is no evidence cited that supports it.**

[10] https://www.gov.uk/government/publications/national-lgbt-survey-summary-report

## 2.5 The qualitative interviews

In addition to the review of published studies the Coventry University team carried out individual semi-structured interviews. Four transgender and two non-binary people were interviewed. The report does not say what sex they were. None of the transgender interviewees reported seeking out or requesting conversion therapy or experiencing aversive techniques. All six are reported as having experience of "gender identity conversion efforts" (and three as also experiencing "sexual orientation conversion efforts").

This is the entirety of the relevant description of the evidence from the interviews in the report:

- "Two said psychiatrists treated their gender identities as if they were a symptom of their mental health condition (schizophrenia, PTSD) and four reported feeling pressured to engage in conversion efforts from family or religious leaders."
- "In one case, a young transgender man reported feeling pressured by his grandparents to have conversion therapy with a priest."
- "In the other three cases, they were initially welcomed into a church, but their church leaders began to express disapproval of their gender identity. They encouraged them to have pastoral counselling and eventually placed conditions on their participation in the church."
- "One transgender interviewee was threatened with eviction from the house she was renting from her church if she did not change her gender expression."
- "Aversive techniques were not reported by interviewees. However, one transgender interviewee reported that a priest tried to instil fear by showing them a graphic video of gender reassignment surgery."

Two transgender individuals (both male) are directly quoted in the report:

> "It became clear that they [church leaders] didn't approve of it and I was frequently encouraged to go and listen to talks. They proceeded to arrange for some counselling sessions with one of their pastoral team. I was

> encouraged to part with all my female wardrobe… They said to me that if I wanted to carry on living there, I really had to stop all this silly stuff."
>
> (Transgender woman, heterosexual, 50s, gender identity change efforts)
>
> "We started talking about my family history. The counsellor convinced me that because my mum left and my dad would spend more time with my two sisters… that I was looking for the attention my sisters had and that was the feelings for my gender identity, so they kept pushing that into my head.
>
> "I would hurt myself, I would self-harm."
>
> (Transgender woman, pansexual, 20s, sexual orientation change efforts and gender identity change efforts)

On the basis of this, and parallels with sexual orientation, several conclusions are drawn:

> "Given that conversion therapy is commonly based on inaccurate information about [...] gender identity, there is scope for raising awareness among healthcare professionals and faith groups."
>
> "Evidence that some mental health professionals might mistake minority [...] gender identities as symptoms of existing mental health conditions suggests that health professionals may benefit from training on issues of gender and sexual diversity."

Based on self-reports the study reports that "psychiatrists treated their gender identities as if they were a symptom of their mental health condition" about individuals with serious mental health issues. This finding is followed through into a conclusion that there is "evidence that some mental health professionals might mistake minority [...] gender identities as symptoms of existing mental health conditions". The researchers carrying out one-hour interviews were in no position to determine whether the psychiatrists were mistaken or not.

More broadly, experiences drawn from the larger group of LGB interviewees is often presented as being indicative of "conversion therapy" related to LGB and T. This is not justified.

The reporting of the interviews may not tell us anything generalisable about “gender identity conversion therapy”, but it does tell us about the attitude of the research team. Pronouncing the medical professionals to be mistaken on principle because they considered other causes or course of action than transition is an ideological position based on the doctrine of gender self-identity.

This approach would class any medical professional or therapist not immediately affirming a person’s gender self-identity as the cause of their unease as a “conversion therapist”.

## 3. A study from inside the gender identity worldview

While it is legitimate for academic researchers to have views on the topics that they study, the Coventry University review is strongly embedded in transgender orthodoxy to the exclusion of other perspectives and principles of evidence. It is not a unbiased review of the evidence, rather it is a view from inside the gender identity worldview.

**This is made clear in the glossary which is set out in ideological terms.** For example, it defines homosexual as "A term used to describe someone who has an emotional, romantic or sexual attraction towards someone of the same sex or gender" thus including male transgender people attracted to females as homosexual women (lesbians). This is a definition that is disputed.[11]

**This may have influenced the selection of interviewees.** When the authors advertised on social media for interviewees, dozens of women responded publicly highlighting the experience of lesbians being pressured to accept men who identify as women as sexual partners. None are included in the analysis.[12] Indeed the lead author publicly stated that he complained to the BBC when it reported on this issue.[13]

Given its definitions the Coventry study would presumably exclude a lesbian being pressurised to have sex with a male transgender person (a "transwoman") from its definition of "conversion therapy" on the basis that the trans person self-identifies as a lesbian.

**The paper is partial in the references it draws from.** The overarching report includes an appendix of references. Gender identity orthodoxy is represented by sources such as Stonewall, *Teen Vogue* and the UN rapporteur Victor Madrigal Borloz. No sources present alternative ("gender critical") views.[14] The paper ignores research describing the new phenomenon of "rapid onset gender dysphoria"[15] or emphasizing the lack of robust evidence to support puberty suppression.

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[11] https://www.bbc.co.uk/news/uk-england-57853385
[12] https://twitter.com/DrAdamJowett/status/1137318304270495744
[13] https://twitter.com/DrAdamJowett/status/1453279038236209163
[14] https://www.gov.uk/government/publications/conversion-therapy-an-evidence-assessment-and-qualitative-study/appendix-4-references
[15] Littman, L. 'Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria.' PLOS One, 2018, https://doi.org/10.1371/journal.pone.0202330

We provide a selection of relevant analytical works which might have been considered as an appendix to this report. Was this literature rejected because of the circular reasoning that it was produced by people judged to be proponents of harmful conversion therapy?

**The study proceeds from the assumption that everything captured by its wide definition of "conversion therapy" must be a bad thing**, and that the only question is whether it can be banned.

While the overarching report notes that there is relatively little evidence on gender identity change efforts, it states only that "further research could specifically examine transgender people's experience of conversion therapies and the forms it takes. Additional research **on the harmful effects of gender identity change efforts** would also be useful." The reports make no mention of detransition or desisistance.

On the question of other countries legislation, the researchers do not distinguish between sexual orientation and gender identity, eliding them together with the statement

> Many legal measures used to restrict conversion therapy appear to apply to both sexual orientation and gender identity change efforts. Some jurisdictions initially brought in measures that applied only to sexual orientation change efforts, and later extended them to include gender identity change efforts.

No analysis or data is provided to back up these statements about "many" and "some"

**By framing the question as being about "conversion therapy", the authors focus on a handful of weak studies as the only available evidence on the topic, and avoid nuance.**

As D'Angelo et al say about the Turban (2020) paper that is the centrepiece of Coventry University's evidence, this approach is actively harmful:

> "Arguably, even more problematic than the flawed analysis itself is the simplistic 'affirmation' versus 'conversion' binary, which permeates Turban et al's (2020) narrative and establishes the foundation for their analysis and conclusions. The notion that all therapy interventions for [gender dysphoria] can be categorically classified into this simplistic binary betrays a misunderstanding of the complexity of psychotherapy. At best, this blunt

classification overlooks a wide range of ethical and essential forms of agenda-free psychotherapy that do not fit into such a binary; at worst, it effectively mis-categorizes ethical psychotherapies that do not fit the “affirmation” descriptor as conversion therapies. Stigmatizing non-”affirmative” psychotherapy for GD as “conversion” will reduce access to treatment alternatives for patients seeking non-biomedical solutions to their distress.”

# 4. Conclusion

The Coventry report set out to show that what it terms “gender identity conversion therapy” as similar to religiously motivated or attempts to “pray the gay away”.

> “The boundaries between religious and psychological approaches are often unclear with many combining the two in a way that could be described as pseudo-scientific.”

But it could not find robust evidence to back this up.

Instead what it demonstrates in practice is that the framework of “conversion therapy” is ill suited to understanding the complexity of questions concerning the treatment of people with gender dysphoria, particularly children, young people and other vulnerable people.

In contrast, the ongoing *Cass Review on Gender Identity Services for Children and Young People* is taking an approach without pre-determined outcomes. It is also undertaking a much more intensive study which is also includes a literature review, assessment of quantitative evidence and qualitative interviews.

The Cass Review is considering questions around clinical models and clinical management approaches, including the best clinical approach for individuals with other complex presentations, the benefits, risks, harms and effects of puberty blockers and the reasons for the increase in referrals of children, particularly girls.[16] The Coventry Studies make no mention of the Cass Review, nor the issues raised in the Bell v Tavistock case concerning the capacity of children to consent to puberty-blocking medication.[17] Permission has been sought for further appeal in this case.

The proposed legislation would shortcut the work of the Cass Review and use criminal law to address the question of how best to treat children with gender dysphoria. It would define the concept of gender identity for the first time in primary legislation, despite this being an area of great uncertainty and contestation.

[16] https://cass.independent-review.uk/

[17] https://www.transparencyproject.org.uk/bell-v-tavistock-court-of-appeal-judgment-an-explainer/

Based on our rapid review of the Coventry Studies we conclude:

1. **The studies present no robust evidence that supports the call for banning or criminalising "conversion therapy" in relation to transgender identity.** The concept and practice remains underspecified and ill-defined and there is no evidence of harm.
2. **Writing the simplistic "affirmation" versus "conversion" binary into criminal and civil law risks doing harm to children and parents, to therapists and other professionals, and to the relationship between them,** without any evidence of the harm it purports to be addressing.
3. **Rushing through any legislation concerning the treatment of children presenting with gender dysphoria before the outcome of the Cass Review is released would be irresponsible and counterproductive to evidence-based policy making.**

Finally, we note with concern that the Government Equalities Office commissioned this piece of work which was clearly based on articulating an ideological framework rather than undertaking an unbiased assessment of evidence. They then held it for four months before releasing it just in time for a rushed six-week consultation on unprecedented new legislation.

## Appendix: Relevant literature that was not considered

Biggs, M (2020). 'Gender Dysphoria and Psychological Functioning in Adolescents Treated with GnRHa: Comparing Dutch and English Prospective Studies.' *Archives of Sexual Behavior*, 49, 2231–36. doi: 10.1007/s10508-020-01764-1.

Biggs, M (2020). 'Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria.' *Archives of Sexual Behavior*, 49, 2227–29. doi: 10.1007/s10508-020-01743-6.

Biggs, M (2021). 'Revisiting the Effect of GnRH Analogue Treatment on Bone Mineral Density in Young Adolescents with Gender Dysphoria'. *Journal of Pediatric Endocrinology and Metabolism*, 34, 937–939. doi: 10.1515/jpem-2021-0180.

Brunskell-Evans, H and Moore, M (eds). *Inventing Transgender Children and Young People,* Cambridge Scholars Publishing, 2019

Brunskell-Evans, H and Moore, M (eds). *Transgender Children and Young People: Born in Your Own Body*, Cambridge Scholars Press, 2018

Brunskell-Evans, H. 'The Medico-Legal "Making" of "The Transgender Child"'. *Medical Law Review,* Volume 27 Issue 4, Autumn 2019, pp640–657, https://doi.org/10.1093/medlaw/fwz013

Churcher Clarke, A, & Spiliadis, A (2019). ' "Taking the lid off the box": The value of extended clinical assessment for adolescents presenting with gender identity difficulties.' *Clinical Child Psychology and Psychiatry*, 24(2), 338–352. https://doi.org/10.1177/1359104518825288

D'Angelo, R, Syrulnik, E, Ayad, S et al. 'One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria.' *Archives of Sexual Behavior* 50, 7–16 (2021). https://doi.org/10.1007/s10508-020-01844-2

Entwistle, K (2020). 'Reality Check: Detransitioner's Testimonies Require Us to Rethink Gender Dysphoria.' *Child and Adolescent Mental Health* 26, 15–16. doi: 10.1111/camh.12380.

Griffin, Lucy, Katie Clyde, Richard Byng, and Susan Bewley. 2020. 'Sex, Gender and Gender Identity: A Re-Evaluation of the Evidence'. BJPsych Bulletin 1–9. doi: 10.1192/bjb.2020.73.

Hakeem, A. 'Changing Sex or Changing Minds: Specialist Psychotherapy and Transsexuality'. Hakeem, A. Group Analysis. *The International Journal of Group Analysis,* Volume 41 Number 2, June 2008, pp182–196.

Hakeem, A. 'Deconstructing Gender in Trans-Gender Identities'. Hakeem, A. Group Analysis. *The International Journal of Group Analysis,* Volume 43 Issue 2, June 2010

Hutchinson, A, Midgen, M, & Spiliadis, A (2020). 'In Support of Research Into Rapid-Onset Gender Dysphoria.' *Archives of Sexual Behavior*, *49*(1), 79–80. https://doi.org/10.1007/s10508-019-01517-9

Kaltiala-Heino, R, Sumia, M, Työläjärvi, M, & Lindberg, N (2015). 'Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development.' *Child and Adolescent Psychiatry and Mental Health*, *9*(1), 9. https://doi.org/10.1186/s13034-015-0042-y

Littman, L. 'Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria.' *PLOS One*, 2018, https://doi.org/10.1371/journal.pone.0202330

Zucker, K J (2018). 'The myth of persistence: Response to "A critical commentary on follow-up studies and 'desistance' theories about transgender and gender non-conforming children" by Temple Newhook et al.' (2018). *International Journal of Transgenderism,* 19(2), 231–245. https://doi.org/10.1080/15532739.2018.1468293

Zucker, K J (2019). 'Adolescents with Gender Dysphoria: Reflections on Some Contemporary Clinical and Research Issues.' *Archives of Sexual Behavior,* 48(7), 1983–1992. https://doi.org/10.1007/s10508-019-01518-8

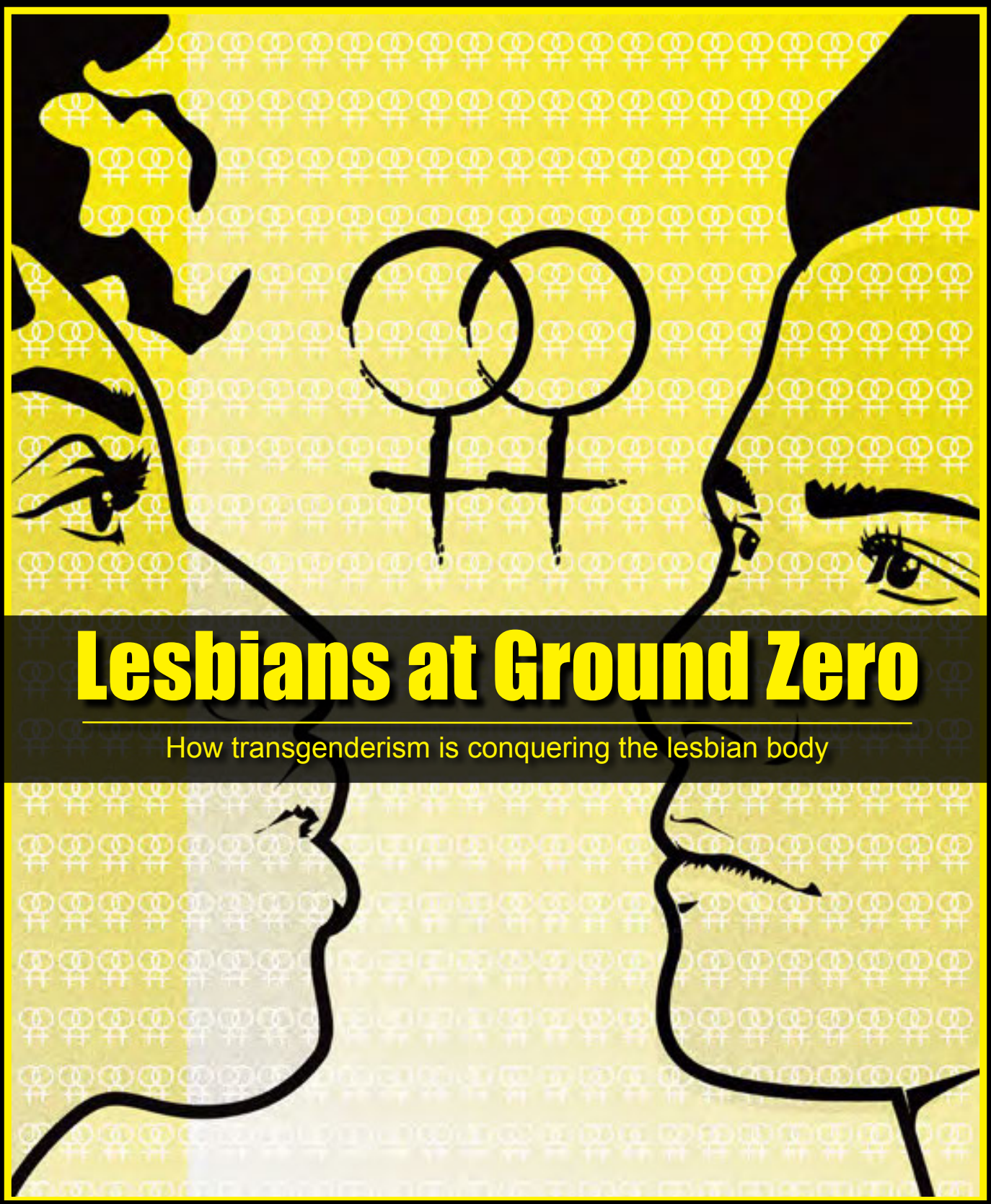
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# Lesbians at Ground Zero

How transgenderism is conquering the lesbian body

Angela C. Wild
**Get The L Out Report**
March 2019

#GetTheLOut
#CottonCeilingIsRape
#LesbiansAtGroundZero

2023

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To L. my love always.
Sisters, I salute you ! xx

(c) Angela C. Wild / Get The L Out 2019

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# Introduction

Following the emergence of high profile “transgender women” [Caitlin Jenner, Kelly Maloney, Munroe Bergdorf...], discussions about transgenderism have become a regular topic for mainstream news outlets.
This has coincided with the proposed reform of the Gender Recognition Act 2004. The government’s consultation about proposed changes to the G.R.A. which ended a few months ago was proposing to introduce what has been called “sex self-id.” (for sex self-identification), aiming to simplify the process for transgender people to “legally change their gender”, potentially enabling anyone to self-identify as the gender of their choice by simply ticking a box, with no professional assessment of gender dysphoria, no social transition, medical transition or surgery being requested from the applicant.

Feminists have questioned publicly whether trans politics poses any concerns for women and girls highlighting the clash of rights existing between women and “transwomen” (Fairplay For Women, 2019, Woman’s Place UK, 2019). If men who transition can legally become women, it becomes impossible for women to maintain women’s right of access to sex-segregated spaces and services exclusively for females. (Equality Act 2010).

## The same is also true for lesbians.

As social media such as Twitter is a crucial tool for spreading ideas, such public discussion has led transactivists to share the view that they are discriminated against because some lesbians refuse to date them, propagating the idea that lesbianism is “transphobic” (Dennis, 2017).

The latter statement invites the question:

## What is the experience of lesbians when confronted with those ideas?

This work aims to investigate this under researched phenomenon, highlighting the impact of transactivism and trans ideology on lesbians. It has a second, crucial aim of ensuring lesbians’ voices and experiences are heard.



# Positionality

An important consideration for any researcher is the position they occupy in relation to the research setting. Feminist researchers argue that we cannot suddenly ignore our own experiences, and stop being human in the name of ‘objective’ research (Stanley & Wise, 1993). McDowell (1992: 409) writes that we must recognise our own position, and include this in our research practice. As a woman, a lesbian and a feminist I have been actively involved in the debate about trans rights and women’s erasure for many years. On a personal level, I suffer from the impact the trans ideology has on women and lesbians. This will be expanded on in the methodology section.

# Key definitions and language

Due to my own positionality, I reject mainstream ways of discussing gender, as well as the terminology typically used by trans and queer ideologies when referring to people who identify with the opposite “gender”. When referring to “transwomen” I will use the term males who call themselves / identify as women / transwomen. As Sheila Jeffreys, a prominent feminist, comments:

**“The female pronoun [is] an honorific, a term…due to women as members of a sex caste that have survived subordination and deserve to be addressed with honour. Men who transgender cannot occupy such a position.” (2014: 9)**

I will use the pronoun associated with their biological sex: “he” when referring to a transwoman. I recognise that this is controversial as gender neutral language has become an expected part of the discourse when discussing issues relating to transgenderism.
Language is never neutral. Language not only shapes people’s consciousness, it is a tool of power in a patriarchal system (Spender, 1985). In recent years, under pressure to be inclusive to men who identify as women, women have been renamed “menstruators” (Guardian, 2018), “non-men” (Beale, 2016), “uterus-bearer” (Qu’emi, 2014), “front-holers” (Human Right Campaign Foundation, 2016), “pregnant person” (Donelly, 2017) and “chest-feeders” (De La Cretaz, 2016). Every aspect of female anatomy and women’s specific experience has been judged to be not inclusive enough, therefore “transphobic”, the current trans ideology seems to be yet another example of how “women have had the power of naming stolen from us” (Daly, 1985: 8). With the banning of sex-specific vocabulary relating to women, talking about ourselves in those terms is a forbidden act. It is a particularly urgent political act to use the vocabulary which is forbidden to us.

## What is feminism if anyone can be a woman regardless of their biological sex or experience of oppression?

# Outline

Drawing on key writers, this essay will outline the development of the trans ideology (in academia and in the mainstream) and how it relates to lesbians specifically. It will highlight the work of early lesbian feminists who have theorised the concepts of lesbian visibility and the conflicts with the wider gay movement (now known as LGBT), as well as the more recent work by lesbian feminists in identifying the lesbian body as a woman-only space to be conquered.

# Key literature

## Development of the trans ideology

Judith Butler in "Gender Trouble" is one of the influential agents in shifting the meaning of the word "woman" (2007). Obsessed about "narrative", "discourse" and "representation", to the exclusion of any other form of oppression, Butler's theory is at pains to explain that the category "woman" is irrelevant politically. Intersecting with race, class, ethnicity etc, there are so many variables it would appear no one knows what a woman is. Butler believes that "woman" is a fabricated construct, not a material reality. She remains abstract and never mentions the bodies of women. Stating that women are a category apart from men because our bodies are biologically different from men's is labelled "biological essentialism". The real meaning of biological essentialism is in fact quite different. It means enforcing behaviours onto an oppressed class of people because of biological differences, then calling that different behaviour "innate", naturalising what has been internalised and placing it out of the realm of the political.

Politically, women are a different category from men because it is in our female bodies and because of our female bodies that oppression is enforced on us by men: through rape and sexual harassment (Brownmiller, 1975), compulsory heterosexual intercourse (Dworkin, 1987 , Barry, 1979), a culture of compulsory motherhood, or enforced pregnancies. Women are a different political category from men because we are born and raised with those experiences our whole lives. The way patriarchy oppresses women varies from woman to woman, depending on those factors of race, class, geography etc, but women's bodies remain central to women's oppression.

The trans ideology relies on the essentialist premise that there is such a thing as a male and a female brain and that it is possible for some people to be "born in the wrong body"[1]. Those "born in the wrong body" experience what has been termed "gender dysphoria": a mismatch between the physical sex of the person and the gender that person feels him or herself to be (NHS, 2016).

NOTES

[1]On the contrary, feminists and scientists argue there is no such thing as a male and female brain (Rippon, 2015, Fine, 2010) rendering the concept of transgenderism invalid.



The fact that humans are a sexually dimorphic species and human reproduction relies on the existence of females and males is denied. "Sex" is said to be "assigned at birth" (NHS, 2016), no longer understood as a material reality but a social construct, while "gender" becomes a characteristic "we are born with; (that) cannot be changed": innate and determining the real essence of a person (National Geographic 2017: 18). In the case of trans people this "gender identity" does not match the physical sex. The term "trans people" is used to describe the people seeking to live "according to their gender identity, rather than their biological sex" (NHS, 2016). "Living according to their gender identity" means "passing": being accepted seamlessly as a member of the opposite sex by society. This relies on adopting the social codes usually associated with the persons of the opposite sex (Jeffreys, 2007). Typically, men who identify as women wear clothes, accessories and make-up, and adopt associated beauty practices traditionally marketed for women; they attempt to adjust their voice tone and body language, thus mimicking sex stereotypes imposed on females. All of this is denounced by feminist theory as sexist and seeks to free women from it (Dworkin, 1974, Wolf, 1991, Jeffreys, 2007).

## Trans ideology and lesbians

Sandy Stone, a male transactivist who identifies as a lesbian, wrote a counterattack on Raymond's work "The Transsexual Empire" (1995) in "The Empire Strikes Back". The arguments of his text ironically largely revolve around male sexual anatomy and sexual pleasure, what he terms "wringing the turkeys neck": the last instance of penile masturbation the night before castrative surgery is performed. He explains that the medical profession was originally responsible for the fact that "transsexuals" were performing gender in a stereotypical way, thus giving the medical profession the performance they expected so that "transsexuals" could obtain the surgery they desired (Stone, 1991). Stone laments the enforcement of binary gendered practices upon the (male) transgender community and calls for "transsexuals" to become "posttransexual": to stop trying to "pass" as women – therefore to be "read" as male who are transsexuals. It can be argued that this shift paved the way for transsexuals to be able to reject castrative surgery - which is the norm today as **most remain genitally intact males** (Reed, 2015) - and yet still be able to call themselves "women" and "lesbians".

Stone's work is key when we fast-forward to 2012 where the term **"cotton ceiling"** started appearing on social media. Drew DeVeau, transactivist and porn performer, invented the term to describe the difficulties faced by men who identify as "trans lesbians" in being accepted as a "real lesbian", finding lesbians reluctant to choose them as sexual partners (Malantino, 2016, TerfIsASlur.com, 2019)[2].

NOTES

[2] The term "cotton ceiling" is copied from the term "glass ceiling". But where the glass ceiling describes the invisible barrier women face to attain a higher position in their field of work, the "cotton ceiling" refers to the knickers worn by the lesbian: the cotton of the knickers being the barrier the trans-identified males' struggle penetrate. This barrier is seen as denying his validity as a lesbian, as only a sexual experience with a lesbian would make him a "real lesbian". Lesbians are accused of using their genitals to "gatekeep womanhood", denying "trans lesbians" their "rights" to be real lesbians via by accessing lesbians sexually.

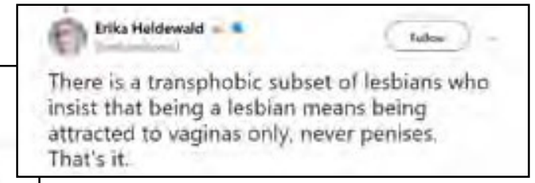
As lesbians argued that they did not want to have sexual relationships with people with penises, the term penis was rebranded "girldick" (Yardley, 2018). Julia Serano uses the terms "girly little estrogenized penis"(Serano, 2007 : 229)3. In this "logic", the penis, in virtue of being attached to a male who identifies as female, automatically becomes a female organ. Lesbians who still refuse to consider "trans lesbians" as sexual partners are called "transphobes" and "vagina fetishists", and figuratively lynched on social media (Cade, 2014, Scarcella, 2018).

Today LGBT organisations give their undivided support to the trans community at the expense of lesbians. The **#GetTheLOut** action and response from LGBT officials exemplifies this position clearly.
In July 2018, a group of activists (of which I am a member) organised a peaceful action at Pride in London: a small group of lesbians marched uninvited in front of the parade carrying banners[4] and distributing leaflets (Get The L Out, 2018). It intended to promote uncompromising lesbian visibility[5]. As the backlash following the action demonstrated, lesbians who dare to publicly challenge the trans narrative are demonised by most LGBT organisations. Pride in London's official statement has called lesbian protesters "disgusting", "bigoted" and "transphobic", "an issue (which) need to be stamped out" (Pride In London, 2018), thus demonising lesbians for stating lesbians have a right to sexual boundaries and to self-definition. Manchester Pride compere Tony Cooper violently criticised the #GetTheLOut action at the Manchester Pride 2018 rally, stating that **lesbian protesters** should have been **"dragged out by their saggy tits"** (Cooper, 2018, Sprocket, 2018). The choice of words is reminiscent of public lynching and witch burning. It is hateful, misogynist, ageist and incites violence against women and lesbians, groups which technically are under the protection of the law as sex and sexual orientation are protected characteristics under the Equality Act, 2010. Cooper's intervention should have been investigated as **hate speech**. Cooper has since started a campaign in Canal Street against "TERFs" (Cooper, 2018b). Lesbians are no longer welcome in Manchester gay village unless they accept dating "trans lesbians".
This statement is nothing more than a redefinition of the word "lesbian".

## The cotton ceiling

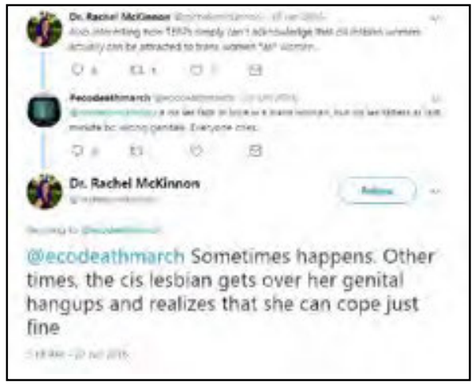
Google search results: the "cotton ceiling".













NOTES

[3]Terms like "lady stick" "lady's penis" are also found to describe the genitals of males who identify as women. As some lesbians use dildos and strap-ons as part of their sexual practices, the term "built-in strap-on" or "strapless" (Human Rights Campaign Foundation, 2016) to refer to the penis, has also been used to highlight the supposed similarity between the real male organ and the plastic replica and the lack of consistency from lesbians in accepting one while rejecting the other.

[4] Slogans used on the banners stated:
Lesbian not queer : we are claiming our affiliation to lesbian feminism and rejected new queer definitions of womanhood and lesbianism
Lesbian = female homosexual : Lesbians are same-sex attracted, lesbians do not want to have sex with people with penises regardless of their gender identity, only females can be lesbians.
Transgenderism erases lesbians : The T in LGBT is in direct conflict with the L. If a "transwoman" can be a lesbian how can lesbians retain sexual autonomy? If the LGBT support "transwomen" they de facto deny lesbian rights to exclusive same sex orientation.
"Get The L Out" : the LGBT does not represent nor advocate for lesbians but speak against us, we need our own separate groups.

[5] Lesbians are rarely seen or represented at Pride in London (Bart, 2018) and report feeling uncomfortable there due to the event's male-centeredness (Glass, 2018)

## Lesbian Feminism, Lesbian Visibility

In her essay “To Be and To Be Seen”, Frye examines the concepts of lesbian existence and lesbian visibility (1983). Through her research of the world “lesbian” in diverse dictionaries and the revealing lack of meaning in its definition, Frye demonstrates how the word “ lesbian” already had no meaning well before post-modernist ideology took over language. Frye concludes that language, created by men, leaves blank the definition of lesbian, purposely excluding lesbians from the conceptual scheme of the patriarchal world. Women are mere “stagehands” in the background of the patriarchal male-focused play, and it is inconceivable to patriarchy that women might have autonomous thoughts of our own, unrelated to men. This would disrupt the patriarchal stage where men’s play is being acted out. On the contrary, a lesbian is a woman who has autonomous thought outside of the male focus, who notices and gives importance to the world of women, thus threatening patriarchal illusions of male-centeredness[6]. Today’s queer definition of lesbianism: “a person who identifies as a woman and is sexually and/or romantically attracted to others who identify as women” (Bangor University, 2019) erases the meaning even further.

Lesbian-feminists have long recorded the divide between the gay rights movement and the lesbian-feminist movement. Rich has highlighted the sexism of the gay men’s movement, as well as the risk of erasing the specific oppression of females by equating lesbians’ experiences with those of gay men (Rich, 1977).
Frye (1983b) maintained that the parallels between experiences of oppression between gay men and lesbians were at best superficial, and any alliance between them was based solely on the fact that members of both groups are labelled “deviant” for not conforming to sex stereotypes and refusing heterosexuality. Her work demonstrates that gay male culture and its political movement is inherently based on male supremacist values of the presumption of male citizen, worship of the penis, homoeroticism, woman-hating, compulsory heterosexuality and presumption of general phallic access, thus antithetic to lesbian feminist politics.

NOTES

[6] Because women can choose to become lesbians (a claim patriarchal queer theory firmly disputes arguing that sexuality is innate and cannot be chosen) the threat of contagion of lesbianism constitutes a real threat to patriarchal society as a whole, which is why lesbian erasure is orchestrated and motivated in patriarchy.



Both Harne (1996) and Jeffreys (2003) recount the shift of the gay movement from a truly radical and revolutionary movement aiming to eradicate sexism as well as homophobia, to a male-centred and misogynist movement promoting sexual objectification, drag performance (which many lesbians saw as misogyny), and pressuring lesbian groups to accept transgender males in their midst. Effectively, the gay movement became a male sexual rights movement. Assimilation within the straight world became its sole purpose, a dramatic departure from its revolutionary origins[7]. Many lesbian feminists describe the lesbian walk-out of the gay movement which led to the creation of Women’s Liberation Movement (Stanley, 1982, Dixon, 1988, Jeffreys, 2003 and Brackx, 1980)[8]. Given that history, it is not surprising to see the male-centred LGBT movement supporting the rights of males who identify as lesbians at the expense of lesbians’ rights to sexual boundaries and women-loving.

## The #GetTheLOut action inscribes itself in a long tradition of women separating from a male-centred movements.




Photo copyright Pam Isherwood

NOTES

[7] A key point of dissent was the shift from understanding heterosexuality as politically constructed - therefore promoting homosexuality and lesbianism as a positive political choice leading to political change - to an essentialist understanding of sexuality where gay men argued they had to be accepted by the straight world as “we can’t help it (...) we are not a threat to you” (Alderson, 1988)

[8] Furthermore, it has been discussed elsewhere that terms like “queer”, “gay” and “LGBT” make lesbians invisible within the neutrality of an alphabet soup and depoliticise lesbianism further. Indeed, most young lesbians do not today use the term “lesbian” to define themselves as it is not “inclusive enough and denotes hostility towards men (trans identified or not).” (Blair & Obinawnne, 2018)

# The lesbian body as a battleground

The consequence of systematic lesbian erasure, combined with the male centred politics of the LGBT, is a constant invasion: **invasion of lesbian spaces and invasion of the lesbian body as the ultimate women-only space,** leading to the destruction of those spaces and the consequent **destruction of lesbianism**.

Raymond's work in "The Transsexual Empire" was the first to address transgenderism critically from a lesbian feminist perspective (1995). Raymond firmly attacks the ethics of a medicalised industry profiting financially from the physical castration of members of the community who suffer from failing to fit into the rigid sex stereotype mould. She attacks the individualisation and medicalisation of what she sees as a political problem, as morally questionable, detrimental to society and anti-feminist. Her chapter "Sappho by surgery: The Transsexually constructed Lesbian-Feminist" addresses the issue of transgender males invading lesbian spaces and describes the case of Sandy Stone (discussed above).

**"All transsexuals rape women's bodies by reducing the real female form to an artefact, appropriating this body for themselves." (Raymond. 1995: 104)**

When Raymond explained that transsexuals rape women's bodies, did she foresee that today those rapes would leave the symbolic to become an embodied reality for the lesbians who do not manage to escape the queer narrative? Despite it being written more than 20 years ago, Raymond's analysis remains as relevant as ever precisely because nowadays males who call themselves lesbians do not typically have castrative surgery (Reed, 2015).

Jeffreys (2014) and Morris (2016) describe the transgender's lobby assault on women-only spaces in. Both cite the attack on the Michigan Womyn Music Festival,a woman-only music festival held since 1976. The festival did not survive and closed down permanently in 2015, erasing decades of lesbian culture in the process.

Morris names the "trans issue" as instrumental in the way a festival like Michigan Womyn Music Festival was targeted. The rhetoric relies heavily on a mixture of misogyny and ageism as the festival's separatist stance was described as a "relic of the second wave" (Meltzer quoted in Morris 2016 : 101). Despise a statement from organiser Lisa Vogel that

**"claiming one week a year as womyn-born womyn is not a contradiction to being trans-positive and trans-allies. (...) there is room for affinity groups to enjoy separate and supportive space, and also come together in broader alliances to fight prejudice that affect us all" (Vogel quoted In Morris : 103)**

The festival, its attendees and the artists who performed there were all labelled "Terfs" (Trans Exclusive Radical Feminist). Artists were targeted and made to apologise for ever performing at Michfest, threats to burn the festival appeared online, leading finally to the organisers announcing the end of a festival that had lasted for 40 years and welcomed almost half of million attendees over the years.



In "Gender Hurts" Jeffreys identifies the lesbian body as "the most intimate of women's spaces" (2014: 180) and discusses the cotton ceiling as an assault against lesbians.

Max Robinson, a young lesbian and detransitioner offers an invaluable, powerful and disturbing insight into the queer community. Robinson names the lies and manipulation behind the concept of "cis privilege": "It was accepted fact that being born female gave you a lifelong advantage over a male who transitioned." (Robinson, 2016). Statements such as these render the oppression of females and the sexual violence perpetrated by men who transition completely invisible. Robinson started to question the trustworthiness of such a statement after several of her female friends were raped or beaten by "transwomen". Robinson also describes how she was targeted as a youngster and deceived into sending nude pictures of herself to adult men who identified as trans. Robinson describes women's inability under queer hegemony to name reality for what it is, therefore to name male violence for what it is. She shows how queer ideology disconnects women from other women, as well as from the past and present women's struggle, and the subsequent inability to place our experience of violence within the feminist political context of the continuum of male violence against women. Her work exposes the incredible social pressures faced by lesbians within the queer community; threats of ostracism from the only place women and girls like herself were ever welcomed into; the constant policing and silencing; the fear women victims experience and their inability to come forward after a rape; their exclusion from the group for daring to name a transwoman as a rapist, the incredible gaslighting women who still dare to call themselves "lesbians" face in those communities.
The extract below about K, her girlfriend who was in a "lesbian relationship" with M, a transwoman, summarises the problems faced by lesbians today:

**"Calling that relationship "lesbianism" left her stranded from the framework she desperately needed in order to contextualize her experiences as a survivor of captivity. It destroyed her ability to call herself a lesbian or a woman for a long time: if lesbians like to sleep with transwomen and were repulsed by the supposed maleness of transmen, how could she be a lesbian herself? If women are what her ex-partner M was, then she, K, must be something else entirely. The language of transition lends itself readily to abusive gaslighting that disguises and distorts women's ability to name what is happening" (Robinson, 2016)**

"Lesbians who see their sisters disappearing are more likely to try to erase themselves." (Robinson, 2016)

What Robinson's work shows is that the pervasiveness of transgenderism and queer theory leave young lesbians with no physical space to discuss their specific issues, no lesbian community to go to for validation and support, no books to refer to, no word to define themselves and no political framework from which to place or maintain sexual boundaries from men.

# Research Outline

## Aims

As a lesbian I have heard many lesbians privately discuss being targeted by transactivists for being lesbians. Those stories were hushed in confidence, suppressed, women justifiably fearing retaliation from perpetrators. This silencing means that there are very few public stories of lesbians on the "cotton ceiling", a point often advanced by transactivists to dismiss lesbians' dissent. The aim of this study was to give silenced lesbians an opportunity to speak anonymously about their experience when faced with men who identify as transwomen, while formally gathering the missing evidence.

The survey aimed to find whether there is a form of social pressure on lesbians to accept trans ideology within the LGBT community, and what form this may take. How does this affect their ability to meet other lesbians? Are lesbian dating sites safe for lesbians? Is this social pressure influencing lesbians' life and their sexual life? If lesbians are pressured online, could they also be pressured offline? Are lesbians experiencing any form of sexual violence from men who call themselves lesbians? If yes what form does this sexual violence take?

## Reflexivity

Before outlining how this research was carried out it is useful to pause to return to the issue of reflexivity and my own standpoint. Feminists have long understood the power of reflexivity as a way of gaining more insight into a particular topic, a desire to dismiss the alleged objectivity usually claimed by patriarchal academics, and an attempt to be honest with regard to the researcher's point of view and experience of the subject (Stanley & Wise, 1993).

During my time as a Women's Studies student, the discussion about transgenderism has received an increasing amount of attention in the media. As a gender critical feminist I have felt the silencing that academia, a patriarchal institution notoriously uncritical of queer theory (Biggs, 2018), implicitly exerts onto its members, staff and students alike. I remember the tension I felt when the subject was mentioned by a fellow student in the first year of my degree, the fear of it being discovered that I had thoughts the university would no doubt label "unacceptable" and "dangerous". I had the opportunity to give a presentation on "Gender" and explained the radical feminist perspective. I was able to discuss dissenting views thanks to one brave teacher. I had the feeling all along that the Women's Study MA was a precious haven for making this discussion possible.

As we had to face the devastating decision the university took to discontinue the Women's Studies MA alongside the whole Life Long Learning Department, we recognised the obvious sexism of that decision, knowing it would affect the ability of future generations of women (particularly working-class mothers) to access education, bringing to an end the possibility we had to learn about our condition in the safe space of a woman-only group. The closing of the course has been an emotional and stressful journey and a struggle to keep going under the circumstances. But in the background of these events, the ideas of Judith Butler resonated, reminding me of the political significance of such events:

Do we really need women's studies courses? And what is a woman anyway?



As a long-time activist I have battled against constant accusations of being "hateful" and "transphobic" because I am one of those who define what a woman is and because I have clear sexual boundaries which exclude men. The relentless attacks and threats have not succeeded in silencing me but have impacted my mental health. Writing about such a topic as part of my degree has been challenging: finding a supervisor prepared to work with me but also confronting my own self-censorship. We have all internalised patriarchy, we all know almost instinctively what we are allowed and not allowed to say when working within the structures of patriarchy. How would this pressure to conform influence the words I used, or affect the clarity of my analysis?

The challenge has been to confront potential attempts by the university itself to silence me or dilute my work. I was relieved that the Ethics Committee reviewing my application had approved it, allowing me to proceed with the project. Their insistence on my use of the term "transwoman" within the survey and on the importance of remaining "objective" and asking non-leading questions was problematic. In agreement with the feminist tradition, I do not consider that there is such a thing as "objectivity" or that "objectivity" is desirable, necessary or ethical in order to produce a valid piece of work (Stanley & Wise 1993). I reflect below on the response I had from a respondent about the use of the term "transwomen" within the survey, a point I wholeheartedly agree with. Overall I was grateful, though conflicted as I knew my politics were in direct confrontation with academia and yet I had no intention of toning them down. The way this work will be received will reveal how academia positions itself vis-a-vis the following questions:

**Have post-modernism and queer theory irreversibly become the dogma or can they be challenged?**
**Are women allowed to define what a woman is?**
**Are dissenting points of view allowed within a university?**
These questions are worthy of a thesis all on their own.

## Research tools and method

The research was initially planned to be a series of interviews conducted with women who would be preselected after taking part in the questionnaire. After careful consideration a questionnaire was deemed more suitable in order to map an under-researched issue. A questionnaire enables the researcher to ask respondents a wider variety of questions in a short space of time (Sarantokos, 2012) and gives respondents the chance to complete the questionnaire in their own time (Curtis and Curtis, 2011).

The survey comprised of 30 questions about lesbians' experience. It had sections relating to the following subjects: respondent identity, their experiences in LGBT groups and on lesbian dating sites, their experiences interacting with men who identify as transwomen as potential sexual partners. For the purpose of the survey, I used the queer terminology "transwomen" as advised by the Ethics Committee. The Ethics Committee believed that the survey should be "objective" but did not consider that the term "transwomen" is not an objective term and is far less widely accepted than they claimed, a point noted by a respondent who complained that the term was incorrect and misleading as "transwomen" are biologically male, therefore "not a subset of women".

The survey was sent to women-only and lesbian-only groups on social media, as well as to individual lesbians in my own networks. **As such the sample does not claim to be a representative sample of the lesbian community. However, the research was to capture the points of view and stories of many, until now, silenced lesbians.**



# Findings

# Findings

Within a few days, 80 women had responded to the survey, far more than originally planned. This rapid engagement demonstrates a keen interest by women who are affected by such issues and the recognition that there is a lack of work and visibility in this area. Several women left private notes, thanking me for the opportunity to speak up. Lesbians were eager to share their stories. The intention was to record lesbians' experiences from the UK (48%), however the survey was also answered by women across the world[9], highlighting that the questions raised concerns for lesbians in different parts of the western world. All age groups were represented. Due to the imposed time constraints of the research, I had to limit the number of questions relating to demographic information and also relating to the location e.g. rural/city provenance. Future research that will attempt to understand these views in more depth and detail will take more factors into considerations.

## Overview of respondents

98.8% of respondents primarily defined themselves as "lesbians"[10], while only two identified as "bisexual" including one as "queer". This choice of word represents a political standpoint (Blair & Obinawnne, 2018). Every woman apart from the "queer" respondent defined lesbianism as "women exclusively attracted to women". The "queer" respondent was dating females, non-binary and trans people, and she alone defined lesbianism in terms of "a self-identified woman attracted to self-identified women".

## The view on "transwomen"

The majority answered "no" to the following questions:

**"Do you believe transwoman are women?" [ NO 87.5% ],**

**"Do you believe transwoman can be lesbians" (NO 95% )**

**"Would you yourself consider a transwoman as a potential sexual partner" (NO 98.8% )**

Most respondents considered "transwomen", based on their biological sex, to be men. The pronouns used by respondents to refer to "transwomen" ranged between "he", "she" and "they". I will use the terminology used by respondents when quoting them to report their word accurately despite it going against the principle laid out above. I will use the term "transwomen" in quotation marks for that reason.

NOTES

[9] United States, Germany, Canada, Ireland, France, Australia, New Zealand. Only 3 women did not specify the country they lived in.

[10] Also calling themselves "dykes"(35%), "butch" (16%) or "femme"(10%), Gay woman (18%)

The following sections will discuss findings in relation to their engagement with LGBT groups, dating sites, lesbians' experiences of sexual pressure and sexual violence by transwomen.

## LGBT groups

The majority of respondents reported being part of lesbian, queer or LGBT groups online (11%), offline (37%) or both (48%). 72% reported being part of strictly women-only groups (excluding "transwomen"). Women were also part of groups which are mixed – including men and women (20%), inclusive of all gender (21%), women-only but including self-identifying women (20%) and welcoming of "transwomen" (26%).

Women who were in groups that were not "women-only" reported **"feeling silenced", "intimidated", "unable to speak freely", "uncomfortable"** with the group policy and wishing the group was for women only but **"dare not say it".** Several reported how **"transwomen derail"** and monopolise the discussion to be solely about their issues while shutting down discussion about women's or lesbians' issues by calling it "transphobic". Group dynamics are described as **"toxic"**. Several women explain how **"transwomen are behaving just like men"**. **Lesbians constantly report being told their sexuality is "wrong" if they openly state they are solely attracted to women.**
Women reported **"threats", "intimidations" and "abuse", by "transwomen" and allies.**

Several respondents explained they understand and respect the need for "transwomen" to meet exclusively amongst themselves but cannot understand the lack of reciprocity accorded to women and lesbians by the trans community.

**50% of women reported being excluded from their LGBT group(s).**

The reason for their removal was made clear: questioning any aspect of the queer doctrine results in women being labelled "transphobic", resulting in a ban. Respondents were banned for sharing articles from feminists that their group disapproved of, or for stating biological facts about sex and anatomy such as: **"just females have periods".**

**Many lesbians reported being excluded if they mentioned for example:**



**"lesbians don't like penises or have sex with people who have or had penises".**

Several respondents have left groups themselves due to intimidation or before being pushed out.
Women who are still in LGBT groups have not been excluded because they report **"not being open with their views".**



**66% of respondents reported being intimidated or receiving threats in their LGBT group(s).**

For questioning the trans doctrine or **just stating they were lesbians** respondents reported experiences including:

**verbal abuse, death and rape threats, pressure to commit suicide, threats of physical or sexual violence, threats to kill family members, receiving "transwoman nudes", threats of "doxing", actual online "doxing" (including exposure of their name, picture and home address), threats of exposure to employers.**

While most of this intimidation happened online, many women also reported offline threats:

- **Two respondents were threatened at their place of work and one lost her job.**
- **A woman's employer was repeatedly contacted with attempts to have her dismissed,**
- **Two respondents were subjected to intimidating behaviour from "transwomen" at lesbian events,**
- **A seventy-year-old woman reported being "physically threatened and forced out" of a group by a physically intimidating "transwoman".**

A respondent observed that "the very presence of transwomen in a woman-only event is enough to silence us for fear of retaliation. There is no need to have a physical threat; their presence serves as a warning".

**Several women have felt the pressure to accept transwomen as women intensifying:**

**"It is not enough that you simply censor and stay silent, you must actively pledge allegiance through the naming of pronouns etc..."**



This pressure to shift from silent passive acceptance to active vocal embracing of trans politics may explain why some reported being pressured by other women within their groups (see chapter on "sexual pressure").

## Underground Women-only spaces

Because of these experiences, women who wanted to gather exclusively with other women have had to create underground women-only groups and have to maintain a constant high level of vigilance and scrutiny to ensure the sex-segregated policy is upheld.

This is true online as well as offline: women-only gatherings still happen but must be planned in secret and are rarely advertised publicly. Women who are part of women-only groups or attend women-only gatherings reported feeling **"safer to speak", "more comfortable",** and not needing to censor themselves. They **"enjoy being with like minded women"** and **"value the women centeredness of the group"**.

The lack of women-only spaces is highlighted by many lesbians who report how much more difficult it has become for them to meet lesbians, because "trans women" are now included in most "women-only spaces".

**"Every other group in my city is either "queer" or for lesbians, bi women and trans. I don't think there is one group exclusively for lesbians in my city of 1 million people"**





**"Lesbians are such an underrepresented group. I was sorely disappointed to attend ONE space that was meant for us to openly talk about our experiences of sex, love, discrimination, sexism, homophobia and other very private things specific to being a female homosexual, and for there to be a man present."**

## Dating sites

48% of respondents reported visiting lesbian dating sites. Of those, 31% have been approached by "transwomen". 12.5% have been on dates with "transwomen", 6% of whom unknowingly. Four respondents report having had a sexual relationship with a "transwoman": three with a "pre-op transwoman", one with a "pre-op transwoman" and also with a "post-op transwoman".

**Two respondents were not aware that the person they were about to have a sexual relationship with was a biological male. If those "transwomen" were pre-op, we can argue that these constitute cases of rape by deception.**

A respondent explained that on dating sites, half of the matches she received were from "transwomen".

**"None were making an effort to pass, one had a beard, another stated they were pre-op and had no intention to change this".**

A woman described feeling violated when she realised the person she had shared intimate messages with online was "a man". Another respondent reported that 90% of the messages she receives come from "transwomen". Although she stated that she has never felt coerced or intimidated, many women experience the very presence of "transwomen" as a violation.



**"There are so many men that appear as "women" on dating sites. It makes me paranoid that someone I match with could be a man".**

## Indirect sexual pressure

**56%** **of the respondents reported being pressured or coerced to accept a transwoman as a sexual partner.**

Much of this pressure happens online. Lesbians are routinely harassed for stating that their sexuality excludes males regardless of their "gender identity". Most respondents reported being subjected to such rhetoric directly or indirectly, and have experienced it as a form of **"psychological coercion"** with the general feeling that it is **"online everywhere"** and **"relentless"**.

The responses show the wide variety of ways in which women have also been directly sexually pressured, ranging from coercion, sexual harassment and sexual assault to rape by deception and rape with physical force.

## Direct sexual pressure and harassment

Often this pressure comes from members of lesbians' social circles. Two respondents reported the pressure they have come under from former girlfriends to **"include transwoman in their dating pool"**.

A respondent was targeted by a woman in an online group:




Lesbians report being told they are **"worse than rapists if they don't date transwomen",** that not dating "transwomen" is akin to **"racism".**

Many lesbians wrote about being questioned endlessly about their sexual preferences and whether they **"would or wouldn't potentially date a transwoman"**. A young women reported being directly pressured to go on dates with a "transwoman" by her friends. She explained she cannot say no directly but has to keep making excuses for fear of being "blacklisted from (her) social groups".

**Women reported being sexually harassed directly by "transwomen".**

- **Being constantly sexually pressured by "transwomen" friends and acquaintances despite repeatedly saying no.**
- **Receiving intimidating and scary sexual pressure from "transwomen" in women's toilets.**
- **Receiving pressure from a "transwoman" friend to allow him to expose his surgically constructed vagina while they are alone.**

## Sexual assault

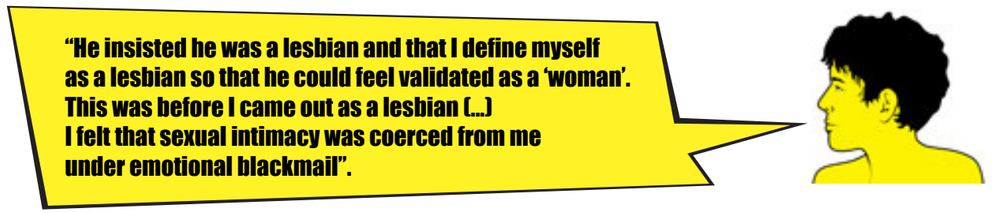
**Many women reported unwanted sexual touching which fit the definition of sexual assault.**

One recalled being pressured to kiss and touch a transwoman **against her will** in a club, another the violating experience of having a **"transwoman slapping (her) ass"** in the women's toilet of a gay club.

Sexual assault stories also happened in private settings, during sleep overs, in situations where women were vulnerable (drunk, asleep or unable to go home). In each case the "transwoman" was a friend who had taken advantage of the situation, **initiating non-consensual sexual contact, touching or masturbating in their presence.**

## Domestic abuse

A woman describes her relationship with a male partner who was a transvestite.




## Online grooming

Several young women report being groomed online while 18 or younger by "older transwomen". Two of those respondents were made to send nude pictures of themselves.

## Deception

Several respondents discussed their experiences of deception while being approached by "transwomen" they assumed to be women. They reported feeling "betrayed" and "violated":

**"Only once I was going to do a 3 way and one of the women was trans but passed very well and I was initially fooled till her partner told me. Fortunately there was no genital sex and they were pre-op. I freaked out afterwards!"**

A respondent recalled being approached by an "androgynous looking" person for a date. After sex the person revealed being a "post-op transwoman". Shocked, the respondent remained in the relationship until she realised that she was "in a relationship with a man who acted like a man".

## Queer coercion

**Queer ideology combined with guilt-tripping were reported to be effective strategies to persuade women to sleep with "transwomen" against their will.**

The woman above who had sex with a "post-op transwoman" stated she had **"bought into the propaganda that sex doesn't matter".**

**Women in the 18-24 years old age group appear particularly vulnerable to these strategies.**

Young women explained how they were pressurised to accept a "transwoman" as a sexual partner:



**"I thought I would be called a transphobe or that it would be wrong of me to turn down a transwoman who wanted to exchange nude pictures"; young women feel pressured to sleep with transwomen "to prove I am not a TERF".**

**The strategy works as a form of conversion therapy for lesbians.**

**"After I came out as a lesbian, I went on many dates/entered relationships with transwoman because the culture I was in said if I didn't do that I was evil and should be banished from everything. I knew I wasn't attracted to them but internalised the idea that it was because of my "transmisogyny" and that if I dated them for long enough I could start to be attracted to them. It was DIY conversion therapy."**





## Rape

Many of the experiences above classify as rape although were not named as such. One of the respondents did name her experience as rape. Her story combines several problems highlighted above:

**"The man I went on a date with, unknowingly, was mutual friends with people I knew, he threatened to out me as a terf and risk my job if I refused to sleep with him. I was too young to argue and had been brainwashed by queer theory so he was a "woman" even if every fibre of my being was screaming throughout so I agree to go home with him. He used physical force when changed my mind upon seeing his penis and raped me."**



# Discussion & Conclusion

The evidence of this research suggests that there is huge pressure in online and offline LGBT, queer and lesbian groups to accept without question the queer ideology and mantra that "transwoman are women".

**The act of defining lesbianism as "same-sex attraction at the exclusion of people who have or had penises" is considered a form of hate speech and violently punished.**

Dissenting voices are aggressively attacked, followed by an immediate ban from the group that can sometimes have consequences for womenlives and livelihoods. Lesbians are a small community of already marginalised individuals, and this exclusion sometimes means exclusion from the only social group women have. The threats on social media and offline groups act both as sexual pressure and silencing, leading to isolation and social exclusion. There is a direct link between threats in online groups and lesbian participation in real life groups or events.

**Many lesbians who have been targeted have developed avoidance strategies towards LGBT in general and complain of feeling unsafe and unwelcome in the LGBT community.**

**Women who dare to say they will not have sex with anyone but a woman, excluding men and men who identify as transwomen, are demonised and name-called.** Terms like "terf", "transphobe", "bigot", rapist", "racist" etc are routinely used against lesbians. **Women who remain silent in groups are asked relentlessly to reveal whether or not they would date a "transwoman".** This constant pressure creates a culture of terror, leading to women policing each other in order to not appear to be a "terf" to the rest of the group. **This trend is intensifying as anyone not actively embracing the trans ideology is suspected of silent "terfing".**

Many lesbians reveal leading a double life where their lesbianism is toned down. Many have no social life or meet underground and explain how difficult and dangerous it has become to meet other lesbians. Lesbian dating sites are infiltrated by men who pose as lesbians (whether they identify as transwoman or not and whether they "pass" as women or not), leading many lesbians to feel unsafe at the thought of unknowingly going on a date with a man. Both in groups and dating sites, the presence of men who identify as transwomen acts as a threat, leading to self-policing and silencing.

**This constant pressure is a form of psychological coercion and leads to lesbians feeling pressurised to accept men who identify as transwomen as sexual partners.**

This is particularly true for younger lesbians, many of whom have only ever known queer/LGBT groups and ideology since they first came out. This constant pressure means that when faced with individual men who identified as transwomen and who were pressuring them for sex, many lesbians felt that they couldn't justify saying no to them, resulting in them having non-consensual sex under pressure.



**Lesbians have been subjected to a wide variety of sexual violence by men who identify as transwomen.**

While experiences of sexual violence were reported by women from every age group, the younger 18-24 age group seemed to be particularly targeted. The sexual violence experiences reported by respondents range from **coercion, online grooming, sexual harassment and assault to rape by deception or with physical force.** Perpetrators have used queer theory mixed with guilt-tripping to pressure, justify or excuse sexual violence.

Consistent with a former study showing that men who transitioned "retain a male pattern regarding criminality" including violent crime and sexual offences, that men who did not transition, (Dhejne et all, 2011 : 6) sexual violence was committed by men who identified as transwomen in a typical male pattern of aggression, whether in public spaces: clubs, women's toilets, with unwanted sexual touching; in acquaintance rape scenario/private setting: either while lesbians were vulnerable (drunk, asleep or unable to leave), or during dates when the women withdrew consent and were then "persuaded" or forcibly raped.

The findings are consistent with lesbian feminist thinkers who theorised that lesbians had nothing to gain by having their experiences conflated with those of gay men in a misogynistic LGBT movement, and that transactivists' invasion of lesbians' spaces could lead to the erasure of lesbians and lesbianism.

- Indeed within the LGBT movement today, young lesbians are denied the right to experience lesbianism as they are pressured to accept male bodies as female bodies.
- Older lesbians, who have led a lesbian life from a young age and experienced discrimination and violence as lesbians draw parallels between their past experiences and the way the trans ideology targets lesbians today.
- Lesbians who have had past heterosexual experiences recount how this is used against them to justify penis inclusion into their lives.

**Lesbians who responded to this survey perceive the sexual pressure they experience, both as a form of rape culture and as conversion therapy, where they are pressured to accept penises in their sexual lives.**
**Heterosexuality is forced upon lesbians under the guise of queer progressiveness.**

# References


Alderson, L. 1988. In Alderson L. and Wistrich, H, Clause 29: Radical feminist perspectives, Trouble and strife No 13. 1988

Bangor University, 2019. We Value Identity. The Bangor University Website [Online] Available at: https://www.bangor.ac.uk/inclusive-community/valuingidentity/ index.php.en. Accessed 18/01/2019

Barry, K. 1979. Female Sexual Slavery. New York: New York University Press

Bartosch, J. 2018. Lesbian Pride, Lesbian Protest. Medium [Online]. 8th July 2018 Available at: https://medium.com/@josephinebartosch/lesbian-pride-lesbianprotest- cea2c1404cc0. Accessed 18/01/2019

Beale, C. 2016. Feminists mock Green Party young women's group for invite to 'non-men'. The Independent [Online] 16th April 2016. Available at: https://www.independent.co.uk/news/uk/feminists-mock-green-party-youngwomens- invite-to-non-men-a6987061.html. Accessed 01/02/2018

Biggs, M. 2018. How Queer Theory Became University Policy. Cognatus News [Online] 24th November 2018 Available at: https://conatusnews.com/how-queertheory- became-university-policy/ Accessed on 24/02/2018

Blair, B & Obinawnne, A 2018, Why I am a Lesbian (Not Queer). AfterEllen Website [Online] 26th April 2018. Available at https://www.afterellen.com/columns/545781-im-lesbian-not-queer Accessed 22/01/2019

Brackx, A. 1980. Prejudice and Pride. In Feminist anthology collective (Eds) No Turning Back. Writings from the Women's Liberation Movement 1975-80. London, The women's press.

Butler, J. 2007. Gender Trouble. Oxon, UK, Routledge

Cade, L. 2014. Why I went to War. Lily Cade Website [Online] Available at: https://www.lilycade.com/why-i-went-to-war/ Accessed 15/01/2018

Cooper, T. 2018a. Tony Cooper Twitter Account. [Online] 29th August 2018. Available at: https://twitter.com/tony-dcooper/status/1034842336176611329. Accessed 18/01/2018

Cooper, T. 2018b. No Terf on our Turf. Tony Cooper Facebook Account. [Online] 8th October 2018. Available at: https://www.facebook.com/tonyd.cooper.3/posts/1108844465938100 Accessed 18/01/2019

Curtis, B and Curtis, C. 2011. Social Research: A Practical Introduction. London: Sage

Daly, M. 1985 Beyond God the Father, 2nd ed. Boston, USA, Beacon Press.

Dennis, R, J. [Online Video]. Are genital preferences transphobic? Riley, J. Dennis YouTube Channel. Available at: https://www.youtube.com/watch? v=k5GYIZKfBmI&vl=de. Accessed 01/02/2018

De la Cretaz, B. 2016. What It's Like to Chestfeed. The Atlantic [online] 23rd August 2016. Available at: https://www.theatlantic.com/health/archive/2016/08/chestfeeding/497015/. Accessed 01/02/2018

Dhejne, C. Lichtenstein, P, Boman, M. Johansson A. L. V. Långström, N and Landén, M. 2011. Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden. PLOS-One [Online] 22nd February 22, 2011/ Available at: https://doi.org/10.1371/journal.pone.0016885 Accessed 01/02/2019

Dixon, J. 1988, Separatism: a look back at anger. In Cant, B. and Hemming, S. (Eds) Radical Records. Thirty years of Lesbian and Gay History. London, Routledge

Donnelly, L. 2017. Don't call pregnant women 'expectant mothers' as it might offend transgender people, BMA says. The Telegraph. [online. Available at: https://www.telegraph.co.uk/news/2017/01/29/dont-call-pregnant-womenexpectant- mothers-might-offend-transgender/. Accessed 01/02/2018

Dworkin, A. 1974. Woman Hating. New York, USA. E.P. Dutton

Dworkin, A. 1987. Intercourse. New York USA. The Free Press

Equality Act 2010. (c.1 s.11 & s.12) The government legislation website [Online] Available at: https://www.legislation.gov.uk/ukpga/2010/15/contents . Accessed 20/01/2019

Fair Play For Women, 2019, Fair Play for Women website. [Online]. Available at: https://fairplayforwomen.com/. Accessed 01/02/2019.

Fine, C. 2010. The Delusions of Gender. London, UK, Icon Books.

Frye, M. 1983a. To Be and To Be Seen: The Politics of Reality in The politics of Reality. pp152–174. Berkeley, USA. Crossing Press]

Frye, M. 1983b. Lesbian Feminism and The Gay Rights Movement: Another View Of Male Supremacy, Another Separatism. in The politics of Reality. pp 128–151. Berkeley, USA. Crossing Press.

Get The L Out. 2018. [Online] Get The L Out website. Available at https://getthelout.wordpress.com/2018/07/05/the-journey-begins/ Accessed 16/01/2019

Glass, J. 2018, LGBT women don't feel comfortable at Pride, new study suggests. PinkNews [Online] 12th June 2018. Available at: https://www.pinknews.co.uk/2018/06/12/lgbt-bisexual-lesbian-women-pridestudy/ Accessed 16/01/2019

Guardian B2B, The Guardian B2B Twitter Account. [Online] 24th October 2018. Available at: https://twitter.com/guardian_b2b/status/1055353012426686464? lang=en Accessed 01/02/2018

Harne, L. 1996. Dangerous Liaisons, Reasserting male power through gay movements. In Harne, L & Miller, E. All The Rage. Reasserting Radical Lesbian Feminism. London, The women's Press. Pp.11-30

Human Rights Campaign Foundation, 2016. Safer Sex for Trans Bodies. The Human Right Campaign Foundation Website. [Online]. Available at https://assets2.hrc.org/files/assets/resources/Trans_Safer_Sex_Guide_FINAL.pdf. Accessed 01/02/2018

Jeffreys, S. 2003. Unpacking Queer Politics. Cambridge, Polity Press

Jeffreys, S. 2007. Beauty and Misogyny, Harmful Cultural Practices in the West. Hove, UK. Routledge

Jeffreys, S. 2014. Gender Hurts. A feminist analysis of the politics of transgenderism. Oxon, Routledge

MacKinnon, C.A. 1979. Sexual Harassment of Working Women: A Case of Sex Discrimination. New Haven, Conn: Yale University Press

Malantina, H. 20016. The Transgender Tipping Point: the Social Death of Sophia Burset. In Householder, A, K; Trier-Bieniek, A. (Eds). Feminist Perspectives on Orange Is the New Black: Thirteen Critical Essays. [E.book]. Jefferson, USA. McFarland. Available at: https://books.google.co.uk/books? id=SnKQDAAAQBAJ&pg=PA103&lpg=PA103&dq=cotton+ceiling+trans&source= bl&ots=JpX6eCdVVj&sig=FbtUtPLw2frf6nmsnwtlgq9t4vc&hl=en&sa=X&ved=2ah UKEwjavemavObYAhWHJ1AKHQgpCZk4FBDoATAGegQIBxAB#v=onepage&q= cotton%20ceiling%20trans&f=false Accessed 18/12/2018

McDowell, L. 1992. Doing Gender: Feminism, Feminists and Research Methods in Human Geography. Transactions of the Institute of British Geographers [Ejournal]. Vol. 17, No. 4 (1992), pp. 399-416. Available at: DOI: 10.2307/622707 https://www.jstor.org/stable/622707. Accessed 01/02/2018

Morris, B, J. 2016. The Disappearing L. Erasure of Lesbian Spaces and Culture. New York, USA, SUNY press

National Geographic, 2017, Helping families talk about gender. National geographic. Special issue. The Gender Issue. pp.18

NHS. 2016. Gender dysphoria. The National Health Service Website [Online] Available at: https://www.nhs.uk/conditions/gender-dysphoria/ Accessed 18/12/2018

Pride In London, 2018. Statement from Pride in London regarding the 2018 protest group. Pride In London Website [Online] Available at: https://prideinlondon.org/news/2018/7/8/statement-from-pride-in-londonregarding-the-2018-protest-group. Accessed 18/01/2019

Qu'emi, J 2014. 4 Ways to Be Gender Inclusive When Discussing Abortion. Everyday Feminism [Online]. 29th August 2014. Available at: https://everydayfeminism.com/2014/08/gender-inclusive-discussing-abortion/ Accessed 01/02/2018

Raymond, J. 1995. The Transsexual Empire. The making of the She-Male. New York, USA, Teachers College Press

Reed, T. 2015. Written evidence submitted by GIRES to the Transgender Equality Inquiry. The British Parliament Website. [Online]. Available at https://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/women-and-equalities-committee/transgender-equality/written/19292.pdf . Accessed 18/12/2018

Rich, A. 1977. The Meaning of Our Love for Women Is What we Have Constantly to Expand. In On Lies, Secrets and Silence. Selected Prose. 1995. London, Norton. Pp 223 – 230

Rippon, G. 2015, A welcome blow to the myth of distinct male and female brains. The new scientist website [Online]. Available at: https://www.newscientist.com/article/dn28584-a-welcome-blow-to-the-myth-ofdistinct- male-and-female-brains/. Accessed 01/02/2018

Robinson, M. Shrinking to Survive. A former transman reports on life inside queer youth culture. 4th Wave Now website [online] 27th April 2016. Available at : https://4thwavenow.com/2016/04/27/shrinking-to-survive-a-former-trans-manreports- on-life-inside-queer-youth-culture/ Accessed 01/02/2019

Sarantokos, S.2012. Social Research. London: Palgrave Macmillan

Scarcella, A. 2017. Why I'm transphobic [Online Video]. Arielle Scarcella YouTube Channel. Available at: https://www.youtube.com/watch?v=dumQfzcrOzk

Serano, J. 2007. Whipping Girl. A transsexual woman on sexism and the scapegoating of femininity. Berkeley, USA. Seal Press

Spender, D. 1985. Man Made Language. 2nd Ed. London, UK. Pandora Press

Sprocket, J. 2018. On Misogyny, on drag, or how it became ok to say "drag them off by their saggy tits." Medium [Online] 28th August 2018. Available at https://medium.com/@janesprocket/on-misogyny-on-drag-or-how-it-became-okto- say-drag-them-off-by-their-saggy-tits-2765873c1dfc. Accessed 18/01/2018

Stanley, E. 1982. Male Needs. the problems and Problems of working with gay men. In Friedman, S and Sarha, E. Eds) On the Problems of Men. Two feminist conferences. London, The women's press

Stanley, L. & Wise, S. 1993. Breaking Out Again. Feminist Ontology and Epistemology. London: Routledge.

Stone, S. 1991, The Empire Strikes Back. A posttranssexual Manifesto. In Stryker, S & Whittle, S (Eds). 2006. The Transgender Studies Reader. pp221-235

TerIsASlur. 2019 [Online] available at https://terfisaslur.com/cotton-ceiling/ Accessed 15/01/2019

Wolf, N. 1991. The Beauty Myth. How images of Beauty are used against women. London, UK, Vintage

Woman's Place UK, 2019, Woman's Place UK Website [Online]. Available at: https://womansplaceuk.org/ Accessed 01/02/2019

Yardley, M. 2018. Girl Dick, the Cotton Ceiling and the Cultural War on Lesbians, Girls and Women. AfterEllen. [Online] 5th December 2018. Available at https://www.afterellen.com/general-news/567823-girl-dick-the-cotton-ceiling-andthe- cultural-war-on-lesbians-girls-and-women. Accessed 15/01/2019

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# Lesbian women talk about meeting 'transbians' on women-only dating sites



by Jo Bartosch — August 7, 2021 in Lesbian Lives 5 min read



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## Jo Bartosch talks to lesbian women about

Remember 'Lisa' from the cult TV series *The L Word*? Played to comedic effect, Lisa claimed to be a "lesbian-identified man." It seems the show's creators were visionary, today every lesbian dating app and meet-up group will include men who claim to be lesbians, sometimes referred to as 'transbians.' The writers of *The L Word* could not have predicted that over a decade on, lesbians would be pressured to accept male transbians as sexual partners.

If there is one thing that unites lesbians aside from loving women and liking IKEA, it is their dislike of cock. Being fragile and emotional creatures, men aren't always robust enough to cope with rejection; consequently, generations of female same sex couples have had to find witty retorts to creepy men offering to 'turn them.' Today, such objectionable fellas can claim to be 'transbians' and enjoy an all-access pass to women's on and offline spaces.

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In 2019 grassroots activist group *Get The L Out* conducted research into this woke new take on age old male entitlement. Findings showed that 56 per cent of the lesbians surveyed reported that they had been "pressured or coerced into accepting a transwoman as a sexual partner." Experiences ranged from being duped into going on dates with males who identified as 'transbians' to rape. It should be noted that only a small minority of men who identify as lesbians have had any surgery or taken any steps towards 'transition' beyond changing clothes and pronouns.

When I asked for women to get in touch with examples of transbians on women-only dating apps, I was expecting a handful of responses; little did I know that within just a few hours I would be inundated by messages from women desperate to share their stories of being harassed, shamed and expelled from lesbian communities.

> When I asked for women to get in touch with examples of transbians on women-only dating apps, I was expecting a handful of responses; little did I know that within just a few hours I would be inundated by messages from women desperate to share their stories of being harassed, shamed and expelled from lesbian communities.

meaningful relationships rather than casual flings. The app proudly claims to “use a Nobel-Prize winning algorithm to help you zero in on the right person for you.”

Lucy explains: “At first all was well, and I enjoyed using the app. I matched with a few people and formed some good connections. The app was a great way to connect with people during lockdown. I even managed to get myself a few social distanced dates.”

Having had problems with other apps, Lucy was careful to select the “woman seeking woman” option. This was so she “would only see profiles of other women who had selected the same.”

But despite this Lucy was “shown profiles of trans women and men who identified as non-binary or gender fluid. There were also a large number of profiles of heterosexual couples who wanted threesomes with another woman.”

Frustrated by attention from biological men and straight couples, Lucy updated her profile “to let users know that I was only seeking other females.” She changed it to read “all I ask is, that you are on time, that you don’t judge me for watching *Love Island*, and that you are a biological female”.

Lucy says: “I did not think what I had written was at all controversial, it would save people wasting their time trying to match with me if they were not female.”

> “Within days of me editing my profile I received a message from Hinge to say that I had been permanently banned from the app... I instantly knew it was due to my stating that I was only interested in females. There was absolutely nothing inappropriate on my profile that could be deemed ‘offensive’, apart from my comment about only wanting to meet females.”

Hinge disagreed. Much to her dismay Lucy recalls:

“Within days of me editing my profile I received a message from Hinge to say that I had been permanently banned from the app. I immediately contacted Hinge to ask why they had taken this action, and was quickly informed it was because I had breached their terms and conditions in respect to ‘offensive content’. I instantly knew it was due to my stating that I was only interested in females. There was absolutely nothing inappropriate on my profile that could be deemed ‘offensive’, apart from my comment about only wanting to meet females.”

For Lucy, such intolerance is reminiscent of the prejudice of earlier decades:

“As a black lesbian who grew up in the 80s, our community were fighting for basic human rights, to be told in 2020 that I was no longer allowed to only want to date females, is beyond disturbing.”

Hinge were contacted for comment but no response was forthcoming.

Lucia used the lesbian dating app Wapa, which is for meeting people and flirting. She explains: “Every time a transgender person tried to contact me I was extremely polite and I replied that I was not interested.”

Lucia only wanted to date women. Because of this she was thrown off Wapa:

“They would never admit I didn’t want to chat because they were not interesting, they would say I was a transphobic bigot… so every fucking time, every fucking time, the rejected person complained”.

> I am always coming across trans women on these sites, as a lesbian I’m not interested and there should be a way I can filter this out (respectfully). It is bizarre that I can filter based on someone’s height or star sign but not on sex which is fundamental to my sexual orientation.”

Another lesbian user of Hinge from the UK told me: “I am always coming across trans women on these sites, as a lesbian I’m not interested and there should be a way I can filter this out (respectfully). It is bizarre that I can filter based on someone’s height or star sign but not on sex which is fundamental to my sexual orientation.”

It should be noted that it is not just men who identify as transbians that plague the women-only sections of dating sites and apps; a number of women reported being contacted by ordinary heterosexual men who don’t claim to be anything other than male.

Once one might have expected the lesbian and gay press to be outraged by the sexual harassment of lesbians. But instead, from *Autostraddle* to *Allure* lesbians are advised to get over their inconvenient dislike of penis. Helpful articles such as “How to Have Lesbian Sex With a Trans Woman” and “Sex With Trans Women 101: A Guide for Queer Cis Women” give tips on dealing with ‘girl dick.’

Ultimately, there is no way to tell whether the transbians who lurk on lesbian dating sites genuinely believe themselves to be women or if they are porn-fuelled fetishists on a power trip. Their motivations don’t matter, what does is that their presence in lesbian communities is having a devastating impact on women’s right to exclusively love other women. Today under the guise of inclusivity the right of abusive men to erode women’s sexual boundaries is facilitated by dating apps and coded into the guidelines of digital communities. Lesbians looking for love online face a stark choice; they can step into the rainbow closet of ‘girl dick’ and ‘transbians’ or close the door on the online world.

**Jo Bartosch is a writer and campaigner for the rights of women and girls.**

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**Markjp** 11 months ago

Great article. The fact that the male lesbians have not had surgery says it all. It is about fury that some women just don't like cock. On tinder I had an approach from what turned out to be a trans man who had apparently had surgery. The conversation was mutually respectful and he/she appeared nice. While I search from someone nice to be with the need to be with the same sex and not gender would be an insurmountable issue for me. For some men who sleep with men it would be ok but that is because they are bisexual and not Gay. Biology matters with sexual attraction and so does being a real Lesbian or Gay person. We have fought for our right to live for too long to be erased.

Reply

**Bryn Blackbird** 11 months ago

It has been absolutely shocking that not only has this not been covered by the mainstream (formerly/ supposedly) "LGB" news covering sites, it has been facilitated by them. Some of the biggest proponents of "comp-het" are the... "LGBT activists". More likely to find heterosexuals who would openly describe it as weird for lesbian sites to have men on it than our supposed community of homosexuals and bisexuals. So great to see a Lesbian and Gay outlet discussing this frankly. We can't let companies and lobbyists bully us into compulsory heterosexuality or compulsory silence.

Reply

**alexbloodfire** 1 year ago

A brilliant article highlighting the genuine and serious difficulties Lesbians are now facing on dating apps.

Reply

**Oiorpata** 1 year ago

So true. This is a massive problem, I feel so sorry for young lesbians coming out and trying to find lesbian groups.

Reply

**Moira Mulholland** 1 year ago

Great article

Reply

Comment

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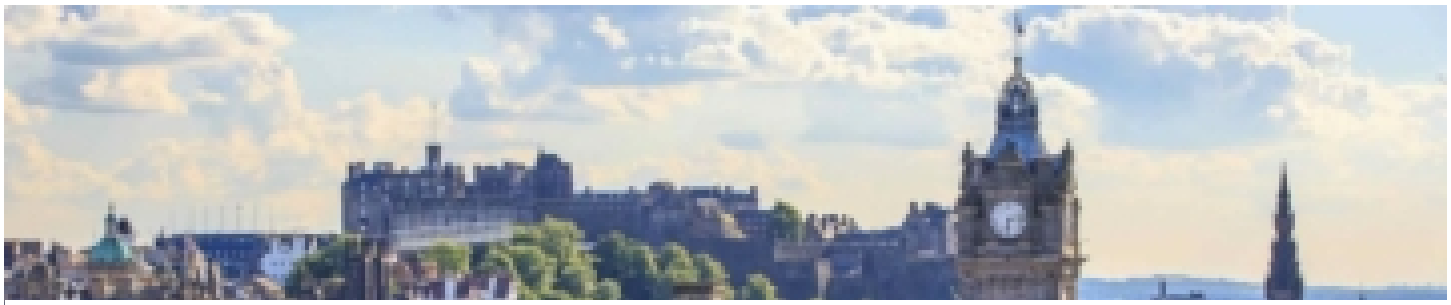
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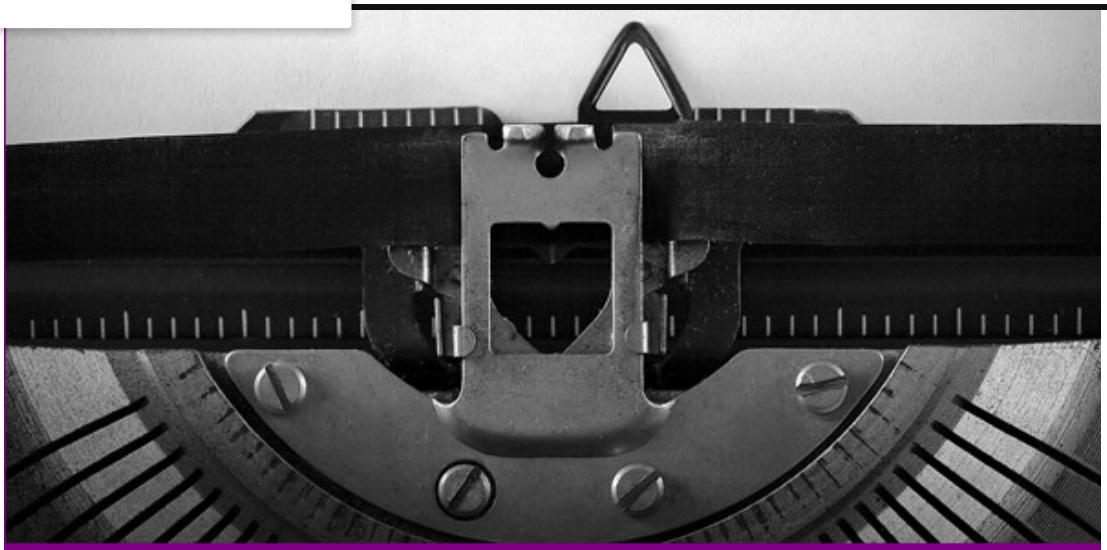
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# 'We're being pressured into sex by some trans women'

By Caroline Lowbridge
BBC News

26 October 2021



GETTY IMAGES

**Is a lesbian transphobic if she does not want to have sex with trans women? Some lesbians say they are increasingly being pressured and coerced into accepting trans women as partners - then shunned and even threatened for speaking out. Several have spoken to the BBC, along with trans women who are concerned about the issue too.**

*Warning: Story contains strong language*

687

"I've had someone saying they would rather kill me than Hitler," says 24-year-

"I've had someone saying they would rather kill me than Hitler," says 24-year-old Jennie*.

"They said they would strangle me with a belt if they were in a room with me and Hitler. That was so bizarrely violent, just because I won't have sex with trans women."

Jennie is a lesbian woman. She says she is only sexually attracted to women who are biologically female and have vaginas. She therefore only has sex and relationships with women who are biologically female.

Jennie doesn't think this should be controversial, but not everyone agrees. She has been described as transphobic, a genital fetishist, a pervert and a "terf" - a trans exclusionary radical feminist.

- **What does transgender mean and what does the law say?**

"There's a common argument that they try and use that goes 'What if you met a woman in a bar and she's really beautiful and you got on really well and you went home and you discovered that she has a penis? Would you just not be interested?'" says Jennie, who lives in London and works in fashion.

"Yes, because even if someone seems attractive at first you can go off them. I just don't possess the capacity to be sexually attracted to people who are biologically male, regardless of how they identify."

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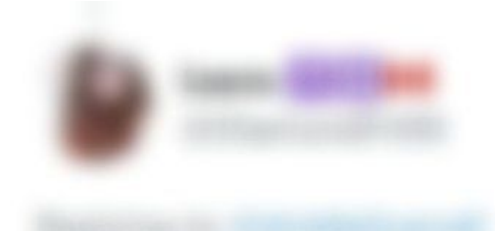
I became aware of this particular issue after I wrote an article about **sex, lies and legal consent**.

Several people got in touch with me to say there was a "huge problem" for lesbians, who were being pressured to "accept the idea that a penis can be a female sex organ".

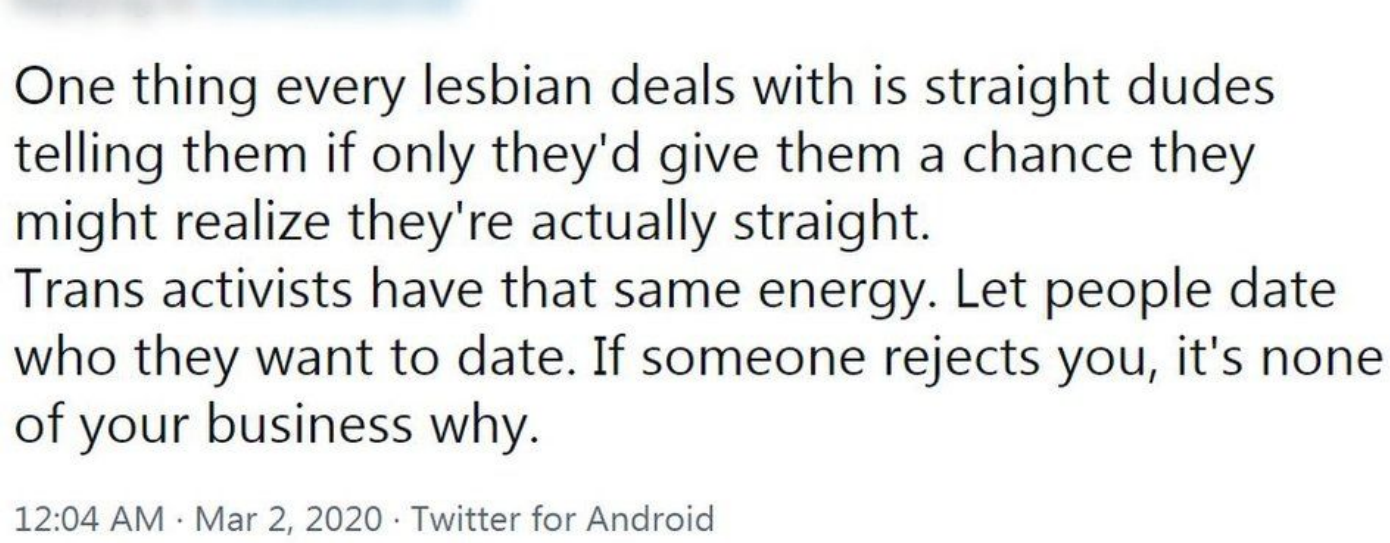
I knew this would be a hugely divisive subject, but I wanted to find out how widespread the issue was.

Ultimately, it has been difficult to determine the true scale of the problem because there has been little research on this topic - only one survey to my knowledge. However, those affected have told me the pressure comes from a minority of trans women, as well as activists who are not necessarily trans themselves.

They described being harassed and silenced if they tried to discuss the issue openly. I received online abuse myself when I tried to find interviewees using social media.



688




This tweet, written by a trans woman, was posted in support of lesbian women who feel pressured by trans activists

One of the lesbian women I spoke to, 24-year-old Amy*, told me she experienced verbal abuse from her own girlfriend, a bisexual woman who wanted them to have a threesome with a trans woman.

When Amy explained her reasons for not wanting to, her girlfriend became angry.

"The first thing she called me was transphobic," Amy said. "She immediately jumped to make me feel guilty about not wanting to sleep with someone."

She said the trans woman in question had not undergone genital surgery, so still had a penis.

"I know there is zero possibility for me to be attracted to this person," said Amy, who lives in the south west of England and works in a small print and design studio.

"I can hear their male vocal cords. I can see their male jawline. I know, under their clothes, there is male genitalia. These are physical realities, that, as a woman who likes women, you can't just ignore."

Amy said she would feel this way even if a trans woman had undergone genital surgery - which some opt for, while many don't.

Soon afterwards Amy and her girlfriend split up.

"I remember she was extremely shocked and angry, and claimed my views were extremist propaganda and inciting violence towards the trans community, as well as comparing me to far-right groups," she said.

## 'I felt very bad for hating every moment'

Another lesbian woman, 26-year-old Chloe*, said she felt so pressured she ended up having penetrative sex with a trans woman at university after repeatedly explaining she was not interested.

They lived near each other in halls of residence. Chloe had been drinking alcohol and does not think she could have given proper consent.

"I felt very bad for hating every moment, because the idea is we are attracted to gender rather than sex, and I did not feel that, and I felt bad for feeling like that," she said.

Ashamed and embarrassed, she decided not to tell anyone.

"The language at the time was very much 'trans women are women, they are always women, lesbians should date them'. And I was like, that's the reason I rejected this person. Does that make me bad? Am I not going to be allowed to be in the LGBT community anymore? Am I going to face repercussions for that instead?' So I didn't actually tell anyone."




PAM ISHERWOOD

Get The L Out has demonstrated at Pride marches around the UK, including in London in 2018

Hearing about experiences like these led one lesbian activist to begin researching the topic. Angela C. Wild is co-founder of Get The L Out, whose members believe the rights of lesbians are being ignored by much of the current LGBT movement.

She and her fellow activists have demonstrated at Pride marches in the UK, where they have faced opposition. Pride in London accused the group of "bigotry, ignorance and hate".

"Lesbians are still extremely scared to speak because they think they won't be believed, because the trans ideology is so silencing everywhere," she said.

690

Angela created a questionnaire for lesbians and distributed it via social media, then **published the results**.

She said that of the 80 women who did respond, 56% reported being pressured or coerced to accept a trans woman as a sexual partner.

While acknowledging the sample may not be representative of the wider lesbian community, she believes it was important to capture their "points of view and stories".

As well as experiencing pressure to go on dates or engage in sexual activity with trans women, some of the respondents reported being successfully persuaded to do so.

"I thought I would be called a transphobe or that it would be wrong of me to turn down a trans woman who wanted to exchange nude pictures," one wrote. "Young women feel pressured to sleep with trans women 'to prove I am not a terf'."

One woman reported being targeted in an online group. "I was told that homosexuality doesn't exist and I owed it to my trans sisters to unlearn my 'genital confusion' so I can enjoy letting them penetrate me," she wrote.




GET THE L OUT

Angela C. Wild (bottom left) published her research in a report called Lesbians At Ground Zero

691

One compared going on dates with trans women to so-called conversion

2056

One compared going on dates with trans women to so-called conversion therapy - the controversial practice of trying to change someone's sexual orientation.

"I knew I wasn't attracted to them but internalised the idea that it was because of my 'transmisogyny' and that if I dated them for long enough I could start to

be attracted to them. It was DIY conversion therapy," she wrote.

Another reported a trans woman physically forcing her to have sex after they went on a date.

"[They] threatened to out me as a terf and risk my job if I refused to sleep with [them]," she wrote. "I was too young to argue and had been brainwashed by queer theory so [they were] a 'woman' even if every fibre of my being was screaming throughout so I agreed to go home with [them]. [They] used physical force when I changed my mind upon seeing [their] penis and raped me."

While welcomed by some in the LGBT community, Angela's report was described as transphobic by others.

"[People said] we are worse than rapists because we [supposedly] try to frame every trans woman as a rapist," said Angela.

"This is not the point. The point is that if it happens we need to speak about it. If it happens to one woman it's wrong. As it turns out it happens to more than one woman."





ROSE OF DAWN

Trans YouTuber Rose of Dawn said some of her lesbian friends have been pressured to accept trans women as sexual partners

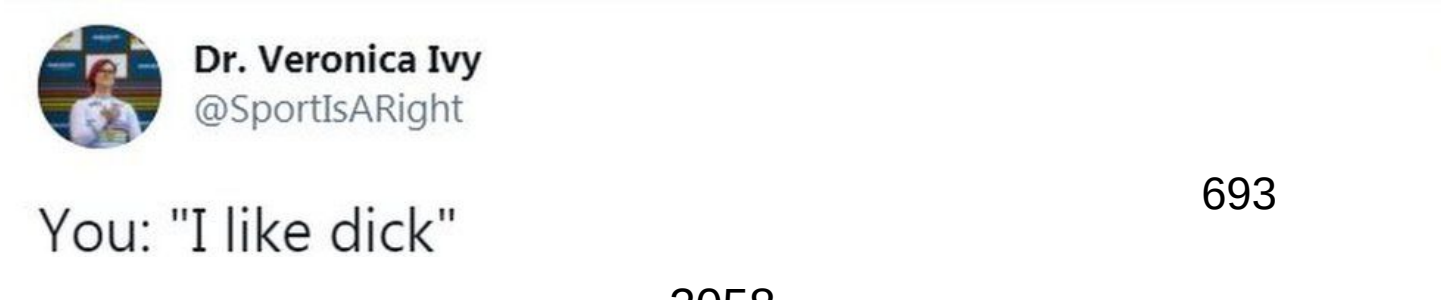
Trans YouTuber Rose of Dawn has discussed the issue on her channel **in a video called "Is Not Dating Trans People 'Transphobic'?"**

"This is something I've seen happen in real life to friends of mine. This was happening before I actually started my channel and it was one of the things that spurred it on," said Rose.

"What's happening is women who are attracted to biological females and female genitalia are finding themselves put in very awkward positions, where if for example on a dating website a trans woman approaches them and they say 'sorry I'm not into trans women', then they are labelled as transphobic."

Rose made the video in response to a series of tweets by **trans athlete Veronica Ivy, then known as Rachel McKinnon,** who **wrote about hypothetical scenarios** where trans people are rejected, and argued that "genital preferences" are transphobic.

I asked Veronica Ivy if she would speak to me but she did not want to.



Girl with dick says 'Hey, wanna date?'
"Oh...no...I only like dick on guys"

Guy responds to date ad: 'Sup girl'
...guy has a vagina
"Oh, sorry, I only like guys with dicks"

Both cases trans people are left in the cold. 'Genital preferences' are transphobic.

11:37 AM · Sep 30, 2019 · Twitter Web App

**95** Retweets **1,593** Quote Tweets **535** Likes




GETTY IMAGES 694

Trans athlete Veronica Ivy, previously known as Rachel McKinnon, believes "genital preferences" are transphobic

Trans athlete Veronica Ivy, previously known as Rachel Mckinnon, believes "genital preferences" are transphobic

Rose believes views like this are "incredibly toxic". She believes the idea that dating preferences are transphobic is being pushed by radical trans activists and their "self-proclaimed allies", who have extreme views which don't reflect the views of trans women she knows in real life.

"Certainly from my own friends group, the trans women I'm friends with, almost all of them agree lesbians are free to exclude trans women from their dating pool," she said.

However, she believes even trans people are afraid to talk openly about this for fear of abuse.

"People like me receive quite a lot of abuse from trans activists and their allies," she said.

"The trans activist side is incredibly rabid against people who they see as stepping out of line."





DEBBIE HAYTON

Debbie Hayton has been accused of propagating hate speech against the trans community, despite being trans herself

Debbie Hayton, a science teacher who transitioned in 2012 and **writes about trans issues**, worries some people transition without realising how hard it will be to form relationships.

Although there is currently little data on the sexual orientation of trans women, she believes most are female-attracted because they are biologically male and most males are attracted to women.

"So when they [trans women] are trying to find partners, when lesbian women say 'we want women', and heterosexual women say they want a heterosexual man, that leaves trans women isolated from relationships, and possibly feeling very let down by society, angry, upset and feeling that the world is out to get them," she said.

Debbie thinks it's fine if a lesbian woman does not want to date a trans woman, but is concerned some are being pressured to do so.

"The way that shaming is used is just horrific; it's emotional manipulation and warfare going on," she said.

"These women who want to form relationships with other biological women are feeling bad about that. How did we get here?"





GETTY IMAGES

Stonewall declined the BBC's requests for an interview

Stonewall is the largest LGBT organisation in the UK and Europe. I asked the charity about these issues but it was unable to provide anyone for interview. However, in a statement, chief executive Nancy Kelley likened not wanting to date trans people to not wanting to date people of colour, fat people, or disabled people.

She said: "Sexuality is personal and something which is unique to each of us. There is no 'right' way to be a lesbian, and only we can know who we're attracted to.

"Nobody should ever be pressured into dating, or pressured into dating people they aren't attracted to. But if you find that when dating, you are writing off entire groups of people, like people of colour, fat people, disabled people or trans people, then it's worth considering how societal prejudices may have shaped your attractions.

"We know that prejudice is still common in the LGBT+ community, and it's important that we can talk about that openly and honestly."




GETTY IMAGES

Stonewall was founded in 1989 by people opposed to what was known as Section 28 - **legislation which stopped councils and schools from "promoting" homosexuality**. The organisation originally focused on issues

**promoting" homosexuality**. The organisation originally focused on issues affecting lesbian, gay and bisexual people, then **in 2015 announced it would campaign for "trans equality".**

A new group - LGB Alliance - has been formed partly in response to **Stonewall's change of focus**, by people who believe the interests of LGB

people are being left behind.

"It's fair to say that I didn't expect to have to fight for these rights again, the rights of people whose sexual orientation is towards people of the same sex," said co-founder Bev Jackson, who also co-founded the UK Gay Liberation Front in 1970.

"We sort of thought that battle had been won and it's quite frightening and quite horrifying that we have to fight that battle again."




GETTY IMAGES

Bev Jackson was one of the founding members of the Gay Liberation Front, which formed in 1970

LGB Alliance says it is particularly concerned about younger and therefore more vulnerable lesbians being pressured into relationships with trans women.

"It's very disturbing that you find people saying 'It doesn't happen, nobody pressures anybody to go to bed with anybody else', but we know this is not the case," said Ms Jackson.

"We know a minority, but still a sizeable minority of trans women, do pressure lesbians to go out with them and have sex with them and it's a very disturbing

phenomenon."

I asked Ms Jackson how she knew a "sizeable minority" of trans women were doing this.

She said: "We don't have figures but we are frequently contacted by lesbians who relate their experience in LGBT groups and on dating sites."

## 'Shyest young women'

Why does she think there has been so little research?

"I certainly think research on this topic would be discouraged, presumably because it would be characterised as a deliberately discriminatory project," she said.

"But also, the girls and young women themselves, since it's likely the shyest and least experienced young women who are the victims of such encounters, would be loath to discuss them."

LGB Alliance has been described as a hate group, anti-trans and transphobic. However, Ms Jackson insists the group is none of these things, and includes trans people among its supporters.

"This word transphobia has been placed like a dragon in the path to stop discussion about really important issues," she said.

"It's hurtful to our trans supporters, it's hurtful to all our supporters, to be called a hate group when we're the least hateful people you can find."

---

The term "cotton ceiling" is sometimes used when discussing these issues, but it is controversial.

It stems from **"glass ceiling"**, which refers to an invisible barrier preventing women from climbing to the top of the career ladder. Cotton is a reference to women's underwear, with the phrase intended to represent the difficulty some trans women feel they face when seeking relationships or sex. "Breaking the cotton ceiling" means being able to have sex with a woman.

The term is first thought to have been used in 2012 by a trans porn actress going by the name of Drew DeVeaux. She no longer works in the industry and I have not been able to contact her.

However, the concept of the cotton ceiling came to wider attention when it was used in the title of a workshop by Planned Parenthood Toronto.





GETTY IMAGES

"Cotton" in the phrase "cotton ceiling" refers to a woman's underwear

The title of the workshop was: "Overcoming the Cotton Ceiling: Breaking Down Sexual Barriers for Queer Trans Women", and the description explained how participants would "work together to identify barriers, strategize ways to overcome them, and build community".

It was led by a trans writer and artist who later went to work for Stonewall (the organisation has asked the BBC not to name her because of safeguarding concerns).

The trans woman who led the workshop declined to speak to the BBC, but Planned Parenthood Toronto stood by its decision to hold the workshop.

In a statement sent to the BBC, executive director Sarah Hobbs said the workshop "was never intended to advocate or promote overcoming any individual woman's objections to sexual activity". Instead, she said the workshop explored "the ways in which ideologies of transphobia and transmisogyny impact sexual desire".

---

## Who else was approached?

In addition to Veronica Ivy, I contacted several other high profile trans women who have either written or spoken about sex and relationships. None of them wanted to speak to me but my editors and I felt it was important to reflect some of their views in this piece.

In a video which has now been deleted, YouTuber Riley J Dennis argued that dating "preferences" are discriminatory.

She asked: "Would you date a trans person, honestly? Think about it for a second. OK, got your answer? Well if you said no, I'm sorry but that's pretty discriminatory."

700

2065

discriminatory.

She explained: "I think the main concern that people have in regards to dating a trans person is that they won't have the genitals that they expect. Because we associate penises with men and vaginas with women, some people think they could never date a trans man with a vagina or a trans woman with a penis.

"But I think that people are more than their genitals. I think you can feel attraction to someone without knowing what's between their legs. And if you were to say that you're only attracted to people with vaginas or people with penises it really feels like you are reducing people just to their genitals."




YouTuber Riley Dennis - who declined to speak to the BBC - argued that "dating preferences" are discriminatory in one of her videos

Another YouTuber, Danielle Piergallini, made a video titled **"The Cotton Ceiling: Transphobia, Sex, and Dating (but not transsexuals)"**.

She said: "I want to talk about the idea that there are a number of people out there who say they're not attracted to trans people, and I think that that is transphobic because any time you're making a broad generalised statement about a group of people that's typically not coming from a good place."

However, she added: "If there is a trans woman who is pre-op and somebody doesn't want to date them because they don't have the genitals that match their preference, that's obviously understandable."

Novelist and poet Roz Kaveney wrote an article called **"Some Thoughts on the Cotton Ceiling"** and another called **"More Cotton Ceiling"**.

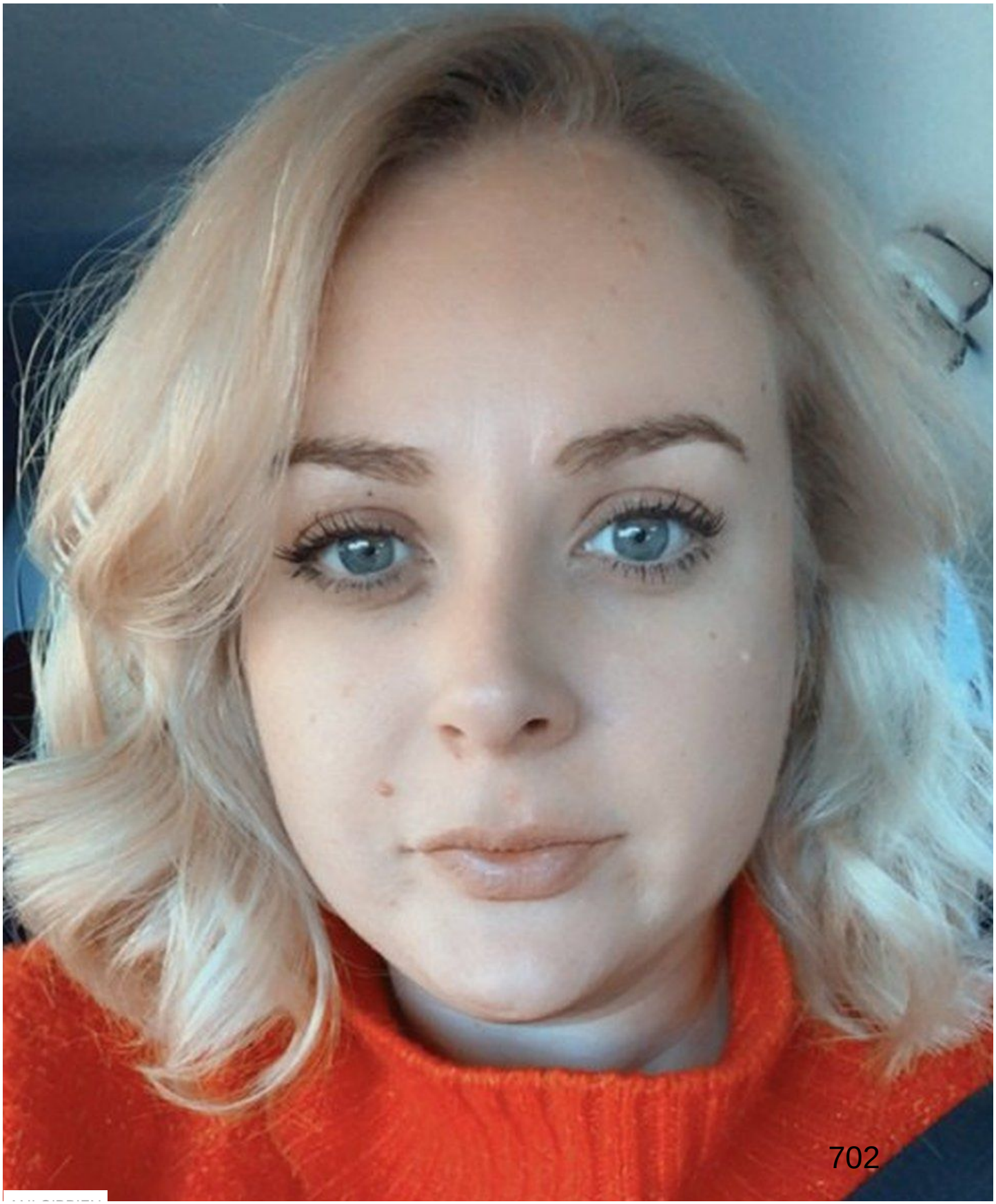
"What is always going on is an assumption that the person is the current status of their bits, and the history of their bits," she wrote in the first article.

"Which is about as reductive a model of sexual attraction as I can imagine."

which is about as reductive a model of sexual attraction as I can imagine.

While this debate was once seen as a fringe issue, most of the interviewees who spoke to me said it has become prominent in recent years because of social media.

Ani O'Brien, spokeswoman for a New Zealand group called Speak Up For Women, created a **TikTok video aimed at younger lesbians**.



Ani, who is 30, told the BBC she is concerned for the generation of lesbians who are now in their teens.

"What we are seeing is a regression where once again young lesbians are being told 'How do you know you don't like dick if you haven't tried it?'" she said.

"We get told we should be looking beyond genitals and should accept that someone says they are a woman, and that's not what homosexuality is.

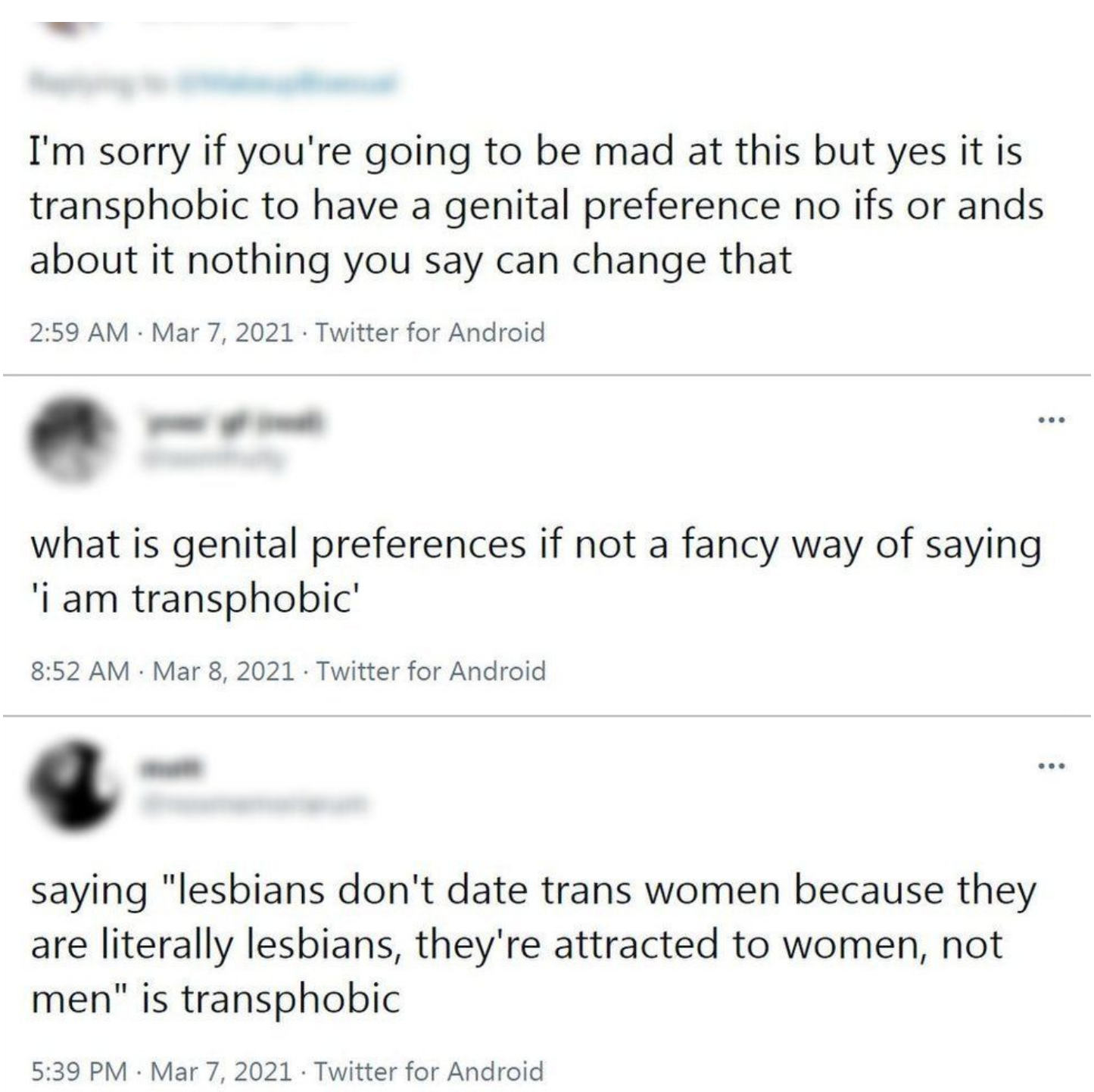
"You don't see as many trans men interested in gay men so they don't get it [the pressure] as much, but you do see a lot of trans women who are interested in women, so we are disproportionately affected by it."

Ani believes these kind of messages are confusing for young lesbians.

"I remember being a teenager in the closet and trying desperately to be straight, and that was hard enough," she said.

"I can't imagine what it would have been like, if I'd finally come to terms with the fact I was gay, to then be faced with the idea that some male bodies are not male so they must be lesbian, and having to contend with that as well."






Ani says she gets contacted on Twitter by young lesbians who do not know how to exit a relationship with a trans woman.

"They tried to do the right thing and they gave them a chance, and realised that they are a lesbian and they didn't want to be with someone with a male body, and the concept of transphobia and bigotry is used as an emotional weapon, that you can't leave because otherwise you're a transphobe," she said.

Like others who have voiced their concerns, Ani has received abuse online.

"I've been incited to kill myself, I've had rape threats," she said. However, she says she is determined to keep speaking out.

"A really important thing for us to do is to be able to talk these things through. Shutting down these conversations and calling them bigotry is really

unhelpful, and it shouldn't be beyond our ability to have hard conversations about some of these things."

**The BBC has changed the names of some of those featured in this article to protect their identities.*

---

*Update 4 November 2021: We have updated this article, published last week, to remove a contribution from one individual in light of comments she has published on blog posts in recent days, which we have been able to verify.*

*We acknowledge that an admission of inappropriate behaviour by the same contributor should have been included in the original article.*

---

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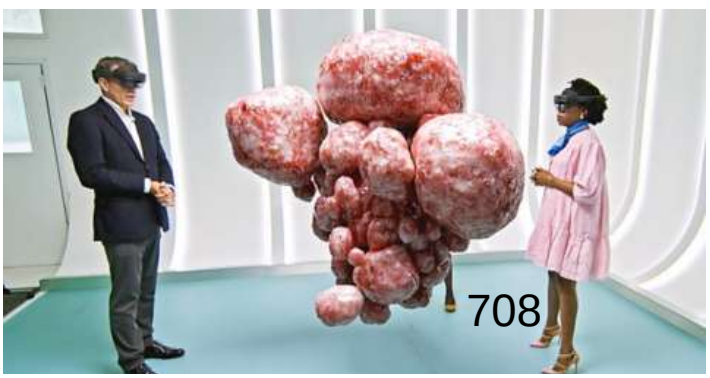
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# Response to the letter by Taiwo Owatemi, Shadow Secretary of State for Women and Equalities in the UK

Misc

**Statement by Bev Jackson of LGB Alliance in response to the letter by Taiwo Owatemi, Shadow Secretary of State for Women and Equalities in the UK**

**The letter by Taiwo Owatemi, Shadow Minister for Women and Equalities, replying to a constituent concerned about the recent escalation of attacks on Professor Kathleen Stock, contains a catalogue of lies and misrepresentations about our organisation, the charity LGB Alliance. We refute them utterly and call upon the Shadow Minister to issue a retraction.**

1.

Owatemi writes that LGB Alliance "should be rejected by all those who believe in equality." On the contrary, our organisation was formed to campaign for preserving the rights, as enshrined in the Equality Act 2010, of people with same-sex sexual orientation. It is impossible to guarantee those rights if the word "sex" is replaced by subjective, self-defined "gender." We need to point this out repeatedly, since almost all LGBT+ groups, those who, as the Shadow Minister states, opposed the decision to grant us charitable status, now deny the central importance of biological sex. Remarkably many LGBT+ groups even claim that to insist on the use of the word sex is a "dog whistle" for "transphobia". In the space of less than 10 years, we've lost the ability to describe our sexual orientation and discuss our rights in law without being deemed transphobic.

2.

The equality of lesbians, in particular, is under attack. It is no coincidence that LGB Alliance was founded by two lesbians, one being

a founding member of the Gay Liberation Front and the other being a former volunteer fundraiser for Stonewall. Those who point out that being a lesbian means being exclusively attracted to other biological females are being vilified by LGBTQ+ groups as “genital fetishists” and “transphobes”. There is a word for this kind of vilification. It is homophobia. 30 years ago, homophobes used to argue lesbians should consider sleeping with men. Nowadays, new-style homophobes from within the LGBTQ+ movement say exactly the same thing …that lesbians should consider having sex with “lesbians who have a penis” – that is, men.

3.

Are we saying that all the LGBTQ+ groups around the country are essentially now homophobic? That is precisely what we are saying. The fact that they do not realise the depth of their homophobia is a sign of how far they have been captured by the convoluted logic of strange new language and ideas.

4.

The Shadow Minister further states that LGB Alliance opposes reform of the Gender Recognition Act. What we oppose is the introduction of gender “self-ID”, according to which any person, without any medical diagnosis, can change their legal sex. The havoc already being caused by moves in this direction, in women’s sport, in women’s prisons, in women’s rape shelters, in women’s hospital wards, is well documented. Less well documented is the damage being inflicted on lesbian and gay teens, who are repeatedly hearing that they may have been “born in the wrong body” and need to “change sex”. This too is homophobia. As an organisation representing LGB people we staunchly reject self-ID and all suggestions that same-sex attracted people might have been “born in the wrong body”.

5.

The Shadow Minister writes that we oppose “LGBT+ inclusive education”. Of course we welcome good RSE education that teaches children about gay and straight relationships, about the changes of puberty, and also teaches them to be tolerant of people who are different. What we oppose is teaching children that everyone has a “gender identity” that may differ from their birth sex. This, again, encourages the false and harmful notion that it is possible to be “born in the wrong body”.

6.

The Shadow Minister further writes that we believe “adolescents should not be able to access puberty blockers” as part of a process of “gender transition”. This is correct. We are pleased to see that “gender experts” from Sweden[1] and Finland[2] to Australia and New Zealand,[3]

and even in the United States,[4] are increasingly expressing concern about the use of puberty blockers. The majority of teens referred to gender clinics are girls. The evidence shows that the majority of those girls will turn out to be lesbian or bisexual.[5] It also shows that some 98% of children who take puberty blockers go on to take cross-sex hormones,[6] which eventually lead to sterility. All those who oppose medicalisation that ends up sterilising "gender-non-conforming youth" should support LGB Alliance.

7.

The growing group of detransitioners, most of them women in their twenties, repeatedly express the wish that they had received better care. Better care does not mean drugs and surgery. It means careful, non-judgmental, impartial psychotherapy to help them explore the reasons for their profound sense of alienation from their bodies.

8.

The Shadow Minister states that opposing the use of puberty blockers is "in flagrant disregard of the entire concept of 'Gillick competency'". This is a misrepresentation of Gillick competency, which was introduced to protect girls wanting to take contraception or to have an abortion without the consent of their parents. Applying this to a medical pathway applicable to children as young as 10 years of age that leads eventually to sterilisation is a gross abuse of the concept, and we are confident that the Supreme Court will settle this matter in its consideration of the Keira Bell case.

9.

The Shadow Minister writes that we criticise measures to make conversion "therapy" illegal. Gay "conversion therapy" is abhorrent and we utterly condemn it. What we dispute is the definition of "conversion therapy". Former clinicians at the Tavistock GIDS clinic have described the process of prescribing drugs and surgery for gender non-conforming youth as a form of "gay conversion therapy".

10.

We criticise proposals to ban "gender identity conversion therapy" because it essentially means enforcing the "affirmative approach" to gender dysphoria. We already hear from UK doctors who tell us that they are instructed by the GMC that the girls coming to their clinic who "identify" as boys must be affirmed as boys and referred to a gender clinic. The irony is that the proposed ban on "gender identity conversion therapy" would actually lead to "conversion therapy" of teens likely to grow up LGB. Suggesting a child who is attracted to someone of the same sex might need hormones and surgery – *that* is a form of "gay conversion therapy" and we strongly oppose it.

11.

The Shadow Minister says we oppose the “very existence of non-binary people”. We do not oppose the existence of anyone. People can “identify” however they choose, but these chosen identities cannot be used to infringe on existing rights of other minorities under law.

12.

The Shadow Minister further writes that we “refuse to condemn as homophobic those who would deny same-sex couples the right to marry”. Here the Shadow Minister remembers the phrase “same-sex”. We strongly support all legal measures to allow same-sex couples to marry. The misrepresentation here arises from the fact that marriage is, and always has been, a controversial concept within the gay and lesbian community. Stonewall opposed it for many years before changing its mind. Many gays and lesbians see marriage as a traditional, conservative, establishment institution that they have no wish to imitate. Some of our supporters will take this view, while others disagree and are happily married. Of course the legal possibility to marry must exist. And of course those who dislike the institution of marriage, whether they are gay or straight, have every right to say so and to remain unmarried.

13.

The Shadow Minister admits that she is “not familiar with Professor Stock’s philosophical writings” yet feels able to be “greatly concerned by her work as a Trustee for the LGB Alliance group”. It is an utter disgrace that an eminent philosopher who was awarded an OBE for services to higher education, and who practises her profession with a scrupulous regard for truth and respect for other views, should be vilified in this way.

14.

Though we are appalled by the casual way in which the Shadow Secretary has seen fit to parrot these lies and misrepresentations about our organisation, and to abuse Professor Stock by association, it should be noted that this malicious communication is only the tip of the iceberg. All around the UK, those who emphasise the importance of biological sex to the rights of women and LGB people are going in fear of losing their livelihood. Many write to us and tell us they agree with us but are silent for fear of losing their jobs.

15.

The Shadow Minister’s trashing of our organisation also signals something that has gone very wrong with the Labour Party and indeed in all the UK’s public institutions. When we hear Keir Starmer say that it is “not right” to say to say that only women have a cervix, and when we hear David Lammy say that he has heard it is possible to grow a cervix with the use of hormones and other treatment we know we

have entered a twilight world, in which you can be attacked, as we saw recently on Twitter, for “fact shaming”. Facts exist. Ignore them at your peril.

16.

Those who want to gain an understanding of how this sorry and increasingly dangerous state of affairs has been allowed to come about are advised to listen to the new 10-part podcast “Nolan Investigates” on Stonewall, which can be found on BBC Sounds.

17.

We expect an apology and a full retraction from the Shadow Secretary for Women and Equalities, to be published at the earliest opportunity.

**Bev Jackson**

**Co-founder, LGB Alliance**

1 https://segm.org/Sweden_ends_use_of_Dutch_protocol

2 https://www.economist.com/science-and-technology/2021/05/13/doubts-are-growing-about-therapy-for-gender-dysphoric-children

3 https://www.theaustralian.com.au/nation/psychiatrists-adopt-new-gender-policy/news-story/9f1b8958312c24f5bed1d9f8101c86bd

4 https://bariweiss.substack.com/p/top-trans-doctors-blow-the-whistle

5 https://www.cambridge.org/core/journals/bjpsych-bulletin/article/sex-gender-and-gender-identity-a-reevaluation-of-the-evidence/76A3DC54F3BD91E8D631B93397698B1A#

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# Stonewall boss defends new strategy amid criticism

By Jessica Parker & Eleanor Lawrie
BBC News

29 May 2021



Nancy Kelley: "I'm comfortable with our direction as an organisation"

**Stonewall head Nancy Kelley has defended the organisation's position amid a freedom of speech row and criticism from a founder.**

Matthew Parris **said in the Times** that Stonewall had become "tangled up in the trans issue" and "cornered into an extremist stance".

But Ms Kelley told the BBC she was "really comfortable" with the direction the charity was going in.

She likened so-called "gender critical" beliefs to anti-Semitism.

The Equality and Human Rights Commission (EHRC) has said its defence of the right to hold "gender critical beliefs" - that sex cannot be changed - "does not have an impact on our commitment to uphold the rights of transgender people".

## Freedom of speech 'has limits'

The new EHRC chair, Lady Falkner, **has said women have the right to question transgender identity** without being abused, stigmatised or risking losing their job.

Ms Kelley said while Stonewall believed in freedom of speech, it was "not without limit".

"With all beliefs including controversial beliefs there is a right to express those beliefs publicly and where they're harmful or damaging - whether it's anti-Semitic beliefs, gender critical beliefs, beliefs about disability - we have legal systems that are put in place for people who are harmed by that."

Challenged as to whether it might be considered offensive to compare anti-Semitic beliefs to gender-critical views, she insisted it was appropriate.

"We're talking about protected groups. We're talking about people that are protected on the basis of their sexuality, people that are protected on the basis of gender identity, people who are protected on the basis of race and that's why I think the analogy is apt."

Journalist and former Tory MP Matthew Parris, one of Stonewall's 14 founders, recently suggested the charity had "lost its way".

In an article for the Times, he said: "The organisation is tangled up in the trans issue, cornered into an extremist stance on a debate that a charity formed to help gay men, lesbian women and bisexual people should never have got itself into."

Ms Kelley said while Mr Parris was entitled to his views, being trans-inclusive was the "absolute norm" for LGBT organisations.

She also denied Stonewall had approved incorrect advice on transgender issues for the University of Essex, which is part of its Diversity Champions workplace inclusion scheme.

A **recent report** found the university had unlawfully blacklisted a speaker after some protesters labelled her a "transphobe".

Ms Kelley said Stonewall had "nothing to do" with the university's process for deciding external speakers and was "really confident" in its legal advice.

Stonewall's been criticised for using the term "gender identity" when referring to the Equality Act's protected characteristic of "gender reassignment".

But Ms Kelley described that as "the difference between natural language and statutory language".

She also expressed frustration that the volume of media coverage and debate around trans rights meant "it can be difficult to get across all the work we do... focusing on the experiences of LGB [lesbian, gay and bisexual] people."

She said the organisation's work could still benefit people, whether or not they agreed with its position, such as improving access to IVF.

That aim is part of **the organisation's new "free to be" strategy**, which includes campaigning for "hate crime and hate speech laws in the UK that protect LGBTQ+ communities" and a pledge to champion inclusion across schools.

- **Human rights body quits Stonewall diversity scheme**
- **Groups criticise conversion therapy 'Groundhog Day'**

## Conversion therapy ban delay 'unnecessary'



GETTY IMAGES

Liz Truss is Equalities Minister as well as Secretary of State for International Trade

The strategy also prioritises a "legally enforceable ban on conversion therapy".

Ms Kelley said the consultation process, planned for September, was an "unnecessary delay" but promised to work closely with the government on the ban.

**Conversion therapy** is defined by health groups, including NHS England, as

attempts to change someone's sexuality or gender identity.

It is understood part of the consultation will look at how to ensure certain medical or other accredited professionals will not be criminalised.

Ms Kelley said a therapist, helping someone explore their gender identity or sexual orientation, wouldn't be caught by a ban, "because that's not seeking to suppress or change something. That's exploring with you."

A government Equality Hub spokeswoman said: "The consultation will seek further views from the public and key stakeholders to ensure that the ban can address the practice while protecting the medical profession; defending freedom of speech; and upholding religious freedom."

Ms Kelly has also called for an "individual cabinet level post" to focus on the equalities brief. Liz Truss holds the role as well as being international trade secretary.

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NEWS

# Sex offending suspect claims transgender harassment in Wi Spa case

By Andy Ngo

September 2, 2021 10:46am Updated




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outlets declaring it an example of bias against the transgendered, or even that it didn't happen. *Slate* said it was a "transphobic hoax."

But on Monday, charges of indecent exposure were discreetly filed against a serial sex offender for the Wi Spa incident, following an investigation by the Los Angeles Police Department.

Sources with knowledge of the case but not authorized to speak publicly say four women and a minor girl came forward to allege that Darren Agee Merager was partially erect in the women's section of Wi Spa. Besides being a suspect in this case, Merager is facing multiple felony charges of indecent exposure over a separate incident in Los Angeles.

Merager, who spoke exclusively to The Post, denies the allegations and says that she is actually the victim of transphobic harassment.




The Wi Spa came under fire in June after letting a person who identified as female walk around with male genitalia.

AP Photo/Damian Dovarganes



Several people filed lawsuits against the LAPD, saying they were targeting people who identify as trans, as well as activists.
Al Seib/Shutterstock

On June 23, several women confronted staff at the Wi Spa in Los Angeles' Koreatown over accusations that a person exposed male genitalia in the women's section. Video of the interaction was posted the following day on Instagram by a woman using the name "Cubana Angel."

"It's okay for a man to go into the women's section, show his penis around the other women, young little girls — underage — in your spa?" she asked the staff. "He's a man! He is a man!" The three-and-a-half-minute video was reposted across social media and promptly went viral.

"Cubana Angel" spoke at a press conference on July 7 in Pasadena next to her attorney. "As I was walking, I noticed something that was really disturbing, something that caused me to feel that I was transported into the men's locker room," the woman said.



Darren Agee Merager is currently facing several felony charges including indecent exposure. Merager has called it “transgender harassment.”



An anti-transgender protester clashes with counter-protesters at the Wi Spa.

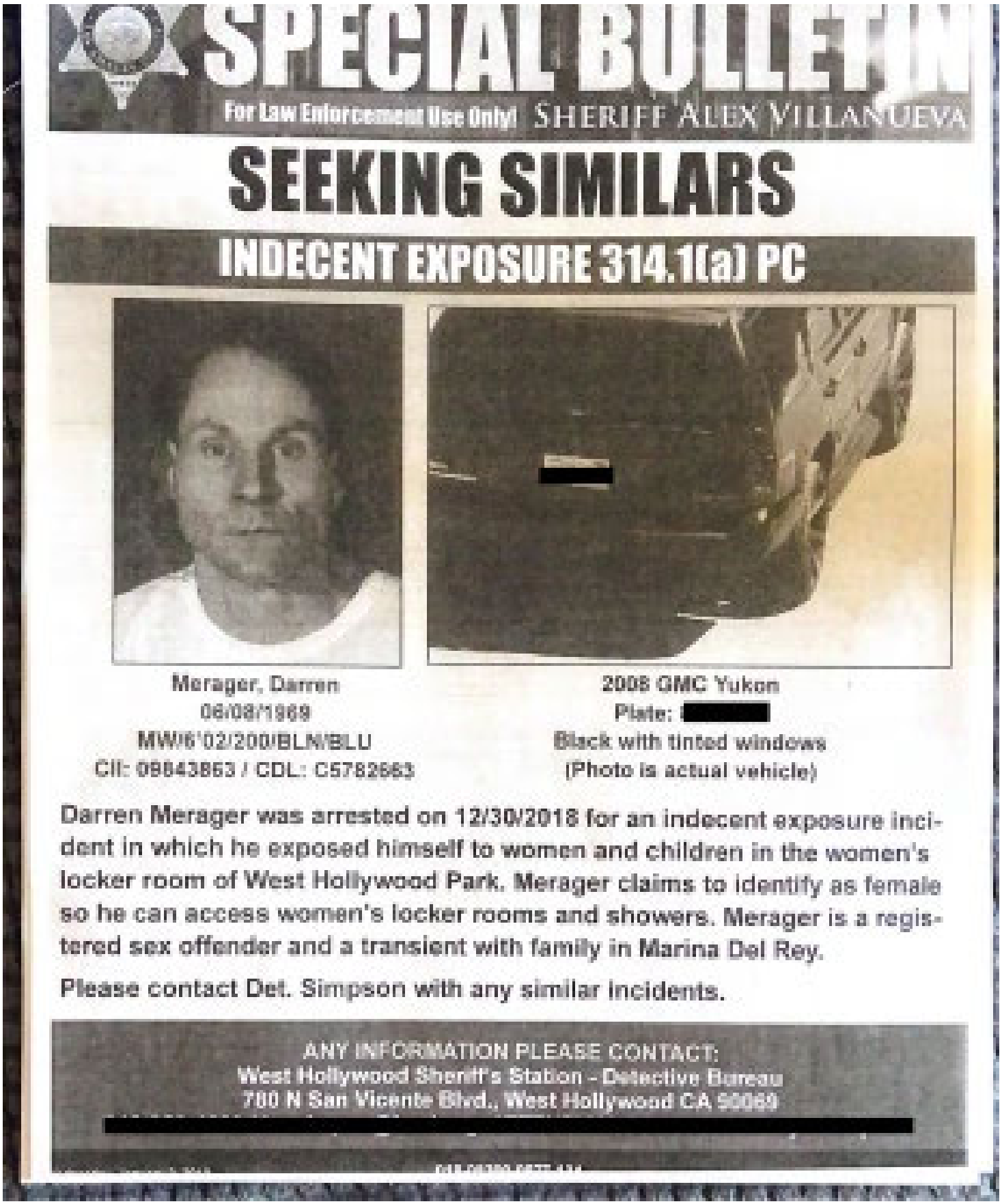
Chelsea Lauren/Shutterstock



She said some women and girls were uncomfortable and began putting their robes back on. She complained to staff, where the video was recorded, but they legally could not do anything because of California law. “We as women have rights to be safe in public spaces and they are being violated by men,” she said.

Both “Cubana Angel” and her attorney, Marc Little, declined to comment for the story.

The video was followed by weeks of sometimes violent face-offs between right-wing and Evangelical Christian protesters at the Wi Spa, and Antifa and far-left counter-protesters. On July 3, after police formed a line to separate the two groups, 40 people were arrested.




Law-enforcement sources revealed that Darren Agee Merager is a tier-one registered sex offender.

The LAPD so far have confirmed few details about the Wi Spa incident. Inquiries sent to the

the Wi Spa incident. As of publication, Merager has not been arrested.

“Everything about the Wi Spa was a bunch of garbage and lies,” Merager said in an interview. She says she is legally female in California and was in a jacuzzi in the women’s section when she was accosted by “Cubana Angel.”

“She never saw me naked. I was underwater with water all the way up to my chest.” Merager denies ever being erect or around children at the spa. She says she is actually the victim of sexual harassment by transphobic women at the Wi Spa.

Law-enforcement sources revealed that Merager is a tier-one registered sex offender with two prior convictions of indecent exposure stemming from incidents in 2002 and 2003 in California. She declined to comment on the convictions. In 2008, she was convicted for failing to register as a sex offender.

A law passed by California Democrats that went into effect this year replaced the state’s lifetime registration requirement to a tiered system. The law allows lower-tiered sex offenders to petition to be removed from the list. However, Merager is not eligible due to ongoing criminal charges. She also has a long criminal history in California that includes nearly a dozen felony convictions for crimes ranging from sex offenses to burglary and escape.



In addition to Merager's new felony charges of indecent exposure, she is also facing six felony counts of indecent exposure over a separate locker room incident in December 2018. Los Angeles County prosecutors accuse Merager of indecent exposure to women and children in a changing area at a swimming pool in West Hollywood Park.

"Merager claims to identify as female so he can access women's locker rooms and showers," reads an internal flyer by the Los Angeles County Sheriff's Department that was sent to law enforcement departments in southern California in late 2018. Merager has pleaded not guilty to all six counts and her next court date for the incident is on Sept. 8. Merager told law enforcement she's transient but bail was set at $150,000 in early 2019, which was paid.

Merager says her open cases involving accusations of indecent exposure show a "pattern of abuse" from a state and society that punishes transgender people. "You allow [trans women] to go in there [women's spaces] and then people simply claim indecent exposure and you're arrested," she says.

Merager says she is speaking with progressive California lawmakers, like state senator Scott Wiener, in the hope that they change state law to better protect trans people.

"If you go into an area where you're expected to be nude, there has to be an indecent exposure exemption," she says. Merager says she may file complaints or lawsuits for the discrimination she says she has been made to suffer by law enforcement and women in the Wi Spa. She says she has been in contact with the Los Angeles County District Attorney's Office since learning of the warrant and plans to turn herself in.

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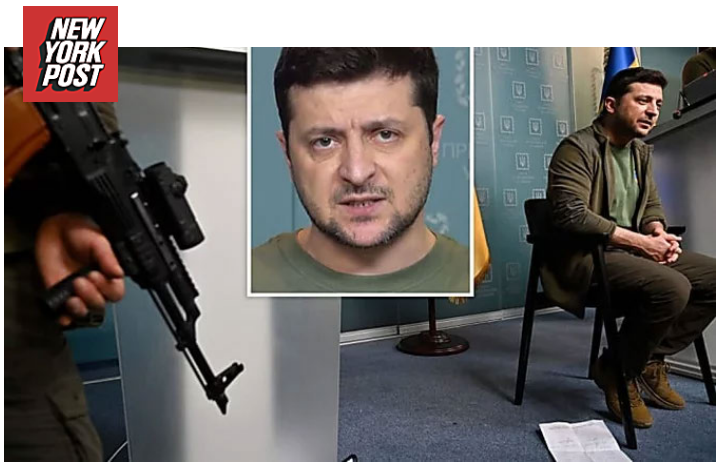


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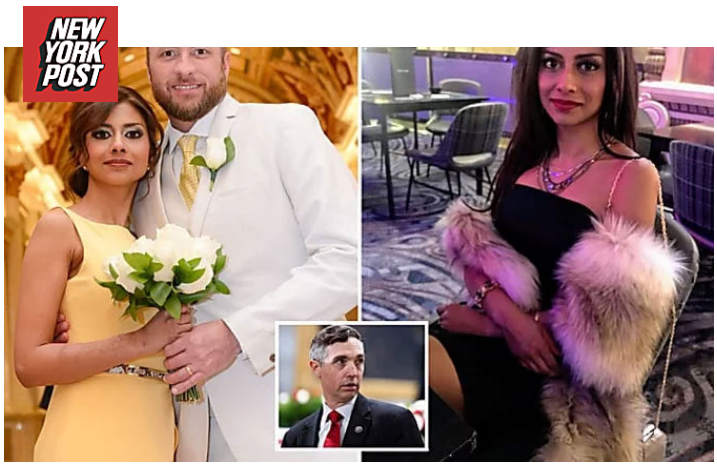








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# Transgender Swimmer in College Athletics

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**Abstract:** There is current scientific and legal controversy about sports competition eligibility regulations for transgender athletes. To better understand and contextualize the effect of androgen-suppression treatment on swimming performance, we compared the gender-related differences in performance of a transgender swimmer who competed in both the male and female NCAA (collegiate) categories to the sex-related differences in performance of world and national class swimmers. These data demonstrate that the gender-related differences in middle distance freestyle performances of a transgender woman are smaller than the observed sex-related differences in performance of top athletes. Our analysis may be useful as a framework for regulators considering participation guidelines which promote fair competition for all athletes, whether cisgender or transgender.

**One-Sentence Summary:** Recent outstanding performances by a transgender woman swimmer are faster than predictions based on historic sex-related differences in swimming performance.

**NOTE: This preprint reports new research that has not been certified by peer review and should not be used to guide clinical practice.**

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## Introduction

The recent outstanding performances by a transgender woman (male-to-female) swimmer have raised controversy about the role of gender affirming hormone treatments on athletic performance and potential "legacy advantages" of testosterone. Substantial evidence demonstrates that testosterone is strongly associated with sex-based differences in sports performance, more so than any other known factor (*1-3*). The pronounced differences between the sexes in endogenous testosterone levels begin at puberty and correspond to sex-specific divergence in skeletal muscle mass, strength and endurance, cardiac output, lung capacity, hematocrit, and, as a result of this divergence, athletic performance (*1*, *2*, *4*). This sex-based dichotomy in testosterone is strong evidence supporting endogenous testosterone as a key biological marker to distinguish competitive cohorts in most sports, excluding those sports that are not determined by maximal skeletal muscle or cardiopulmonary performance (for example, chess or electronic sports).

In this context, measuring testosterone levels is the standard practice in many athletic settings. Under the rules of the National Collegiate Athletic Association (NCAA), which governs intercollegiate competition in the US, transgender women who are treated with gender affirming hormones for at least one year may compete as part of women's sports teams. These rules do not currently distinguish between sports and events, nor do they require that transgender women provide evidence of testosterone levels considered within the normal female range or provide for monitoring for compliance. There is controversy about whether this rule is sufficient to mitigate the so-called legacy effects of hormone— exposure to years of normal male endogenous testosterone concentrations which are, on average, 10 to 20 times greater than normal female testosterone concentrations (*4*). In an effort to determine the extent to which the recent performances by a transgender athlete (with more than 12 consecutive months of gender affirming hormone treatment) might be outliers, we compared the percentage differences in best times of this athlete in the men's and women's categories at several freestyle distances to the male to female best time percentage differences of a sample of world and national class swimmers.

The top male and female freestyle swimming performance times at each of six recognized Olympic distances (50, 100, 200, 400, 800 and 1500 m) were obtained, as were corresponding data from NCAA imperial distances of similar durations. Swimming times from long course (50m pool), short course meters (25m pool), and short course yards (25-yard pool) were downloaded from the USA Swimming Database (https://www.usaswimming.org/times/ncaa/ncaa-division-i) for top 25 NCAA times and from the International Swimming Federation (FINA) Database (https://www.fina.org/swimming/rankings) for top 200 World record times. We then paired the male vs. female times (e.g. $1^{st}$ vs $1^{st}$, $2^{nd}$ vs $2^{nd}$, etc.) within each swimming distance and pool configuration and then calculated a percentage difference for each pair.

After two years of both gender affirming hormone therapy and elite-level swimming training, swimming performance times by a transgender woman were slower by ~5% across all measured swimming event distances (**Figure 1A**). Despite slower performances, the transgender woman swimmer experienced improvements in performance relative to sex-specific NCAA rankings, including producing the best swimming times in the NCAA for two swimming events (**Table 1**).

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As a comparator group, we then compared these data to male-vs-female differences in top swimming performances of all-time in the NCAA and world. As expected, based on known physiological differences between the sexes and historical trends, males had faster performances than females in all swimming event distances ($P$<0.001, **Figure 1B**). These differences between swimming performances of males and females were greatest and ~10-15% for shorter distance events (50 to 200 m) and smaller at ~7-10% for longer distance events (400 to 1500 m). Of note, these trends were observed in data representing both NCAA-record and world-record performances. Comparing the recent case of the transgender woman swimmer to the historical comparator group of top athletes, we note that her recent performances (compared to her performance times as a man) have smaller differences than comparator data. These data show that for middle distance events (100, 200 and 400m or their imperial equivalents) lasting between about one and five minutes, the decrements in performance of the transgender woman swimmer are less than expected on the basis of a comparison of a large cohort of world and national class performances by female and male swimmers as shown in **Figure 1**.

These analyses were limited by a lack of information on key performance-influencing factors before and after androgen suppression for the transgender woman swimmer (for example, training levels and testosterone concentrations). However, it is possible that the relative improvements in this swimmer's rankings in the women's category relative to the men's category are due to legacy effects of testosterone on a number of physiological factors that can influence athletic performance. In this context, our analysis may be useful as a framework for regulators considering participation guidelines for transgender athletes in the female category. It also raises questions about the duration of the performance enhancing effects of endogenous testosterone after transitioning. Of note, these data present a single case and should not be used to infer definitive effects of gender affirming hormone therapy or legacy effects of testosterone— these topics warrant further investigation.

Accommodations should be made in sports to safeguard fairness for all athletes — whether cisgender or transgender — and will likely vary between sports and events at different levels of competition. While striving for fair and inclusive policies for all athletes, both the magnitude and duration of the profound influence of testosterone on sports performance should be recognized with appropriate consideration.

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## References and Notes

1. D. J. Handelsman, A. L. Hirschberg, S. Bermon, Circulating Testosterone as the Hormonal Basis of Sex Differences in Athletic Performance. *Endocr Rev* **39**, 803-829 (2018).
2. J. W. Senefeld *et al.*, Sex differences in youth elite swimming. *PLoS One* **14**, e0225724 (2019).
3. E. J. Howden *et al.*, Females have a blunted cardiovascular response to one year of intensive supervised endurance training. *J Appl Physiol (1985)* **119**, 37-46 (2015).
4. J. W. Senefeld *et al.*, Divergence in Timing and Magnitude of Testosterone Levels Between Male and Female Youths. *JAMA* **324**, 99-101 (2020).

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**Author contributions:**

Conceptualization: JWS, SKH, DLC, MJJ

Data Curation: JWS

Formal Analysis: JWS

Methodology: JWS, SKH, DLC, MJJ

Visualization: JWS, SKH, DLC, MJJ

Writing – original draft: JWS, SKH, DLC, MJJ

Writing – review & editing: JWS, SKH, DLC, MJJ

**Competing interests:** Authors declare that they have no competing interests.

**Data and materials availability:** All individual data is available in the online databases listed in the text and group data is available in the main text.

## Supplementary Materials

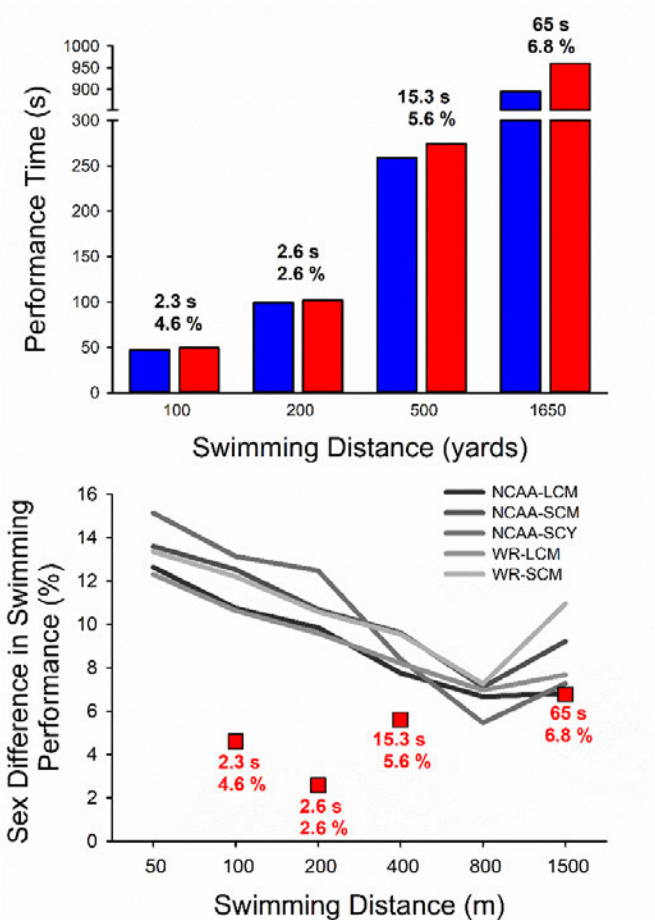
Materials and Methods

Sex differences in swimming performance time were calculated for each event distance as: [(male's performance time) – (female's performance time)] × (female's performance time)$^{-1}$ × 100%. All procedures accessed public information and did not require ethical review as determined by the Mayo Clinic Institutional Review Board in accordance with the Code of Federal Regulations, 45 CFR 46.102, and the *Declaration of Helsinki*.

Statistical Analysis. Data were reported as means ± SD within the text. Separate mixed-model univariate analyses of variance (ANOVAs) were used to compare the dependent variables (swimming velocity and relative performance (%1$^{st}$ place) of boys and girls, and sex differences in swimming velocity) between three independent variables [age (5-18 years), US ranking (1$^{st}$-100$^{th}$) and event distance (50 m – 1500 m)]. For all other analyses, significance was determined at $p < 0.05$. All analyses were performed with IBM Statistical Package for Social Sciences version 28 statistical package (IBM, Armonk, NY, USA).

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**Fig. 1. Differences in freestyle swimming performances between men's and women's categories for both a transgender woman (male-to-female) swimmer and top swimming performances of all-time in the NCAA and world. (A)** Bar graph displaying the season's best performance time of a transgender woman swimmer, including best times from the 2018-2019 NCAA season in the men's category (blue bars) and from the 2021-2022 NCAA season in the women's category (red bars). The differences in both performance time and relative performance (%) between the men's and women's NCAA categories are delineated in text above each set of comparable bars. **(B)** The grey-scale line charts represent male-vs-female differences in top swimming performances of all-time in the NCAA and world. The differences in performance time of transgender woman swimmer are represented as red squares on metric distances corresponding to imperial NCAA distances. NCAA, National Collegiate Athletic Association; LCM, long course meters; SCM, short course meters; SCY, short course yards; WR, world record.



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**Table 1. Personal best freestyle swimming performances by a transgender woman (male-to-female transition) in NCAA college athletics in both men's and women's competition categories.** Personal best performances represent performances from the 2018-2019 NCAA competition season in the men's category and from the 2021-2022 NCAA competition season in the women's category. Unranked indicates that the performance was not within the best ~600 performances of the season. NCAA, National Collegiate Athletic Association.

| | Swimming Event Distance (yards) | | | |
|---|---|---|---|---|
| | **100** | **200** | **500** | **1650** |
| ***Men's Category*** | | | | |
| Performance Time (s) | 47.15 | 99.31 | 258.72 | 894.76 |
| '18-'19 NCAA Ranking (No.) | Unranked | 551st | 65th | 32nd |
| ***Women's Category*** | | | | |
| Performance Time (s) | 49.42 | 101.93 | 274.06 | 959.71 |
| '18-'19 NCAA Ranking (No.)[B] | 132nd | 4th | 4th | 19th |
| '21-'22 NCAA Ranking (No.) | 94th | 1st | 1st | 6th |
| ***Categorical Differences***[A] | | | | |
| Performance Time (s) | -2.3 | -2.6 | -15.3 | -65.0 |
| Performance Time (%) | -4.6% | -2.6% | -5.6% | -6.8% |
| '18'-19 NCAA Ranking (No.)[C] | -- | +547 | +61 | +13 |

[A]These rankings were interpolated based on season's best performance times in the 2021-2022 NCAA season.

[B]The categorical differences represents the differences in performance of the transgender woman between men's and women's competition categories. See Materials and Methods for further details.

[C]These data were calculated using 2018-2019 NCAA rankings in the men's category and interpolated women's rankings in the 2018-2019 NCAA season. The positive differences indicate that the transgender woman swimmer experienced improvements in performance relative to sex-specific NCAA rankings.




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**Alex Drummond**
@grrlalex

Such a pleasure to visit this fab school and meet you all :-)

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**LGBTQ**

Posted on Jul 16, 2015

# This Trans Woman Kept Her Beard And Couldn't Be Happier

"I'm widening the bandwidth of how to be a woman." Alex Drummond talks to BuzzFeed News about why she kept her beard after transitioning – and how others react.



by **Patrick Strudwick**
BuzzFeed LGBT Editor, UK

100 comments

**This is Alex Drummond. She's a 51-year-old psychotherapist and photographer from Cardiff.**



*Alex Drummond*

**Six years ago, Drummond started living as a woman and kept her awesome bushy beard. She also decided not to opt for hormones or surgery.**




*YouTube*

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**In this short video she discusses some of her reasons for not conforming to traditional ideas about gender. "I'm widening the bandwidth of how to be a woman," she says.**

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*youtube.com / Via My Genderation / Fox Fisher / Lewis Hancox*

**Drummond told BuzzFeed News about how she came to transition, the bullying she suffered as a child, and what happens when she walks down the street.**

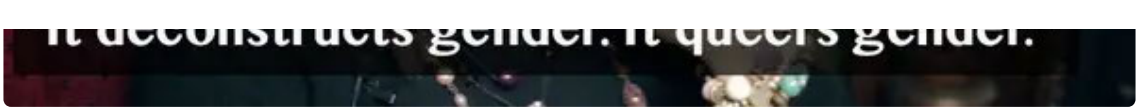
**Many trans women seek to feminise their appearance, but you've chosen a beard – why?**

**Alex Drummond:** I was aware that I was unlikely ever to pass as natal female, so what I wanted to do is to see if it was possible to create another space. I did it in a very radical way; I was testing new ground. I knew that simply shaving my beard and putting breasts on wasn't going to make me pass, and I used to work for an architect and he used to say, "When you're designing something you either make it very deliberately level or very deliberately off." So that was the philosophy.

What I want to do is to widen the bandwidth of gender, to make it more possible for more people to come out as a transgender, to live authentic lives. If all you ever see is trans women who completely pass and are completely convincing as natal females, then those of us who just don't have that kind of luck won't have the confidence to come out.

For the people who don't pass I can say "don't be afraid" because what I've discovered is you don't need to pass, what you need is to act authentically. And if a child sees me and thinks, "Bloody hell, so it's not as simple as pink or blue or football or ballet – there must be 101 possibilities in between," then maybe I can serve the greater good.






*YouTube*

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**What sort of reactions do you get?**

**AD:** It's actually very positive. For all the stories of trans women having a miserable time and being picked on, there are plenty of us having perfectly good lives. I get very little hassle, if any, and I get a lot of positive reactions. I think that's to do with inner confidence and positivity – if you feel anxious about your appearance in the sense of "someone might spot I'm a natal male" then that anxiety comes out. If you feel grounded and comfortable in your own skin you don't bring that anxiety across. I walk with confidence because I've accepted myself and I can radiate that out.

**What do people say to you on the street?**

**AD:** Most people treat me entirely normally: It just works. I've had women come up to me and say, "I love your look." The thing of walking down the street and somebody looking twice and going, "Is that a man or a woman?", is people can see I'm presenting as female and can see the beard, so seemingly I'm doing something with gender. It's made people stop and think. An American couple stopped me the other day, and said, "What's the outfit?" And I explained it to them and they were really cool with it. But they could see there's something to question.





*YouTube*

**Do you have a dual relationship with gender or is it more complex?**

**AD:** It's more complex because if I was 19 today growing up in a family with supportive parents I would probably transition more conventionally, because at that age I could have passed more easily and it might have been safer for my body to take the impact of surgery and hormones.

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**Why did you decide against taking hormones or having surgery?**

**AD:** It would be an unhelpful risk for me. For some people it's riskier than others. What I wanted to see is if it's possible to transition without having to do that. That's an important thing that came from the 2010 Equality Act – prior to that you needed this medicalised route to gain a transgender identity, but since 2010 you don't need to subject your body to medical science to have [one's gender] converted.

*Ragnar Singsaas / Getty Images*

Conchita Wurst at the Eurovision Song Contest, 2014

**When Conchita Wurst won Eurovision, she really jolted people with her appearance. She's not trans, but how did you feel when that was happening?**

**AD:** The bitch stole my look! [*laughs*] That day when she appeared on the Eurovision Song Contest my Facebook feed went mental! It was so funny. I would love to meet Conchita because she's questioning gender. And even the name Wurst: Everyone at first thought it was a dick joke about sausage. But the truth of it was that "wurst" was a reference to the Austrian expression "I don't give a sausage" – "I don't give a damn." It is a much more intelligent thing than a drag queen going, "I'm a girl with a dick." But it really did question the idea of what male or female might be and because a lot of people related very well to Conchita after that I did get a few people asking me if I was her.

**But the very notion that beards are a male thing is bullshit, because lots of women have facial hair to varying degrees...**

**AD:** Indeed. That American couple, when I said I identify as a trans woman, they said, "Well, why have you got a beard?" I said, "Well there ain't no law against a woman having a beard."

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**And a lot of women go to great lengths to remove their facial hair. But you're not conforming to that...**

**AD:** No, and yet paradoxically, I have had the hair on my arms removed because I don't like having hairy arms because that doesn't feel feminine, so go figure [*laughs*]!



*Alex Drummond*

**You mention in the video that you grew your beard in your thirties to butch up – what was happening for you at that time?**

**AD:** I'd been wrestling with mixed feelings about identifying as female but that not being an option and so was trying to fit in and be masculine. I'd

worked as a builder and had an uber masculine identity. Ever since my twenties I'd had long hair and it was a really important part of my identity and then it started thinning so I cut my hair off and it was just the most awful thing. So I thought, "Right, well, I'll be uber masculine and have this beard and shaved head and I'll butch up."

**Where did that desire to seek out a hyper masculine identity come from?**

**AD:** Growing up in the seventies I got bullied a lot for being perceived as gay. I identify as lesbian as I'm female and attracted to women so it was my gender non-conformity that was being read as gay. So I thought if I don't look feminine I won't be read as gay therefore people won't pick on me.

**How bad was the bullying?**

**AD:** I was bullied and attacked every day and it was just awful. I say school is one of the most dangerous places you can send a child because there's absolutely no protection. The chronic fear I think is the most traumatising bit. When I got beaten up it was over and done with, but when you go in day after day after day and the same gang are taunting you and threatening you, that's harder to deal with because that doesn't go away. In secondary school this one boy picked on me at the wrong moment and I threw him over my shoulder and he was flat out, and that brought me some peace. But it soon resumed.

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**What's the connection between saying "enough is enough" in that moment and who you are today?**

**AD:** People say to trans people, "Aren't you brave for coming out!" And I say, "No, I'll tell you what's brave, it's the kid who went to school and had to face that fear and terror, day in, day out." I was a very disempowered kid who was trying to not get spotted or visibly outed and became a young adult who also tried to not be visibly outed, but I reached a point where I thought, "Actually, I don't need to be vulnerable to you people, because I'm going to fight back."

**What was the turning point where you went from being this hyper-masculine person to being yourself?**

**AD:** Well, it was my master's degree. I had been dressing up in secret because of all the shame I had, I believed it was some kind of perversion. I identified as female but didn't have a framework, a language or an understanding of it. I was really struggling with internalised shame. But the more I read, the more I realised it wasn't a pathology, it was a natural phenomenon, and I suddenly got introduced to this term "transgender" and had a healthy way of understanding how I felt.

**You identify as lesbian – how do other women react to you?**

**AD:** I've been in a long-term committed relationship for a long time now so I'm spoken for, but certainly I draw out the inner lesbian in women! I get a lot of positive reactions and I'm not to everyone's taste but I get some really nice affirmations. I never got complimented when I was living as male and trying to pass as male and yet as a woman I regularly get complimented on how I look. Actually, that's really sweet.

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6 years ago

Has a beard. Doesn't take female hormones. Sleeps with women. This person, in all aspects besides attire, is a man. Period.

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6 years ago

Why not just be a feminine, gender non-conforming straight man? There's nothing wrong with that. Is it just not cool enough for the label-obsessed tumblr crowd these days? That's what he actually is outside of his imagination, and it would be a lot braver and binary-smashing than... Read more

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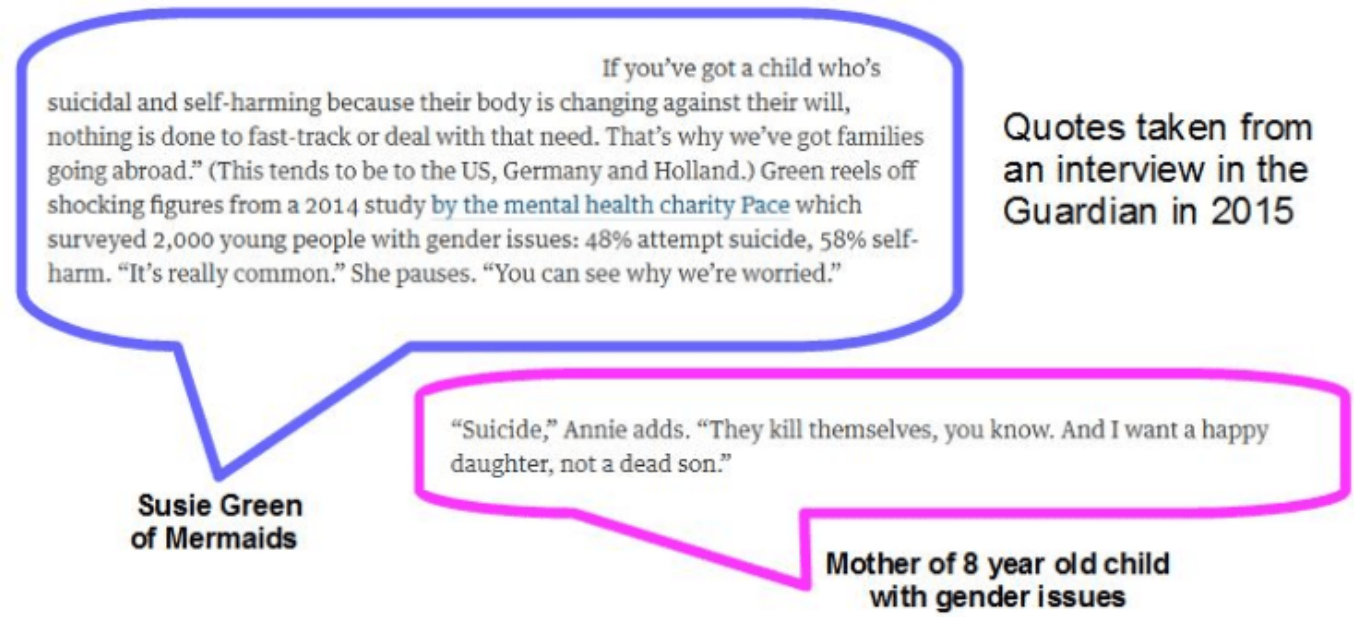
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(https://fairplayforwomen.com/)

# Trans suicide facts and myths

16th November 2018 by FPFW (https://fairplayforwomen.com/author/nlw/)




Every parent faced with a child claiming they think they are transgender will have heard the terrifying statistics about high suicide rates when transgender children are not supported in their preferred gender identity. It is frequently mentioned in news reports covering transgender issues and is often a strong emotional motivator for parents to support their child's wish to transition. It is suggested that 'affirmation' and social and medical transition is the only answer to help children with gender dysphoria.

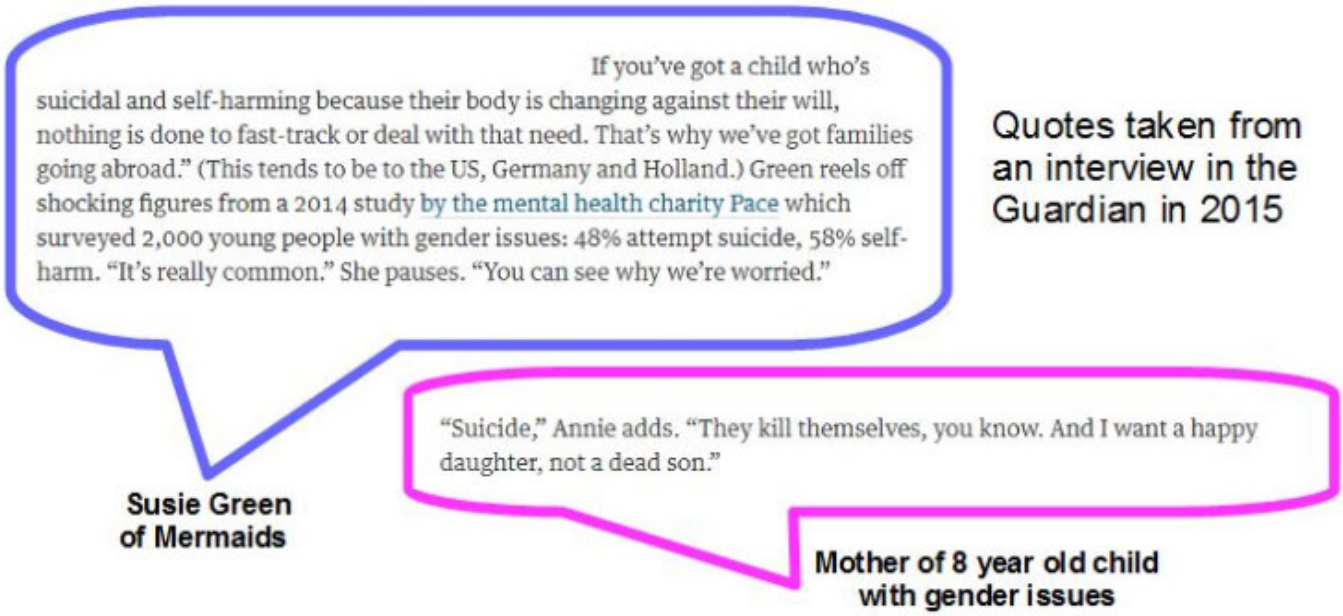
**However, is this really true? Is there strong evidence to support this widely held view? We strongly believe that the answer is no.**

Although there is no doubt that children and young people suffering gender dysphoria are an extremely vulnerable group deserving of our support and care, the oft-quoted suicide statistics are from surveys which are not robust and there is no evidence that transition is a

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‘cure.’

Any risk of suicide is terrifying for parents, every suicide is an awful tragedy and for this reason we feel that exaggerating the risk and constantly using the threat of suicide is extremely unhelpful and irresponsible. We have attempted to sort out the actual facts of this emotive subject, and we present our findings here.




There have been two studies conducted in the UK. We have analysed both in detail as well as contacting the academic groups who carried out the studies. We believe there are fundamental weaknesses in both studies which seriously undermines the claim that suicide is a major risk. We present our findings below.

## STUDY 1:

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The RaRE study (https://www.transgendertrend.com/wp-content/uploads/2017/10/RARE_Research_Report_PACE_2015.pdf) was a lottery-funded project set-up by the LGBT charity PACE. The lead academic was Dr Nuno Nodin from the Royal Holloway University of London (RHUL). A number of different aspects relevant to the LGBT community was investigated. One part of this included asking transgender people about their history of suicidal thoughts and attempts.

The study was conducted by questionnaire using a non-probability sampling method. This means that the questionnaire was promoted within the LGBT community and people chose whether or not to fill it in. In total 2078 questionnaires were analysed, however only 120 of these were transgender people, and only 27 of these were under the age of 26 years old. It is only the results from the 27 young trans people that was reported in relation to suicide. Of these 27 young trans people 13 of them reported having attempted suicide at some point in the past. This is where the 48% of all trans youth attempt suicide stat comes from.

We have a number of problems with this study:

1. We don't believe that the suicide history of just 27 self-selected trans people is sufficiently large for parents to make life-changing decisions for their children.
2. Participants were not randomly selected. This will mean that trans people who have experienced the most difficulties in life may be more likely to fill in the form. This risks artificially increasing the % of participants with a suicide history.
3. We don't know when these suicide attempts occurred. Some or all may have occurred after social and/or medical transition and so may not reflect the true suicide risk if trans children are not supported to transition.
4. We also are not told if these 13 young trans people consider themselves gay or straight. Other data from the study shows that people who identify as lesbian, gay or


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bisexual are almost twice as likely to have attempted suicide that those who identify as straight (34% compared to 18%). This data is more robust than the trans data because it includes 289 LGB and 196 straight people. As LGB is clearly a risk factor for attempting suicide then surely we need to know if the trans people were gay or straight. If the majority of the trans people with a suicide history were gay whereas the majority of trans people with no suicide history were straight then this may have skewed the data making it look like a trans-related increase in suicide when actually it more accurately reflects the fact they were gay.

There is also disturbing evidence (https://www.transgendertrend.com/a-scientist-reviews-transgender-suicide-stats/) that the transgender charity Mermaids has misrepresented the study to make it appear stronger than it really is. This occurred during a presentation at a conference in front of an audience of lawyers, press, NHS representatives and government officials.

> *We contacted the lead academic who conducted the research and asked him these questions. He agreed with the limitations of the study that we pointed out. We then asked whether he was aware that his data had been misrepresented by others and presented without making these limitation clear. He agreed it was unfortunate when* ***"research is used by non-scientists in the context of their own agendas"*** *and that he would "continue to clarify the nature and breadth of the RaRE study findings."*


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**From:** [redacted]
**Sent:** 22 February 2017 10:58
**To:** Nuno.Nodin@rhul.ac.uk
**Subject:** PACE RaRe study: Transgender questions

Dear Dr Nudin,
I have recently read the RaRe research study that you conducted and am very interested in the results regarding the rate of suicides for transgender people. This study is hugely influentially in the debate to enhance transgender rights and protections and I have a few technical questions that I hope you could help answer for me to help me in my discussions with others about transgender issues.

1) 2078 people were asked to complete a survey looking into LGBT issues in which a number of questions about suicide were asked. However when looking specifically at the responses by people that identify as transgender, the publication only shows the data from a subset of people that were 26 years old or under. This 'young' subset included 485 people of which only 27 were transgender. It is sometimes criticised that 27 is a very small number of people from which to draw big conclusions. What were the results from the whole group (i.e. all 2078)? This larger subset includes the experiences of 120 transgender people and would be a very useful figure to know and may be more persuasive in my arguments.

2) In the 26 year old and under data set there were 13 trans people who report having attempted suicide in the past. However, you do not report when their past suicide occurred. Was it before they transitioned or after they transitioned?

3) You also do not report whether these 13 young trans people consider themselves gay or straight. Other data from the study shows that people who identify as lesbian, gay or bisexual are almost twice as likely to have attempted suicide that those who identify as straight (34% compared to 18%). This data is very convincing because it includes 289 LGB and 196 straight people. Seeing as LGB is clearly a risk factor for attempting suicide then it would be relevant to know if the trans people were gay or straight. If the majority of them were gay whereas the majority of the cis-gender comparators were straight then this may have skewed the data making it look like a trans-related increase in suicide when actually it just reflects the fact they were gay. Where you able to control for this potential bias?

Any answers you can give to my questions will be very much appreciated. The rights of transgender people are important and as a member of the LGBT community myself I am very interested in data like this.

Best wishes,
Dr Nicola Williams

**From:** Nodin, Nuno [redacted]
**Sent:** 29 March 2017 14:21
**To:** [redacted]
**Subject:** RE: PACE RaRe study: Transgender questions

Dear Nicola

My most sincere apologies for my very delayed reply to your email. Things are finally quieting down a bit for me with the term coming to an end this week, so I've made a priority of replying to you now.

1) We only reported data for the young people's suicide indicators as this was the age group that was defined by the projects specifications. However, you are right in that we collected the same data for all of our sample, including for the 120 all ages trans-identified participants. I remember we ran descriptive and there were similarly high numbers of attempted suicides amongst this larger subset. Unfortunately I haven't been able to find these reports in my old files but I will continue to look and I will share them with you once I find them.

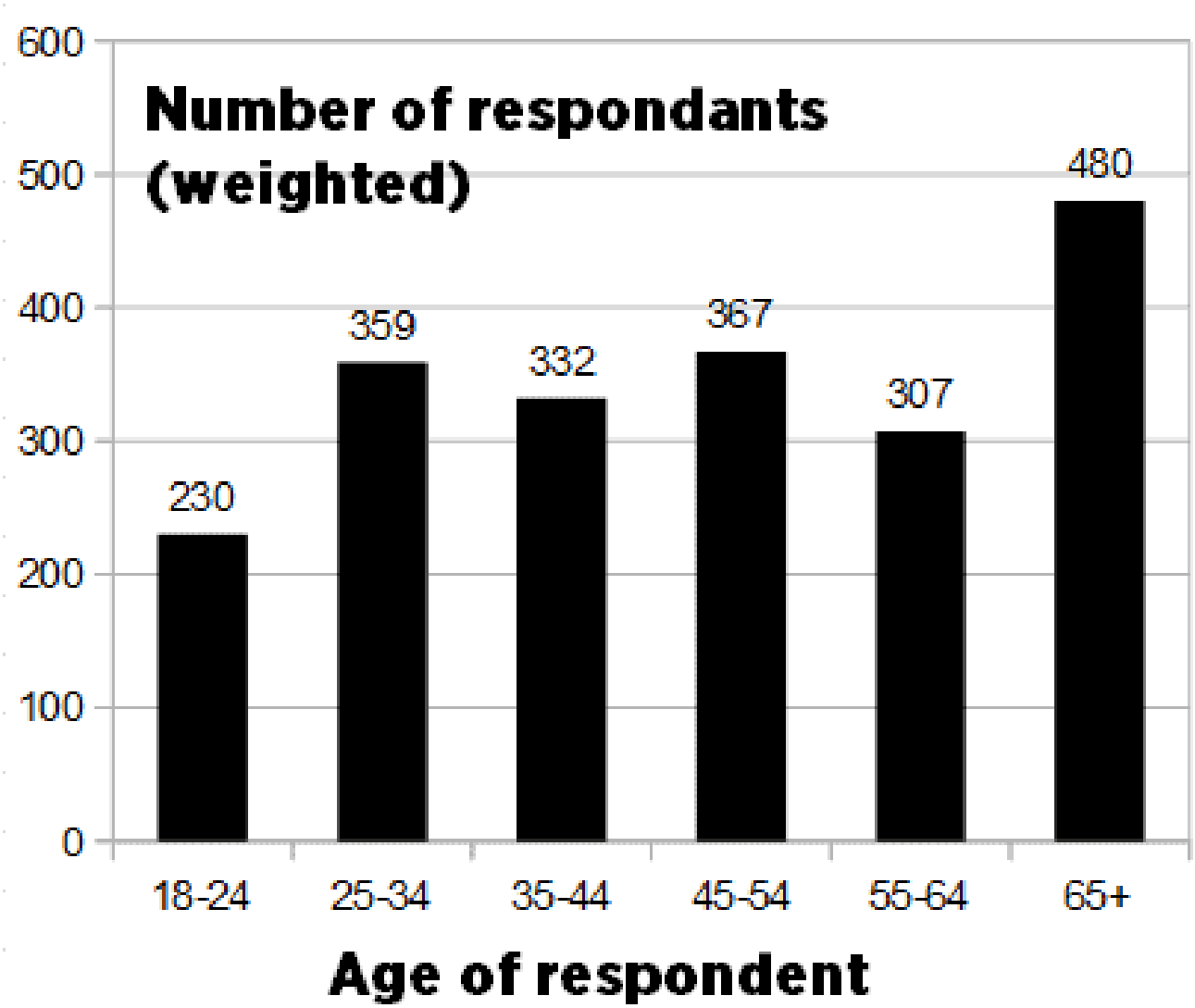
2) I'm afraid we did not collect data about transition (trans identity was self-declared, therefore some participants may identify as trans without having an intention of undergoing a transition)

3) I agree with you that sexual orientation is a possible confounder in respect of the suicide attempt indicators for the trans identified participants. We were unable at the time of preparing the report (due to various pressures of time and capacity) to go into deeper levels of analysis of our data that would allow us, among other things, to control for sexual orientation when studying the findings for the trans identified participants. Some challenges, chiefly the closure of PACE early last year, meant that some of that work (which was planned) had to be put on hold and is now slowly starting to be done.

Again my apologies for the delay in the reply. Do let me know if you have any other questions that I may be able to reply about the RaRE Research.

Best wishes
Nuno Nodin


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**From:** Nodin, Nuno [redacted]
**Sent:** 12 June 2017 10:37
**To:** [redacted]
**Subject:** Re: PACE RaRe study: Transgender questions

Dear Nicola

Apologies for the delayed reply.

It is indeed unfortunate that the findings from the RaRE study have been misinterpreted, even when this is something that happens often when research is used by non-scientists in the context of their own agendas. I have always tried to clarify the nature and breadth of the RaRE findings whenever this has come to my attention and will of course continue to do so.

Best wishes
Nuno

## STUDY 2:


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In 2016 Stonewall commissioned the Centre for Family Research at the University of Cambridge to conduct a survey with young people who are lesbian, gay, bi or trans (LGBT), or who think they might be, on their experiences in secondary schools and colleges across Britain. Between November 2016 and February 2017, 3,713 LGBT young people aged 11-19 completed an online questionnaire. Many aspects of LGBT life were asked about in this study (https://www.transgendertrend.com/wp-content/uploads/2017/10/the_school_report_2017.pdf) . We have summarised the results relating to self-harm and suicide in the table below (*Figure 1*)

Once again the study was conducted by questionnaire using a non-probability sampling method. This means that the questionnaire was promoted to LGBT students in secondary schools and children chose whether or not to fill it in. In total 3717 questionnaires were analysed and of these 594 were from young people who self-identified as transgender. This is significantly higher than the 27 trans respondents in the earlier PACE study. The reported data shows that transgender young people experience high levels of self-harm (84%), suicidal thoughts (92%) and suicide attempts (45%). However, very high albeit slightly lower levels are seen for the non-trans young people.

*Figure 1:*

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Summary of self-harm & suicide data from Stonewall School report 2017

| | % of n = 3717 LGBT respondents | Self-harmed | Suicide ideation | Suicide attempt |
|---|---|---|---|---|
| Trans^ | 16% n = 594 | 84% | 92% | 45% |
| Not trans^ | 84% n = 3119 | 61% | 70% | 22% |
| Non-Binary" | 13% n= 482 | 84% | 89% | 35% |
| Female* | 54% n = 2000 | 71% | 73% | 25% |
| Male* | 34% n = 1262 | 51% | 71% | 24% |
| Lesbian/Gay | 38% n = 1411 | 59% | 71% | NT |
| Bisexual | 37% n = 1374 | 67% | 74% | NT |
| Queer | 17% n = 631 | 79% | 86% | NT |
| LGBT Bullied | 45 % n = 1671 | 75% | 84% | 37% |
| LGBT Not bullied | 55 % n = 2042 | 58% | 67% | 17% |
| General pop | - | 10% NHS data | 25% Data from Young Minds | 13% (F) 5% (M) 16-24yrs NHS data |

** Self declared gender identity – this may or may not be same as natal sex*
*^ Trans students may be also be LGBQ or straight. 'Not Trans' will all be LGBQ*
*" Currently unknown whether Non-binary are also considered trans*

Despite the high number of respondents we have a number of major problems with this study. We asked the lead researcher for a methodology report but none was available. In the absence of such a report we followed up with a serious of detailed technical questions (see *Figure 2*). However, **despite repeated requests no answers were forthcoming**. There has also been no publication based on this study in any peer reviewed journal so it is impossible to verify the validity of the results. For these reasons we have serious doubts over the robustness of this study and do not believe the data is sufficiently reliable.

The issues with the study include:

1. The questionnaire used non-probability based sampling methodology and so has all the same limitations as described above for the PACE study.
2. All the data presented are based on self-declared gender identity and not natal sex. This is important since suicide attempts are known to be more common for natal girls compared to natal boys in the general population. Recent GIDS referral data shows that trans-identification is more common in natal girls than in natal boys. These underlying trends will bias the final outcomes. (We have done further work to uncover natal sex of the trans children in this study

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(https://www.transgendertrend.com/stonewall-school-report-what-does-suicide-rate-mean/).)

3. It is unknown what % of the trans respondents also identified as LGB. Was this based on being attracted to people opposite to their natal sex or opposite to their transgender identity?
4. There is also no definition of transgender and it is unclear whether non-binary is included under trans. 13% of respondents reported as non-binary and 16% reported as trans. It is unclear what percentage of trans students were also non-binary.
5. Obvious confounding factors that affect self harm/suicide such as mental health issues were not controlled for in the study.

Figure 2:

**Sent:** 05 July 2017 07:21
**To:** Vj227@cam.ac.uk
**Subject:** Re: Stonewall School Report 2017

Dear Dr Vasanti Jadva

Thank you very much for your swift reply. In the absence of a technical report describing the methodology and results in more detail can I ask you few questions please to help me further understand the research conclusions?

1) You have told me that a non-probability sampling method was used. Were all respondents included in the final data set. Where any measures taken to ensure the sampling was representative of the LGBT population in schools? How did you get parental permission for the under-16s? What quality control procedures were in place? What proportion of the questionnaires were back-checked? Was this study design approved by an ethic committee and was the study outcome peer reviewed in any way. Will there be a peer reviewed journal publication to follow. How did you validate that the responses genuinely were from children; how did you eliminate fake respondents?

2) How were the questions worded regarding self harm, suicide ideation and suicide attempts. Could you send me a copy of the questionnaire for reference? Its well known that respondents can easily misunderstand questions in this area and inflation of the numbers of suicide attempts can occur if definitions are not clear.

3) You have presented data on the distribution of self-declared gender identity but not natal sex. Was this different to the question asked in 2012? What was the natal female : natal male ratio for the respondents? What was the % of report of self harm, suicide ideation and suicide attempts for natal male & natal females in your study. As you quote in your report NHS data shows that suicide attempts are more common for natal girls (13%) compared to natal boys (5%) in the general population ages 16-24. Is a similar pattern seen in your study.

4) What was the age distribution of respondents? You have reported that 30% attended six form college and 11% attended FE college so from this I can presume at least 41% were aged 16-18. What percentage of respondent were 11-13 and 14-16 and how did 19 year olds appear in the study when they are post school age? Was any form of quota sampling used to ensure the age ranges accurately reflected the school population?

5) What was the % of respondents reporting suicide attempts for each of the different sexual orientations. This data was missing from the report but was included for suicide ideation and self-harm. Was there any reason that this result was omitted from the final report?

6) You quoted 16% of respondents reported identifying as trans. How did this vary across ages and natal sex. Recent GIDS referral data shows that trans identification is more common in natal girl than in natal boys. Did your study data also reflect this trend. In 2012 the study was not promoted to transgender children and only 2% identified as such. Can you comment on this dramatic increase in trans identification since 2012 and whether this reflect societal change or is a manifestation of the self-selecting study design.

7) Were the respondents identifying as non-binary included in the trans category? 13% of respondents reported as non-binary and 16% reported as trans. What percentage of trans student were also NB. What definitions were used in the survey to guide respondents how to answer the identification section and could a respondent identify as both non-binary and trans?

8) You report that 84% of LGBT students who are bullied have had suicidal thoughts. However, the % of LGBT students who were never bullied and also have suicidal thought is also extremely high (67%). So for the vast majority of these cases bullying is not the main driver for suicidal ideation. I'd be very interested to hear your thoughts on this aspect of the data. Do you think this may reflect a high incidence of mental health issues in the LGBT student community. Did you ask about and/or control for mental health issues such as depression and anxiety etc.

9) What % of the trans respondents also identified as LGB. Was this based on being attracted to people opposite to their natal sex or opposite to their transgender identity?

10) What in your view are the limitations of the study and do you have plans to follow up any of this work. Are there any caveats to be highlighted when these results are communicated to professionals or the general pubic? Can these results be used in generalisations pertaining to the entire UK school population?

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> ***CONCLUSION: There are fundamental methodology issues with both UK studies that report that almost half of transgender young people attempt suicide. This data is poor quality and should not be relied upon by parents when considering how best to support their children. The misuse of suicide figures is ethically questionable.***

Our findings were confirmed by the UK Independent Factchecking charity Fullfact, after trans activist Paris Lees made this claim on the BBC 2 Question Time programme in March 2018:

> *"45% of young trans people in this country, modern Britain, have attempted suicide. Not thought about, attempted."*

Fullfact found (https://fullfact.org/health/young-trans-people/):

> *"We can't say how representative this is of the young trans community in Britain as a whole – the overall sample was not adjusted to try and be representative."*

The Tavistock and Portman GIDS clinic states that amongst children referred to the clinic "**suicide is extremely rare**" (taken from the Tavistock evidence base (http://gids.nhs.uk/evidence-base)).

At a conference in Bristol in October 2017, Dr Polly Carmichael, Director and Consultant Clinical Psychologist at the Tavistock clini, stated that the PACE survey is "deeply flawed" and that rates of self-harm, distress and suicidal ideation are similar to CAMHS figures overall. Dr Carmichael's full talk is available on this page (https://www.acamh.org/event/gender/) and we summed it up in this thread (https://threadreaderapp.com/thread/972480762208489473.html).

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Dr Carmichael expressed concerns about the use of suicide statistics in the discourse around gender dysphoric young people which is so negative, and suggests a lack of agency and resilience.

This is our position. Every suicide is a terrible tragedy and we must be extremely careful in any message we send to young people on this subject. The Samaritans guidance (https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide/suicide-reporting-10-things-remember) states that we should avoid speculation about any one 'trigger' for suicide and that we need to exercise caution in repeating suicide statistics. We would like to see this advice followed more carefully in the case of young people struggling with gender identity issues.

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## Prisons, crime and protecting women

The facts about transgender prisoners (https://fairplayforwomen.com/transgender-prisoners/)
Karen White & prison review (https://fairplayforwomen.com/prison-review/)
Sex attacks in female prisons (https://fairplayforwomen.com/sex-attacks-mps-must-investigate-risks-of-transgender-prisoners/)
Female inmate suing the government (https://fairplayforwomen.com/why-female-inmate-suing-government-transgender-prisoners/)
Refuge shelters deeply worried (https://fairplayforwomen.com/rebirth/)
How do women in prison feel about sharing with transgender prisoners? (https://fairplayforwomen.com/insidetime/)
Can you believe what you read about sexual and violent crimes? (https://fairplayforwomen.com/ipso/)
Factsheets (https://fairplayforwomen.com/factsheets/)

## Sport and the human body

Biological sex differences (https://fairplayforwomen.com/biological-sex-differences/)
Chromosomes, sex and gender (https://fairplayforwomen.com/chromosomes-biological-sex-gender/)

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Guidelines for single-sex sport policy (https://fairplayforwomen.com/sport_policy/)

A scientist reviews the IOC's transgender inclusion policy (https://fairplayforwomen.com/emma_hilton/)

The science and statistics behind the transgender debate (https://fairplayforwomen.com/science-statistics-behind-transgender-debate/)

Safeguarding in sport still matters (https://fairplayforwomen.com/safeguarding_sport/)

Testosterone reduction policies (https://fairplayforwomen.com/compliance/)

Rachel McKinnon transwoman cyclist (https://fairplayforwomen.com/mckinnon/)

You can help (https://fairplayforwomen.com/donate/)

## Making policy and the law

The Equality Act 2010 and women's rights (https://fairplayforwomen.com/equality-act-2010_womens-rights/)

GRA reform (https://fairplayforwomen.com/campaigns/gra-reform/)

Advice and guidance for policy makers (https://fairplayforwomen.com/policy-guidance/)

Equality impact analysis advice (https://fairplayforwomen.com/mbm/)

Public Sector Equality Duty (https://fairplayforwomen.com/equality-act-2010_womens-rights/#jump2)

Changing room policy advice (https://fairplayforwomen.com/changing_rooms/)

Scottish Government omits women's evidence (https://fairplayforwomen.com/eqia/)

The Scottish bill that stole the word woman (https://fairplayforwomen.com/scottish_stole_woman/)

What can I do now? (https://fairplayforwomen.com/equality-act-2010_womens-rights/#jump10)

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# ‘I won’t take lectures!’ Lammy bites back as he is confronted with trans comments on 5Live

SHADOW Justice Secretary David Lammy roared he would not take "lectures" on his history of rights campaigning as a black man after he was confronted with his comments on the trans community where he said there were "dinosaur" Labour members who wanted to "hoard rights" from them.

**David Lammy clashes with reporter ove...**

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David Lammy was grilled by BBC (/express.co.uk/latest/bbc) Radio 5 Live's Rachel Burden and was confronted with his comments on trans rights where he accused some Labour (/express.co.uk/latest/labour-party) members of hoarding rights. Ms Burden pressured Mr Lammy to answer the comments as she accused the Labour frontbencher of attacking women in his party for being worried about their protected spaces being under threat. But Mr Lammy appeared furious at the suggestion and told Ms Burden, as a black man, he would take no lectures from her on rights campaigning.

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Mr Lammy appeared at a Labour Party conference fringe event and discussed trans rights with those in attendance.

But the frontbencher's comments at the event caused a stir when he was reported as saying "there are some dinosaurs on the right" and "those dinosaurs exist in our own party".

He added those individuals were hoarding rights and said there were always debates around giving no rights to groups who have been denied them for a long time.

But many have questioned who Mr Lammy was referring to as "dinosaurs" with Ms Burden asking Mr Lammy if he was referring to women during his appearance on 5 Live.

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David Lammy raged on 5 Live about the criticisms of his trans rights comments (Image: Getty)



David Lammy referred to some Labour members as dinosaurs (Image: Getty)

He told the programme: "I specifically called those people anti-trans so unless you identify as being anti-trans I think it's disingenuous to describe that as a woman.

"This is a sensitive debate that needs much more light than dark."

Ms Burden added there were many women who see their rights being "eroded" because of the trans debate and asked Mr Lammy whether it was transphobic to believe women who are born biologically female should be entitled to their own spaces.

Mr Lammy avoided the point and discussed statistics that show a quarter of trans people commit suicide.

**Alastair Campbell grills Lammy on Lab...**



David Lammy clashed with Rachel Burden who believed he was referring to women (Image: Getty)

He added there were many women who were sensitive of their safe spaces with Ms Burden then stating it was wrong to call those women worried about their rights as being "dinosaurs".

Mr Lammy said: "With great respect to you... as a black man who is a descendant of enslaved people, I am not going to take any lectures about rights.

"I have fought hard for rights on behalf of all sorts of people, I stood up in Parliament and argued for same-sex marriage, I'm someone who identifies as a feminist so I'm not going to take any lectures on rights..."

Ms Burden interrupted and said she was not lecturing the Labour shadow secretary but was echoing concerns many women have on the trans issue.

Mr Lammy appeared to get angry with the radio host, calling the debate a "distraction" and said he was "calling it out for what it is".

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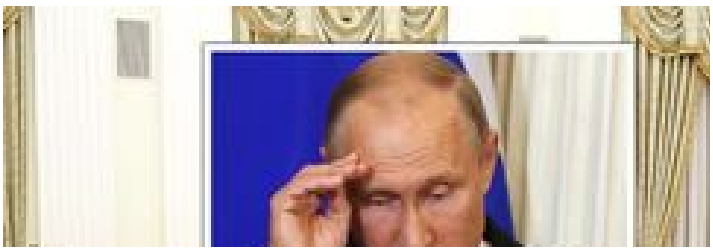
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David Lammy said the interview could have focused on many other topics (Image: Getty)

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The pair continued to argue and shout over each other as the programme was forced to cut for the news bulletin.

Trans issues have dominated parts of the Labour conference this week after a Labour MP refused to attend over safety fears due to her comments on trans people.

Rosie Duffield criticised a tweet that said "individuals with a cervix" and was called transphobic by trans rights supporters.

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Labour leader Sir Keir Starmer said it was "not right" to say only women have a cervix with Labour frontbenchers coming to his defence.

Shadow Trade Secretary Emily Thornberry said it was "factually inaccurate" to say only women have a cervix.

BBC (/latest/bbc)

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recognition panel takes applications from across the UK, and the Scottish Government will co
what it means for Scotland, so will she commit to co-operating with the Scottish Government?

**Elizabeth Truss** ›

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I am very interested in what the hon. Lady has said, because my understanding is that the Scottish Government's draft Bill to reform the GRA has been paused. I would be very happy to take this up with her at a later opportunity. In terms of human rights law, of course we are committed to that and we continue to lead the world in LGBT rights and human rights. We will shortly be hosting an international LGBT conference.

**Sara Britcliffe** ›
(Hyndburn) (Con)

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Does my right hon. Friend agree that it is important to reflect on the need to treat members of the trans community with kindness and respect and to find a way to make the path to self-determination not only cheaper but easier?

**Elizabeth Truss** ›

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I absolutely agree with my hon. Friend, and it is important that we address the issues that transgender people have had with the process—namely, the cost and the bureaucracy. We do not want finance to be a barrier to people to be able to go through the gender recognition certificate process.

**James Murray** ›
(Ealing North) (Lab/Co-op) [V]

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It has been well over two years since the Government first sought views on how to reform the Gender Recognition Act. The consultation received more than 100,000 responses, the vast majority of which were in favour of reform, yet the truth is that the Government have chosen to change little about the process of acquiring a gender recognition certificate. They have chosen to leave in place a lengthy, medicalised process that requires medical reports, statutory declarations, consideration by a panel, and more. Why have the Government taken so long to respond, only to ignore the wishes and destroy the hopes of so many in the trans community?

**Elizabeth Truss** ›

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As I made clear earlier, the Government do not believe in moving towards a model of self-ID. This is a serious process that has taken time for us to consider, but our view is that we need to maintain proper checks and balances in the system. We have addressed the issues that transgender people highlighted as important to them around healthcare, bureaucracy and the costs of the process, making the process kinder and more straightforward.

**Nicola Richards** ›
(West Bromwich East) (Con)

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May I take this opportunity to thank my right hon. Friend for engaging with me and others on this issue? The community are feeling frustrated by the lack of substance in the conclusion to this lengthy consultation. Notwithstanding her valid point about reforms to healthcare, will she acknowledge that these changes are minimal, with waiting lists of well over 13,000 people pre-covid? This is of great concern, given that research shows that 84% of trans people have thought about suicide, with 50% attempting it. Will she commit to further working with me and others who care passionately that the Government get this right? Will she report back to us on her work with colleagues in the Department of Health and Social Care and on her progress?

Yesterday was the Transgender Day of Remembrance—a day when we took a moment to celebrate the incredible contribution that trans people make to our communities, and to reflect and remember our trans siblings who have been killed, committed suicide, faced prejudice or not been able to live or be recognised in a way of their choosing. I firmly believe that today's debate is about exactly that: living in a way of our choosing, without fear or prejudice, under a legislative framework that supports people to do exactly that.

I started school in the year section 28 was introduced. Section 28 meant that schools and teachers could not talk to students openly about their sexual orientation or gender identity without fear of losing their jobs. So much legislation related to LGBTI rights has been, and still is, based on fear rather than acceptance, but we have come a long way in all parts of the UK. I commend the Minister and her Government on their work, as well as the other Governments around the UK—particularly the Scottish Government, who have gone a little bit further. I hope that at some point the Minister and I can meet to discuss how scrapping the spousal veto in Scotland has meant greater equality for trans people.

Section 28 was scrapped in 2003. By then I was halfway through my university degree. I grew up believing that, if I came out, I could not live a normal life and I would not have equal rights. I am an ardent feminist and an openly gay MP. I am not about to shut the door on the equality of trans people just because people like me now have greater equality. Those of us in the LGBTI+ community, and all of us who believe in equality and enjoy greater equality, must do all that we can to support others who are marginalised and discriminated against. Although the legislation on gender recognition was groundbreaking in 2004, it is now out of date. Medicalising and marginalising people who are trans is absolutely wrong.

We recently celebrated a new chapter in Scotland for LGBTI people. Inclusive education has become a reality—the UK Government are also working on that. I want to take a moment to recognise Liam Stevenson and Jordan Daly from Time for Inclusive Education, plus all the many organisations that have supported us with their briefings today, including Stonewall Scotland, LGBT Youth Scotland and the Scottish Trans Alliance, which worked on the legislation and policies in Scotland alongside John Swinney, Angela Constance and Christina McKelvie.

I appreciate that sexuality and gender identity are two very different things, but I faced challenges in terms of coming to my sexuality. I did not come out until I was 32. I cannot imagine how difficult it must be for somebody who is trans who is trying to operate in a system where their transition is medicalised, where they have to travel hundreds and sometimes thousands of miles—as the hon. Member for Oxford West and Abingdon mentioned, many trans people feel that going abroad is their only choice.

I have met a number of young trans people in my Livingston constituency, some pre-op, some post-op. The challenges they have faced are truly heartbreaking. Even in Scotland, which came second top in inclusiveness on the LGBTI global index, we still have a significant way to go. Living in a country and society where someone's orientation or identity does not have legal recognition, and where they do not have equal rights, is corrosive to the soul. At the core is the need to reform the legislation—changing our societal view and structures will follow from changing the law on gender recognition.

I recognise that the debate has become very polarised, which is a source of great sadness to me. I do not think it helps when the media sensationalise. There are cases where systems are being abused, and we must recognise and address those concerns, but we must not make policy based on a few individuals who seek to abuse the system. There will always be those who seek to abuse the system. That is regrettable and those people should be dealt with appropriately, but we should not make policy on that basis.

**Danielle Rowley** ›

Share

As the hon. Lady has rightly pointed out, a small minority would seek to cause others harm. However, more than half of trans people in the UK have attempted suicide and 84% have said that they have experienced suicidal thoughts. Does the hon. Lady agree that a lot more needs to be done to protect and support them?

**Hannah Bardell** ›

Share

I could not agree more. The hon. Lady makes a very powerful point. It is a stain on our society that many trans people feel so marginalised. In this debate and in the wider discussion, we must do all that we can to raise our voices to show our support and ensure that our policies and our laws properly support and recognise them.

The Scottish Government consultation on reforming the Gender Recognition Act 2004 ran from 9 November 2017 to 1 March 2018. There were 15,697 responses and 60% of respondents were in support of the Government's proposals. It is important to recognise and understand why 40% were not in favour, but those are the figures none the less

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# Media Guidelines

## for Reporting Suicide

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# 10 things to remember when reporting suicide

1 Avoid reporting methods of suicide in articles, such as describing someone as having died by hanging, particularly in headlines.

2 Include references to suicide being preventable and signpost sources of support, such as Samaritans' helpline. This can encourage people to seek help, which could save lives.

*When life is difficult, Samaritans are here – day or night, 365 days a year. You can call them for free on 116 123, email them at jo@samaritans.org, or visit www.samaritans.org to find your nearest branch.*

3 Avoid dramatic headlines and strong terms such as 'suicide epidemic'. Never suggest that someone died instantly or that their death was quick, easy, painless, inevitable or a solution to their problems.Steer clear of language that sensationalises or glorifies suicide.

4 Don't refer to a specific site or location as popular or known for suicides, for example, 'notorious site' or 'hot spot' and refrain from providing information, such as the height of a bridge or cliff.

5 Avoid dramatic, emotive or sensational pictures or video footage. Excessive imagery can glamourise a death and lead vulnerable individuals to over-identify with the deceased.

6 Avoid excessive amounts of coverage and overly prominent placement of stories, such as a front page splash or making it a lead story, and do not link to previous stories about suicide.

7 Treat social media with particular caution and avoid mentioning or linking to comments, or websites/forums that promote or glamourise suicide. Similarly, it is safer not to open comments sections on suicide stories and careful consideration should be given around the appropriateness of promoting stories through push notifications.

8 Including content from suicide notes or similar messages left by a person who has died should be avoided. They can increase the likelihood of people identifying with the deceased. It may also romanticise a suicide or cause distress to the bereaved family and friends.

9 Speculation about the 'trigger' or cause of a suicide can oversimplify the issue and should be avoided. Suicide is extremely complex and most of the time there is no single event or factor that leads someone to take their own life.

10 Young people are more susceptible to suicide contagion. When covering the death of a young person, do not give undue prominence to the story or repeat the use of photographs, including galleries. Don't use emotive, romanticised language or images – a sensitive, factual approach is much safer. Coverage that reflects the wider issues around suicide, including that it is preventable, can help reduce the risk of suicidal behaviour. Include clear and direct references to resources and support organisations.




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# Introduction

Suicide is a major public health concern and is therefore a subject that is very much in the public interest.

**While sensitive reporting can inform and educate the public about suicide and the signs to look out for, there is strong and consistent research evidence that some forms of news reporting lead to increases in suicide rates.**

Media coverage can influence how people behave in a crisis and their beliefs about the options open to them. The research shows that certain types of media depictions, such as explicitly describing a method and sensational and excessive coverage, can lead to imitational suicidal behaviour among vulnerable people.

For example, in the five months following Robin Williams' suicide in 2014, there were 1,841 more suicide deaths in the USA compared to the same time period from the previous year – a 9.85% rise.

In contrast, some forms of reporting can help save lives. Coverage describing a person or character seeking help and coming through a difficult time can serve as a powerful testimony to others that this is possible, and can have a protective influence over audiences.

Stories can highlight that suicide is preventable and direct vulnerable people to sources of support. We know from international research that when media guidelines are followed this has a positive effect by improving reporting standards.

Suicide is a very complex topic that presents a distinct set of challenges for journalists, who must balance reporting on a sensitive issue and informing the public while considering what influence coverage may have on vulnerable people, including the possibility of imitational behaviour. At the same time, avoiding intrusion into the grief and shock of the bereaved.

These guidelines are advisory and are in no way intended to limit press freedom. Their purpose is to reinforce industry codes of practice and editorial policies, to support journalists and programme makers in producing the highest standards of coverage of suicide. They offer practical recommendations and tips for covering the topic in what is a challenging and evolving media environment. They are informed by extensive international research into media portrayals of suicide and wide consultation with media professionals, academics, and those with lived experience.

Samaritans has worked closely with journalists, programme makers and media organisations over many years to support responsible coverage of suicide. These media guidelines are central to this work. As well as the core guidelines, there is a series of online resources outlining further advice for specific aspects of covering suicide, including working with people who have been bereaved, reporting on inquests and content for documentaries and drama. These are available on the **media advisory** section of our website.

**Samaritans' Media Advisory Service** also provides free advice and training to support informed and safe coverage. Journalists and programme makers can get in touch directly with enquiries about suicide content, including breaking news.

> "Suicide is a really difficult topic to get right and the training really helped the team forge a greater understanding of the need to take a responsible approach. Talking through the issues undoubtedly also helped grow confidence in portraying suicide and its effects in a sensitive way."
>
> **Will Banks, Assistant Editor**
> **BBC Radio Oxford**



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# Reporting suicide – research and evidence

A significant body of academic research from across the world, known as the Werther effect, has found links between certain types of reporting of suicides and increased suicide rates.

**For instance, stories that include descriptions of the method of suicide and where coverage has been overly prominent, extensive or sensationalised, can lead to imitational suicidal behaviour. Some people are more susceptible to this effect than others.**

## What does the research tell us?

Dramatic headlines that explicitly reference a suicide method can have harmful effects and potentially lead to imitative behaviour. If people who may be vulnerable, such as people with mental health problems, young people and those who have been bereaved are provided with details about suicide methods, it can lead to more deaths using the same method. In some circumstances, this has led to the introduction of new, highly lethal methods of suicide into populations, resulting in an overall increase in suicide deaths. People who survive a suicide attempt, and most do, get a second chance at getting support and appropriate treatment. Those using highly lethal suicide methods get no second chance.

The research literature identifies the phenomenon known as 'suicide contagion'. This occurs when a suicide or attempted suicide serves as a 'model' or example for subsequent suicidal behaviour. The 'model' could be a famous person or celebrity, but could also be a relative, neighbour or friend living in the local community. The contagious effect may be precipitated by pervasive grief or over-identification with the person who has died, or the circumstances in which they took their own life.

Young people are a particularly vulnerable audience in relation to media coverage of suicide. They are more susceptible to imitational suicidal behaviour and more likely to be influenced by the media than other age groups. Young people are also at greater risk of contagion if they have been affected by a suicide. Often the deaths of young people receive disproportionate, emotive coverage compared with other deaths by suicide, which can increase the risk of influencing imitational suicidal behaviour.

Another smaller body of evidence shows that sensitive portrayals of suicide, focusing on someone overcoming a crisis, can have a protective influence. This is known as the Papageno effect. Coverage describing a person or character seeking help and coming through a difficult time can serve as a powerful testimony to others that this is possible. This type of coverage can encourage people to seek help and has been linked to falls in suicide rates.

> “There is abundant international evidence that media reporting and portrayals of suicide can be extremely influential. Poor media practice can cause further loss of life, especially in more vulnerable groups such as the young and people with mental health problems. On the other hand, careful and responsible media handling of this important issue can contribute to suicide prevention.”
>
> **Professor Keith Hawton, Director Centre for Suicide Research, University of Oxford**


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# Best practice – reporting tips

The current media environment is a very demanding one for journalists and reporting on suicide can be particularly challenging.

**Samaritans' media advice team is available to provide support when covering suicide and self-harm at mediaadvice@samaritans.org Samaritans also offers confidential briefings and advice sessions for media outlets.**

**There are many ways to produce sensitive, informed coverage of suicide, here are some helpful tips:**

## Dos and Don'ts

### Think about the impact of coverage on your audience

- Your story might have an effect on vulnerable individuals or people connected to the person who has died. Providing information on how to contact organisations where people can find support, including helpline numbers, can encourage people who are struggling and may be experiencing suicidal thoughts, to seek help. This could save lives.
- It can be helpful to include trigger warnings at the beginning of a piece covering suicide, allowing those who may be vulnerable to make a choice on the suitability of your content for them.
- Remember that even good news stories, where a person has survived and recovered from a suicide attempt, can run the risk of leading to imitative behaviour if they refer to a suicide method or location. Please bear this in mind if covering a suicide attempt made by a celebrity.

When life is difficult, Samaritans are here – day or night, 365 days a year.

You can call them for free on **116 123**, email them at **jo@samaritans.org**, or visit **samaritans.org** to find your nearest branch.

### Avoid mentioning suicide methods

- Providing details of suicide methods has been linked to increases in suicide rates and shown to influence vulnerable people to imitate suicidal behaviour. Placing information about a method in a report, for example describing someone as having died by hanging, can reinforce awareness of specific methods, and increase perceptions of its effectiveness, especially if prominently featured.
- Avoid providing details of a location if it is a public place such as a cliff, bridge or railway line. Publishing information about locations is likely to result in more deaths at that location.
- Never describe a suicide method as quick, easy, painless or effective. Referring to a person as having 'died instantly' for example, is not advised.
- Steer clear of portraying anything that is easy to imitate, for example where the materials or ingredients involved are readily available and providing details on how it was carried out. This can increase risk by presenting suicide as easily achievable.

> "Our research has demonstrated how suicide in public places is influenced by media reporting, and this is why locations and methods should not be reported. By following these guidelines journalists and commentators can play an important role in preventing suicide and saving lives."
>
> **Siobhan O'Neil**
> **Professor of Mental Health Sciences**
> **Ulster University**

- Details of novel or unusual suicide methods should never be reported. Incidences of people using new or unusual methods of suicide have been shown to increase following coverage. Reporting may also drive people to the internet to research these methods. More information on reporting of suicide methods and inquests is available on the **media advisory** section of our website.
- While mentioning a previously unknown method is not advised, this also applies to known or common methods. Mentioning a known method can generate prolonged awareness of that particular method and reinforce perceptions that it is lethal, effective or easily available.

## Apply extra consideration to headlines for suicide stories

- Avoid naming the suicide method or using the word 'suicide' in headlines, this can significantly increase the risk among vulnerable groups. Use alternatives such as 'taken his/her/their own life'.
- Headlines can often sensationalise or oversimplify the context of suicide, for instance by linking a particular event such as a job loss directly to a person's death. For example, a headline that reads 'bullied to death', would sensationalise and oversimplify suicide, and this could increase the risk of influencing suicidal behaviour among others who may be bullied.

## Avoid oversimplification and consider the wider context

- It is important not to brush over or underplay the complex reality of suicide and its devastating impact on those left behind.
- Oversimplification of the causes or perceived 'triggers' for a suicide can be misleading. As mentioned in the previous section, the suggestion that a single circumstance or incident, such as bullying, job loss, relationship breakdown or a bereavement, was the cause increases the risk of contagion. Vulnerable people experiencing similar issues are more likely to over-identify with the deceased when a single reason is given.
- Combining references to perceived 'triggers', for example debt problems, with descriptions of an easy to imitate suicide method in the same report could put people who are vulnerable and experiencing similar problems, at greater risk.
- Avoid making unsubstantiated links when there are none. For example, don't refer to others who have died recently by using names or photographs or reporting they died at the same location. This can unintentionally link the deaths and can be misleading and distressing to families.
- Steer clear of presenting suicidal behaviour as an understandable response to a crisis or adversity. This can contribute to unhelpful and risky normalising of suicide as an appropriate response to distress.

> "Samaritans' media advisory service is an invaluable help for editors looking to report difficult stories in a sympathetic and responsible way. The guidance provided by Samaritans has helped the Telegraph & Argus many times. I believe every journalist should be aware of the service – and the training provided by Samaritans – as a key part of their job."
>
> **Nigel Burton**
> **Group Editor of Newsquest Yorkshire**


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## Aim for non-sensationalising, sensitive coverage:

Research shows that the more sensationalised the reporting, the greater the potential impact on suicidal behaviour.

- Take care not to sensationalise any aspect of a story. Breaking news, instant publishing, social media reach and competition for clicks can all place journalists under increased pressure when producing reports, increasing the possibility of sensational coverage.
- Before publishing, consider if the draft headline or sub-headline dramatises the story, includes the suicide method, or uses emotive or sensationalist terms.
- Avoid contributing to locations becoming 'known' suicide sites. Labelling a location as a 'suicide hot spot' or 'notorious site' increases people's awareness of the method and location, potentially transforming it into an iconic site widely known for suicides, which can draw vulnerable people to the location.
- Don't refer to a possible rise in suicides in a specific place or among a particular group as an 'epidemic', 'spate' or other similar term. Two or more people taking their own lives who, for example, share a similar background, age or live in a similar geographic area may be coincidence. Steer clear of implying a connection where there may be none. Evidence suggests that reference to clusters can lead to additional suicides.
- Comments or photographs provided by witnesses following a suicide should be avoided as these may include graphic details and speculation, which can increase the risk of imitative behaviour and could cause distress to bereaved families. Such individuals are unlikely to know that what they are saying could increase the risk of suicide if reported, or be aware of media guidelines and regulation.
- Suicide notes or similar messages posted on social media should be handled with particular care. Reporting the content of these risks sensationalising or romanticising suicidal behaviour, increasing the likelihood of vulnerable people over-identifying with the person who has died. It can also cause distress to those who have been bereaved.
- Repeated use of photographs of the deceased should be avoided as this increases the likelihood of vulnerable people identifying with them. Similarly, avoid using images of others who have previously died by suicide to illustrate subsequent stories about them, or someone else. This can suggest unsubstantiated links between the deaths and overstate the prevalence of suicide. It is also extremely distressing for bereaved families.
- Apply extra vigilance when considering using or linking to online sources, websites, social media reactions or comments for a suicide story. Using verbatim quotes can be problematic. Speculation and emotional outpourings are sometimes shared online, particularly with regards to young people. These can easily be misreported, wrongly repeated as fact or spread without due consideration for bereaved or vulnerable people. They also risk glamourising suicidal behaviour, for example referring to 'tributes flooding in on social media.'
- Be mindful of sharing suicide stories on social media as this can increase the risk of sensationalising a death.

## Avoid melodramatic depictions of suicide and its aftermath

- It is not advisable to share or embed links to a site, groups, forums or comments that glamourise, romanticise or glorify suicidal behaviour. For example, avoid sharing social media posts targeting young people with dramatic or upsetting memorials of a death. Be particularly wary of overemphasising community expressions of grief as this can unintentionally suggest that people are honouring suicidal behaviour, rather than mourning a death.
- Reporting suicide as a tragic waste and an avoidable loss is more helpful in preventing further deaths. A sensitively reported story that explores the emotional devastation of suicide on family and friends may encourage people experiencing suicidal thoughts to seek help.

## Consider carefully the positioning, prominence and illustration of reports

- Avoid positioning a story too prominently, for example on the front page, as a lead bulletin, or at the top of an online breaking news feed. This may significantly increase the likelihood of influencing vulnerable people.
- Take extra care with the selection and placement of photos and video. Consider if it is appropriate or necessary to include a large or prominently placed picture of a person who has died, or link to a video of a memorial or funeral. This is particularly important for stories featuring young people as it risks glamourising a death. If you must use a picture it is safer to use neutral, non-emotive images.
- Avoid using footage or images of locations, for example a cliff or a bridge, especially if it is a place where a number of suicides or suicide attempts have taken place. Including these images can promote the site as an iconic place to take your life and draw vulnerable people to it. It can also increase people's perception of the lethality/effectiveness of a specific suicide method.

## Treat high profile deaths by suicide with particular care

- When a death or suicide attempt involves a celebrity or high-profile person there is a greater likelihood of others identifying with the person.
- A research summary from 2020 has shown that media reporting about celebrity suicides is associated with a 13% increase in suicides in the following 1–2months. The research also shows that when the media reported on specific suicide methods used by a celebrity, there was a 30% increase in deaths by the same method.
- It is particularly important to avoid the use of emotive or dramatic language and images, including public tributes and memorials, which may romanticise or glamourise suicidal behaviour. Glamourised reporting appears to be associated with increases in subsequent suicides compared with non-celebrity coverage.

More information on how to report a celebrity suicide can be found on the **media guidelines** section of our website.


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## Be wary of reporting too much detail from inquests

- Journalists reporting on inquests should apply careful consideration when selecting which elements to report. Inquests routinely include significant amounts of information about the circumstances surrounding a death, as well as explicit details of the suicide method. While this level of detail is necessary for a coroner to fully investigate a death and reach a verdict, it is often inappropriate for a wider audience.
- Paramedics and police officers who attended the scene of a suicide, may give specific and graphic evidence to the inquest so apply due caution when covering their statements. This is especially important as such individuals are unlikely to be aware that what they are saying could increase the risk of suicidal behaviour if reported.
- Be wary of repeating reasons or 'triggers' suggested by witnesses during a hearing, as there is a risk of oversimplification.
- Remember that inquests can be very distressing for bereaved people, so please report with sensitivity. Refer to the general Dos and Don'ts.

More information on how to report on an inquest can be found on the **media guidelines** section of our website.

## Additional points to consider

### Educate and inform

- Whenever possible, refer to the wider issues associated with suicide, such as risk factors like mental health problems, alcohol and substance misuse and deprivation. Refer to the long-term impact that a suicide can have on the bereaved. Informed discussion of such issues can encourage a better understanding of suicide.
- Include references in stories to suicide being preventable and mention when possible that sources of support, such as Samaritans, are available and easy to access. This can have a positive impact on vulnerable individuals, including encouraging them to seek help.
- Online suicide prevention resources can help raise awareness of the risks surrounding suicide and offer support, without promoting suicidal behaviour. However, be wary of referring to sites that do not fall specifically into this category.




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## Avoid opening up stories about suicide for comments

There is a risk that comments alongside articles will romanticise suicidal behaviour, for example references to a person going to 'a better place' or 'heaven gained another angel'. Some individuals may use comment sections to share their experiences of suicide attempts or self-harm, which may influence some people who are vulnerable. Comments may also lead to inaccurate speculation about a cause or method of suicide and have the potential to be inappropriate or offensive to family and friends.

## Be mindful of statistics

- Using 'trend' data within suicide stories can be problematic. Be aware that suicide rates in a single year may deviate from an overall trend. This can be especially the case if focusing on the number of suicides in small geographic areas or particular groups. It is best to look at timeframes of three or more years to identify significant patterns.
- When talking to particularly vulnerable groups, for example children and young people, apply caution when quoting statistics. Bear in mind that while the statistics may be concerning, alarmist reports can have the effect of normalising or exaggerating the prevalence of suicide.
- For the most up-to-date statistics and explanatory notes for suicides in the UK and Ireland go to **Samaritans' Suicide Statistics Report.** For any additional questions or information contact **mediaadvice@samaritans.org**

## Treat murder-suicide with care

- A murder-suicide is when a person kills members of their family before taking their own life, or where an individual murders a number of people in a public place, such as a school, before taking their life. Murder-suicides are rare but can attract exceptional levels of media attention. The circumstances of these deaths can be dramatic and disturbing and reporting them should adhere to the general **Media Guidelines for Reporting Suicide.** Caution is required since imitative behaviour also applies to murder-suicide.

For more information see **Samaritans' guide for reporting murder-suicides.**

## Consider use of language

The terms and phrases used when reporting suicide are important. Inappropriate or careless use of language can sensationalise or glorify a death. Careful use can contribute to more sensitive coverage, reducing the risk of influencing imitational behaviour or causing distress to bereaved family and friends.

| Do use | Don't use |
|---|---|
| **A suicide** | **Commit suicide** |
| **Taken his/her/ their own life** | **Suicide victim** |
| **Ended his/her/ their own life** | **Suicide 'epidemic', 'wave', 'iconic site', 'hot spot'** |
| **Die by/death by suicide** | **Cry for help** |
| **Suicide attempt** | **A 'successful', 'unsuccessful' or 'failed' suicide attempt** |
| **Attempted suicide** | **Suicide 'tourist' or 'jumper'** |
| **Person at risk of suicide** | |


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# Suicide: the facts

- Suicide is a significant public health and social inequality issue, with more than 6,000 people across the UK and Republic of Ireland taking their own lives each year. Tens of thousands more attempt suicide. Suicides are preventable with timely, evidence-based interventions.
- In response to the strong evidence-base indicating that inappropriate reporting of suicide can lead to further deaths, many countries have incorporated responsible media reporting into national suicide prevention strategies.
- Suicide is more common among some groups than others. For example, it is more likely among men than women, and in particular men in their 40s and 50s from a lower socio-economic group.
- Suicide is complex and most of the time there isn't one event or factor that leads someone to take their own life. It is usually a combination of lots of different factors interacting with each other to increase risk. A combination of individual, community, and societal factors contribute to the risk of suicide.
- More than 1 in 20 people make a suicide attempt at some point in their lives. Their choice of method is the most important determinant of whether they live or die. While previous suicide attempts is a risk factor for dying by suicide at a later point, research shows that only a small proportion of those who attempt suicide and survive will go on to die by suicide at a later date.
- Self-harm is a sign of serious emotional distress and, while most people who self-harm will not go on to take their own life, it is a risk factor for future suicide.
- A suicide cluster is when a greater number of suicides than expected occur in a location or community. Research has found links between the type (sensationalist) and volume of coverage of suicides by young people, and subsequent suicide clusters and suicides by other young people.
- Some people considering suicide may hint at or even disclose to friends or relatives that they intend to take their own lives. Other people who are feeling suicidal might not mention it at all or give any indication of their intention. There is no evidence to suggest that asking someone if they are OK will make them feel worse. Talking can help.
- Only a third of people who die by suicide have been in contact with specialist mental health services in the year before their death.

## Media and suicide codes of practice

Media codes of practice and current regulation have recognised the research evidence on the potentially harmful effects of inappropriate media coverage with the inclusion of clauses that address reporting suicide.

For links to all main reporting regulations and codes of practice within the UK, see the **media advisory** section of our website.



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## Contact Samaritans' Media Advice team

Samaritans' media advice team is available to provide support when covering suicide and self-harm:

**Phone**
**+44 (0) 20 8394 8300/377**
**Or +44 (0) 20 3874 9186**

**Email**
**mediaadvice@samaritans.org**

**Web**
**samaritans.org/mediaguidelines**

**twitter.com/samaritans**
**#reportingsuicide**

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April 2020

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# Suicide

▶ One long-ranging study estimated a suicide rate for gender dysphoric people of 0.6%. Expand

MORTALITY SUICIDE

▶ There is no high quality evidence to suggest that the overall attempted suicide rate of transgender youth is 41%. Expand

MORTALITY RESEARCH QUALITY SUICIDE

▶ People with psychiatric conditions – and sometimes neurodiverse conditions – are much more likely to die by suicide than gender dysphoric people. Expand

AUTISM COMORBIDITY MENTAL HEALTH MORTALITY NEURODIVERSITY SUICIDE

▶ Suicide rarely has one cause: it is difficult for statistical studies on suicide to extricate gender dysphoria from other factors. Expand

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▼ There is little evidence that medical transition decreases suicidality. Expand

There is little evidence that medical transition decreases suicidality.

When it comes to gender dysphoric children, there is little evidence that medical transition decreases suicide rates. There is little evidence to assert that puberty blockers are necessary to prevent suicide [1].

After sex reassignment surgery, one study showed that adult transsexual clients were 4.9 times more likely to have made a suicide attempt and 19.1 times more likely to have died from suicide, after adjusting for prior psychiatric comorbidity [2]. Similarly, an Australian paper [3] notes that many patients have poor outcomes which put them at risk of suicide.

A prominent study [4] claiming that medical transition alleviated suicidality had to be corrected [5], to clarify that it proved "no advantage of surgery" in this regard.

A long-term Swedish study [6] finds that post-operative transgender people have "considerably higher risks" for suicidal behavior.

Similarly, a study in the European Journal of Endocrinology [7] demonstrates that suicide rates among transgender male-to-females were 51% higher than the general population.

REFERENCES

[1] Biggs, M. (2020). Puberty Blockers and Suicidality in Adolescents Suffering from Gender Dysphoria. Archives of Sexual Behavior (49): 2227–2229. [Link]

[2] Zucker, K.J., Lawrence, A.A., Kreukels, B.P. (2016). Gender Dysphoria in Adults. Annu Rev Clin Psychol. 12: 217-47. [Link]

[3] D'Angelo, R. (2018). Psychiatry's ethical involvement in gender-affirming care. Australasian Psychiatry 26 (5): 460-463. [Link]

[4] Bränström, R. & Pachankis, J. E. (2019). Reduction in Mental Health Treatment Utilization Among Transgender Individuals After Gender-Affirming Surgeries: A Total Population Study. American Journal of Psychiatry 177 (8): 727-734. [Link]

[5] American Journal of Psychiatry (2020). Correction to Bränström and Pachankis. Published online: 1 August 2020. [Link]

[6] Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L. V., Långström, N., & Landén, M. (2011). 'Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden'. PLoS ONE, 6(2). [Link]

[7] Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A. & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. European Journal of Endocrinology 164 (4). [Link]

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# Cambridge University Press Advocates for Bestiality.

thenationalpulse.com/2021/08/13/cambridge-university-press-advocates-for-bestiality/

Catherine Salgado August 13, 2021



**Cambridge University Press published an article advocating for "bestiality/zoophilia" within the context of "animal advocacy" and the LGBTQ+ narrative on sexuality.**

The article by Kathy Rudy, titled "LGBTQ. . .Z?" was published on March 25th 2020 by Cambridge University Press and taken from *Hypatia: A Journal of Feminist Philosophy*, Volume 27, Issue 3, Summer 2012.

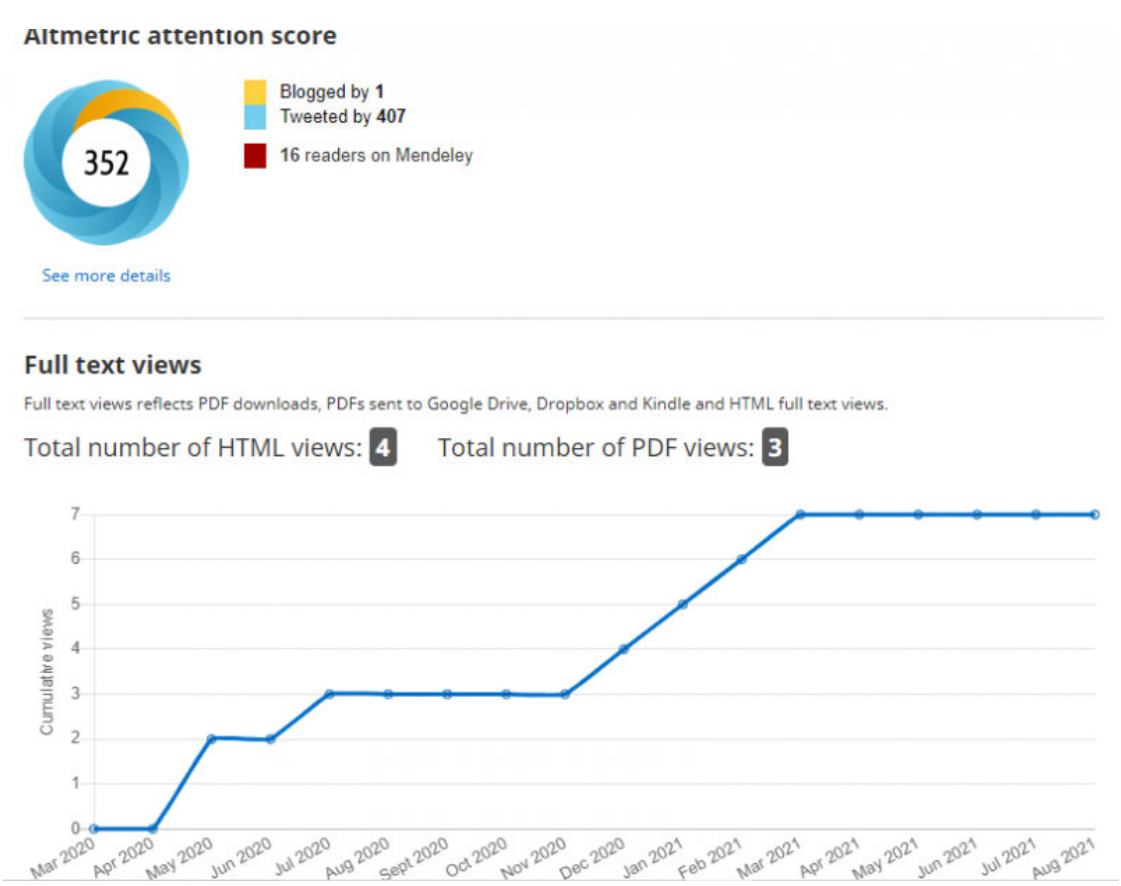
This issue was a *Hypatia* "Special Issue: Animal Others," published in 2020 under Cambridge Core. The Cambridge Core is described on its website as "the home of academic content from Cambridge University Press."

The article's abstract claims that bestiality is a "new form of animal advocacy" and relies on "queer theory" to make its argument. The article's abstract states:

"In this essay, I draw the discourses around bestiality/zoophilia into the realm of queer theory in order to point to a new form of animal advocacy, something that might be called, in shorthand, loving animals. My argument is quite simple: if all interdicts against bestiality depend on a firm notion of exactly what sex is (and they do), and if queer theory disrupts that firm foundation by arguing that sexuality is impossible to define beforehand and pervades many different kinds of relations (and it does), then viewing bestiality in the frame of queer theory can give us another way to conceptualize the limitations of human exceptionalism. By focusing on transformative connections between humans and animals, a new form of animal advocacy emerges through the revolutionary power of love."

The piece seems to have had comparatively few views on Cambridge Core but was tweeted over 400 times.

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The site states, “Cambridge Core is the place to find valuable, useful and inspirational research and academic information. With over 1.8 million journal articles and 46,000+ books, Cambridge Core is the central destination for academic research.” This “valuable, useful and inspirational” content includes the article attempting to normalize and even celebrate bestiality.



WILEY

LGBTQ...Z?

Author(s): KATHY RUDY

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# LGBTQ...Z?

KATHY RUDY

*In this essay, I draw the discourses around bestiality/zoophilia into the realm of queer theory in order to point to a new form of animal advocacy, something that might be called, in shorthand, loving animals. My argument is quite simple: if all interdicts against bestiality depend on a firm notion of exactly what sex is (and they do), and if queer theory disrupts that firm foundation by arguing that sexuality is impossible to define beforehand and pervades many different kinds of relations (and it does), then viewing bestiality in the frame of queer theory can give us another way to conceptualize the limitations of human exceptionalism. By focusing on transformative connections between humans and animals, a new form of animal advocacy emerges through the revolutionary power of love.*

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> I think many adults (and I am among them) are trying, in our work, to keep faith with vividly remembered promises made to ourselves in childhood: promises to make invisible possibilities and desires visible; to make the tacit things explicit; to smuggle queer representation in where it must be smuggled and, with the relative freedom of adulthood, to challenge queer eradicating impulses frontally.... (Sedgwick 1993, 3)

I start my thinking with two conflicting and competing realities. The first is the pervasive social taboo against bestiality and zoophilia; the act of sex with animals is so prohibited in contemporary American culture that it is often difficult to speak of such things in public. This is interesting. Humans can kill animals, force them to breed with each other, eat them, surround them, train them, hunt them, nail them down and cut them open for science, and for the most part, the humans who perform those acts can be thought of as normal, functioning members of society. Yet having sex with animals remains an almost unspeakable anathema. Indeed, it was Peter Singer who first proposed in his 2001 essay

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"Heavy Petting" that from the animals' point of view, having sex with them wasn't nearly as harmful as killing or torturing them. Although he condemned all sex acts where animals were killed, he brought up the interesting point that in many cases, animals appear to initiate sex, to have erections, to seek out genital intimacy, and so on. Why, then, in this most intimate domain, is our use of animals most vociferously condemned?

The second reality that needs to be taken into consideration for this essay is the burgeoning pet culture in America of the last thirty or so years. Humans have never been closer to their pets, or spent more time or money on them.[1] Part of me would like to see these new developments as seeds of transgression, or early markers of the demise of human exceptionalism. That is, in one sense the intense relationships some of us have with pets could itself be disruptive of the human-oriented world most of us inherited. Although I completely recognize that the vast majority of humans who participate in relationships with their pets don't recognize those relationships as transgressive, part of me would like to claim that for them anyway. It's not that the family dog is himself a paradigm-shifting entity, but the massive scale of pet culture could signal a shift that many of us humans have indeed fallen in love with someone besides ourselves.

But we don't think of pet culture that way at all. For the most part, pet animals are add-ons to postmodern, consumption-based, globalized life, not paradigm shifters. The easiest answer, and one that I will circle around and around in this essay, is that pets are not really threatening to twenty-first-century American life precisely because of the deeply ingrained taboos against bestiality. After all, we may love them, but we don't really love them, right? We don't ever view our love of animals as transgressive simply because the activities of bestiality and zoophilia seem so unthinkable. Loving animals is safe, for most of us, because it is not "that." As Midas Dekkers aptly expresses it, "the high regard in which love for animals is held is matched only by the fierceness of the taboo on having sex with them" (Dekkers 1994, 149).

Enter queer theory. At the most cursory level, queer theory persuasively teaches us that sex itself is difficult to define; sexuality pervades many different levels of many different relationships; and sexual identity is famously unstable. Sex is an energy that can be tapped into but never nailed down. So in relation to bestiality, queer theory points out that the "that" that is performed between humans and animals by necessity must remain unnamed. Stated differently, the widespread social ban on bestiality rests on a solid notion of what sex is, and queer theory persuasively argues we simply don't have such a thing. The interdict against bestiality can only be maintained if we think we always/already know what sex is. And, according to queer theory, we don't.

To tell this part of the story well, I need to reveal the event that prompted me—in the middle of writing a book about animals and ethics—to return to

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queer theory as a central organizing theme: that event was the death of Eve Sedgwick in the spring of 2009. Eve was a mentor to me when I was in grad school at Duke, and a wise senior colleague when I first joined the faculty there. I found myself rereading some of her books after her death as a way to invite her to be more present in my life, as a way for me to remember her well. To my knowledge, although Eve mentions bestiality and zoophilia in passing, she never turns her wise and clever gaze completely on the subject. The rest of this essay, then, is something of a thought experiment connecting Eve's insights about queerness and sexuality with my own obsessions about animals. It has been exceedingly fun to write this for her.

Studying with Eve Sedgwick as a young scholar was like adding a new and different dimension to the feminist theory I brought with me to grad school. Before Eve, I rummaged through liberal, radical, and socialist theories of gender to make arguments about the importance and value of women in the world. Before Eve, gender was pretty much an unchecked constant in my intellectual landscape; it was the thing I worried over all the time in every context, but never really saw because it loomed so large. In looking back on that time, I lived in a very two-dimensional world where the things that "made" gender (and feminism) went more or less unstudied.

Exploring feminist theory with Eve was like stepping into an Imax 3-D movie for the first time. I wasn't just watching the movie of gender any more; I was in it and could see behind and beneath the structures that before had been utterly flat. Eve was a different kind of feminist; she cared about all the regular things the rest of us cared about, but she also cared about how gender itself was made. In watching the world through her eyes, I got to see a differently inflected reality; it wasn't the case, as I had previously thought, that gender came first and sexual preference flowed from there. Rather all of our identities stemmed, in part, out of our desires. To be sure, lots of feminists before Sedgwick noted that gender was "socially constructed." From Beauvoir to Barrett and many others, we already knew that gender was made, but from those perspectives it mostly looked like society or culture or language or something outside us pressed down on us like cookie-cutters and made us into men and women. With Eve, the thing that made us gendered also came from inside of us. It came in the way we identified outside ourselves, it came in the way we desired an other and made ourselves into a person who could be in relation to that particular other; it came in the ways we loved. Our realities are made for us through the worlds and meanings available to us, but they are also made by the connections in the affective realm. Whom we loved mattered, not just as a point of feminist justice but because that process of love contained the seeds of world-making.

I was a lesbian when I knew Eve at Duke back in the 1990s. I had "come out" in my early twenties, and it was an identity that almost fit for a long time. Well into my thirties I tried very hard to make that description of myself work

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for me. For ten years I "settled down" with one partner, focused on family life, "owned" only two dogs and one cat (with no fenced yard). I tried very hard to be reasonable about the animals; I would put them in kennels when we traveled and lock them in bedrooms when we entertained. But when I wasn't with them I was miserable. It was like they carried a piece of my heart, and when they weren't involved in some function or activity, a part of me wasn't present either. Eve knew of these predilections and always encouraged me to think about them in a positive frame. Claiming a solid "gay" identity never felt right to Eve, and she filled the world with feminist queer theory to explain why "being woman" or "being gay," although certainly not wrong, wasn't quite right either. "Being lesbian" wasn't quite right for me either, mostly because my mind was always on the dogs. From as far back as I can remember, dogs have been the most vibrant, colorful, and important players in the landscape of my life. When I was a child, they were my very best friends. Soon after Eve left Duke, I found myself single, and in part due to her influence, I decided to pay serious attention to these intense feelings I had toward animals. Like the epigraph that opens this essay, I wanted to return to a childhood promise to make my relationships with them more visible and explicit.[2]

For me, paying attention to that childhood first love of animals was possible only as a result of Eve's formulation of theory. In her world, gender and sexuality were terribly messy and unwieldy constructs, and she was absolutely delighted when they could be rendered even messier and more unwieldy. Had she lived, reaching outside the boundaries of the human would have been the next logical step in her feminism. Following Eve, I filled my new house with six rescues of various shapes and sizes, and multitudes of fosters looking for new homes. People think I am crazy. But I have never ever been happier.

So here I sit with my six dogs, wondering, from the theory-world Eve bequeathed to me, what could it mean to love animals? What does it mean to make myself in relation to the love I have for these dogs? How do they help me construct my gender, my class, my race, the inward, internal topography of identities and desires that connect me to the world? How does living inside this 3-D, big-screen movie with dogs all around me look to the rest of the world? How does it feel to the dogs themselves? And how does it look to me, inside it?

There is not an adequate name for the kind of life I lead, the way my desires organize themselves around animals. In the first half of the twentieth century, the heterosexual public either detested or felt sorry for women who were named by the then emerging category "lesbian." They thought that the only women who would ever choose lesbianism were ugly, or unfeminine, or somehow lacking in the ability to capture a man. Now, on the other side of gay rights, feminism, and queer theory, such ideas seem silly or quaint, almost forgotten. But can people like me even hope for such liberation, when choosing animals as partners or

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companions doesn't really even have an adequate name? At best, we fall under the radar of identity and are named (wrongly) as gay or straight, single or married, parents or childless. Our most important relationships, though, are never recognized. At worst, we are pitied. Like those early lesbians, people "feel sorry" for us because we can't seem to sustain "real" relationships with "real" people (see, for example, Nast 2006a). I came out as a lesbian nearly twenty-five years ago and although that was hard on friends and family who were homophobic, the task of coming out as a lesbian was a piece of cake compared to coming out as—what?

I know I love my dogs with all my heart, but I can't figure out if that love is sexually motivated. Queer theory has schooled me in ways that make the question of what counts as sex seem rather unintelligible. How do we cordon off sexual desire from all the other desires that move our lives? What does sex mean? Do I think I'm having sex with my dogs when they kiss my face? How do we know beforehand what sex is? I get more affection from my dogs than I ever did from any girlfriend. We all always sleep together, sometimes under the blankets when it's cold. When I was gay, was I gay because of a narrowly defined genital act that I performed with a person who happened to be another woman? Those words don't make any sense to me. I was gay then, I believe, because I chose to share my emotional, financial, and daily life with a person of the same gender. Now I choose to share that same life with six dogs.

Although I am not arguing that living with pets is necessarily a life-shifting paradigm, I am suggesting that the number of people who find community and communion with domesticated animals has both risen recently and become more visible. In a queer frame, this phenomenon is extremely interesting, as it—loving animals—could constitute a new way of being with another species. Put differently, queer theory teaches us that it's not really a question of whether we have "sex" with animals; rather it's about recognizing and honoring the affective bonds many of us share with other creatures. Those intense connections between humans and animals could be seen as revolutionary, in a queer frame. But instead, pet love is sanitized and rendered harmless by the presence of the interdict against bestiality. The discourses of bestiality and zoophilia form the identity boundary that we cannot pass through if we want our love of animals to be seen as acceptable.

In American public culture today, conversations about bestiality and zoophilia exist in four different locations.[3] I want to look briefly at those positions, and then move to analyze them through the lens of queer theory. Ultimately, of course, my argument is not *for* or *against* humans having sex with animals, but is a meditation on both the elusive nature of sex itself and the subjectivities of human versus nonhuman animals. The line policed by the fear of bestiality is about more than just what we can or can't do with our pets. As we shall see, it helps to form the very architecture of human exceptionalism.

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The first two sites I speak about are (1) "bestiality" and (2) "zoophilia"; both exist mostly on the Internet, where sex with animals is portrayed more or less as a form of pornography. Acts are performed either by objectifying animals to the point where they are treated as props for certain sexual encounters (bestiality), or conversely, by endowing animals with human characteristics, such as the desire to express love for their humans through sexual intimacy (zoophilia). The third site is closely associated with (3) "animal rights," where sex with animals is strongly condemned because animals are seen as needing protection from human manipulation in general, and sex with them can never be anything but a misuse of human power. Finally, sex with animals is discussed in (4) "mental health" literature, where the context is almost always therapeutic intervention; these therapy-based works reflect a dominant cultural notion that sex with animals needs to be "cured" because it's simply not normal. Attitudes and arguments from these four venues give us unique vantage points to think about what sex is and what animals are.

On many bestiality websites (1), the dominant orientation toward animals really supports and adheres to the idea that animals are nothing more than forms of property. On these private, for-pay websites, animals are dressed up, stimulated, filmed from angles that don't show their faces or their expressions. They are, in short, props or tools to aid the human-centered sexual experience.[4] In the logic of these practices, sex with these "things" is no more wrong than sex with other "things," such as dildos, blow-up dolls, and so on. In these settings, sex acts don't happen "between" humans and animals; rather, humans are simply using animals for their own pleasure and fantasy. For these bestialists, it doesn't matter if the animal lives or dies as a result of this activity; the goal here is human pleasure. Examples of using animals as things include inserting rodents into a human rectum for pleasure, or beheading chickens and other birds at the point of orgasm to intensify the convulsions of the sphincter, or withholding food and fluids from dogs for long periods of time so they will lick and swallow various human secretions and excretions. From this point of view, such bestial practices aren't wrong because animals have no subjectivity, no self-interest. After all, we kill them to eat them or because we don't want them infesting our homes, why not use them for a little sexual pleasure first? Here, humans occupy a place in the world that is unrivaled.

A counterdiscourse emerges within the realm of pornography that portrays sex between humans and animals differently. Self-described zoophiles (2) argue that humans involved in loving relationships with animals are distinct from bestials; for zoophiles, animals are not "things," rather they are full and equal partners in sexual discovery. Zoophilia, they say, does not involve animal cruelty; it's not about hurting animals for human pleasure but about loving animals to pleasure both the human and the animal. In this frame, animals are not only not "things," they are in fact capable of entering into something like a partnership

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with humans, for love and for sex. Indeed, in loving relationships, zoophilists suggest, animals can experience such a robust subjectivity that they not only give consent to sexual acts, they also can initiate those acts, communicate their desires for specific kinds of pleasure, and even opt out of sex if they so choose. In this perspective, animals aren't less-than-human pieces of property; they become something very close to human. From a zoophile's perspective, although nonhuman animals don't use spoken or written language, they can communicate their sexual desires in a myriad of ways. Here, nonhuman animals are elevated to the level of human subjectivity and granted the kinds of characteristics usually reserved only for humans.

On the other side of the debate, the taboo against sex with animals is secured and reinforced by two unlikely bedfellows. Possibly the strongest admonition against bestiality and/or zoophilia comes from the discourse of animal rights (3). For theorists committed to a platform that releases animals from "enslavement" by humans, humans and animals having sex is always and unconditionally wrong simply because animals cannot give consent. Much like children, prisoners, or slaves, they say, animals are subject to such coercion that they cannot participate in meaningful sexual encounters. It's not a question of pain or pleasure, but simply that by the very nature of their lack of agency, they cannot give consent to such acts. Partly it's a question of lacking a common language, but according to many animal rights' theorists, even if we suddenly were able to communicate with nonhuman animals, sex between humans and animals would be wrong because animals are not authors of their own worlds. Piers Beirne calls all sex between human and non-human animals "interspecies sexual assault" and argues "animals are beings without an effective voice" (Beirne 1997, 323). Essentially, most people in the animal rights movement think that because animals are powerless and voiceless, sex between humans and animals is always wrong.[5]

Finally, most material addressing both bestiality and zoophilia from psychological perspectives (4) reflects disgust at the idea of human/animal sex. In these essays and books, the desire to have sex with animals is seen as abnormal and in need of cure. The most liberal approaches try to explain how someone came to develop a predilection for bestiality, but I found no therapeutically based literature that advocated for acceptance of these practices. In each essay, there is the unquestioned perception that such behavior needs to be corrected. There seems to be a general sense of disgrace in wider American culture that fuels and reinforces the need for therapeutic resolution. This taboo on sex with animals is a powerful force that also functions, I suggest, to help us differentiate ourselves from animals very well. In the interdict against sex with animals, animals emerge as figures over which we define our superiority. In other words, maintaining the ontological boundary between humans and animals requires us to feel disgusted by breaches of that boundary, most especially around the issue of sex. Our psychological approaches operationalize this boundary by "curing" those who cross it.

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I've mapped the four sites as a "pro and con" diagram above (two in favor of sex with animals, but from different positions, two opposed to sex with animals, but also from different positions.) But in an interesting way, the pro and con sides of the argument also act as mirrors for each other's ontologies. That is, bestialists (1) and therapists (4) both see animals as "less than human"; whereas bestials use this less-than status as the reason to accept sex practices with animals ("who cares what happens to them, they are just things"), many therapists see sex with animals as degrading to the humans because animals are less than us ("we belittle humanity to engage in sex with unworthy creatures"). Similarly, zoophiles (2) see animals as equal or equivalent to humans, and therefore think sex with animals is fine as long as it's not abusive, painful, or degrading; animal rights activists (3) also see animals as equal or equivalent to humans, but because animals are so highly regarded, many activists believe that animals need protection from human domination (much the way children or mentally handicapped people need protection from those who would abuse them).

If Eve Sedgwick had written about sex with animals, I bet she wouldn't be interested in validating any of the four orientations. She would want to know how the four views compete with one another, and on what grounds they share in their common definitions about subjects and practices. She would want to know how we ended up in a world where these frameworks constructed our only options. She would want to know how the categories themselves came into being, how they rub up against one another, how they overlook and obscure many aspects of a life filled with animals. Eve would ask how we organized ourselves such that animals either have to be just like us, or not like us at all, and thus have no value. She would want to know how it was possible that all animals can exist in one category. She would want to examine how our perceptions about the gender of animals both construct and reflect our perceptions about the gender of our selves. Are there other ways to think about animals other than "equal to us" or "less than us?" Are there ways to think about sex with animals other than in terms of right or wrong? What is it that can't be said? What other realities do these four positions obscure?

It's worth noting just how much slippage exists among positions that try to define themselves against one another. What looks different on the surface may be similar underneath (and vice versa). Eve addresses the way the subject positions of gay men and lesbians do or do not relate: "There can't be an apriori decision about how far it will make sense to conceptualize lesbian and gay male identities together. Or separately" (Sedgwick 1990, 36). The same is true, for example, for the distinction between bestiality (1) and zoophilia (2). Although zoophiles try to distance themselves from bestials, the two occupy similar domains on the Internet, and I suspect many viewers care little about the affective relationships zoophiles advocate. They are lumped together in the therapeutic literature, and also by the condemnatory discourses of animal rights. A whole

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series of questions emerges to blur the distinction: How can we be certain about what kind of bond exists behind the sex? How does one know beforehand the difference between bestiality and zoophilia? Is a woman who becomes sexually aroused riding a horse a bestial or a zoophile? What if she gets aroused only on the back of one particular horse? Can emotional bonds exist, say, between a farmer and the livestock he is about to slaughter for meat? Although killing animals in the act of sex is more associated with bestiality, what if the sex and the killing are separated by periods of days or weeks or years? Can you love someone and still kill her?

Slippage and condensation occur on the other side of the divide as well. Although animal rights activists intend only to protect animals from human abuse, in their interdicts against human/animal sex, they also shore up the psychosocial position that human sex with animals is somehow abnormal. Both positions oppose sex with animals, and in doing so they perform a kind of violence on animals by lumping them all together into one seamless identity.

Here is Eve on the question of human identity categories: "People are different from each other. It is astonishing how few respectable conceptual tools we have for dealing with this self-evident fact. A tiny number of inconceivably coarse axes of categorization have been painstakingly inscribed in current critical and political thought: gender, race, class, nationality, sexual orientation are pretty much the available distinctions" (Sedgwick 1990, 22). With these words, Sedgwick opened up not only the study of sexuality but also the study of human identity to attend to complexity and messiness. I want now to extend this insight to nonhuman animals. If, as she argues, the available tools to categorize humans are paltry, the labels associated with animals are downright crude. Although the discourse of species recognizes certain biological differences between animals, most humans categorize animals only in the broadest strokes: as pets, livestock, or wild animals. These categorizations are slippery: a given species can occupy multiple categories (for example, feral cats, wild horses, and pet pigs all come to mind). Our method of categorizing animals is not only blunt, it is famously unstable. Thus, mostly we refer to all of them as "animals."

The problem with both the animal rights and the psychotherapeutic positions is that they want to make universal rules for all animals, and in so doing sacrifice the richness of particularity. They advance an agenda that produces the human/animal duality as firmly and narrowly as the homo/hetero binary. They crowd all animals into one categorical way of thinking and tell us, even if subconsciously, that humans and animals occupy different ontological realms, that one is EITHER human OR animal, never neither, never both. It's precisely the same logic that forces us to conform to the homo/hetero binary.

What I am trying to introduce here is the possibility that as human and nonhuman, animals share an intensely bonded life together, we are all becoming something new, something part human, part animal, a part of one another. Both

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antisex positions rest on the idea that all humans are different from all other animals, and the wall between them can never be breached. Like the ways we used to think of race or gender "identity," these positions contend that one's species rests on physical markers that are immutable, that belonging to the categories of "animal" or "human" is grounded in a biological essence untouched by culture. Positions that universalize all animals—even if allegedly to improve their lives—are unable to explore heterogeneity and fragmentation within each category.

Put differently, both animal rights (3) and psychosocial perspectives (4) do not believe that borders can be crossed. Queer theory, on the other hand, tells us that few of us have stable identities anymore, that borders are always crossed. We're all changing, shifting, splitting ourselves up this way and that. It labels these processes "hailing," "suturing," and "interpolation"; where once we saw ourselves affiliated in one way, a new interpretive community emerges to capture our passions and move us differently. I am asking the reader to entertain the possibility that the same kinds of shifts and disruptions happen with categories like "human," "rabbit," "ape," or "dog." As the result of our relationships, interpolations occur; my dogs and I have changed each other such that I am no longer only human and they are no longer only canine. For these particular dogs and this particular person, something rather magical has happened to alter not only the way we perceive, but also the way we live in the world.

In keeping with queer theory, I am asking the reader here to imagine the possibility that certain kinds of relationships can undo even the strongest and most trenchant categories. No one would deny that, as a result of their physical differences, my dogs experience the world differently than I do (for example, they hear better and smell better, but they can't read or write, and so on). But using only those experiences to invoke a unitary and stable world with unbridgeable boundaries for them (what we call species) completely discounts the other experiences they have had as a result of living with me, of us being a family together.[6] They know what my words mean, even if they can't write or speak. I've learned to be much more attuned to smell and sound and other shifts of energy that are hard to put into words. These experiences matter because they change us all.

Detractors of pet-keeping might call this kind of life sad. We are investing in these creatures, they think, because we cannot "find" a human person to love. But from my perspective, it looks completely different. These majestic, wonderful beings are not empty ciphers; they have needs and desires that they communicate to me in a myriad of ways, and in listening and responding to them, I am not only changed but fulfilled. They help me carry my burdens and increase my joys. I know I am content when they rest soundly at my feet. It's not so much that I am no longer a lesbian, then, it's that the binary of gay and straight no longer has anything to do with me. My preference these days is canine.

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Collectively, the four positions tell us that it's perfectly fine to love animals, to sleep with them, to cuddle with them, to enjoy their bodies in a myriad of ways, but if we have "sex" with them, we immediately locate ourselves in the dangerous territory of bestiality. As Dekkers notes:

> If you drop the requirement that for sexual contact something has to be inserted somewhere and that something has to be fiddled with, and it is sufficient simply to cuddle, to derive a warm feeling from each other, to kiss perhaps at times, in brief to love, then bestiality is not a deviation but a general rule, not even something shameful but the done thing. After all, who does not wish to be called an animal lover? (Dekkers 1994, 149)

But without a coherent and agreed upon definition of sex (which queer theory persuasively argues is impossible), the line between "animal lover" and zoophile is not only thin, it is nonexistent. How do we know beforehand whether loving them constitutes "sex," and how can such sex be so dangerous if it so nebulous and undefined? In other words, the sense of danger associated with human/animal sex emerges as a result of a cultural anxiety about our own animality. That is, if we do "that" (leaving "that" unnamed and unrepresented), we will lose something about what it means to be human, to be superior.

Indeed, Dekkers, along with Alphonso Lingus, argues that sex itself turns us humans into animals, that in orgasm, animality saturates every pore and gene and bone of our being. As Dekkers claims, "every sexual encounter is a breaking of bounds, and intrusion into an alien realm, every sexual encounter retains a whiff of bestiality" (Dekkers 1994, 3).[7] Both of these authors argue for the pervasiveness of bestiality by insisting that it underlies all acts of love; in making love even to a fellow human, we are always encountering an animal or animalized other. Although this is clearly an interesting idea, my claim is slightly different. I'm not so much arguing that through sex we all become animals, but more that in deep connection, we all—humans and animals alike—become something different. The very contours of stable identities shift under the revolutionary power of love.

My point, then, is not to make something called bestiality more visible, but by using animal love in various permutations, to disrupt the stability and superiority of human identity. Convincing love stories between humans and animals—such as J. R. Ackerley's *My Dog Tulip* (1956) or Mark Doty's *Dog Years* (2007)—do just this; that is, they don't tell us of an identity called bestiality but show us a world transformed by human/animal love. Such love destabilizes what we think know about sex, what we think we know about gender, and what we think we know about being human. It can lead to what Margret Grebowicz calls "an inscription of a wholly new imaginary of animality and the condition for the possibility of new imaginaries of gender" (Grebowicz 2010, 14).[8] It can also lead,

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I think, to a different imaginary of what it means to be human. As Kalpana Seshadri-Crooks articulates it, "the ethical questions that follow [bestiality] entail an intervention at the level of the fundamental fantasy of being human" (Seshadri-Crooks 2003, 112).

Animals are emerging in the academy as a newly legitimized subject matter, and it's not a moment too soon. At no point in history have humans used animals like we're using them in America today. Factory farms crank out three pounds of meat per person per day from twenty billion food animals who function literally as flesh machines; thousands of breeders offer inbred, often aggressive, damaged pets for sale on the Internet and in pet stores everyday; millions upon millions of homeless pets are killed every year in shelters across America simply because they lack homes, and we humans don't want to deal with them in our communities; the black market in exotic animals from chimps to tigers to wolves crosses through zoos, laboratories, and collectors of all sorts; and the number of animals maimed and killed for the testing of products and pharmaceuticals is almost double what it was twenty years ago. In terms of sheer numbers alone, the situation for animals in America today has never been more dire. Something Eve wrote reflects the urgency I now feel toward these questions. She was writing, of course, about the homo/hetero boundary, but I take the liberty here of inserting my own agenda (and I hope wherever she is, she won't mind): "an understanding of virtually any aspect of modern Western culture must be, not merely incomplete, but damaged in its central substance to the degree that it does not incorporate a critical analysis of modern [human/animal definitions]" (Sedgwick 1990, 1).

Thinking about bestiality/zoophilia and the human/animal boundary is a good way into a larger discussion of these urgent problems, but only if we subject bestiality/zoophilia to the scrutiny of feminist queer theory. That is, we need to ask a set of questions that problematizes the limited subject positions we allow animals to occupy, and opens the conversation about sex itself onto a wider territory: what do we mean by sex? What kinds of ideologies accompany a worldview that separates all human animals from every other living thing on earth? How can we bridge this gap sexually, metaphorically, and literally? How can we deploy a discourse of sexuality that grants animals agency and fulfillment? How can we make a more fulfilling world for ourselves and for other animals? What do sex, animals, and sex with animals contribute to this world-making? Perhaps a preliminary answer to some of these questions, then, lies in a refiguring of my title: L, G, B, T, Z, **and** overarching all of them, Q?

*In Loving Memory of Eve Sedgwick*

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## Notes

1. Much has been written on the recent rise of pet culture in America; a full survey of that material is beyond the scope of this essay. See Haraway 2003; Grier 2006, Nast 2006b.

2. Of note here is a delightful chapter entitled "Why the (Lesbian) Child Requires an Interval of Animal: The Family Dog as a Time Machine," in Kathryn Stockton's *The Queer Child*. She writes, for example, "The family dog is not just a pet. It is a metaphor for all that is loyal, familial, and family-photogenic" (Stockton 2009, 90). Although I like the ways Stockton talks about the importance of animals in the life of a queer child, my goal in this essay is to make the family dog into something much more present than a metaphor.

3. Throughout human history, of course, the vast majority of discussions around bestiality existed in the twinned realms of moral theology and juridical practices. Interdicts against bestiality go as far back as the book of Leviticus, or farther, and are brought forward in court cases involving bestiality up through the Western seventeenth century. In most of these cases, events, and rules, bestiality is used as an attempt to regulate sexuality more generally, and all formed the foundation of the longstanding taboo we have inherited. In claiming that bestiality today resides in four locations, I do not mean to diminish the historical record at all. Rather, my point is that the taboo against bestiality is so widely accepted today that neither the church nor the courts need to involve themselves in policing it. Iterations of popular culture manage to accomplish this policing just fine on their own. For historical works on bestiality, see Canup 1990; Liliequist 1991; Godbeer 2002; Rydstrom 2003.

4. For an excellent feminist analysis of bestiality pornography, see Grebowicz 2010.

5. It's interesting to note that many formulations of animal rights secure their arguments based on the similarity of humans to nonhuman animals. As Tom Regan writes, "we understand their behavior because we understand ourselves and our behavior.... There is somebody there behind those canine eyes, somebody with wants and needs" (Regan 2004, 55). One might ask animal rights advocates why we couldn't also know their wants and needs in relation to sex.

6. Eve wrote extensively on this question of family, and as a result I am somewhat hesitant to insert it here, unproblematized. The term sets up a hierarchy where heteronormative coupling resulting in human children is "natural," and every other social arrangement gains legitimacy only insofar as it can argue its likeness to "the family." Nevertheless, recuperation may be possible. As Eve writes: "it's been a ruling intuition for me to disengage the bonds of blood, of law, of habitation, of privacy, of companionship and succor, from the lockstep of their unanimity in the system called 'family'" (Sedgwick 1993, 6). I take her to mean that her familial affections were not ruled by blood ties or marital contracts, that they floated outside these domains in ways that were unpredictable and queer. It's only in this sense that I want to make family with my dogs.

7. For a similar analysis, see Lingus in Steeves 1999.

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8. Of course, I do not mean to suggest that feminist theory in general or even in its queer inflections embraces or should embrace bestiality. Many feminists would disagree. See Adams 1995; Adams and Donovan 2007; Boggs 2010.

## References

Ackerley, J. R. 1956. *My dog Tulip*. London: Secker & Warburg.

Adams, Carol J. 1995. Bestiality: The unmentioned abuse. *The Animal's Agenda* 15 (6): 30–31.

Adams, Carol, and Josephine Donovan. 2007. *The feminist care tradition in animal ethics: a reader*. New York: Columbia University Press.

Beirne, Piers. 1997. Rethinking bestiality: Towards a concept of interspecies sexual assault. *Theoretical Criminology* 1 (3): 317–40.

Boggs, Colleen Glenney. 2010. American bestiality: Sex, animals, and the construction of subjectivity. *Cultural Critique* 76: 98–125.

Canup, John. 1990. *Out of the wilderness: The emergence of an American identity in colonial New England*. Middletown, Conn.: Wesleyan University Press.

Dekkers, Midas. 1994. *Dearest pet: On bestiality*. London and New York: Verso.

Doty, Mark. 2007. *Dog years: A memoir*. New York: HarperCollins.

Godbeer, Richard. 2002. *Sexual revolution in early America: Gender relations in the American experience*. Baltimore: Johns Hopkins University Press.

Grebowicz, Margret. 2010. When species meat: Confronting bestiality pornography. *Humanimalia: A journal of human/animal interface studies* 1 (2): 1–17.

Grier, Katherine C. 2006. *Pets in America: A history*. Chapel Hill, N.C.: University of North Carolina Press.

Haraway, Donna Jeanne. 2003. *The companion species manifesto: Dogs, people, and significant otherness*. Chicago: Prickly Paradigm Press.

Liliequist, Jonas. 1991. Peasants against nature: Crossing the boundaries between man and animal in seventeenth- and eighteenth-century Sweden. *Journal of the History of Sexuality* 1 (3): 393–423.

Nast, Heidi. 2006a. Loving whatever: Alienation, neoliberalism and pet-love in the twenty-first century. *ACME: An International E-Journal for Critical Geographies* 5 (2): 300–27.

———. 2006b. Critical pet studies? *Antipode* 38 (5): 894–906.

Regan, Tom. 2004. *Empty cages: Facing the challenge of animal rights*. Lanham, Md.: Rowman & Littlefield.

Rydstrom, Jens. 2003. *Sinners and citizens: Bestiality and homosexuality in Sweden, 1880–1950*. Chicago: University of Chicago Press.

Sedgwick, Eve Kosofsky. 1990. *Epistemology of the closet*. Berkeley: University of California Press.

———. 1993. *Tendencies*. Durham, N.C.: Duke University Press.

Seshadri-Crooks, Kalpana. 2003. Being human: bestiality, anthropophagy, and law. *UMBR(a)* 1 (1): 97–115.

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Singer, Peter. 2001. Heavy petting. *Nerve*. February 14, 2009. http://www.utilitarian.net/singer/by/2001—.htm (accessed January 2, 2012).

Steeves, H. Peter, ed. 1999. Animal others: On ethics, ontology, and animal life. In *SUNY Series in Contemporary Continental Philosophy*. Albany: State University of New York Press.

Stockton, Kathryn Bond. 2009. *The queer child, or growing sideways in the twentieth century*. Durham, N.C.: Duke University Press.

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← **Thread**

**Malcolm Clark**
@TwisterFilm

1./ Is the Beeb careless about paedophilia? One reason it might be is its closeness to madcap LGBTQ+ activists who seem themselves to be blasé about child safeguarding. How else to explain why the BBC is still showcasing this film presented by a notorious paedophile, Ian Dunn. 👇




11:23 PM · Dec 22, 2021 · Twitter Web App

**Malcolm Clark** @TwisterFilm · Dec 22, 2021

Replying to @TwisterFilm

2./ 'Glad to Be Gay' is one of the films in the BBC's Gay Archive. And who is Dunn? He was exposed in the 1980s as one of the founders of the Paedophile Information Exchange. Yet here's the BBC Pride staff group last week suggesting people check out the films. No questions asked.

5 2 8

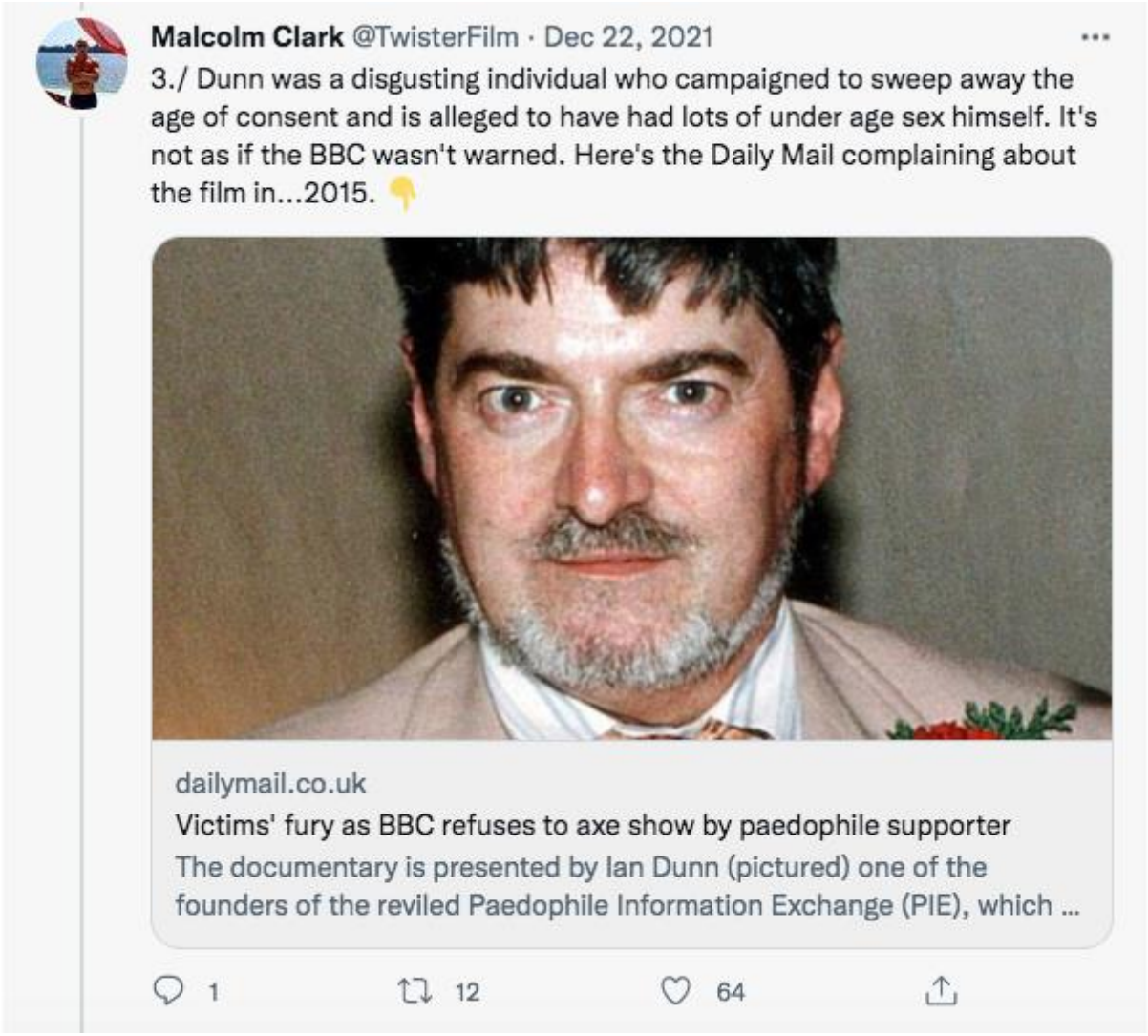
**BBC Pride** @BBCPride · 5d

Did you know the BBC has a huge collection of archive content available to view on the gay rights movement in the UK?

You can see programming going right back to 1957 after the publication of the Wolfenden Report

It's all available here:




Malcolm Clark @TwisterFilm · Dec 22, 2021
3./ Dunn was a disgusting individual who campaigned to sweep away the age of consent and is alleged to have had lots of under age sex himself. It's not as if the BBC wasn't warned. Here's the Daily Mail complaining about the film in...2015. 👇
dailymail.co.uk
Victims' fury as BBC refuses to axe show by paedophile supporter
The documentary is presented by Ian Dunn (pictured) one of the founders of the reviled Paedophile Information Exchange (PIE), which ...
1
12
64


Malcolm Clark @TwisterFilm · Dec 22, 2021
4./ There's an argument for allowing access to the film as a historical item. But it's a total ethical failure not to highlight the TRUTH about Dunn. Here's what happened to the National Museum when they presented Dunn as some sort of gay rights hero.👇
scotsman.com
National Library of Scotland criticised over tribute to paedophile camp...
Bosses at the National Library of Scotland have removed an exhibit which paid tribute to a late gay rights campaigner after it was revealed...
2
10
58

**Malcolm Clark** @TwisterFilm · Dec 22, 2021

5./ Even the Greens' Patrick Harvie had to apologise for taking an award in Dunn's name tho I'm not sure he ever handed it back. IF the BBC took advice from mainstream LGB staff I'd guarantee they'd urge the Beeb to highlight Dunn's appalling mixed record and terrible legacy. 👇



power within the Holyrood chamber. A vocal supporter of the SNP's controversial Named Person scheme, he was one of two MSPs who accepted awards commemorating a gay rights activist who fought to legalise paedophilia.

It emerged in January 2007 that he and Lib Dem Margaret Smith, a lesbian, both received the Ian Dunn Memorial Award for Activism. Dunn, who died in 1998, was a gay rights activist in later life but in the 1970s co-founded an organisation that promoted sexual relations between adults and children.

THE award named after him was presented by gay rights campaigners to honour public figures who have worked to promote equality and tolerance of the lesbian and gay community in Scotland.

Mr Harvie was forced into retreat after his acceptance of the award was disclosed, saying he

He called for the award (now discontinued) to be renamed but in 2014 it emerged that the MSP had never sent it back – a decision his spokesman at the time seemed unable to explain adequately.

Mr Harvie was also criticised when it emerged he was a senior figure in the Gay and Lesbian Humanist Association.

The group believed 'gay children' were at risk in Catholic schools, claiming that the Catholic Church 'hates them' and is responsible for their 'unchecked bullying'.

At the time, Mr Harvie was branded a 'fascist', determined to introduce 'sexual anarchy' into schools. Asked if he would quit the association, he said: "It would be absurd to leave an organisation because of one badly written press release."

Despite these unedifying rows,

alised – that Mr Harvie could be handed a Cabinet post in the then Scottish Executive.

It was expected that the election would lead to a scramble among the main political parties to form a workable alliance, placing 'fringe' movements such as the Greens in an extremely powerful position.

Ultimately, the SNP formed a minority administration, but for four years Alex Salmond relied on the Greens to prop up key policies.

Now, with history repeating itself, Mr Salmond's successor faces striking another similarly undignified alliance to allow her to govern effectively – but one which may leave her credibility broken beyond repair.

1 7 57

**Malcolm Clark** @TwisterFilm · Dec 22, 2021

6./ Instead the BBC relies on its LGBTQ+ Queer Theory influenced activists who seem to share the tin ear of the likes of Peter Tatchell on the horror felt by the public at paedophilia. Here's Tatchell's uplifting obituary to Dunn, the notorious paedo. 👇

independent.co.uk
Obituary: Ian Dunn
IAN DUNN was a pioneer for lesbian and gay human rights, remaining a central figure in the battle for ...

1 10 64


Malcolm Clark @TwisterFilm · Dec 22, 2021
7./ The BBC has been advised by Stonewall and other weird organisations for years. You have to wonder why in all that time the BBC has not removed a paedophile from its showcase history of gay rights. Maybe they don't care about gay people's reputation? 👇
bbc.co.uk
The Gay Rights Movement
In 1967, homosexuality was partially decriminalised in England and Wales. Since then, terms like 'clause 28', 'the age of consent' and 'civi...
1
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74

25th September 2020 mermaids_author

# Do you use the phrase: 'Born in the wrong body'?

Language matters. In a world filled with social media posts, forums, blogs and online articles; all of them demanding answers to be picked apart, it's difficult sometimes to find the right words. That would be the case if we were talking about any subject, but when the discussion is around something so personal and individual as gender identity… it's tough.

One of the most exciting things about our work over the past 25 years has been bearing witness to young people changing and moulding the way they express who they are. We've seen certain words and phrases disappear while some other words have moved back into everyday language.

**One particular phrase, which has been used for a long time by people, is 'I was born in the wrong body'.**

**We recently posted** that 'no child is born in the wrong body', which is our broad position as a charity. Why? Because we believe that transgender people shouldn't be expected or encouraged to reject their entire amazing, intelligent, beautiful, creative bodies, simply because of gender incongruity. Still, we also know some people – including some of our amazing patrons – do use that phrase to express who they are. It is your right to use whatever words you choose to describe yourself. As a charity representing lots of different people, however, we have to make sure our language is as inclusive as possible, especially for people who might be struggling with their gender.

> **To me now, the phrase feels like something that was given to us.**
>
> AYLA HOLDOM, MERMAIDS PATRON

Of course, the phrase is one we've used ourselves in the past and, at the time, it seemed helpful. Back then, the idea that anyone – let alone a young person – could be transgender or gender-diverse was a new concept for many of those we spoke to. That collective lack of experience meant transgender people and support organisations had to find some way of explaining what being trans meant. At best a difficult task, at worst a harmful and humiliating one. After all…

**Nobody should have to simplify, redact or misrepresent their own innate self, simply to please the minds of those who struggle to comprehend it.**



Model, campaigner and Mermaids patron, Munroe Bergdorf used to say she was born in the wrong body but then decided it wasn't right for her: 'I've come to understand why the phrase 'born in the wrong body' is unhelpful to me. I know why I used to use it; because other people struggled to understand, but looking back I know it did me harm. Saying you have the wrong body feels like a kind of self-abuse, and it's not the same as saying 'I need to adjust my body to be my true self'. That's a different thing. We only get one body and it's really important, especially for younger people to know they are unique and beautiful. I would say to younger people that transitioning is hard so you need to look after your body, love it and respect it.'



Film director and Mermaids patron, Jake Graf, is an extraordinary champion of trans young people, partly because he speaks so openly about his own journey. For him, language and understanding of trans identities has moved a long way over the last ten years and that's something to be celebrated, but he still feels he was born in the 'wrong' body: 'I have always felt since I was a child that my body didn't match my identity. I've made changes with surgery and hormones, but I still feel my body is not the one that I was meant to be in. Although I'm now comfortable with myself and in my own body I do still feel a slight disconnect with parts of it and would always describe myself as having been born in the wrong body. It's important people can use that phrase for themselves, without having to feel uncomfortable about it.'



Mermaids CEO, Susie Green said: 'Language is evolving all the time, and I find it incredibly humbling to be a part of that journey for so many young people. In the past, I've explained my daughter's journey and her feelings in exactly this way. It can be so difficult to explain these things to people who're hearing about gender identity for the first time.  Certain phrases can make it easier, but no words will ever do justice to reality. **Still, and I cannot stress this enough,**

**it is not for Mermaids or anyone else to instruct people on how to describe themselves and there is no judgement whatsoever if you feel it's right for you to say you were born in the wrong body.'**



National Police Air Service Pilot, Ayla Holdom used the phrase to explain her identity to **cisgender** people but then decided to stop: 'It never felt right deep down because my body is my body and since I've gotten older I've come to respect that. I used to feel uncomfortable with myself and the way I fitted into the world, but I never hated my body. I've been really blessed to have the body I've got. **To me now, the phrase feels like something that was given to us.** The problem is, it's so hard to describe what gender incongruence feels like so you do end up using a sort of shorthand. As trans people, none of us became valid the day we had our surgeries or interventions so society needs to understand that we are trans because we're trans not because of our bodies.'

> **I just don't get why it's such a big deal to people who aren't affected by it. My body, my choice!**
>
> DIVINA DE CAMPO, RUPAUL'S DRAG RACE UK STAR AND MERMAIDS ALLY

That's an important point. So often people fixate on bodies, rather than talking about people as complete individuals. It can lead to inaccurate and often harmful discussion online and in the press. Still, it doesn't get us down at Mermaids. We know there are millions of trans allies out there ready to listen and empower trans lives and we're seeing our young people growing in confidence every day.



Former British Army Captain, Hannah Graf MBE has been an inspiration to our service users for many years. She feels there's an important distinction to be made around the phrase: 'To me, it depends on who's talking to whom. I would never tell anyone else they're in the wrong body but I might use it about myself sometimes because it can be a useful way to describe my experience. If we can't do that then how can we expect people to empathise with us and give support? Likewise, it would be wrong for me to suggest that any child is in the wrong body but if a young person says they are then they should be listened to and acknowledged.'




https://twitter.com/Divinadecampo

Rupaul's Drag Race UK star, Divina De Campo says, no matter your position, it's important to focus on the positive: 'Life is the most amazing and incredible gift. The fact we're even alive is in itself incredible! That being said people are born with all kinds of issues and questions about their own bodies, not just trans people. The important thing is that people feel free to express themselves with their bodies and their language in a way that makes them feel empowered. We all experience the world differently and no-one is 100% certain that what we experience is the same for everyone else. To me, feeling like my body isn't right is valid. **I just don't get why it's such a big deal to people who aren't affected by it. My body, my choice!'**

The question of language and messaging is an important part of our work as a charity. We always do our best to stay attuned to our service users and supporters, and we don't always get it spot on. Thankfully, we have junior and senior staff with lived experience who help to keep us right.



Our Director of Legal and Policy, Lui Asquith said: 'As a non-binary person, the language I use to describe the relationship between my body and my gender identity has changed throughout my life. It responds to what I'm experiencing at any one time really, and it is a very personal

decision. It's never ok to tell an individual that the way they wish to describe themselves is wrong. There will be terms that I use today that I won't use in 10 years' time and then I'll probably be rolling my eyes. The current language of our 'community' will be the history of language to the next generation and I think that's a history to respect, look back on with interest and embrace.'

Hollyoaks actress, Annie Wallace added "Back when I transitioned, many years ago, I thought that "being born in the wrong body" was an easy shortcut to explain how I felt to people who couldn't understand what being transgender meant at all. But it's much more complex than that.  For many years, I hoped my mind would feel at home in its body, but unfortunately that never came to pass. The more I tried to ignore it, the stronger the feeling would come back. Eventually, I reached the point where my body had to be changed to
fit the mind.

For some, body modification is absolutely the right thing to do, and for others, it's not. No-one should feel pressured to be a "proper trans person" through surgery. Everyone's journey is different. In the past, things were fairly cut and dried and there was an expected surgical path for trans people. Today, there are more options, and wider spectum of gender than ever before, and along with that, a greater understanding of
the nuances."




YouTuber and head of Mermaids socials, Jake Edwards has talked publicly about their journey as a non-binary young person. They manage social media and monitor traffic when we get a particularly strong reaction to our communications. **A recent post** on Twitter gained a lot of attention from people who thought we were somehow shifting or even 'pulling a 180' in our position.

Which, Jake says, is strange and revealing: 'Yes it's a bit weird to be honest. We've enjoyed making our position on various things really clear recently and in some of those cases, people have been finding out we're not so opposed on certain points as they'd imagined. You might think that's a good thing, but some seem very angry about it. To me, needing to adjust your body

isn't the same as rejecting your whole body. Personally, I absolutely do not think my body is wrong; I don't feel that there was a mistake when I was born, and I don't think I needed to 'fix' myself. As someone who has taken hormones and had surgery, I view those things as… how can I put it?… kind of personal upgrades to who I was supposed to be, if that makes sense? Not that they'd be right for other people. Sure, I may have seen those upgrades as essential, but my body wasn't wrong without them. Surgery was essential for me to live my happiest and most fulfilling life, because I could look at myself in the mirror and see something that reflected the inside.'

Thanks Jake and thanks everyone who gave us their thoughts. This article isn't supposed to be the end of a conversation; in fact, it would be great if it started a new discussion around this area of language and gender identity. For now, as always, we call for people to listen to trans people before speaking about them.






NATIONAL
LOTTERY FUNDED

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Guidance

# Plan your relationships, sex and health curriculum

Information to help school leaders plan, develop and implement the new statutory curriculum.

From:
Department for Education (/government/organisations/department-for-education)
Published
24 September 2020
Last updated
17 February 2022 —

### Applies to England

### Contents

- Creating a policy for the new curriculum
- Adapting an existing programme of study
- Deciding what to teach at primary and secondary level
- Teaching these subjects
- Planning your curriculum
- Using external agencies
- Choosing resources
- Creating an inclusive classroom
- Ensuring content is appropriate
- Dealing with sensitive issues
- Handling difficult questions
- Right to request withdrawal
- Identifying teachers' needs
- Assessment and evaluation

This guidance is aimed at:

- headteachers and principals

- senior leadership teams
- teachers
- curriculum co-ordinators
- governing bodies and proprietors

It gives some basic principles to help school leaders plan and prepare for the new statutory curriculum. Schools have the flexibility to design their own curriculum to ensure it meets the needs of pupils and the community, as well as the statutory requirements.

Schools are required to teach:

- relationships education (all primary aged pupils)
- relationships and sex education (RSE) (all secondary aged pupils)
- health education (all pupils in state-funded schools only)

Ofsted school inspectors will evaluate the provision for relationships education, relationships and sex education and health education in line with the school inspection handbook (https://www.gov.uk/government/publications/school-inspection-handbook-eif) and in the context of this guidance.

Independent schools are required to teach personal, social, health and economic (PHSE) education.

Sex education at primary school is not compulsory but can be taught if a school decides that it is appropriate to do so.

All pupils should receive teaching on lesbian, gay, bisexual and transgender (LGBT) relationships during their school years. Secondary schools should include LGBT content in their teaching. Primary schools are strongly encouraged, and enabled, when teaching about different types of family, to include families with same sex parents.

Headteachers and teachers must read the statutory guidance (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education) in full. It contains information on what schools should do and sets out the legal duties you must meet.

## Creating a policy for the new curriculum

It is important to read the developing a policy (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#developing-a-policy) section of the statutory guidance to ensure you understand what you need to comply with.

All schools must have a written policy in place for the new relationships education and relationships and sex education curriculum.

Policies are typically approved by the governing body, or the appropriate body if that is not the governing body (for example, the trust board).

You will need to decide the outline of your curriculum and consult with parents and carers on the policy before finalising it.

The statutory guidance suggests typical sections you may wish to include in your policy such as:

- details of the content or scheme of work and when each topic is taught, taking the age of pupils into account
- who delivers relationships education or relationships and sex education
- whether you're using any external organisations to teach part of the curriculum
- how the policy has been produced, and how it will be kept under review, in both cases working with parents and carers, as set out in the advice on engaging parents with relationships education (https://www.gov.uk/government/publications/engaging-parents-with-relationships-education-policy)
- how the delivery of the content will be made accessible to all pupils, including those with special educational needs and disabilities (SEND)
- an explanation of the right to withdraw pupils from sex education classes
- requirements on schools in law, for example (where relevant), the Human Rights Act 1998 (https://www.legislation.gov.uk/ukpga/1998/42/contents), the Equality Act 2010 and the Education Act 1996 (https://www.legislation.gov.uk/ukpga/1996/56/contents)
- how often the policy is updated
- who approves the policy

Where parents and carers have complaints which cannot be resolved through informal discussion, you should ask them to follow your school's (curriculum) complaints policy.

## Integration to the whole school ethos

You should already have a statement of values and ethos. This may include personal qualities and behaviours you seek to foster.

Consider making a link between your values and ethos statement and your relationships, sex and health education policy.

## Adapting an existing programme of study

Many schools who are planning their curriculum for relationships education, relationships and sex education and health education will be doing so within a broader personal, social, health and economic (PSHE) education framework (https://www.gov.uk/government/publications/personal-social-health-and-economic-education-pshe).

You could choose to teach the new compulsory content within the PSHE education framework if this model meets the needs of your pupils. The new curriculum and your PSHE education framework do not need to be seen as separate subjects.

PSHE education remains non-statutory in maintained schools although the new subjects cover much of the content typically included in a PSHE education programme. PSHE education continues to be compulsory in independent schools, as set out in the Education (Independent School Standards) Regulations 2014 (http://www.legislation.gov.uk/uksi/2014/3283/schedule/made#:~:text=The%20Education%20%28Independent%20School%20Standards%29%20Regulations%202014%201,Quality%20of%20leadership%20in%20and%20management%20of%20schools).

Before you plan your new curriculum, you need to review your current curriculum plan in light of the statutory requirements. Your school may already have some provision in place that will support delivery. For example, a wider school ethos of inclusion and anti-bullying procedures.

## Deciding what to teach at primary and secondary level

The statutory guidance specifies:

- what topics need to be taught at primary level and secondary level

- what pupils should know by the end of each level

It does not break the curriculum up by key stage, year group or age. This is because decisions about when to teach topics will vary by school and context.

Use your knowledge of your pupils to choose whether to:

- introduce secondary requirements in primary with pupils who are ready (with parental consultation and consent)
- include primary requirements in secondary teaching where pupils have gaps in their understanding, to build their knowledge before they progress (this is likely to be needed as the new curriculum is introduced)

Try to identify what pupils already know at the start of a lesson or topic. Topics should be revisited, as necessary.

Consider working with your academy trust or local authority and local public health teams when embedding statutory relationships, sex and health education within your whole school ethos. They can work with you to help make sure:

- you are clear on what has been covered already, for example, what a secondary school pupil might have been taught in primary school
- teaching progresses smoothly from key stage to key stage
- you understand local health profiles of children and young people within the catchment area of the school, which can help you identify priorities in the curriculum
- you have a knowledge of the wider specialist support services (including sexual health services) available to children and young people in the area

Contact your local public health team to find out what tailored local support is available. The names of current local directors of public health (https://www.adph.org.uk/current-directors-of-public-health/) are available on the Association of Directors for Public Health website. You can also contact them through your local authority.

## Teaching these subjects

These subjects should be set in the context of a whole-school approach to supporting pupils to be safe, happy and prepared for life beyond school. It is important that as you begin to plan your curriculum, you are clear about your approach to pedagogy and connect to wider school approaches on how pupils learn to promote good progress.

The evidence and expert guidance on how children are best taught applies to these topics as to all others.

Teaching should:

- clearly explain the knowledge, facts and concepts needed
- provide adequate opportunities for pupils to recall the acquired knowledge, facts and concepts to develop an understanding of the topic

The training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) provide some examples of good practice and approaches you might consider when preparing to teach about individual subjects.

You can deliver a carefully sequenced and coherent curriculum, by:

- identifying the essential concepts, knowledge, skills and principles of the subject and providing an opportunity for all pupils to learn and master these critical components
- ensuring pupils' thinking is focused on key ideas within the subject
- working with experienced colleagues to accumulate and refine a collection of powerful analogies, illustrations, examples, explanations and demonstrations
- using resources and materials aligned with the school curriculum (for example, printed or online textbooks or shared resources designed by experienced colleagues that carefully sequence content)
- being aware of common misconceptions and discussing with experienced colleagues how to help pupils master important concepts

A good summary of what we know about effective pedagogy and how to apply it is in the Early Career Framework (https://www.gov.uk/government/publications/supporting-early-career-teachers).

## Planning your curriculum

The relationships education, relationships and sex education and health education curriculum complements several other curriculum subjects. You should look for opportunities to draw links between the subjects and integrate teaching where appropriate.

For example, it may be helpful to know:

- in secondary schools when relevant aspects of science (biology) are taught in relation to sex education
- in primary schools when relevant aspects of puberty are taught in science
- when and how physical education covers the benefits of an active lifestyle and cardiovascular exercise
- how content in computing relates to online and media topic
- when literary texts which touch on emotional aspects of relationships are studied in English

## Points to consider when planning your curriculum

When planning your curriculum, consider mapping out terms, years and key stages to help decide which topics you will cover and when. Also, consider whether there are topics which will need to be covered more than once as pupils grow in maturity.

You will also need to consider the most appropriate method for teaching certain topics. This could mean having:

- regular lessons – for example, a weekly or fortnightly slot in class taught by the class teacher
- a teacher or other appropriate adult in school who teaches a particular topic to all classes in turn
- additional whole school / key stage assemblies, either led by staff at school or by a carefully selected external speaker or expert - it's important to remember that assemblies should not be a substitution for timetabled lessons

It is possible that you may see an increase in disclosures as a result of teaching the new subjects. You should remind all staff members of the correct procedures to follow, should any disclosures from individual pupils be prompted by lessons in these subjects.

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

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## Using external agencies

External agencies (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements) can provide speakers, tools and resources to enhance and supplement the curriculum.

It is important when using external agencies to take particular care that the agency and any materials used are appropriate and in line with your school's legal duties regarding political impartiality, which you can find more information about in our guidance on political impartiality in schools (https://www.gov.uk/government/publications/political-impartiality-in-schools).

Schools are responsible for ensuring that speakers, tools and resources do not undermine the fundamental British values of democracy, the rule of law, individual liberty, and mutual respect and tolerance of those with different faiths and beliefs.

When deciding on the external agencies and resources to use, you should make appropriate checks to ensure that the agencies' approach to teaching relationships education, relationships and sex education and health education and the resources that they plan to use comply with:

- your school's policy
- the Teaching Standards
- the Equality Act 2010
- the Human Rights Act 1998
- the Education Act 1996

You should engage with agencies to ensure their approach to teaching about relationships education, relationships and sex education and health education is balanced and the resources they intend to use are age-appropriate and aligned to the developmental stage of the pupils being taught. Schools should exercise their judgement reasonably, in line with their legal responsibilities, in the selection of providers and resources to be used. You should exercise extreme caution when working with external agencies and proceed only if you have full confidence in the agency, its approach and the resources it uses.

Schools should not under any circumstances work with external agencies that take or promote extreme political positions or use materials produced by such agencies. More information on this, including examples of extreme political positions, can be found in guidance on political impartiality in schools (https://www.gov.uk/government/publications/political-impartiality-in-schools).

It is important to be clear about what you want from an external agency, tool or resource. You should consider the range of options available to ensure what you use is best suited and appropriate to your school and pupils and are of a high quality and sufficient value.

If you are using external speakers to deliver part of the curriculum, then it is important to make sure the expert and any tool or resource they might use meets the outcome of that part of the curriculum.

External experts and resources can also be useful for developing curriculum planning ideas, activities and identifying age-appropriate outcomes.

It is important that you review any case study material and look for feedback from others they have worked with.

You should be clear what they are going to say and what their position on the issues to be discussed are. You should ask to see any materials that external agencies may use in advance.

Make sure you know the named individuals who will be there, any need for Disclosure and Barring Service (DBS) checks and that there is an agreed protocol should any safeguarding issue arise, for example from a disclosure.

You should also conduct a basic online search (as parents and carers may do this). It is important that anything you or parents and carers would be concerned about is addressed beforehand.

Before a session with an external speaker, it is important to check protocols for taking pictures or using any personal data the external speaker may get from the session.

Remember teachers should not be afraid to say 'no', or in extreme cases stop a session. These are your pupils and you are responsible for what is said to them.

It is good practice for the teacher to be in the room, so they know what was discussed and can follow up with their pupils. They will also understand what has been discussed if a pupil makes a disclosure later.

## Choosing resources

There are many external resources (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#use-of-materials) available to support the delivery of your lessons, these include:

- lesson plans
- complete curriculum plans
- other classroom materials such as videos or posters

Any materials you intend to use should align with the teaching requirements set out in the statutory guidance.

Many organisations actively promote external resources to schools. It is important when choosing resources to take particular care that any materials used are appropriate and in line with your school's legal duties regarding political impartiality, which you can find more information about in our guidance on political impartiality in schools (https://www.gov.uk/government/publications/political-impartiality-in-schools).

Schools should not under any circumstances use resources produced by organisations that take extreme political positions on matters. This is the case even if the material itself is not extreme, as the use of it could imply endorsement or support of the organisation.

When deciding if a resource is suitable, you should consider if it:

- aligns to the teaching requirements set out in the statutory guidance
- would support pupils in applying their knowledge in different contexts and settings
- is age-appropriate - think about the age, developmental stage and background of your pupils
- is evidence-based and contains robust facts and statistics
- fits into your curriculum plan
- is from a credible source

It is also important to consider whether the resource is compatible with approaches to teaching which are known to be effective. These approaches are summarised in the Early Career Framework (https://www.gov.uk/government/publications/supporting-early-career-teachers). The resources you choose should deliver knowledge in a way that supports the building of pupils' confidence.

Resources should also be sensitive to pupils' experiences as some may have already been exposed or at risk of content being taught. You should ensure that resources do not exhibit any content that may provoke distress.

A series of DfE training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) are also available which subject leads can use to train other teachers.



## Creating an inclusive classroom

You should consider what it is like for a diverse range of pupils to be taught about these topics and how individual pupils may relate to particular topics, including complex and sensitive subjects that might personally affect them.

These topics should help all pupils understand their physical and emotional development and enable them to make positive decisions in their lives.

The approach you take to planning and teaching these subjects should take account of those pupils who may be at different stages of cognitive development to their peers. For example, for some pupils in secondary schools, there may be a need to focus on primary content beyond age 11.

You should also make sure the framing of issues is appropriate and that additional time is taken to explain to parents and carers what will be taught and why.

Some pupils may have already been exposed to, or be at risk of exposure to, the experiences and content being taught. Developing a sensitive teaching style will be key to ensuring all pupils feel safe and supported in lessons and able to engage with the key messages.

As well as classroom teaching, you may want to consider other options including digital approaches, one-to-one discussions, teaching in small groups or targeted sessions for some pupils.

## Supporting pupils with additional needs

It is important to read the supporting pupils with special educational needs and disabilities (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#pupils-with-special-educational-needs) section of the statutory guidance.

Relationships education, relationships and sex education and health education must be accessible for all pupils and this is particularly important when you are planning teaching for pupils with special educational needs and disabilities (SEND).

Subject leaders should liaise with the class teacher and special educational needs co-ordinator (SENCO) to make sure:

- the needs of all pupils are met
- the curriculum is fully accessible
- education, health and care (EHC) plans are followed

If your school is a mainstream school, you should ensure that teaching is differentiated to support pupils with SEND to fully access the curriculum. This might include revisiting earlier topics or spending longer on a topic. Effective use of teaching assistants will support this.

You should also use your own expertise and knowledge to differentiate activities within lessons where needed.

Specialist resources can be used to support effective teaching. You can use the picture exchange communication system (PECS) to create resources or image-based books for pupils with SEND.

There are specific duties set out in:

- schedule 10 of the Equality Act 2010 (http://www.legislation.gov.uk/ukpga/2010/15/schedule/10) to support the participation of disabled pupils
- chapter 6 of the SEND code of practice (https://www.gov.uk/government/publications/send-code-of-practice-0-to-25), to support the participation of pupils with SEND

## The Equality Act 2010 and Public Sector Equality Duty

Schools are required to comply with relevant requirements of the Equality Act 2010 (https://www.legislation.gov.uk/ukpga/2010/15/contents). Chapter 1 of Part 6 of the Act applies to schools.

The content of the school curriculum is exempt from the duties imposed on schools by Part 6 of the Equality Act.

This means schools are free to include a full range of issues, ideas and materials in their curriculum. Schools are not required to equally weight all of the protected characteristics within the curriculum.

The Public Sector Equality Duty (https://www.equalityhumanrights.com/en/publication-download/public-sector-equality-duty-guidance-schools-england) (as set out in section 149 of the Equality Act 2010) requires all public authorities (including state-funded schools) in the exercise of their function, to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it

Relevant protected characteristics are:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race
- religion or belief
- sex and sexual orientation

State-funded schools must ensure that the public sector equality duty is discharged when taking decisions.

Pupils should leave school with a proper understanding of the importance of equality and respecting and understanding differences. This includes differences in religion, belief, or sexual orientation.

The guidance for promoting fundamental British values (https://www.gov.uk/government/publications/promoting-fundamental-british-values-through-smsc) provides some helpful principles to guide practice.

## Ensuring content is appropriate

The safety of children is of paramount importance in school.

Teachers should be aware of age-inappropriate material on the internet. Great caution should be exercised before setting any assignment, in class or at home, that involves researching a subject where there is a high risk that a child could accidentally be exposed to age-inappropriate material, such as pornography. Particularly at primary level, you should be careful not to expose children to over-sexualised content.

Knowledge about safer sex and sexual health is important to ensure that young people are equipped to make safe, informed and healthy choices. This should be delivered in a non-judgemental, factual way and allow scope for young people to ask questions in a safe environment. Schools have the freedom to develop an age-appropriate, developmental curriculum which meets the needs of their young people, in consultation with parents and the local community.

You should be mindful of the law and legal requirements and be careful not to condone or encourage illegal political activity, including violent action against people, criminal damage to property, hate crime or terrorism, or the use of illegal drugs.

We are aware that topics involving gender and biological sex can be complex and sensitive matters to navigate. You should not reinforce harmful stereotypes, for instance by suggesting that children might be a different gender based on their personality and interests or the clothes they prefer to wear. Resources used in teaching about this topic must always be age-appropriate and evidence based. Materials which suggest that non-conformity to gender stereotypes should be seen as synonymous with having a different gender identity should not be used and you should not work with external agencies or organisations that produce such material. While teachers should not suggest to a child that their non-compliance with gender stereotypes means that either their personality or their body is wrong and in need of changing, teachers should always seek to treat individual students with sympathy and support.

You should work together with parents on any decisions regarding your school's treatment of their child, in line with the school's safeguarding policy and the statutory guidance on working together to safeguard children (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2).

## Dealing with sensitive issues

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

What is sensitive or likely to give parents, carers or teachers cause for anxiety may vary according to the context of the school.

Conversations within your lessons should not lead to any type of bullying, ostracising or other forms of social or emotional harm. Pupils should be aware of this and lessons should be delivered in such a way to ensure this does not happen.

To help create a safe environment for pupils when teaching these topics, you should consider:

- setting ground rules for lessons, where needed, particularly around not sharing personal information (there is guidance on how to create ground rules in the individual subject training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education))
- stopping discussions if personal information is shared in lessons and following up with pupils later where needed
- not promising confidentiality if a pupil confides something concerning
- telling pupils they can ask for help and they will be taken seriously

## Managing a sensitive class discussion

Occasionally teachers may find that managing a whole class discussion is a useful stage in the teaching of a particular topic.

Whole class discussions can be a useful way to model listening respectfully to the views of others.

## Distancing techniques

You can avoid embarrassment and protect pupils' privacy by always depersonalising discussion, for example, using a case study to illustrate an issue.

Pupils can then talk about a fictional character in the case study without having to share personal information.

You should manage and lead discussions attentively. If the discussion is at risk of straying, you need to be prepared to redirect it back to intended topics.

It is generally not helpful to ask pupils to lead or chair discussions on sensitive topics as there can be a greater risk of going off-topic.

## Handling difficult questions

Teaching in these subjects should allow appropriate opportunities for pupils to ask questions to check and test their understanding.

Most questions will be relevant to what the teacher has explained, and general questions should be welcomed. Pupils should not feel penalised or censored for asking sensible or relevant questions, even if they are occasionally awkward.

Sometimes, pupils may ask questions which go beyond what the teacher has planned and may stray into sensitive territory.

There is no single way to address all such questions – some may be handled straightforwardly for the whole class to hear.

You should be mindful and explain to teachers that a question may occasionally raise a possible safeguarding concern, and the school's safeguarding process should be followed in such cases.

The individual subject training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) include advice on handling difficult questions.

### Primary level

Some questions may relate to sex education which the school may not be teaching, or not yet. These should generally not be answered in front of the whole class.

Strategies to handle such questioning could include offering a word outside the lesson, referring to another more senior member of staff or offering a simple 'holding' answer and mentioning the question to parents and carers at the end of the day.

> It is important to read the managing difficult questions (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/relationships-education-primary#managing-difficult-questions) section of the statutory guidance.

### Secondary level

Questions relating to sex education may come up anytime. There might be pupils whose parents or carers do not want them to receive sex education in school, therefore particular care should be taken when answering questions in front of these pupils.

Where a pupil who is withdrawn from sex education asks a question relating to sex education content, teachers should offer a brief 'holding response', usually via a senior member of staff and draw the issue to the attention of the pupil's parents and carers, unless there is a safeguarding concern and then the school's

safeguarding process should be followed in such cases.

For pupils who are not withdrawn from sex education, it may be appropriate to speak discreetly with the pupil asking the question at the end of the lesson to address their question or to ensure the answer is covered in subsequent teaching which is clearly designated as sex education.

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

## Right to request withdrawal

It is important to read the right to be excused from sex education (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#right-to-be-excused-from-sex-education-commonly-referred-to-as-the-right-to-withdraw) (also referred to as the right to withdraw) section of the statutory guidance to ensure you understand what you need to comply with.

You should be clear in your published policy when in the curriculum different aspects of sex education are taught.

The policy should state clearly that parents and carers have the right to request withdrawal from all or part of sex education. It should also tell them who to contact to make such a request - this will usually be the headteacher, in the first instance.

When a request is received, consider meeting with the parents and carers to:

- discuss the background to their request
- offer assurances about your school's approach
- set out the benefits of pupils accessing sex education in school

If parents and carers decline an invitation to a discussion, you must still process their request for withdrawal in the normal way.

If the parents still want withdrawal after such a discussion, unless there are exceptional circumstances, parents and carers' request should be granted until 3 terms before the pupil turns 16. For example, if the pupil's 16th birthday is in February of year 11, that point would be February in year 10.

At that point, if the pupil wishes to be taught sex education, you must ensure they receive it in one of those 3 terms and continue to be taught it while the child remains in school.

## Right to withdraw – pupils with special educational needs and disabilities (SEND)

In most cases, there should be no difference in the approach between SEND pupils (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#pupils-with-special-educational-needs) and other pupils.

However, in cases where the nature or degree of the pupil's special educational need or disability, possibly combined with their domestic or social circumstances, mean that they are demonstrably very likely to be at unusual risk from sexual activity or sexual exploitation, then your headteacher may judge that an exception should be made.

In such exceptional cases, your headteacher may decline a parental request for withdrawal (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#right-to-be-excused-from-sex-education-commonly-referred-to-as-the-right-to-withdraw).

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

## Record keeping and informing parents and carers

You should keep a record of all discussions with parents, carers and pupils concerning the right to withdraw, exceptions and decisions not to grant it.

Where possible, you should share records of all discussions with parents and carers to make sure all parties are clear about the decisions.

## Primary sex education (where taught)

**Primary schools are not required to teach sex education but must teach relationships education and have regard to the statutory guidance in full.**

Primary schools may already have age-appropriate sex education programmes in place. There is no need to change these if your curriculum is working well. However, sex education is outside the content defined for relationships and health education in primary schools.

You need to set out clearly in your policy if you are teaching sex education. You must also be aware of the parental right of withdrawal at primary. You should make it clear to parents and carers in your policy and set out a practical method for them to communicate to school if this is their wish. Stating clearly exactly what aspects of sex education are covered in what terms and years is helpful to allow parents and carers to make this decision.

Parents and carers cannot withdraw their child from:

- relationships education
- health education
- national curriculum science (https://www.gov.uk/government/publications/national-curriculum-in-england-science-programmes-of-study)

Read our advice on engaging parents and carers on relationships education (https://www.gov.uk/government/publications/engaging-parents-with-relationships-education-policy) which explains why it is important to engage with parents and carers, as soon as possible, and gives tips on how to do this.

## Identifying teachers' needs

## Teacher wellbeing

It is essential that teachers can maintain their own wellbeing when delivering the curriculum. There may be times that a topic triggers feelings or thoughts, including of historic, recent or current trauma.

It is important for school leaders to appreciate the different nature of these subjects, and be understanding of teachers' individual circumstances and the support they may need.

You may want to engage teachers in considering their own needs in advance.

It is important that teaching is balanced and not dependent on any personal views teachers may have. Teachers should operate at all times within the framework of their school's policy, the Teaching Standards (https://www.gov.uk/government/publications/teachers-standards) and comply with the Equality Act (https://www.legislation.gov.uk/ukpga/2010/15/contents). There is no obligation on teachers to offer information personal to themselves or to share personal views.

**Teachers are not required to answer personal questions asked by pupils and should consider, with the support of their school, how best to handle any such questions.**

## Teacher training

Teacher training activities may help your teachers feel supported. You might also consider activities that support teachers to reflect on their own values around the subject and consider ways to present an unbiased and evidence-based curriculum to pupils.

Use the teacher training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) to train groups of teachers on the different topics within the curriculum.

## Assessment and evaluation

## Assessment

Schools should have the same high expectations of the quality of pupils' work in these subjects as for other curriculum areas. A strong curriculum will build on the knowledge pupils have previously acquired, including in other subjects, with regular feedback provided on pupil progress.

Lessons should be planned to ensure that all pupils of differing abilities are suitably challenged. You should identify and assess the needs of pupils who may require extra support or intervention.

Whilst there is no formal examined assessment for these subjects, you could use tests, written assignments or self-evaluations, to capture progress.

## Evaluation

Schools should continuously evaluate and review the implementation of relationships education, relationships and sex education and health education, to ensure the quality of provision.

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1. 17 February 2022
   Added a link to the guidance on political impartiality in schools.
2. 24 September 2020
   First published.

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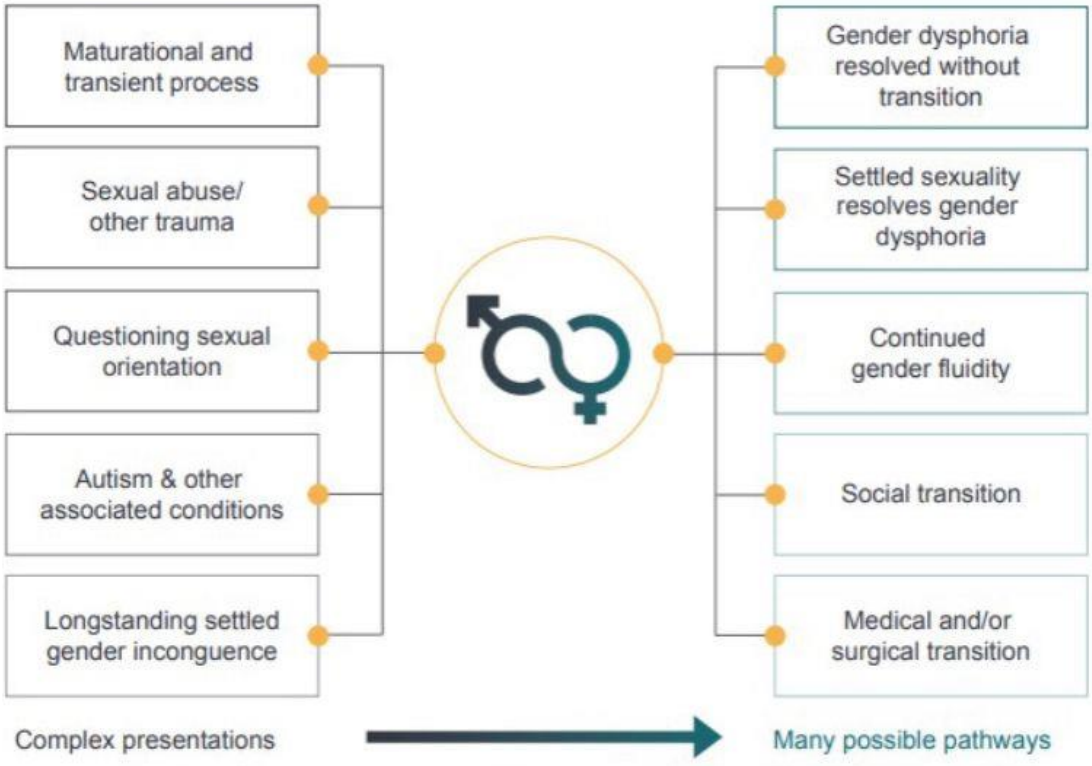
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**Complex presentations and complex pathways – exemplars, not comprehensive lists**




**Epidemiology:** Epidemiologists collect data to find out how common a condition is, who is most likely to be affected, what the age distribution is and so on. This allows health service planners to work out how many services are needed, where they should be established, and what staff are needed.

They also report on changes in who is most affected, which may mean that either the disease is changing, or the susceptibility of the population is changing.



Neutral Citation Number: [2020] EWHC 3274 (Admin)

Case No: CO/60/2020

**IN THE HIGH COURT OF JUSTICE**
**ADMINISTRATIVE COURT**
**DIVISIONAL COURT**

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 01/12/2020

**Before** :

**THE PRESIDENT OF THE QUEEN'S BENCH DIVISION**
**LORD JUSTICE LEWIS**
**MRS JUSTICE LIEVEN**

- - - - - - - - - - - - - - - - - - - - -

**Between :**

**(1) QUINCY BELL**
**(2) MRS A**

**Claimants**

**and**

**THE TAVISTOCK AND PORTMAN NHS FOUNDATION TRUST**

**Defendant**

**NATIONAL HEALTH SERVICE COMMISSIONING BOARD (NHS ENGLAND)**

**Interested Party**

**(1) UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST**
**(2) LEEDS TEACHING HOSPITALS NHS TRUST**
**(3) TRANSGENDER TREND LTD**

**Interveners**

**Mr Jeremy Hyam QC and Mr Alasdair Henderson** (instructed by **Sinclairslaw**) for the **Claimants**
**Ms Fenella Morris QC and Ms Nicola Kohn** (instructed by **DAC Beachcroft**) for the **Defendant**
**The Interested Party** did not appear and was not represented
**Mr John McKendrick QC** (instructed by **Hempsons**) for the **First and Second Interveners**
**Mr Paul Skinner and Mr Aidan Wills** (instructed by **Ai Law)** for the **Third Intervener**
Hearing dates: **7 and 8 October 2020**

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# Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

THE PRESIDENT OF THE QUEEN'S BENCH DIVISION
LORD JUSTICE LEWIS
MRS JUSTICE LIEVEN

**Dame Victoria Sharp P., Lord Justice Lewis, Lieven J**.

*SECTION A: INTRODUCTION AND BACKGROUND*

1. This is the judgment of the court.

2. This is a claim for judicial review of the practice of the defendant, the Tavistock and Portman NHS Foundation Trust, through its Gender Identity Development Service (GIDS) and the first and second Interveners (the Trusts) of prescribing puberty-suppressing drugs to persons under the age of 18 who experience gender dysphoria.

3. Gender dysphoria or GD is a condition where persons experience distress because of a mismatch between their perceived identity and their natal sex, that is, their sex at birth. Such persons have a strong desire to live according to their perceived identity rather than their natal sex.

4. Those with gender dysphoria may be referred to GIDS. GIDS may, in turn, refer them to one of two NHS Trusts (the first and second Interveners) whose clinicians may be prepared to undertake medical interventions in relation to those with gender dysphoria. We are concerned in this case with the administration of gonadotropin-releasing hormone agonists (GnRHa) which are hormone or puberty blocking drugs (also called PBs) to suppress the physical developments that would otherwise occur during puberty.

5. Puberty blocking drugs can in theory be, and have in practice been, prescribed for gender dysphoria through the services provided by the defendant to children as young as 10. It is the practice of the defendant, through GIDS, to require the informed consent of those children and young persons to whom such drugs are prescribed.

6. The issue at the heart of this claim is whether informed consent in the legal sense can be given by such children and young persons.

7. The claimants' case is that children and young persons under 18 are not competent to give consent to the administration of puberty blocking drugs. Further, they contend that the information given to those under 18 by the defendant is misleading and insufficient to ensure such children or young persons are able to give informed consent. They further contend that the absence of procedural safeguards, and the inadequacy of the information provided, results in an infringement of the rights of such children and young persons under Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (the Convention).

8. In our view, it is appropriate to consider first, whether a child under 16, or a young person between 16 and 18, can give the requisite consent; and secondly, if, in principle, they can do so, whether the information provided by the defendant and the Trusts is adequate for achieving informed consent.

9. The court in this case is concerned with the legal requirements of the process of obtaining consent for the carrying out of medical treatment. In considering this issue the court has had to consider evidence on the use of PBs, their impact on the patients, both in the short and long term, and the evidence of the efficacy of their use. The court is not deciding on the benefits or disbenefits of treating children with GD with PBs, whether in the long or short term. The court has been given a great deal of evidence

about the nature of GD and the treatments that may or may not be appropriate. That is not a matter for us. The sole legal issue in the case is the circumstances in which a child or young person may be competent to give valid consent to treatment in law and the process by which consent to the treatment is obtained.

10. We have had placed before us written evidence from a wide variety of those engaged in issues surrounding GD and a number of individuals who have been treated or are still being treated with PBs.

11. On behalf of the defendant and the Trusts there are statements from Dr Polly Carmichael, Director of GIDS, Professor Gary Butler, Consultant in Paediatric Endocrinology at University College Hospital London, and Dr Nurus-Sabah Alvi, Consultant in Paediatric Endocrinology at Leeds General Infirmary and Clinical Lead for Endocrine Liaison Clinics of the GIDS, Leeds. These witnesses describe the process that the children and young people go through at GIDS and at the Trusts. The court has also had a wide range of evidence from a variety of people concerned with the treatment of those under 18 with PBs. We will refer to that evidence and its sources as appropriate below. Our references to a child or children will be to those under the age of 16, and to young person(s) to anyone under the age of 18, save where it is clear from the context that we are referring to anyone under the age of 18.

*Gender Dysphoria*

12. Gender dysphoria is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) which provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults:

> "In adolescents and adults gender dysphoria diagnosis involves a difference between one's experienced gender and assigned gender, and significant distress or problems functioning. It lasts at least six months and is shown by at least two of the following:
>
> 1. A marked incongruence between one's experienced / expressed gender and primary and / or secondary sex characteristics
>
> 2. A strong desire to be rid of one's primary and / or secondary sex characteristics
>
> 3. A strong desire for the primary and / or secondary sex characteristics of the other gender
>
> 4. A strong desire to be of the other gender
>
> 5. A strong desire to be treated as the other gender
>
> 6. A strong conviction that one has the typical feelings and reactions of the other gender.
>
> In children, gender dysphoria diagnosis involves at least six of the following and an associated significant distress or impairment in function, lasting at least six months:

1. A strong desire to be of the other gender or an insistence that one is the other gender

2. A strong preference for wearing clothes typical of the other gender

3. A strong preference for cross-gender roles in make-believe play or fantasy play

4. A strong preference for toys, games or activities stereotypically used or engaged in by the other gender

5. A strong preference for playmates of the other gender

6. A strong rejection of toys, games and activities typical of one's assigned gender

7. A strong dislike of one's sexual anatomy

8. A strong desire for the physical sex characteristics that match one's experienced gender."

*Gender Identity Development Service (GIDS)*

13. The defendant is an NHS Foundation Trust employing specialist staff including child psychologists, psychotherapists, psychiatrists, social workers, family therapists and nurses. Since 1989 it has provided a gender identity development service, a specialised service providing care to patients up to the age of 18 suffering from GD. GIDS is commissioned by the National Health Service Commissioning Board. The statutory mechanism is that under section 3B of the NHS Act 2006, the Secretary of State has the power to require NHS England to arrange services or facilities as may be prescribed by regulations. The Secretary of State has exercised that power (pursuant to Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2296, which concerns specified services for rare and very rare conditions) that NHS England must arrange for the provision of services including, pursuant to para 56 of Schedule 4, a gender identity development service specifically for children and adolescents in addition to gender dysphoria services more generally (para 57).

14. Schedule 2, Part A of the NHS Standard Contract, pursuant to which GIDS is provided, sets out the Service Specification which establishes the context of the service, its aims and objectives and the manner in which it will be delivered. As set out in the Service Specification, the service is commissioned to provide specialist assessment, consultation and care including psychological support and physical treatments. The purpose of the treatment is *"to help reduce the distressing feelings of a mismatch between their natal (assigned) sex and their gender identity."* The service also provides support to family and carers of children and young persons so affected.

15. GIDS recognises three stages of physical intervention that may be appropriate in cases of GD. Stage 1 is the administration of GnRHa (one form of puberty blocker). This is clinically appropriate for children and young people who have reached Tanner Stage 2

of puberty and above. Tanner Stage 2 marks the beginning of the physical development of puberty. In natal girls this is the start of development of the breasts, and in boys the testicles and scrotum begin to get larger. Stage 2 of the treatment is the administration of cross-sex hormones (CSH) which can only be prescribed from around the age of 16. Stage 3 is gender reassignment surgery which is only available via adult services to people aged over 18.

16. GIDS takes referrals from across England and Wales and from a wide range of professionals in the health, social services and education sectors, and the voluntary sectors. When a referral is made, the case will be discussed with the relevant regional team. If the intake is successful, then the child will then progress to the GIDS waiting list.

17. As at November 2019 the waiting time for a first assessment at GIDS was between 22-26 months. When a young person reaches the top of the waiting list, they will be invited to the first of a number of assessment appointments at GIDS. The assessment process laid out in the Service Specification anticipates that the assessment process will typically span three to six sessions over 6 months or longer. Most young people will have more sessions than this, and the younger the age the more sessions are likely.

18. Dr Carmichael said that during assessments young persons will be asked, for example, about: the onset of their gender dysphoria; the consistency of their feelings about their gender; how they identify (cross-gender, non-binary, etc); their relationships with peers and family members; their social functioning in general, thoughts about or experience of puberty; their relationship to their bodies; their attractions or romantic relationships as appropriate based on their age and maturity; and their hopes and expectations for the future.

19. As this case is brought by way of judicial review of the GIDS policy and practice, rather than a challenge to an individual treatment decision, it is not possible to give a detailed analysis of the facts of an individual case and the degree to which all the matters referred to by Dr Carmichael were explored in the particular case. We refer at paras 78 to 89 below to the evidence of the experience of the first claimant and some of the other patients of the GIDS service.

20. Dr Carmichael sets out the broad range of professionals who work within GIDS, their specialism in working with young people with GD and the care that is taken when discussing the young person's expression of their gender identity.

21. At the end of the assessment period the clinicians will agree a care plan with the young person and their family. Where the young person fulfils the criteria in the Service Specification and has reached at least Tanner Stage 2 of puberty, they will be referred by GIDS to the first and second Interveners for consultation and/or physical assessment with endocrinologists with a view to being prescribed PBs. Dr Carmichael explains that before any referral to the Trusts, GIDS clinicians discuss the treatment with the young person, including explaining side effects.

*The Age and Patient Group for Puberty Blockers*

22. Until 2011 PBs were only available at GIDS for those aged 16 or older. In 2011 PBs started to be prescribed for those aged 12-15 and in mid-puberty. This was first done between 2011-14 at University College London Hospital (UCLH) under an approved research study known as the Early Intervention Study. The Study took an uncontrolled treatment cohort of 12-15 year olds with established and persistent GD in England. The Study recruited children for 3 years, but there was then a period until February 2019 when the last cohort member began the next stage of therapy (cross-sex hormones).

23. One of the issues raised in these proceedings is the non-existent or poor evidence base, as it is said to be, for the efficacy of such treatment for children and young persons with GD.

24. In that context, we note that though this research study was commenced some 9 years ago, at the time of the hearing before us the results of this research had yet to be published. Dr Carmichael says in her witness statement dated 2 February 2020 that a paper is now being finalised for publication. At the hearing we were told that that this paper had been submitted for peer-review but that Professor Viner, one of the authors of it, had yet to respond to issues raised by the reviewers, as he has been otherwise engaged in working on issues relating to the coronavirus pandemic.

25. The court was however provided with a paper entitled *"The Early Intervention Study. An evaluation of early pubertal suppression in a carefully selected group of adolescents with "Gender Identity Disorder". A statement and update on the Early Intervention Study (dated 2020)".* We refer further to this paper at para 73 below.

26. There are now two types of endocrine clinic: a clinic for under 15s, referred to as the early intervention clinic, and a clinic for over 15s. The Service Specification states that the early intervention clinic will continue to follow the 2011 Protocol, save that PBs will now be considered for any children *under the age of 12* if they are in established puberty.

27. The age distribution of those treated with PBs in each year between 2011 and 2020 was not provided to the court. Although the defendant and the Trusts said that such data was available, in the sense that the ages of the children are known, the data has not been collated for each year. However, Ms Ailsa Swarbrick, the Divisional Director of Gender Services at the Trust, has presented evidence in relation to patients referred to endocrinology services in 2019-20 and those treated in earlier years but who were discharged from GIDS in 2019-2020. This work was done in response to recommendations in the GIDS Review Action Plan 2019 (a Review commissioned by the Trust following a report by Dr David Bell) that data would help to inform clinical and service developments and a process of continuous improvement.

28. We note here that we find it surprising that such data was not collated in previous years given the young age of the patient group, the experimental nature of the treatment and the profound impact that it has.

29. As it is, for the year 2019/2020, 161 children were referred by GIDS for puberty blockers (a further 10 were referred for other reasons). Of those 161, the age profile is as follows:

> 3 were 10 or 11 years old at the time of referral;
>
> 13 were 12 years old;
>
> 10 were 13 years old;
>
> 24 were 14 years old;
>
> 45 were 15 years old;
>
> 51 were 16 years old;
>
> 15 were 17 or 18 years old.

For the year 2019/20, therefore, 26 of the 161 children referred were 13 or younger; and 95 of the 161 (well over 50%) were under the age of 16.

30. It follows from the information that the court does have on age distribution that some young people could be on PBs for a number of years, in the most extreme case for 5 years between the age of 10 and when they start CSH at 16.

31. Apart from the age distribution, there are other aspects of the patient group which are relevant to this case. The number of referrals to GIDS has increased very significantly in recent years. In 2009, 97 children and young people were referred. In 2018 that number was 2519.

32. Further, in 2011 the gender split was roughly 50/50 between natal girls and boys. However, in 2019 the split had changed so that 76 per cent of referrals were natal females. That change in the proportion of natal girls to boys is reflected in the statistics from the Netherlands (Brik et al "*Trajectories of Adolescents Treated with Gonadotropin-Releasing Hormone Analogues for Gender Dysphoria"* 2018). The defendant did not put forward any clinical explanation as to why there had been this significant change in the patient group over a relatively short time.

33. It is recorded in the GIDS Service Specification and the wider literature that a significant proportion of those presenting with GD have a diagnosis of Autistic Spectrum Disorder (ASD). The Service Specification says:

> "There seems to be a higher prevalence of autistic spectrum disorder (ASD) conditions in clinically referred, gender dysphoric adolescents than in the general adolescent population. Holt, Skagerberg & Dunsford (2014) found that 13.3% of referrals to the service in 2012 mentioned comorbid ASD (although this is likely to be an underestimate). This compares with 9.4% in the Dutch service; whereas in the Finnish service, 26% of adolescents were diagnosed to be on the autism spectrum (Kaltiala-Heino et al. 2015)."

34. The court asked for statistics on the number or proportion of young people referred by GIDS for PBs who had a diagnosis of ASD. Ms Morris said that such data was not available, although it would have been recorded on individual patient records. We therefore do not know the proportion of those who were found by GIDS to be *Gillick* competent who had ASD, or indeed a mental health diagnosis.

35. Again, we have found this lack of data analysis – and the apparent lack of investigation of this issue - surprising.

*The process of taking consent*

36. The position taken by GIDS is that they will only refer a young person for PBs if they determine that person is competent to give consent, i.e. is *Gillick* competent within the meaning of competence identified in the decision of the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112.

37. Dr Carmichael explained that GIDS takes consent from the young person to their case being referred to the Trusts for treatment; however the consent for the actual prescription of the PBs is taken separately by the clinicians working for the Trusts. She set out the careful process by which GIDS gives information to the young persons and to their parents in order to seek to ensure that the young person is in a position to give valid consent. The court was taken through the statements of Dr Carmichael and Professor Butler and various documents to show the level of information and dialogue that was involved in achieving lawful consent to the treatment. The Service Specification includes Section 3.2 on "Informed Consent". This states *"The consequences of treatment decisions can be significant and life-changing"* and states:

> "All efforts will be made to ensure that clients are aware of the longer term consequences of the endocrine treatments, including implications for fertility, and the decision of the competence of the client will be jointly made by the endocrine and psychological members of the Service's integrated team.
>
> The current context of treatment decisions about cross sex hormones in adolescence is that there is limited scientific evidence for the long-term benefits versus the potential harms of the intervention. There are also concerns that it is uncertain whether or not a young person will continue to identify as transgender in the future, given that some subsequently identify in a different way."

38. The defendant has recently adopted a Standard Operating Procedure for the taking of consent in GIDS. This has taken 2 years to develop and is dated 31 January 2020. Dr Carmichael says at para 33 of her first statement:

> "In advance of any referral by the Trust of a young person for consideration by an endocrinologist for GnRHa treatment, GIDS clinicians discuss treatment with the young person. This includes, checking that the young person's hopes for treatment are realistic, explaining what the treatment can and cannot do, discussing any potential

> side-effects, discussing fertility and potential impact on genital development for birth registered males. We have developed visual aids to support this process.
>
> UCLH and LTH have collated extensive written information to help young people and their parents further understand the nature of the drugs, their limitations and the possible side effects. These written documents are given to young people at their first endocrine clinic visit. The written documents act as a reference point for patients with questions whilst they contemplate whether they would like to go ahead with the referral, and subsequently with treatment. In particular, informational slides titled "Have you thought about having children in the future?" explains the impact GnRHa treatment can have on fertility in explicit terms. Young people and their families are encouraged to raise any questions with their GIDS clinicians or at their next endocrine clinic visit."

39. Ms Morris emphasised that the process of ensuring that consent could validly be given was a discursive and iterative one that involved multiple discussions and answering any questions the young people or their parents might raise. Dr Carmichael said at para 35: "*The GIDS clinicians make it very clear to children and young people that there are both known and unknown risks associated with GnRHa treatment."* Further, she said at para 41: "*In my experience, those young people we see who are recommended for GnRHa treatment understand the implications and limitations of treatment with GnRHa treatment and are able to consent to this stage of treatment."*

40. Professor Butler described the approach to consent at the Trusts as follows:

> "For those under 15 years of age all the pre-assessment consultations are individual and occur with a consultant or senior clinical fellow on at least two visits. Parental support (or that of their guardian or social services where appropriate) is a pre-requisite for the under 15 year stream. On occasions, a young person is not deemed, on clinical examination, to be at an appropriate stage of puberty so further follow-up visits are arranged thereafter at 6-12 monthly intervals until a person is deemed at an appropriate physical stage for intervention and taking of consent. This also gives the opportunity to judge the level of emotional cognitive and psychosocial maturity, and capacity.
>
> The decisions at UCLH and Leeds do not automatically follow on from those made at the GIDS Tavistock. They are a reassessment of physical maturity and cognitive capacity in their own right. They may be at odds with the Tavistock formulation (an infrequent event) and thus would be returned to the Tavistock MDT for reconsideration."

41. Professor Butler said that in his clinic they are careful to ensure that the force behind the decision to seek treatment comes from the young person themselves and is not a consequence of pressure upon them from others around them. The Trusts work closely

with parents to reach a solution that is satisfactory to all and meets the best interests of the child. His clinic has never sought to apply to the Court under its inherent jurisdiction "against" parental opinions because he is concerned that would cause familial frictions. Equally, he suggested UCLH would not wish to have to apply to the court for consent on behalf of the child because it would delay treatment and put an additional burden on GIDS and the Trusts; and because "*it would also increase the distress suffered by the young people themselves, finding that their right to autonomous decision making had been removed from them."*

42. Professor Butler said a full written information package is provided to older adolescents. For those under 15 there is an initial individual consultation because of the need for "*individualising the approach for very young people, taking special care to assess their level of knowledge and understanding and they are given the written information package then.*" In relation to impacts on fertility and sexual functioning he says:

> "It is also relevant for the consultation purposes that matters of fertility are discussed and counselling by the team takes place, and the option of meeting a fertility specialist is offered, and often taken up. The options of fertility preservation are discussed with all the young people and it is a requirement of the consent process that they fully understand this at an age appropriate level. This understanding must include that they are unable to have the typical sexual relationship of their identified gender with another person on account of their biological sex organ development, and that other surgical procedures may be necessary later on to achieve this possibility."

43. He then said: "*it is an absolute requirement before starting any treatment that a young person can fully understand this effect on fertility and sexual functioning according to their age and level of maturation."*

44. The court asked for statistical material on the number, if any, of young people who had been assessed to be suitable for PBs but who were *not* prescribed them because the young person was considered not to be *Gillick* competent to make the decision, whether at GIDS or the Trusts. Ms Morris could not produce any statistics on whether this situation had ever arisen. She suggested that in the main, GIDS would work with the young person to give them further information, discuss the matter further and in some cases wait until they had achieved further maturity. The court gained the strong impression from the evidence and from those submissions that it was extremely unusual for either GIDS or the Trusts to refuse to give PBs on the ground that the young person was not competent to give consent. The approach adopted appears to be to continue giving the child more information and to have more discussions until s/he is considered *Gillick* competent or is discharged.

45. Relevant to the evidence of consent is the evidence of Professor Scott (Director of University College London's Institute of Cognitive Neuroscience). She *"seeks to explain, from a neuroscientific point of view, why I have significant doubts about the ability of young people under the age of 18 years old to adequately weigh and*

*appreciate the significant consequences that will result from the decision to accept hormonal treatment for gender dysphoria."*

46. She explained the neurological development of adolescents' brains that leads to teenagers making different, more risky decisions than adults. She said further that this is backed up by behavioural studies showing that when decision making is "hot" (i.e. more emotional), under 18 year olds make less rational decisions than when the responses are made in a colder, less emotional context. Her conclusion was that:

> "11. … given the risk of puberty blocking treatment, and the fact that these will have irreversible effects, that have life-long consequences, it is my view that even if the risks are well explained, that in the light of the scientific literature, that it is very possible for an adolescent to be unable to fully grasp the implications of puberty-blocking treatment. All the evidence we have suggests that the complex, emotionally charged decisions required to engage with this treatment are not yet acquired as a skill at this age, both in terms of brain maturation and in terms of behaviour."

*Parental consent*

47. If a child cannot give consent for treatment because they are not *Gillick* competent then the normal position in law would be that someone with parental responsibility could consent on their behalf. Mr Hyam sought at one point to argue that a decision as to giving PBs would fall outside the scope of parental responsibility because of the nature of the treatment concerned. However, the GIDS practice in relation to acting on parental consent alone is quite clear. In the response to the pre-action protocol letter the defendant said:

> "36. There is a fundamental misunderstanding in your letter, which states that parents can consent to pubertal suspension on behalf of a child who is not capable of doing so. This is not the case for this service, as is clear from the above. Although the general law would permit parent(s) to consent on behalf of their child, GIDS has never administered, nor can it conceive of any situation where it would be appropriate to administer blockers on a patient without their consent. The Service Specification confirms that this is the case."

It follows that is not necessary for us to consider whether parents could consent to the treatment if the child cannot lawfully do so because this is not the policy or practice of the defendant and such a case could not currently arise on the facts.

*The effect of Puberty Blockers*

48. PBs have been used for many years to stop precocious puberty. This is a condition experienced largely by children aged 7 or under when puberty commences at a very early age. This condition is seen more often in natal girls but sometimes in natal boys. PBs are used to stop this early onset of puberty and the use of them ceases when the child reaches an appropriate age for puberty. As can be seen from the evidence this use of PBs does not interfere with the onset of puberty at a normal biological age and, as such, will not interfere with normal development of puberty through adolescence.

49. The use of PBs in cases of GD is quite different. We have some evidence of the history of this treatment and the meaning of puberty from Professor Hruz (Associate Professor of Paediatrics, Endocrinology and Diabetes at Washington University, St Louis, USA) on behalf of the claimants.

50. In summary, PBs were first used for such treatment at a Dutch gender clinic in the late 1990s. That clinic developed a protocol, often referred to as the Dutch protocol. The Dutch protocol was published in the European Journal of Endocrinology in 2006 and called for puberty suppression to begin at the age of 12 after a diagnosis of GD. Puberty is understood in medicine or biology as a process of physiological change involving the process of maturation of the gonads. Hormones in a part of the brain secrete a gonadotropin-releasing hormone which, in turn, stimulates the pituitary gland to secrete other hormones. These stimulate the growth of the gonads, that is ovaries in females and testes in males. Further hormones are secreted which contribute to the further development of the primary sex characteristics, the uterus in females and the penis and scrotum in males. The hormones contribute to the development of secondary sex characteristics including breasts and wider hips in girls and wider shoulders, deeper voices and increased muscle mass in boys. Further growth hormones are released, which stimulate growth. With regular injection of the PBs there is no progression of puberty and some regression of the first stages of already developed sexual characteristics. This means that in girls *"breast tissue will become weak and may disappear completely"* and in boys *"testicular volume will regress to a lower volume."*

51. Under the Dutch protocol, the introduction of CSH starts at age 16. As Professor Hruz explained:

> "29. Then, starting at age 16, cross-sex hormones are administered while GnRH analogue treatment continues, in order to induce something like the process of puberty that would normally occur for members of the opposite sex. In female-to-male patients, testosterone administration leads to the development of "a low voice, facial and body hair growth, and a more masculine body shape" as well as to clitoral engagement and further atrophying of breast tissue. In patients seeking a male-to-female transition, the administration of estrogens will result in "breast development and a female-appearing body shape." Cross-sex hormone administration for these patients will be prescribed for the rest of their lives."

52. There is some dispute as to the purpose of prescribing PBs. According to Dr Carmichael, the primary purpose of PBs is to give the young person time to think about their gender identity. This is a phrase which is repeated on a number of the GIDS and Trust information documents. The Health Research Authority carried out an investigation into the Early Intervention Study in 2019. Its report was somewhat critical of the description of the purpose and said:

> "The research team described the purpose of pubertal suppression as 'to induce a sex hormone-neutral environment to provide young people with space to decide whether to progress further with gender reassignment treatment as an adult.' This phrase appears to have caused confusion as it has been interpreted by some that the puberty suppression was for use in

> any children presenting to the clinic, that there would be no change in the course of any gender identity dysphoria during this time, and that the child could then choose to progress to cross-sex hormone treatment or to stop treatment with subsequent onset of puberty in the birth gender. It has been noted that the participants in this study and other research involving early puberty suppression have progressed to cross-sex hormones. This has raised concerns that the treatment might be responsible for generating persistence, rather than 'creating space to decide'.
>
> It would have reduced confusion if the purpose of the treatment had been described as being offered specifically to children demonstrating a strong and persistent gender identity dysphoria at an early stage in puberty, such that the suppression of puberty would allow subsequent cross-sex hormone treatment without the need to surgically reverse or otherwise mask the unwanted physical effects of puberty in the birth gender. The present study was not designed to investigate the implications on persistence or desistence of offering puberty suppression to a wider range of patients, it was limited to a group that had already demonstrated persistence and were actively requesting puberty blockers."

53. Professor Butler said that PBs:

> "may have some help or advantage in the support of transgender adolescents in some aspects of mental health functioning, in particular with reducing the risk of reduction of suicidal ideation and actual suicidal actions themselves."

54. See further the reference at para 73 below to the paper presented by Dr Carmichael and Professor Viner in 2014, referring to the Early Intervention Study and the limited evidence of psychological benefit.

55. As is clear from the literature and referred to by the HRA, the other purpose of giving PBs is stopping the development of the physical effects of puberty (something that obviously varies depending on at what age and stage in pubertal development the PBs are commenced) because slowing or preventing the early development of secondary sex characteristics during puberty can make a later transition (both medical and social) to living as the opposite sex easier.

*The relationship between Puberty Blockers and Cross-Sex Hormones (CSH)*

56. GIDS and the Trust place reliance on the fact that Stage 1 treatment with PBs and Stage 2 treatment (CSH) are separate. Thus, so it is said, it is possible for a young person to come off the PBs at any point and not proceed to taking CSH. On one view, this is correct. However, the evidence that we have on this issue clearly shows that practically all children / young people who start PBs progress on to CSH.

57. No precise numbers are available from GIDS (as to the percentage of patients who proceed from PBs to CSH). There was some evidence based on a random sample of those who in 2019-2020 had been discharged or had what is described as a closing summary from GIDS. However the court did have the evidence of Dr de Vries. Dr de Vries is a founding board member of EPATH (European Professional Association for Transgender Health) and a member of the WPATH (World Professional Association for Transgender Health) Committee on Children and Adolescents and its Chair between 2010 and 2016, and leads the Centre of Expertise on Gender Dysphoria at the Amsterdam University Medical Centre in the Netherlands (CEGD). This is the institution which has led the way in the use of PBs for young people in the Netherlands; and is the sole source of published peer reviewed data (in respect of the treatment we are considering) produced to the court. She says that of the adolescents who started puberty suppression, only 1.9 per cent stopped the treatment and did not proceed to CSH.

58. We were told that the defendant did not have any data recording the proportion of those on puberty blockers who progress to cross-sex hormones. We were told that in part this resulted from the fact that some would have progressed to adult services and would not be recorded by the defendant. Ms Swarbrick had carried out an analysis of a random sample of 312 of 1648 files of patients discharged from GIDS from 1st March 2019 to 4th March 2020. Dr Carmichael summarised this as:

> "…based on a random sample of those referred to GIDS who had been discharged or had a closing summary from GIDS in 19-20 (analysis B) 16% of patients (49 individuals) had accessed the endocrinology service during their time with GIDS. Of those 16%, 55% (27 individuals) were subsequently approved for or accessed cross-sex hormones during their time with GIDS. This number represents 8.7% of all the patients discharged from GIDS that year. We also know that of the 49 patients who were referred to endocrinology for GnRHa whilst at GIDS, two did not commence GnRHa treatment, and a further five were discharged from GIDS without being referred on to another gender service."

59. We find it surprising that GIDS did not obtain full data showing the figures and the proportion of those on puberty blockers who remain within GIDS and move on to cross-sex hormones. Although neither Dr Carmichael nor Professor Butler could give the equivalent figures in the United Kingdom to those from the Netherlands, the language used in their witness statements suggests that a similarly high proportion of children and young people in the United Kingdom move from PBs onto CSH.

*The impact of Puberty Blockers and their reversibility*

60. Both WPATH and the Endocrine Society in their documentation describe PBs as fully reversible. Professor Butler says that "*we do not know everything about the blocker and as far as we know it is a safe reversible treatment with a well-established history."* Dr Alvi also referred to the history of the use of PBs as showing that they are fully reversible. However, it is important to note that apart from the Amsterdam study, the history of the use of PBs relied upon in this context is *from the treatment of precocious*

*puberty* which is a different condition from GD, and where PBs are used in a very different way.

61. Dr de Vries was somewhat more nuanced in her evidence. She said:

> "Puberty blocking treatment is fully reversible (see for example section 2.0 of the Endocrine Society's Clinical Practice Guidelines…). By fully reversible I mean that the administration of puberty blockers in young people has no irreversible physical consequences, for example for fertility, voice deepening or breast growth".

62. At para 20 of her evidence she said:

> "Ethical dilemmas continue to exist around … the uncertainty of apparent long-term physical consequences of puberty blocking on bone density, fertility, brain development and surgical options."

63. The GIDS Early Intervention Young Person Information Sheet states:

> "What are the possible benefits of starting on hormone blockers?
>
> We have looked at other countries who have given this treatment **and the results** suggest that:
>
> - Hormone blockers which block the body's natural sex hormones may improve the way you feel about yourself.
> - If you decide to stop the hormone blockers early **your physical development** will return as usual in your natal gender. **As far as we are aware**, the hormone blockers will not harm your physical or psychological development.
> - Hormone blockers will make you feel less worried about growing up in the wrong body and will give you more time and space to think about your gender identity.
>
> What are the possible disadvantages and risks of the hormone blockers?
>
> - Possible side effects from the hormone blockers are hot flushes, headache, nausea and weight gain.
> - A short term effect is that your bone strength is shown not to grow as fast as it usually would whilst you are on hormone blockers. However, this will resume once your body is exposed to hormones again. That is why we have to do a bone scan every year to check the thickness of your bones. **We do not fully know how hormone blockers will affect bone strength, the development of your sexual organs, body shape or your final adult height. There**

> **could be other long-term effects of hormone blockers in early puberty that we don't yet know about.**
>
> - Hormone blockers could affect your memory, your concentration or the way you feel about your gender and how likely you are to change your mind about your gender identity.
>
> - Hormone blockers could affect your ability to have a baby. It could take 6 to 12 months longer after stopping the hormone blockers before natal boys start making sperm again or natal girls start maturing eggs in their ovaries. However, hormone blockers do not work as a contraceptive. If you are sexually active, please ask your doctor for advice about birth control." (emphasis added)

64. A number of aspects of this asserted reversibility are raised by the claimants. PBs stop the physical changes in the body when going through puberty. But in reliance on the evidence of Professor Levine (Clinical Professor of Psychiatry at Western Reserve University, Ohio) and Professor Hruz, the claimants assert that neurological and psychological changes occurring in puberty are less well understood than the physiological changes. Further, the degree to which neurological differences are caused by biological factors like hormones and genes are matters of debate. Professor Levine set out evidence on the degree to which young people mature through adolescence through both social and personal experiences. For young people on PBs that maturing process is stopped or delayed with potential social and psychological impacts which could be described as non-reversible.

65. Thus, the central point made by the claimants is that although most of the physical consequences of taking PBs may be reversible if such treatment is stopped, the child or young person will have missed a period, however long, of normal biological, psychological and social experience through adolescence; and that missed development and experience, during adolescence, can never be truly be recovered or "reversed".

66. It is to be noted that prior to June 2020, the NHS website on PBs said:

> "The effects of treatment with GnRH analogues are considered to be fully reversible, so treatment can usually be stopped at any time."

67. In June 2020 this section was updated to read as follows:

> "**Little is known about the long-term side effects of hormone or puberty blockers in children with gender dysphoria.**
>
> Although the Gender Identity Development Service (GIDS) advises that is a physically reversible treatment if stopped, **it is not known what the psychological effects may be.**

> **It's also not known whether hormone blockers affect the development of the teenage brain or children's bones**. Side effects may also include hot flushes, fatigue and mood alterations." (emphasis added)

68. A second key part of the argument about reversibility turns on the relationship between PBs and CSH and the degree to which commencing PBs in practice puts a young person on a virtually inexorable path to taking CSH. CSH are to a very significant degree not reversible. As is set out above at para 57 above, a very high proportion of those who start PBs move on to CSH and thus in statistical terms once a child or young person starts on PBs they are on a very clear clinical pathway to CSH.

*Evidence base to support the use of Puberty Blockers for Gender Dysphoria*

69. The claimants submit that the treatment of PBs for GD is properly described as (i) experimental (ii) a treatment with a very limited evidence base, and (iii) as a highly controversial treatment. The claimants rely on witness statements from a number of undoubted experts in various relevant fields and from academic institutions in the United Kingdom, the USA, Sweden and Australia who refer to the controversial nature of the treatment and its limited evidential support.

70. It is not however the court's role to judge the weight to be given to various different experts in a judicial review. In our view, more important is the evidence from the defendant and the evidence base *it* relies upon for the use of PBs. In the USA the treatment of GD is not an FDA approved use and as such PBs can only be used "off-label". That does not prevent clinicians, whether in the USA or the United Kingdom, from using PBs for this purpose, as long as their use falls within the clinician's professional expertise. Professor Butler explained that it is very common for paediatric medicines to be used off-label and that this factor does not render the treatment in any sense experimental.

71. However, the lack of a firm evidence base for their use is evident from the very limited published material as to the effectiveness of the treatment, however it is measured.

72. Paul Jenkins, Chief Executive of the defendant said:

> "…it is correct that in recent years, some clinicians [at the Trust] have raised their concerns about the use of GnRHa for young people presenting with gender dysphoria. Indeed, some have called for the Trust to alter its practices and have done so in a variety of ways. We are keenly aware that the subject of gender dysphoria raises complex issues and that many have strong opinions about it."

73. The Evaluation Paper on the Early Intervention Study at GIDS, referred to in para 25 above, gives some (albeit limited) material on the outcome of that study. It summarised a meeting paper presented by Dr Carmichael and Professor Viner in 2014 (but not published in a peer review journal) as follows:

> "The reported qualitative data on early outcomes of 44 young people who received early pubertal suppression. It noted that 100% of young people stated that they wished to continue on GnRHa, that 23 (52%) reported an improvement in mood since starting the blocker but that 27% reported a decrease in mood. **Noted that there was no overall improvement in mood or psychological wellbeing using standardized psychological measures**." (emphasis added)

74. Ms Morris submitted it is not for this court to determine clinical disagreements between experts about the efficacy of a treatment. We agree. That is a matter for the relevant NHS and regulatory bodies to oversee and to decide. However the degree to which the treatment is experimental and has, as yet, an unknown impact, does go to the critical issue of whether a young person can have sufficient understanding of the risks and benefits to be able lawfully to consent to that treatment.

*Persistence*

75. The claimants submit that there is good evidence that for a significant proportion of young people presenting with GD, the condition resolves itself through adolescence without treatment with PBs. Further, that PBs serve to increase the likelihood of GD, and, as such, can be positively harmful to the child or young person's long-term health. According to DSM5: "*in natal males, persistence of [gender dysphoria] has ranged from 2.2% to 30%. In natal females, persistence has ranged from 12% to 50%."* These figures need to be treated with some caution because it may be that the cohort whose persistence was being considered in these statistics was at a lower age and with less clearly established GD than the young people being treated at GIDS.

76. The Dutch study argued that adolescents who show established GD rarely identify as their biological sex. Professor Hruz suggested there may be two reasons for this. It may be that the clinicians made sound diagnoses of persistent GD. Alternatively, it may be that the very fact of the diagnosis and the course of treatment which affirmed that diagnosis (that is, both gender affirmative psychotherapy and the use of PBs) solidified the feeling of cross-gender identification and led the young people to commit to sex reassignment more strongly than they would have done if there had been a different diagnosis and treatment.

77. As already indicated, it is not our role to adjudicate on the reasons for persistence or otherwise of GD. However, the nature of this issue highlights the highly complex and unusual nature of this treatment and the great difficulty there is in fully understanding its implications for the individual young person. In short, the treatment may be supporting the persistence of GD in circumstances in which it is at least possible that without that treatment, the GD would resolve itself.

*SECTION B: EVIDENCE OF THE CLAIMANTS AND OTHER INDIVIDUALS*

78. The first claimant was born a female. In her witness statement in these proceedings she set out her experience of being prescribed PBs and then CSH. It should be noted that some of the details relating to her treatment and the information she was given (at GIDS and the first defendant) is disputed. This case is a judicial review of the GIDS policy,

not a tort action relating to the specific facts surrounding the first claimant's treatment and it is not necessary therefore to resolve any factual dispute. We simply record the first claimant's account. She describes a highly traumatic childhood. From the age of 4 or 5 she displayed gender non-conformity, associating more with male games and clothes. She felt highly alienated at secondary school and took birth control pills to stop her periods. She felt disgusted by her body and became depressed and highly anxious. From the age of 14 she began actively to question her gender identity and started to look at YouTube videos and do research on the internet about gender identity disorder and the transition process. She said: "*I thought I had finally found the answer as to why I felt so masculine, uncomfortable with my female body and why I was so much more similar to a stereotypical boy than to a stereotypical girl in physical expression and interests."*

79. When she was 15, the first claimant was referred to GIDS. When she was at the local Children and Adolescent Mental Health Services clinic she remembered: *"the psychiatrist attempted to talk of the gender spectrum as a way of persuading me to not pursue medical transition. I took this as a challenge to how serious I was about my feelings and what I wanted to do and it made me want to transition more. Now I wish I had listened to her."* She was first seen at GIDS aged 16 and had a number of appointments spread out over 1 year and 9 months. She was referred to UCLH in June 2013 and after three appointments commenced PBs. She was given advice about the impact on her fertility, but her priority was to move on to testosterone. She said that at 16, she was not thinking about children and, in any event, egg storage was not available on the NHS.

80. In April 2014 she was referred to an adult Gender Identity Clinic to discuss surgery. She "*was visualising myself becoming a tall, physically strong young man where there was virtually no difference between me and a biological boy."* After commencing testosterone at 17, changes to her body commenced rapidly: these changes included genital changes, her voice dropping and the growth of facial and body hair. She was on testosterone for 3 years but increasingly began to doubt the process of transition:

> "27. I started to have my first serious doubts about transition. These doubts were brought on by for the first time 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. There was an unspoken "code" a lot of the time that I felt I was missing. I remember telling a close male friend at the time about these transition doubts, who responded by telling me that I was being silly and I believed him. This was reinforced by the online forums that I browsed where the consensus was that most transsexual people have doubts and that that is a normal part of transitioning, so the doubts should be ignored. I continued on, pushing the doubts in the far back of my mind and no more doubts creeped in for a while."

81. Despite these doubts, when she was 20, she had a double mastectomy. In the year following this:

> "31. … I started to realise that the vision I had as a teenager of becoming male was strictly a fantasy and that it was not possible. My biological make-up was still female and it showed, no matter how much testosterone was in my system or how much I would go to the gym. I was being perceived as a man by society, but it was not enough. 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."

82. She described facing the reality of taking a regular dose of drugs for the rest of her life to maintain her male appearance; and the need to have a hysterectomy if she remained a man because of the atrophy of her reproductive organs if she continued to take testosterone.

83. From January 2019 the first claimant stopped taking testosterone. She now wishes to identify as a woman and is seeking to change her legal sex back to that on her original birth certificate. She said:

> "39. … It is only until recently that I have started to think about having children and if that is ever a possibility, I have to live with the fact that I will not be able to breastfeed my children. I still do not believe that I have fully processed the surgical procedure that I had to remove my breasts and how major it really was. I made a brash decision as a teenager, (as a lot of teenagers do) trying to find confidence and happiness, except now the rest of my life will be negatively affected. I cannot reverse any of the physical, mental or legal changes that I went through. Transition was a very temporary, superficial fix for a very complex identity issue."

84. The defendant submits the first claimant was given the fullest possible information after a large number of consultations (at least 10) and that she was *Gillick* competent to make the decision to take PBs. Further, the defendant produced witness statements from a number of children and young people who are strongly supportive of the treatment they have received.

85. J is a 20 year old transgender man who received PBs in 2012 at the age of 12 followed by CSH in 2015. He described how he felt a strong need to become a boy from an early age and how he was bullied at school for his behaviour. He found the onset of female puberty horrifying and unbearable. After a number of sessions at GIDS he was prescribed PBs from the age of 12.

86. According to J he was given the fullest possible information from the clinicians at GIDS as to the benefits and disbenefits of the treatment. The clinicians strongly challenged his desire to transition and why he had chosen to express his gender identity as male. He was advised as to the impact on fertility if he chose to go on to CSH and surgery. He said: "*I made the decision to proceed with pubertal suppression without pursuing egg preservation. It was a difficult decision to make because I did not know whether I would want biological children in adulthood, but I was certain I would never want to*

*carry a child and give birth. Ultimately, I made the decision because I had a poor quality of life and without immediate treatment I did not feel I had a future at all."* He says: "*We discussed sex and I told them the idea of it disgusted me. I knew I would be unable to consider having a sexual relationship as an adult with my body so wrongly formed."* He ended his witness statement by saying that he is thankful that his pubertal development was halted as it removed the distress caused by continued development, but he wishes that the PBs were started earlier which would have prevented the need for breast surgery later.

87. S is a 13 year old trans boy who is on the waiting list at GIDS. He was told that he would have to wait for approximately 24 months to be seen and with his parents decided to see a private provider, GenderGP, where he has been prescribed PBs. We note at this point that the GP in question was removed from the professional register and now operates from outside the United Kingdom. S in his witness statement said:

> "13. … I haven't really thought about parenthood – I have been asked about it by the gender identity specialist I have mentioned but I just have no idea what me in the future is going to think. I haven't had a romantic relationship and it's just not a thing that is really on my radar at the moment."

88. N, an 18 year old trans woman, who was prescribed PBs when she was 17 years old said:

> "12. The treatment of hormone blockers may very well have saved my life. In the period of my life that I was prescribed them my mental health was spiralling due to my dysphoria and this impacting on my daily life, learning and social interactions. While the first injections of gonapeptyl were slow to take effect they eventually began to alleviate my dysphoria in very real ways. I had to shave less and I didn't have to fear pubertal development anymore. I had the time necessary to think about my situation and decide on further courses of action. This also helped my mental health as it gave me significantly less issues overall allowing me to focus and concentrate on aspects in my life alongside my gender identity rather than my fears of puberty and development overtaking everything else in my life."

89. The second claimant, Mrs A, is the mother of a 15 year old girl who has ASD. The daughter has a history of mental health and behavioural problems. She "*is desperate to run away from all that made her female"* and has been referred to CAMHS (Child and Adolescent Mental Health Services). Mrs A is very concerned that her daughter would be referred to GIDS and prescribed PBs. However the daughter has not currently been referred to GIDS and having regard to the defendant's current practice, would not meet the criteria for PBs because her parents would not support that treatment. Mrs A's interest in this action is therefore largely theoretical.

*SECTION C: SUBMISSIONS*

90. The claimants' primary case is that children or young persons under the age of 18 are not capable of giving consent to the administration of PBs. Their secondary case is that the information given by the defendant and the Interested Party is misleading and inadequate to form the basis for informed consent to be given. In their statement of issues, the claimants put issue one as the adequacy of the information and issue two whether children and young people are capable of giving consent. In our view, the first issue must be whether *Gillick* competence can be achieved, and the secondary or alternative issue, whether the information being given is adequate. We deal with the arguments in that order.

91. Mr Hyam also raised a third issue (at least in writing). This was a submission that if any young person under the age of 18 is prescribed PBs, their case should be referred to the Court of Protection. In oral argument he accepted that the Court of Protection, being a creature of statute, would have no jurisdiction to consider such referrals. We think that the substance of issue three falls within the terms of issue one.

92. Mr Hyam stressed that the claimants were not calling into question that GD existed. Nor were they questioning that it could cause extreme distress or that PBs should never be given to people under 18 or that it was never in their best interests for it to be prescribed. The central issue was whether those under 18 could give informed consent.

93. Mr Hyam submitted that a child still going through puberty is not capable of properly understanding the nature and effect of PBs and weighing the consequences and side effects properly. He pointed to the evidence of the individuals, including that put forward on behalf of the defendant, to show that children of this age cannot understand the implications of matters such as the loss of the ability to orgasm, the potential need to construct a neo-vagina, or the loss of fertility. He argued that the use of PBs to address GD does not have an adequate evidence base to support it and thus should properly be described as experimental treatment. There is evidence that PBs can have significant side effects and there is strong evidence that once a child commences on PBs they will progress to CSH which will cause irreversible changes to the child's body with lifelong medical, psychological and emotional implications for the child. He relies on the harm potentially caused to these vulnerable young people as evidenced by the witness statement of the first claimant.

94. He submitted that the advice given to the children and young persons is misleading because they are told that the PBs are fully reversible when the current evidence on reversibility or the long term implications of the treatment is limited and unclear. He said further, that the reality is that PBs pave the way for CSH which do have irreversible impacts. Further, the information provided by GIDS fails to tell the child that there are no proven benefits to this treatment in either physical or psychological terms. The information is misleading as to the reversibility of PBs, their purpose and their benefits.

95. In those circumstances he submitted that the court should be guided by the approach of the Court of Protection in its *Practice Guidance (Court of Protection: Serious Medical Treatment)* [2020] 1 WLR 641 which sets out those decisions relating to medical treatment where an application should be made to the Court of Protection.

96. Paras 10 and 11 of that Guidance state:

> "10. In any case which is not about the provision of life-sustaining treatment, but involves the serious interference with the person's rights under the ECHR, it is:
>
> "highly probable that, in most, if not all, professionals faced with a decision whether to take that step will conclude that it is appropriate to apply to the court to facilitate a comprehensive analysis of [capacity and] best interests, with [the person] having the benefit of legal representation and independent expert advice."
>
> This will be so even where there is agreement between all those with an interest in the person's welfare.
>
> 11. Examples of cases which may fall into paragraph 10 above will include, but are not limited to: (a) where a medical procedure or treatment is for the primary purpose of sterilisation; (b) where a medical procedure is proposed to be performed on a person who lacks capacity to consent to it, where the procedure is for the purpose of a donation of an organ, bone marrow, stem cells, tissue or bodily fluid to another person; (c) a procedure for the covert insertion of a contraceptive device or other means of contraception; (d) where it is proposed that an experimental or innovative treatment to be carried out; (e) a case involving a significant ethical question in an untested or controversial area of medicine."

97. The defendant and the first and second Interveners make common cause. Ms Morris argued that the care and treatment provided at GIDS fell within the terms of the Service Specification laid down by NHS England (NHSE) as required in accordance with the international frameworks of WPATH and the Endocrine Society and by the domestic regulatory frameworks of the General Medical Council and the Care Quality Commission. The NHSE is currently undertaking a review of the efficacy of treatment for GD (the Cass Review) which will report in due course, and its findings will be reflected in the Service Specification.

98. She argued that the process at GIDS was "deeply *Montgomery* compliant" (i.e. it met the requirements for informed consent identified by the Supreme Court in *Montgomery v Lanarkshire Health Board* [2015] AC 1430) having regard to the frequent consultations, discussions and the provision of detailed, but age appropriate, information. The "vast majority" of the children referred for PBs are 15 or older she said, and the information given is varied depending on the age and maturity of the child or young person. Where the assessment is that the individual is not initially *Gillick* competent, time is taken to see if their understanding develops and competency can be achieved. The information that is given is what is salient for that individual at that age.

99. As to those between the ages of 16-18, if the young person, the parents and the clinicians are agreed then she submitted there is no justiciable issue and the court has no jurisdiction.

100. Mr McKendrick for the first and second Interveners argued that the child or young person did not need to understand the impact of CSH on their fertility because that did

not fall to be decided at the stage of prescribing PBs. The PBs provided the space for the person to think about further stages. In appropriate cases, a natal girl or young person's eggs could be harvested and preserved in order to preserve their fertility. The critical thing for the child was that s/he had GD and that there was no alternative physical treatment to PBs. Once the child or young person had reached the Endocrine Clinic at the Trust, there was no alternative psychological treatment available because that was a matter within the purview of GIDS and GIDS had referred the child for PBs, although ongoing psychological treatment is provided at GIDS alongside treatment with PBs. Therefore, the Trust clinicians were faced with a child in acute distress with no alternative treatment options. The purpose of the treatment was to alleviate distress and that, according to Mr McKendrick, had been achieved.

101. When asked by the court what evidence there was that the PBs did achieve the purpose of alleviating distress, in the light of the lack of published research, Mr McKendrick pointed to the evidence of experienced endocrinologists in both Trusts who could see the real benefits of the treatment.

102. Like Ms Morris, Mr McKendrick said the current practice was not to proceed only on parental consent. However, he did argue that if the child's consent was rendered invalid, the treatment would continue to be lawful if the parents had consented.

103. The third Intervener is Transgender Trend Ltd., an organisation that provides evidence-based information and resources for parents and schools concerning children with GD. Ms Davies-Arai is the director of that organisation and she has filed a witness statement in these proceedings. She set out concerns about the lack of evidence as to the impacts and effectiveness of PBs and in relation to which patients it is most likely to help. Much of her evidence focused on the increase of referrals to GIDS of teenage natal girls and the cultural factors, including material on the internet and social media, which may play a part in this. She said that GIDS does not offer young people with GD a range of ways to interpret their experience, and the GIDS pathway offers a minimal challenge to the beliefs and ideas of the young person.

104. Mr Skinner on behalf of Transgender Trend said the case was particularly important because it concerned the deliberate provision by the State of medical treatment to children and young people which may cause harm. The court should be anxious to ensure that vulnerable children, for example those with ASD, are provided with the full protection of the law.

*SECTION D: THE LAW*

105. In *Gillick v West Norfolk and Wisbech Health Authority* [1986] AC 112, the House of Lords considered the lawfulness of the Secretary of State's policy on giving contraceptive advice to children without parental consent. The House of Lords held by a majority that a doctor could lawfully give contraceptive advice and treatment to a girl aged under 16 if she had sufficient maturity and intelligence to understand that nature and implications of the proposed treatment and provided that certain conditions were satisfied.

106. Lord Fraser at p. 169B-E said:

> "It seems to me verging on the absurd to suggest that a girl or boy aged 15 could not effectively consent, for example, to have a medical examination of some trivial injury to his body or even to have a broken arm set. Of course the consent of the parents should normally be asked, but they may not be immediately available. Provided the patient, whether the boy or a girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he advises. After all, a minor under the age of 16 can, with certain limits, enter into a contract. He or she can also sue and be sued, and can give evidence on oath. …."
>
> Accordingly, I am not disposed to hold now, for the first time, that a girl less than 16 lacks the power to give valid consent to contraceptive advice or treatment, merely on account of her age."

107. Lord Scarman at p. 186A-D said:

> "The law relating to parent and child is concerned with the problems of the growth and maturity of the human personality. If the law should impose upon the process of "growing up" fixed limits where nature knows only a continuous process, the price would be artificiality and a lack of realism in an area where the law must be sensitive to human development and social change. If certainty be thought desirable, it is better that the rigid demarcations necessary to achieve it should be laid down by legislation after a full consideration of all the relevant factors than by the courts confined as they are by the forensic process to the evidenced adduced by the parties and to whatever may properly fall within the judicial notice of judges. Unless and until Parliament should think fit to intervene, the courts should establish a principle flexible enough to enable justice to be achieved by its application to the particular circumstances proved by the evidence placed before them."

And at p.189C-E:

> "When applying these conclusions to contraceptive advice and treatment it has to be borne in mind there is much that has to be understood by a girl under the age of 16 if she is to have legal capacity to consent to such treatment. It is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved. There are moral and family questions, especially her relationship with her parents; long-term problems associated with the emotional impact of pregnancy and its termination; and there are the risks to health of sexual intercourse at her age, risks which contraception may diminish but cannot eliminate. It follows that a doctor will have to satisfy himself that she is able to appraise these factors

> before he can safely proceed upon the basis that she has at law capacity to consent to contraceptive treatment. And it further follows that ordinarily the proper course will be for him, as the guidance lays down, first to seek to persuade the girl to bring her parents into consultation and, if she refuses, not to prescribe contraceptive treatment unless he is satisfied that her circumstances are such that he ought to proceed without parental knowledge and consent."

And p. 191C-D:

> "The truth may well be that the rights of parents and children in this sensitive area are better protected by the professional standards of the medical profession than by "a priori" legal lines of division between capacity and the lack of capacity to consent since any such general dividing line is sure to produce in some cases injustice, hardship, and injury to health."

108. In *R (Axon) v Secretary of State for Health (Family Planning Association Intervening)* [2006] QB 539 Silber J considered *Gillick* in the context of Article 8 of the Convention, the United Nations Convention on the Rights of the Child (UNCRC) and the increasing emphasis on the autonomy of the child. He held that the principles set out in *Gillick* continued to apply, see para 152.

109. There are two cases dealing with children aged 16 or over who refused medical treatment in circumstances where clinicians considered it was clinically indicated. The issue in each was whether the court could nevertheless, authorise the treatment. *Re W (a Minor) (Medical Treatment: Court's Jurisdiction)* [1993] Fam. 64, concerned the case of a 16 year old girl with anorexia nervosa. The local authority applied under the inherent jurisdiction of the High Court to give medical treatment to W without her consent and against her wishes. W relied on section 8 of the Family Law Reform Act 1969, which states:

> "Section 8 is in these terms:
>
> (1) The consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age; and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his parent or guardian. (2) In this section 'surgical, medical or dental treatment' includes any procedure undertaken for the purposes of diagnosis, and this section applies to any procedure which is ancillary to any treatment as it applies to that treatment. (3) Nothing in this section shall be construed

> as making ineffective any consent which would have been effective if this section had not been enacted."

110. The Court of Appeal held that section 8 did not confer on a minor an absolute right to determine whether or not she received medical treatment but protected the medical practitioner from an action in trespass. Lord Donaldson analysed *Gillick* and said that Lord Scarman would necessarily have considered that the purpose of section 8 was to provide the medical practitioners treating the child with a defence to either criminal assault or a civil claim for trespass, see pages 76G-H and 78D-F. Lord Donaldson described the effect of the section as being a *"legal flak jacket",* whereby the 16-17 year old is conclusively proved to be *Gillick* competent but this did not mean that someone else who has parental responsibility cannot give consent for the treatment.

111. When applying his analysis to the facts of W's case, Lord Donaldson said at p. 80G-81B:

> "I have no doubt that the wishes of a 16 or 17-year-old child or indeed of a younger child who is "Gillick competent" are of the greatest importance both legally and clinically, but I do doubt whether Thorpe J was right to conclude that W was of sufficient understanding to make an informed decision. I do not say this on the basis that I consider her approach irrational. I personally consider that religious or other beliefs which bar any medical treatment or treatment of particular kinds are irrational, but that does not make minors who hold those beliefs any the less "Gillick competent". They may well have sufficient intelligence and understanding fully to appreciate the treatment proposed and the consequences of their refusal to accept that treatment. What distinguishes W from them, and what with all respect I do not think that Thorpe J took sufficiently into account (perhaps because the point did not emerge as clearly before him as it did before us), is that it is a feature of anorexia nervosa that it is capable of destroying the ability to make an informed choice. It creates a compulsion to refuse treatment or only to accept treatment which is likely to be ineffective. This attitude is part and parcel of the disease and the more advanced the illness, the more compelling it may become. Where the wishes of the minor are themselves something which the doctors reasonably consider need to be treated in the minor's own best interests, those wishes clearly have a much reduced significance."

112. Lord Donaldson concluded at p. 84A-B that:

> "No minor of whatever age has power by refusing consent to treatment to override a consent to treatment by someone who has parental responsibility for the minor and a fortiori a consent by the court. Nevertheless such a refusal is a very important consideration in making clinical judgments and for parents and the courts in deciding whether themselves to give consent. Its importance increases with the age and maturity of the minor."

113. Balcombe LJ at p. 87G-H agreed with Lord Donaldson that the parents of a 16 and 17 year old retained the right to consent to treatment even if she did not consent, and that the court could continue to exercise its inherent jurisdiction. Nolan LJ did not express a view as to whether parents could consent to treatment where the child had refused, but considered that the court under its inherent jurisdiction could continue to do so. He said, at p. 94D-E:

> "To take it a stage further, if the child's welfare is threatened by a serious or imminent risk that the child will suffer grave and irreversible mental or physical harm, then once again the court when called upon has a duty to intervene. It makes no difference whether the risk arises from the action or inaction of others, or from the action or inaction of the child. Due weight must be given to the child's wishes, but the court is not bound by them. In the present case, Thorpe J was apparently satisfied on the evidence before him that such a risk existed. In my judgment, he was fully entitled to take this view. By the time the matter came to this court, it was impossible to take any other view. For these reasons, I would dismiss the appeal save to the extent of making the necessary variation of the order of Thorpe J."

114. We were taken to two cases concerning the application of *Gillick* in particularly difficult medical and ethical situations, which are of some assistance in the present case. In *Re L (Medical Treatment: Gillick Competency*) [1998] 2 F.L.R. 810 Sir Stephen Brown P. considered the case of a 14 year old girl with a life threatening condition involving the possibility of a blood transfusion. L was a Jehovah's Witness and would not consent to the blood transfusion. The court ordered that the medical treatment should take place without her consent. The expert clinician appointed by the Official Solicitor is recorded as giving the following evidence:

> "He makes the point that the girl's view as to having no blood transfusion is based on a very sincerely, strongly held religious belief which does not in fact lend itself in her mind to discussion. It is one that has been formed by her in the context of her own family experience and the Jehovah's Witness meetings where they all support this view. He makes the point that there is a distinction between a view of this kind and the constructive formulation of an opinion which occurs with adult experience. That has not happened of course in the case of this young girl."

115. Sir Stephen Brown then concluded at p. 813:

> "It is, therefore, a limited experience of life which she has – inevitably so – but this is in no sense a criticism of her or of her upbringing. It is indeed refreshing to hear of children being brought up with the sensible disciplines of a well-conducted family. But it does necessarily limit her understanding of matters which are as grave as her own present situation. It may be that because of her belief she is willing to say, and to mean it, 'I am willing to accept death rather than to have a blood transfusion', but it is quite clear in this case that she has not been able to be given all the

> details which it would be right and appropriate to have in mind when making such a decision.
>
> I do not think that in this case this young girl is 'Gillick competent'. I base that upon all the evidence that I have heard. She is certainly not 'Gillick competent' in the context of all the necessary details which it would be appropriate for her to be able to form a view about."

116. *Re S (A Child) (Child Parent: Adoption Consent)* [2019] 2 Fam 177 also concerned a child under 16. In that case Cobb J considered the competence of a mother under the age of 16 to consent to her baby being placed for adoption. Cobb J held that it was appropriate and helpful in determining *Gillick* competence to read across and borrow from the relevant concepts and language in the Mental Capacity Act 2005 but cognisant of some fundamental differences, in particular that the assumption of capacity in section 1(2) of that Act did not apply and there was no requirement for any diagnostic characteristic as there is in section 2(1) of the Mental Capacity Act 2005, see paras 15,16 and 60.

117. At paras 34 to 37 Cobb J considered what test he should apply to the information that S needed to understand and then set out the information that would be relevant for the decision in question:

> "34. Macur J in *LBL v RYJ and VJ* [2011] 1 FLR 1279, para 24 held that it would not be necessary for a decision-maker to be able to comprehend "all the peripheral detail" in the assessment of capacity to make the relevant decision; in a case concerning residence and the provision of education, Macur J went on to say, at para 58:
>
> "In [the expert's] view it is unnecessary for his determination of RYJ's capacity that she should understand all the details within the statement of special educational needs. It is unnecessary that she should be able to give weight to every consideration that would otherwise be utilised in formulating a decision objectively in her 'best interests'. I agree with his interpretation of the test in section 3 which is to the effect that the person under review must comprehend and weigh the salient details relevant to the decision to be made. To hold otherwise would place greater demands upon RYJ than others of her chronological age/commensurate maturity and unchallenged capacity."
>
> 35. In the same vein, Baker J remarked in *H v A Local Authority* [2011] EWHC 1704 at [16(xi)]: "[the] courts must guard against imposing too high a test of capacity to decide issues such as residence because to do so would run the risk of discriminating against persons suffering from a mental disability."
>
> 36. Although not cited in argument, I further remind myself of the comments of Chadwick LJ in the Court of Appeal in *Masterman-Lister v Brutton & Co (Nos 1 and 2)* [2003] 1 WLR 1511, para 79: "a person should not be held unable to understand the information relevant to a

> decision if he can understand the explanation of that information in broad terms and simple language…" So, says Ms Dolan, it is not necessary for S to understand all the peripheral and non-salient information in the adoption consent form in order to be declared capacitous. Nor does she even need to fully understand the legal distinctions between placement for adoption under a placement order and not under a placement order. Indeed, Ms Dolan herself relies in this regard on *In re A (Adoption: Agreement: Procedure)* [2001] 2 FLR 455, para 43 where Thorpe LJ observes that the differences between freeing and adoption are "complex in their inter-relationship and it is not to be expected that social workers should have a complete grasp of the distinction between the two, or always to signify the distinction in their discussion with the clients" (my emphasis)." If social workers are not expected to understand the complexities of the legislation (or its predecessor) or explain the distinction accurately to the parents with whom they are working asks Ms Dolan, why should a person under the age of 16 be expected to be able to grasp them in order to be able to be declared capacitous?
>
> 37. Accordingly, argues the local authority, the salient or "sufficient" information which is required to be understood by the child parent regarding extra-familial adoption is limited to the fundamental legal consequences of the same. The factors discussed at the hearing include: (i) your child will have new legal parents, and will no longer be your son or daughter in law, (ii) adoption is final, and non-reversible; (iii) during the process, other people (including social workers from the adoption agency) will be making decisions for the child, including who can see the child, and with whom the child will live; (iv) you may obtain legal advice if you wish before taking the decision; (v) the child will live with a different family forever; you will (probably) not be able to choose the adopters; (vi) you will have no right to see your child or have contact with your child; it is highly likely that direct contact with your child will cease, and any indirect contact will be limited; (vii) the child may later trace you, but contact will only be re-established if the child wants this; (viii) there are generally two stages to adoption; the child being placed with another family for adoption, and being formally adopted; (ix) for a limited period of time you may change your mind; once placed for adoption, your right to change your mind is limited, and is lost when an adoption order is made."

118. Cobb J's conclusions were these:

> "60… It follows that in order to satisfy the Gillick test in this context the child parent should be able to demonstrate "sufficient" understanding of the "salient" facts around adoption; she should understand the essential "nature and quality of the transaction" (per Munby J in *Sheffield City Council v E* [2005] Fam 326, para 19) and should not need to be concerned with the peripheral.

> 61. It will, however, be necessary for the competent child decision-maker to demonstrate a "full understanding" of the essential implications of adoption when exercising her decision-making, for the independent CAFCASS officer to be satisfied that the consent is valid. If consent is offered under section 19 and/or section 20 of the 2002 Act, it will be necessary for a form to be signed, even if not in the precise format of that identified by Practice Direction 5A. I accept that on an issue as significant and life-changing as adoption, there is a greater onus on ensuring that the child understands and is able to weigh the information than if the decision was of a lesser magnitude: see Baker J in *CC v KK and STCC* [2012] COPLR 627, para 69. This view is consistent with the Mental Capacity Act 2005 Code of Practice, which provides, at paragraph 4.19:
>
> "a person might need more detailed information or access to advice, depending on the decision that needs to be made. If a decision could have serious or grave consequences, it is even more important that a person understands the information relevant to that decision.""

119. In determining the level of understanding that the child needs to have to consent to PBs, Mr Hyam attached considerable importance to the decision of the Supreme Court in *Montgomery v Lancashire Health Board*. That case concerned an action in negligence brought by a mother on behalf of her child. The child was disabled as a result of complications during delivery and the mother argued that she should have been advised as to the possibility of delivery by elective caesarean. The central issue for present purposes was the information that the doctor needed to have given the patient in order to establish that she had given informed consent for the treatment.

120. Lord Kerr set out the requirements placed on a doctor in providing information on risks of injury from treatment in the following terms at para 87:

> "An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken. The doctor is therefore under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it."

121. Mr Hyam submitted that in determining whether a child is *Gillick* competent the court should consider what would a *"reasonable person in the patient's position understand",* and in asking that question, he submitted that the "reasonable person" is one with adult knowledge.

122. Ms Morris went to the opposite extreme. She submitted that when deciding what information needs to be given to the patient and understood by them, the test is a reasonable person in that individual's position, i.e. a reasonable 12 year old (or other

age) with GD. She said that the "salient" information that needs to be provided is what that reasonable patient would attach importance to. She said that seeking consent, certainly for treatment with lifelong implications such as sterilisation will always involve some *"act of imagination"*. Many patients facing life changing treatment, such as the loss of fertility in cancer treatment or endometriosis, will not have had experience of what they are foregoing, for example, fertility. She submitted that the court ought not to be pronouncing on hypothetical cases: rather, it should or could consider the facts of one specific case as and when it arises.

123. Mr McKendrick submitted that the correct approach in deciding what information was material was to assume a reasonable child of the individual's age.

124. Mr Skinner pointed out that *Montgomery* concerned an adult and therefore the presumption of capacity in the Mental Capacity Act 2005 applied. That presumption is inapplicable in a case concerning *Gillick* competency where the very issue is whether the child is competent to make the decision. The decision in *Montgomery* was of limited assistance, therefore, in the present case. In determining competence, the child must have sufficient understanding of the factors that are not just relevant to him or her now but which on an objective basis ought to be given weight in the future.

125. In our view, the following principles can be derived from the cases to which we have referred:

126. First, the question as to whether a person under the age of 16 is *Gillick* competent to make the relevant decision will depend on the nature of the treatment proposed as well as that person's individual characteristics. The assessment is necessarily an individual one. Where the decision is significant and life changing then there is a greater onus to ensure that the child understands and is able to weigh the information, see *Re S* at para 60.

127. Secondly, however, that does not mean that it is not possible for the court to draw some lines. The Trusts themselves accept that a 7 year old being treated with PBs for precocious puberty cannot give informed consent and his or her parents must give that consent because of the young age of the child concerned and the nature of the treatment.

128. Thirdly, efforts should be made to allow the child or young person to achieve *Gillick* competency where that is possible. Clinicians should therefore work with the individual to help them understand the treatment proposed and its potential implications in order to help them achieve competence.

129. Fourthly, however, that does not mean that every individual under 16 can achieve *Gillick* competence in relation to the treatment proposed. As we discuss below, where the consequences of the treatment are profound, the benefits unclear and the long-term consequences to a material degree unknown, it may be that *Gillick* competence cannot be achieved, however much information and supportive discussion is undertaken.

130. Fifthly, in order to achieve *Gillick* competence it is important not to set the bar too high. It is not appropriate to equate the matters that a clinician needs to explain, as set out in *Montgomery*, to the matters that a child needs to understand to achieve *Gillick* competence. The consequence of Mr Hyam's approach would be significantly to raise

the bar for competence and capacity, which would be contrary both to the common law and to a child's Article 8 rights and the importance of supporting individual autonomy.

131. We adopt the language of Chadwick LJ in *Masterman-Lister v Brutton and Co (Nos 1 and 2)* [2003] 1 WLR 151: a person should be able to "*understand an explanation of that information in broad terms and simple language"*, see *Re S* at para 36. Although this was said in a case that concerned an adult's capacity, in our judgment the same approach should be applied to a case concerning *Gillick* competence. The child or young person needs to be able to demonstrate sufficient understanding of the salient facts, see *Re S* at para 60.

132. Sixthly, we agree with Mr Skinner, that in deciding what facts are salient and what level of understanding is sufficient, it is necessary to have regard to matters which are those which objectively ought to be given weight in the future although the child might be unconcerned about them now. On the facts of this case there are some obvious examples, including the impact on fertility and on future sexual functioning.

*SECTION E: CONCLUSIONS*

133. The principal issue before this court is in some ways a narrow one. Can a child or young person under the age of 16 achieve *Gillick* competence in respect of the decision to take PBs for GD? The legal position of 16 and 17 year olds is different, and we deal with that below.

134. The starting point is to consider the nature of the treatment proposed. The administration of PBs to people going through puberty is a very unusual treatment for the following reasons. Firstly, there is real uncertainty over the short and long-term consequences of the treatment with very limited evidence as to its efficacy, or indeed quite what it is seeking to achieve. This means it is, in our view, properly described as experimental treatment. Secondly, there is a lack of clarity over the purpose of the treatment: in particular, whether it provides a "pause to think" in a "hormone neutral" state or is a treatment to limit the effects of puberty, and thus the need for greater surgical and chemical intervention later, as referred to in the Health Research Authority report. Thirdly, the consequences of the treatment are highly complex and potentially lifelong and life changing in the most fundamental way imaginable. The treatment goes to the heart of an individual's identity, and is thus, quite possibly, unique as a medical treatment.

135. Furthermore, the nature and the purpose of the medical intervention must be considered. The condition being treated, GD, has no direct physical manifestation. In contrast, the treatment provided for that condition has direct physical consequences, as the medication is intended to and does prevent the physical changes that would otherwise occur within the body, in particular by stopping the biological and physical development that would otherwise take place at that age. There is also an issue as to whether GD is properly categorised as a psychological condition, as the DSM-5 appears to do, although we recognise there are those who would not wish to see the condition categorised in that way. Be that as it may, in our judgment for the reasons already identified, the clinical intervention we are concerned with here is different in kind to other treatments or clinical interventions. In other cases, medical treatment is used to remedy, or alleviate the symptoms of, a diagnosed physical or mental condition, and

the effects of that treatment are direct and usually apparent. The position in relation to puberty blockers would not seem to reflect that description.

136. Indeed the consequences which flow from taking PBs for GD and which must be considered in the context of informed consent, fall into two (interlinking) categories. Those that are a direct result of taking the PBs themselves, and those that follow on from progression to Stage 2, that is taking cross-sex hormones. The defendant and the Trusts argue that Stage 1 and 2 are entirely separate; a child can stop taking PBs at any time and that Stage 1 is fully reversible. It is said therefore the child needs only to understand the implications of taking PBs alone to be *Gillick* competent. In our view this does not reflect the reality. The evidence shows that the vast majority of children who take PBs move on to take cross-sex hormones, that Stages 1 and 2 are two stages of one clinical pathway and once on that pathway it is extremely rare for a child to get off it.

137. The defendant argues that PBs give the child "time to think", that is, to decide whether or not to proceed to cross-sex hormones or to revert to development in the natal sex. But the use of puberty blockers is not itself a neutral process by which time stands still for the child on PBs, whether physically or psychologically. PBs prevent the child going through puberty in the normal biological process. As a minimum it seems to us that this means that the child is not undergoing the physical and consequential psychological changes which would contribute to the understanding of a person's identity. There is an argument that for some children at least, this may confirm the child's chosen gender identity at the time they begin the use of puberty blockers and to that extent, confirm their GD and increase the likelihood of some children moving on to cross-sex hormones. Indeed, the statistical correlation between the use of puberty blockers and cross-sex hormones supports the case that it is appropriate to view PBs as a stepping stone to cross-sex hormones.

138. It follows that to achieve *Gillick* competence the child or young person would have to understand not simply the implications of taking PBs but those of progressing to cross-sex hormones. The relevant information therefore that a child would have to understand, retain and weigh up in order to have the requisite competence in relation to PBs, would be as follows: (i) the immediate consequences of the treatment in physical and psychological terms; (ii) the fact that the vast majority of patients taking PBs go on to CSH and therefore that s/he is on a pathway to much greater medical interventions; (iii) the relationship between taking CSH and subsequent surgery, with the implications of such surgery; (iv) the fact that CSH may well lead to a loss of fertility; (v) the impact of CSH on sexual function; (vi) the impact that taking this step on this treatment pathway may have on future and life-long relationships; (vii) the unknown physical consequences of taking PBs; and (viii) the fact that the evidence base for this treatment is as yet highly uncertain.

139. It will obviously be difficult for a child under 16 to understand and weigh up such information. Although a child may understand the concept of the loss of fertility for example, this is not the same as understanding how this will affect their adult life. A child's attitude to having biological children and their understanding of what this really means, is likely to change between childhood and adulthood. For many children, certainly younger children, and some as young as 10 and just entering puberty, it will not be possible to conceptualise what not being able to give birth to children (or conceive children with their own sperm) would mean in adult life. Similarly, the

meaning of sexual fulfilment, and what the implications of treatment may be for this in the future, will be impossible for many children to comprehend.

140. Ms Morris submitted that many decisions about complex and long-lasting medical treatment will involve the patient having, to some degree, to imagine themselves into an uncertain future of which they have no experience. However, for the reasons that we have explained in para 135 above we consider the treatment in this case to be in entirely different territory from the type of medical treatment which is normally being considered.

141. Some of the children and young people who have been treated at GIDS say in their witness statements that the thought of sex disgusted them, or they did not really think about fertility. These normal reactions do not detract from the difficulties surrounding consent and treatment with PBs. That adolescents find it difficult to contemplate or comprehend what their life will be like as adults and that they do not always consider the longer-term consequences of their actions is perhaps a statement of the obvious.

142. These various difficulties are compounded by the particular difficulties prevalent in the cohort of children treated at GIDS. On the defendant's case, they suffer considerable psychological distress by reason of their GD and are highly vulnerable. In those circumstances, the consequences of taking PBs on their fertility for example, or on their sexual life, may be viewed as a relatively small price to pay for what may be perceived as a solution to their immediate and real psychological distress. It would not follow however that their weighing of risks and benefits when they might start taking PBs would prevail in the longer-term.

143. The difficulty of achieving informed consent in these circumstances is further exacerbated by the lack of evidence as to the efficacy of PBs in treating GD and the long-term outcomes of taking it. We entirely accept that the fact that a treatment is experimental, or that the long-term outcomes are not yet known, does not of itself prevent informed consent being given. Otherwise no experimental treatment could ever be consented to. However, the combination here of lifelong and life changing treatment being given to children, with very limited knowledge of the degree to which it will or will not benefit them, is one that gives significant grounds for concern.

144. We do not think that the answer to this case is simply to give the child more, and more detailed, information. The issue in our view is that in many cases, however much information the child is given as to long-term consequences, s/he will not be able to weigh up the implications of the treatment to a sufficient degree. There is no age appropriate way to explain to many of these children what losing their fertility or full sexual function may mean to them in later years.

145. *Gillick* makes clear that any decision is treatment and person specific. However, for the reasons that we have set out above, we think that it is appropriate in this case to give clear guidance as to the application of the *Gillick* tests to the treatment and cohort of children in question. The conclusion we have reached is that it is highly unlikely that a child aged 13 or under would ever be *Gillick* competent to give consent to being treated with PBs. In respect of children aged 14 and 15, we are also very doubtful that a child of this age could understand the long-term risks and consequences of treatment in such a way as to have sufficient understanding to give consent. However, plainly the

increased maturity of the child means that there is more possibility of achieving competence at the older age.

146. In respect of a young person aged 16 or over, the legal position is different. There is a presumption of capacity under section 8 of the Family Law Reform Act 1969. As is explained in *Re W*, that does not mean that a court cannot protect the child under its inherent jurisdiction if it considers the treatment not to be in the child's best interests. However, so long as the young person has mental capacity and the clinicians consider the treatment is in his/her best interests, then absent a possible dispute with the parents, the court generally has no role. We do not consider that the court can somehow adopt an intrusive jurisdiction in relation to one form of clinical intervention for which no clear legal basis has been established.

147. We do however recognise that in the light of the evidence that has emerged, and the terms of this judgment, clinicians may well consider that it is not appropriate to move to treatment, such as PBs or CSH, without the involvement of the court. We consider that it would be appropriate for clinicians to involve the court in any case where there may be any doubt as to whether the long-term best interests of a 16 or 17 year old would be served by the clinical interventions at issue in this case.

148. We express that view for these reasons. First, the clinical interventions involve significant, long-term and, in part, potentially irreversible long-term physical, and psychological consequences for young persons. The treatment involved is truly life changing, going as it does to the very heart of an individual's identity. Secondly, at present, it is right to call the treatment experimental or innovative in the sense that there are currently limited studies/evidence of the efficacy or long-term effects of the treatment.

149. The position of the defendant and the Trusts is that they consider it would be an intrusion into the child or young person's autonomy if a decision about treatment with PBs were to be made by the court not by the patient. They are concerned about the use of NHS and court resources if these decisions have to be made by the court. We do not consider that this is the correct approach. In principle, a young person's autonomy should be protected and supported; however, it is the role of the court to protect children, and particularly a vulnerable child's best interests. The decisions in respect of PBs have lifelong and life-changing consequences for the children. Apart perhaps from life-saving treatment, there will be no more profound medical decisions for children than whether to start on this treatment pathway. In those circumstances we consider that it is appropriate that the court should determine whether it is in the child's best interests to take PBs. There is a real benefit in the court, almost certainly with a child's guardian appointed, having oversight over the decision. In any case, under the inherent jurisdiction concerning medical treatment for those under the age of 18, there is likely to be a conflict between the support of autonomy and the protective role of the court. As we have explained above, we consider this treatment to be one where the protective role of the court is appropriate.

150. The claimants' alternative ground is that the information provided by the defendant and the Trusts is inadequate to form the basis of informed consent. We accept that the defendant and the Trusts have in their written information, to children, young people and their parents and carers, tried hard to explain the potential consequences of PBs, including that of moving on to CSH, and to give full information. They have also

attempted to do this in an age appropriate manner. The problem is not the information given, but the ability of the children and young people, to understand and most importantly weigh up that information. The approach of the defendant appears to have been to work on the assumption that if they give enough information and discuss it sufficiently often with the children, they will be able to achieve *Gillick* competency. As we have explained above, we do not think that this assumption is correct.

*OVERALL CONCLUSION*

151. A child under 16 may only consent to the use of medication intended to suppress puberty where he or she is competent to understand the nature of the treatment. That includes an understanding of the immediate and long-term consequences of the treatment, the limited evidence available as to its efficacy or purpose, the fact that the vast majority of patients proceed to the use of cross-sex hormones, and its potential life changing consequences for a child. There will be enormous difficulties in a child under 16 understanding and weighing up this information and deciding whether to consent to the use of puberty blocking medication. It is highly unlikely that a child aged 13 or under would be competent to give consent to the administration of puberty blockers. It is doubtful that a child aged 14 or 15 could understand and weigh the long-term risks and consequences of the administration of puberty blockers.

152. In respect of young persons aged 16 and over, the legal position is that there is a presumption that they have the ability to consent to medical treatment. 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, we recognise that clinicians may well regard these as cases where the authorisation of the court should be sought prior to commencing the clinical treatment.

153. We have granted a declaration to reflect the terms of this judgment.

occupational, or other important areas of functioning.

## Terminology[1,2]

- **Cisgender**: Describes a person whose gender identity aligns in a traditional sense with the sex assigned to them at birth.
- **Gender diverse:** An umbrella term describing individuals with gender identities and/or expressions that vary from expected developmental norms. This includes people who identify as multiple genders or with no gender at all.
- **Gender dysphoria**: A concept designated in the *DSM-5* as clinically significant distress or impairment related to a strong desire to be of another gender, which may include desire to change primary and/or secondary sex characteristics. Not all transgender or gender diverse people experience dysphoria.
- **Gender expression**: The outward manifestation of a person's gender, which may or may not reflect their inner gender identity based on traditional expectations. Gender expression incorporates how a person carries themselves, their dress, accessories, grooming, voice/speech patterns and conversational mannerisms, and physical characteristics.
- **Gender identity**: A person's inner sense of being a girl/woman, boy/man, some combination of both, or something else, including having no gender at all. This may or may not correspond to the gender assigned at birth.
- **Nonbinary:** A term used by some individuals whose gender identity is

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# What Is Gender Dysphoria?

The term "transgender" refers to a person whose sex assigned at birth (i.e. the sex assigned by a physician at birth, usually based on external genitalia) does not match their gender identity (i.e., one's psychological sense of their gender). Some people who are transgender will experience **"gender dysphoria,"** which refers to psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity. Though gender dysphoria often begins in childhood, some people may not experience it until after puberty or much later.

People who are transgender may pursue multiple domains of gender affirmation, including social affirmation (e.g., changing one's name and pronouns), legal affirmation (e.g., changing gender markers on one's government-issued documents), medical affirmation (e.g., pubertal suppression or gender-affirming hormones), and/or surgical affirmation (e.g., vaginoplasty, facial feminization surgery, breast augmentation, masculine chest reconstruction, etc.). Of note, not all people who are transgender will desire all domains of gender affirmation, as these are highly personal and individual decisions.

It is important to note that gender identity is different from gender expression. Whereas gender identity refers to one's psychological sense of their gender, gender expression refers to the way in which one presents to the world in a gendered way. For example, in much of the U.S., wearing a dress is considered a "feminine" gender expression, and wearing a tuxedo is considered a "masculine" gender expression. Such expectations are culturally defined and vary across time and culture. One's gender expression does not necessarily align with their gender identity. Diverse gender expressions, much like diverse gender identities, are not indications of a mental disorder.

Gender identity is also different from sexual orientation. Sexual orientation refers to the types of people towards which one is sexually attracted. People who are transgender have the same diversity of sexual orientations as people who are cisgender (people whose sex assigned at birth matches their gender identity).

Diagnosis | Treatment | Challenges/Complications

## Diagnosis

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)[1] provides for one overarching diagnosis of gender dysphoria with separate specific criteria for children and for adolescents and adults.

The DSM-5 defines gender dysphoria in adolescents and adults as a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least 6 months, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)

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- A strong desire for the primary and/or secondary sex characteristics of the other gender
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender)
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender)
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender)

In order to meet criteria for the diagnosis, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The DSM-5 defines gender dysphoria in children as a marked incongruence between one's experienced/expressed gender and assigned gender, lasting at least 6 months, as manifested by at least six of the following (one of which must be the first criterion):

- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)
- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing
- A strong preference for cross-gender roles in make-believe play or fantasy play
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender
- A strong preference for playmates of the other gender
- In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities
- A strong dislike of one's sexual anatomy
- A strong desire for the physical sex characteristics that match one's experienced gender

As with the diagnostic criteria for adolescents and adults, the condition must also be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

---

### Terminology[12]

- **Cisgender**: Describes a person whose gender identity aligns in a traditional sense with the sex assigned to them at birth.
- **Gender diverse:** An umbrella term describing individuals with gender identities and/or expressions that vary from expected developmental norms. This includes people who identify as multiple genders or with no gender at all.
- **Gender dysphoria**: A concept designated in the *DSM-5* as clinically significant distress or impairment related to a strong desire to be of another gender, which may include desire to change primary and/or secondary sex characteristics. Not all transgender or gender diverse people experience dysphoria.
- **Gender expression**: The outward manifestation of a person's gender, which may or may not reflect their inner gender identity based on traditional expectations. Gender expression incorporates how a person carries themselves, their dress, accessories, grooming, voice/speech patterns and conversational mannerisms, and physical characteristics.
- **Gender identity**: A person's inner sense of being a girl/woman, boy/man, some combination of both, or something else, including having no gender at all. This may or may not correspond to the gender assigned at birth.
- **Nonbinary:** A term used by some individuals whose gender identity is neither girl/woman nor boy/man.
- **Sex/gender assigned at birth:** Traditional designation of a person as "female," "male," or "intersex" based on anatomy (external genitalia and/ or internal reproductive organs) and/or biology (sex chromosomes and/or

hormones). "Sex" and "gender" are often used interchangeably, but they are distinct entities. It is best to distinguish between sex, gender identity, and gender expression and to avoid making assumptions about a person regarding one of these characteristics based on knowledge of the others. This is sometimes abbreviated as AFAB (assigned female at birth) or AMAB (assigned male at birth).

- **Sexual orientation**: Describes the types of individuals toward whom a person has emotional, physical, and/or romantic attachments.
- **Transgender**: An umbrella term describing individuals whose gender identity does not align in a traditional sense with the gender they were assigned at birth. It may also be used to refer to a person whose gender identity is binary and not traditionally associated with that assigned at birth.

## + References

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Jack Turban, M.D., M.H.S.
November 2020

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Gender medicine

# Doubts are growing about therapy for gender-dysphoric children

Drug treatments seem to do little good, and may be harmful




May 13th 2021

GENDER MEDICINE was once an obscure specialty. Patients with gender dysphoria were typically middle-aged men wishing to live as women. Things are different now. First, there are many more patients. Referrals to a specialist clinic attached to the Free University of Amsterdam rose 20-fold between 1980 and 2015. The Gender Identity Development Service (GIDS) at the Tavistock Clinic in London, England and Wales's only paediatric gender clinic, sees 30 times more people than a decade ago. The patients have changed, too. Most are now female and in their teens. Many are treated with drugs to block the onset of puberty. These are often followed by hormones to promote development of physical characteristics of the opposite sex, as part of an approach called affirmation therapy.

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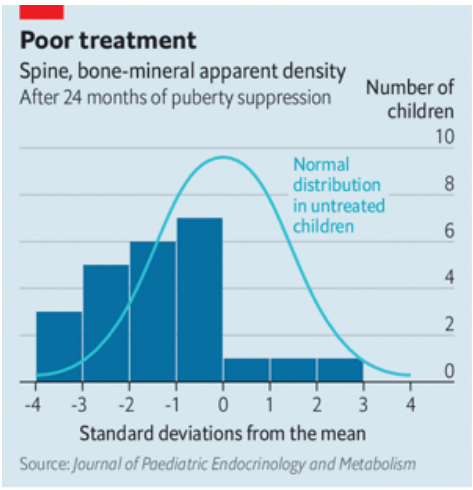
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to drugs. In September Britain launched a top-down review of the field. In December the High Court of England and Wales ruled that under-16s were unlikely to be able to consent meaningfully to taking puberty blockers, leading GIDS to suspend new referrals, though a subsequent ruling held that parents could consent on their children's behalf. On April 6th Arkansas passed laws that make prescribing puberty blockers and cross-sex hormones to children illegal. Also in April the Astrid Lindgren Children's Hospital in Stockholm, a part of the Karolinska Institute, announced that it would stop prescribing puberty blockers and cross-sex hormones to those under 18, except in clinical trials.

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Those sceptical of affirmation therapy point out two problems. Evidence is lacking, and what exists is not reassuring. A review by Sweden's health authorities in 2019 found little research, mostly of poor quality. Britain's National Institute for Health and Care Excellence found that puberty blockers did little to dispel gender dysphoria or improve patients' mental health (though they do not make such feelings worse). Moreover, existing studies suggest that, without intervention, most children with gender dysphoria end up reconciled to their natal sex as adults.



The Economist

There is also evidence that the drugs may cause serious harm. One example is described by Michael Biggs of Oxford University in a letter published on April 26th in the *Journal of Paediatric Endocrinology and Metabolism*. Bone-mineral density

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groups (more that two standard deviations below the mean, see chart).

One patient, who began puberty blockers aged 12, suffered four fractures by the age of 16. That medical history, says Dr Biggs, would usually be enough to diagnose

osteoporosis—normally a disease of the elderly. Animal studies suggest puberty blockers may cause cognitive damage, too. Cross-sex hormones have been linked to heart disease, strokes and sterility.

The combination of rising prescriptions and flimsy evidence leads some doctors to fear a medical scandal is brewing. Others think that the only scandal would be to change course. A bill before Canada's parliament, for instance, would leave affirmation as the only legal treatment for gender dysphoria. The argument continues. ■

*This article appeared in the Science & technology section of the print edition under the headline "Second thoughts"*

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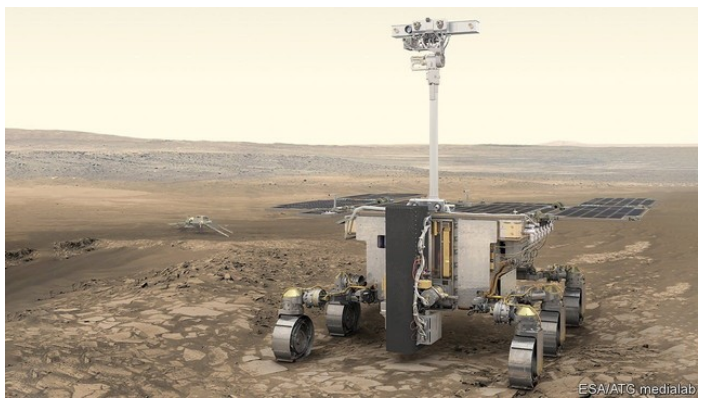
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# BREAKING: Sweden drastically changes protocol, prioritizes psychotherapy

By Guest Author

*Genspect has quickly translated the following article from the Swedish publication Lakartidningen.se, which was published February 22, 2022. Please also read SEGM's quick analysis of this ground-breaking change here, with a more thorough assessment coming soon.*

**The National Board of Health and Welfare: Young people should only be given hormone treatment in exceptional cases**

*The National Board of Health and Welfare is now calling for restraint when it comes to hormone treatment in minors with gender dysphoria. According to the authority, treatment should be offered only in exceptional cases outside the framework of research.*

By Katrin Trysell

katrin.trysell@lakartidningen.se

The National Board of Health and Welfare is currently working to update the knowledge support for care of young people with gender dysphoria that was established in 2015. This is happening in stages and now the authority comes with new recommendations regarding puberty blocking  and cross-sex hormone treatment in this group.

The National Board of Health and Welfare therefore calls for restraint with treatment in persons under 18 years of age. According to the authority, the risks of hormone treatment currently outweigh the possible benefits for the group as a whole.

The National Board of Health and Welfare relies, among other things, on a review of relevant studies on the effect and safety of hormone treatment carried out by the Swedish Agency for Medical and Social Evaluation (SBU). In the report, which is published today, the SBU concludes that it is not yet possible to draw any definite conclusions regarding this.

Hormone treatment should henceforth be given within the framework of research, according to Thomas Lindén, head of department at the National Board of Health and Welfare.

“While waiting for a research study to be put in place, our assessment is that the treatments can be given in exceptional cases,” he says in a press release.

According to SBU, based on current evidence, it is also not possible to determine how common it is for people who undergo gender-confirming treatment to later change their perception of their gender identity, interrupt treatment or in some aspect regret it. At the same time, it has been documented that detransition occurs, and there may also be an unknown figure, the National Board of Health and Welfare states.

For the group that regrets or interrupts an initiated treatment, there may be a risk that the treatment has led to poorer health or quality of life, says Thomas Lindén.

According to the National Board of Health and Welfare, puberty blocking or cross-sex hormone treatment should therefore only be offered in exceptional cases outside the framework of studies. The authority has developed criteria that care can be based on in the clinical assessment.

According to the authority, the clinical assessments should be in line with the criteria in the ‘Dutch protocol’. Central to this is that gender incongruity debuted during childhood, persisted over time, and that the development of puberty led to clear suffering.

The National Board of Health and Welfare also writes that these complex multidisciplinary assessments must be made under “an overall operational responsibility within the units that receive a permit to conduct national highly specialized care.”

SBU’S CONCLUSIONS:

The scientific evidence is not sufficient to assess the effects on gender dysphoria, psychosocial conditions, cognitive function, body size, body composition or metabolism of puberty blocking or cross sex-hormone treatment in children and adolescents with gender dysphoria.

There is some support at the group level for the fact that puberty blockers (GnRH) slows down the bone building that can be expected to occur during the following puberty (low reliability) but that the bone density achieved at the start of treatment is maintained (low reliability).

There is some support at the group level for young people who have received puberty blockers, during a cross sex hormone treatment with estrogen or testosterone, to recover bone density (low reliability), but it is not possible to determine whether bone density will eventually reach the level of young people in the surrounding population.

The scientific evidence is not sufficient to assess how often young people after the psychological / psychiatric and medical investigation has been initiated due to psychosocial problems that are considered to be due to gender dysphoria, choose not to start or to voluntarily discontinue puberty or cross sex hormone treatment.

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# Dutch puberty-blocker pioneer: Stop "blindly adopting our research"

Posted on **March 16, 2021**

**by Grace Williams**

On February 27, *Algemeen Dagblad*, the second-most widely read newspaper in the Netherlands, published an astonishing article. Written by Berendien Teteleptal, the author reports that "more research on sex changes in young people under the age of 18 is urgently needed. Doctors who provide transgender care in Nijmegen and Amsterdam say they know too little about the target group and the long-term effects." (See here for an English translation of the article.)

What makes this article surprising is that it was a Dutch team of researcher-clinicians (one of whom is extensively quoted in the piece) who *pioneered* the use of puberty blockers in children with gender dysphoria; this practice is now widespread in the western world.




— VU University Medical Center, Amsterdam

After reading this article, I went back through some of the posts on 4thWaveNow that have mentioned Dutch research. One of the posts dates back to November 2015, not long after Denise, the founder of 4thWaveNow, started blogging, entitled "Skeptical ethicist: 'A medical doctor is not a candy seller'."

In the post, Denise describes an article published in June 2015 in the *Journal of Adolescent Health*. Published by a group of Dutch gender dysphoria researchers, the authors report on a qualitative survey of 17 gender clinics in 10 Western countries. The survey revealed that quite a few professionals on these teams (pediatric

endocrinologists, psychologists, psychiatrists, and ethicists) have reservations about early medical treatment. "The article concludes in a way that makes me feel a whisper of hope for the future."

*Several professionals mentioned that participation in the study made them think more explicitly about the various themes, and it encouraged them to discuss the issues in their teams. In the Dutch teams, we therefore introduced moral deliberation sessions to talk about these ethical topics. The first reactions of the professionals were positive; the sessions made them rethink aspects of the protocol.*

That the top Dutch researcher-clinicians are now openly discussing their concerns in the mainstream media shows the prescience of Denise's whisper of hope from almost six years ago. Does their concern stem from these "moral deliberation sessions" they started after the 2015 empirical ethical study? Could another factor be the recent ruling in the Keira Bell case by the British High Court, limiting the use of puberty blockers in gender-dysphoric children?



— Thomas Steensma

Quoted in the aforementioned article by Tetelaptal, Thomas Steensma, one of the lead researcher-clinicians at the Center of Expertise on Gender Dysphoria in Amsterdam, asks some critical questions that U.S. "affirmative" clinicians largely ignore. Teteleptal writes:

*Because what is behind the large increase of children who have suddenly registered for transgender care since 2013? And what is the quality of life for this group long after the sex change? There is no answer to those questions. And that must happen, think Steensma and colleagues from Nijmegen.*

*"We don't know whether studies we have done in the past can still be applied to this time. Many more children are registering, and also a different type," says Steensma. "Suddenly there are many more girls applying who feel like a boy. While the ratio was the same in 2013, now three times as many children who were born as girls register, compared to children who were born as boys."*

Steensma also raises questions about the effect of early medical intervention on future fertility:

*It is still unclear whether these administered hormones affect the fertility of boys and girls. "We just don't know," says Steensma. "Little research has been done so far on treatment with puberty blockers and hormones in young people. That is why it is also seen as experimental. We are one of the few countries in the world that conducts ongoing research about this. In the United Kingdom, for example, only now, for*

*the first time in all these years, a study of a small group of transgender people has been published. This makes it so difficult, almost all research comes from ourselves."*

Not only does he lament the lack of research, Steensma expresses frustration that some practitioners are applying Dutch research without adequate assessment of their patients:

*We conduct structural research in the Netherlands. But* ***the rest of the world is blindly adopting our research.*** *While every doctor or psychologist who engages in transgender health care should feel the obligation to do a proper assessment before and after intervention.*

**The Dutch have always exercised more caution**

The Dutch have always been more careful in their use of interventions like puberty blockers, taking care to conduct thorough assessments before proceeding. Many Dutch clinicians have practiced what has been characterized as "watchful waiting," in contrast to the affirmation approach promoted by the most prominent gender clinicians in the United States.

It's worth noting that it's not just *medical* transition for which the Dutch have urged a slow and deliberative approach. As reported in this 2016 4thWaveNow post, the Dutch have also advised caution when it comes to social transitioning of young children. In a 2011 journal article, Steensma et al. write:

*As for the clinical management in children before the age of 10, we suggest a cautious attitude towards the moment of transitioning. Given our findings that some girls, who were almost (but not entirely) living as boys in the childhood years, experienced great trouble when they wanted to return to the female gender role, we believe that parents and caregivers should fully realize the unpredictability of their child's psychosexual outcome. They may help the child to handle their gender variance in a supportive way, but without taking social steps long before puberty, which are hard to reverse.*

A 2013 study conducted by Steensma et al. found that social transition was one of the factors associated with the persistence of gender dysphoria. "Childhood social transitions were important predictors of persistence, especially among natal boys," the authors write.

**No medical consensus**

Recently, at about the same time the article discussing Steensma's concerns were reported in *Algemeen Dagblad*, transgender woman Rachel Levine appeared before a US Senate committee in a hearing to confirm Levine as President Biden's assistant secretary of health. During the hearing, Senator Rand Paul asked Levine this question: "Do you believe that minors are capable of making such a life-changing decision as changing one's sex?"

To which Levine responded: "Transgender medicine is a very complex and nuanced field with robust research and standards of care that have been developed, and if I am fortunate enough to be confirmed as the assistant secretary of health, I will look forward to working with you and your office and coming to your office and discussing the particulars of the standards of care for transgender medicine."

Never mind that Levine failed to provide a public, direct answer to the senator's question; note how differently Levine describes transgender medicine from how Steensma characterizes it. Levine refers to "robust research" and "standards of care." Meanwhile, Steensma, who conducted the very research on which many US "affirmative" clinicians are basing their treatment protocols, tells a reporter: "*Little research has been done so far on treatment with puberty blockers and hormones in young people. That is why it is also seen as* ***experimental***."

If you had heard only Levine's testimony on this matter, you might be excused for concluding that there is widespread medical consensus for the use of medical interventions in gender dysphoric minors, but you would be wrong. As Dutch researchers noted in the 2015 journal article mentioned above, "**in actual practice, no consensus exists whether to use these early medical interventions.**" This was true in 2015, and it remains true in 2021.

It would, of course, be going too far to suggest that Steensma no longer believes that puberty blockers and cross-sex hormones should ever be used in the treatment of adolescent gender dysphoria. Clearly he believes it's appropriate in certain cases. In fact that's the hallmark of the Dutch approach: individual assessment, tailored to each unique case. According to this article published by the same author on February 28 in *de Gelderlander*, another Dutch publication,

*Steensma does not endorse the judgment of the British court. According to him, there are children who can oversee the consequences. "But that's an individual process. You can't compare individuals with one another. We are not saying that hormone treatments are good for everyone. We would also never say that they are not good for anyone. We make the assessment per person."*

Again, though: In contrast to the "Wild West" of pediatric transgender medical care in the United States, where minors can get puberty blockers, hormones, and sometimes even surgery with very little assessment, the Dutch approach has traditionally been considerably more cautious and nuanced. In the *de Gelderlander* piece Teteleptal writes, "Steensma is perturbed by the method of some clinics and practitioners in America, for example, where puberty blockers seem to be the solution to everything." ( English translation here.)



— Annelou de Vries

Steensma is not alone amongst Dutch clinicians. Annelou L.C. de Vries a psychiatrist with the Department of Child and Adolescent Psychiatry at Amsterdam University Medical Centers, who, like her colleagues, has published widely on pediatric gender issues for many years. In a commentary published in the October 2020 issue of *Pediatrics*, de Vries writes:

*According to the original Dutch protocol, one of the criteria to start puberty suppression was "a presence of gender dysphoria from early childhood on." Prospective follow-up studies evaluating these Dutch transgender adolescents showed improved psychological functioning. However, authors of case histories*

*and a parent-report study warrant that gender identity development is diverse, and a new developmental pathway is proposed involving youth with post puberty adolescent-onset transgender histories. These youth did not yet participate in the early evaluation studies. This raises the question whether the positive outcomes of early medical interventions also apply to adolescents who more recently present in overwhelming large numbers for transgender care, including those that come at an older age, possibly without a childhood history of GI [gender incongruence]. It also asks for caution because some case histories illustrate the complexities that may be associated with later-presenting transgender adolescents and describe that some eventually detransition.*

Given their stated concerns, we can hope Steensma, de Vries and their colleagues, as well as researchers in other countries, will design studies to explore why there's been such a dramatic increase in the number of gender-dysphoric adolescents with no history of childhood gender dysphoria, as well as why some of these young people later detransition. Lisa Littman's 2018 paper based on parental reports is a good first step, but much more research is needed. Social contagion, along with other potential factors such as internalized homophobia, sexual trauma, autism and other neuro-atypical conditions, deserve careful and ongoing investigation by gender-dysphoria researchers.

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March 3, 2022

# National Academy of Medicine in France Advises Caution in Pediatric Gender Transition

*Medical care of children and adolescents with transgender identity*

The National Academy of Medicine in France has issued a press release in which it cautions medical practitioners that the growing cases of transgender identity in young people are often socially-mediated and that great caution in treatment is needed. The Academy draws attention to the fact that hormonal and surgical treatments carry health risks and have permanent effects, and that it is not possible to distinguish a durable trans identity from a passing phase of an adolescent's development.

SEGM has translated the press release, which is provided in full below. Both the original press release in French, and its unofficial SEGM translation are appended.

## National Academy of Medicine, France

***Press Release***

## Medical Care of Children and Adolescents with Transgender Identity

*This press release was adopted by the National Academy of Medicine, France on February 25, 2022, with 59 votes in favor, 20 votes against, and 13 abstaining. It was approved in its revised version by the Administrative Council on February 28, 2022.*

Transgender identity is a feeling of identifying as a gender different from that assigned at birth, which is persistent and lasts more than 6 months. This experience can cause significant and prolonged distress, which can contribute to an increased risk of suicide [a].

No genetic predisposition has been found.

While this condition has been long recognized, a sharp increase in demand for medical interventions has been observed (1,2) first in North America, then in Northern Europe, and, more recently, in France, particularly among children and adolescents. A recent study of a number of high schools in Pittsburgh revealed a prevalence that is clearly higher than previously estimated in the United States (3): 10% of students declared themselves to be transgender or non-binary or were unsure of their gender [b]. In 2003, the Royal Children's Hospital in Melbourne diagnosed only one child with gender dysphoria, whereas today it treats nearly 200.

Whatever the mechanisms involved in adolescents - excessive engagement with social media,  greater social acceptability, or influence by those in one's social circle - this epidemic-like phenomenon manifests itself in the emergence of cases or even clusters of cases in the adolescents' immediate surroundings (4). This primarily social problem is due, in part, to the questioning of an overly dichotomous view of gender identity by some young people.

The demand for medical interventions, due to the distress that this condition (which is not a mental illness per se) causes, leads to a growing supply of care in the form of consultations or care in specialized clinics. This involves many pediatric subspecialties. The psychiatric consultations are utilized first, and if the identity is authentic and the discomfort persists, endocrinology, gynecology and, ultimately, surgery become involved.

However, great medical caution must be taken in children and adolescents, given the vulnerability, particularly psychological, of this population and the many undesirable effects and even serious complications that can be caused by some of the therapies available. In this regard, it is important to recall the recent decision (May 2021) of the Karolinska University Hospital in Stockholm to prohibit the use of puberty blockers.

If France allows the use of puberty blockers or cross-sex hormones with parental authorization and no age limitations, the greatest caution is needed in their use, taking into account the side-effects such as the impact on growth, bone weakening, risk of sterility, emotional and intellectual consequences and, for girls, menopause-like symptoms.

As for surgical treatments, specifically mastectomy, which is allowed in France at the age of 14, and surgeries relating to the external genitalia (vulva, penis), it must be emphasized that these procedures are irreversible.

When medical care is provided for this reason, it is essential to ensure medical and psychological support, first for the affected children and adolescents, but also for their parents, especially since there is no test to distinguish between persisting gender dysphoria and transient adolescent dysphoria. Moreover, the risk of over-diagnosis is real, as evidenced by the growing number of young adults wishing to detransition [c]. It is, therefore, appropriate to extend the phase of psychological care as much as possible.

**The National Academy of Medicine draws the medical community's attention to the growing demand for care in the context of transgender identity in children and adolescents, and recommends the following:**

Children and adolescents expressing a desire to transition, as well as their families, should receive extended psychological support;
Should the desire to transition persist, the decision to treat with puberty blockers or cross sex-hormones must be considered carefully and within the framework of multidisciplinary consultations;
Medical studies should include clinical information specifically adapted for informing and guiding young people and their families;
Continued research into both, clinical and biological, as well as ethical aspects of this matter, still lacking in France, is needed;
Parents addressing their children's questions about transgender identity or associated distress should remain vigilant regarding the addictive role of excessive engagement with social media, which is both harmful to the psychological development of young people and is responsible for a very significant part of the growing sense of gender incongruence.

Glossary:

a. Gender dysphoria is the medical term used to describe the distress resulting from the incongruence between the experienced gender and the gender assigned at birth (5).

b. A non-binary person is a person whose gender identity is neither male nor female.

c. A transgender person adopts the appearance and lifestyle of a sex different from that assigned at birth. Whether born a man or a woman, the transgender person modifies, or even rejects, his or her original sexual identity. The sex registered on their official documents  does not match the appearance presented. This does not necessarily involve medical interventions.

References:


1. NHS, The Tavistock and Portman, Referrals to the Gender Identity Development Services (GIDS) for children and adolescents level off in 2018-19, 28 June 2019 (https://tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/
2. Swedish national health Council, Report on the prevalence of persons diagnosed with gender dysphoria since 1998 among registered citizens of Sweden, 2020, www.socialstyrelsen.se
3. Kidd K.M., Sequeira G.M., Douglas C. et al, Prevalence of gender diverse youth in an urban school district, Pediatrics, 2021, vol 147, issue 6
4. Littman, L., Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLoS ONE, 2018, 13(8), e0202330. https://doi.org/10.1371/journal.pone. 0202330; Correction: PLoS ONE 2019; 14(3): e0214157. Published online 2019 Mar 19. doi:10.1371/journal.pone.0214157
5. Martinerie L., Condat A., Bargiacchi A., et al., Management of endocrine disease. Approach to the management of children and adolescents with gender dysphoria, European Journal of Endocrinology, 2018, 179, p. 1219-1237


Attachments

22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf

English Translation_22.2.25-Communique-PCRA-19-Medecine-et-transidentite-genre.pdf




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July 2, 2021

# One Year Since Finland Broke with WPATH "Standards of Care"

*Finland prioritizes psychotherapy over hormones, and rejects surgeries for gender-dysphoric minors*

A year ago, the Finnish Health Authority (PALKO/COHERE) deviated from WPATH's "Standards of Care 7," by issuing new guidelines that state that psychotherapy, rather than puberty blockers and cross-sex hormones, should be the first-line treatment for gender-dysphoric youth. This change occurred following a systematic evidence review, which found the body of evidence for pediatric transition inconclusive.

Although pediatric medical transition is still allowed in Finland, the guidelines urge caution given the unclear nature of the benefits of these interventions, largely reserving puberty blocker and cross-sex hormones for minors with early-childhood onset of gender dysphoria and no co-occurring mental health conditions. Surgery is not offered to those <18. Eligibility for pediatric gender reassignment is being determined on a "case-by-case basis" in two centralized gender dysphoria research clinics.

The qualifying criteria for gender reassignment of youth, articulated in the 2020 Finnish treatment guidelines, are consistent with the original Dutch protocol, but represent a significant tightening of the more recent practices promoted by WPATH. WPATH Standards of Care 7 (SOC7) allows for hormones and surgery to be offered to youth with a pubertal-onset of gender dysphoria which is frequently complicated by mental health problems or neurocognitive comorbidities (such as ADHD and autism-spectrum disorders), following only a cursory assessment. Assessments by mental health professionals can be bypassed altogether according to the "informed consent model" of care endorsed by WPATH SOC7.

The Finnish guidelines warn of the uncertainty of providing any irreversible "gender-affirming" interventions for those 25 and under, due to the lack of neurological maturity. The guidelines also raise the concern that puberty blockers may negatively impact brain maturity and impair the young person's ability to provide informed consent to the subsequent and more irreversible parts of the Dutch protocol: cross-sex hormones and surgeries.

The Finnish guidelines reflect the growing international concern about the unexplained sharp rise in adolescents presenting with gender dysphoria, which is occurring in increasingly complex developmental and mental health contexts, and often without a childhood history of gender-related distress. There are significant questions as to whether the Dutch protocol (hormonal and surgical interventions for youth), designed for a distinctly different population of high-functioning teens with childhood-onset cross-sex identification and with no significant mental health comorbidites, is appropriate for this novel population.

The guidelines reference a recent Finnish study, which noted that adolescents who were high functioning before cross-sex hormones continued to do well after, but those who had "*psychiatric treatment needs or problems in school, peer relationships and managing everyday matters outside of home continued to have problems.*" The study concluded that *"medical gender reassignment is not enough to improve functioning and relieve psychiatric comorbidities*."

The guidelines also mentioned that a key study on puberty blockers, which utilized a comparison group of waitlisted adolescents, failed to show a statistically significant difference between the treated and waitlisted groups at the study end-period at 18 months. Although in the abstract of that study, the authors chose to highlight the small improvements in the puberty-blocked group at 12 months, the actual study conclusion – which remains behind a paywall and hidden to most readers – showed that by 18 months, no significant differences could be found.

The Finnish Health Authority states that the guidelines will not be further revised until research is able to: explain the recent sharp rise in adolescents presenting with gender dysphoria; determine whether transgender identities in this population are stable or will evolve; assess whether gender-affirming treatments are able to improve health outcomes of those who present with co-occurring mental health problems, including improvements in depression and suicide; and quantify the rate of regret.

The Finnish gender identity services program is a worldwide leader in pediatric gender medicine. The 2020 Finnish guidelines represent a strong signal that the pioneers of pediatric medical transition are concerned about unintended harm to the growing number of gender dysphoric adolescents presenting for care. The guidelines echo the concerns voiced by the principal investigator of the Dutch protocol, who warned the medical community in a commentary published in *Pediatrics* in 2020 that a "*new developmental pathway"* of gender dysphoria has emerged, including patients with "*postpuberty adolescent-onset transgender histories*" and "*more mental health challenges*," adding, "*these youth did not yet participate in the early evaluation studies. This raises the question whether the positive outcomes of early medical interventions also apply to adolescents who more recently present in overwhelming large numbers for transgender care*."

While the official summary of the guidelines has been available on the Finnish Health Authority's site for a year (see June 2020), SEGM has just completed the translation of the full text of the Finnish guidelines for minors. **It is an unofficial translation**. The original and the translated versions of the guidelines are attached below.

Attachments
Finnish_Guidelines_2020_Minors_Unofficial Translation.pdf
Finnish_Guidelines_2020_Minors_Original.pdf


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# To Be, or Not to Be? More Counseling Needed for Gender Dysphoria

Becky McCall

August 19, 2021

Clinicians should not blindly accept a person's self-diagnosis as transgender and desire to medically transition without closer inspection; rather, they should make a distinction between 'acceptance' and conducting an in-depth, respectful, and collaborative exploration of an individual's claims about what they believe will best promote their well-being.

These are the conclusions of two experts in ethics and clinical psychology in an extended essay published in the *Journal of Medical Ethics.*

"It's not about making life harder for people who wish to transition but about improving care for all people who identify as transgender," said lead author Alessandra Lemma, DClin Psych, visiting professor in the psychoanalysis unit at University College London, UK, speaking to *Medscape Medical News*.

She stressed that the argument is neither for nor against medical transitioning per se.

"It's an invitation to think about how the medical and mental health care communities can best support anyone considering a transition, whether they eventually pursue that course of action or not. The provision of psychotherapy, irrespective of whether the individual medically transitions or not, makes for a better outcome either way," said Lemma, who cares for adolescents as well as adults with gender dysphoria in her private practice in London.

## Reflective Space Has Been Eroded in Gender Identity Services for the Young

There has been an exponential increase in the number of adolescents who identify as transgender in Western countries in recent years. *Medscape Medical News* has covered the debate in detail, which has intensified worldwide in the last 12 months, regarding how best to treat youth with gender dysphoria.

This has "raised concern about how the laudable aims of gender affirmative care may be ushering children and young people too quickly into medical transitioning," generally defined as treatment with puberty blockers in minors followed by cross-sex hormones to transition to the opposite sex, "leading subsequently to a wish to detransition with all the attendant physical and psychological complications," write Lemma and her co-author, Julian Savulescu, MD, professor of practical ethics, University of Oxford, UK.

While the UK and other countries such as Finland have tightened regulations regarding the treatment of minors, "these medical interventions continue to be provided in many other countries," they note.

Such affirmative care has recently been interpreted by "influential sections of the transgender community" as forbidding "'questioning' of any kind of the person's stated gender and what will help them," the essayists state.

But Lemma noted that, for teenagers, this is typically a time to "try on" different identities and ways of presenting oneself to the world.

"All this requires a reflective space during the decision-making process, and this has been eroded in many gender identity services for young people especially, with a massive pressure on services."

Family issues, trauma, and comorbid conditions can all influence people too, she notes, adding that what may be happening unconsciously may be driving the decision to modify the body.

"I cannot see that it would be harmful to anyone to have the opportunity to really think about what they are doing before making decisions about medical interventions," she asserted.

## Decision to Transition Must Be Judged to Be Autonomous

Lemma notes that even in those instances where medical transitioning, on balance, is the best option, it's important to acknowledge that the process has a psychological impact.

"What matters is that in facing a major life-changing decision, an individual has the opportunity to understand the developmental and social experiences that drive their experience of gender dysphoria such that the decisions they make about medical transitioning can be said to be taken more autonomously," she and Savulescu write.

And for those people who opt for full gender reassignment surgery, they are the first to say, "I don't think I could have got through this as well as I have without psychological support," Lemma remarked.

Ultimately, what's important is to ensure the protection of those individuals whose needs will most likely not be met by medical transitioning, while not making it impossible for those who are suffering to get the care they need in order to transition, she concluded.

*J Med Ethics.* Published online July 30, 2021. Full text

*In 2016, Lemma was professor of psychological therapies at the Tavistock and Portman NHS Foundation Trust and Essex University. During that time she worked with adult transgender individuals at the Portman Clinic but not at the Gender Identity Service at the*

*Tavistock Clinic. Currently, she works in private practice with transgender individuals at the Queen Anne Street Practice, London. Savulescu has reported no relevant financial relationships.*

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# Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria

Lisa Littman

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## Correction

**19 Mar 2019:** Littman L (2019) Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. PLOS ONE 14(3): e0214157. https://doi.org/10.1371/journal.pone.0214157 | **View correction**

## Abstract


#### Purpose

In on-line forums, parents have reported that their children seemed to experience a sudden or rapid onset of gender dysphoria, appearing for the first time during puberty or even after its completion. Parents describe that the onset of gender dysphoria seemed to occur in the context of belonging to a peer group where one, multiple, or even all of the friends have become gender dysphoric and transgender-identified during the same timeframe. Parents also report that their children exhibited an increase in social media/internet use prior to disclosure of a transgender identity. Recently, clinicians have reported that post-puberty presentations of gender dysphoria in natal females that appear to be rapid in onset is a phenomenon that they are seeing more and more in their clinic. Academics have raised questions about the role of social media in the development of gender dysphoria. The purpose of this study was to collect data about parents' observations, experiences, and perspectives about their adolescent and young adult (AYA) children showing signs of an apparent sudden or rapid onset of gender dysphoria that began during or after puberty, and develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

#### Methods

For this descriptive, exploratory study, recruitment information with a link to a 90-question survey, consisting of multiple-choice, Likert-type and open-ended questions was placed on three websites where parents had reported sudden or rapid onsets of gender dysphoria occurring in their teen or young adult children. The study's eligibility criteria included parental response that their child had a sudden or rapid onset of gender dysphoria and parental indication that their child's gender dysphoria began during or after puberty. To maximize the chances of finding cases meeting eligibility criteria, the three websites (4thwavenow, transgender trend, and youthtranscriticalprofessionals) were selected for targeted recruitment. Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought might include eligible participants to expand the reach of the project through snowball sampling techniques. Data were collected anonymously via SurveyMonkey. Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. Open-ended responses from two questions were targeted for qualitative analysis of themes.

#### Results

There were 256 parent-completed surveys that met study criteria. The AYA children described were predominantly natal female (82.8%) with a mean age of 16.4 years at the time of survey completion and a mean age of 15.2 when they announced a transgender-identification. Per parent report, 41% of the AYAs had expressed a non-heterosexual sexual orientation before identifying as transgender. Many (62.5%) of the AYAs had reportedly been diagnosed with at least one mental health disorder or neurodevelopmental disability prior to the onset of their gender dysphoria (range of the number of pre-existing diagnoses 0–7). In 36.8% of the friendship groups described, parent participants indicated that the majority of the members became transgender-identified. Parents reported subjective declines in their AYAs' mental health (47.2%) and in parent-child relationships (57.3%) since the AYA "came out" and that AYAs expressed a range of behaviors that included: expressing distrust of non-transgender people (22.7%); stopping spending time with non-transgender friends (25.0%); trying to isolate themselves from their families (49.4%), and only trusting information about gender dysphoria from transgender sources (46.6%). Most (86.7%) of the parents reported that, along with the sudden or rapid onset of gender dysphoria, their child either had an increase in their social media/internet use, belonged to a friend group in which one or multiple friends became transgender-identified during a similar timeframe, or both

#### Conclusion

This descriptive, exploratory study of parent reports provides valuable detailed information that allows for the generation of hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among AYAs. Emerging hypotheses include the possibility of a potential new subcategory of gender dysphoria (referred to as rapid-onset gender dysphoria) that has not yet been clinically validated and the possibility of social influences and maladaptive coping mechanisms. Parent-child conflict may also explain some of the findings. More research that includes data collection from AYAs, parents, clinicians and third party informants is needed to further explore the roles of social influence, maladaptive coping mechanisms, parental approaches, and family dynamics in the development and duration of gender dysphoria in adolescents and young adults.


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**Data Availability:** The data cannot be made available due to ethical and regulatory restrictions. The study participants did not provide consent to have their responses shared publicly, shared in public databases, or shared with outside researchers. The Program for the Protection of Human Subjects (PPHS) at the Icahn School of Medicine at Mount Sinai is not permitting the sharing of data beyond what is reported in the paper owing to the sensitive nature of the collected information, the context of the study topic, its release's possible impact on the participants' reputation and standing in the community, and the risk of participant recognition through linkage of details. As participants' identifiers were not collected it is not possible to contact participants and ask for their consent to disclose at this time. For any questions about restriction on data sharing, please contact PPHS at the Icahn School of Medicine at Mount Sinai (IRB@mssm.edu).

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**Competing interests:** Lisa Littman, MD, MPH, provides public health consulting on topics unrelated to this research. She is a member of several professional organizations including the American College of Preventive Medicine (ACPM), the American Public Health Association (APHA), the Society for Adolescent Health and Medicine (SAHM), the Society of Family Planning (SFP), the International Academy of Sex Research (IASR), and the World Professional Association for Transgender Health (WPATH).

## Introduction

In recent years, a number of parents have begun reporting in online discussion groups such as 4thwavenow in the US (https://4thwavenow.com) and Transgender Trend in the UK (https://www.transgendertrend.com) that their adolescent and young adult (AYA) children, who have had no histories of childhood gender identity issues, experienced a perceived sudden or rapid onset of gender dysphoria. Parents have described clusters of gender dysphoria 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 [1–8]. 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 [1–2, 9]. These types of presentations have not been described in the research literature for gender dysphoria [1–10] 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. (Note: The terminology of "natal sex", including the terms "natal female" and "natal male", will be used throughout this article. Natal sex refers to an individual's sex as it was observed and documented at the time of birth. Some researchers also use the terminology "assigned at birth".)

## Background

#### Gender dysphoria in adolescents

Gender dysphoria (GD) is defined as an individual's persistent discomfort with their biological sex or assigned gender [11]. Two types of gender dysphoria studied include early-onset gender dysphoria, where the symptoms of gender dysphoria begin in early childhood, and late-onset gender dysphoria, where the symptoms begin after puberty [11]. Late-onset gender dysphoria that occurs during adolescence is now called adolescent-onset gender dysphoria. The majority of adolescents who present for care for gender dysphoria are individuals who experienced early-onset gender dysphoria that persisted or worsened with puberty although an atypical presentation has been described where adolescents who did not experience childhood symptoms present with new symptoms in adolescence [7, 12]. Adolescent-onset of gender dysphoria has only recently been reported in the literature for natal females [5,10, 13–14]. In fact, prior to 2012, there were little to no research studies about adolescent females with gender dysphoria first beginning in adolescence [10]. Thus, far more is known about adolescents with early-onset gender dysphoria than adolescents with adolescent-onset gender dysphoria [6, 15]. Although not all research studies on gender dysphoric adolescents exclude those with adolescent-onset gender dysphoria [10], it is important to note that most of the studies on adolescents, particularly those about gender dysphoria persistence and desistance rates and outcomes for the use of puberty suppression, cross-sex hormones, and surgery only included subjects whose gender dysphoria began in childhood and subjects with adolescent-onset gender dysphoria would not have met inclusion criteria for these studies [16–24]. Therefore, most of the research on adolescents with gender dysphoria to date is not generalizable to adolescents experiencing adolescent-onset gender dysphoria [16–24] and the outcomes for individuals with adolescent-onset gender dysphoria, including persistence and desistence rates and outcomes for treatments, are currently unknown.

As recently as 2012, there were only two clinics (one in Canada and one in the Netherlands) that had gathered enough data to provide empirical information about the main issues for gender dysphoric adolescents [25]. Both institutions concluded that the management of adolescent-onset gender dysphoria is more complicated than the management of early-onset gender dysphoria and that individuals with adolescent-onset are more likely to have significant psychopathology [25]. The presentation of gender dysphoria can occur in the context of severe psychiatric disorders, developmental difficulties, or as part of large-scale identity issues and, for these patients, medical transition might not be advisable [13]. The APA Task Force on the Treatment of Gender Identity Disorder notes that adolescents with gender dysphoria "should be screened carefully to detect the emergence of the desire for sex reassignment in the context of trauma as well as for any disorder (such as schizophrenia, mania, psychotic depression) that may produce gender confusion. When present, such psychopathology must be addressed and taken into account prior to assisting the adolescent's decision as to whether or not to pursue sex reassignment or actually assisting the adolescent with the gender transition." [25].



#### Demographic and clinical changes for gender dysphoria

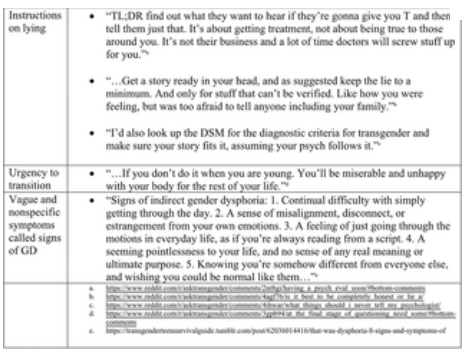
Although, by 2013, there was research documenting that a significant number of natal males experienced gender dysphoria that began during or after puberty, there was little information about this type of presentation for natal females [5]. Starting in the mid-2000s there has been a substantial change in demographics of patients presenting for care with most notably an increase in adolescent females and an inversion of the sex ratio from one favoring natal males to one favoring natal females [26–28]. And now, some clinicians have noted that they are seeing increasingly in their clinic, the phenomenon of natal females expressing a post-puberty rapid onset of gender dysphoria [14]. Some researchers have suggested that increased visibility of transgender people in the media, availability of information online, with a partial reduction of stigma may explain some of the increases in numbers of patients seeking care [27], but these factors would not explain the reversal of the sex ratio, disproportionate increase in adolescent natal females, and the new phenomenon of natal females experiencing gender dysphoria that begins during or after puberty. If there were cultural changes that made it more acceptable for natal females to seek transition [27], that would not explain why the reversal of the sex ratio reported for adolescents has not been reported for older adult populations [26]. There are many unanswered questions about potential causes for the recent demographic and clinical changes for gender dysphoric individuals.

#### Social and peer influences

Parental reports (on social media) of friend clusters exhibiting signs of gender dysphoria [1–4] and increased exposure to social media/internet preceding a child's announcement of a transgender identity [1–2, 9] raise the possibility of social and peer influences. In developmental psychology research, impacts of peers and other social influences on an individual's development are sometimes described using the terms peer contagion and social contagion, respectively. The use of "contagion" in this context is distinct from the term's use in the study of infectious disease, and furthermore its use as an established academic concept throughout this article is not meant in any way to characterize the developmental process, outcome, or behavior as a disease or disease-like state, or to convey any value judgement. Social contagion [29] is the spread of affect or behaviors through a population. Peer contagion, in particular, is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially have negative effects on their development [30]. Peer contagion has been associated with depressive symptoms, disordered eating, aggression, bullying, and drug use [30–31]. Internalizing symptoms such as depression can be spread via the mechanisms of co-rumination, which entails the repetitive discussion of problems, excessive reassurance seeking (ERS), and negative feedback [30, 32–34]. Deviancy training, which was first described for rule breaking, delinquency, and aggression, is the process whereby attitudes and behaviors associated with problem behaviors are promoted with positive reinforcement by peers [35, 36].

Peer contagion has been shown to be a factor in several aspects of eating disorders. There are examples in the eating disorder and anorexia nervosa literature of how both internalizing symptoms and behaviors have been shared and spread via peer influences [37–41] which may have relevance to considerations of a rapid onset of gender dysphoria occurring in AYAs. Friendship cliques can set the norms for preoccupation with one's body, one's body image, and techniques for weight loss, and can predict an individual's body image concerns and eating behaviors [37–39]. Peer influence is intensified in inpatient and outpatient treatment settings for patients with anorexia and counter-therapeutic subcultures that actively promote the beliefs and behaviors of anorexia nervosa have been observed [39–41]. In these settings, there is a group dynamic where the "best" anorexics (those who are thinnest, most resistant to gaining weight, and who have experienced the most medical complications from their disease) are admired, validated, and seen as authentic while the patients who want to recover from anorexia and cooperate with medical treatment are maligned, ridiculed, and marginalized [39–41]. Additionally, behaviors associated with deceiving parents and doctors about eating and weight loss, referred to as the "anorexic tricks," are shared by patients in a manner akin to deviancy training [39–41]. Online environments provide ample opportunity for excessive reassurance seeking, co-rumination, positive and negative feedback, and deviancy training from peers who subscribe to unhealthy, self-harming behaviors. The pro-eating disorder sites provide motivation for extreme weight loss (sometimes calling the motivational content "thinspiration")[42–44]. Such sites promote validation of eating disorder as an identity, and offer "tips and tricks" for weight loss and for deceiving parents and doctors so that individuals may continue their weight-loss activities [42–44]. If similar mechanisms are at work in the context of gender dysphoria, this greatly complicates the evaluation and treatment of impacted AYAs.

In the past decade, there has been an increase in visibility, social media, and user-generated online content about transgender issues and transition [45], which may act as a double-edged sword. On the one hand, an increase in visibility has given a voice to individuals who would have been under-diagnosed and undertreated in the past [45]. On the other hand, it is plausible that online content may encourage vulnerable individuals to believe that nonspecific symptoms and vague feelings should be interpreted as gender dysphoria stemming from a transgender condition. Recently, leading international academic and clinical commentators have raised the question about the role of social media and online content in the development of gender dysphoria [46]. Concern has been raised that adolescents may come to believe that transition is the only solution to their individual situations, that exposure to internet content that is uncritically positive about transition may intensify these beliefs, and that those teens may pressure doctors for immediate medical treatment [25]. There are many examples on popular sites such as Reddit (www.reddit.com with subreddit ask/r/transgender) and Tumblr (www.tumblr.com) where online advice promotes the idea that nonspecific symptoms should be considered to be gender dysphoria, conveys an urgency to transition, and instructs individuals how to deceive parents, doctors, and therapists to obtain hormones quickly [47]. Fig 1 includes examples of online advice from Reddit and Tumblr.



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|---|---|
| Instructions on lying | • "TL;DR find out what they want to hear if they're gonna give you T and then tell them just that. It's about getting treatment, not about being true to those around you. It's not their business and a lot of time doctors will screw stuff up for you."[a]<br>• "…Get a story ready in your head, and as suggested keep the lie to a minimum. And only for stuff that can't be verified. Like how you were feeling, but was too afraid to tell anyone including your family."[b]<br>• "I'd also look up the DSM for the diagnostic criteria for transgender and make sure your story fits it, assuming your psych follows it."[c] |
| Urgency to transition | • "…If you don't do it when you are young. You'll be miserable and unhappy with your body for the rest of your life."[d] |
| Vague and nonspecific symptoms called signs of GD | • "Signs of indirect gender dysphoria: 1. Continual difficulty with simply getting through the day. 2. A sense of misalignment, disconnect, or estrangement from your own emotions. 3. A feeling of just going through the motions in everyday life, as if you're always reading from a script. 4. A seeming pointlessness to your life, and no sense of any real meaning or ultimate purpose. 5. Knowing you're somehow different from everyone else, and wishing you could be normal like them…"[e] |
| | a. https://www.reddit.com/r/asktransgender/comments/2ot9qs/having_a_psych_eval_soon/#bottom-comments<br>b. https://www.reddit.com/r/asktransgender/comments/4ag7l6/is_it_best_to_be_completely_honest_or_lie_a/<br>c. https://www.reddit.com/r/asktransgender/comments/4hwar/what_things_should_i_never_tell_my_psychologist/<br>d. https://www.reddit.com/r/asktransgender/comments/3qp0t4/at_the_final_stage_of_questioning_need_some/#bottom-comments<br>e. https://transgendertecsurvivalguide.tumblr.com/post/82036014416/that-was-dysphoria-8-signs-and-symptoms-of |

**Fig 1. Example quotes of online advice from Reddit and Tumblr.**
https://doi.org/10.1371/journal.pone.0202330.g001

#### Purpose

Rapid presentations of adolescent-onset gender dysphoria occurring in clusters of pre-existing friend groups are not consistent with current knowledge about gender dysphoria and have not been described in the scientific literature to date [1–8]. The purpose of this descriptive, exploratory research is to (1) collect data about parents' observations, experiences, and perspectives about their AYA children showing signs of a rapid onset of gender dysphoria that began during or after puberty, and (2) develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

## Materials and methods

The Icahn School of Medicine at Mount Sinai, Program for the Protection of Human Subjects provided approval of research for this project (HS#: 16–00744).

#### Participants

During the recruitment period, 256 parents completed online surveys that met the study criteria. The sample of parents included more women (91.7%) than men (8.3%) and participants were predominantly between the ages of 45 and 60 (66.1%) (Table 1). Most respondents were White (91.4%), non-Hispanic (99.2%), and lived in the United States (71.7%). Most respondents had a Bachelor's degree (37.8%) or graduate degree (33.1%). The adolescents and young adults (AYAs) described by their parents were predominantly female sex at birth (82.8%) with an average current age of 16.4 years (range, 11–27 years). See Table 2.

| Characteristics of Parent-respondents | | n | % |
|---|---|---|---|
| Sex | | 254 | |
| | Female | 233 | 91.7 |
| | Male | 21 | 8.3 |
| Age (y) | | 254 | |
| | 18–29 | 3 | 1.2 |
| | 30–44 | 74 | 29.1 |
| | 45–60 | 168 | 66.1 |
| | >60 | 9 | 3.5 |
| Race/Ethnicity* | | 255 | |
| | White | 233 | 91.4 |
| | Other** | 22 | 8.6 |
| Country of Residence | | 254 | |
| | US | 182 | 71.7 |
| | UK | 39 | 15.4 |
| | Canada | 17 | 6.7 |
| | Other | 16 | 6.3 |
| Education | | 254 | |
| | Bachelor's degree | 96 | 37.8 |
| | Graduate degree | 84 | 33.1 |
| | Some college or Associates degree | 63 | 24.8 |
| | HS grad or GED | 10 | 3.9 |
| | <High School | 1 | 0.4 |
| Parent attitude on allowing gay and lesbian couples to marry legally | | 256 | |
| | Favor | 220 | 85.9 |
| | Oppose | 19 | 7.4 |
| | Don't know | 17 | 6.6 |
| Parent belief that transgender people deserve the same rights and protections as others | | 255 | |
| | Yes | 225 | 88.2 |
| | No | 8 | 3.1 |
| | Don't know | 20 | 7.8 |
| | Other | 2 | 0.8 |

* may select more than one answer.
** declining order includes: Other, Multiracial, Asian, Hispanic.
https://doi.org/10.1371/journal.pone.0202330.t001

**Table 1. Demographic and other baseline characteristics of parent respondents.**
https://doi.org/10.1371/journal.pone.0202330.t001

| Characteristics of AYAs | | n | % |
|---|---|---|---|
| AYA sex at birth (natal sex) | | 256 | |
| | Female | 212 | 82.8 |
| | Male | 44 | 17.2 |
| AYA average current age (range of ages) | 16.4 (11–27) | 256 | |
| Academic diagnoses | | 253 | |
| | Gifted | 120 | 47.4 |
| | Learning Disability | 11 | 4.3 |
| | Both | 27 | 10.7 |
| | Neither | 95 | 37.5 |
| Natal female expressed sexual orientation before announcement* | | 212 | |
| | Asexual | 18 | 8.5 |
| | Bisexual or Pansexual | 78 | 36.8 |
| | Gay or Lesbian | 58 | 27.4 |
| | Straight (Heterosexual) | 75 | 35.4 |
| | Did not express | 57 | 26.9 |
| Natal male expressed sexual orientation before announcement* | | 44 | |
| | Asexual | 4 | 9.1 |
| | Bisexual or Pansexual | 5 | 11.4 |
| | Gay | 5 | 11.4 |
| | Straight (Heterosexual) | 25 | 56.8 |
| | Did not express | 11 | 25.0 |
| Gender dysphoria began | | 256 | |
| | During puberty | 125 | 48.8 |
| | After puberty | 131 | 51.2 |
| Along with a rapid onset of GD, the AYA also: | | 256 | |
| | Belonged to a friend group where one or multiple friends became transgender-identified during a similar timeframe | 55 | 21.5 |
| | Had an increase in social media/internet use | 51 | 19.9 |
| | Both of the above | 116 | 45.3 |
| | Neither | 13 | 5.1 |
| | Don't know | 21 | 8.2 |

* may select more than one answer.
https://doi.org/10.1371/journal.pone.0202330.t002

**Table 2. Demographic and other baseline characteristics of AYAs.**
https://doi.org/10.1371/journal.pone.0202330.t002

#### Procedure

A 90-question survey instrument with multiple choice, Likert-type, and open-ended questions was created by the researcher. The survey was designed for parents (respondents) to complete about their adolescent and young adult children. The survey was uploaded onto Survey Monkey (SurveyMonkey, Palo Alto, CA, USA) via an account that was HIPPA-enabled. IRB approval for the study from the Icahn School of Medicine at Mount Sinai in New York, NY was received. Recruitment information with a link to the survey was placed on three websites where parents and professionals had been observed to describe what seemed to be a sudden or rapid onset of gender dysphoria (4thwavenow, transgender trend, and youthtranscriticalprofessionals), although the specific terminology "rapid onset gender dysphoria" did not appear on these websites until the recruitment information using that term was first posted on the sites. Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought might include eligible participants to expand the reach of the project through snowball sampling techniques. The survey was active from June 29, 2016 to October 12, 2016 (3.5 months) and took 30–60 minutes to complete. Participants completed the survey at a time and place of their own choosing. Data were collected anonymously and stored securely with Survey Monkey.

Participation in this study was voluntary and its purpose was clearly described in the recruitment information. Electronic consent was obtained. Participants had the option to withdraw consent at any time prior to submitting responses. Inclusion criteria were (1) completion of a survey with parental response that the child had a sudden or rapid onset of gender dysphoria; and (2) parental indication that the child's gender dysphoria began during or after puberty. There was logic embedded in the survey that disqualified surveys that answered "no" (or skipped the question) about whether the child had a sudden or rapid onset of gender dysphoria and 23 surveys were disqualified prior to completion (20 "no" answers and 3 skipped answers). After cleaning the data for the 274 completed surveys, 8 surveys were excluded for not having a sudden or rapid onset of gender dysphoria and 10 surveys were excluded for not having gender dysphoria that began during or after puberty, which left 256 completed surveys for inclusion. As the survey was voluntary there was no refusal or dropout rate.

#### Recruitment sites

There were four sites known to post recruitment information about the research study. The first three were posted due to direct communication with the moderators of the sites. The fourth site posted recruitment information secondary to the snowball sampling technique. The following descriptions provide details about these sites.

#### 4thwavenow

4thwavenow was created in 2015. The site, as seen in digitally archived screenshots from 2015 and 2016, stated that it is a "safe place for gender-skeptical parents and their allies", offered support for parents, and expressed concern about the rush to diagnose young people as transgender and the rush to proceed to medical treatment for them [2, 48]. By June 2016, the site had expanded to include the writing of several parents, "formerly trans-identified people, and people with professional expertise and experience with young people questioning their gender identity" [9]. The perspective of this site might be described as cautious about medical and surgical transition overall—specifically with a cautious or negative view of medical and surgical interventions for children, adolescents, and young adults and an accepting view that mature adults can make their own decisions about transition [2, 9].

#### Transgendertrend

Transgendertrend was founded in November 2015. The digitally archived screenshots from November 2015 and July 2016 "Who Are We?" section include the following description, "We are an international group of parents based mainly in the UK, US and Canada, who are concerned about the current trend to diagnose 'gender non-conforming' children as transgender. We reject current conservative, reactionary, religious-fundamentalist views about sexuality. We come from diverse backgrounds, some with expertise in child development and psychology, some who were themselves extreme gender non-conforming children and adolescents, some whose own children have self-diagnosed as 'trans' and some who know supportive trans adults who are also questioning recent theories of 'transgenderism'" [49]. In July of 2016, there was additional text added, expressing concern about legislation regarding public bathrooms and changing rooms [50].

#### Youth trans critical professionals

Youth Trans Critical Professionals was created in March 2016. The digitally archived screenshot from the April 2016 "About" section stated the following: "This website is a community of professionals "thinking critically about the youth transgender movement. We are psychologists, social workers, doctors, medical ethicists, and academics. We tend to be left-leaning, open-minded, and pro-gay rights. However, we are concerned about the current trend to quickly diagnose and affirm young people as transgender, often setting them down a path toward medical transition. Our concern is with medical transition for children and youth. We feel that unnecessary surgeries and/or hormonal treatments which have not been proven safe in the long-term represent significant risks for young people" [51].

#### Parents of transgender children

Parents of Transgender Children is a private Facebook group with more than 8,000 members [52]. The current "About" section states that requests to join the group "will be denied if you are not the parent (or immediate caregiver or family member) of a transgender, gender-fluid, gender-questioning, agender, or other gender-nonconforming child (of any age); or if you are uncooperative during screening" and that the "group is comprised of parents and parenting figures, as well as a select group of advocates INVITED by the admin[istrative] staff to assist & help us with understanding legal and other concerns" [52]. Although the parent discussions and comments are not viewable to non-members [52], this group is perceived to be pro -gender-affirming. The

Parents of Transgender Children Facebook group is considered to be a site to find parents who are supportive of their child's gender identity [53], and it is listed as a resource in a gender affirming parenting guide [54] and by gender affirming organizations [55–56].

## Measures

#### Basic demographic and baseline characteristics

Basic demographic and baseline characteristic questions, including parental attitudes about LGBT rights, were included. Parents were asked about their children's mental health disorders and neurodevelopmental disabilities that were diagnosed before their child's onset of gender dysphoria as well as during and after. The question, "Has your child been formally identified as academically gifted, learning disabled, both, neither?" was used as a proxy to estimate rates of academic giftedness and learning disabilities. Questions about trauma and non-suicidal self-injury were also included as were questions about social difficulties described in a previous research study about gender dysphoric adolescents [13].

#### DSM-5 diagnostic criteria for gender dysphoria in children

The DSM 5 criteria for gender dysphoria in children consist of eight indicators of gender dysphoria [57]. To meet criteria for diagnosis, a child must manifest at least six out of eight indicators including the one designated A1, "A strong desire to be the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender)." Three of the indicators (A1, A7, and A8) refer to desires or dislikes of the child. Five of the indicators (A2-A6) are readily observable behaviors and preferences such as a strong preference or strong resistance to wearing certain kinds of clothing; a strong preference or strong rejection of specific toys, games and activities; and a strong preference for playmates of the other gender [57]. The eight indicators were simplified for language and parents were asked to note which, if any, their child had exhibited prior to puberty. The requirement of six-month duration of symptoms was not included.

#### DSM-5 diagnostic criteria for gender dysphoria in adolescents and adults

The DSM-5 criteria for gender dysphoria in adolescents and adults consist of six indicators of gender dysphoria [57]. To meet criteria for diagnosis, an adolescent or adult must manifest at least two of the six indicators. The six indicators were simplified for language, the first indicator was adjusted for a parent to answer about their child, and parents were asked to note which, if any, their child was expressing currently. The requirement of six-month duration of symptoms was not included.

#### Exposure to friend groups and social media/internet content

Survey questions were developed to describe AYA friend groups, including number of friends that became transgender-identified in a similar time period as the AYA, peer group dynamics and behaviors, and exposure to specific types of social media/internet content and messages that have been observed on sites popular with teens, such as Reddit and Tumblr.

#### Behaviors, outcomes, clinical interactions

Survey questions were developed to specifically quantify adolescent behaviors that had been described by parents in online discussions and observed elsewhere. Participants were asked to describe outcomes such as their child's mental well-being and parent-child relationship since becoming transgender-identified. Parents were also asked about experiences with clinicians and their children's disposition regarding steps taken for transition and duration of transgender-identification both for children who were still transgender-identified and for children who were no longer transgender-identified.

#### Coping with strong or negative emotions

Two questions about the AYAs' ability to cope with negative and strong emotions were included. One question was "How does your child handle strong emotions? (please select the best answer)." Offered answers were "My child is overwhelmed by strong emotions and goes to great lengths to avoid feeling them," "My child is overwhelmed by strong emotions and tries to avoid feeling them," "My child neither avoids not seeks out strong emotions," "My child tries to seek out situations in order to feel strong emotions," "My child goes to great lengths to seek out situations in order to feel strong emotions," "None of the above," "I don't know." The other question was "How would you rate your child's ability to deal with their negative emotions and channel them into something productive?" An example was given regarding dealing with a low test grade by studying harder for the next test (excellent) or by ignoring it, throwing a tantrum, blaming the teacher or distracting themselves with computer games, alcohol, drugs, etc. (extremely poor). Offered answers were: excellent, good, fair, poor, extremely poor, and I don't know.

## Data analysis

Statistical analyses of quantitative data were performed using Excel and custom shell scripts (Unix). Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. ANOVAs, chi-squared, and t-tests comparisons were used where appropriate using publicly available calculators and $p<0.05$ was considered significant. Qualitative data were obtained from open text answers to questions that allowed participants to provide additional information or comments. The types of comments and descriptions were categorized, tallied, and reported numerically. A grounded theory approach was selected as the analytic strategy of choice for handling the qualitative responses because it allowed the researcher to assemble the data in accordance with the salient points the respondents were making without forcing the data into a preconceived theoretical framework of the researcher's own choosing [58]. Illustrative respondent quotes and summaries from the qualitative data are used to illustrate the quantitative results and to provide relevant examples. Two questions were targeted for full qualitative analysis of themes (one question on friend group behaviors and one on clinician interactions). For these questions, a second reviewer with expertise in qualitative methods was engaged (MM). Both the author (LL) and reviewer (MM) independently analyzed the content of the open text answers and identified major themes. Discrepancies were resolved with collaborative discussion and themes were explored and refined until agreement was reached for the final lists of themes. Representative quotes for each theme were selected by LL, reviewed by MM, and agreement was reached.

## Results

#### Baseline characteristics

Baseline characteristics (Table 1) included that the vast majority of parents favored gay and lesbian couples' right to legally marry (85.9%) and believed that transgender individuals deserve the same rights and protections as other individuals in their country (88.2%). Along with the sudden or rapid onset of gender dysphoria, the AYAs belonged to a friend group where one or multiple friends became gender dysphoric and came out as transgender during a similar time as they did (21.5%), exhibited an increase in their social media/internet use (19.9%), both (45.3%), neither (5.1%), and don't know (8.2%) (Table 2). For comparisons, the first three categories will be combined and called "social influence" (86.7%) and the last two combined as "no social influence" (13.3%). Nearly half (47.4%) of the AYAs had been formally diagnosed as academically gifted, 4.3% had a learning disability, 10.7% were both gifted and learning disabled, and 37.5% were neither. Sexual orientation as expressed by the AYA prior to transgender-identification is listed separately for natal females and for natal males (Table 2). Overall, 41% of the AYAs expressed a non-heterosexual sexual orientation prior to disclosing a transgender-identification.

It is important to note that none of the AYAs described in this study would have met diagnostic criteria for gender dysphoria in childhood (Table 3). In fact, the vast majority (80.4%) had zero indicators from the DSM-5 diagnostic criteria for childhood gender dysphoria with 12.2% possessing one indicator, 3.5% with two indicators, and 2.4% with three indicators. Breaking down these results, for readily observable indicators (A2-6), 83.5% of AYAs had zero indicators, 10.2% had one indicator, 3.9% had two indicators, and 1.2% had three indicators. For the desire/dislike indicators (A1, A7, A8), which a parent would have knowledge of if the child expressed them verbally, but might be unaware if a child did not, 95.7% had zero indicators and 3.5% had one indicator. Parents responded to the question about which, if any, of the indicators of the DSM criteria for adolescent and adult gender dysphoria their child was experiencing currently. The average number of positive current indicators was 3.5 (range 0–6) and 83.2% of the AYA sample was currently experiencing two or more indicators. Thus, while the focal AYAs did not experience childhood gender dysphoria, the majority of those who were the focus of this study were indeed gender dysphoric at the time of the survey completion.

| Characteristics | | n | |
|---|---|---|---|
| AYAs who would have met diagnostic criteria for gender dysphoria in childhood | | 0 | 0 |
| Number of DSM 5 indicators for gender dysphoria in children exhibited prior to puberty | | 255 | |
| | Zero indicators | 205 | 80.4 |
| | One indicator | 31 | 12.2 |
| | Two indicators | 9 | 3.5 |
| | Three indicators | 6 | 2.4 |
| | Four indicators | 3 | 1.2 |
| Desire/Dislike Indicators (A1, A7, or A8) | | 255 | |
| | Zero indicators | 244 | 95.7 |
| | One indicators | 9 | 3.5 |
| | Two indicators | 0 | 0 |
| | Three indicators | 1 | 0.4 |
| Readily observable indicators (A2-A6) | | 254 | |
| | Zero indicators | 212 | 83.5 |
| | One indicator | 26 | 10.2 |
| | Two indicators | 10 | 3.9 |
| | Three indicators | 3 | 1.2 |
| | Four indicators | 3 | 1.2 |
| Average number of DSM 5 indicators for adolescent and adult gender dysphoria that the AYA is experiencing currently (range) | | | |
| | 3.5 (range 0–6) | 247 | |
| AYAs currently experiencing two or more indicators of gender dysphoria for adolescents and adults | | 250 | |
| | Yes | 208 | 83.2 |
| | No | 40 | 16.0 |
| | Don't know | 2 | 0.8 |

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**Table 3. DSM 5 Indicators for gender dysphoria.**
https://doi.org/10.1371/journal.pone.0202330.t003

The AYAs who were the focus of this study had many comorbidities and vulnerabilities predating the onset of their gender dysphoria, including psychiatric disorders, neurodevelopmental disabilities, trauma, non-suicidal self-injury (NSSI), and difficulties coping with strong or negative emotions (Table 4). The majority (62.5%) of AYAs had one or more diagnoses of a psychiatric disorder or neurodevelopmental disability preceding the onset of gender dysphoria (range of the number of pre-existing diagnoses 0–7). Many (48.4%) had experienced a traumatic or stressful event prior to the onset of their gender dysphoria. Open text descriptions of trauma were categorized as "family" (including parental divorce, death of a parent, mental disorder in a sibling or parent), "sex or gender related" (such as rape, attempted rape, sexual harassment, abusive dating relationship, break-up), "social" (such as bullying, social isolation), "moving" (family relocation or change of schools); "psychiatric" (such as psychiatric hospitalization), and medical (such as serious illness or medical hospitalization). Almost half (45.0%) of AYAs were engaging in non-suicidal self-injury (NSSI) behavior before the onset of gender dysphoria. Coping styles for these AYAs included having a poor or extremely poor ability to handle negative emotions productively (58.0%) and being overwhelmed by strong emotions and trying to avoid (or go to great lengths to avoid) experiencing them (61.4%) (Table 4). The majority of respondents (69.4%) answered that their child had social anxiety during adolescence; 44.3% that their child had difficulty interacting with their peers, and 43.1% that their child had a history of being isolated (not associating with their peers outside of school activities).

| Characteristics | | n | % |
|---|---|---|---|
| Mental disorder or neurodevelopmental disability diagnosed prior to the onset of gender dysphoria* | | 231 | |
| | Anxiety | 117 | 46.6 |
| | Depression | 99 | 39.4 |
| | Attention Deficit Hyperactivity Disorder (ADHD) | 29 | 11.6 |
| | Obsessive Compulsive Disorder (OCD) | 21 | 8.4 |
| | Autism Spectrum Disorder (ASD) | 20 | 8.0 |
| | Eating Disorder | 12 | 4.8 |
| | Bipolar Disorder | 8 | 3.2 |
| | Psychosis | 6 | 2.4 |
| | None of above | 94 | 37.5 |
| | (Other) Borderline | 3 | 1.2 |
| | (Other) Oppositional Defiant Disorder | 2 | 0.8 |
| Traumatic or stressful experience prior to the onset of gender dysphoria | | 252 | |
| | Yes | 122 | 48.4 |
| | No | 91 | 36.1 |
| | Don't know | 38 | 15.1 |
| | Other | 1 | 0.4 |
| Types of trauma* | | 113 | |
| | Family | 50 | 44.2 |
| | Sex/Gender related | 34 | 30.1 |
| | Social | 23 | 20.4 |
| | Moving | 20 | 17.7 |
| | Psychiatric | 9 | 8.0 |
| | Medical | 7 | 6.2 |
| Non-suicidal self-injury (NSSI) before the onset of gender dysphoria | | 180 | |
| | | 81 | 45.0 |
| Ability to handle negative emotions productively | | 255 | |
| | Excellent/Good | 34 | 13.3 |
| | Fair | 70 | 27.5 |
| | Poor/Extremely Poor | 148 | 58.0 |
| | Don't know | 3 | 1.2 |
| Coping style for dealing with strong emotions | | 254 | |
| | Overwhelmed by strong emotions and tries to /goes to great lengths to avoid feeling them | 156 | 61.4 |
| | Neither avoids nor seeks out strong emotions | 29 | 11.4 |
| | Tries to/goes to great lengths to seeks out strong emotions | 33 | 13.0 |
| | Don't know | 25 | 9.8 |
| | None of the above | 11 | 4.3 |
| Social vulnerabilities | | 255 | |
| | During adolescence child had social anxiety | 177 | 69.4 |
| | Child had difficulty interacting with their peers | 113 | 44.3 |
| | History of being isolated (not interacting with peers outside of school activities) | 110 | 43.1 |
| | Child felt excluded by peers throughout most of grade school | 93 | 36.5 |
| | Child had persistent experiences of being bullied before the onset of gender dysphoria | 74 | 29.0 |

*may select more than one answer.

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**Table 4. AYA baseline comorbidities and vulnerabilities predating the onset of gender dysphoria.**
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#### Announcing a transgender-identification

At the time the AYA announced they were transgender-identified ("came out"), most were living at home with one or both parents (88.3%) and a small number were living at college (6.2%). The average age of announcement of a transgender-identification was 15.2 years of age (range 10–21) (Table 5). Most of the parents (80.9%) answered affirmatively that their child's announcement of being transgender came "out of the blue without significant prior evidence of gender dysphoria." Respondents were asked to pinpoint a time when their child seemed not at all gender dysphoric and to estimate the length of time between that point and their child's announcement of a transgender-identity. Almost a third of respondents (32.4%) noted that their child did not seem gender dysphoric when they made their announcement and 26.0% said the length of time from not seeming gender dysphoric to announcing a transgender identity was between less than a week to three months. The most striking examples of "not seeming at all gender dysphoric" prior to making the announcement included a daughter who loved summers and seemed to love how she looked in a bikini, another daughter who happily wore bikinis and makeup, and another daughter who previously said, "I love my body!"

The majority of respondents (69.2%) believed that their child was using language that they found online when they "came out." A total of 130 participants provided optional open text responses to this question, and responses fell into the following categories: why they thought the child was using language they found online (51); description of what the child said but didn't provide a reason that they suspected the child was using language they found online (61); something else about the conversation (8) or the child (7) and don't know (3). Of the 51 responses describing reasons why respondents thought their child was reproducing language they found online, the top two reasons were that it didn't sound like their child's voice (19 respondents) and that the parent later looked online and recognized the same words and phrases that their child used when they announced a transgender identity (14 respondents). The observation that it didn't sound like their child's voice was also expressed as "sounding scripted," like their child was "reading from a script," "wooden," "like a form letter," and that it didn't sound like their child's words. Parents described finding the words their child said to them "verbatim," "word for word," "practically copy and paste," and "identical" in online and other sources. The following quotes capture these top two observations. One parent said, "It seemed different from the way she usually talked—I remember thinking it was like hearing someone who had memorized a lot of definitions for a vocabulary test." Another respondent said, "The email [my child sent to me] read like all of the narratives posted online almost word for word."



| Characteristics | | n | % |
|---|---|---|---|
| Age of AYA when the AYA announced a transgender identification (range) | 13.2 average (10–21) | 255 | |
| Living arrangement at announcement | | 256 | |
| | Living at home with one or both parents | 226 | 88.3 |
| | Living at college or university | 16 | 6.2 |
| | Other | 14 | 5.5 |
| AYA's announcement came from "out of the blue, without significant prior evidence of gender dysphoria" | | 256 | |
| | Yes | 207 | 80.9 |
| | No | 33 | 12.9 |
| | Other | 16 | 6.2 |
| If a time was pinpointed when the child seemed not at all gender dysphoric, how long between that time and the child's announcement of a transgender identity? | | 250 | |
| | Did not seem at all gender dysphoric when they announced and transgender identity | 81 | 32.4 |
| | Less than a week to 3 months | 65 | 26.0 |
| | 4–6 months | 31 | 12.4 |
| | 7–9 months | 10 | 4.0 |
| | 10–12 months | 29 | 11.6 |
| | More than 12 months | 20 | 8.0 |
| | Don't know | 14 | 5.6 |
| Parent suspects that when the child first announced a transgender identity, that the child used language that they found online | | 253 | |
| | Yes | 175 | 69.2 |
| | No | 53 | 20.9 |
| | N/A | 25 | 9.9 |
| Parent thinks their child is correct in their child's belief of being transgender | | 255 | |
| | Yes | 6 | 2.4 |
| | No | 195 | 76.5 |
| | Don't know | 38 | 14.9 |
| | Other | 16 | 6.3 |
| How soon after the announcement did the AYA ask for transition? | | 255 | |
| | At the same time | 86 | 33.7 |
| | Between less than one week to one month | 33 | 12.9 |
| | 2–5 months after announcement | 26 | 10.2 |
| | 6 or more months after announcement | 19 | 7.5 |
| | Other | 16 | 6.3 |
| | N/A | 75 | 29.4 |
| Intention and request for transition* | | 189 | |
| | AYA told the parent that they want cross-sex hormones | 127 | 67.2 |
| | AYA told the parent that they want to go to a gender therapist/gender clinic | 111 | 58.7 |
| | AYA told the parent that they want surgery | 101 | 53.4 |
| | AYA brought up the issue of suicides in transgender teens as a reason that their parent should agree to treatment | 59 | 31.2 |
| AYA has very high expectation that transitioning will solve their problems in social, academic, occupational, or mental health areas | | 256 | |
| | Yes | 143 | 55.9 |
| | No | 13 | 5.1 |
| | Don't know | 100 | 39.1 |
| AYA was willing to work on basic mental health before seeking gender treatments | | 253 | |
| | Yes | 111 | 43.9 |
| | No | 71 | 28.1 |
| | Don't know | 30 | 11.9 |
| | N/A | 41 | 16.2 |

*may select more than one answer.

https://doi.org/10.1371/journal.pone.0202330.t005

**Table 5. Announcing a transgender-identification.**
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The following case summaries were selected to illustrate peer, trauma, and psychiatric contexts that might indicate more complicated clinical pictures.

- A 12-year-old natal female was bullied specifically for going through early puberty and the responding parent wrote "as a result she said she felt fat and hated her breasts." She learned online that hating your breasts is a sign of being transgender. She edited her diary (by crossing out existing text and writing in new text) to make it appear that she has always felt that she is transgender.
- A 14-year-old natal female and three of her natal female friends were taking group lessons together with a very popular coach. The coach came out as transgender, and, within one year, all four students announced they were also transgender.
- A natal female was traumatized by a rape when she was 16 years of age. Before the rape, she was described as a happy girl; after the rape, she became withdrawn and fearful. Several months after the rape, she announced that she was transgender and told her parents that she needed to transition.
- A 21-year-old natal male who had been academically successful at a prestigious university seemed depressed for about six months. Since concluding that he was transgender, he went on to have a marked decline in his social functioning and has become increasingly angry and hostile to his family. He refuses to move out or look for a job. His entire family, including several members who are very supportive of the transgender community, believe that he is "suffering from a mental disorder which has nothing to do with gender."
- A 14-year-old natal female and three of her natal female friends are part of a larger friend group that spends much of their time talking about gender and sexuality. The three natal female friends all announced they were trans boys and chose similar masculine names. After spending time with these three friends, the 14-year-old natal female announced that she was also a trans boy.

The majority (76.5%) of the surveyed parents felt that their child was incorrect in their belief of being transgender (Table 5). More than a third (33.7%) of the AYAs asked for medical and/or surgical transition at the same time that they announced they were transgender-identified. Two thirds (67.2%) of the AYAs told their parent that they wanted to take cross-sex hormones; 58.7% that they wanted to see a gender therapist/gender clinic; and 53.4% that they wanted surgery for transition. Almost a third (31.2%) of AYAs brought up the issue of suicides in transgender teens as a reason that their parent should agree to treatment. More than half of the AYAs (55.9%) had very high expectations that transitioning would solve their problems in social, academic, occupational or mental health areas. While 43.9% of AYAs were willing to work on basic mental health before seeking gender treatments, a sizable minority (28.1%) were not willing to work on their basic mental health before seeking gender treatment. At least two parents relayed that their child discontinued psychiatric care and medications for pre-existing mental health conditions once they identified as transgender. One parent, in response to the question about if their child had very high expectations that transitioning would solve their problems elaborated, "Very much so. [She] discontinued anti-depressant quickly, stopped seeing psychiatrist, began seeing gender therapist, stopped healthy eating. [She] stated 'none of it' (minding what she ate and taking her Rx) 'mattered anymore.' This was her cure, in her opinion."

#### Friend-group exposure

The adolescent and young adult children were, on average, 14.4 years old when their first friend became transgender-identified (Table 6). Within friendship groups, the average number of individuals who became transgender-identified was 3.5 per group. In 36.8% of the friend groups described, the majority of individuals in the group became transgender-identified. The order that the focal AYA "came out" compared to the rest of their friendship group was calculated from the 119 participants who provided the number of friends coming out both before and after their child and 74.8% of the AYAs were first, second or third of their group. Parents described intense group dynamics where friend groups praised and supported people who were transgender-identified and ridiculed and maligned non-transgender people. Where popularity status and activities were known, 60.7% of the AYAs experienced an increased popularity within their friend group when they announced a transgender-identification and 60.0% of the friend groups were known to mock people who were not transgender or LGBTIA (lesbian, gay, bisexual, transgender, intersex, or asexual).

| Characteristics | | n | % |
|---|---|---|---|
| The AYA has been part of a friend group where one or more friends has come out as transgender around a similar timeframe as they did | | 254 | |
| | Yes | 176 | 69.3 |
| | No | 47 | 18.5 |
| | Don't know | 31 | 12.2 |
| Age of AYA when their first friend became transgender-identified (range) | 14.4 average (11–21) | 174 | |
| Number of friends from the friendship group who became gender dysphoric average (range) | 3.5 average (2–10) | 138 | |
| Where numbers known, friend groups where the MAJORITY of the friends in the friendship group became transgender-identified | | 125 | |
| | Yes | 46 | 36.8 |
| | No | 79 | 63.2 |
| Order of the AYAs "coming out" compared to the others in the friendship group | | 119 | |
| | First in the friendship group | 4 | 3.4 |
| | Second in the friendship group | 52 | 43.7 |
| | Third in the friendship group | 33 | 27.7 |
| | Fourth in the friendship group | 18 | 15.1 |
| | Fifth in the friendship group | 5 | 4.2 |
| | Sixth or Seventh in the friendship group | 6 | 5.0 |
| Where popularity status known, change in popularity within friend group when AYA announced their transgender-identification | | 178 | |
| | Increased popularity | 108 | 60.7 |
| | Decreased popularity | 11 | 6.2 |
| | Unchanged popularity | 59 | 33.1 |
| Where friend group activities known, friend group known to mock people who are not transgender/LGBT | | 145 | |
| | Yes | 87 | 60.0 |
| | No | 58 | 40.0 |

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**Table 6. Friend group exposure.**
https://doi.org/10.1371/journal.pone.0202330.t006

For the question about popularity changes when the child came out as having a transgender-identification, 79 participants provided optional open text responses which were categorized as: descriptions of the responses the child received (39); descriptions of the friends (14); description that the child did not "come out" to friends (8); not sure (9); speculation on how the child felt from the response (4), other (5). Of the 39 descriptions of responses, 19 of these responses referred to positive benefits the child received after coming out including positive attention, compliments, increased status, increased popularity, increased numbers of online followers, and improved protection from ongoing bullying. The following are quotes from parents about the perceived benefits of transgender-identification afforded to their child. One respondent said, "Great increase in popularity among the student body at large. Being trans is a gold star in the eyes of other teens." Another respondent explained, "not so much 'popularity' increasing as 'status'…also she became untouchable in terms of bullying in school as teachers who ignored homophobic bullying …are now all at pains to be hot on the heels of any trans bullying." Seven respondents described a mixed response where the child's popularity increased with some friends and decreased with others. Seven respondents described a neutral response such as "All of the friends seemed extremely accepting." Two described a temporary increase in their child's popularity: "There was an immediate rush of support when he came out. Those same friends have dwindled to nothing as he rarely speaks to any of them now." Another described the loss of friends. And two parents described that "coming out" prevented the loss of friends explained by one respondent as "to not be trans one would not have been included in his group."

Several AYAs expressed significant concern about the potential repercussions from their friend group when they concluded that they were not transgender after all. There were two unrelated cases with similar trajectories where the AYAs spent some significant time in a different setting, away from their usual friend group, without access to the internet. Parents described that these AYAs made new friendships, became romantically involved with another person, and during their time away concluded that they were not transgender. In both cases, the adolescents, rather than face their school friends, asked to move and transfer to different high schools. One parent said that their child, "…couldn't face the stigma of going back to school and being branded as a fake or phony. … Or worse, a traitor or some kind of betrayer…[and] asked us if we could move." In the other case, the parent relayed that their child thought none of the original friends would understand and expressed a strong desire to "…get out of the culture that 'if you are cis, then you are bad or oppressive or clueless.'" Both families were able to relocate and both respondents reported that their teens have thrived in their new environments and new schools. One respondent described that their child expressed relief that medical transition was never started and felt there would have been pressure to move forward had the family not moved away from the peer group.

#### Qualitative analysis

The open-ended responses from the question about whether the AYAs and friends mocked, teased, or made fun of individuals who weren't transgender or LGBTIA was selected for additional qualitative analysis. Seven major themes were identified from the comments provided by participants and are described, with representative supporting quotes.

Theme: Groups targeted.

The groups targeted for mocking by the friend groups are often heterosexual (straight) people and non-transgender people (called "cis" or "cisgender"). Sometimes animosity was also directed towards males, white people, gay and lesbian (non-transgender) people, aromantic and asexual people, and "terfs". One participant explained, "They are constantly putting down straight, white people for being privileged, dumb and boring." Another participant elaborated, "In general, cis-gendered people are considered evil and unsupportive, regardless of their actual views on the topic. To be heterosexual, comfortable with the gender you were assigned at birth, and non-minority places you in the 'most evil' of categories with this group of friends. Statement of opinions by the evil cis-gendered population are consider phobic and discriminatory and are generally discounted as unenlightened."

Theme: Individuals targeted.

In addition to targeting specific groups of people for mocking, the AYAs and their friend groups also directed mocking towards individuals in the AYAs' lives such as parents, grandparents, siblings, peers, allies, and teachers. The following quotes describe individuals targeted. One participant said, "They call kids who are not LGBT dumb and cis. And the mocking has been aimed at my transgender-identified child's [sibling]." Another parent said, "They definitely made fun of parents and teachers who did not agree with them." And a third participant said, "…they were asked to leave [a school-based LGBT club] because they were not queer enough [as straight and bisexual allies]. [One of them] was [then] bullied, harassed and denounced online."

Theme: Behaviors occurred both in person and in online settings.

Parents observed the behaviors both in-person and in online settings, and specifically mentioned seeing posts and conversations on Tumblr, Twitter, Facebook, and Instagram. On participant said, “They speak with derision about how cis-gendered people do not understand them and are so close-minded.” Another participant said, “I hear them disparaging heterosexuality, marriage and nuclear families.” Another participant said, “On my daughter's Tumblr blog, she has liked or favorited or re-posted disparaging comments about those who aren't transgender or seem to misunderstand the transgender identity.” And another parent reported, “Her real life friends don't [mock non-LGBT people] but online they are always swapping jokes and comments about cisgender and about transphobia.”

Theme: Examples of behaviors.

Participants gave many examples of the observed behaviors that were mocking towards non-transgender people and non-LGB people. One participant said, “My daughter called me a ‘breeder’ and says things in a mocking ‘straight person voice’. Her friends egg her on when she does this.” Another parent offered, “If they aren't mocking ‘cis’ people, they are playing pronoun police and mocking people who can't get the pronouns correct.” Another participant said, “New vocabulary includes ‘cis-stupid’ and ‘cis-stupidity.’” And a fourth participant described, “They assume anyone that is critical about being transgender (even just asking questions) is either ignorant or filled with hate.”

Theme: Emphasizing victimhood.

Participants described that their children and friend group seemed to focus on feeling as though they were victims. One participant described, “They seem to wear any problems they may have, real or perceived like badges of honor…I feel like they want to believe they are oppressed & have really 'been through life', when they have little life experience.” Another participant said, “…there is a lot of feeling like a victim [and being] part of a victimized club.” Another parent said “But all talk is very 'victim' centered”. And finally, another said, “They passionately decry ‘Straight Privilege’ and ‘White Male Privilege’—while emphasizing their own ‘Victimhood.’”

Theme: Consequences of behaviors.

A few participants describe that because of their child’s behavior, there were consequences, including making it difficult for one child to return to her school and the following description from another parent, “Most relatives have blocked her on [social media] over constant jokes regarding cis and straight people.”

Theme: Fueling the behaviors.

In some cases, parents describe a synergistic effect of kids encouraging other kids to persist in the behavior as was described in a previous quote, “Her friends egg her on when she does this” as well as the following, “Lots of discussion revolving around how their teachers ‘discriminate’ or are ‘mean’ to them based on their declared LGBTIA identity, and they get each other riled up convincing each other of their persecution by these perceived wrongs … privately they mock our intolerance, and in person act upon these false beliefs by treating us as people out to get them…”

#### Internet/social media exposure

In the time period just before announcing that they were transgender, 63.5% of AYAs exhibited an increase in their internet/social media (Table 7). To assess AYA exposure to existing online content, parents were asked what kind of advice their child received from someone/people online. AYAs had received online advice including how to tell if they were transgender (54.2%); the reasons that they should transition right away (34.7%); that if their parents did not agree for them to take hormones that the parents were “abusive” and “transphobic” (34.3%); that if they waited to transition they would regret it (29.1%); what to say and what not to say to a doctor or therapist in order to convince them to provide hormones (22.3%); that if their parents were reluctant to take them for hormones that they should use the “suicide narrative” (telling the parents that there is a high rate of suicide in transgender teens) to convince them (20.7%); and that it is acceptable to lie or withhold information about one’s medical or psychological history from a doctor or therapist in order to get hormones/get hormones faster (17.5%). Two respondents, in answers to other questions, described that their children later told them what they learned from online discussion lists and sites. One parent reported, “He has told us recently that he was on a bunch of discussion lists and learned tips there. Places where teens and other trans people swap info. Like to use [certain, specific] words [with] the therapist when describing your GD, because [they are] code for potentially suicidal and will get you a diagnosis and Rx for hormones.” Another parent disclosed, “The threat of suicide was huge leverage. What do you say to that? It’s hard to have a steady hand and say no to medical transition when the other option is dead kid. She learned things to say that would push our buttons and get what she wanted and she has told us now that she learned that from trans discussion sites.”



| | | n | |
|---|---|---|---|
| AYAs internet/social media use just prior to announcement | | 255 | |
| | Increased social media/internet use | 162 | 63.5 |
| | Decreased social media/internet use | 3 | 1.2 |
| | Unchanged social media/internet use | 49 | 19.2 |
| | Don't know | 41 | 16.1 |
| AYA exposure to internet content/advice* | | 253 | |
| | How to tell if they are transgender | 136 | 54.2 |
| | The reasons that they should transition right away | 87 | 34.7 |
| | That if their parents did not agree to take them for hormones, that the parents are "abusive" and "transphobic" | 86 | 34.3 |
| | That if they waited to transition they would regret it | 73 | 29.1 |
| | That if they didn't transition immediately they would never be happy | 72 | 28.7 |
| | How to order physical items (binders, packers, etc) without parents finding out | 67 | 26.7 |
| | What to say and what NOT to say to a doctor or therapist in order to convince them to provide hormones | 56 | 22.3 |
| | That if their parents are reluctant to take them for hormones, that they should use the "suicide narrative" to convince them (telling the parents that there is a high rate of suicide in transgender teens) | 52 | 20.7 |
| | Medical advice about the risks and benefits of hormones | 55 | 21.9 |
| | Medical advice about the risks and benefits of surgery | 47 | 18.7 |
| | That it is acceptable to lie to or withhold information about one's medical or psychological history from a doctor or therapist in order to get hormones/ get hormones faster | 44 | 17.5 |
| | How to hide physical items from parents | 40 | 15.9 |
| | How to hide or make excuses for physical changes | 26 | 10.4 |
| | How to get money from others online in order to pay for medications, etc | 25 | 10.0 |
| | How to get hormones from online sources | 24 | 9.6 |
| | How to hide hormones from parents | 21 | 8.4 |
| | I don't know if my child received online advice about these topics | 127 | 50.6 |

*may select more than one answer.

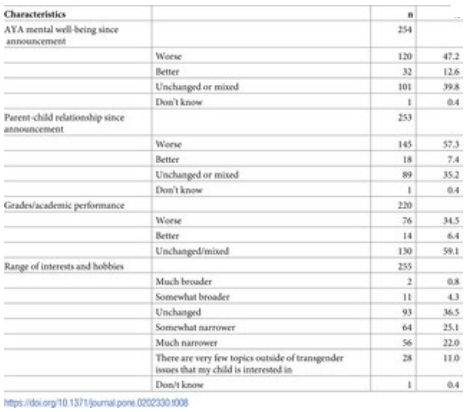
https://doi.org/10.1371/journal.pone.0262330.t007

**Table 7. Internet/Social media exposures.**
https://doi.org/10.1371/journal.pone.0202330.t007

Parents identified the sources they thought were most influential for their child becoming gender dysphoric. The most frequently answered influences were: YouTube transition videos (63.6%); Tumblr (61.7%); a group of friends they know in person (44.5%); a community/group of people that they met online (42.9%); a person they know in-person (not online) 41.7%. In contrast to the majority of responses, two participants commented that they didn't think the sources influenced their child to become gender dysphoric, rather they gave their child a name for their feelings or gave the child confidence to come out. The following quotes illustrate the dominant quantitative findings. One parent wrote, "We believe the biggest influence was the online pro-transition blogs and youtube videos. We feel she was highly influenced by the 'if you are even questioning your gender-you are probably transgender' philosophy…In the 'real world' her friends, other trans peers, and newfound popularity were additional areas of reinforcement." Another respondent described the online influence as part of a different question, "I believe my child experienced what many kids experience on the cusp of puberty—uncomfortableness!—but there was an online world at the ready to tell her that those very normal feelings meant she's in the wrong body."

#### Mental well-being, mental health, and behaviors

The trajectories of the AYAs were not consistent with the narrative of discovering one's authentic self and then thriving. Specifically, parents reported that, after "coming out," their children exhibited a worsening of their mental well-being. Additionally, parents noted worsening of the parent-child relationship and observed that their children had narrowed their interests (Table 8). Although small numbers of AYAs had improvement in mental well-being (12.6%), parent-child relationship (7.4%), grades/academic performance (6.4%), and had broadened their interests and hobbies (5.1%); the most common outcomes were worsened mental well-being (47.2%); worsened parent child relationship (57.3%); unchanged or mixed grades/academic performance (59.1%); and a narrowed range of interests and hobbies (58.1%). One parent describing her child's trajectory offered, "After announcing she was transgender, my daughter's depression increased significantly. She became more withdrawn. She stopped participating in activities which she previously enjoyed, stopped participating in family activities, and significantly decreased her interaction with friends. Her symptoms became so severe that she was placed on medication by her physician." Table 9 describes cumulative rates of mental illness and neurodevelopmental disability at the time of survey.



| Characteristics | | n | |
|---|---|---|---|
| AYA mental well-being since announcement | | 254 | |
| | Worse | 120 | 47.2 |
| | Better | 32 | 12.6 |
| | Unchanged or mixed | 101 | 39.8 |
| | Don't know | 1 | 0.4 |
| Parent-child relationship since announcement | | 253 | |
| | Worse | 145 | 57.3 |
| | Better | 18 | 7.4 |
| | Unchanged or mixed | 89 | 35.2 |
| | Don't know | 1 | 0.4 |
| Grades/academic performance | | 220 | |
| | Worse | 76 | 34.5 |
| | Better | 14 | 6.4 |
| | Unchanged/mixed | 130 | 59.1 |
| Range of interests and hobbies | | 255 | |
| | Much broader | 2 | 0.8 |
| | Somewhat broader | 11 | 4.3 |
| | Unchanged | 93 | 36.5 |
| | Somewhat narrower | 64 | 25.1 |
| | Much narrower | 56 | 22.0 |
| | There are very few topics outside of transgender issues that my child is interested in | 28 | 11.0 |
| | Don/t know | 1 | 0.4 |

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**Table 8. Outcomes and behaviors.**
https://doi.org/10.1371/journal.pone.0202330.t008



| Characteristics | | n | |
|---|---|---|---|
| Mental disorder or neurodevelopmental disability | | 243 | |
| | Anxiety | 154 | 63.4 |
| | Depression | 143 | 58.8 |
| | Attention Deficit Hyperactivity Disorder (ADHD) | 36 | 14.8 |
| | Obsessive Compulsive Disorder (OCD) | 30 | 12.3 |
| | Autism Spectrum Disorder (ASD) | 30 | 12.3 |
| | Eating Disorder | 17 | 7.0 |
| | Bipolar Disorder | 17 | 7.0 |
| | Psychosis | 8 | 3.3 |
| | None of above | 52 | 21.4 |
| | (Other) Borderline | 7 | 2.9 |
| | (Other) Oppositional Defiant Disorder | 2 | 0.8 |

https://doi.org/10.1371/journal.pone.0202330.t009

**Table 9. AYA Cumulative mental disorder and neurodevelopmental disability diagnoses.**
https://doi.org/10.1371/journal.pone.0202330.t009

A total of 63.8% of the parents have been called "transphobic" or "bigoted" by their children for one or more reasons, the most common being for: disagreeing with the child about the child's self-assessment of being transgender (51.2%); recommending that the child take more time to figure out if their feelings of gender dysphoria persist or go away (44.6%); expressing concerns for the child's future if they take hormones and/or have surgery (40.4%); calling their child by the pronouns they used to use (37.9%); telling the child they thought that hormones or surgery would not help them (37.5%); recommending that their child work on other mental health issues first to determine if they are the cause of the dysphoria (33.3%); calling the child by their birth name (33.3%); or recommending a comprehensive mental health evaluation before starting hormones and/or surgery (20.8%) (Table 10). There were eight cases of estrangement. Estrangement was child-initiated in six cases where the child ran away, moved out, or otherwise refused contact with parent. There were two cases where the estrangement was initiated by the parent because the AYA's outbursts were affecting younger siblings or there was a threat of violence made by the AYA to the parent.

| | | n | % |
|---|---|---|---|
| Parents have been called "transphobic," or "bigoted" by their child for the following reasons: | | 240 | |
| | Disagreeing with their child about the child's assessment of being transgender | 123 | 51.2 |
| | Recommending that their child take more time to figure out if their feelings of gender dysphoria persist or go away | 107 | 44.6 |
| | Expressing concerns for their child's future if the child were to take hormones and/or have surgery | 97 | 40.4 |
| | Referring to their child by the pronouns that they used to use before announcement | 91 | 37.9 |
| | Telling their child that they thought hormones/surgery would not help them | 90 | 37.5 |
| | Calling their child by the child's birth name | 80 | 33.3 |
| | Recommending that their child work on other mental health issues first to determine if they are the cause of their dysphoria | 80 | 33.3 |
| | Recommending therapy for basic mental health issues (not related to gender) | 74 | 30.8 |
| | Recommending a comprehensive evaluation before starting hormones and/or surgery | 50 | 20.8 |
| | None of the above | 87 | 36.2 |
| Distrust and isolating behaviors exhibited by AYAs[a] | | 251 | |
| | Expressed distrust of information about gender dysphoria and transgenderism coming from mainstream doctors and psychologists | 130 | 51.8 |
| | Tried to isolate themselves from their family | 124 | 49.4 |
| | Expressed that they ONLY trust information about gender dysphoria and transgenderism that comes from transgender websites and/or transgender people and sources | 117 | 46.6 |
| | Lost interest in activities where participants aren't predominantly transgender or LGBTIA | 81 | 32.3 |
| | Lost interest in activities that were not related to transgender or LGBTIA issues | 65 | 25.9 |
| | Stopped spending time with friends who are not transgender | 63 | 25.1 |
| | Expressed distrust of people who are not transgender | 57 | 22.7 |
| | Expressed hostility towards people who are not transgender | 46 | 18.3 |
| | None of the above | 44 | 17.5 |
| Other behavior and outcomes for AYAs[a] | | 249 | |
| | Withdrawn from family | 112 | 45.0 |
| | Told other people or posted on social media that their parent is "transphobic", "abusive", or "toxic" because the parent does not agree with the child's assessment of being transgender | 107 | 43.0 |
| | Refused to speak to parent | 71 | 28.5 |
| | Defended the practice of lying to or withholding information from therapists or doctors in order to obtain hormones for transition more quickly | 41 | 16.5 |
| | Tried to run away | 17 | 6.8 |
| | Been unable to obtain a job | 25 | 10.0 |
| | Been unable to hold a job | 18 | 7.2 |
| | Dropped out of college | 12 | 4.8 |
| | Dropped out of high school | 12 | 4.8 |
| | Needed to take a leave of absence from college | 12 | 4.8 |
| | Been fired from a job | 9 | 3.6 |
| | Needed a leave of absence from high school | 1 | 0.4 |
| | None of the above | 86 | 34.5 |
| For any of the above, is this a significant change from the child's baseline behavior? | | 101 | |
| | Yes | 115 | 71.4 |
| | No | 46 | 28.6 |

[a]may select more than one answer.

https://doi.org/10.1371/journal.pone.0202330.t010

**Table 10. Additional behaviors.**

https://doi.org/10.1371/journal.pone.0202330.t010

AYAs are reported to have exhibited one or more of the following behaviors: expressed distrust of information about gender dysphoria and transgenderism coming from mainstream doctors and psychologists (51.8%); tried to isolate themselves from their family (49.4%); expressed that they only trust information about gender dysphoria and transgenderism that comes from transgender websites and/or transgender people and sources (46.6%); lost interest in activities where participants aren't predominantly transgender or LGBTIA (32.3%); stopped spending time with friends who were not transgender (25.1%); expressed distrust of people who were not transgender (22.7%) (Table 10). Many AYAs have also: withdrawn from their family (45.0%); told other people or posted on social media that their parent is "transphobic," "abusive," or "toxic" because the parent does not agree with child's self-assessment of being transgender (43.0%); refused to speak to their parent (28.5%), defended the practice of lying to or withholding information from therapists or doctors in order to obtain hormones for transition more quickly (16.5%); tried to run away (6.8%). The behaviors and outcomes listed above were considered significant changes from the child's baseline behaviors for 71.4% of respondents checking any of the items.

There was a subset of eight cases where parents described watching their child have declining mental well-being as they became gender dysphoric and transgender-identified and then had improving mental well-being as they dropped or backed away from a transgender-identification. One parent described a marked change in her daughter when she was out of school temporarily. "[Her] routine was disrupted. She spent all day on the internet, and lost her many school friends—her only friends were on-line and members of the trans community. In three months, my daughter announced she is trans, gender dysphoric, wants binders and top surgery, testosterone shots…she started self-harming. Now back at school…she tweeted that she's so young, isn't sure if she is trans, no longer wants to be referred to by the male name she had chosen…Since she has started back at school and is being exposed to a wide variety of people she is WAY happier." Another parent described, "My daughter's insight has improved considerably over the last few years, and she has also outgrown the belief that she is transgender. My daughter actually seemed to be looking for a reason for her depression which is now being successfully treated…My daughter is MUCH happier now that she is being treated for her genuine issues. Coming out as trans made her much worse for a while."

There was a subset of 30 cases where the AYAs' transgender-identification occurred in the context of a decline in their ability to function (such as dropping out of high school or college, needing a leave of absence from high school or college, and/or being unable to obtain or hold a job), which parents reported as a significant change from their child's baseline behavior. The declines were substantial as 43.3% of these AYAs had been identified as academically gifted students (some described as top of their class in high school, earning outstanding grades at prestigious universities) before they began to fail their classes, drop out of high school or college, and became unable to hold a job. In most of these cases (76.7%), there was one or more psychiatric diagnosis made at the same time or within the year (60.0%) or within two years (16.7%) of the AYA's new transgender-identification. Of the 23 individuals who had a psychiatric diagnosis made within two years of assuming a transgender-identification, 91.3% (21/23) were diagnosed with depression; 73.9% (17/23) with anxiety; 26.0% (6/23) with bipolar disorder; 17.4% (4/23) with borderline personality disorder; 8.7% (2/23) with psychosis/psychotic episode: and 8.7% (2/23) with an eating disorder.

#### Clinical encounters

Parents were asked if their child had seen a gender therapist, gone to a gender clinic, or seen a physician for the purpose of beginning transition and 92 respondents (36.2%) answered in the affirmative (Table 11). Many of the respondents clarified that their child had seen a clinician regarding their gender dysphoria for evaluation only. Although participants were not asked directly what kind of provider their child saw, specialties that were mentioned in answers included: general psychologists, pediatricians, family doctors, social workers, gender therapists, and endocrinologists. For parents who knew the content of their child's evaluation, 71.6% reported that the clinician did not explore issues of mental health, previous trauma, or any alternative causes of gender dysphoria before proceeding and 70.0% report that the clinician did not request any medical records before proceeding. Despite all of the AYAs in this study sample having an atypical presentation of gender dysphoria (no gender dysphoria prior to puberty), 23.8% of the parents who knew the content of their child's visit reported that the child was offered prescriptions for puberty blockers and/or cross-sex hormones at the first visit.



| | | n | % |
|---|---|---|---|
| Did the AYA see a gender therapist, go to a gender clinic or see a physician for the purpose of transition? | | 254 | |
| | No | 151 | 59.4 |
| | Yes | 92 | 36.2 |
| | Don't know | 11 | 4.3 |
| Did the therapist/physician/clinic staff explore issues of mental health, previous trauma, or any alternative causes of gender dysphoria before proceeding? | | 100 | |
| | Yes | 21 | 21.0 |
| | No | 53 | 53.0 |
| | Don't know | 26 | 26.0 |
| Did the therapist/physician/clinic staff request any medical records before proceeding? | | 99 | |
| | Yes | 21 | 21.2 |
| | No | 49 | 49.5 |
| | Don't know | 29 | 29.3 |
| Of parents who knew the content of the visit, did the AYA receive an Rx for puberty blockers and/or cross-sex hormones at their first visit? | | 80 | |
| | AYA received an Rx for puberty blockers and/or cross-sex hormones at their first visit | 17 | 21.2 |
| | AYA was offered a Rx for puberty blockers and/or cross-sex hormones at their first visit, but AYA or parent declined | 2 | 2.5 |
| | Total number of AYAs who received or were offered an Rx at first visit | 19 | 23.8 |
| | AYAs who did not receive/were not offered an Rx at their first visit | 61 | 76.2 |
| Did AYA misrepresent their history to the doctor or relay their history accurately? | | 96 | |
| | Parent is reasonably sure or positive that their child misrepresented or omitted parts of their history | 64 | 66.7 |
| | Parent is reasonable sure or positive that their child relayed their history completely and accurately | 12 | 12.5 |
| | Don't know | 20 | 20.8 |

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**Table 11. Interactions with clinicians.**
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One participant described, “For the most part, I was extremely frustrated with providers NOT acknowledging the mental disorder, anxiety, depression, etc before recommending hormone replacement therapy.” And two participants described how the clinician treating their child’s gender dysphoria refused to speak with the patients’ primary care physicians. One participant said, “When we phoned the clinic, the doctor was hostile to us, told us to mind our own business. Our family doctor tried to reach our son’s new doctor, but the trans doctor refused to speak with her.” Another respondent shared “The pediatrician/‘gender specialist’ did not return calls or emails from the primary care physician who requested to talk with her about my son’s medical history before she saw and treated him…she disregarded all historical information provided by the family and primary care physician…did not verify any information provided by my…son at his first visit even after being provided with multiple other historical sources which differed significantly from his story.”

When asked about whether their child relayed their history completely and accurately to clinicians or whether they misrepresented or omitted parts of their history, of those who knew the content of their child’s visit, 84.2% of the parent respondents were reasonably sure or positive that their child had misrepresented or omitted parts of their history. Twenty-eight participants provided optional open text responses to this question and the responses were categorized into: describing how the parent knew that the child misrepresented their history (5); the content of what the child misrepresented (6 misrepresenting in general, 4 misrepresenting to the clinician for a total of 10 examples); don’t know/not sure (4); expressing certainty (1); and not relevant (8). For the five participants describing how they knew, the reasons included: being present when it happened, reading the report from the gender specialist, being told by their child that the child had misrepresented the truth, and being informed by the child’s psychiatrist. One respondent shared, “I have read the report from the gender specialist and it omits all the relevant context painting an almost unrecognizable picture of my son.” A second parent simply responded, “I was present.” Another respondent relayed about their (natal male) child, “My daughter told me and her mother that the first therapist she saw asked her stereotypical questions…She was afraid that if she didn’t describe herself as a ‘typical girl’ she would not be believed.” And finally, one respondent wrote, “He has said now that he did [misrepresent his history] and used key words he was advised to say.” Ten participants provided 13 examples of the content of misrepresentations and of these, 6 examples could have been easily verified to be false (claiming to be under the care of a psychiatrist, claiming to be on medication to treat a psychiatric condition, how one was doing academically, and claiming a childhood history of having playmates of one sex when the opposite was observed, and claiming strong childhood preferences for specific toys and clothing that is the opposite of what multiple individuals observed). Three of the content examples would have been challenging to verify as false including: how one was feeling as a child, how one was feeling when a picture was taken, and whether one was from an abusive home. And four of the content examples did not provide enough information to determine if they would be easy or challenging to verify as false, such as “My child distorts her history and our family life on a regular basis,” and “He has created an entire narrative that just isn’t true.”

In addition to the previously mentioned case where the child literally rewrote her history by editing her diary, there were seven respondents who conveyed a process where their child was constantly rewriting their personal history to make it consistent with the idea that they always were transgender and/or had created a childhood history that was not what others had observed. It is unclear whether this process was deliberate or if the individuals were unaware of their actions. The following are quotes describing this phenomenon. One parent said, “…she is actively rewriting her personal history to support the idea that she was always trans.” Another respondent added,”…my daughter denies events I recollect from her childhood and puberty that contradicts her narrative of ‘always knowing she was a boy.’” Another respondent offered, “He is rewriting his personal history to suit his new narrative.” And a fourth respondent described, “[Our] son has completely made up his childhood to include only girl friends and dressing up in girls clothes and playing with dolls, etc. This is not the same childhood we have seen as parents.”

#### Qualitative analysis

The open-ended comments from the question about whether the clinician explored mental health, trauma or alternative causes of gender dysphoria before proceeding were selected for qualitative analysis. Nine major themes emerged from the data. Each theme is described in the following paragraphs with supporting quotes from participants.

Theme: Failure to explore mental health, trauma or alternative causes of GD.

Parents described that clinicians failed to explore their child’s mental health, trauma, or any alternative causes for the child’s gender dysphoria. This failure to explore mental health and trauma occurred even when patients had a history of mental health disorder or trauma, were currently being treated for a mental health disorder, or were currently experiencing symptoms. One participant said, “Nothing other than gender dysphoria was considered to explain my daughter's desire to transition.” Another participant said, “My daughter saw a child therapist and the therapist was preparing to support transgendering and did not explore the depression and anxiety or previous trauma.”

Theme: Insufficient evaluation.

Another theme was insufficient evaluation where parents described evaluations that were too limited or too superficial to explore mental health, trauma or alternative causes of gender dysphoria. The following are three quotes by three different parents describing insufficient evaluations. One parent said, “The exploration was egregiously insufficient, very shallow, no effort to ask questions, engage in critical thinking about coexisting anxiety, or put on the brakes or even slow down.” Another participant stated, “When we tried to give our son’s trans doctor a medical history of our son, she refused to accept it. She said the half hour diagnosis in her office with him was sufficient, as she considers herself an expert in the field.” And a third parent wrote, “We were STUNNED by the lack of information, medical history sought by therapist and radical treatment suggestion. [One ]visit. The idea is, ‘if they say they were born in the wrong body, they are. To question this will only hurt her and prolong her suffering.’ [Our] daughter has had trauma in [the] past. [She] never was asked about it. [The] therapist did not ask parents a single question about our daughter.”

Theme: Unwillingness or disinterest in exploring mental health, trauma or alternative causes of GD.

Parents described that clinicians did not seem interested or willing to explore alternative causes. One parent described. “Her current therapist seems to accept her self diagnosis of gender dysphoria and follows what she says without seeming too much interested in exploring the sexual trauma in her past.” Another parent wrote, “The Asperger psychiatrist did not seem to care whether our daughter's gender dysphoria stemmed from Asperger's. If our daughter wanted to be male, then that was enough.” And a third parent said. “The therapist did ask about those issues but seemed to want to accept the idea wholeheartedly that my daughter was transgender first and foremost, all other factors aside.”

Theme: Mental health was explored.

A few parents had the experience where the clinician either made an appropriate referral for further evaluation or the issues had been addressed previously. One parent said, “[The] previous mental health issues [were] already explored by other therapists ([my] child was in therapy and medicated before coming out as transgender).”

Theme: Failure to communicate with patients’ medical providers.

Several participants described clinicians who were unwilling to communicate with primary care physicians and mental health professionals even those professionals who were currently treating the patient. One participant relayed, “She did not review the extensive psychiatric records that were available in a shared EMR [electronic medical record] and she did not consult with his outpatient psychiatrist prior to or after starting cross-sex hormonal therapy.” Another parent said, “My child had been seen for mental health issues for several years before presenting this new identity, but the endocrinologist did not consult the mental health professionals for their opinions before offering hormones.”

Theme: Misrepresentation of information by the patient.

Several participants described how their child misrepresented their history to the clinician, thus, limiting the clinician’s ability to adequately explore mental health, trauma and alternative causes. One participant wrote, “At [the] first visit, [my] daughter's dialogue was well-rehearsed, fabricated stories about her life told to get [the] outcome she desired. She parroted people from the internet.” Another parent reported, “My son concealed the trauma and mental health issues that he and the family had experienced.” And a third parent said, “I overheard my son boasting on the phone to his older brother that ‘the doc swallowed everything I said hook, line and sinker. Easiest thing I ever did.’”

Theme: Transition steps were pushed by the clinician.

Some parents described clinicians who seemed to push the process of transition before the patient asked for it. One parent described that the doctor gave her daughter a prescription that she didn’t ask for, “The family doctor who gave her the Androgel Rx [prescription] did NOT ask her many questions (she was surprised by this), nor did he await her assessment by a licensed psychiatrist before giving her this Rx. Nor did she ask him for this Rx.” Another parent reported that she and her child were at the endocrinologist’s office only to ask questions, and described, “…[he] didn't listen to a word we were saying. He was too eager to get us set up with a ‘gender therapist’ to get the legal form he needed to start hormones, all while making sure we set up our next appointment within 6 months to start the hormones…”

Theme: Parent views were discounted or ignored.

Parents describe that the clinicians did not take their concerns seriously. One parent described, “I have to say I don't know, but it is hard to believe that they adequately examined the history of bullying and being ostracized for being different, and the autistic traits that would lend a person like my son to risk everything for identifying with a group. I know that in the few contacts I had with the providers, my concerns were discounted.” And another said, “All of our emails went unanswered and were ignored. We are left out of everything because of our constant questioning of this being right for our daughter [because of her] trauma and current depression, anxiety and self-esteem problems.”

Theme: Parent had concerns about the clinicians’ competence, professionalism or experience.

Parents expressed doubts about the clinicians regarding their experience, competence or professionalism. One parent said, “The clinic told me they explored these issues. I asked the risk manager at [redacted] if they'd considered a personality disorder. ‘Oh, no,’ she laughed. ‘That's only with the older patients, not the teenagers.’ I'm deeply suspicious of their competence.” Another parent described, “What does concern me is that the people she talked to seemed to have no sense of professional duties, but only a mission to promote a specific social ideology.”

#### Steps towards transition and current identification status

This section reports on the duration of AYA transgender-identification (time from the AYA’s announcement of a transgender identity until the time the parent completed the survey) that covers, on average, 15.0 months (range 0.1–120 months) with a median of 11 months (Table 12). The steps taken towards transition during this timeframe are listed in Table 12. At the end of the timeframe, 83.2% of the AYAs were still transgender-identified, 5.5% were not still transgender-identified (desisted), 2.7% seemed to be

backing away from transgender-identification, and 8.6% of the parents did not know if their child was still identifying as transgender. Descriptions of backing away or moving from transgender-identified to not transgender-identified include the following. One parent observed, “She identified as trans for six months … Now back at school, she is thinking maybe she's not trans.” Another parent offered, “My daughter [identified] as trans from ages 13–16. She gradually desisted as she developed more insight into who she is.” One parent described that after one year of identifying as transgender, “basically, she changed her mind once she stopped spending time with that particular group of friends.” The duration of transgender-identification of the AYAs who were still transgender-identified at the time of survey was compared to the duration of those who were no longer transgender-identified and those who seemed to be backing away from a transgender-identification (combined) by t-test. The difference between these groups was statistically significant ($p = .025$), with a t-value of -2.25 showing that those who were no longer transgender-identified and backing away had a longer duration of identification (mean = 24.1 months) and those who were still transgender-identified had a shorter mean duration (mean = 14.4 months).



| | | n | |
|---|---|---|---|
| Transition Steps* | | 256 | |
| | Changed hairstyle | 216 | 84.4 |
| | Changed style of clothing | 210 | 82.0 |
| | Asks to be called a new name | 188 | 73.4 |
| | Asks for different pronouns | 175 | 68.4 |
| | Taken cross-sex hormones | 29 | 11.3 |
| | Legally changed name on government documents | 19 | 7.4 |
| | Taken anti-androgens | 11 | 4.3 |
| | Taken puberty blockers | 7 | 2.7 |
| | Had surgery | 5 | 2.0 |
| | None of the above | 14 | 5.5 |
| Disposition | | 256 | |
| | Still transgender-identified | 215 | 83.2 |
| | Not transgender-identified any more (desisted) | 14 | 5.5 |
| | Seems to be backing away from transgender-identification | 7 | 2.7 |
| | Parent doesn't know if the child is still transgender-identified | 22 | 8.6 |
| | De-transitioned (also counted in desisted category) | 3 | 1.2 |
| Duration of transgender-identification overall | Median duration 11 months, Mean duration 15.8 months (range 0.1 months-120 months), median 11 months | 225 | |
| Duration of transgender-identification if still transgender-identified | Median duration 11 months, mean duration 14.4 months, ange (0.1 months-72 months) | 204 | |
| Duration of transgender-identification if no longer transgender-identified | Median duration 12 months, mean duration 24.2 months, range (.75 months to 120 months) | 13 | |
| Duration of transgender-identification if backing away | Median duration 12 months, mean duration 15 months, range (3 months-36 months) | 8 | |

*may select more than one answer.

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**Table 12. Transition steps and disposition.**
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To explore the differences between the AYAs who had exposure to social influence (friend group, internet/social media, or both) and AYAs who did not have a clear exposure to social influence (neither and don’t know), a series of chi-squared calculations were performed for selected variables. (See Table 13.) Statistically significant differences were revealed for AYAs with exposure to social influences having worse outcomes for mental well-being and parent-child relationships, and greater numbers exhibiting distrust, isolating and anti-social behaviors including: narrowed range of interests and hobbies, expressing that they only trusted information from transgender sources, trying to isolate themselves from their family, losing interest in activities that weren’t predominantly with transgender or LGBTIA participants, and telling people or posting on social media that their parent is “transphobic,” “abusive,” or “toxic” because the parent doesn’t agree with the child’s assessment of being transgender. Although the differences in additional isolating and anti-social behaviors did not reach statistical significance, these behaviors trended towards higher rates in the AYAs who were exposed to social influence and may have not reached significant levels due to small numbers. No significant difference for age of AYA (at announcement or at time of survey completion) was detected between groups by a one-way ANOVA.



| | | SI n (%) | NSI n (%) | |
|---|---|---|---|---|
| Sex | | 222 | 34 | .123 |
| | Female | 187 (84.2) | 25 (73.5) | |
| | Male | 35 (15.8) | 9 (26.5) | |
| **Indicators of childhood GD** | | 221 | 33 | .004 |
| | **0–2 indicators** | **216 (97.7)** | **29 (87.9)** | |
| | **3–4 indicators** | **5 (2.3)** | **4 (12.1)** | |
| Currently have two or more GD indicators | | 214 | 34 | .808 |
| | Yes | 179(83.6) | 29 (85.3) | |
| | No | 35(16.4) | 5(14.7) | |
| **No mental health or NDD diagnoses before onset of GD** | | 222 | 34 | .036 |
| | **Answered "None of the above"** | **87(39.9)** | **7 (20.6)** | |
| **Mental well-being since announcement** | | 220 | 33 | .001 |
| | **Worse** | **114 (51.8)** | **6 (18.2)** | |
| | **Better** | **24 (10.9)** | **8 (24.2)** | |
| | **Unchanged/Mixed** | **82 (37.3)** | **19 (57.6)** | |
| **Parent-child relationship since announcement** | | 219 | 33 | .006 |
| | **Worse** | **134 (61.2)** | **11 (33.3)** | |
| | **Better** | **13 (5.9)** | **5 (15.2)** | |
| | **Unchanged/Mixed** | **72 (32.9)** | **17 (51.5)** | |
| **Range of interests and hobbies** | | **220** | **34** | **<.0.001** |
| | **Broader range of interests and hobbies** | **10 (4.5)** | **3 (8.8)** | |
| | **Narrowed range of interest and hobbies** | **139 (63.2)** | **9 (26.5)** | |
| | **Unchanged range** | **71 (32.3)** | **22 (64.7)** | |
| Distrust and Isolating Behaviors | | 222 | 34 | |
| | **Tried to isolate themselves from family** | **114(51.4)** | **10 (29.4)** | **.017** |
| | **Expressed that they ONLY trust information about GD and transgenderism that comes from transgender sources** | **107 (48.2)** | **10 (29.4)** | **.041** |
| | **Lost interest in activities where participants aren't predominantly transgender or LGBTIA** | **78 (34.2)** | **5 (14.7)** | **.023** |
| | Stopped spending time with non-transgender friends | 59 (26.6) | 4 (11.8) | .062 |
| | Expressed distrust of people who are not transgender | 52 (23.4) | 5 (14.7) | .255 |
| | **Told people or posted on social media that their parent is "transphobic," "abusive," or "toxic" because the parent doesn't agree with the child's assessment of being transgender** | **102 (45.9)** | **5 (14.7)** | **<0.001** |
| | Defended the practice of lying to or withholding information from doctors/therapists to get hormones for transition more quickly | 38 (17.1) | 3 (8.8) | .219 |
| | Brought up the issue of suicide in transgender teens as a reason parents should agree to treatment | 55 (24.8) | 4 (11.8) | .093 |
| Did the AYA misrepresent their history to the doctor or relay it accurately? | | 68 | 8 | .075 |
| | Parent is reasonable sure or positive that their child misrepresented or omitted parts of their history | 59 (86.8) | 5 (62.5) | |
| | Parent is reasonable sure or positive that child relayed their history completely and accurately | 9 (13.2) | 3 (37.5) | |

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**Table 13. chi-squared comparisons for exposure to social influence (SI) vs not exposure to social influence (NSI).**
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## Discussion

This research describes parental reports about a sample of AYAs who would not have met diagnostic criteria for gender dysphoria during their childhood but developed signs of gender dysphoria during adolescence or young adulthood. The strongest support for considering that the gender dysphoria was new in adolescence or young adulthood is the parental answers for DSM 5 criteria for childhood gender dysphoria. Not only would none of the sample have met threshold criteria, the vast majority had zero indicators. Although one might argue that three of the indicators could plausibly be missed by a parent (A1, A7, and A8 if the child had not expressed these verbally), five of the indicators (A2-6) are readily observable behaviors and preferences that would be difficult for a parent to miss. Six indicators (including A1) are required for a threshold diagnosis. The nonexistent and low numbers of readily observable indicators reported in the majority of this sample does not support a scenario in which gender dysphoria was always present but was only recently disclosed to the parents.

Parents reported that before the onset of their gender dysphoria, many of the AYAs had been diagnosed with at least one mental health disorder or neurodevelopmental disability and many had experienced a traumatic or stressful event. Experiencing a sex or gender related trauma was not uncommon, nor was experiencing a family stressor (such as parental divorce, death of a parent, or a mental health disorder in a sibling or parent). Additionally, nearly half were described as having engaged in self-harm prior to the onset of their gender dysphoria. In other words, many of the AYAs and their families had been navigating multiple challenges and stressors before gender dysphoria and transgender-identification became part of their lives. This context could possibly contribute to friction between parent and child and these complex, overlapping difficulties as well as experiences of same-sex attraction may also be influential in the development of a transgender identification for some of these AYAs. Care should be taken not to overstate or understate the context of pre-existing diagnoses or trauma in this population as they were absent in approximately one third and present in approximately two thirds of the sample.

This research sample of AYAs also differs from the general population in that it is predominantly natal female, white, and has an over-representation of individuals who are academically gifted, non-heterosexual, and are offspring of parents with high educational attainment [59–61]. The sex ratio favoring natal females is consistent with recent changes in the population of individuals seeking care for gender dysphoria. Gender clinics have reported substantial increases in referrals for adolescents with a change in the sex ratio of patients moving from predominantly natal males seeking care for gender dysphoria to predominantly natal females [26–28, 62]. Although increased visibility of transgender individuals in the media and availability of information online, with a partial reduction of stigma might explain some of the rise in the numbers of adolescents presenting for care [27], it would not directly explain why the inversion of the sex ratio has occurred for adolescents but not adults or why there is a new phenomenon of natal females experiencing late-onset and adolescent-onset gender dysphoria. The unexpectedly high rate of academically gifted AYAs may be related to the high educational attainment of the parents and may be a reflection of parents who are online, able to complete online surveys and are able to question and challenge current narratives about gender dysphoria and transition. There may be other unknown variables that render academically gifted AYAs susceptible to adolescent-onset and late-onset gender dysphoria. The higher than expected rate of non-heterosexual orientations of the AYAs (prior to announcement of a transgender-identity) may suggest that the desire to be the opposite sex could stem from experiencing homophobia as a recent study showed that being the recipient of homophobic name calling from one's peers was associated with a change in gender identity for adolescents [63]. The potential relationship of experienced homophobia and the development of a rapid onset of gender dysphoria during adolescence or young adulthood as perceived by parents deserves further study.

This sample is distinctively different than what is described in previous research about gender dysphoria because of the distribution of cases occurring in friendship groups with multiple individuals identifying as transgender, the preponderance of adolescent (natal) females, the absence of childhood gender dysphoria, and the perceived suddenness of onset. In this study, parental reports of transgender identification duration in AYAs suggest that in some cases (~8% in this study) gender dysphoria and transgender-identification may be temporary, and that longer observation periods may be needed to assess such changes. Further research is needed to verify these results. There have been anecdotal reports of adolescents who desisted approximately 9–36 months after showing signs of a rapid onset of gender dysphoria, but longitudinal research following AYAs with gender dysphoria would be necessary to study desistance trends. Although it is still unknown whether transition in gender dysphoric individuals decreases, increases, or fails to change the rates of attempted or completed suicides [64], this study documents AYAs using a suicide narrative as part of their arguments to parents and doctors towards receiving support and transition services. Despite the possibility that the AYAs are using a suicide narrative to manipulate others, it is critical that any suicide threat, ideation or concern is taken seriously and the individual should be evaluated immediately by a mental health professional.

The majority of parents were reasonably sure or certain that their child misrepresented or omitted key parts of their history to their therapists and physicians. In some cases, the misrepresentation of one's history may simply be a deliberate act by a person who is convinced that transition is the only way that they will feel better and who may have been coached that lying is the only way to get what they think they need. For others, the misrepresentation may not be a conscious act. The creation of an alternate version of one's childhood that conforms to a story of always knowing one was transgender and that is in sharp contrast to the childhood that was observed by third parties raises the question of whether there has been the creation of false childhood memories as part of, or outside of, the therapy process. Respondent accounts of clinicians who ignored or disregarded information (such as mental health symptoms and diagnoses, medical and trauma histories) that did not support the conclusion that the patient was transgender, suggests the possibility of motivated reasoning and confirmatory biases on the part of clinicians. In the 1990s, the beliefs and practices of many mental health professionals may have contributed to their patients' creation of false childhood memories consistent with a child sexual abuse narrative and research since then has shown that false childhood memories of mundane events can be implanted in laboratory settings [65–67]. It may be worthwhile to explore if, in today's culture, there might be beliefs and practices of some mental health professionals that are contributing to their patients' creation of false childhood memories consistent with an "always knew/always were transgender" narrative.

## Emerging hypotheses

#### Hypothesis 1: Social influences can contribute to the development of gender dysphoria

It is unlikely that friends and the internet can make people transgender. However, it is plausible that the following can be initiated, magnified, spread, and maintained via the mechanisms of social and peer contagion: (1) the *belief* that non-specific symptoms (including the symptoms associated with trauma, symptoms of psychiatric problems, and symptoms that are part of normal puberty) should be perceived as gender dysphoria and their presence as proof of being transgender; 2) the *belief* that the only path to happiness is transition; and 3) the *belief* that anyone who disagrees with the self-assessment of being transgender or the plan for transition is transphobic, abusive, and should be cut out of one's life. The spread of these beliefs could allow vulnerable AYAs to misinterpret their emotions, incorrectly believe themselves to be transgender and in need of transition, and then inappropriately reject all information that is contrary to these beliefs. In other words, "gender dysphoria" may be used as a catch-all explanation for any kind of distress, psychological pain, and discomfort that an AYA is feeling while transition is being promoted as a cure-all solution.

One of the most compelling findings supporting a potential role of social and peer contagion in the development or expression of a rapid onset of gender dysphoria is the clusters of transgender-identification occurring within friendship groups. The expected prevalence of transgender young adult individuals is 0.7% [8]. Yet, according to the parental reports, more than a third of the friendship groups described in this study had 50% or more of the AYAs in the group becoming transgender-identified in a similar

time frame. This suggests a localized increase to more than 70 times the expected prevalence rate. This is an observation that demands urgent further investigation. One might argue that high rates of transgender-identified individuals within friend groups may be secondary to the process of friend selection: choosing transgender-identified friends deliberately rather than the result of group dynamics and observed coping styles contributing to multiple individuals, in a similar timeframe, starting to interpret their feelings as consistent with being transgender. More research will be needed to finely delineate the timing of friend group formation and the timing and pattern of each new declaration of transgender-identification. Although friend selection may play a role in these high percentages of transgender-identifying members in friend groups, the described pattern of multiple friends (and often the majority of the friends in the friend group) *becoming* transgender-identified in a similar timeframe suggests that there may be more than just friend selection behind these elevated percentages.

There are many insights from our understanding of peer contagion in eating disorders and anorexia that may apply to the potential role(s) of peer contagion in the development of gender dysphoria. Just as friendship cliques can set the level of preoccupation with one's body, body image, weight, and techniques for weight loss [37–39], so too may friendship cliques set a level of preoccupation with one's body, body image, gender, and the techniques to transition. The descriptions of pro-anorexia subculture group dynamics where the thinnest anorexics are admired while the anorexics who try to recover from anorexia are ridiculed and maligned as outsiders [39–41] resemble the group dynamics in friend groups that validate those who identify as transgender and mock those who do not. And the pro-eating-disorder websites and online communities providing inspiration for weight loss and sharing tricks to help individuals deceive parents and doctors [42–44] may be analogous to the inspirational YouTube transition videos and the shared online advice about manipulating parents and doctors to obtain hormones.

#### Hypothesis 2: Parental conflict might provide alternative explanations for selected findings

Parents reported subjective declines in their AYAs' mental health and in parent-child relationships after the children disclosed a transgender identification. Additionally, per parent report, almost half of the AYAs withdrew from family, 28.5% refused to speak to a parent, and 6.8% tried to run away. It is possible that some of these findings might be secondary to parent-child conflict. Parent-child conflict could arise from disagreement over the child's self-assessment of being transgender. It is also possible that some parents might have had difficulty coping or could have been coping poorly or maladaptively with their child's disclosure. Other potential explanations for the above findings include worsening of AYAs' pre-existing (or onset of new) psychiatric conditions or the use of maladaptive coping mechanisms. To further evaluate these possibilities, future studies should incorporate information about family dynamics, parent-child interactions, parent coping, child coping, and psychiatric trajectories. This study did not collect data about the parents' baseline coping styles, how they were coping with their child's disclosure, and whether their coping seemed to be maladaptive or adaptive. Nor did it explore parents' mental well-being. Future studies should explore these issues as well.

Although most parents reported an absence of childhood indicators for gender dysphoria, it is possible that these indicators might have existed for some of the AYAs and that some parents either failed to notice or ignored these indicators when they occurred. Because the readily observable indicators could also have been observed by other people in the child's life, future studies should include input from parents, AYAs and from third party informants such as teachers, pediatricians, mental health professionals, babysitters, and other family members to verify the presence or absence of readily observable behaviors and preferences during childhood. Parental approaches to their child's gender dysphoria might contribute to specific outcomes. This study did not specifically explore parental approaches to gender dysphoria or parental views on medical or surgical interventions. Additional studies that explore whether parents support or don't support: gender exploration; gender nonconformity; non-heterosexual sexual identities; mental health evaluation and treatment; and exploration of potential underlying causes for dysphoria would be extremely valuable. It would also be worthwhile to explore whether parents favor affirming the child as a person or affirming the child's gender identity and whether parents hold liberal, cautious, or negative views about the use of medical and surgical interventions for gender dysphoria in AYAs.

#### Hypothesis 3: Maladaptive coping mechanisms may underlie the development of gender dysphoria for some AYAs

For some individuals, the drive to transition may represent an ego-syntonic but maladaptive coping mechanism to avoid feeling strong or negative emotions similar to how the drive to extreme weight loss can serve as an ego-syntonic but maladaptive coping mechanism in anorexia nervosa [68–69]. A maladaptive coping mechanism is a response to a stressor that might relieve the symptoms temporarily but does not address the cause of the problem and may cause additional negative outcomes. Examples of maladaptive coping mechanisms include the use of alcohol, drugs, or self-harm to distract oneself from experiencing painful emotions. One reason that the treatment of anorexia nervosa is so challenging is that the drive for extreme weight loss and weight loss activities can become a maladaptive coping mechanism that allows the patient to avoid feeling and dealing with strong emotions [69–70]. In this context, dieting is not felt as distressing to the patient, because it is considered by the patient to be the solution to her problems, and not part of the problems. In other words, the dieting and weight loss activities are ego-syntonic to the patient. However, distress is felt by the patient when external actors (doctors, parents, hospital staff) try to interfere with her weight loss activities thus curtailing her maladaptive coping mechanism.

Findings that may support a maladaptive coping mechanism hypothesis include that the most likely description of AYA ability to use negative emotions productively was poor/extremely poor and the majority of AYAs were described as "overwhelmed by strong emotions and tries to/goes to great lengths to avoid experiencing them." Although these are not validated questions, the findings suggest, at least, that there is a history of difficulty dealing with emotions. The high frequency of parents reporting AYA expectations that transition would solve their problems coupled with the sizable minority who reported AYA unwillingness to work on basic mental health issues before seeking treatment support the concept that the drive to transition might be used to avoid dealing with mental health issues and aversive emotions. Additional support for this hypothesis is that the sample of AYAs described in this study are predominantly female, were described by parents as beginning to express symptoms during adolescence and contained an overrepresentation of academically gifted students which bears a strong resemblance to populations of individuals diagnosed with anorexia nervosa [71–75]. The risk factors, mechanisms and meanings of anorexia nervosa [69–70, 76] may ultimately prove to be a valuable template to understand the risk factors, mechanisms, and meanings for some cases of gender dysphoria.

Transition as a drive to escape one's gender/sex, emotions, or difficult realities might also be considered when the drive to transition arises after a sex or gender-related trauma or within the context of significant psychiatric symptoms and decline in ability to function. Although trauma and psychiatric disorders are not specific for the development of gender dysphoria, these experiences may leave a person in psychological pain and in search of a coping mechanism. The first coping mechanism that a vulnerable

person adopts may be the result of their environment and which narratives for pain and coping are most prevalent in that environment—in some settings a gender dysphoria/drive to transition may be the dominant paradigm, in some settings a body dysphoria/drive for extreme weight loss is dominant, and in another the use of alcohol and drugs to cope with pain may be dominant. Because maladaptive coping mechanisms do not address the root cause of distress and may cause their own negative consequences, an outcome commonly reported for this sample, AYAs experiencing a decline in their mental well-being after transgender-identification, is consistent with this hypothesis. There was a subset of AYAs for whom parents reported improvement in their mental well-being as they desisted from their transgender-identification which would not be inconsistent with moving from a maladaptive coping mechanism to an adaptive coping mechanism.

If the above hypotheses are correct, rapid onset of gender dysphoria that is socially mediated and/or used as a maladaptive coping mechanism may be harmful to AYAs in the following ways: (1) non-treatment or delayed treatment for trauma and mental health problems that might be the root of (or at least an inherent part of) the AYAs' issues; (2) alienation of the AYAs from their parents and other crucial social support systems; (3) isolation from mainstream, non-transgender society, which may curtail educational and vocational potential; and (4) the assumption of the medical and surgical risks of transition without benefit. In addition to these indirect harms, there is also the possibility that this type of gender dysphoria, with the subsequent drive to transition, may represent a form of intentional self-harm. Promoting the affirmation of a declared gender and recommending transition (social, medical, surgical) without evaluation may add to the harm for these individuals as it can reinforce the maladaptive coping mechanism, prolong the length of time before the AYA accepts treatment for trauma or mental health issues, and interfere with the development of healthy, adaptive coping mechanisms. It is especially critical to differentiate individuals who would benefit from transition from those who would be harmed by transition before proceeding with treatment.

## Reflections

Clinicians need to be aware of the myriad of barriers that may stand in the way of making accurate diagnoses when an AYA presents with a desire to transition including: the developmental stage of adolescence; the presence of subcultures coaching AYAs to mislead their doctors; and the exclusion of parents from the evaluation. In this study, 22.3% of AYAs were reported as having been exposed to online advice about what to say to doctors to get hormones, and 17.5% to the advice that it is acceptable to lie to physicians; and the vast majority of parents were reasonably sure or positive that their child misrepresented their history to their doctor or therapist. Furthermore, although parents may be knowledgeable informants on matters of their own child's developmental, medical, social, behavioral, and mental health history- and quite possibly *because* they are knowledgeable- they are often excluded from the clinical discussion by the AYAs, themselves. An AYA telling their clinician that their parents are transphobic and abusive may indeed mean that the parents are transphobic and abusive. However, the findings of this research indicate that it is also possible that the AYA calls the parent transphobic and abusive because the parent disagrees with the child's self-diagnosis, has expressed concern for the child's future, or has requested that the child be evaluated for mental health issues before proceeding with treatment.

The findings of this study suggest that clinicians need to be cautious before relying solely on self-report when AYAs seek social, medical or surgical transition. Adolescents and young adults are not trained medical professionals. When AYAs diagnose their own symptoms based on what they read on the internet and hear from their friends, it is quite possible for them to reach incorrect conclusions. It is the duty of the clinician, when seeing a new AYA patient seeking transition, to perform their own evaluation and differential diagnosis to determine if the patient is correct or incorrect in their self-assessment of their symptoms and their conviction that they would benefit from transition. This is not to say that the convictions of the patient should be dismissed or ignored, some may ultimately benefit from transition. However, careful clinical exploration should not be neglected, either. The patient's history being significantly different than their parents' account of the child's history should serve as a red flag that a more thorough evaluation is needed and that as much as possible about the patient's history should be verified by other sources. The findings that the majority of clinicians described in this study did not explore trauma or mental health disorders as possible causes of gender dysphoria or request medical records in patients with atypical presentations of gender dysphoria is alarming. The reported behavior of clinicians refusing to communicate with their patients' parents, primary care physicians, and psychiatrists betrays a resistance to triangulation of evidence which puts AYAs at considerable risk.

It is possible that some teens and young adults may have requested that their discussions with the clinicians addressing gender issues be kept confidential from their parents, as is their right (except for information that would put themselves or others at harm). However, maintaining confidentiality of the patient does not prevent the clinician from listening to the medical and social history of the patient provided by the parent. Nor does it prevent a clinician from accepting information provided by the patient's primary care physicians and psychiatrists. Because adolescents may not be reliable historians and may have limited awareness and insight about their own emotions and behaviors, the inclusion of information from multiple informants is often recommended when working with or evaluating minors. One would expect that if a patient refuses the inclusion of information from parents and physicians (prior and current), that the clinician would explore this with the patient and encourage them to reconsider. At the very least, if a patient asks that all information from parents and medical sources be disregarded, it should raise the suspicion that what the patient is presenting may be less than forthcoming and the clinician should proceed with caution.

The argument to surface from this study is not that the insider perspectives of AYAs presenting with signs of a rapid onset of gender dysphoria should be set aside by clinicians, but that the insights of parents are a pre-requisite for robust triangulation of evidence and fully informed diagnosis. All parents know their growing children are not always right, particularly in the almost universally tumultuous period of adolescence. Most parents have the awareness and humility to know that even as adults they are not always right themselves. When an AYA presents with signs of a rapid onset of gender dysphoria it is incumbent upon all professionals to fully respect the young person's insider perspective but also, in the interests of safe diagnosis and avoidance of clinical harm, to have the awareness and humility themselves to engage with parental perspectives and triangulate evidence in the interest of validity and reliability.

The strengths of this study include that it is the first empirical description of a specific phenomenon that has been observed by parents and clinicians [14] and that it explores parent observations of the psychosocial context of youth who have recently identified as transgender with a focus on vulnerabilities, co-morbidities, peer group interactions, and social media use. Additionally, the qualitative analysis of responses about peer group dynamics provides a rich illustration of AYA intra-group and inter-group

behaviors as observed and reported by parents. This research also provides a glimpse into parent perceptions of clinician interactions in the evaluation and treatment of AYAs with an adolescent-onset (or young adult-onset) of gender dysphoria symptoms.

The limitations of this study include that it is a descriptive study and thus has the known limitations inherent in all descriptive studies. This is not a prevalence study and does not attempt to evaluate the prevalence of gender dysphoria in adolescents and young adults who had not exhibited childhood symptoms. Likewise, this study's findings did not demonstrate the degree to which the onset of gender dysphoria symptoms may be socially mediated or associated with a maladaptive coping mechanism, although these hypotheses were discussed here. Gathering more data on the topics introduced is a key recommendation for further study. It is not uncommon for first, descriptive studies, especially when studying a population or phenomenon where the prevalence is unknown, to use targeted recruiting. To maximize the possibility of finding cases meeting eligibility criteria, recruitment is directed towards communities that are likely to have eligible participants. For example, in the first descriptive study about children who had been socially transitioned, the authors recruited potential subjects from gender expansive camps and gender conferences where parents who supported social transition for young children might be present and the authors did not seek out communities where parents might be less inclined to find social transition for young children appropriate [77]. In the same way, for the current study, recruitment was targeted primarily to sites where parents had described the phenomenon of a rapid onset of gender dysphoria because those might be communities where such cases could be found. The generalizability of the study must be carefully delineated based on the recruitment methods, and, like all first descriptive studies, additional studies will be needed to replicate the findings.

Three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender. One of the sites that posted recruitment information is perceived to be pro-gender-affirming. Hence, the populations viewing these websites might hold different views or beliefs from each other. And both populations may differ from a broader general population in their attitudes about transgender-identified individuals. This study did not explore specific participant views about medical and surgical interventions for gender dysphoric youth or whether participants support or don't support: exploration of gender identity, exploration of potential underlying causes for gender dysphoria, affirmation of children as valued individuals or affirmation of children's gender identity. Future studies should explore all these issues. This study cannot speak to those details about the participants.

Respondents were asked, "Do you believe that transgender people deserve the same rights and protections as others in your country?" which is a question that was adapted from a question used for a US national poll [78]. Although this question cannot elicit specific details about a persons' beliefs about medical interventions, beliefs about transgender identification, or their beliefs about their own child, it can be used to assess if the participants in this study are similar in their basic beliefs about the rights of transgender people to the participants in the US national poll. The majority (88.2%) of the study participants gave affirmative answers to the question which is consistent with the 89% affirmative response reported in a US national poll [78]. All self-reported results have the potential limitation of social desirability bias. However, comparing this self-report sample to the national self-report sample [78], the results show similar rates of support. Therefore, there is no evidence that the study sample is appreciably different in their support of the rights of transgender people than the general American population. It is also important to note that recruitment was not limited to the websites where the information about the study was first posted. Snowball sampling was also used so that any person viewing the recruitment information was encouraged to share the information with any person or community where they thought there could be potentially eligible participants, thus substantially widening the reach of potential respondents. In follow up studies on this topic, an even wider variety of recruitment sources should be attempted.

Another limitation of this study is that it included only parental perspective. Ideally, data would be obtained from both the parent and the child and the absence of either perspective paints an incomplete account of events. Input from the youth would have yielded additional information. Further research that includes data collection from both parent and child is required to fully understand this condition. However, because this research has been produced in a climate where the input from parents is often neglected in the evaluation and treatment of gender dysphoric AYAs, this research supplies a valuable, previously missing piece to the jigsaw puzzle. If Hypothesis 3 is correct that for some AYAs gender dysphoria represents an ego-syntonic maladaptive coping mechanism, data from parents are especially important because affected AYAs may be so committed to the maladaptive coping mechanism that their ability to assess their own situation may be impaired. Furthermore, parents uniquely can provide details of their child's early development and the presence or absence of readily observable childhood indicators of gender dysphoria are especially relevant to the diagnosis. There are, however, obvious limitations to relying solely on parent report. It is possible that some of the participating parents may not have noticed symptoms of gender dysphoria before their AYA's disclosure of a transgender identity; could have been experiencing shock, grief, or difficulty coping from the disclosure; or even could have chosen to deny or obscure knowledge of long term gender dysphoria. Readers should hold this possibility in mind. Overall, the 200 plus responses appear to have been prepared carefully and were rich in detail, suggesting they were written in good faith and that parents were attentive observers of their children's lives. Although this research adds the necessary component of parent observation to our understanding of gender dysphoric adolescents and young adults, future study in this area should include both parent and child input.

This research does not imply that no AYAs who become transgender-identified during their adolescent or young adult years had earlier symptoms nor does it imply that no AYAs would ultimately benefit from transition. Rather, the findings suggest that *not all* AYAs presenting at these vulnerable ages are correct in their self-assessment of the cause of their symptoms and *some* AYAs may be employing a drive to transition as a maladaptive coping mechanism. It may be difficult to distinguish if an AYA's declining mental health is occurring due to the use of a maladaptive coping mechanism, due to the worsening of a pre-existing (or onset of a new) psychiatric condition, or due to conflict with parents. Clinicians should carefully explore these options and try to clarify areas of disagreement with confirmation from outside sources such as medical records, psychiatrists, psychologists, primary care physicians, and other third party informants where possible. Further study of maladaptive coping mechanisms, psychiatric conditions and family dynamics in the context of gender dysphoria and mental health would be an especially valuable contribution to better understand how to treat youth with gender dysphoria.

More research is needed to determine the incidence, prevalence, persistence and desistence rates, and the duration of gender dysphoria for adolescent-onset gender dysphoria and to examine whether rapid-onset gender dysphoria is a distinct and/or clinically valid subcategory of gender dysphoria. Adolescent-onset gender dysphoria is sufficiently different from early-onset of gender dysphoria that persists or worsens at puberty and therefore, the research results from early-onset gender dysphoria should

not be considered generalizable to adolescent-onset gender dysphoria. It is currently unknown whether the gender dysphorias of adolescent-onset gender dysphoria and of late-onset gender dysphoria occurring in young adults are transient, temporary or likely to be long-term. Without the knowledge of whether the gender dysphoria is likely to be temporary, extreme caution should be applied before considering the use of treatments that have permanent effects such as cross-sex hormones and surgery. Research needs to be done to determine if affirming a newly declared gender identity, social transition, puberty suppression and cross-sex hormones can cause an iatrogenic persistence of gender dysphoria in individuals who would have had their gender dysphoria resolve on its own and whether these interventions prolong the duration of time that an individual feels gender dysphoric before desisting. There is also a need to discover how to diagnose these conditions, how to treat the AYAs affected, and how best to support AYAs and their families. Additionally, analyses of online content for pro-transition sites and social media should be conducted in the same way that content analysis has been performed for pro-eating disorder websites and social media content [44]. Finally, further exploration is needed for potential contributors to recent demographic changes including the substantial increase in the number of adolescent natal females with gender dysphoria and the new phenomenon of natal females experiencing late-onset or adolescent-onset gender dysphoria.

## Conclusion

Collecting data from parents in this descriptive exploratory study has provided valuable, detailed information that allows for the generation of hypotheses about potential factors contributing to the onset and expression of gender dysphoria among AYAs. Emerging hypotheses include the possibility of a potential new subcategory of gender dysphoria (referred to as rapid-onset gender dysphoria) that has not yet been clinically validated and the possibility of social influences and maladaptive coping mechanisms contributing to the development of gender dysphoria. Parent-child conflict may also contribute to the course of the dysphoria. More research that includes data collection from AYAs, parents, clinicians and third party informants is needed to further explore the roles of social influence, maladaptive coping mechanisms, parental approaches, and family dynamics in the development and duration of gender dysphoria in adolescents and young adults.

## Supporting information

**S1 Appendix. Survey instrument.**
https://doi.org/10.1371/journal.pone.0202330.s001
(PDF)

**S2 Appendix. COREQ checklist.**
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## References

1. 4thwavenow website. Do no harm: an interview with the founder of youth trans critical professionals. Available from: https://4thwavenow.com/2016/04/05/do-no-harm-an-interview-with-the-founder-of-youth-trans-critical-professionals/
2. 4thwavenow (2015, August 20). About. Retrieved from https://web.archive.org/web/20150820025032/ http://4thwavenow.com/about/
3. 4thwavenow website. One mother's story: A teen's transformation in only 3 months. Available from: https://4thwavenow.com/2015/06/29/one-mothers-story-a-teens-transformation-in-only-3-months/
4. 4thwavenow website. Internet parenting expert berates mom of teen who grew out of trans identity. Available from: https://4thwavenow.com/2016/07/28/internet-parenting-expert-berates-mom-of-teen-who-grew-out-of-trans-identity/
5. Steensma TD, Kreukels BPC, deVries ALC, Cohen-Kettenis PT. Gender identity development in adolescence. Hormones and Behavior. 2013; 64:288–297. pmid:23998673
View Article • PubMed/NCBI • Google Scholar
6. Leibowitz S, de Vries ALC. Gender dysphoria in adolescence. International Review of Psychiatry. 2016; 28: 21–35. pmid:26828376
View Article • PubMed/NCBI • Google Scholar
7. Cohen-Kettenis PT, Klink D. Adolescents with gender dysphoria. Best Practice & Research Clinical Endocrinology & Metabolism. 2015; 29: 485–495.
View Article • Google Scholar
8. Flores AR, Herman JL, Gates GJ, Brown TNT. How Many Adults Identify as Transgender in the United States? Los Angeles, CA. 2016: The Williams Institute.
9. 4thwavenow (2016, January 20). About. Retrieved from https://web.archive.org/web/20160120003530/ http://4thwavenow.com/about/
10. Zucker KJ, Bradley SJ, Owen-Anderson A, Kibblewhite SJ, Wood H, Singh D, Choi K. Demographics, Behavior Problems, and Psychosexual Characteristics of Adolescents with Gender Identity Disorder or Transvestic Fetishism, Journal of Sex & Marital Therapy. 2012; 38:2, 151–189, pmid:22390530
View Article • PubMed/NCBI • Google Scholar

11. Zucker KJ, Lawrence AA, Kreukels BPC. Gender dysphoria in adults. Annu Rev Clin Psychol. 2016; 12:217–47. pmid:26788901
View Article • PubMed/NCBI • Google Scholar

12. Edwards-Leeper L, Spack NP. Psychological evaluation and medical treatment of transgender youth in an interdisciplinary "gender management service" (GeMS) in a major pediatric center. Journal of Homosexuality. 2012; 59 (3): 321–336. pmid:22455323
View Article • PubMed/NCBI • Google Scholar

13. Kaltiala-Heino R, Sumia M, Tyolajarvi M, Lindberg N. Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. Child and Adolescent Psychiatry and Mental Health. 2015; 9:9: 1–9. pmid:25873995
View Article • PubMed/NCBI • Google Scholar

14. Bonfatto M, Crasnow E. Gender/ed identities: an overview of our current work as child psychotherapists in the Gender Identity Development Service. Journal of Child Psychotherapy. 2018; 44 (1): 29–46.
View Article • Google Scholar

15. Kaltiala-Heino R, Bergman H, Tyolajarvi M, Frisen L. Gender dysphoria in adolescence: current perspectives. Adolescent Health, Medicine and Therapeutics. 2018; 9:31–41. pmid:29535563
View Article • PubMed/NCBI • Google Scholar

16. Wallien MSC, Cohen-Kettenis PT. Psychosexual outcome of gender dysphoric children. J. Am. Acad. Child Adolescent Psychiatry. 2008; 47 (12): 1413–1423.
View Article • Google Scholar

17. Steensma TD; McGuire JK, Kreukels BPC, Beekman AJ, Cohen-Kettenis PT. Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. Journal of the Academy of Child & Adolescent Psychiatry. 2013; 53(6): 582–590.
View Article • Google Scholar

18. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clinical Child Psychology and Psychiatry. 2010; 16 (4):499–516.
View Article • Google Scholar

19. Delemarre-van de Waal HA, Cohen-Kettenis PT. Clinical management of gender identity disorder in adolescents: a protocol on psychological and paediatric endocrinology aspects. European Journal of Endocrinology. 2006;155: S131–S137.
View Article • Google Scholar

20. de Vries ALC, Steensma TD, Doreleijers TAH, Cohen-Kettenis PT. Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J Sex Med. 2011; 8:2276–2283. pmid:20646177
View Article • PubMed/NCBI • Google Scholar

21. de Vries ALC, McGuire JK, Steensma TD, Wagenaar ECF, Doreleijers TAH, Cohen-Kettenis PT. Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics. 2014; 134 (4): 696–704. pmid:25201798
View Article • PubMed/NCBI • Google Scholar

22. Schagen SEE, Cohen-Kettenis PT, Delemarre-van de Waal HA, Hannema SE. Efficacy and safety of gonadotropin-releasing hormone agonist treatment to suppress puberty in gender dysphoric adolescents. J Sex Med. 2016; 13: 1125–1132. pmid:27318023
View Article • PubMed/NCBI • Google Scholar

23. Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M. Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med. 2015; 12:2206–2214. pmid:26556015
View Article • PubMed/NCBI • Google Scholar

24. Cohen-Kettenis PT, van Goozen SHM. Sex reassignment of adolescent transsexuals: a follow up study. Journal of the academy of child & adolescent Psychiatry. 1997; 36(2): 263–271.
View Article • Google Scholar

25. Byne W, Bradley SJ, Coleman E, Eyler AE, Green R, Menvielle EJ, et al. Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder. Archives of Sexual Behavior. 2012; 41: 759–796. pmid:22736225
View Article • PubMed/NCBI • Google Scholar

26. Zucker KJ. Epidemiology of gender dysphoria and transgender identity. Sex Health. 2017 Oct;14(5):404–411. pmid:28838353
View Article • PubMed/NCBI • Google Scholar

27. Aitken MA, Steensma TD, Blanchard R, VanderLaan DP, Wood H, Fuentes A, et al. Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. J Sex Med. 2015; 12:756–763. pmid:25612159
View Article • PubMed/NCBI • Google Scholar

**28.** de graaf NM, Giovanardi G, Zitz C, Carmichael P. Sex Ratio in Children and Adolescents Referred to the Gender Identity Development Service in the UK (2009–2016). Archives of Sexual Behavior. 2018, 47:1301–1304. pmid:29696550
View Article • PubMed/NCBI • Google Scholar

**29.** Marsden P. Memetics and social contagion: Two sides of the same coin? Journal of Memetics: Evolutionary Models of Information Transmission. 1998; 12: 68–79.
View Article • Google Scholar

**30.** Dishion TJ and Tipsord JM. Peer contagion in child and adolescent social and emotional development. Annual Review of Psychology. 2011; 62: 189–214. pmid:19575606
View Article • PubMed/NCBI • Google Scholar

**31.** Prinstein MJ. Moderators of peer contagion: A longitudinal examination of depression socialization between adolescents and their best friends. Journal of Clinical Child and Adolescent Psychology. 2007; 36:159–170. pmid:17484689
View Article • PubMed/NCBI • Google Scholar

**32.** Schwartz-Mette RA, Rose AJ. Co-rumination mediates contagion of internalizing symptoms within youths' friendships. Developmental Psychology. 2012; 48: 1355–1365. pmid:22369336
View Article • PubMed/NCBI • Google Scholar

**33.** Schwartz-Mette RA, Smith RL. When does co-rumination facilitate depression contagion in adolescent friendships? Investigating intrapersonal and interpersonal factors. J of Clin Child Adolesc Psychol. 2016;1: 1–13 pmid:27586501
View Article • PubMed/NCBI • Google Scholar

**34.** Starr LR. When support seeking backfires: co-rumination, excessive reassurance seeking and depressed mood in the daily lives of young adults. Journal of Social and Clinical Psychology. 2015; 34 (5): 436–457. pmid:29151669
View Article • PubMed/NCBI • Google Scholar

**35.** Dishion TJ, Spracklen JM, Andrews DW, Patterson GR. Deviancy training in male adolescents' friendships. Behavior Therapy. 1996; 27:373–390.
View Article • Google Scholar

**36.** Dishion TJ, McCord J, Poulin F. When interventions harm: peer groups and problem behavior. American Psychologist. 1999; 54(9): 755–764. pmid:10510665
View Article • PubMed/NCBI • Google Scholar

**37.** Paxton SJ, Schutz HK, Wertheim EH, Muir SL. Friendship clique and peer influences on body image concerns, dietary restraint, extreme weight-loss behaviors, and binge eating in adolescent girls. Journal of Abnormal Psychology. 1999; 108:255–266. pmid:10369035
View Article • PubMed/NCBI • Google Scholar

**38.** Eisenberg ME, Neumark-Sztainer D. Friends' dieting and disordered eating behaviors among adolescents five years later: Findings from project EAT. Journal of Adolescent Health. 2010; 47: 67–73. pmid:20547294
View Article • PubMed/NCBI • Google Scholar

**39.** Allison S,' Warin M, Bastiampillai T. Anorexia nervosa and social contagion: clinical implications. Aust N Z J Psychiatry. 2014; 48(2):116–20. pmid:23969627
View Article • PubMed/NCBI • Google Scholar

**40.** Vandereycken W. Can eating disorders become 'contagious' in group therapy and specialist inpatient care? European Eating Disorders Review. 2011; 19: 289–295. pmid:21394837
View Article • PubMed/NCBI • Google Scholar

**41.** Warin M. Reconfiguring relatedness in anorexia. Anthropology and Medicine. 2006; 13: 41–54. pmid:26868611
View Article • PubMed/NCBI • Google Scholar

**42.** Harshbarger JL, Ahlers-Schmidt CR, Mayans L, Mayans D, Hawkins JH. Pro-anorexia websites: what a clinician should know. Int J Eat Disord. 2009; 42:367–370. pmid:19040264
View Article • PubMed/NCBI • Google Scholar

**43.** Custers K. The urgent matter of online pro-eating disorder content and children: clinical practice. Eur J Pediatr. 2015; 174: 429–433. pmid:25633580
View Article • PubMed/NCBI • Google Scholar

**44.** Rouleau CR, von Ranson KM. Potential risks of pro-eating disorder websites. Clinical Psychology Review. 2011; 31:525–531. pmid:21272967
View Article • PubMed/NCBI • Google Scholar

**45.** Bechard B, VanderLaan DP, Wood H, Wasserman L, Zucker KJ. Psychosocial and psychological vulnerability in adolescents with gender dysphoria: a "proof of principle" study. J Sex Marital Ther. 2017; 43(7):678–88. pmid:27598940
View Article • PubMed/NCBI • Google Scholar

46. Brunskell-Evans Heather and Moore Michele, eds. Transgender children and young people: born in your own body, 244. Newcastle upon Tyne, UK: Cambridge scholars Publishing, 2018. Print.

47. Transgender Reality website. https://transgenderreality.com/about/. Last accessed 9/26/2017.

48. 4thwavenow (2016, December 26). Retrieved from https://web.archive.org/web/20161226093345/ https://4thwavenow.com/

49. Transgender Trend (2015, November 22). Home. Retrieved from https://web.archive.org/web/20151122011724/ http://www.transgendertrend.com/

50. Transgender Trend (2016, July 26). About us. Retrieved from https://web.archive.org/web/20160726021427/ http://www.transgendertrend.com/about_us/

51. Youth Trans Critical Professionals (2016, April 5.) About. Retrieved from https://web.archive.org/web/20160405015522/ http://youthtranscriticalprofessionals.org/about/

52. Parents of Transgender Children Facebook Group. Available from: https://www.facebook.com/groups/108151199217727/

53. Vooris JA. Life uncharted: Parenting transgender, gender-creative and gay children. PhD Thesis, University of Maryland, College Park. 2016. Available from: https://drum.lib.umd.edu/bitstream/handle/1903/18947/Vooris_umd_0117E_17593.pdf?sequence=1

54. Angello M, Bowman A. Raising the transgender child: A complete guide for parents, families, and caregivers. 1st ed. Berkeley: Seal Press; 2016.

55. PFLAG and Trans Youth Education & Support of Colorado (TYES). Colorado Resources for Families of Gender Expansive Youth. Available from https://static1.squarespace.com/static/5b10b6968ab722b1af17a9ca/t/5bd1175ac83025ad6e7aeb8f/1540429660858/PFLAG_TYES_Resources_091916.pdf

56. PFLAG Greater Providence. News and Views; 17, (6): 2016. Available from: https://www.pflagprovidence.org/uploads/2/5/8/1/25814882/2016-12-07_november—december_2016_pflag_newsletter—final.pdf

57. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (Fifth ed.). Arlington, VA: American Psychiatric Publishing; 2013.

58. Moore M. Grounded Theory. In: Goodley D, Lawthom R, Clough P, and Moore M. Researching Life Stories: Method, Theory and Analyses in a Biographical Age. London: RoutledgeFalmer; 2004. pp 118–121.

59. The Twice Exceptional Dilemma. National Education Association. 2006.http://www.nea.org/assets/docs/twiceexceptional.pdf Last accessed 10/6/17.

60. Copen CE, Chandra A, Febo-Vazquez I. Sexual behavior, sexual attraction, and sexual orientation among adults aged 18–44 in the United States: Data from the 2011–2013 National Survey of Family Growth. National health statistics reports; no 88. Hyattsville, MD: National Center for Health Statistics. 2016.

61. Ryan CL, Bauman K. Educational Attainment in the United States: 2015. US Census. https://www.census.gov/content/dam/Census/library/publications/2016/demo/p20-578.pdf

62. Wood H, Sasaki S, Bradley SJ, Singh D, Fantus S, Owen-Anderson A, et al. Patterns of referral to a gender identity service for children and adolescents (1976–2011): Age, sex ratio, and sexual orientation [Letter to the editor]. J Sex Marital Ther. 2013; 39:1–6. pmid:23152965
View Article • PubMed/NCBI • Google Scholar

63. Delay D, Martin CL, Cook RE, Hanish LD. The influence of peers during adolescence: does homophobic name calling by peers change gender identity?. J Youth Adolescence. 2018; 47:636–649.
View Article • Google Scholar

64. Marshall E, Claes L, Bouman WP, Witcomb GL, Arcelus J, et al. Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. Int Rev Psychiatry 2016; 28:58–69. pmid:26329283
View Article • PubMed/NCBI • Google Scholar

65. Loftus EF, Davis D. Recovered Memories. Annu. Rev. Clin. Psychol. 2006; 2:469–98. pmid:17716079
View Article • PubMed/NCBI • Google Scholar

66. Appelbaum PS. Third-party suits against therapists in recovered-memory cases. Psychiatric Services. 2001; 52 (1): 27–28. pmid:11141524
View Article • PubMed/NCBI • Google Scholar

67. Brainerd CJ, Reyna VF. False Memory in Psychotherapy In: The Science of False Memory, Oxford Psychology Series Number 38. New York: Oxford University Press. 2005. Pp 361–422.

68. Fiore F, Ruggiero GM, Sassaroli S. Emotional dysregulation and anxiety control in the psychopathological mechanism underlying drive for thinness. Frontiers in Psychiatry. 2014; 5 (43): 1–5.
View Article • Google Scholar

69. Marzola E, Panepinto C, Delsedime N, Amianto F, Fassino S, Abbate-Daga G. A factor analysis of the meanings of anorexia nervosa: intrapsychic, relational, and avoidant dimensions and their clinical correlates. BMC Psychiatry. 2016; 16:190. pmid:27267935
View Article • PubMed/NCBI • Google Scholar

**70.** Halmi KA. Perplexities of treatment resistence in eating disorders. BMC Psychiatry 2013, 13:292: 1–6.
View Article • Google Scholar

**71.** Steinhausen HC, Jensen CM. Time trends in lifetime incidence rates of first-time diagnosed anorexia nervosa and bulimia nervosa. Int. J. Eat. Disord. 2015; 48:845–850. pmid:25809026
View Article • PubMed/NCBI • Google Scholar

**72.** Raevuori A, Keski-Rahkonen A, Hoek HW. A review of eating disorders in males. Curr Opin Psychiatry. 2014;27:426–430. pmid:25226158
View Article • PubMed/NCBI • Google Scholar

**73.** Favaro A, Caregaro L, Tenconi E, Bosello R, Santonastaso P. Time trends in age at onset of anorexia nervosa and bulimia nervosa. J Clin Psychiatry. 2009; 70:1715–1721. pmid:20141711
View Article • PubMed/NCBI • Google Scholar

**74.** Lopez C, Stahl D, Tchanturia K. Estimated intelligence quotient in anorexia nervosa: a systematic review and meta-analysis of the literature. Ann Gen Psychiatry 2010; 9: 40. pmid:21182794
View Article • PubMed/NCBI • Google Scholar

**75.** Schilder CMT, van Elburg AA, Snellen WM, Sternheim LC, Hoek HW, Danner UN. Intellectual functioning of adolescent and adult patients with eating disorders. Int J Eat Disord. 2017 May; 50(5):481–489. pmid:27528419
View Article • PubMed/NCBI • Google Scholar

**76.** Guarda AS. Treatment of anorexia nervosa: insights and obstacles. Physiology & Behavior. 2008; 94: 113–120.
View Article • Google Scholar

**77.** Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental health of transgender children who are supported in their identities. Pediatrics. 2016; 137: 31–38.
View Article • Google Scholar

**78.** Jones RP, Cox D. Most Americans Favor Rights and Legal Protections for Transgender People. PRRI. 2011.Available from http://www.prri.org/research/american-attitudes-towards-transgender-people/.

Once school staff understand the areas in which a child or young person is planning to transition, they can think about how to support these changes at school. It is vital that the staff team provides informed and consistent support to individuals who are transitioning. More information on social aspects of transition can be found in section 6.

Be aware that some pupils and students, including those with SEND, may not feel the same pressures or awareness of 'fitting in' socially, or may have empathy differences that make it difficult for them to understand their families or friends' perspectives or feelings. Once they have 'come out' to one person they may have unrealistic ideas or timeframes about how their journey will progress, and this can leave little time to build a supportive plan. Schools will need to develop plans that meet the needs of an individual but provide effective support for them and the wider community.

Some trans pupils and students will need support in developing scripts and responses to questions they may be asked about their transition. This may include phrases such as 'It's none of your business…' 'I have always been a boy / girl'. 'Non-binary means…' This support can be done with a trusted adult at school, family and working in collaboration with another appropriate professional.

From Brighton and Hove council trans inclusion toolkit 2021 which is used by many different councils outside of Brighton.
https://www.brighton-hove.gov.uk/sites/default/files/2021-09/BHCC_Trans%20Inclusion%20Schools%20Toolkit%20_Version4_Sept21.pdf

# Search Results for: comorbidities

▼ Trans-identified young people are prone to elevated rates of depression and/or anxiety. Expand

Transgender-identified youth are prone to elevated rates of depression and/or anxiety.

A study [1] which compared the medical records of 1333 trans-identified children and adolescents between the ages of 3 and 17 years old with a similar cohort of non-trans-identified children and adolescents showed that 49% of males and 62% of females had depressive disorders.

An Australian study [2], with a smaller sample of gender dysphoric children and adolescents, found depression and anxiety rates of 62.0% and 63.3% respectively.

The majority of parent respondents in Littman's 2018 study [3] – 69.4% – answered that their child had social anxiety during adolescence; 44.3% said that their child had difficulty interacting with their peers, and 43.1% that their child had a history of being isolated (not associating with their peers outside of school activities).

946

Similar conclusions have been found [4] for adults with gender dysphoria, who suffer from elevated rates of mood disorders (48.9% among natal males, 36.1% among natal females) and anxiety (38.8% among natal males, 33.3% among natal females). A further paper [5] found somewhat lower figures, giving a prevalence of 42.1% for mood disorders and 26.8% for anxiety disorders.

REFERENCES


[1] Becerra-Culqui, T.A. Liu, Y., Nash, R., Cromwell, L., Flanders, W.D., Getahun, D. Giammattei, S.V., Hunkeler, E.M., Lash, T.L., Millman, A., Quinn, V.P., Robinson, B., Roblin, D., Sandberg, D.E., Silverberg, M.J., Tangpricha, V. & Goodman, M. (2018). 'Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics 141(5). [Link]

[2] Kozlowska, K., McClure, G., Chudleigh, C., Maguire, A.M., Gessler, D., Scher, S. & Ambler, G.R. (2021). 'Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service'. Human Systems, 1(1), 70–95. [Link]

[3] Littman, L. (2018). Rapid-onset gender dysphoria in adolescents and young adults: A study of parental reports. PLOS ONE, 13 (8). [Link]

[4] Mazaheri Meybodi, A., Hajebi, A., & Ghanbari Jolfaei, A. (2014). Psychiatric Axis I: Comorbidities among Patients with Gender Dysphoria. Psychiatry journal 2014. [Link]

[5] de Freitas, L. D., Léda-Rêgo, G., Bezerra-Filho, S., & Miranda-Scippa, Â. (2020). Psychiatric disorders in individuals diagnosed with gender dysphoria: A systematic review. Psychiatry and Clinical Neurosciences, 74 (2), 99–104. [Link]


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# Do children grow out of gender dysphoria?



**Desistance studies in children with Gender Dysphoria**

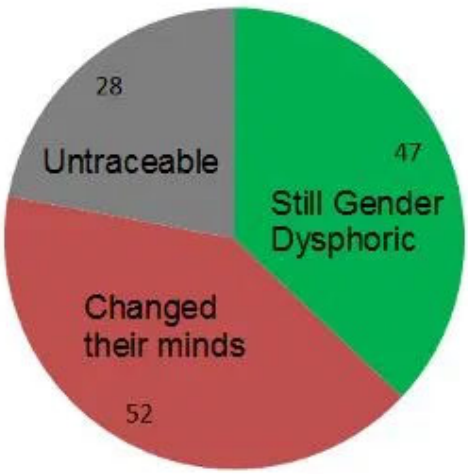
949

Ten studies have been conducted looking at whether gender dysphoria persists throughout childhood. On average 80% of children change their minds and do not continue into adulthood as transgender. Some of these studies are very old, the first being published in 1968 and others in the 1980s. This was during a time when being transgender was not accepted as widely in society as it is now so it can be argued that this may have influenced many to change their minds. An analysis of all published studies can be seen here (http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html).

However, the most recent study published in 2013 confirms once again that gender dysphoria does not persist in most children past puberty. Link to research here. (https://www.transgendertrend.com/wp-content/uploads/2017/10/Steensma-2013_desistance-rates.pdf)

In this Dutch study they identified 127 children who were referred to the Gender Identity clinic in Amsterdam when they were under the age of 12. They then looked to see if these children were still gender dysphoric by the time they reached adolescence at age 15. 47 (37%) of these children had persisted. **However 80 (64%) of children had either desisted (52) or were no longer traceable (28).** See Figure 1. Since there is only one Gender Identity clinic for children in Holland it can be assumed that the latter no longer required support and so had also desisted.

*Figure 1:*



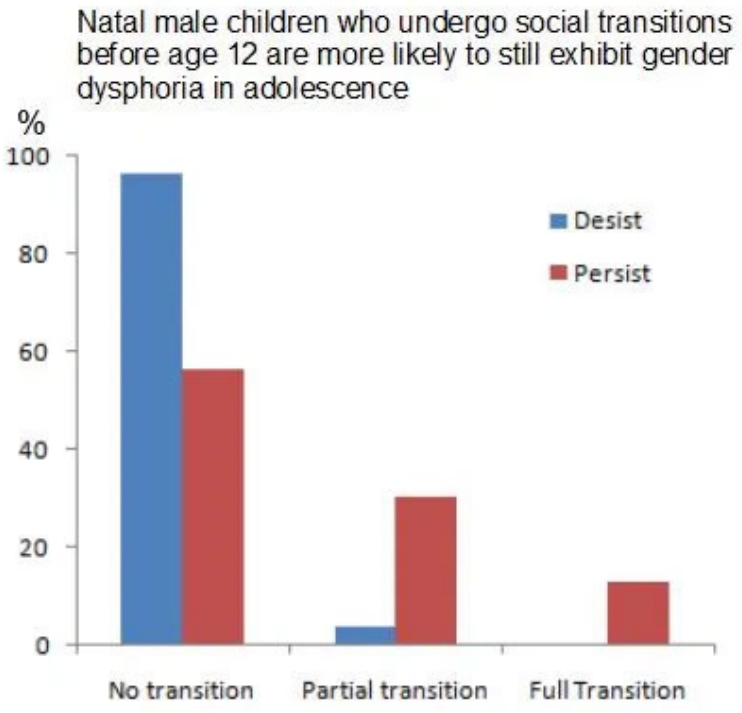

(https://i0.wp.com/www.transgendertrend.com/wp-content/uploads/2017/10/steensma-2013-pie.jpg?ssl=1)

It is well known that the on-set of puberty is an important time when personal identities begin to form and develop. Interestingly, at the gender clinic in this study the children were not given puberty blockers until age 15 and so most will have started their natural puberty by the time of follow-up. It is currently unknown what role puberty plays in the observed resolution of gender dysphoria in most of the children in the study. It is also unknown whether the increased use of puberty blockers in younger children, thereby postponing puberty altogether, will inadvertently increase persistence rates for gender dysphoria. No long term studies on the effect of puberty suppression have yet been conducted.

***Evidence obtained from the children's Gender Identity Clinic in the UK (Tavistock clinic) is that 40% of the children referred to them progress onto puberty blockers. This correlates well with the results from the Dutch study. Alarmingly however, almost all children who start puberty blockers then go onto cross-sex hormones suggesting that desistance after medication begins is very rare. This may of course reflect the increased certainty of the persisters at this stage. Or it may be that it is simply too difficult to consider or admit to a change of mind. Long term studies are needed to determine how long these children persist in their new gender identity and whether they de-transition later in life. This is currently unknown.***

Childhood social transitions (name changes and presenting as the opposite sex using hairstyles and dress) were also shown to be important predictors for persistence of gender dysphoria into adolescence, especially for boys (see Figure 2). The reasons for this are currently unknown. The independent role and impact that social transitions play on persistence has never been studied. It may be that social transitions make it easier to persist in their new gender identity or conversely it may make it more difficult psychologically for the gender dysphoria to resolve and for children to desist. Long term studies are urgently needed in this area.

*Figure 2:*




(https://www.transgendertrend.com/wp-content/uploads/2017/10/steensma-2013-social-trans.jpg)

> ***CONCLUSION: Most children grow out of their gender dysphoria as they reach adolescence. Social transitions and/or puberty blockers are frequently used to ameliorate symptoms in these children. However, the long-term psychological impact of these therapeutic strategies on children is unknown. Therapeutic approaches for children with gender dysphoria are not evidence based and long-term outcome studies are urgently needed in this area.***

If you'd like to read more about the area of childhood desistance here (http://nymag.com/scienceofus/2016/07/whats-missing-from-the-conversation-about-transgender-kids.html) is an excellent article by Jesse Singal written in 2016.

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# Factors Associated With Desistence and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study

Thomas D. Steensma, Ph.D., Jenifer K. McGuire, Ph.D., M.P.H., Baudewijntje P.C. Kreukels, Ph.D., Anneke J. Beekman, B.Sc., Peggy T. Cohen-Kettenis, Ph.D.

**Objective:** To examine the factors associated with the persistence of childhood gender dysphoria (GD), and to assess the feelings of GD, body image, and sexual orientation in adolescence. **Method:** The sample consisted of 127 adolescents (79 boys, 48 girls), who were referred for GD in childhood (<12 years of age) and followed up in adolescence. We examined childhood differences among persisters and desisters in demographics, psychological functioning, quality of peer relations and childhood GD, and adolescent reports of GD, body image, and sexual orientation. We examined contributions of childhood factors on the probability of persistence of GD into adolescence. **Results:** We found a link between the intensity of GD in childhood and persistence of GD, as well as a higher probability of persistence among natal girls. Psychological functioning and the quality of peer relations did not predict the persistence of childhood GD. Formerly nonsignificant (age at childhood assessment) and unstudied factors (a cognitive and/or affective cross-gender identification and a social role transition) were associated with the persistence of childhood GD, and varied among natal boys and girls. **Conclusion:** Intensity of early GD appears to be an important predictor of persistence of GD. Clinical recommendations for the support of children with GD may need to be developed independently for natal boys and for girls, as the presentation of boys and girls with GD is different, and different factors are predictive for the persistence of GD. J. Am. Acad. Child Adolesc. Psychiatry, 2013;52(6):582–590. **Key Words:** childhood gender dysphoria, desistence, persistence, sexual orientation, social role transitioning

Many children who experience gender dysphoria (GD), a sense of discomfort from incongruence between their gender identity and assigned sex, will not continue to experience dysphoria into adolescence and adulthood. However, a substantial minority (2–27% across studies) will continue to report GD and may seek services for gender reassignment later in life. To date, the prospective follow-up studies on children with GD, for whom the majority would meet the *DSM-IV-TR* diagnostic criteria for Gender Identity Disorder (GID)[1] collectively reported on the outcomes of 246 children. At the time of follow-up in adolescence or adulthood, these studies showed that, for the majority of children (84.2%; n = 207), the GD desisted.[2] These studies were conducted across several decades during which the opportunity and social acceptance for gender reassignment has increased dramatically. The current study focuses on children in a context in which gender reassignment is available, generally socially accepted, and covered by health insurance.

This article is discussed in an editorial by Dr. Peter T. Daniolos on page 569.

Knowledge of the factors associated with persistence of childhood GD is limited. Prospectively, 1 study by Wallien and Cohen-Kettenis,[3] reporting on the outcome in adolescence and early adulthood for 77 clinically referred children with GD (21 persisters and 56 desisters), found that the percentage of a complete childhood GID diagnosis was higher for children with persisting GD than for children with desisting GD. Furthermore, compared to the desisters, the persisters showed more gender-variant behavior and a higher intensity of GD in childhood. In

line with these findings, Drummond *et al.*[4] showed that girls with persisting GD recalled significantly more gender-variant behavior and GD during childhood than the girls classified as having desisting GD. More recently, another study by Singh[5] in 139 natal boys with GD confirmed the link between the intensity of childhood GD and adolescent and adult persistence of GD. Singh also found that desistence of GD was associated with a higher social class; however other possible indicators, such as psychological functioning or the quality of peer relations, were not different between the persisters and desisters in childhood.

Indications of more subtle childhood differences between persisters and desisters were reported in a qualitative follow-up study of 25 children with GD (14 persisters and 11 desisters) by Steensma *et al.*[2] They found that both the persisters and desisters reported cross-gender identification from childhood, but their underlying motives appeared to be different. The persisters explicitly indicated that they believed that they *were* the "other" sex. The desisters, however, indicated that they identified as girlish-boys or boyish-girls who only *wished* they were the "other" sex. With regard to the reported bodily discomfort by the persisters as well as by the desisters, the persisters indicated that their discomfort originated from the experience of incongruence between their bodies and their gender identity, whereas the desisters indicated that the discomfort was more likely to be a result of the wish for another body to fulfill the desired social gender role. As the information was based on subjective recollection and was therefore susceptible to biased recall,[6] these findings should be interpreted with caution. Taken together, the prior research suggests that persistence of childhood GD is most closely linked to the intensity of the GD in childhood, the amount of gender-variant behavior, and possible differences in motives or cognitive constructions of the dysphoria.

Most long-term studies of GD also examined adolescent or adult sexual orientation and found an association between the presence of childhood GD and a heightened report of a sexual orientation directed towards the same natal sex or to both sexes.[2] In short, childhood GD may predict a later desire for gender reassignment in some, and an increased report of same sex attractions only in others. Remaining children reported desistence of GD and predominately opposite sex attractions. The proportions of children on each of these 3 developmental pathways have not been fully established.

The present study examined possible factors associated with persistence of childhood GD by comparing a number of childhood variables (e.g., demographic background, GD, gender-variant behavior, psychological functioning, and quality of peer relations) between adolescent persisters and desisters who were clinically referred to our gender identity service in childhood. In addition to this, we examined psychosexual outcomes, body image, and the intensity of GD at the time of follow-up in adolescence.

## METHOD

### Participants and Procedure

The study sample consisted of 127 adolescents (79 boys, 48 girls), who were referred and diagnosed in childhood (< 12 years of age) at the Center of Expertise on Gender Dysphoria at the Vrije Universiteit (VU) University Medical Center in Amsterdam, the Netherlands. This sample differs from the previous persistence study from the Amsterdam clinic.[3] The diagnostic procedure in childhood consisted of several sessions with the child and/or the parents, including an psychodiagnostic assessment of the child. The aim of the diagnostic phase is to determine whether the criteria for a GID diagnosis[1] are met and to evaluate the cognitive, psychological and psychosocial functioning of the child and the functioning of the family, in order to give parents pedagogical advice or advice to treat co-existing problems.[7]

Between 2000 and 2008, 225 children (144 boys, 81 girls) were consecutively referred to the clinic. From this sample, 127 adolescents were selected who were 15 years of age or older during the 4-year period of follow-up between 2008 and 2012. Of these adolescents, 47 adolescents (37%, 23 boys, 24 girls) were identified as persisters. They reapplied to the clinic in adolescence, requested medical treatment, were diagnosed again with GID, and considered eligible for treatment (puberty suppression with GnRH analogues first, cross-sex hormone treatment after the age of 16, and surgery after 18 (details of treatment in de Vries and Cohen-Kettenis[7]). As the Amsterdam clinic is the only gender identity service in the Netherlands where psychological and medical treatment is offered to adolescents with GD, we assumed that for the 80 adolescents (56 boys and 24 girls), who did not return to the clinic, that their GD had desisted, and that they no longer had a desire for gender reassignment. Demographic characteristics of the sample are provided in Table 1.

In this study, information on demographic background, psychological functioning, GD and cross-gender identification in childhood was retrieved from the medical charts for all adolescents. At the time of follow-up, and with approval of the Ethics Committee

**TABLE 1** Demographic Characteristics as a Function of Desistence and Persistence and Sex

| Characteristic | Persistence (n = 47) | | Desistence (n = 80) | | Responders[a] (n = 46) | | Parents[a] (n = 6) | | Nonresponders[a] (n=28) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Boys (n = 23) | Girls (n = 24) | Boys (n = 56) | Girls (n = 24) | Boys (n = 31) | Girls (n = 15) | Boys (n = 5) | Girls (n = 1) | Boys (n = 20) | Girls (n = 8) |
| Age in childhood, y | | | | | | | | | | |
| Mean | 9.33 | 9.83 | 8.70 | 9.35 | 8.84 | 9.23 | 8.92 | 10.48 | 8.43 | 9.44 |
| SD | 1.49 | 1.36 | 1.52 | 1.44 | 1.41 | 1.54 | 1.43 | — | 1.73 | 1.34 |
| Range | 7–12 | 6–12 | 6–12 | 6–12 | 6–12 | 6–12 | 7–12 | — | 6–12 | 7–12 |
| Age at follow-up, y | | | | | | | | | | |
| Mean | 16.12 | 16.33 | 16.10 | 16.07 | 16.05 | 16.03 | 15.92 | 16.32 | 16.21 | 16.10 |
| SD | .91 | 1.25 | .92 | .82 | .93 | .80 | .74 | — | .97 | .95 |
| Range | 15–18 | 15–19 | 15–19 | 15–18 | 15–18 | 15–18 | 15–17 | — | 15–19 | 15–18 |
| Interval, y | | | | | | | | | | |
| Mean | 6.80 | 6.50 | 7.39 | 6.72 | 7.21 | 6.81 | 6.99 | 5.84 | 7.78 | 6.66 |
| SD | 1.62 | 1.42 | 1.29 | 1.51 | 1.18 | 1.67 | 1.87 | — | 1.29 | 1.33 |
| Childhood diagnosis (%) | | | | | | | | | | |
| GID | 91.3 | 95.8 | 39.3 | 58.3 | 48.4 | 66.7 | 0.0 | 0.0 | 35.0 | 50.0 |
| Subthreshold | 8.7 | 4.2 | 60.7 | 41.7 | 51.6 | 33.3 | 100.0 | 100.0 | 65.0 | 50.0 |
| Social role (%) | | | | | | | | | | |
| No transitioning | 56.5 | 41.7 | 96.4 | 54.2 | 93.5 | 53.3 | 100.0 | 0.0 | 100.0 | 62.5 |
| Partial transitioning | 30.4 | 54.2 | 3.6 | 45.8 | 6.5 | 46.7 | 0.0 | 100.0 | 0.0 | 37.5 |
| Complete transitioning | 13.0 | 4.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Parents' MS (%) | | | | | | | | | | |
| Both | 82.6 | 79.2 | 69.6 | 54.2 | 80.6 | 60.0 | 80.0 | 0.0 | 50.0 | 50.0 |
| Other[b] | 17.4 | 20.8 | 30.4 | 45.8 | 19.4 | 40.0 | 20.0 | 100.0 | 50.0 | 50.0 |
| SES (%)[b] | | | | | | | | | | |
| I High | 17.4 | 13.0 | 26.4 | 29.2 | 30.0 | 26.7 | 0.0 | 0.0 | 27.8 | 37.5 |
| II Med | 56.5 | 56.5 | 39.6 | 54.2 | 33.3 | 53.3 | 80.0 | 100.0 | 38.9 | 50.0 |
| III Low | 26.1 | 30.4 | 34.0 | 16.7 | 36.7 | 20.0 | 20.0 | 0.0 | 33.3 | 12.5 |
| Full-scale IQ | | | | | | | | | | |
| Mean | 103.30 | 99.42 | 101.96 | 100.55 | 100.10 | 102.50 | 107.20 | — | 103.61 | 97.13 |
| SD | 12.51 | 14.34 | 12.81 | 15.93 | 13.07 | 14.14 | 9.78 | — | 13.09 | 19.22 |

*Note: GID = gender identity disorder; MS = marital status.*
[a] *This column is a subgroup of the Desistence column.*
[b] *For parents' MS and socioeconomic status (SES), see text for classification.*

of the VU University Medical Center, the adolescents were contacted to participate in the study. Upon agreement, an informed consent form and a set of questionnaires, assessing information on current GD, body image, and sexual orientation was mailed. All 47 persisters participated in the study. Of the 80 desisters, 46 adolescents sent back the questioners (57.5%) and 6 (7.5%) adolescents refused to participate, but allowed their parents to fill out the parent questionnaires. Twenty-eight adolescents were classified as nonresponders: 12 (15%) did not send back the questionnaires despite follow-up contacts, another 12 (15.0%) were untraceable. In 4 cases (5.0%), the adolescents and the parents indicated that the GD from the past remitted, but these individuals refused to participate.

## Measures: Childhood

*Demographics.* Seven demographic measures were coded in childhood: natal sex, age at assessment, diagnosis, social role transition, parents' marital status, parents' social class, and Full-Scale IQ.

The diagnosis, made by either a child psychologist or psychiatrist, was categorized as follows: children who met all criteria for a *DSM-IV-TR* GID diagnosis, or children who did not meet all criteria and were subthreshold for a GID diagnosis. Social role transition was determined through 2 questions by 1 of the parents around the time of referral. Parents indicated whether their child had socially transitioned to the preferred gender role on a 3-point scale; no; yes, but not in all situations; or yes, completely. In an open

question, they could give further information on hairstyle, clothing, and in which pronoun and name the child was addressed. Based on this information, the children were categorized as follows: no social transition; partial transition (transition in clothing style and hairstyle, but without a change of name and pronoun change); complete transition (transition in clothing and hairstyle; change of name and use of pronoun). Because of the unequal distribution over the 3 categories for boys and girls (Table 1), the 3-point scale was recoded into a dichotomous scale in which 0 indicated no transitioning (category 1) and 1 indicated some transitioning (categories 2 and 3). Marital status of the parents was categorized as either living with both biological parents (or adoptive parents from birth) or all other categories (e.g., single parent, divorced, blended family, living in a group home). To determine parents' social class, a 5-point scale was used where 1 = university degree and 5 = grade 8 or less, and recoded into an education rating between 1.0 and 2.0 = 1 (high), 2.5 to 3.5 = 2 (medium), and 4.0 to 5.0 = 3 (low). Full-Scale IQ was assessed using the Dutch version of the Wechsler Intelligence Scale for Children.[8]

*Gender Identity and Gender Dysphoria.* The Dutch version of the Gender Identity Interview for Children (GIIC)[9] is a 12-item child informant instrument that measures 2 factors: "cognitive gender confusion" and "affective gender confusion." Cognitive gender confusion is assessed by 4 questions asking whether the child identifies as a boy or a girl, Affective gender confusion is assessed by means of 8 questions focusing on affective aspects of gender identity (e.g., "Are there any things that you don't like about being a boy?"). Higher scores on the GIIC reflect more gender-atypical responses.

The Dutch version of the Gender Identity Questionnaire (GIQ)[10] is a 14-item parent-report questionnaire representing 1 factor. The focus of items is on gender-variant behaviors, with higher scores coded in this study to represent a greater frequency of gender-variant behaviors.

*Psychological Functioning and the Quality of Peer Relations.* Psychological functioning was assessed through parental report, by the Dutch version of the Child Behavior Checklist/ 4-18 (CBCL),[11] and through teacher report, by the Dutch version of the Teacher's Report Form (TRF).[12] This study used: the mean Total problem score, i.e., the sum of all items rated 1 or 2; the mean Internalizing behavior score; and the mean Externalizing behavior score.

On the CBCL, there are 2 items related to gender identity: item 5 ("Behaves like the opposite sex") and item 110 ("Wishes to be the opposite sex"). These gender related items were analyzed as separate predictors based on the findings from Cohen-Kettenis *et al.*,[13] and were not included in the 3 above-mentioned scales of the CBCL and TRF.

We created a Peer Relations Scale from 3 items: "Doesn't get along with other kids" (item 25), "Gets teased a lot" (item 38), and "Not liked by other kids" (item 48), based on findings from Zucker *et al.*,[14] who used this composite scale from the CBCL in a study and found a Cronbach's alpha of 0.81.

## Measures: Adolescence

*Gender Identity, Gender Dysphoria, and Body Image.* The Gender Identity Interview for Adolescents and Adults (GIAA),[15,16] is a 27-item adolescent and adult informant instrument with 1 factor. The items measure gender identity problems and GD for the past 12 months (e.g., "In the past 12 months, have you felt satisfied being a boy?"). Lower scores on the GIAA reflect more gender atypical responses.

The Utrecht Gender Dysphoria Scale (UGDS),[17] is a 12-item questionnaire measuring 1 factor. The items measure the intensity of GD (e.g., "I continuously want to be treated like a boy/man."). There are separate versions of the UGDS for males (UGDS-M) and females (UGDS-F). Higher scores indicate more GD.

The Body Image Scale (BIS)[18] is a 30-item questionnaire that measures body satisfaction and consists of 3 scales: Primary sex characteristics (e.g., genitals), secondary sex characteristics (e.g., breasts, body hair), and neutral body characteristics (e.g., hands, legs). Higher scores indicate greater dissatisfaction.

*Sexual Orientation.* We examined 4 indicators of sexual orientation: "To whom do you feel attracted?" (sexual attraction), "About whom do you fantasize sexually?" (sexual fantasy), "With whom have you kissed?" (sexual behavior), and "How do you identify yourself?" (sexual identity).[3] The sexual behavior domain was assessed by asking about kissing because we expected that many of the adolescents would not have had sexual intercourse. The questions were rated on a 7-point Kinsey scale ranging from exclusively heterosexual (0) to exclusively homosexual (6).[19] According to their scores, the adolescents were classified in 3 sexual orientation categories: attracted to other sex (Kinsey rating 0–1); attracted to both sexes (Kinsey rating 2–4); and attracted to same sex (Kinsey rating 5–6).

*Parent Report.* The questionnaire for parents was used when the adolescent refused to participate, and consisted of 9 questions assessing GD in their offspring. As for sexual orientation, 2 questions assessed sexual attraction ("To whom does your son or daughter feel attracted?") and sexual identity ("How does your son or daughter identify him- or herself?"). Both questions were classified following the same procedure as mentioned above.

## Statistical Analysis

The desister subgroups (responders, reports from parents, and nonresponders), were compared in demographics, childhood psychological functioning, the quality of peer relations, and childhood GD using independent-samples Kruskal–Wallis and $\chi^2$ Tests.

Logistic regression analyses examined bivariate and multivariate contributions of demographic variables, psychological functioning, quality of peer relations, and childhood GD on probability of persistence of GD in adolescence.

Analyses of variance, t tests, and $\chi^2$ tests compared persisters and desisters on current reports of GD, body image, and sexual orientation.

## RESULTS

### Combination of Response Groups

For the 3 desister groups, no significant differences were observed between the responders, parents who responded, and nonresponders for the demographic variables, except for childhood diagnosis ($\chi^2[2] = 6.90$, $p < .05$). The adolescents for whom the parents responded were more likely to have a subthreshold diagnosis for GID than the responders and nonresponders. However, in their scores on the childhood measures of GD and psychological functioning, the 3 groups were not significantly different. Given this information, the 3 groups were combined to 1 group of desisters for further analyses.

### Predictors of Persistence

Bivariate logistic regressions estimated the individual contribution of the childhood variables to examine which variables predicted persistence of GD (Table 2). Age and natal sex were the only significant demographic predictors. Older children and girls were more likely to be persisters than younger children and boys. Gender relevant items from the CBCL and TRF, social role transition, responses to the GIIC and GIQ, and receipt of a GID diagnosis in childhood were all significant indicators of adolescent persistence of GD.

To examine the simultaneous contribution of multiple factors, multivariate logistic regressions were run for the combined sample and separately by natal sex. Variables were retained in the model based on their unique contribution to explaining persistence of GD. Variables with very high correlations with other GD measures (e.g., whether or not a diagnosis was given) were not useful for the multivariate model and thus were dropped (Table 3).

In the combined group, the following variables collectively accounted for 58% of the variability in the persistence of GD: age at intake, social role transition, and both cognitive and affective responses to the GIIC. Once these variables were accounted for, responses to the GIQ did not predict additional variance in persistence. Cognitive responses to the GIIC were the strongest predictor, accounting for 11% of the unique variability in persistence of GD.

**TABLE 2** Childhood Predictors of Persistence of Gender Dysphoria (GD) Into Adolescence (N = 127, n = 47 Persisters, n = 80 Desisters)

| Dependent variable: Persistence of GD | Bivariate OR (CI) |
|---|---|
| Natal boy | .41 (.20–.87)* |
| Age at intake | 1.37 (1.06–1.76)* |
| Two parents | 2.27 (.96–5.37) NS |
| High socioeconomic status | .30 (.18–1.69) NS |
| Medium socioeconomic status | .55 (.55–3.04) NS |
| Full-Scale IQ | 1.00 (.97–1.03) NS |
| CBCL total problem | .99 (.97–1.01) NS |
| CBCL internalizing | .98 (.93–1.03) NS |
| CBCL externalizing | .98 (.94–1.03) NS |
| CBCL peer relations | .99 (.79–1.24) NS |
| CBCL gender (items 5 and 110) | 4.64 (2.28–9.44)** |
| CBCL item 5 | 37.56 (4.95–284.87)** |
| CBCL item 110 | 5.13 (2.14–12.33)** |
| TRF total problem score | 1.00 (.98–1.01) NS |
| TRF internalizing | .98 (.93–1.03) NS |
| TRF externalizing | 1.01 (.97–1.06) NS |
| TRF peer relations | 1.05 (.81–1.36) NS |
| TRF item 5 | 1.74 (1.05–2.89)* |
| Childhood role transition | 5.38 (2.36–12.27)** |
| Gender identity disorder diagnosis | 17.93 (5.14–62.55)** |
| Gender identity interview total | 1.33 (1.19–1.49)** |
| GII cognitive items | 1.95 (1.46–2.60)** |
| GII affective items | 1.30 (1.15–1.47)** |
| Gender Identity Questionnaire | 5.10 (2.03–12.79)** |

*Note: CBCL = Child Behavior Checklist; OR = odds ratio; TRF = Teacher Report Form*
*p < .05, **p < .001.

Among natal males, 62% of the variability in the persistence of GD was accounted for by age at intake, social role transition, the cognitive subscale of the GIIC, and the total score of the GIQ. Once these variables were accounted for, responses to the affective component of the GIIC did not predict additional variance in persistence. Social role transition accounted for the largest portion of unique variability (12%), whereas each of the other significant predictors accounted for 6% to 7% of unique variability in persistence of GD. To further examine the effect of childhood social role transitioning on later persistence in natal boys, the boys who transitioned were compared with boys who did not for their scores on the childhood measures of GD. Boys who transitioned had significantly higher scores than those who had not

**TABLE 3** Childhood Predictors of Persistence of Gender Dysphoria (GD) Into Adolescence Using Multivariate Logistic Regression (N = 127, n = 47 Persisters, n = 80 Desisters)

| Dependent variable: Persistence of GD | Combined Sample OR (95% CI) | Natal boys OR (95% CI) | Natal girls OR (%CI) |
|---|---|---|---|
| Age at intake | 1.65 (1.12–2.44)** | 1.90 (1.10–3.30)* | 1.98 (.88–4.49) NS |
| Childhood role transition | 5.06 (1.61–15.87)** | 22.43 (2.69–187.07)** | 1.85 (.27–12.87) NS |
| GII cognitive | 1.68 (1.21–2.34)** | 1.55 (1.06–2.28)* | 2.04 (1.02–4.09)* |
| GII affective | 1.19 (1.02–1.38)* | 1.10 (.91–1.33) NS | 1.47 (1.05–2.07)* |
| GIQ | 2.47 (.75–8.16) NS | 7.01 (1.17–42.01)* | .40 (.05–3.49) NS |

*Note: GII = Gender Identity Interview; GIQ = Gender Identity Questionnaire; OR = odds ratio.*
*p < .05, **p < .01.

transitioned for the 2 gender related CBCL items combined (mean = 3.91 versus mean = 2.88, respectively; $t$ [61.50] = −6.15, $p < .001$); the cognitive scale of the GIIC (mean = 2.64 versus mean = 0.95, respectively, t [74] = −2.74, $p = .008$), and a borderline significance for the total score of the GIIC (mean = 12.64 versus mean = 9.45, respectively, $t$ [74] = −1.99, $p = .051$), but not for the gender related TRF item, the affective scale of the GIIC or the GIQ.

For natal females, 62% of the variability in the persistence of GD was accounted for by cognitive and affective responses to the GIIC. Once these variables were entered, none of the other predictors contributed unique variance to persistence. Cognitive and affective responses to the GIIC explained 15% each of the unique variability in persistence of GD.

### Adolescent Reports

*Gender Identity and Body Image.* Adolescents' reports of GD and body image were compared across persisters and desisters (Table 4), and showed that persisters reported more GD than desisters in the mean total scores of both the GIIAA and the UGDS. Clinically, for the GIIAA, scores of less than 3 indicate GD;[16] 87.2% of the persisters met the criterion compared to 0% of the desisters. For the UGDS, scores of more than 40.0 indicate GD (Steensma, Kreukels, Jürgensen, Thyen, de Vries and Cohen-Kettenis, unpublished material, 2013); 97.9% of the persisters met the criterion compared to 2.2% of the desisters (1 bisexual, natal girl). As for body image, the persisters reported more body dissatisfaction for primary and secondary sex characteristics and neutral body characteristics, than the desisters. There were no main effects for sex or significant interactions between sex and persistence for GD or body image.

*Sexual Orientation.* Table 5 shows sexual orientation percentages for persisters, desisters and the 2 groups combined. Persisters were more likely to report a sexual orientation toward their natal sex across each of the indicators of sexual orientation: attraction ($\chi^2$ [2] = 43.16, $p < .001$), fantasy ($\chi^2$ [2] = 45.95, $p < .001$), behavior ($\chi^2$ [2] = 56.81, $p < .001$), and identity ($\chi^2$ [2] = 47.69, $p < .001$) compared to the desisters.

Among desisters, natal boys were more likely to report same sex attractions ($\chi^2$ [2] = 9.94, $p < .05$), fantasy ($\chi^2$ [2] = 11.76, $p < .05$), and identity ($\chi^2$ [2] = 16.26, $p < .001$), but not behavior, than natal girls. Within the group of persisters, there were no significant differences between natal boys and girls on any indicator of sexual orientation.

## DISCUSSION

The present study aimed to identify associated factors with the persistence of GD into adolescence, and to assess the current feelings of GD, body image, and sexual orientation. Our findings regarding the gender identity of the adolescents were in line with the earlier findings; the persisters reported higher intensities of GD, more body dissatisfaction, and higher reports of a same-sex sexual orientation compared to the desisters.[3,4] As for the factors associated with the persistence of GD, we replicated the earlier findings on the link between the intensity of GD in childhood and persistence of GD,[3,4,5] showed that the chance of persisting was greater in natal girls with GD than in boys,[3] and that psychological functioning and the quality of peer relations did not predict the persistence of GD.[5] In addition to this, we found that formerly nonsignificant (age at childhood assessment) and unstudied factors (cognitive and/or affective gender identity responses on the GIIC and a social role transition) were associated with the persistence of GD. Furthermore, our multivariate model revealed that the factors associated with the persistence of GD were different between natal sexes.

**TABLE 4** Mean Scores on the Gender Identity Measures and the Body Image Scale (BIS) in Adolescence

| | Persistence | | | Desistence | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | All (n = 47) | Boys (n = 23) | Girls (n = 24) | All (n = 46) | Boys (n = 31) | Girls (n = 15) | | | |
| Natal Sex | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) | Persisters vs. Desisters[b] | | |
| GIIAA | | | | | | | *F* | *df* | *p* |
| Total score | 2.65 (.33) | 2.62 (.34) | 2.69 (.32) | 4.33 (.35) | 4.35 (.34) | 4.28 (.39) | 510.78 | 1, 89 | .001 |
| BIS[a] | | | | | | | | | |
| Primary | 3.84 (.66) | 3.82 (.65) | 3.86 (.68) | 2.21 (.70) | 2.14 (.66) | 2.34 (.78) | 117.09 | 1, 88 | .001 |
| Secondary | 2.79 (.64) | 2.75 (.70) | 2.82 (.59) | 2.24 (.65) | 2.24 (.67) | 2.23 (.63) | 15.43 | 1, 88 | .001 |
| Neutral | 2.56 (.62) | 2.71 (.63) | 2.42 (.59) | 2.09 (.63) | 2.05 (.61) | 2.16 (.70) | 11.53 | 1, 88 | .001 |
| UGDS-M | | | | | | | | | |
| Total score | — | 52.22 (5.54) | — | — | 13.48 (3.11) | — | −30.18 | 32.18 | .001 |
| UGDS-F | | | | | | | | | |
| Total score | — | — | 53.79 (5.01) | — | — | 23.00 (10.23) | −10.87 | 18.27 | .001 |

*Note: UGDS-F = Utrecht Gender Dysphoria Scale for females; UGDS-M = UGDS for males.*

[a]*For 1 persister, a natal boy, the Body Image Scale was not available, n = 46 for persisters and n = 22 for persister boys.*

[b]*For the Gender Identity Interview for Adolescents and Adults (GIIAA) and BIS domains, there were no significant differences between boys and girls, or an interaction for Status (Persistence/Desistence) × Sex.*

With regard to the predictive factors for persistence, we expected to observe differences between natal boys and girls. To date, several studies on children with GD showed that girls who are referred to gender identity services generally present a greater level of gender-variant behavior[9,10,13] and are generally older in age at the time of referral than boys.[13] Furthermore, visual inspection of the demographic characteristics of our sample (Table 1) indeed indicates that girls had a higher age at referral, a greater percentage who fulfilled a childhood GID diagnosis, and partial transitioning among the majority of girls (irrespective of a later persistence or desistence) at the time of referral, compared to boys. It seems therefore conceivable that the differences in childhood presentation of boys and girls with GD resulted in different factors being associated with persistence of GD, which may have implications for a different approach in the clinical management of boys and girls with GD. For natal boys, gender-variant behaviors, their gender role presentation, and parent reports on the intensity of gender role behaviors provide important indicators of the child's desires and future development. However, because the role of parental report on gender-variant behaviors and surface behaviors such as gender role transitioning, are of less value in predicting a future persistence of GD in girls, it seems important to provide extra focus on girls' own experiences of cross-gender identification and wishes.

Although the relative value of the factors associated with the persistence of GD differed between the natal boys and girls, a central and shared predictor for persistence for both boys and girls in our model included the cognitive responses to the GIIC. When asked with what sex they identified ("Are you a boy or a girl?"), children who expressed cross-gender identification had a greater chance of persisting GD. This seems to be in concordance with the underlying motives reported by the persisters and desisters in the qualitative study by Steensma *et al.*[2] Persisters indicated that they believed that they were the "other" sex, and the desisters indicated they wished they were the "other" sex; this difference may also underlie our finding of a higher report of cognitive cross-gender identification in the persisters than in the desisters; either they experience an alternative gender identification, or they interpreted the question differently. Nonetheless, explicitly asking children with GD with which sex they identify seems to be of great value in predicting a future outcome for both boys and girls with GD.

Childhood social transitions were important predictors of persistence, especially among natal boys. Social transitions were associated with more intense GD in childhood, but have never been independently studied regarding the possible impact of the social transition itself on cognitive representation of gender identity or persistence. As we previously indicated, the percentage of transitioned children is increasing and seems to exceed the percentages known from prior literature for the persistence of GD,[20] which could result in a larger proportion of children who have to change back to their original gender role, because

**TABLE 5** Percentage of Sexual Orientation for Desisters, Persisters, and Combined

| Group/Sexual Domain | Attraction | | Fantasy | | Behavior | | Sexual Identity | |
|---|---|---|---|---|---|---|---|---|
| | Boys | Girls | Boys | Girls | Boys | Girls | Boys | Girls |
| Desistence/natal sex, n | 29 | 14 | 29 | 11 | 22 | 9 | 31 | 15 |
| Other sex, % | 34.5 | 85.7 | 24.1 | 81.8 | 63.6 | 100.0 | 22.6 | 80.0 |
| Both sexes, % | 24.1 | 7.1 | 37.9 | 18.2 | 22.7 | 0.0 | 41.9 | 20.0 |
| Same sex, % | 41.4 | 7.1 | 37.9 | 0.0 | 13.6 | 0.0 | 35.5 | 0.0 |
| Persistence/natal sex, n | 23 | 24 | 21 | 24 | 17 | 20 | 23 | 24 |
| Other sex, % | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Both sexes, % | 4.3 | 4.2 | 0.0 | 4.2 | 0.0 | 0.0 | 8.7 | 4.2 |
| Same sex, % | 95.7 | 95.8 | 100 | 95.8 | 100 | 100 | 91.3 | 95.8 |
| Combined/natal sex, n | 52 | 38 | 50 | 35 | 39 | 29 | 54 | 39 |
| Other sex, % | 19.2 | 31.6 | 14.0 | 25.7 | 35.9 | 31.0 | 13.0 | 30.8 |
| Both sexes, % | 15.4 | 5.2 | 22.0 | 8.6 | 12.8 | 0.0 | 27.8 | 10.2 |
| Same sex, % | 65.4 | 63.2 | 64.0 | 65.7 | 51.3 | 69.0 | 59.3 | 59.0 |

*Note: The domain sexual behavior was assessed by asking about kissing because we expected that many of the adolescents would not have had sexual intercourse.*

of desisting GD, accompanied with a possible struggle[2]; or it may, with the hypothesized link between social transitioning and the cognitive representation of the self, influence the future rates of persistence. Future prospective follow-up studies on children with GD, where cognitive markers and specific indicators of social transitioning are incorporated, may shed more light on this question. Until there is more knowledge about this mechanism, and because the clinical management of children with GD in general should not be aimed to block gender-variant behaviors,[21] the proposed approach regarding social transitioning in the Standards of Care of the World Professional Association for Transgender Health (WPATH) seems to be best fitting:

> Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices …[22]

In conclusion, factors associated with persistence appear to vary among natal boys and girls. These factors may be indicated by intensity of GD, and may seem to be clinically significant at different ages for boys and girls, but are not associated with psychological health or demographic background factors. In addition, the ways in which GD is managed in the family may be associated with individuals' cognitive representation of their own gender. Finally, clinical recommendations for the support of children with GD may need to be developed independently for natal boys and for girls, as the presentation of boys and girls with GD is different, and different factors are predictive of the persistence of GD. &

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## REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR. 4th edition, text revision. Washington, DC: American Psychiatric Association; 2000.
2. Steensma TD, Biemond R, de Boer F, Cohen-Kettenis PT. Desisting and persisting gender dysphoria after childhood: a qualitative follow-up study. Clin Child Psychol Psychiatry. 2011;16:499-516.
3. Wallien MSC, Cohen-Kettenis PT. Psychosexual outcome of gender-dysphoric children. J Am Acad Child Adolesc Psychiatry. 2008;47:1413-1423.
4. Drummond KD, Bradley SJ, Peterson-Badali M, Zucker KJ. A follow-up study of girls with gender identity disorder. Dev Psychol. 2008;44:34-45.
5. Singh D. A follow-up study of boys with gender identity disorder. Doctoral dissertation, University of Toronto; 2012.

6. Ross MW. Retrospective distortion in homosexual research. Arch Sex Behav. 1980;9:523-531.
7. de Vries AL, Cohen-Kettenis PT. Clinical management of gender dysphoria in children and adolescents: the Dutch approach. J Homosex. 2012;59:301-320.
8. Wechsler, D. Wechsler Intelligence Scale for Children: Manual (3rd ed.). (Dutch translation by Kort W, Schittekatte M, Dekker PH, Verhaeghe P, Compaan EL lic. Bosmans M lic. Vermeir G.); 2005.
9. Wallien MSC, Quilty LC, Steensma TD, *et al*. Cross-national replication of the Gender Identity Interview for Children. J Pers Assess. 2009;91:545-552.
10. Cohen-Kettenis PT, Wallien MSC, Johnson LL, Owen-Anderson AFH, Bradley SJ, Zucker KJ. A parent-report Gender Identity Questionnaire for children: a cross-national, cross-clinic comparative analysis. Clin Child Psychol Psychiatry. 2006;11: 397-405.
11. Verhulst FC, van der Ende J, Koot HM. Handleiding voor de CBCL/4-18 [Manual for the CBCL/4-18]. Erasmus University, Department of Child and Adolescent Psychiatry, Rotterdam, the Netherlands: Sophia Children's Hospital; 1996.
12. Verhulst FC, van der Ende J, Koot HM. Handleiding voor de teacher's report form (TRF) [Manual for the Teacher's Report Form]. Erasmus University, Department of Child and Adolescent Psychiatry. Rotterdam, the Netherlands: Sophia Children's Hospital; 1997.
13. Cohen-Kettenis PT, Owen A, Kaijser VG, Bradley SJ, Zucker KJ. Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: a cross-national, cross-clinic comparative analysis. J Abnorm Child Psychol. 2003;31:41-53.
14. Zucker KJ, Bradley SJ, Sanikhani M. Sex differences in referral rates of children with gender identity disorder: some hypotheses. J Abnorm Child Psychol. 1997;25:217-227.
15. Deogracias JJ, Johnson LL, Meyer-Bahlburg HFL, Kessler SJ, Schober JM, Zucker KJ. The Gender Identity / Gender Dysphoria Questionnaire for Adolescents and Adults. J Sex Res. 2007;44: 370-379.
16. Singh D, Deogracias JJ, Johnsons LL, *et al*. The Gender Identity/ Gender Dysphoria Questionnaire for Adolescents and Adults: further validity evidence. J Sex Res. 2010;47:49-58.
17. Doorn CD, Kuiper AJ, Verschoor AM, Cohen-Kettenis PT. Het verloop van de geslachtsaanpassing: een 5-jarige prospectieve studie [The course of sex reassignment: a 5 year prospective study]. Rapport voor de Nederlandse Ziekenfondsraad [Report for the Dutch National Health Council]; 1996.
18. Lindgren TW, Pauly IB. A body image scale for evaluating transsexuals. Arch Sex Behav. 1975;4:639-656.
19. Kinsey AC, Pomeroy WB, Martin CE. Sexual behavior in the human male. Philadelphia: WB Saunders; 1948.
20. Steensma TD, Cohen-Kettenis PT. Gender transitioning before puberty. Arch Sex Behav. 2011;40:649-650.
21. Adelson SL. Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. J Am Acad Child Adolesc Psychiatry. 2012;51:957-974.
22. Coleman E, Bockting W, Botzer M, *et al*. Standards of care for the health of transsexual, transgender and gender non-conforming people, version 7. Int J Transgender. 2012;13:165-232.

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# What's Missing From the Conversation About Transgender Kids

By Jesse Singal

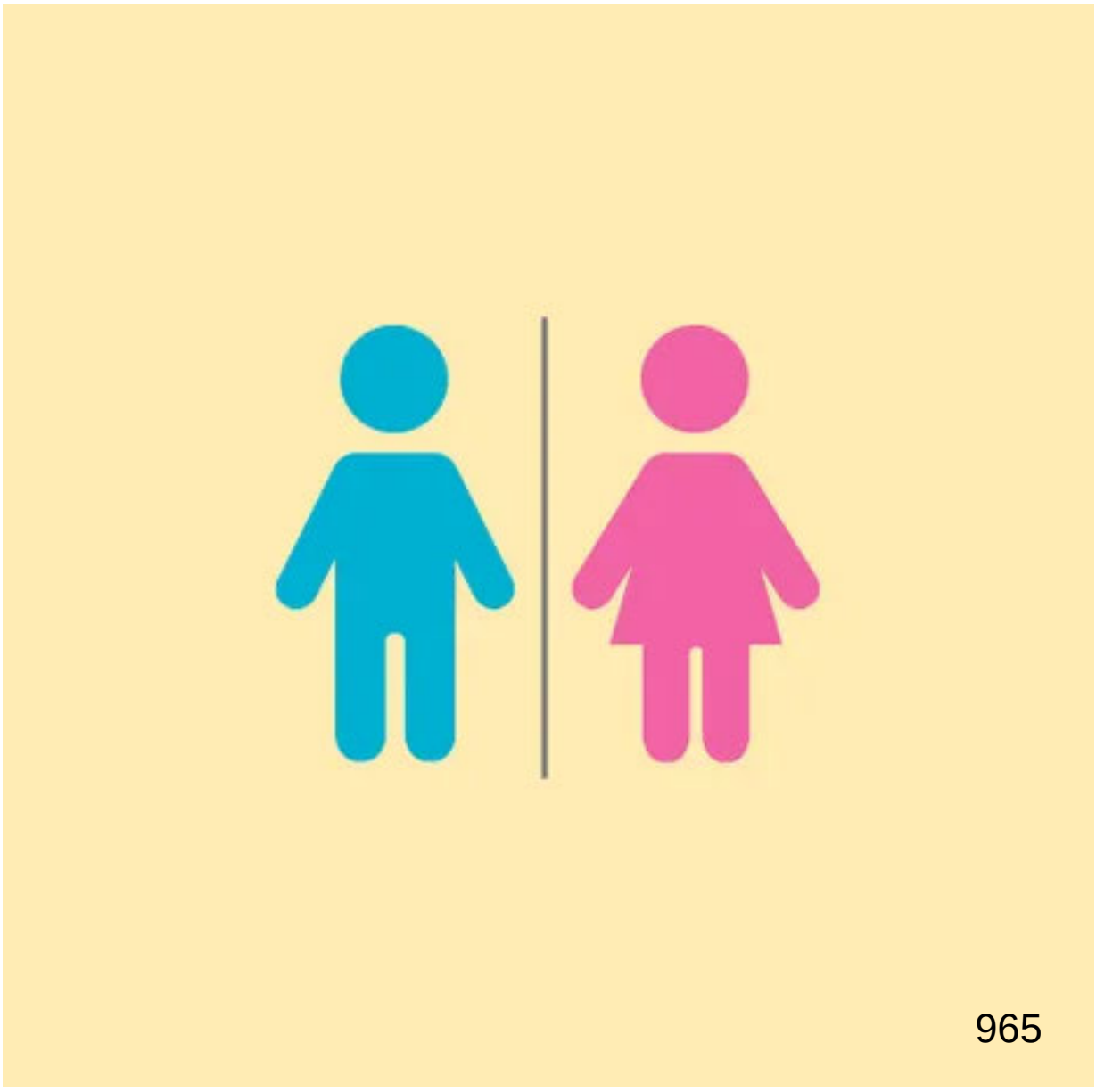


Photo: Yukipon

As anyone who has read much about the subject can attest, the discussion about kids with gender dysphoria — that is, discomfort with their body and the feeling that they should have been born the other sex, or that they *are* the other sex — can get extremely heated and tricky. Much of the controversy stems from questions of age: How young is too young to help a child socially transition — that is, to change their name and pronoun, and possibly the way they present themselves? To prescribe them cross-sex hormones to begin the process of physically transitioning?

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For children with persistent gender dysphoria who are approaching adolescence, current best practice is to prescribe them so-called puberty blockers. Delaying the onset of puberty both forestalls the sometimes very uncomfortable experience of a child going through puberty in a body they aren't comfortable in, and buys them and their families time to figure out what to do. Sometimes, this eventually leads to the prescription of cross-sex hormones, and sometimes it leads to surgery after that.

Some people, though, are arguing that kids — particularly those who have socially transitioned at a young age — shouldn't have to wait that long. Recently in the *Guardian*, for example, Kate Lyons reported on the current state of this debate in Britain: specifically, whether children who identify as transgender should be given access to cross-sex hormones, or possibly even surgery, at younger ages than what is current practice.

"He had been on puberty blockers since the age of 9," Helen Webberly, a general practitioner, told Lyons, discussing a 12-year-old patient to whom she prescribed cross-sex hormones. "He would have to now wait until 16 to get testosterone. This child has always been a boy, never worn a dress, always played with boys. He was so ready, his mates are starting puberty and he's desperate to start puberty. I felt and the mother felt and the child felt it was the right time, so that child's now on cross-sex hormones." As the article explains, Britain's National Health Service does have guidelines stating that cross-sex hormones shouldn't be prescribed until age 16, but these guidelines only apply to public clinics — doctors in private practice, like Webberly, have a fair amount of leeway to take the approach they feel is best for their patients.

One doctor quoted near the top of the piece had some qualms with the idea of prescribing cross-sex hormones at a young age, though:

> Dr James Barrett, a consultant psychiatrist at the Charing Cross clinic, the oldest gender identity service in the UK, said he had concerns about treating children with cross-sex hormones.
>
> "If you wait until puberty has got a little way along, a fair proportion of the children change the clinical presentation and feel more like straightforward lesbian and gay kids," said Barrett. "They don't seek social role change any more and will end up with no need for lifelong medical intervention, surgery and with no loss of natural fertility should they want children."

Here Barrett is referring to the so-called desistance literature, and another doctor sounds a similar note toward the bottom of the article. "Desistance," in this context, means the tendency for gender dysphoria to resolve itself as a child gets older and older. All else being equal, this research suggests

that the most likely outcome for a child with gender dysphoria is that they will grow up to be cisgender and gay or bisexual. Researchers don't know why that is, but it appears that in some kids, nascent homo- or bisexuality manifests itself as gender dysphoria. In others, gender dysphoria can arise as a result of some sort of trauma or other unresolved psychological issue, and goes away either with time or counseling. And in still others, of course, it *is* a sign that the child will identify as transgender for their whole adult life. While the actual percentages vary from study to study, overall, it appears that about 80 percent of kids with gender dysphoria end up feeling okay, in the long run, with the bodies they were born into.

Desistance doesn't even come up by name in the *Guardian* article, but it's an absolutely vital concept. Anyone thinking or writing about trans kids, in fact, should be familiar with exactly what this body of research does and doesn't say, and how it applies to the early, evolving science of helping kids with gender dysphoria feel better.

Part of problem is that some people don't accept the desistance findings at all — they argue that the studies demonstrating high levels of desistance in gender-dysphoric kids are fatally flawed, and further that the very concept of desistance itself is really just a pretense for allowing bigots to deny the reality of trans people's identities. This is understandable, in light of the very real discrimination trans people face every day and past misdeeds committed by the mental-health Establishment, but it's also unfortunate: We can't have an intelligent, informed discussion about these tricky issues if we're going to ignore what is, at the moment, a solid scientific consensus.

So what does that consensus say, exactly? According to a very helpful January blog post from James Cantor, a sex researcher at the Centre for Addiction and Mental Health, or CAMH, in Toronto, there have been 11 studies, going back to 1972, examining the question of how often kids with gender dysphoria end up identifying as transgender in the long run. Given how far back these studies stretch, and how small several of them are, I'm going to focus on the two most recent studies, which together have a larger sample size than the rest of the literature combined. One, "Factors Associated With Desistance and Persistence of Childhood Gender Dysphoria: A Quantitative Follow-Up Study," was lead-authored by the gender-dysphoria specialist Thomas Steensma and published in 2013 in the *Journal of the American Academy of Child and Adolescent Psychiatry*. The other one, the clinical psychologist Devita Singh's 2012 dissertation, is unpublished, but you can read it in PDF form here .

Both studies sought, among other things, to track down a bunch of people who were patients at gender-dysphoria clinics as children and/or adolescents to see whether they ended up identifying as trans in the long run. Steensma is affiliated with the Center of Expertise on Gender Dysphoria at VU University Medical Center, a famous gender clinic in Amsterdam that has pioneered progressive treatments for gender dysphoria, including the use of puberty blockers (the so-called "Dutch Protocol"), and he and his colleagues drew their sample from there, while Singh drew her sample from the Gender Identity Clinic at CAMH, where she did her dissertation research. (As Science of Us reported in February, the GIC was shuttered late last year and its director, the sex researcher and gender-dysphoria specialist Kenneth Zucker, fired, largely a result of false accusations leveled against him, after a lengthy campaign from a segment of LGBT activists who accused him — wrongly, in light of the available evidence — of harming his clients by practicing "conversion therapy" on them.)

The Amsterdam study reported on 127 adolescents, 79 of them boys, and found that 80 of those adolescents, or about two-thirds, had desisted — that is, now identified as cisgender — at the time of followup. Singh, meanwhile, found that of the 139 former GIC patients she got in touch with, all of them natal males (that is, born with a penis), 122, or 88 percent, had desisted.

And when you combine these two studies with the other, admittedly earlier and smaller ones Cantor lists, all of which find the same thing, the case grows even stronger. While the numbers vary from study to study, as you would expect to between research conducted at different times in different places, the basic storyline is *always* the same: If a kid has gender dysphoria, the most likely outcome is that he or she will grow up to be a cisgender, gay or bisexual adult.

If you accept the studies, that is. A lot of people don't, and their critiques deserve to be heard. So let's go through a couple of the most prominent ones.

Perhaps the meatiest criticism of these studies is the claim that they didn't *really* examine kids who had gender dysphoria. Rather, some critics argue, the studies lumped in a bunch of kids who were merely gender non*conforming*: girly boys and tomboyish girls who exhibited some behaviors stereotypically associated with the other sex, but who weren't truly dysphoric in the sense of feeling unease with their body, stating a desire to be the other sex or an insistence that they are the other sex, or some combination of the above.

To see why this would matter, imagine I have a rather old-fashioned view of gender relations, and I see a little boy with long hair. "A boy with long hair? No way!" I say to myself, knowingly. "This kid must have gender dysphoria." If I checked back in ten or 20 years, found that that kid identified as cisgender, and declared that *Whoa, I guess he desisted*, that would clearly be false: He never really had gender dysphoria in the first place.

This claim has been made many times about Zucker's clinic — that he and his colleagues were "treating" kids not for gender dysphoria, but for gender nonconformity (think Robin Williams trying to teach Nathan Lane to walk like John Wayne in *The Birdcage*). Two smart trans writers and advocates, Brynn Tannehill and Julia Serano, have made this argument. In her Huffington Post article "The End of the Desistance Myth," until recently (I'll explain in a moment) Tannehill claimed that "when investigators reviewed the files of children admitted to CAHM, 72 percent of them never met the clinical criteria for juvenile gender dysphoria in the first place ... 90 percent of the kids Dr. Zucker claimed to 'cure' were never transgender in the first place."

And when I emailed Serano for the Zucker story, she made the same argument (as an aside, you should read her Daily Beast article about navigating the dating scene as a trans woman in San Francisco). I didn't end up quoting from Serano's response, but she posted it online afterward, and it reads, in part: "These children [at Zucker's clinic] are not necessarily brought in for "gender dysphoria" but for gender non-conformity. I've already conceded (as most trans activists & advocates would), many of these gender non-conforming kids will not grow up to be cross-gender-identified."

If Tannehill, Serano, and other critics of the desistance literature like Kristina Olson and Lily Durwood in Slate are correct and the kids at the GIC and the Amsterdam clinic were really just gender nonconforming — if they were little boys who liked to do ballet and play with dolls, for example, but didn't otherwise express any discomfort with being boys — then these critics would be right to suspect that the desistance literature is misleading. It would be garbage-in, garbage-out thing: If you aren't studying kids who really had gender dysphoria in the first place, your followup data about them isn't going to tell you much.

But is that really what was happening? At the time of Singh's dissertation and her subjects' treatment at the GIC, gender dysphoria was captured by the *DSM-IV* entry for what was then called "gender identity disorder," which has since been renamed, in the *DSM-5*, to the less pathologizing "gender dysphoria." Singh notes that of the 139 participants she successfully contacted for followup, "88 (63.3%) met diagnostic criteria for GID in childhood and the remaining 51 (36.7%) were subthreshold for the diagnosis," which is close to the 70 percent figure Zucker and his colleagues have

noted when describing the GID's patient population overall. (I Twitter DMed Tannehill to ask where she got her "72 percent" and "90 percent" numbers from. She said she was extrapolating from a set of 12 random patient charts examined during the investigation of Zucker's clinic. But there's no need to extrapolate like this, since we have the actual percentages for both Singh's study and the broader patient population. Tannehill has since removed those figures from her article.)

In a short appendix starting on page 275, Singh helpfully includes the diagnostic criteria for this condition from the *DSM-IV*. It's long, but worth reading in full:

> A. A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex. AA In children, the disturbance is manifested by four (or more) of the following:
>
> 1. Repeatedly stated desire to be, or insistence that he or she is, the other sex.
>
> 2. In boys, preference for cross-dressing or simulating female attire; in girls, insistence on wearing only stereotypical masculine clothing.
>
> 3. Strong and persistent preferences for cross-sex roles in make-believe play or persistent fantasies of being the other sex.
>
> 4. Intense desire to participate in the stereotypical games and pastimes of the other sex.
>
> 5. Strong preference for playmates of the other sex.
>
> In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.
>
> B. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
>
> In children, the disturbance is manifested by any of the following: In boys: assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and-tumble play and rejection of male stereotypical toys, games, and activities.
>
> In girls: rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate or marked aversion toward normative female clothing.
>
> In adolescents and adults, the disturbance is manifested by symptoms such as preoccupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.
>
> C. The disturbance is not concurrent with a physical intersex condition.
>
> D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Some of the items listed above, of course, aren't, *on their own*, a sign of gender dysphoria. If a little boy likes playing with little girls, that alone offers zero evidence he's gender dysphoric. But the overall criteria are much more stringent than that, and include as a requirement "clinically significant distress or impairment in social, occupational, or other important areas of functioning." It's hard to imagine a kid meeting *all* the necessary criteria in the *DSM-IV* and not "actually" being gender dysphoric, if the term is going to mean anything.

Since 63 percent of the subjects in Singh's study met these criteria, this really wasn't a sample of children who were "just" gender nonconforming. Plus, as Singh points out in her dissertation, there wasn't even a statistically significant difference in the desistance rates between those who did and didn't meet the criteria — subthreshold kids were *just as likely* to eventually identify as trans. In the Steensma study, meanwhile, about 70 percent of the patients got a GID diagnosis as kids. (In that sample, a GID diagnosis *did* predict persistence to a certain extent — an interesting, unexplained difference between the two sets of findings that may come down to cultural differences between the two countries and/or other factors.) Overall, however you slice it, both studies really did look at children who had legitimate gender dysphoria.

Tannehill also levels an important critique against the Steensma study in her HuffPo article: that the ~~80~~ 24 subjects in that study who were lost to followup were counted by the researchers as having desisted from their gender dysphoria, despite the fact that the researchers couldn't actually check because they were, well, lost to followup. She claims this artificially inflated the study's reported desistance rate.

But the researchers explain exactly why they did this: "As the Amsterdam clinic is the only gender identity service in the Netherlands where psychological and medical treatment is offered to adolescents with GD, we assumed that for the 80 adolescents (56 boys and 24 girls), who did not return to the clinic, that their GD had desisted, and that they no longer had a desire for gender reassignment." This isn't a bulletproof assumption, of course — maybe some of those patients moved to another country, or something — but every research article involves approximations, and it would be hard to come up with a storyline in which this group had enough persisters in it to nudge the overall numbers all that much. (**Update**: The truth here is actually a bit more complicated. The researchers *were* able to get in touch with 56 of the 80 kids who stopped coming to the clinic, or their parents, and obtain enough information to determine whether they were still gender dysphoric. Either zero or one of them qualified as gender dysphoric at followup, depending on the scale used. I've posted an in-the-weeds explanation here, but the key takeaway is that it's accurate to say that *24* lost-to-followup kids were assumed to no longer have dysphoria without the researchers knowing for sure, *not* 80 as Serano and I initially reported — this research is stronger than I initially presented it to be. This was my mistake for not reading the study more carefully.)

Again: Every study that has been conducted on this has found the same thing. At the moment there is strong evidence that even many children with rather severe gender dysphoria will, in the long run, shed it and come to feel comfortable with the bodies they were born with. The critiques of the desistance literature presented by Tannehill, Serano, Olson and Durwood, and others don't come close to debunking what is a small but rather solid, strikingly consistent body of research.

That said, it's completely understandable *why* the concept of desistance makes some trans people as well as some of their allies uncomfortable. A huge part of the challenge of being transgender, after all, is having your identity — your very sense of self — endlessly, exhaustingly critiqued, invalidated, and disregarded by people who couldn't possibly understand where you're coming from. In addition to the well-established threats they face in the form of physical violence and legislation aimed at ostracizing them, trans people are constantly dealing with the *psychological* threat of being told that they aren't really what they say they are, that they're just crazy or broken or delusional.

So when they and their allies encounter claims that many gender-dysphoric kids aren't *really* trans, or won't be in the long run, they hear in those claims some loud and uncomfortable echoes. And the fact that these claims often come from the psychiatric Establishment, which does not have a good track record when it comes to treatment of sexual minorities, only exacerbates matters: Why should trans people trust institutions that have treated them so poorly over the years?

There aren't really any good answer to these questions — how can you begrudge anyone whose very identity is at stake their suspicion or their unease? All we can do is look at and closely critique the most recent studies that have been done on this subject. And those studies continue to find what has always been found: There is something about the complexities of kids' identity formation — both their gender identity and their nascent sexuality — that makes this stuff really, really complicated. If a kid is gender dysphoric, it may or may not mean that they will grow up to be trans. To say so isn't to indict trans people, and anyone who uses the desistance data as a cudgel against them is missing the point entirely: Adolescents and kids are *different* from adults in vital ways. We recognize this in every other conversation about human behavior, and we should recognize it here.

It's worth pointing out that the desistance percentages may change over time. As I noted in my GIC article, more and more clinicians are embracing what is known as the "gender-affirming" approach. In this model, if young children's claims about their gender identity are "insistent, persistent, and consistent," these claims are taken as face-value evidence that the child is actually trans, and should be socially transitioned with little delay. Zucker and his colleagues' view was that since, in their theoretical model at least, gender is partly a matter of behavior and identity being learned and reinforced over time, socially transitioning a young kid is likely to reinforce their dysphoria. "I have predicted that we would see rates of persistence increasing overtime as more children engage in social transitioning in childhood," Singh told me in an email. In other words, if kids who begin socially transitioning shortly after their first appointment at a gender-affirming clinic are more likely to persist and come to permanently identify as trans, and more and more gender-dysphoric kids find their ways into these clinics, the overall desistance rate may well drop over time.

In the long run, we'll be better at this stuff — we'll be better at understanding how to best help gender-dysphoric kids grow up to be confident, happy adults, whether they end up trans or cis, gay or straight or bi. The Steensma and Singh studies, for example, both provide early evidence that the severity of a child's gender dysphoria predicts the likelihood they'll identify as trans in the long run. But it's a probability thing — it can simultaneously be true that severe dysphoria makes it more likely that a kid will end up identifying as trans, but also that many kids who are very dysphoric *do* desist in the long run. "Some of the children who desisted were just as extreme [in their gender dysphoria] as some of the children who persisted," Singh said, referring to her dissertation.

But cycling back to the questions raised in the *Guardian* article and in this discussion overall — when should kids be put on hormones? How young is too young for surgery? — given the scientific uncertainty at the moment, it's vital children be asked thoughtful, respectful questions about why they feel the way they do, that clinicians understand that gender dysphoria can mean any number of different things. "What's happening is our society is moving faster than the evidence base," one expert told Lyons, and it's a sentiment worth keeping in mind.

Childhood gender dysphoria, in short, is complicated and deserves a nuanced public conversation. The increasingly popular belief that gender dysphoria *must* mean a child will identify as trans in the long run has the opposite effect: It renders a complicated subject simple; it makes it harder to ask the questions that need to be asked. That doesn't help anyone.



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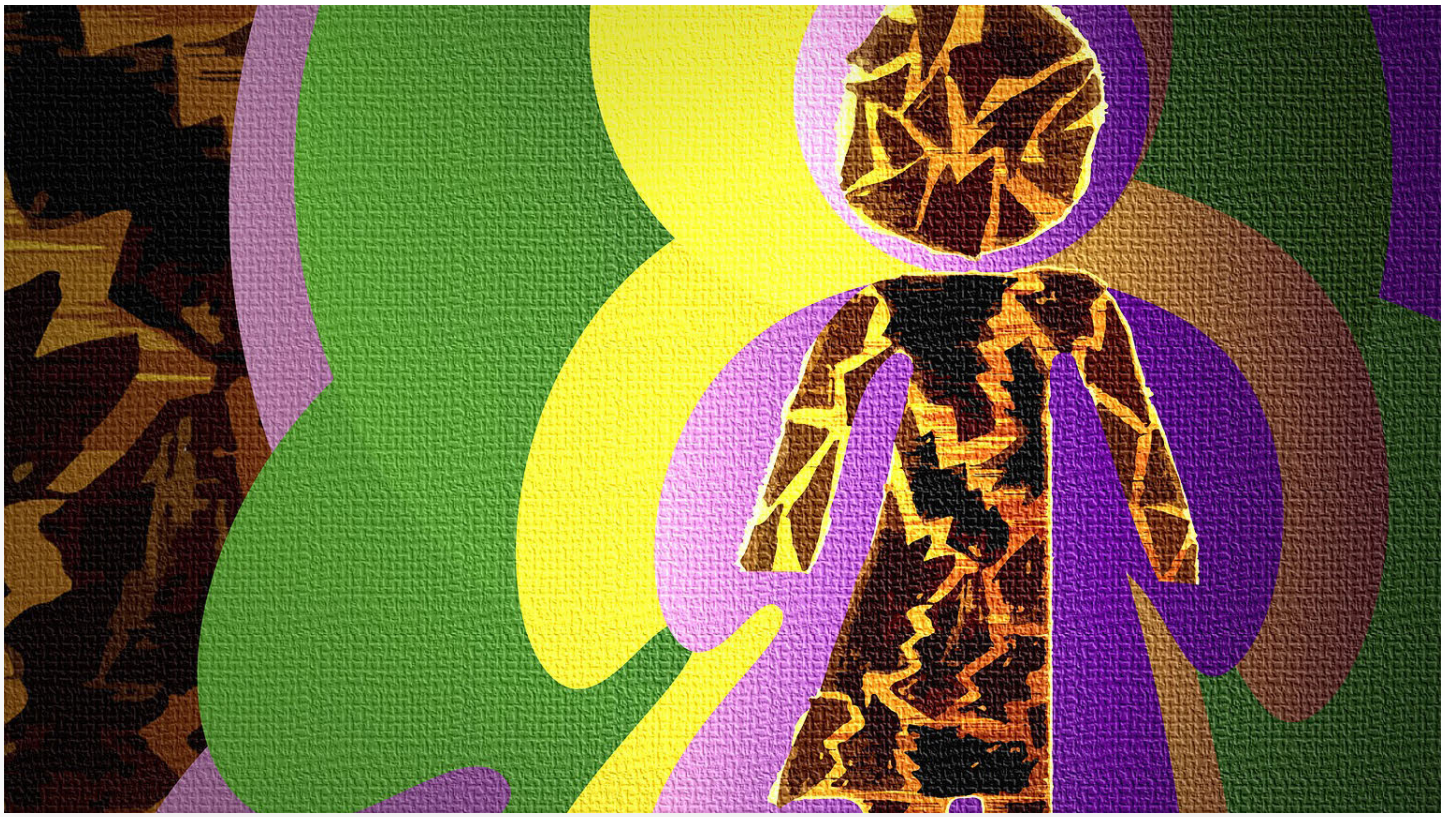



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Quillette





# The Unspoken Homophobia Propelling the Transgender Movement in Children

Debra Soh
23 Oct 2018 • 5 min read

When I was a Ph.D. student in sexology, I had a conversation with a colleague that forever cemented, in my mind, why I needed to speak out against the transitioning of children with gender dysphoria. Nowadays, every left-leaning parent and educator seems content to take a child's word at face value if they say they were [illegible]ng body, not realizing that by doing so, an important conversation is being

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On the day in question, our research lab had just finished our weekly meeting, and I chatted with my colleague as I packed up my things to head back to my office. He had told me previously about his son, who from the moment he was born, announced that a mistake had been made—“I’m a girl,” he would say.

As a little boy, his son loved playing with dolls. He would wear his mother’s dresses and high heels, and wanted to grow his hair long like Princess Jasmine from the movie, “Aladdin.” At school, he preferred the company of girls to that of boys, who were

rambunctious and mean. After many years of therapy and fighting constantly about the course of action they would take, his son had come out as gay.

I grew up as a straight woman in the gay community, at a time when homophobia was rampant in North American society. I witnessed the harassment and ignorance that my friends faced on a daily basis. Most, as a result, hid their sexual orientation from anyone outside of the community, and few were openly out to their families.

Although things have definitely improved since then, discrimination against gay people still exists. And as I’ve watched as glowing stories about transgender children have flooded every progressive news outlet over the last few years, every one of them appalls and saddens me. Because the underlying story that the public isn’t privy to is that many of these children would have grown up to be gay, but are instead undergoing a new form of conversion therapy.

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Conversion therapy seeks to change a person's sexual orientation. No mental health professional in their right mind conducts this type of therapeutic intervention anymore, because it is understood that sexual orientation is immutable from a very young age. Gender identity, however—whether someone feels masculine or feminine—is flexible in prepubescent children and grows more stable into adulthood.

Therapy that seeks to help gender dysphoric children grow comfortable in their birth sex (known in the research literature as the "therapeutic approach") has been conflated with conversion therapy, but this is inaccurate. All of the available research following gender dysphoric children longitudinally shows that the majority desist; they outgrow their feelings of dysphoria by puberty and grow up to be gay in adulthood, not transgender.

Children will say they "are" the opposite sex because that's the only language they have to express to adults that they want to do things the opposite sex does. Cross-sex behavior has also been shown to be a strong predictor of homosexuality in men. Previous research tells us that even children who are severe in their feelings of dysphoria will desist.

Another phenomenon that points to homophobia as a possible motivation for transitioning is that of rapid-onset gender dysphoria (ROGD), wherein adolescent and college-aged girls suddenly declare to their parents that they want to transition, without any previous signs of being distressed about their birth sex. This desire to transition usually manifests during or after puberty, yet these girls don't meet any of the diagnostic criteria for gender dysphoria.

A study published last month on ROGD—one that gained widespread media attention for infuriating transgender activists—found that a large proportion of these girls had come out as lesbian or bisexual prior to coming out as transgender.

Why would this be the case? Along with the physical and emotional disc[illegible] typical of undergoing puberty, it has become more socially acceptable [illegible] transgender man than a gay woman. The study's findings also showed that transitioning increased students' popularity among their peers and offered greater protection from

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increased students' popularity among their peers and offered greater protection from harassment, because teachers were more concerned about anti-trans bullying than bullying that was anti-gay.

As children grow up, parents will undoubtedly notice if their son is effeminate. For those who are troubled at the thought of having a girly son, transitioning offers a promising solution—by allowing a child to transition, a feminine boy now presents as a feminine girl. A little boy who enjoys indulging in make-up and other female-typical activities will bring about much less attention and criticism if he were a girl.

This same logic extends to a child's future sexual orientation. On some level, these parents likely know that there is a chance their feminine son will grow up to be sexually attracted to men. Instead of allowing this to happen, they may be more than happy to go along with facilitating their child's requests to transition to the opposite sex, so that to the outside world, that child will appear heterosexual—an adolescent boy who is attracted to other boys will appear to be straight if he transitions to female. What's most disturbing is that these parents will be lauded as open-minded and "on the right side of history," when in actuality, they are homophobic. In some cases, a child may internalize their families' anti-gay sentiments, which adds to their desire to transition.

Saying any of these things aloud will get a person branded as transphobic, and I understand why some transgender activists and their allies find this information so threatening; it could potentially be used as evidence that transgender people don't really exist, or they should be forced to not feel the way that they do. One meta-analysis of 28 studies showed that transitioning can indeed be beneficial for some adults, but in the event that a child can grow to be comfortable in the body they were given, it shouldn't be controversial to contend that this would be a better outcome than a lifetime of hormones and possible surgery and sterility.

Since I began writing about this issue several years ago, many of my friends have told me how relieved they were to not have grown up in today's political climate. As children, they similarly voiced unhappiness about their bodies and felt that they identified with the opposite sex, but eventually grew up to feel comfortable living as gay men. They fear they would have decided to transition, because transitioning is now considered a viable, and almost commonplace, way to resolve this.

Transgender activism has successfully piggybacked onto the hard-won victories of the gay rights movement. The public understands that attitudes towards ga[illegible] once abhorrent, and they also understand that many interventions aimed [illegible] gay people were unethical. Most empathic people have consequently been persuaded

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that being transgender is the same, in this regard, as being gay—that it is something that shouldn't be questioned and should always be affirmed.

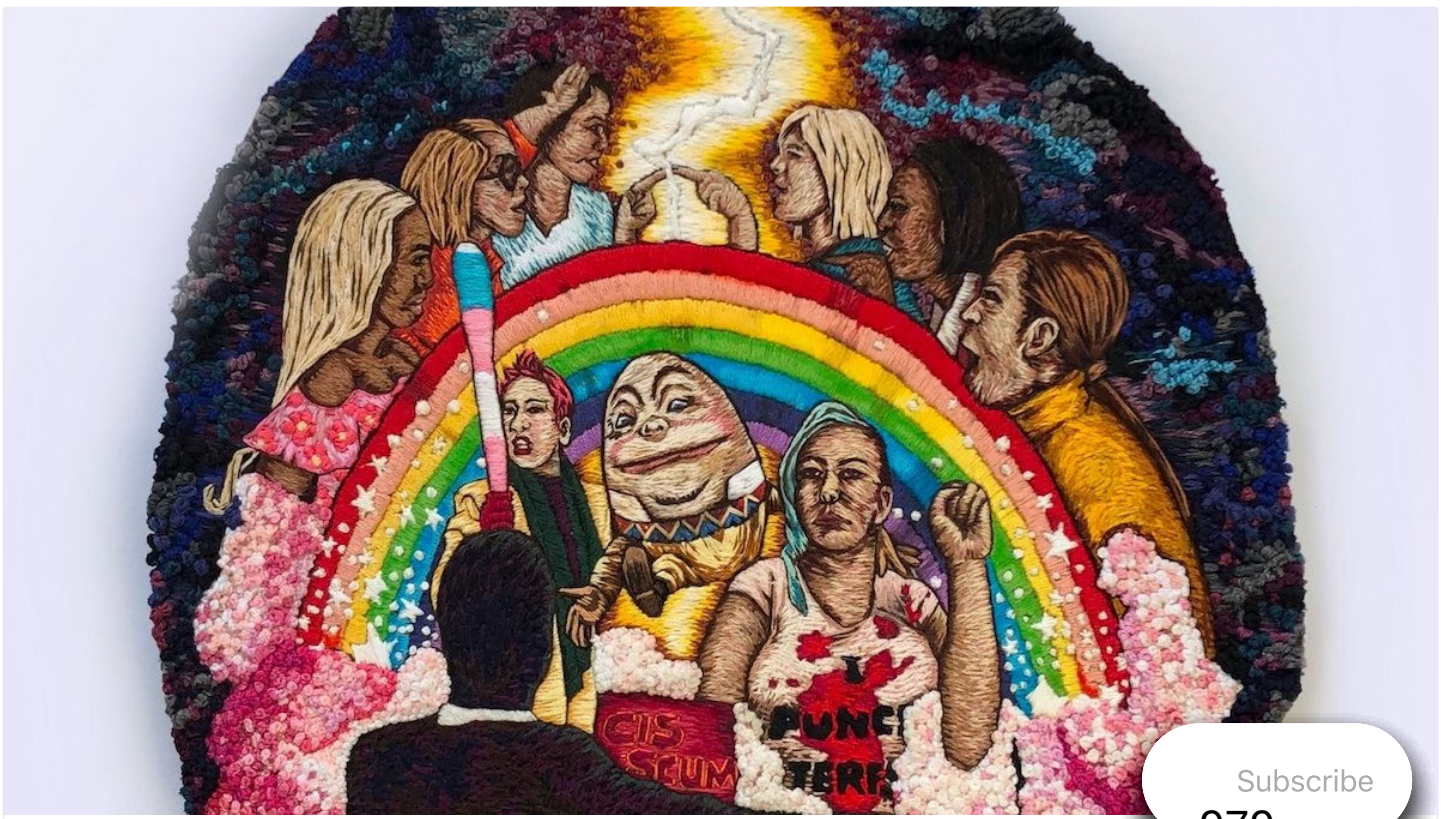
Yet of children who exhibit signs of gender dysphoria, we aren't yet able to tell who will fall into the category of those who will desist (which is the majority) as opposed to the minority who persist and who would actually benefit from transitioning. In determining the answer, we must be resolute in following the scientific evidence, and not forget that gay people deserve love and acceptance, too.

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**Debra Soh**

Debra W. Soh holds a Ph.D. in sexual neuroscience research from York University and writes about the science and politics of sex. Follow her at @DrDebraSoh.


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## When Sons Become Daughters: It's Time to Admit That Reflexive 'Affirmation' Has Been a Mistake

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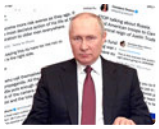
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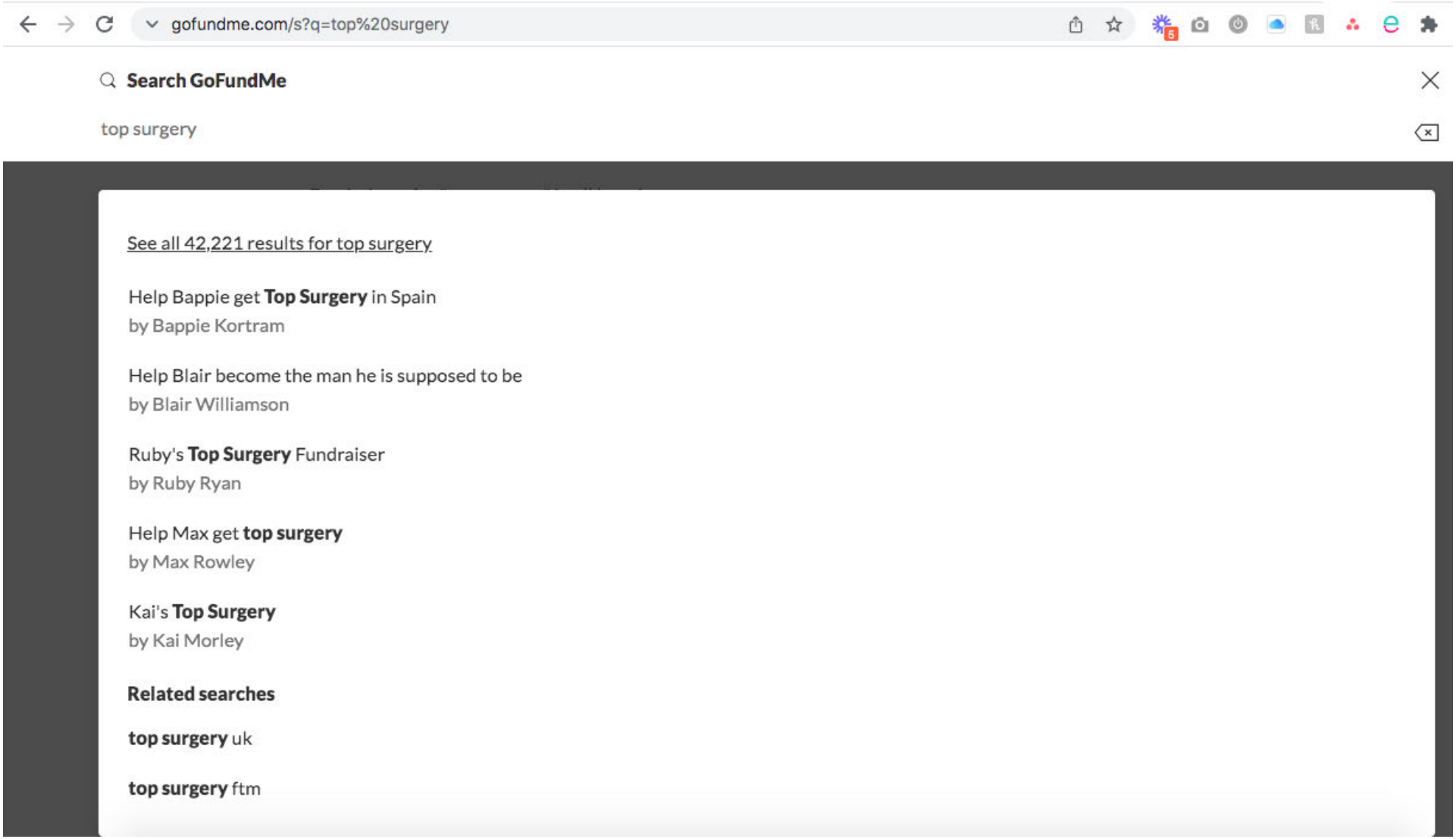
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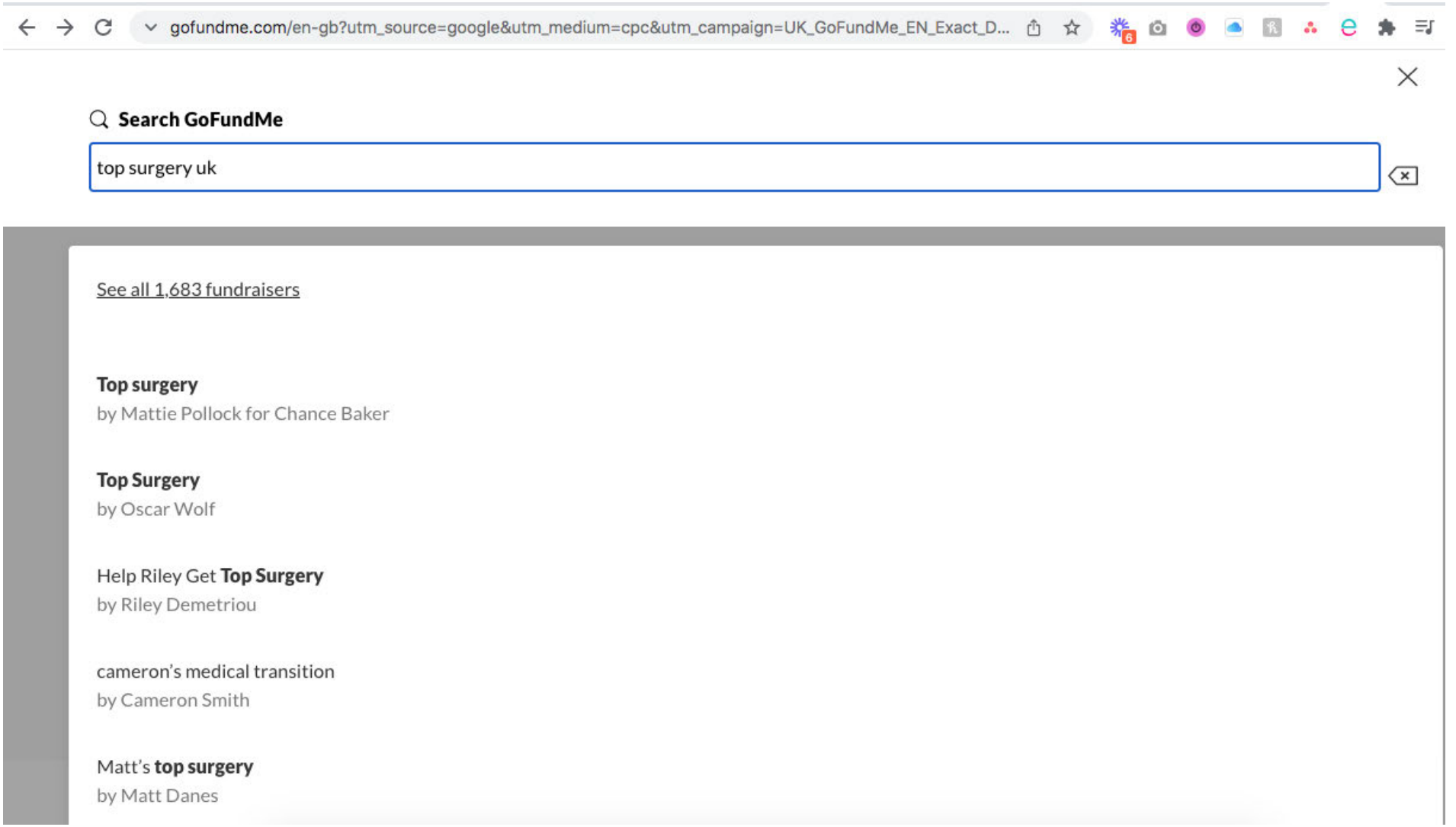
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**LGB Alliance response to**

**DCMS Influencer Consultation**

**Fri 7th May 2021**

*DCMS Committee is inviting written submissions addressing the following areas:*

1. *How would you define 'influencers' and 'influencer culture'? Is this a new phenomenon?*
2. *Has 'influencing' impacted popular culture? If so, how has society and/or culture changed because of this side of social media?*
3. *Is it right that influencers are predominantly associated with advertising and consumerism, and if not, what other roles do influencers play online?*
4. *How are tech companies encouraging or disrupting the activities of influencing?*
5. *How aware are users of the arrangements between influencers and advertisers? Should policymakers, tech companies and influencers and advertisers themselves do more to ensure these arrangements are transparent?*

**INTRODUCTION**

**LGB Alliance submission to the DCMS Committee inquiry on Influencer Culture**

https://lgballiance.org.uk/

This submission is made on behalf of LGB Alliance. We welcome the opportunity to respond to the Committee's inquiry into influencer culture and hope this submission is of interest. If you have any questions regarding our response, please contact kate.harris@lgballiance.org.uk

LGB Alliance is a group that represents the interests of a rapidly growing number of lesbian, gay and bisexual people. We represent thousands of LGB people who have grave concerns about the loss of our rights, specifically in relation to moves to replace, in law and elsewhere, the category of 'sex' with 'gender identity', 'gender expression' or 'sex characteristics'.

We are long-time gay and lesbian activists who fought for the rights of people with a same-sex sexual orientation. These hard-won rights are now under serious threat.

**Why we are interested in this inquiry**

We have serious concerns about the role that influencers in the media, especially social media, are playing in promoting a culture based on certain beliefs. These beliefs, which are linked to queer theory, teach that everyone has a 'gender identity', separate from their biological sex, and that this 'gender identity' should take priority over biological sex in all areas of life, including health provisions, prisons, sport and – the area of primary concern to LGB Alliance – sexual orientation. These beliefs are being promoted to children and young people as if they were facts instead of beliefs. We believe this is causing grave harm.

**Is 'influencer culture' a new phenomenon?**

Certainly not. It has always been the case that certain groups in society congregate around certain newspapers, tv or radio channels etc. Indeed, it could be said that 'influencer culture' dates back to opinion writers such as Addison and Steele publishing their views (and promoting coffee houses) in

the *Spectator* in the early 18th century. However, the rise and growing dominance of social media have transformed this culture in three essential ways:

1. **Quantitatively**. The sheer number of media outlets means that people can choose from a vast repertoire of opinions. They can choose a single influencer, or group of influencers, with a particular point of view on YouTube, Tumblr, TikTok or Facebook, and ignore virtually all others.
2. **Accuracy**. Most influencers are not subject to fact checking. Conspiracy theories and unsubstantiated opinions spread like wildfire without any authoritative control mechanism to curb them.
3. **Youth**. Since young people who have grown up in the internet age tend to be more tech-savvy than older generations, they have taken control of social media. This has led to a troubling reversal, in which older generations are expected to defer to the young. Refusing to do so leads to abuse, threats, boycotts, and in some cases loss of work or livelihood.

**We will now list some of the changes in contemporary culture that are specifically relevant to LGB Alliance and that we believe can be attributed to a large extent to the spread of gender identity theory by hugely popular influencers: celebrities, once trusted human rights organisations that are now advocates for a specific world view, and young vloggers such as those on YouTube.**

- Many teens who are attracted to people of the same sex, especially those on the autism spectrum and/or with a range of other problems, are gravitating to influencers who persuade them that their distress is attributable to a single factor: gender. They develop gender dysphoria and are referred to youth gender identity services, where only their gender dysphoria is addressed and none of their other issues. Youth gender identity services have seen a huge increase in referrals, especially among girls, in the last 8-9 years. This is of special concern to LGB Alliance since research shows that most of these girls are lesbians.[1]
- No research has been conducted to explore the causes for this sudden and rapid growth in referrals. There is a complete absence of data. Theories are advanced, however, in film documentaries such as *Dysphoric* by Vaishnavi Sundar.
- Although gender identity theory is spread in multiple ways, including at schools, we hear constantly from detransitioners and others affected that influencers operating on social media platforms are playing a major role. A long catalogue of young YouTube influencers, some of whom have millions of followers, is described in the important book *Irreversible Damage* by Abigail Shrier.

The following paragraphs describe these developments in more detail. Our submission will focus on the emerging scandal of the medicalisation of confused children to illustrate the issues surrounding influencer culture.

**Background**

- Gender dysphoria in children has long been a recognised condition. It has been treated at the Gender Identity Development Services (GIDS) within the Tavistock & Portman NHS Hospital Trust for over 30 years. Historically the number of children has been very small and the majority were male.
- There has been a huge increase in referrals in the last decade – from 77 in 2009/10 to 2,728 in 2019/20. The increase is even starker for girls – from 32 in 2009/10 to 1,981 in 2019/20; a

[1] See https://www.cambridge.org/core/journals/bjpsych-bulletin/article/sex-gender-and-gender-identity-a-reevaluation-of-the-evidence/76A3DC54F3BD91E8D631B93397698B1A

more than 60-fold increase. In 2019/20 girls accounted for over 70% of referrals. No one can explain why this has happened. The subject has not been researched.

- The trend in care for these young people has been away from 'watchful waiting' towards adherence to the 'affirmative model'. This model is presented by the influencers referred to above as the only humane approach. Any other approach is vilified and condemned throughout the 'liberal' media, especially in the US, as vile and 'transphobic'.
- At this point we are obliged to say that leading organisations such as the US bodies WPATH and the Endocrine Society, often quoted as experts, are themselves biased 'influencers'.[2] [3] Their policies are rooted in ideological convictions. It is therefore all the more alarming that their views carry so much weight.
- The affirmative model is not a harm-free pathway
    - The affirmative model means that there is a lack of robust and meticulous psychological assessment.
    - Prior to puberty – in some cases from 9 or 10 years of age – children may be prescribed puberty blockers
    - From age 16, children and young people can be prescribed cross-sex hormones

  The following article gives an overview of the state of current evidence relating to the use of puberty blockers and cross-sex hormones in children: Current Evidence - Transgender Trend.

  In summary, little is known about the long-term side effects or what effects hormone blockers have on the development of the teenage brain or children's bones.

    - Evidence shows that desistance rates are high if left untreated by medical means
    - Puberty blockers and cross-sex hormones represent the start of a pathway of lifetime medicalisation, surgery, sterility and other health risks – clots, cancer, etc.
- We believe that the care of gender dysphoric children must be based on robust medical evidence. At the moment there is no evidence to support the use of the 'affirmative model' adopted by GIDS. Emerging evidence in fact suggests the opposite – that the approach used may be encouraging children towards irreversible medical interventions they may later regret.
- We welcome the recent letter from Hilary Cass to the NHS outlining her interim care plan for children and young people with gender dysphoria https://cass.independent-review.uk/letter-to-nhs-england-may2021/

[2] The criteria for Board Member and Officer Positions of WPATH include the following: 'Members affirm commitment to affirmative care and body autonomy'. 'Affirmative care' means accepting a (young) person's self-diagnosis and proceeding on that basis. This represents a specific position, with which some professionals will disagree, especially in the case of minors. See https://www.wpath.org/media/cms/Documents/Elections/FINAL%20Criteria%20for%20Board%20Member%20and%20Officer%20Positions%20-%20WPATH%20BOD%202020%20Election.pdf?_t=1593103571. https://www.endocrine.org/news-and-advocacy/news-room/2021/endocrine-society-applauds-ama-resolution-supporting-access-to-gender-affirming-care

[3] A recent statement from the Endocrine Society includes the following paragraph: 'After transgender and gender diverse minors start puberty, prescribing hormone blockers to delay puberty is the recommended strategy if desired and if diagnostic and treatment criteria are met. Hormone blockers are commonly prescribed to delay puberty in children who experience early puberty. This treatment, which is reversible, gives adolescents more time to explore their options.' Again, this represents a specific position, including contentious assertions. See https://www.endocrine.org/news-and-advocacy/news-room/2021/endocrine-society-applauds-ama-resolution-supporting-access-to-gender-affirming-care

**The role of influencers**

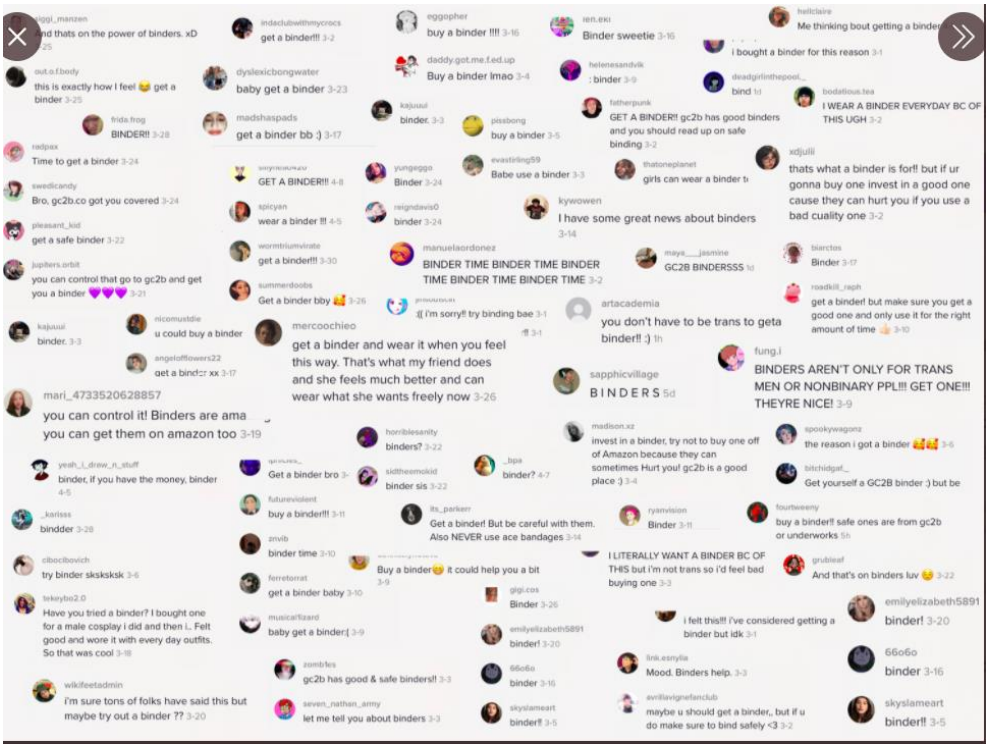
- Prominent campaign organisations and individual high-profile influencers use social media accounts with vast followings to promote the normalisation of gender identity treatment.
- They appear to be driving a cultural shift in which the extreme and harmful medicalisation of children (many of them likely to grow up lesbian and gay if not medicalised) has become accepted and immune to challenge – even immune to the need to provide scientific evidence.
- We often see influencers (including organisations and professional bodies) make statements or suggestions that are demonstrably false:
    - Puberty blockers are wrongly presented as a 'pause button'
    - Puberty blockers are wrongly referred to as 'fully reversible and harmless'
    - It is wrongly (and irresponsibly) claimed that teens with gender dysphoria are more likely to commit suicide if not treated with puberty blockers
    - The huge impact of drugs and surgery is trivialised; it is suggested that these are essential for a child with gender dysphoria to lead a fulfilled life
    - It is wrongly asserted that puberty blockers and surgery improve mental health

***None of these assertions is supported by current medical evidence.***

- **Influencers: a few examples**
    - A celebrity with 1.1 million followers on Twitter recently claimed that puberty blockers had often been used for heavy periods and are not permanent.
    - Celebrities supporting and promoting the transgender organization Mermaids – *Munroe Bergdorf, Amanda Jette Knox, Olly Pike* #DigiFest2020 - Mermaids (mermaidsuk.org.uk)
    - Several young female-to-male YouTubers produce attractive videos that are extremely popular. For example, there is one with 22 million views and 165,000 subscribers, and another with 12 million views and 300,000 subscribers. They hold out the prospect of solving problems by 'transitioning' and joining a warm and welcoming community. Troubled teens grappling with a range of issues may fix on gender as the heart of their problem.

- Examples of gender ideology organisations promoting the use of influencers in their campaigns:
    - Mermaids – a transgender rights organisation campaigning for lowering the age where children may receive puberty suppressing and hormone treatment despite NICE guidelines and lack of evidence of medical benefit. This organisation encourages 'influencers' to champion their cause: https://twitter.com/Mermaids_Gender/status/1284472994916642817?s=20
    - GenderGP – an online overseas practice serving transgender people run by a suspended GP – promotes podcasts with influencers as part of their campaign strategy Podcast | GenderGP Transgender Services

Much activism takes place on other channels such as Tik Tok, Tumblr, Facebook and so on. Last April, a 17-year-old girl described being distressed about her female body and wishing she had a flat chest. These are the responses she received on Tik Tok:




- This is just one example of the normalisation of an ideology that is driving children towards making ill-informed decisions which will change their lives forever. The end result is a lifetime of medication, and will frequently include infertility, a lack of sexual feeling, and numerous medical risks.
- In our opinion, influencers have played a key role in normalisation of this extreme ideology, which is unsupported by any credible evidence. They have also promoted the dogma 'any challenge is bigotry'. A great many children (disproportionately gender non-conforming children who have been shown statistically to be more likely to grow up lesbian/gay)[4] are being harmed as a result.
- Something is badly wrong with a media system in which influencers are able to disseminate harmful disinformation to impressionable and troubled youngsters and to create an atmosphere in which even professionals working in the field fear to challenge this narrative.

  How do we know professionals fear to challenge it? Because they write and tell us. [Tavistock trust whistleblower David Bell: 'I believed I was doing the right thing' | Transgender | The Guardian]
- The whole subject of safeguarding of our children appears to have fallen by the wayside as an 'old-fashioned' or 'conservative' concern. We strongly reject this categorisation. Whenever we and others attempt to bring facts and evidence to the debate, celebrities and other influencers aggressively shoot them down.

[4] See https://pubmed.ncbi.nlm.nih.gov/18981931/; https://www.genderhq.org/trans-children-gender-dysphoria-desistance-gay

- We must urgently consider ways in which disinformation spread by influencers can be corrected in order to prevent another such scandal as the one currently emerging.
- LGB Alliance will be fundraising for a studio where we will seek to redress the damage done and to find new ways of encouraging children and young people to explore and embrace their diverse lives: using video, music and social media. No such resources exist at the moment. Any confused child looking online will be vulnerable to the powerful video messages of those who advocate changes based on gender identity.

***RESPONSES TO QUESTIONS***

*1 How would you define 'influencers' and 'influencer culture'? Is this a new phenomenon?*

We take quite a broad view of the definition of 'influencers'. The term is mainly associated with those who influence the consumption of products and services. It is also used in relation to media and popular culture. Our own submission focuses on the latter. However, we wish to say that beyond the UK, especially in the United States, drugs like puberty blockers and surgical operations such as mastectomies are regarded as consumer products and promoted in the same way. We will illustrate our point with a couple of examples. Indeed, the conflation of popular culture, health solutions, and consumer products is itself a troubling development that should be addressed elsewhere.

Example: A medical practitioner dancing around some vegetation with a musical background while advertising double mastectomies as 'Teetus deletus'

https://images.app.goo.gl/BYCiQkZ1o7zw7jjCA

Another ad for double mastectomy

https://twitter.com/S0uthRiding/status/1227331481716056065?s=20

The influencers we discuss in our submission have multiplied exponentially in recent years. Those discussed here follow and promote an ideology that takes society back to pre-Enlightenment days.

Science and evidence-based dialogue no longer carry weight. Freedom of speech is replaced by a series of mantras which must be learned by heart and repeated by believers. Biological facts established over millennia are dismissed as 'transphobic', frequently 'hateful' and sometimes 'not worthy of being heard in civilised society'. Such ideas are promoted by the small but powerful group of 'gender identity' or 'queer theory' influencers and repeated by celebrities.

*2. Has 'influencing' impacted popular culture? If so, how has society and/or culture changed because of this side of social media?*

'Influencing' has a major impact on popular culture, especially with young people. Influencers gloss over the unresearched, ideological and potentially very harmful outcomes of gender identity theory.

First, campaigners teach that everyone has a 'gender identity' – a feeling – which is more important than biological sex. Those of us who insist we do not have a gender identity and find the idea sexist and regressive are dismissed or mocked.

Organisations once set up to campaign for people with same-sex sexual orientation now focus on 'gender identity' instead. Stonewall, for example, no longer refers to same-sex sexual orientation; it says same-*gender* attraction instead. Let's spell out what that means. It means that two males, both

with a penis, who identify as women, can refer to themselves as a 'lesbian' couple. It is hard to put into words how offensive that is for lesbians, who see our rights and even our own definitions for ourselves swept away. Young lesbians are pressured to say they would consider male-bodied people as potential sexual partners. Otherwise they are called 'transphobic'. Worst of all, this attitude is marketed as 'progressive'. We maintain it is the exact opposite of progressive.

In 2015 Stonewall recommended to the Women & Equalities Select Committee that there should be:

- A review of the Equality Act 2010 to include 'gender identity' rather than 'gender reassignment' as a protected characteristic and to remove exemptions, such as access to single-sex spaces

  https://www.stonewall.org.uk/women-and-equalities-select-committee-inquiry-transgender-equality

What this means is that in Stonewall's ideal world, there would no longer be any places for lesbians or gay men (or indeed women) to be together without the opposite sex.

Another example is the careless promotion of the largely unknown effects of puberty blockers, cross sex hormones and surgery – which are all presented online as if they are nothing to worry about. Indeed – double mastectomies for girls wishing to 'live as boys' is euphemistically called 'top surgery'. At the most recent count, over 34,000 girls are fundraising on GoFundMe to finance the removal of their breasts.

*3. Is it right that influencers are predominantly associated with advertising and consumerism, and if not, what other roles do influencers fulfil online?*

As we have shown, there is a trend in popular culture, especially in the United States, to see those demanding specific solutions to their health problems as consumers rather than patients requiring unbiased expert assessment, diagnosis and treatment. There is a harmful conflation between commercial products, health solutions, and cultural kudos. Influencers are driving and/or exacerbating this trend. The influencers we are concerned about use harmful incorrect data (debunked suicide stats, reversibility of PBs, pause button, misrepresentation of the law regarding single-sex spaces (EqA 2010) to promote this ideology. Most frequently they refuse to engage in debate and block those who ask questions. Much of their output uses emotional blackmail techniques which serve to shut down any critical engagement. ('Don't discuss this or I will feel unsafe? Is this a "safe space"?')

4. *How are tech companies encouraging or disrupting the activities of influencing?*

Tech companies facilitate the activities of the influence culture that we are discussing. For instance, Amazon refused to allow Abigail Shrier to promote her book on their site. Twitter, Facebook, Medium and YouTube frequently restrict or shut down accounts that promote women's or LGB rights and challenge gender identity ideology. In addition, social media companies make no attempt to correct or prevent the influencers' dissemination of 'fake news' in support of gender identity ideology. They behave as if the ideas put forward by gender critical people are abhorrent. In other words, those who promote the rights of women and people with same-sex sexual orientation are now regarded by social media companies as bigots – and censored.

What this means is that Twitter, Facebook, Medium, YouTube and Amazon are themselves among the most powerful 'influencers' in promoting the gender identity ideology that is causing so much harm. They bear a heavy burden of responsibility – which will eventually become clear.

5. *How aware are users of the arrangements between influencers and advertisers? Should policymakers, tech companies and influencers and advertisers themselves do more to ensure these arrangements are transparent?*

A few months ago, BoyzMagazine was bankrupted by influencers who were angry that BM had suggested that its readers watch an LGB Alliance webinar. The angry mob brought pressure to bear on advertisers, and one by one they all caved. Every publication is fearful of losing its advertising revenue. Although most users are probably unaware of these underlying mechanisms, the power of aggressive influencers to protest and to shut off advertising revenue has become increasingly clear. This poses a serious threat to freedom of expression. Transparency itself cannot solve this problem.

# Doctor who treats trans kids as young as 12 under investigation (https://www.gaystarnews.com/article/gp-investigation-trans-kids/)

11 SEP 2017



A doctor known for treating trans teenagers as young as 12 is under investigation.

Doctor Helen Webberley is known for running an online trans medical clinic.

She set up her private gender clinic in her home in Monmouthshire, Wales in late 2014.

After multiple complaints from some London's NHS gender specialists, the General Medical Council has launched an investigation into her practice.

Webberley explained to GSN: 'Normally if a doctor has an issue with another doctor, you call or email them. I'm easily accessible! But apparently, that's not the way these guys work. It's the same guys in London who are making the complaints.

'There were just so many complaints, the GMC got scared. When it was in the papers about me treating the 12-year old, they just got scared and decided they should launch a full investigation..'

Dr. Webberley's clinic work with trans patients has been placed under an 'interim order of conditions'.

This means she can continue her work with her patients but on a supervised basis.

Webberley believes 'if they were really worried, they would have suspended my work completely.'

## 'I was warned'

The investigation did not come as a surprise to her though.

Webberley explained: 'I was warned. When I first started, I was told that if you look at the history, don't be surprised if it happens to you.'

The cases referenced are that of Russell Reid and Richard Curtis.

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(https://www.gaystarnews.com/)

Curtis' case came in 2013. Similar to Webberley, he gave hormones to children under the age of 16. It was said he 'lacks the specialist knowledge and skills to adequately treat such patients on his own.'

Webberley anticipated she would potentially also be investigated and so did everything 'whiter than white' and followed every protocol.

She explained she is irritated by and embarrassed about the investigation. But, it will protect her and her work.

'If the GMC can look at everything I do, I can come out with my "certificate" validating what I do. It will allow more GPs like me to consider also helping their trans patients', she added.

## 'The case of the 12-year old was very unusual'

Webberley earned herself attention in 2016 for treating a 12-year old.

She explained: 'The case of the 12-year old was very unusual. They were very distressed and it was the charity Mermaids who suggested I help them. I asked how old they were and they said 12.

'Just in case one person might change their mind, the NHS won't let trans kids be treated any earlier than 16. That's damaging for most children. They should have the option to be able to do it earlier than 16.'

The NHS is notorious for keeping trans waiting months for appointments.

'There's a gap in their teens because they're not allowed to be referred to the gender identity clinic until they're 16.

'And then it takes months for them to get that appointment. And by the time they have that appointment they might be 17 and starting to be moved over to the adult services, where it could take over a year for them to get an appointment.'

## 'Webberley is a godsend'

When news of the case of the 12-year old came out, Webberley explained some people were skeptical and the trans community watched her very carefully.

Now though, she has the seal of approval.

'When the news of the investigation broke yesterday, Twitter and Facebook didn't stop. The support is amazing.

We hear the doctors in the news saying I shouldn't be doing this, but the community is saying "leave her alone because what she's doing is amazing."'

It takes one look at Webberley's Twitter to confirm this.

One Twitter user said: 'Thank you. Your service has literally saved me whilst I'm stuck on the cruelty of the ever expanding wait to actually see an NHS GIC.'

Another labeled Webberley a 'godsend' to an over-stretched NHS.

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TWEET text=Doctor%20who%20treats%20trans%20kids%20as%20young%20as%2012%20under%20investigation&via=gaystarnews&url=https://www.gay

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## The Bodyguards Of The Most Protected Celebrities

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## Clive Myrie's Wife Is Probably The Most Beautiful Woman In The UK

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## 25 Worst Movies Ever, According To Rotten Tomatoes

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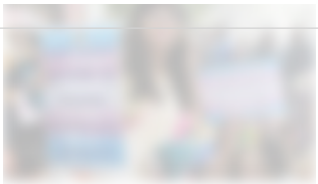
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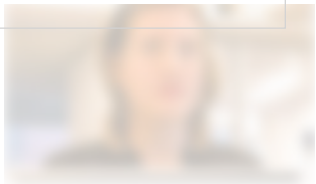
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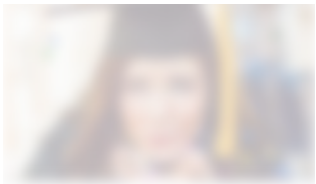
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To any parent who is watching their teen go through a puberty that doesn't match their gender identity. Please ask @GenderGP for help.

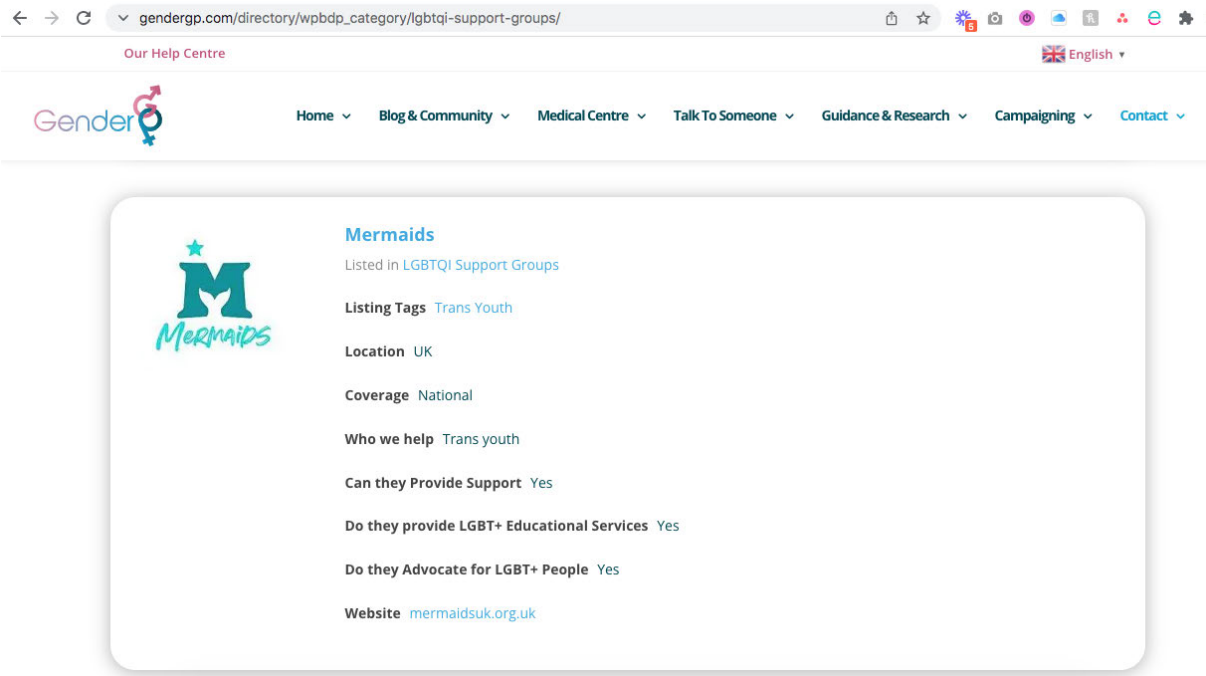
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**NHSE sanctions limit basic healthcare for young trans people**




https://twitter.com/Mermaids_Gender/status/1302982735435362311




https://www.gendergp.com/directory/wpbdp_category/lgbtqi-support-groups/

Oct 8, 2020, 11:57am EDT | 5,788 views

# Transgender People Could Lose Medication In U.K. Pharmacy Regulator Row



**Jamie Wareham** Contributor ⓘ
Diversity, Equity & Inclusion
*I report on LGBT life, identities and being queer.*

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Thousands of transgender people have lost access to their medication through a private health service, following an investigation from the U.K.'s pharmacy regulator.

GenderGP, a private gender identity service, has been told by their chemist Clear Chemist, they are now unable to fulfil their prescriptions.

The change has come following the pharmacy regulator, the General Pharmaceutical Council, conducting a "targeted visit." It aimed to find out if the pharmacy was meeting the required standards "in relation to managing risks" for "safeguarding vulnerable patients."

"We are now considering what further regulatory action to take," Duncan Rudkin, Chief Executive of the General Pharmaceutical Council, tells me.

"In the meantime, the superintendent pharmacist of Clear Chemist has advised us that he has taken the decision to only dispense prescriptions to patients over 18 years old where the patient has given consent to speak with their GP about their prescribed treatment. We are working with the pharmacy on key issues, including signposting to other services and continuity of care for their patients."

GenderGP say this action will leave all of its 3000 patients without a guarantee their medication can continue, as many access the care entirely through the private company– and not with their GPs.

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GenderGP tells me they are now seeking alternatives supplies, whilst they ensure safeguards which mean some patients over the age of 18, will still be able to get medication from Clear Chemist.

For some patients, they will have as little as a five-week supply left.

Transgender and sexual health groups, including Spectra, have called the move by the regulator "irresponsible."

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GenderGP was founded by Dr Helen Webberley in 2015, and been at the centre of several media rows, amid hostile anti-trans rhetoric in the U.K. press.

Following Dr Webberley's conviction of operating a healthcare service without the required registration–its assets are now owned by Harland International, which is registered in Hong Kong.

Dr Webberley continues to works as a non-medical advisor from her home in the U.K.. At the same time, a team of international doctors provide care. She is currently suspended from working as a doctor by the General Medical Council and has been awaiting a hearing for five years now.

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LONDON, UNITED KINGDOM - SEPTEMBER 12, 2020: Transgender people and their supporters march along the ... [+] BARCROFT MEDIA VIA GETTY IMAGES

## Why is GenderGP back in the news?

Despite this history, the company is currently legally providing a private health service, albeit an unconventional one, as the only private gender identity service available to U.K. people of all ages.

Transgender people have been turning to the service, as they face over two years of waiting times, in some cases, nearly three years, for NHS Gender Identity Services. NHS services are meant to deliver services within a standard 18-week target.

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This week a BBC investigation found that parents on the trans youth charity Mermaid's private forums were signposting GenderGP to each other as their children wait, sometimes years, for NHS care.

This investigation has created yet another media row, as Mermaids have recently stopped signposting to GenderGP on its website. This follows advice about distancing itself from the difficulties and media hype around GenderGP.

But the BBC found discussions about GenderGP on the charity's private forums were ongoing. Mermaids now say it will now investigate adding the charity "only recommends the NHS."

The row ultimately means, thousands of transgender people who rely on the service – some who do so as they wait for NHS support – are potentially facing the coming weeks and months without medication.




Testosterone Replacement Therapy (TRT) using testosterone gel. Hypogonadism concept. GETTY

## "I don't really know how I'm going to function" – GenderGP patient

"We live in a country petrified about providing trans healthcare." Dr Helen Webberley, who founded GenderGP tells me.

"This is going to cause real agony and anguish. There could be suicide, self-harm and tragedies."

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Speaking to GenderGP's patients who have reached out to me, this anguish is evident as they share stories about looking as far to the black market to fill the gap in their medication:

"By GenderGP's prescribing pharmacy being targeted in this way, this will force me to find a private physician who will prescribe. And then [I will] probably have to purchase my medications through the black market, which is incredibly dangerous." Jamie tells me, who is currently on a waiting list over two years long.

Many of the patients will only have five weeks worth of supply left, like Ada:

"I guess after fighting for a year and a half to get here I feel like I've now got five weeks to figure something else out. While being faced with the prospect of losing my progress with HRT," Ada tells me.

"At that point, I don't really know how I'm going to function in the sense of leaving the house to go to the shop or continue being able to work. Without it I don't know what I'm going to do."

Sam tells me, his "entire chest sunk" when he heard the "inexplicably terrifying" news that this might impact his access to medication. He's been relying on the service for 20 months now following a "harrowing experience" with the NHS.

"If I don't get my treatment, I could be placed back into a state of dysphoria that I have not been in for well over a year now," he says.

GenderGP is currently advising their patients where they can access alternative medicines here.

Trans advocacy charity Gendered Intelligence is advising anyone at risk of losing their medications to make an appointment with a GP to get a bridging prescription. The charity added on social media:

"They have a duty to continue your prescription until you're seen by a GIC, including monitoring with blood tests."

This is outlined in the guidance provided by the General Medical Council in 2018. It says that accessing private care should have no impact on U.K. patients access to gender identity services under the NHS. GPs should also "cooperate with Gender Identity Clinics and other gender specialists by prescribing medications."

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Further adding that it may be appropriate to offer a prescription, even if so far they've been seeking the medication from unregulated sources. This is advised in cases "where the prescription is intended to mitigate a risk of self-harm and is supported by appropriate specialist advice."

Meanwhile, Webberley tells me that GenderGP and ClearChemist are working on solutions so that they can still dispense. She tells me they are doing "by ensuring safeguarding meets any regulatory requirements."

"Ultimately though, we must not forget that amid this hype, the patients' prescriptions are running out, and they have no alternative. What will happen if those 3000 patients go without care? That is a massive safeguarding risk, and it's easy to lose that point."

*Updated: 9 October, 1:45pm – This story has been updated to reflect a change after Clear Chemist has told GenderGP can continue to serve some patients who are over the age of 18, with the required safeguards in place.*

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Equality and Human Rights Commission

Shona Robison,
Cabinet Secretary for Social Justice,
Housing and Local Government
**By email only**

**From**: Baroness Kishwer Falkner,
Chairwoman

Our ref: 833Robison

Wednesday 26 January 2022

Dear Cabinet Secretary,

Following our meeting on 21 January, I am writing as promised with our position on reform of the Gender Recognition Act 2004.

Like you, we are concerned at the polarised debate on this issue. It is causing much distress to people on all sides. We want to work with you and other interested parties to support a careful and respectful discussion of potential changes to the law.

As you know, some lawyers, academics, data users and others have increasingly expressed concerns about the potential implications of changing the current criteria for obtaining a Gender Recognition Certificate (GRC).

These concerns centre on the potential consequences for individuals and society of extending the ability to change legal sex from a small defined group, who have demonstrated their commitment and ability to live in their acquired gender, to a wider group who identify as the opposite gender at a given point. The potential consequences include those relating to the collection and use of data, participation and drug testing in competitive sport, measures to address barriers facing women, and practices within the criminal justice system, inter alia.

As such, we consider that more detailed consideration is needed before any change is made to the provisions in the Act.

We recognise that many trans people have criticised the current process to obtain a GRC as being intrusive, medically-based, bureaucratic, expensive and lengthy. We welcomed the UK Government's reduction of the fee for obtaining a GRC and commitment to digitalize the process, which we encourage them to deliver at speed.

We are also concerned about the unacceptably long waiting times for gender identity services – in some cases over five years for an initial appointment. We strongly welcome your commitment to improve gender identity services in Scotland so that individuals with gender dysphoria can obtain the support and treatment they need and begin the process of gaining legal recognition of their acquired gender. We continue to press the UK government to progress improvements.

As we work to promote and uphold equality and human rights law, we will continue to call for urgent improvements to gender identity services throughout Britain.

We otherwise consider that the established legal concept of sex, together with the existing protections from gender reassignment discrimination for trans people and the ability for them to obtain legal recognition of their gender, collectively provide the correct balanced legal framework that protects everyone. This includes protecting trans people from discrimination and harassment, and safeguarding their human rights. Our focus is on continuing to

seek opportunities to use our powers to support litigation to protect trans people's rights.

We will write to you shortly to update you on our forthcoming guidance for single-sex service providers.

We look forward to working with you and others in Scotland to take forward these important issues.

Yours sincerely,

Baroness Kishwer Falkner

**Chairwoman**

**Equality and Human Rights Commission |**

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Manchester, M4 3AQ

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# Overview

## Gender dysphoria

**Overview**

- Signs (Link: www.nhs.uk/conditions/gender-dysphoria/symptoms/)
- How to get help and support (Link: www.nhs.uk/conditions/gender-dysphoria/how-get-help-and-support/)
- Treatment (Link: www.nhs.uk/conditions/gender-dysphoria/treatment/)

**Gender dysphoria is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity.**

This sense of unease or dissatisfaction may be so intense it can lead to depression and anxiety and have a harmful impact on daily life.

## What is gender identity?

Gender identity refers to our sense of who we are and how we see and describe ourselves.

Most people identify as "male" or "female". These are sometimes called "binary" identities.

But some people feel their gender identity is different from their biological sex.

For example, some people may have male genitals and facial hair but do not identify as a male or feel masculine.

Some may have female genitals and breasts but do not identify as a female or feel feminine.

Some people do not define themselves as having a "binary" identity. For them the concept of gender is not relevant to their identity.

They may use different terms, such as agender, gender diverse, gender non-conforming, to describe their identity. However, as a group, they are often called "non-binary".

### Gender dysphoria and gender identity

Many people with gender dysphoria have a strong, lasting desire to live a life that "matches" or expresses their gender identity. They do this by changing the way they look and behave.

Some people with gender dysphoria, but not all, may want to use hormones and sometimes surgery to express their gender identity.

Gender dysphoria is not a mental illness, but some people may develop mental health problems because of gender dysphoria.

## Signs of gender dysphoria

People with gender dysphoria may have changed their appearance, their behaviour or their interests.

They may also show signs of discomfort or distress, including:

- low self-esteem
- becoming withdrawn or socially isolated
- depression or anxiety
- taking unnecessary risks
- neglecting themselves

Read more about the signs of gender dysphoria (Link: www.nhs.uk/conditions/gender-dysphoria/symptoms/).

### Children and gender identity

Children may show an interest in clothes or toys that society tells us are more often associated with the opposite gender. They may be unhappy with their physical sex characteristics.

However, this type of behaviour is reasonably common in childhood and is part of growing up. It does not mean that all children behaving this way have gender dysphoria or other gender identity issues.

A small number of children may feel lasting and severe distress, which gets worse as they get older. This often happens around puberty, when young people might feel that their physical appearance does not match their gender identity.

This feeling can continue into adulthood with some people having a strong desire to change parts of their physical appearance, such as facial hair or breasts.

Find out more information if you think your child might have gender dysphoria (Link: www.nhs.uk/live-well/healthy-body/think-your-child-might-be-trans-or-non-binary/).

## How to get help

See a GP if you think you or your child may have gender dysphoria.

If the GP agrees, they can refer you to a gender dysphoria clinic (GDC) where you'll be assessed by a specialist team.

You do not need to be assessed by a mental health service first, and the GP does not need prior approval from their Clinical Commissioning Group (CCG) responsible for local health services.

You can self-refer to a GDC, but a referral by the GP is best. This is because they can give the GDC your detailed medical history.

If you are already seeing a doctor or psychologist for other conditions, ask them if they can refer you to a GDC.

Referrals for children and young people up to 18 years will be to the Gender Identity Development Service (GIDS) (Link: https://gids.nhs.uk/) for children and adolescents.

Referrals for adults to one of the gender dysphoria clinics in England (Link: www.nhs.uk/live-well/healthy-body/how-to-find-an-nhs-gender-identity-clinic/) may be made from 17 years of age.

### Waiting times

As there has been a huge increase in the number of people seeking a referral to a gender dysphoria clinic, waiting times can be long..

Find out how your GP and other organisations can support you while you wait to see a GDC (Link: www.nhs.uk/conditions/gender-dysphoria/how-get-help-and-support/).

## Treatment for gender dysphoria

After a detailed assessment to confirm the diagnosis of gender dysphoria and what it means for you, the GDC team will work with you on an agreed treatment plan.

If you are assessed as not having gender dysphoria, the GDC may recommend other forms of support to your GP.

Treatments provided by the GDC are intended to provide lasting relief from gender dysphoria. This can mean different things to different people.

For some people, treatment may just involve acceptance and affirmation or confirmation of their identity. For others, it may involve bigger changes, such as changes to their voice, hormone treatment or surgery.

Read more about treatments for gender dysphoria (Link: www.nhs.uk/conditions/gender-dysphoria/treatment/).

## What causes gender dysphoria?

The exact cause of gender dysphoria is unclear.

Gender development is complex and there are still things that are not known or fully understood.

Gender dysphoria is not related to sexual orientation. People with gender dysphoria may identify as straight, gay, lesbian or bisexual.

## How common is gender dysphoria?

No one really knows because not all people who have a sense of unease about their identity, or already identify as gender diverse, need or ask for support from the NHS.

The number of people being referred and diagnosed with the condition has increased a lot over the last decade. In 2018/19 around 8,000 people were referred to adult gender dysphoria services in England.

## Video: being a trans man - Jay's story

In this video, Jay describes his transition, the expert help he received, his relationship and how he feels now.

Media last reviewed: 1 November 2021
Media review due: 1 November 2024

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

www.wpath.org

# Standards of Care

## for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professional Association for Transgender Health

7th Version

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WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

# Standards of Care

## for the Health of Transsexual, Transgender, and Gender Nonconforming People

The World Professiona Association for Transgender Health

7th Version[1] | www.wpath.org

1 This is the seventh version of the Standards of Care. The original SOC were published in 1979. Previous revisions were in 1980, 1981, 1990, 1998, and 2001.

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# Purpose and Use of the Standards of Care

The World Professional Association for Transgender Health (WPATH)[1] is an international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect for transgender health. The vision of WPATH is to bring together diverse professionals dedicated to developing best practices and supportive policies worldwide that promote health, research, education, respect, dignity, and equality for transsexual, transgender, and gender nonconforming people in all cultural settings.

One of the main functions of WPATH is to promote the highest standards of health care for individuals through the articulation of *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People*. The *SOC* are based on the best available science and expert professional consensus.[2] Most of the research and experience in this field comes from a North American and Western European perspective; thus, adaptations of the *SOC* to other parts of the world are necessary. Suggestions for ways of thinking about cultural relativity and cultural competence are included in this version of the *SOC*.

The overall goal of the *SOC* is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well-being, and self-fulfillment. This assistance may include primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments. While this is primarily a document for health professionals, the *SOC* may also be used by individuals, their families, and social institutions to understand how they can assist with promoting optimal health for members of this diverse population.

WPATH recognizes that health is dependent upon not only good clinical care but also social and political climates that provide and ensure social tolerance, equality, and the full rights of citizenship. Health is promoted through public policies and legal reforms that promote tolerance and equity

1 Formerly the Harry Benjamin International Gender Dysphoria Association

2 *Standards of Care (SOC), Version 7* represents a significant departure from previous versions. Changes in this version are based upon significant cultural shifts, advances in clinical knowledge, and appreciation of the many health care issues that can arise for transsexual, transgender, and gender nonconforming people beyond hormone therapy and surgery (Coleman, 2009a, b, c, d).



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for gender and sexual diversity and that eliminate prejudice, discrimination, and stigma. WPATH is committed to advocacy for these changes in public policies and legal reforms.

## The Standards of Care Are Flexible Clinical Guidelines

The *SOC* are intended to be flexible in order to meet the diverse health care needs of transsexual, transgender, and gender nonconforming people. While flexible, they offer standards for promoting optimal health care and guiding the treatment of people experiencing gender dysphoria – broadly defined as discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

As for all previous versions of the *SOC*, the criteria put forth in this document for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable for the accumulation of new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

The *SOC* articulate standards of care but also acknowledge the role of making informed choices and the value of harm reduction approaches. In addition, this version of the *SOC* recognizes and validates various expressions of gender that may not necessitate psychological, hormonal, or surgical treatments. Some patients who present for care will have made significant self-directed progress towards gender role changes, transition, or other resolutions regarding their gender identity or gender dysphoria. Other patients will require more intensive services. Health professionals can use the *SOC* to help patients consider the full range of health services open to them, in accordance with their clinical needs and goals for gender expression.



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# Global Applicability of the Standards of Care

While the *SOC* are intended for worldwide use, WPATH acknowledges that much of the recorded clinical experience and knowledge in this area of health care is derived from North American and Western European sources. From place to place, both across and within nations, there are differences in all of the following: social attitudes towards transsexual, transgender, and gender nonconforming people; constructions of gender roles and identities; language used to describe different gender identities; epidemiology of gender dysphoria; access to and cost of treatment; therapies offered; number and type of professionals who provide care; and legal and policy issues related to this area of health care (Winter, 2009).

It is impossible for the *SOC* to reflect all of these differences. In applying these standards to other cultural contexts, health professionals must be sensitive to these differences and adapt the *SOC* according to local realities. For example, in a number of cultures, gender nonconforming people are found in such numbers and living in such ways as to make them highly socially visible (Peletz, 2006). In settings such as these, it is common for people to initiate a change in their gender expression and physical characteristics while in their teens, or even earlier. Many grow up and live in a social, cultural, and even linguistic context quite unlike that of Western cultures. Yet almost all experience prejudice (Peletz, 2006; Winter, 2009). In many cultures, social stigma towards gender nonconformity is widespread and gender roles are highly prescriptive (Winter et al., 2009). Gender nonconforming people in these settings are forced to be hidden, and therefore may lack opportunities for adequate health care (Winter, 2009).

The *SOC* are not intended to limit efforts to provide the best available care to all individuals. Health professionals throughout the world – even in areas with limited resources and training opportunities – can apply the many core principles that undergird the *SOC*. These principles include the following: Exhibit respect for patients with nonconforming gender identities (do not pathologize differences in gender identity or expression); provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria, when present; become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria; match the treatment approach to the specific needs of patients, particularly their goals for gender expression and need for relief from gender dysphoria; facilitate access to appropriate care; seek patients' informed consent before providing treatment; offer continuity of care; and be prepared to support and advocate for patients within their families and communities (schools, workplaces, and other settings).

Terminology is culturally and time-dependent and is rapidly evolving. It is important to use respectful language in different places and times, and among different people. As the *SOC* are translated into other languages, great care must be taken to ensure that the meanings of terms are accurately translated. Terminology in English may not be easily translated into other languages, and vice versa. Some languages do not have equivalent words to describe the various terms within this document; hence, translators should be cognizant of the underlying goals of treatment and articulate culturally applicable guidance for reaching those goals.

III

# The Difference Between Gender Nonconformity and Gender Dysphoria

## Being Transsexual, Transgender, or Gender Nonconforming Is a Matter of Diversity, Not Pathology

WPATH released a statement in May 2010 urging the de-psychopathologization of gender nonconformity worldwide (WPATH Board of Directors, 2010). This statement noted that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative."

Unfortunately, there is stigma attached to gender nonconformity in many societies around the world. Such stigma can lead to prejudice and discrimination, resulting in "minority stress" (I. H. Meyer, 2003). Minority stress is unique (additive to general stressors experienced by all people), socially based, and chronic, and may make transsexual, transgender, and gender nonconforming individuals more vulnerable to developing mental health concerns such as anxiety and depression (Institute of Medicine, 2011). In addition to prejudice and discrimination in society at large, stigma can contribute to abuse and neglect in one's relationships with peers and family members, which in turn can lead to psychological distress. However, these symptoms are socially induced and are not inherent to being transsexual, transgender, or gender nonconforming.

## Gender Nonconformity Is Not the Same as Gender Dysphoria

*Gender nonconformity* refers to the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex (Institute of Medicine, 2011). *Gender dysphoria* refers to discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b). Only *some* gender nonconforming people experience gender dysphoria at *some* point in their lives.

Treatment is available to assist people with such distress to explore their gender identity and find a gender role that is comfortable for them (Bockting & Goldberg, 2006). Treatment is individualized: What helps one person alleviate gender dysphoria might be very different from what helps another person. This process may or may not involve a change in gender expression or body modifications. Medical treatment options include, for example, feminization or masculinization of the body through hormone therapy and/or surgery, which are effective in alleviating gender dysphoria and are medically necessary for many people. Gender identities and expressions are diverse, and hormones and surgery are just two of many options available to assist people with achieving comfort with self and identity.

Gender dysphoria can in large part be alleviated through treatment (Murad et al., 2010). Hence, while transsexual, transgender, and gender nonconforming people may experience gender dysphoria at some point in their lives, many individuals who receive treatment will find a gender role and expression that is comfortable for them, even if these differ from those associated with their sex assigned at birth, or from prevailing gender norms and expectations.

## Diagnoses Related to Gender Dysphoria

Some people experience gender dysphoria at such a level that the distress meets criteria for a formal diagnosis that might be classified as a mental disorder. Such a diagnosis is not a license for stigmatization or for the deprivation of civil and human rights. Existing classification systems such as the *Diagnostic Statistical Manual of Mental Disorders (DSM)* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (*ICD*) (World Health Organization, 2007) define hundreds of mental disorders that vary in onset, duration, pathogenesis, functional disability, and treatability. All of these systems attempt to classify clusters of symptoms and conditions, not the individuals themselves. A disorder is a description of something with which a person might struggle, not a description of the person or the person's identity.

Thus, transsexual, transgender, and gender nonconforming individuals are not inherently disordered. Rather, the distress of gender dysphoria, when present, is the concern that might be diagnosable and for which various treatment options are available. The existence of a diagnosis for such dysphoria often facilitates access to health care and can guide further research into effective treatments.

Research is leading to new diagnostic nomenclatures, and terms are changing in both the *DSM* (Cohen-Kettenis & Pfäfflin, 2010; Knudson, De Cuypere, & Bockting, 2010b; Meyer-Bahlburg, 2010; Zucker, 2010) and the *ICD*. For this reason, familiar terms are employed in the *SOC* and definitions are provided for terms that may be emerging. Health professionals should refer to the most current diagnostic criteria and appropriate codes to apply in their practice areas.

# IV
# Epidemiologic Considerations

Formal epidemiologic studies on the incidence[3] and prevalence[4] of transsexualism specifically or transgender and gender nonconforming identities in general have not been conducted, and efforts to achieve realistic estimates are fraught with enormous difficulties (Institute of Medicine, 2011; Zucker & Lawrence, 2009). Even if epidemiologic studies established that a similar proportion of transsexual, transgender, or gender nonconforming people existed all over the world, it is likely that cultural differences from one country to another would alter both the behavioral expressions of different gender identities and the extent to which gender dysphoria – distinct from one's gender identity – is actually occurring in a population. While in most countries, crossing normative gender boundaries generates moral censure rather than compassion, there are examples in certain cultures of gender nonconforming behaviors (e.g., in spiritual leaders) that are less stigmatized and even revered (Besnier, 1994; Bolin, 1988; Chiñas, 1995; Coleman, Colgan, & Gooren, 1992; Costa & Matzner, 2007; Jackson & Sullivan, 1999; Nanda, 1998; Taywaditep, Coleman, & Dumronggittigule, 1997).

For various reasons, researchers who have studied incidence and prevalence have tended to focus on the most easily counted subgroup of gender nonconforming individuals: transsexual individuals who experience gender dysphoria and who present for gender-transition-related care at specialist gender clinics (Zucker & Lawrence, 2009). Most studies have been conducted in European

3 **incidence**—the number of new cases arising in a given period (e.g., a year)
4 **prevalence**—the number of individuals having a condition, divided by the number of people in the general population

countries such as Sweden (Wålinder, 1968, 1971), the United Kingdom (Hoenig & Kenna, 1974), the Netherlands (Bakker, Van Kesteren, Gooren, & Bezemer, 1993; Eklund, Gooren, & Bezemer, 1988; van Kesteren, Gooren, & Megens, 1996), Germany (Weitze & Osburg, 1996), and Belgium (De Cuypere et al., 2007). One was conducted in Singapore (Tsoi, 1988).

De Cuypere and colleagues (2007) reviewed such studies, as well as conducted their own. Together, those studies span 39 years. Leaving aside two outlier findings from Pauly in 1968 and Tsoi in 1988, ten studies involving eight countries remain. The prevalence figures reported in these ten studies range from 1:11,900 to 1:45,000 for male-to-female individuals (MtF) and 1:30,400 to 1:200,000 for female-to-male (FtM) individuals. Some scholars have suggested that the prevalence is much higher, depending on the methodology used in the research (for example, Olyslager & Conway, 2007).

Direct comparisons across studies are impossible, as each differed in their data collection methods and in their criteria for documenting a person as transsexual (e.g., whether or not a person had undergone genital reconstruction, versus had initiated hormone therapy, versus had come to the clinic seeking medically-supervised transition services). The trend appears to be towards higher prevalence rates in the more recent studies, possibly indicating increasing numbers of people seeking clinical care. Support for this interpretation comes from research by Reed and colleagues (2009), who reported a doubling of the numbers of people accessing care at gender clinics in the United Kingdom every five or six years. Similarly, Zucker and colleagues (2008) reported a four- to five-fold increase in child and adolescent referrals to their Toronto, Canada clinic over a 30-year period.

The numbers yielded by studies such as these can be considered minimum estimates at best. The published figures are mostly derived from clinics where patients met criteria for severe gender dysphoria and had access to health care at those clinics. These estimates do not take into account that treatments offered in a particular clinic setting might not be perceived as affordable, useful, or acceptable by all self-identified gender dysphoric individuals in a given area. By counting only those people who present at clinics for a specific type of treatment, an unspecified number of gender dysphoric individuals are overlooked.

Other clinical observations (not yet firmly supported by systematic study) support the likelihood of a higher prevalence of gender dysphoria: (i) Previously unrecognized gender dysphoria is occasionally diagnosed when patients are seen with anxiety, depression, conduct disorder, substance abuse, dissociative identity disorders, borderline personality disorder, sexual disorders, and disorders of sex development (Cole, O'Boyle, Emory, & Meyer III, 1997). (ii) Some crossdressers, drag queens/kings or female/male impersonators, and gay and lesbian individuals may be experiencing gender dysphoria (Bullough & Bullough, 1993). (iii) The intensity of some people's gender dysphoria fluctuates below and above a clinical threshold (Docter, 1988). (iv) Gender nonconformity among FtM individuals tends to be relatively invisible in many cultures, particularly to Western health

professionals and researchers who have conducted most of the studies on which the current estimates of prevalence and incidence are based (Winter, 2009).

Overall, the existing data should be considered a starting point, and health care would benefit from more rigorous epidemiologic study in different locations worldwide.

# V

# Overview of Therapeutic Approaches for Gender Dysphoria

## Advancements in the Knowledge and Treatment of Gender Dysphoria

In the second half of the 20th century, awareness of the phenomenon of gender dysphoria increased when health professionals began to provide assistance to alleviate gender dysphoria by supporting changes in primary and secondary sex characteristics through hormone therapy and surgery, along with a change in gender role. Although Harry Benjamin already acknowledged a spectrum of gender nonconformity (Benjamin, 1966), the initial clinical approach largely focused on identifying who was an appropriate candidate for sex reassignment to facilitate a physical change from male to female or female to male as completely as possible (e.g., Green & Fleming, 1990; Hastings, 1974). This approach was extensively evaluated and proved to be highly effective. Satisfaction rates across studies ranged from 87% of MtF patients to 97% of FtM patients (Green & Fleming, 1990), and regrets were extremely rare (1-1.5% of MtF patients and <1% of FtM patients; Pfäfflin, 1993). Indeed, hormone therapy and surgery have been found to be medically necessary to alleviate gender dysphoria in many people (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

As the field matured, health professionals recognized that while many individuals need both hormone therapy and surgery to alleviate their gender dysphoria, others need only one of these treatment options and some need neither (Bockting & Goldberg, 2006; Bockting, 2008; Lev, 2004). Often with the help of psychotherapy, some individuals integrate their trans- or cross-gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body. For others, changes in gender role and expression are sufficient to alleviate



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gender dysphoria. Some patients may need hormones, a possible change in gender role, but not surgery; others may need a change in gender role along with surgery, but not hormones. In other words, treatment for gender dysphoria has become more individualized.

As a generation of transsexual, transgender, and gender nonconforming individuals has come of age – many of whom have benefitted from different therapeutic approaches – they have become more visible as a community and demonstrated considerable diversity in their gender identities, roles, and expressions. Some individuals describe themselves not as gender nonconforming but as unambiguously cross-sexed (i.e., as a member of the other sex; Bockting, 2008). Other individuals affirm their unique gender identity and no longer consider themselves either male or female (Bornstein, 1994; Kimberly, 1997; Stone, 1991; Warren, 1993). Instead, they may describe their gender identity in specific terms such as transgender, bigender, or genderqueer, affirming their unique experience that may transcend a male/female binary understanding of gender (Bockting, 2008; Ekins & King, 2006; Nestle, Wilchins, & Howell, 2002). They may not experience their process of identity affirmation as a "transition," because they never fully embraced the gender role they were assigned at birth or because they actualize their gender identity, role, and expression in a way that does not involve a change from one gender role to another. For example, some youth identifying as genderqueer have always experienced their gender identity and role as such (genderqueer). Greater public visibility and awareness of gender diversity (Feinberg, 1996) has further expanded options for people with gender dysphoria to actualize an identity and find a gender role and expression that is comfortable for them.

Health professionals can assist gender dysphoric individuals with affirming their gender identity, exploring different options for expression of that identity, and making decisions about medical treatment options for alleviating gender dysphoria.

## Options for Psychological and Medical Treatment of Gender Dysphoria

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person (e.g., Bockting, Knudson, & Goldberg, 2006; Bolin, 1994; Rachlin, 1999; Rachlin, Green, & Lombardi, 2008; Rachlin, Hansbury, & Pardo, 2010). Treatments options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;

- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

## Options for Social Support and Changes in Gender Expression

In addition (or as an alternative) to the psychological and medical treatment options described above, other options can be considered to help alleviate gender dysphoria, for example:

- Offline and online peer support resources, groups, or community organizations that provide avenues for social support and advocacy;
- Offline and online support resources for families and friends;
- Voice and communication therapy to help individuals develop verbal and non-verbal communication skills that facilitate comfort with their gender identity;
- Hair removal through electrolysis, laser treatment, or waxing;
- Breast binding or padding, genital tucking or penile prostheses, padding of hips or buttocks;
- Changes in name and gender marker on identity documents.

# VI

# Assessment and Treatment of Children and Adolescents with Gender Dysphoria

There are a number of differences in the phenomenology, developmental course, and treatment approaches for gender dysphoria in children, adolescents, and adults. In children and adolescents, a rapid and dramatic developmental process (physical, psychological, and sexual) is involved and

there is greater fluidity and variability in outcomes, particular in prepubertal children. Accordingly, this section of the *SOC* offers specific clinical guidelines for the assessment and treatment of gender dysphoric children and adolescents.

## Differences between Children and Adolescents with Gender Dysphoria

An important difference between gender dysphoric children and adolescents is in the proportion for whom dysphoria persists into adulthood. Gender dysphoria during childhood does not inevitably continue into adulthood.[5] Rather, in follow-up studies of prepubertal children (mainly boys) who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6-23% of children (Cohen-Kettenis, 2001; Zucker & Bradley, 1995). Boys in these studies were more likely to identify as gay in adulthood than as transgender (Green, 1987; Money & Russo, 1979; Zucker & Bradley, 1995; Zuger, 1984). Newer studies, also including girls, showed a 12-27% persistence rate of gender dysphoria into adulthood (Drummond, Bradley, Peterson-Badali, & Zucker, 2008; Wallien & Cohen-Kettenis, 2008).

In contrast, the persistence of gender dysphoria into adulthood appears to be much higher for adolescents. No formal prospective studies exist. However, in a follow-up study of 70 adolescents who were diagnosed with gender dysphoria and given puberty suppressing hormones, all continued with the actual sex reassignment, beginning with feminizing/masculinizing hormone therapy (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010).

Another difference between gender dysphoric children and adolescents is in the sex ratios for each age group. In clinically referred, gender dysphoric children under age 12, the male/female ratio ranges from 6:1 to 3:1 (Zucker, 2004). In clinically referred, gender dysphoric adolescents older than age 12, the male/female ratio is close to 1:1 (Cohen-Kettenis & Pfäfflin, 2003).

As discussed in section IV and by Zucker and Lawrence (2009), formal epidemiologic studies on gender dysphoria – in children, adolescents, and adults – are lacking. Additional research is needed to refine estimates of its prevalence and persistence in different populations worldwide.

5 Gender nonconforming behaviors in children may continue into adulthood, but such behaviors are not necessarily indicative of gender dysphoria and a need for treatment. As described in section III, gender dysphoria is not synonymous with diversity in gender expression.

## Phenomenology in Children

Children as young as age two may show features that could indicate gender dysphoria. They may express a wish to be of the other sex and be unhappy about their physical sex characteristics and functions. In addition, they may prefer clothes, toys, and games that are commonly associated with the other sex and prefer playing with other-sex peers. There appears to be heterogeneity in these features: Some children demonstrate extremely gender nonconforming behavior and wishes, accompanied by persistent and severe discomfort with their primary sex characteristics. In other children, these characteristics are less intense or only partially present (Cohen-Kettenis et al., 2006; Knudson, De Cuypere, & Bockting, 2010a).

It is relatively common for gender dysphoric children to have co-existing internalizing disorders such as anxiety and depression (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003; Wallien, Swaab, & Cohen-Kettenis, 2007; Zucker, Owen, Bradley, & Ameeriar, 2002). The prevalence of autistic spectrum disorders seems to be higher in clinically referred, gender dysphoric children than in the general population (de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010).

## Phenomenology in Adolescents

In most children, gender dysphoria will disappear before or early in puberty. However, in some children these feelings will intensify and body aversion will develop or increase as they become adolescents and their secondary sex characteristics develop (Cohen-Kettenis, 2001; Cohen-Kettenis & Pfäfflin, 2003; Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Data from one study suggest that more extreme gender nonconformity in childhood is associated with persistence of gender dysphoria into late adolescence and early adulthood (Wallien & Cohen-Kettenis, 2008). Yet many adolescents and adults presenting with gender dysphoria do not report a history of childhood gender nonconforming behaviors (Docter, 1988; Landén, Wålinder, & Lundström, 1998). Therefore, it may come as a surprise to others (parents, other family members, friends, and community members) when a youth's gender dysphoria first becomes evident in adolescence.

Adolescents who experience their primary and/or secondary sex characteristics and their sex assigned at birth as inconsistent with their gender identity may be intensely distressed about it. Many, but not all, gender dysphoric adolescents have a strong wish for hormones and surgery. Increasing numbers of adolescents have already started living in their desired gender role upon entering high school (Cohen-Kettenis & Pfäfflin, 2003).

Among adolescents who are referred to gender identity clinics, the number considered eligible for early medical treatment – starting with GnRH analogues to suppress puberty in the first Tanner stages – differs among countries and centers. Not all clinics offer puberty suppression. If such treatment is offered, the pubertal stage at which adolescents are allowed to start varies from Tanner stage 2 to stage 4 (Delemarre-van de Waal & Cohen-Kettenis, 2006; Zucker et al., in press). The percentages of treated adolescents are likely influenced by the organization of health care, insurance aspects, cultural differences, opinions of health professionals, and diagnostic procedures offered in different settings.

Inexperienced clinicians may mistake indications of gender dysphoria for delusions. Phenomenologically, there is a qualitative difference between the presentation of gender dysphoria and the presentation of delusions or other psychotic symptoms. The vast majority of children and adolescents with gender dysphoria are not suffering from underlying severe psychiatric illness such as psychotic disorders (Steensma, Biemond, de Boer, & Cohen-Kettenis, published online ahead of print January 7, 2011).

It is more common for adolescents with gender dysphoria to have co-existing internalizing disorders such as anxiety and depression, and/or externalizing disorders such as oppositional defiant disorder (de Vries et al., 2010). As in children, there seems to be a higher prevalence of autistic spectrum disorders in clinically referred, gender dysphoric adolescents than in the general adolescent population (de Vries et al., 2010).

## Competency of Mental Health Professionals Working with Children or Adolescents with Gender Dysphoria

The following are recommended minimum credentials for mental health professionals who assess, refer, and offer therapy to children and adolescents presenting with gender dysphoria:

1. Meet the competency requirements for mental health professionals working with adults, as outlined in section VII;

2. Trained in childhood and adolescent developmental psychopathology;

3. Competent in diagnosing and treating the ordinary problems of children and adolescents.

## Roles of Mental Health Professionals Working with Children and Adolescents with Gender Dysphoria

The roles of mental health professionals working with gender dysphoric children and adolescents may include the following:

1. Directly assess gender dysphoria in children and adolescents (see general guidelines for assessment, below).

2. Provide family counseling and supportive psychotherapy to assist children and adolescents with exploring their gender identity, alleviating distress related to their gender dysphoria, and ameliorating any other psychosocial difficulties.

3. Assess and treat any co-existing mental health concerns of children or adolescents (or refer to another mental health professional for treatment). Such concerns should be addressed as part of the overall treatment plan.

4. Refer adolescents for additional physical interventions (such as puberty suppressing hormones) to alleviate gender dysphoria. The referral should include documentation of an assessment of gender dysphoria and mental health, the adolescent's eligibility for physical interventions (outlined below), the mental health professional's relevant expertise, and any other information pertinent to the youth's health and referral for specific treatments.

5. Educate and advocate on behalf of gender dysphoric children, adolescents, and their families in their community (e.g., day care centers, schools, camps, other organizations). This is particularly important in light of evidence that children and adolescents who do not conform to socially prescribed gender norms may experience harassment in school (Grossman, D'Augelli, & Salter, 2006; Grossman, D'Augelli, Howell, & Hubbard, 2006; Sausa, 2005), putting them at risk for social isolation, depression, and other negative sequelae (Nuttbrock et al., 2010).

6. Provide children, youth, and their families with information and referral for peer support, such as support groups for parents of gender nonconforming and transgender children (Gold & MacNish, 2011; Pleak, 1999; Rosenberg, 2002).

Assessment and psychosocial interventions for children and adolescents are often provided within a multi-disciplinary gender identity specialty service. If such a multidisciplinary service is not available, a mental health professional should provide consultation and liaison arrangements with a pediatric endocrinologist for the purpose of assessment, education, and involvement in any decisions about physical interventions.

## Psychological Assessment of Children and Adolescents

When assessing children and adolescents who present with gender dysphoria, mental health professionals should broadly conform to the following guidelines:

1. Mental health professionals should not dismiss or express a negative attitude towards nonconforming gender identities or indications of gender dysphoria. Rather, they should acknowledge the presenting concerns of children, adolescents, and their families; offer a thorough assessment for gender dysphoria and any co-existing mental health concerns; and educate clients and their families about therapeutic options, if needed. Acceptance and removal of secrecy can bring considerable relief to gender dysphoric children/adolescents and their families.

2. Assessment of gender dysphoria and mental health should explore the nature and characteristics of a child's or adolescent's gender identity. A psychodiagnostic and psychiatric assessment – covering the areas of emotional functioning, peer and other social relationships, and intellectual functioning/school achievement – should be performed. Assessment should include an evaluation of the strengths and weaknesses of family functioning. Emotional and behavioral problems are relatively common, and unresolved issues in a child's or youth's environment may be present (de Vries, Doreleijers, Steensma, & Cohen-Kettenis, 2011; Di Ceglie & Thümmel, 2006; Wallien et al., 2007).

3. For adolescents, the assessment phase should also be used to inform youth and their families about the possibilities and limitations of different treatments. This is necessary for informed consent, but also important for assessment. The way that adolescents respond to information about the reality of sex reassignment can be diagnostically informative. Correct information may alter a youth's desire for certain treatment, if the desire was based on unrealistic expectations of its possibilities.

## Psychological and Social Interventions for Children and Adolescents

When supporting and treating children and adolescents with gender dysphoria, health professionals should broadly conform to the following guidelines:

1. Mental health professionals should help families to have an accepting and nurturing response to the concerns of their gender dysphoric child or adolescent. Families play an important role in the psychological health and well-being of youth (Brill & Pepper, 2008; Lev, 2004). This also applies to peers and mentors from the community, who can be another source of social support.

2. Psychotherapy should focus on reducing a child's or adolescent's distress related to the gender dysphoria and on ameliorating any other psychosocial difficulties. For youth pursuing sex reassignment, psychotherapy may focus on supporting them before, during, and after reassignment. Formal evaluations of different psychotherapeutic approaches for this situation have not been published, but several counseling methods have been described (Cohen-Kettenis, 2006; de Vries, Cohen-Kettenis, & Delemarre-van de Waal, 2006; Di Ceglie & Thümmel, 2006; Hill, Menvielle, Sica, & Johnson, 2010; Malpas, in press; Menvielle & Tuerk, 2002; Rosenberg, 2002; Vanderburgh, 2009; Zucker, 2006).

Treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth has been attempted in the past without success (Gelder & Marks, 1969; Greenson, 1964), particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

1. Families should be supported in managing uncertainty and anxiety about their child's or adolescent's psychosexual outcomes and in helping youth to develop a positive self-concept.

2. Mental health professionals should not impose a binary view of gender. They should give ample room for clients to explore different options for gender expression. Hormonal or surgical interventions are appropriate for some adolescents, but not for others.

3. Clients and their families should be supported in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity, as well as the timing of changes in gender role and possible social transition. For example, a client might attend school while undergoing social transition only partly (e.g., by wearing clothing and having a hairstyle that reflects gender identity) or completely (e.g., by also using a name and pronouns congruent with gender identity). Difficult issues include whether and when to inform other people of the client's situation, and how others in their lives should respond.

4. Health professionals should support clients and their families as educators and advocates in their interactions with community members and authorities such as teachers, school boards, and courts.

5. Mental health professionals should strive to maintain a therapeutic relationship with gender nonconforming children/adolescents and their families throughout any subsequent social changes or physical interventions. This ensures that decisions about gender expression and the treatment of gender dysphoria are thoughtfully and recurrently considered. The same reasoning applies if a child or adolescent has already socially changed gender role prior to being seen by a mental health professional.

## Social Transition in Early Childhood

Some children state that they want to make a social transition to a different gender role long before puberty. For some children, this may reflect an expression of their gender identity. For others, this could be motivated by other forces. Families vary in the extent to which they allow their young children to make a social transition to another gender role. Social transitions in early childhood do occur within some families with early success. This is a controversial issue, and divergent views are held by health professionals. The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood. Outcomes research with children who completed early social transitions would greatly inform future clinical recommendations.

Mental health professionals can help families to make decisions regarding the timing and process of any gender role changes for their young children. They should provide information and help parents to weigh the potential benefits and challenges of particular choices. Relevant in this respect are the previously described relatively low persistence rates of childhood gender dysphoria (Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008). A change back to the original gender role can be highly distressing and even result in postponement of this second social transition on the child's part (Steensma & Cohen-Kettenis, 2011). For reasons such as these, parents may want to present this role change as an exploration of living in another gender role, rather than an irreversible situation. Mental health professionals can assist parents in identifying potential in-between solutions or compromises (e.g., only when on vacation). It is also important that parents explicitly let the child know that there is a way back.

Regardless of a family's decisions regarding transition (timing, extent), professionals should counsel and support them as they work through the options and implications. If parents do not allow their young child to make a gender role transition, they may need counseling to assist them with meeting their child's needs in a sensitive and nurturing way, ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment. If parents do allow their young child to make a gender role transition, they may need counseling to facilitate a positive experience for their child. For example, they may need support in using correct pronouns, maintaining a safe and supportive environment for their transitioning child (e.g., in school, peer group settings), and communicating with other people in their child's life. In either case, as a child nears puberty, further assessment may be needed as options for physical interventions become relevant.

## Physical Interventions for Adolescents

Before any physical interventions are considered for adolescents, extensive exploration of psychological, family, and social issues should be undertaken, as outlined above. The duration of this exploration may vary considerably depending on the complexity of the situation.

Physical interventions should be addressed in the context of adolescent development. Some identity beliefs in adolescents may become firmly held and strongly expressed, giving a false impression of irreversibility. An adolescent's shift towards gender conformity can occur primarily to please the parents and may not persist or reflect a permanent change in gender dysphoria (Hembree et al., 2009; Steensma et al., published online ahead of print January 7, 2011).

Physical interventions for adolescents fall into three categories or stages (Hembree et al., 2009):

1. *Fully reversible interventions*. These involve the use of GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty. Alternative treatment options include progestins (most commonly medroxyprogesterone) or other medications (such as spironolactone) that decrease the effects of androgens secreted by the testicles of adolescents who are not receiving GnRH analogues. Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses.

2. *Partially reversible interventions*. These include hormone therapy to masculinize or feminize the body. Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia caused by estrogens), while other changes are not reversible (e.g., deepening of the voice caused by testosterone).

3. *Irreversible interventions*. These are surgical procedures.

A staged process is recommended to keep options open through the first two stages. Moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions.

## Fully Reversible Interventions

Adolescents may be eligible for puberty suppressing hormones as soon as pubertal changes have begun. In order for adolescents and their parents to make an informed decision about pubertal delay, it is recommended that adolescents experience the onset of puberty to at least Tanner Stage 2. Some children may arrive at this stage at very young ages (e.g., 9 years of age). Studies

evaluating this approach only included children who were at least 12 years of age (Cohen-Kettenis, Schagen, Steensma, de Vries, & Delemarre-van de Waal, 2011; de Vries, Steensma et al., 2010; Delemarre-van de Waal, van Weissenbruch, & Cohen Kettenis, 2004; Delemarre-van de Waal & Cohen-Kettenis, 2006).

Two goals justify intervention with puberty suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues; and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment.

Puberty suppression may continue for a few years, at which time a decision is made to either discontinue all hormone therapy or transition to a feminizing/masculinizing hormone regimen. Pubertal suppression does not inevitably lead to social transition or to sex reassignment.

**Criteria for puberty suppressing hormones**

In order for adolescents to receive puberty suppressing hormones, the following minimum criteria must be met:

1. The adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed);

2. Gender dysphoria emerged or worsened with the onset of puberty;

3. Any co-existing psychological, medical, or social problems that could interfere with treatment (e.g., that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

4. The adolescent has given informed consent and, particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process.

**Regimens, monitoring, and risks for puberty suppression**

For puberty suppression, adolescents with male genitalia should be treated with GnRH analogues, which stop luteinizing hormone secretion and therefore testosterone secretion. Alternatively, they may be treated with progestins (such as medroxyprogesterone) or with other medications that block testosterone secretion and/or neutralize testosterone action. Adolescents with female genitalia should be treated with GnRH analogues, which stop the production of estrogens and

progesterone. Alternatively, they may be treated with progestins (such as medroxyprogesterone). Continuous oral contraceptives (or depot medroxyprogesterone) may be used to suppress menses. In both groups of adolescents, use of GnRH analogues is the preferred treatment (Hembree et al., 2009), but their high cost is prohibitive for some patients

During pubertal suppression, an adolescent's physical development should be carefully monitored – preferably by a pediatric endocrinologist – so that any necessary interventions can occur (e.g., to establish an adequate gender appropriate height, to improve iatrogenic low bone marrow density) (Hembree et al., 2009).

Early use of puberty suppressing hormones may avert negative social and emotional consequences of gender dysphoria more effectively than their later use would. Intervention in early adolescence should be managed with pediatric endocrinological advice, when available. Adolescents with male genitalia who start GnRH analogues early in puberty should be informed that this could result in insufficient penile tissue for penile inversion vaginoplasty techniques (alternative techniques, such as the use of a skin graft or colon tissue, are available).

Neither puberty suppression nor allowing puberty to occur is a neutral act. On the one hand, functioning in later life can be compromised by the development of irreversible secondary sex characteristics during puberty and by years spent experiencing intense gender dysphoria. On the other hand, there are concerns about negative physical side effects of GnRH analog use (e.g., on bone development and height). Although the very first results of this approach (as assessed for adolescents followed over 10 years) are promising (Cohen-Kettenis et al., 2011; Delemarre-van de Waal & Cohen-Kettenis, 2006), the long-term effects can only be determined when the earliest treated patients reach the appropriate age.

## Partially Reversible Interventions

Adolescents may be eligible to begin feminizing/masculinizing hormone therapy, preferably with parental consent. In many countries, 16-year-olds are legal adults for medical decision-making and do not require parental consent. Ideally, treatment decisions should be made among the adolescent, the family, and the treatment team.

Regimens for hormone therapy in gender dysphoric adolescents differ substantially from those used in adults (Hembree et al., 2009). The hormone regimens for youth are adapted to account for the somatic, emotional, and mental development that occurs throughout adolescence (Hembree et al., 2009).



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## Irreversible Interventions

Genital surgery should not be carried out until (i) patients reach the legal age of majority in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention.

Chest surgery in FtM patients could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust in a more masculine gender role, before undergoing irreversible surgery. However, different approaches may be more suitable, depending on an adolescent's specific clinical situation and goals for gender identity expression.

## Risks of Withholding Medical Treatment for Adolescents

Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence (Nuttbrock et al., 2010), withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents.

# VII
# Mental Health

Transsexual, transgender, and gender nonconforming people might seek the assistance of a mental health professional for any number of reasons. Regardless of a person's reason for seeking care, mental health professionals should have familiarity with gender nonconformity, act with appropriate cultural competence, and exhibit sensitivity in providing care.

This section of the *SOC* focuses on the role of mental health professionals in the care of adults seeking help for gender dysphoria and related concerns. Professionals working with gender dysphoric children, adolescents, and their families should consult section VI.

# Competency of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

The training of mental health professionals competent to work with gender dysphoric adults rests upon basic general clinical competence in the assessment, diagnosis, and treatment of mental health concerns. Clinical training may occur within any discipline that prepares mental health professionals for clinical practice, such as psychology, psychiatry, social work, mental health counseling, marriage and family therapy, nursing, or family medicine with specific training in behavioral health and counseling. The following are recommended minimum credentials for mental health professionals who work with adults presenting with gender dysphoria:

1. A master's degree or its equivalent in a clinical behavioral science field. This degree or a more advanced one should be granted by an institution accredited by the appropriate national or regional accrediting board. The mental health professional should have documented credentials from a relevant licensing board or equivalent for that country.

2. Competence in using the *Diagnostic Statistical Manual of Mental Disorders* and/or the *International Classification of Diseases* for diagnostic purposes.

3. Ability to recognize and diagnose co-existing mental health concerns and to distinguish these from gender dysphoria.

4. Documented supervised training and competence in psychotherapy or counseling.

5. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

6. Continuing education in the assessment and treatment of gender dysphoria. This may include attending relevant professional meetings, workshops, or seminars; obtaining supervision from a mental health professional with relevant experience; or participating in research related to gender nonconformity and gender dysphoria.

In addition to the minimum credentials above, it is recommended that mental health professionals develop and maintain cultural competence to facilitate their work with transsexual, transgender, and gender nonconforming clients. This may involve, for example, becoming knowledgeable about current community, advocacy, and public policy issues relevant to these clients and their families. Additionally, knowledge about sexuality, sexual health concerns, and the assessment and treatment of sexual disorders is preferred.



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Mental health professionals who are new to the field (irrespective of their level of training and other experience) should work under the supervision of a mental health professional with established competence in the assessment and treatment of gender dysphoria.

## Tasks of Mental Health Professionals Working with Adults Who Present with Gender Dysphoria

Mental health professionals may serve transsexual, transgender, and gender nonconforming individuals and their families in many ways, depending on a client's needs. For example, mental health professionals may serve as a psychotherapist, counselor, or family therapist, or as a diagnostician/assessor, advocate, or educator.

Mental health professionals should determine a client's reasons for seeking professional assistance. For example, a client may be presenting for any combination of the following health care services: psychotherapeutic assistance to explore gender identity and expression or to facilitate a coming out process; assessment and referral for feminizing/masculinizing medical interventions; psychological support for family members (partners, children, extended family); or psychotherapy unrelated to gender concerns or other professional services.

Below are general guidelines for common tasks that mental health professionals may fulfill in working with adults who present with gender dysphoria.

## Tasks Related to Assessment and Referral

**1. Assess gender dysphoria**

Mental health professionals assess clients' gender dysphoria in the context of an evaluation of their psychosocial adjustment (Bockting et al., 2006; Lev, 2004, 2009). The evaluation includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in person or online contact with other transsexual, transgender, or gender nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role

of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to or better accounted for by other diagnoses.

Mental health professionals with the competencies described above (hereafter called "a qualified mental health professional") are best prepared to conduct this assessment of gender dysphoria. However, this task may instead be conducted by another type of health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy. This professional may be the prescribing hormone therapy provider or a member of that provider's health care team.

**2. Provide information regarding options for gender identity and expression and possible medical interventions**

An important task of mental health professionals is to educate clients regarding the diversity of gender identities and expressions and the various options available to alleviate gender dysphoria. Mental health professionals then may facilitate a process (or refer elsewhere) in which clients explore these various options, with the goals of finding a comfortable gender role and expression and becoming prepared to make a fully informed decision about available medical interventions, if needed. This process may include referral for individual, family, and group therapy and/or to community resources and avenues for peer support. The professional and the client discuss the implications, both short- and long-term, of any changes in gender role and use of medical interventions. These implications can be psychological, social, physical, sexual, occupational, financial, and legal (Bockting et al., 2006; Lev, 2004).

This task is also best conducted by a qualified mental health professional, but may be conducted by another health professional with appropriate training in behavioral health and with sufficient knowledge about gender nonconforming identities and expressions and about possible medical interventions for gender dysphoria, particularly when functioning as part of a multidisciplinary specialty team that provides access to feminizing/masculinizing hormone therapy.

**3. Assess, diagnose, and discuss treatment options for co-existing mental health concerns**

Clients presenting with gender dysphoria may struggle with a range of mental health concerns (Gómez-Gil, Trilla, Salamero, Godás, & Valdés, 2009; Murad et al., 2010) whether related or unrelated to what is often a long history of gender dysphoria and/or chronic minority stress. Possible concerns include anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders (Bockting et al., 2006; Nuttbrock et al., 2010; Robinow, 2009). Mental health professionals should screen for these and other mental health concerns and incorporate

the identified concerns into the overall treatment plan. These concerns can be significant sources of distress and, if left untreated, can complicate the process of gender identity exploration and resolution of gender dysphoria (Bockting et al., 2006; Fraser, 2009a; Lev, 2009). Addressing these concerns can greatly facilitate the resolution of gender dysphoria, possible changes in gender role, the making of informed decisions about medical interventions, and improvements in quality of life.

Some clients may benefit from psychotropic medications to alleviate symptoms or treat co-existing mental health concerns. Mental health professionals are expected to recognize this and either provide pharmacotherapy or refer to a colleague who is qualified to do so. The presence of co-existing mental health concerns does not necessarily preclude possible changes in gender role or access to feminizing/masculinizing hormones or surgery; rather, these concerns need to be optimally managed prior to or concurrent with treatment of gender dysphoria. In addition, clients should be assessed for their ability to provide educated and informed consent for medical treatments.

Qualified mental health professionals are specifically trained to assess, diagnose, and treat (or refer to treatment for) these co-existing mental health concerns. Other health professionals with appropriate training in behavioral health, particularly when functioning as part of a multidisciplinary specialty team providing access to feminizing/masculinizing hormone therapy, may also screen for mental health concerns and, if indicated, provide referral for comprehensive assessment and treatment by a qualified mental health professional.

**4. If applicable, assess eligibility, prepare, and refer for hormone therapy**

The *SOC* provide criteria to guide decisions regarding feminizing/masculinizing hormone therapy (outlined in section VIII and Appendix C). Mental health professionals can help clients who are considering hormone therapy to be both psychologically prepared (for example, has made a fully informed decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has been evaluated by a physician to rule out or address medical contraindications to hormone use; has considered the psychosocial implications). If clients are of childbearing age, reproductive options (section IX) should be explored before initiating hormone therapy.

It is important for mental health professionals to recognize that decisions about hormones are first and foremost the client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

Referral for feminizing/masculinizing hormone therapy

People may approach a specialized provider in any discipline to pursue feminizing/masculinizing hormone therapy. However, transgender health care is an interdisciplinary field, and coordination of care and referral among a client's overall care team is recommended.

Hormone therapy can be initiated with a referral from a qualified mental health professional. Alternatively, a health professional who is appropriately trained in behavioral health and competent in the assessment of gender dysphoria may assess eligibility, prepare, and refer the patient for hormone therapy, particularly in the absence of significant co-existing mental health concerns and when working in the context of a multidisciplinary specialty team. The referring health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Health professionals who recommend hormone therapy share the ethical and legal responsibility for that decision with the physician who provides the service.

The recommended content of the referral letter for feminizing/masculinizing hormone therapy is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for hormone therapy have been met, and a brief description of the clinical rationale for supporting the client's request for hormone therapy;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

**5. If applicable, assess eligibility, prepare, and refer for surgery**

The *SOC* also provide criteria to guide decisions regarding breast/chest surgery and genital surgery (outlined in section XI and Appendix C). Mental health professionals can help clients who are considering surgery to be both psychologically prepared (for example, has made a fully informed

decision with clear and realistic expectations; is ready to receive the service in line with the overall treatment plan; has included family and community as appropriate) and practically prepared (for example, has made an informed choice about a surgeon to perform the procedure; has arranged aftercare). If clients are of childbearing age, reproductive options (section IX) should be explored before undergoing genital surgery.

The *SOC* do not state criteria for other surgical procedures, such as feminizing or masculinizing facial surgery; however, mental health professionals can play an important role in helping their clients to make fully informed decisions about the timing and implications of such procedures in the context of the overall coming out or transition process.

It is important for mental health professionals to recognize that decisions about surgery are first and foremost a client's decisions – as are all decisions regarding healthcare. However, mental health professionals have a responsibility to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared. To best support their clients' decisions, mental health professionals need to have functioning working relationships with their clients and sufficient information about them. Clients should receive prompt and attentive evaluation, with the goal of alleviating their gender dysphoria and providing them with appropriate medical services.

### Referral for surgery

Surgical treatments for gender dysphoria can be initiated with a referral (one or two, depending on the type of surgery) from a qualified mental health professional. The mental health professional provides documentation – in the chart and/or referral letter – of the patient's personal and treatment history, progress, and eligibility. Mental health professionals who recommend surgery share the ethical and legal responsibility for that decision with the surgeon.

- One referral from a qualified mental health professional is needed for breast/chest surgery (e.g., mastectomy, chest reconstruction, or augmentation mammoplasty).

- Two referrals – from qualified mental health professionals who have independently assessed the patient – are needed for genital surgery (i.e., hysterectomy/salpingo-oophorectomy, orchiectomy, genital reconstructive surgeries). If the first referral is from the patient's psychotherapist, the second referral should be from a person who has only had an evaluative role with the patient. Two separate letters, or one letter signed by both (e.g., if practicing within the same clinic) may be sent. Each referral letter, however, is expected to cover the same topics in the areas outlined below.

The recommended content of the referral letters for surgery is as follows:

1. The client's general identifying characteristics;

2. Results of the client's psychosocial assessment, including any diagnoses;

3. The duration of the mental health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;

4. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the patient's request for surgery;

5. A statement about the fact that informed consent has been obtained from the patient;

6. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.

For providers working within a multidisciplinary specialty team, a letter may not be necessary, rather, the assessment and recommendation can be documented in the patient's chart.

**Relationship of Mental Health Professionals with Hormone-Prescribing Physicians, Surgeons, and other Health Professionals**

It is ideal for mental health professionals to perform their work and periodically discuss progress and obtain peer consultation from other professionals (both in mental health care and other health disciplines) who are competent in the assessment and treatment of gender dysphoria. The relationship among professionals involved in a client's health care should remain collaborative, with coordination and clinical dialogue taking place as needed. Open and consistent communication may be necessary for consultation, referral, and management of postoperative concerns.

## Tasks Related to Psychotherapy

**1. Psychotherapy is not an absolute requirement for hormone therapy and surgery**

A mental health screening and/or assessment as outlined above is needed for referral to hormonal and surgical treatments for gender dysphoria. In contrast, psychotherapy – although highly recommended – is not a requirement.

The *SOC* do not recommend a minimum number of psychotherapy sessions prior to hormone therapy or surgery. The reasons for this are multifaceted (Lev, 2009). First, a minimum number of sessions tends to be construed as a hurdle, which discourages the genuine opportunity for personal growth. Second, mental health professionals can offer important support to clients throughout all

phases of exploration of gender identity, gender expression, and possible transition – not just prior to any possible medical interventions. Third, clients differ in their abilities to attain similar goals in a specified time period.

**2. Goals of psychotherapy for adults with gender concerns**

The general goal of psychotherapy is to find ways to maximize a person's overall psychological well-being, quality of life, and self-fulfillment. Psychotherapy is not intended to alter a person's gender identity; rather, psychotherapy can help an individual to explore gender concerns and find ways to alleviate gender dysphoria, if present (Bockting et al., 2006; Bockting & Coleman, 2007; Fraser, 2009a; Lev, 2004). Typically, the overarching treatment goal is to help transsexual, transgender, and gender nonconforming individuals achieve long-term comfort in their gender identity expression, with realistic chances for success in their relationships, education, and work. For additional details, see Fraser (Fraser, 2009c).

Therapy may consist of individual, couple, family, or group psychotherapy, the latter being particularly important to foster peer support.

**3. Psychotherapy for transsexual, transgender, and gender nonconforming clients, including counseling and support for changes in gender role**

Finding a comfortable gender role is, first and foremost, a psychosocial process. Psychotherapy can be invaluable in assisting transsexual, transgender, and gender nonconforming individuals with all of the following: (i) clarifying and exploring gender identity and role, (ii) addressing the impact of stigma and minority stress on one's mental health and human development, and (iii) facilitating a coming out process (Bockting & Coleman, 2007; Devor, 2004; Lev, 2004), which for some individuals may include changes in gender role expression and the use of feminizing/masculinizing medical interventions.

Mental health professionals can provide support and promote interpersonal skills and resilience in individuals and their families as they navigate a world that often is ill prepared to accommodate and respect transgender, transsexual, and gender nonconforming people. Psychotherapy can also aid in alleviating any co-existing mental health concerns (e.g., anxiety, depression) identified during screening and assessment.

For transsexual, transgender, and gender nonconforming individuals who plan to change gender roles permanently and make a social gender role transition, mental health professionals can facilitate the development of an individualized plan with specific goals and timelines. While the experience of changing one's gender role differs from person to person, the social aspects of the experience are usually challenging – often more so than the physical aspects. Because changing



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gender role can have profound personal and social consequences, the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role.

Many transsexual, transgender, and gender nonconforming people will present for care without ever having been related to or accepted in the gender role that is most congruent with their gender identity. Mental health professionals can help these clients to explore and anticipate the implications of changes in gender role, and to pace the process of implementing these changes. Psychotherapy can provide a space for clients to begin to express themselves in ways that are congruent with their gender identity and, for some clients, overcome fear about changes in gender expression. Calculated risks can be taken outside of therapy to gain experience and build confidence in the new role. Assistance with coming out to family and community (friends, school, workplace) can be provided.

Other transsexual, transgender, and gender nonconforming individuals will present for care already having acquired experience (minimal, moderate, or extensive) living in a gender role that differs from that associated with their birth-assigned sex. Mental health professionals can help these clients to identify and work through potential challenges and foster optimal adjustment as they continue to express changes in their gender role.

**4. Family therapy or support for family members**

Decisions about changes in gender role and medical interventions for gender dysphoria have implications for not only clients, but also their families (Emerson & Rosenfeld, 1996; Fraser, 2009a; Lev, 2004). Mental health professionals can assist clients with making thoughtful decisions about communicating with family members and others about their gender identity and treatment decisions. Family therapy may include work with spouses or partners, as well as with children and other members of a client's extended family.

Clients may also request assistance with their relationships and sexual health. For example, they may want to explore their sexuality and intimacy related concerns.

Family therapy might be offered as part of the client's individual therapy and, if clinically appropriate, by the same provider. Alternatively, referrals can be made to other therapists with relevant expertise to work with family members, or to sources of peer support (e.g., online or offline support networks of partners or families).



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**5. Follow-up care throughout life**

Mental health professionals may work with clients and their families at many stages of their lives. Psychotherapy may be helpful at different times and for various issues throughout the life cycle.

**6. Etherapy, online counseling, or distance counseling**

Online or etherapy has been shown to be particularly useful for people who have difficulty accessing competent psychotherapeutic treatment and who may experience isolation and stigma (Derrig-Palumbo & Zeine, 2005; Fenichel et al., 2004; Fraser, 2009b). By extrapolation, etherapy may be a useful modality for psychotherapy with transsexual, transgender, and gender nonconforming people. Etherapy offers opportunities for potentially enhanced, expanded, creative, and tailored delivery of services; however, as a developing modality it may also carry unexpected risk. Telemedicine guidelines are clear in some disciplines in some parts of the United States (Fraser, 2009b; Maheu, Pulier, Wilhelm, McMenamin, & Brown-Connolly, 2005) but not all; the international situation is even less defined (Maheu et al., 2005). Until sufficient evidence-based data on this use of etherapy is available, caution in its use is advised.

Mental health professionals engaging in etherapy are advised to stay current with their particular licensing board, professional association, and country's regulations, as well as the most recent literature pertaining to this rapidly evolving medium. A more thorough description of the potential uses, processes, and ethical concerns related to etherapy has been published (Fraser, 2009b).

## Other Tasks of the Mental Health Professional

**1. Educate and advocate on behalf of clients within their community (schools, workplaces, other organizations) and assist clients with making changes in identity documents**

Transsexual, transgender, and gender nonconforming people may face challenges in their professional, educational, and other types of settings as they actualize their gender identity and expression (Lev, 2004, 2009). Mental health professionals can play an important role by educating people in these settings regarding gender nonconformity and by advocating on behalf of their clients (Currah, Juang, & Minter, 2006) (Currah & Minter, 2000). This role may involve consultation with school counselors, teachers, and administrators, human resources staff, personnel managers and employers, and representatives from other organizations and institutions. In addition, health providers may be called upon to support changes in a client's name and/or gender marker on identity documents such as passports, driver's licenses, birth certificates, and diplomas.



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**2. Provide information and referral for peer support**

For some transsexual, transgender, and gender nonconforming people, an experience in peer support groups may be more instructive regarding options for gender expression than anything individual psychotherapy could offer (Rachlin, 2002). Both experiences are potentially valuable, and all people exploring gender issues should be encouraged to participate in community activities, if possible. Resources for peer support and information should be made available.

## Culture and its Ramifications for Assessment and Psychotherapy

Health professionals work in enormously different environments across the world. Forms of distress that cause people to seek professional assistance in any culture are understood and classified by people in terms that are products of their own cultures (Frank & Frank, 1993). Cultural settings also largely determine how such conditions are understood by mental health professionals. Cultural differences related to gender identity and expression can affect patients, mental health professionals, and accepted psychotherapy practice. WPATH recognizes that the *SOC* have grown out of a Western tradition and may need to be adapted depending on the cultural context.

## Ethical Guidelines Related to Mental Health Care

Mental health professionals need to be certified or licensed to practice in a given country according to that country's professional regulations (Fraser, 2009b; Pope & Vasquez, 2011). Professionals must adhere to the ethical codes of their professional licensing or certifying organizations in all of their work with transsexual, transgender, and gender nonconforming clients.

Treatment aimed at trying to change a person's gender identity and lived gender expression to become more congruent with sex assigned at birth has been attempted in the past (Gelder & Marks, 1969; Greenson, 1964), yet without success, particularly in the long term (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). Such treatment is no longer considered ethical.

If mental health professionals are uncomfortable with or inexperienced in working with transsexual, transgender, and gender nonconforming individuals and their families, they should refer clients to a competent provider or, at minimum, consult with an expert peer. If no local practitioners are available, consultation may be done via telehealth methods, assuming local requirements for distance consultation are met.



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## Issues of Access to Care

Qualified mental health professionals are not universally available; thus, access to quality care might be limited. WPATH aims to improve access and provides regular continuing education opportunities to train professionals from various disciplines to provide quality, transgender-specific health care. Providing mental health care from a distance through the use of technology may be one way to improve access (Fraser, 2009b).

In many places around the world, access to health care for transsexual, transgender, and gender nonconforming people is also limited by a lack of health insurance or other means to pay for needed care. WPATH urges health insurance companies and other third-party payers to cover the medically necessary treatment to alleviate gender dysphoria (American Medical Association, 2008; Anton, 2009; The World Professional Association for Transgender Health, 2008).

When faced with a client who is unable to access services, referral to available peer support resources (offline and online) is recommended. Finally, harm reduction approaches might be indicated to assist clients with making healthy decisions to improve their lives.

# VIII
# Hormone Therapy

### Medical Necessity of Hormone Therapy

Feminizing/masculinizing hormone therapy – the administration of exogenous endocrine agents to induce feminizing or masculinizing changes – is a medically necessary intervention for many transsexual, transgender, and gender nonconforming individuals with gender dysphoria (Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998). Some people seek maximum feminization/masculinization, while others experience relief with an androgynous presentation resulting from hormonal minimization of existing secondary sex characteristics (Factor & Rothblum, 2008). Evidence for the psychosocial outcomes of hormone therapy is summarized in Appendix D.

Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Hormone therapy can provide significant comfort to patients who do not wish to make a social gender role transition or undergo surgery, or who are unable to do so (Meyer III, 2009).

Hormone therapy is a recommended criterion for some, but not all, surgical treatments for gender dysphoria (see section XI and Appendix C).

**Criteria for Hormone Therapy**

Initiation of hormone therapy may be undertaken after a psychosocial assessment has been conducted and informed consent has been obtained by a qualified health professional, as outlined in section VII of the *SOC*. A referral is required from the mental health professional who performed the assessment, unless the assessment was done by a hormone provider who is also qualified in this area.

The criteria for hormone therapy are as follows:

1. Persistent, well-documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country (if younger, follow the *Standards of Care* outlined in section VI);

4. If significant medical or mental health concerns are present, they must be reasonably well-controlled.

As noted in section VII of the *SOC*, the presence of co-existing mental health concerns does not necessarily preclude access to feminizing/masculinizing hormones; rather, these concerns need to be managed prior to or concurrent with treatment of gender dysphoria.

In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use. It is unethical to deny availability or eligibility for hormone therapy solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis B or C.

In rare cases, hormone therapy may be contraindicated due to serious individual health conditions. Health professionals should assist these patients with accessing non-hormonal interventions for gender dysphoria. A qualified mental health professional familiar with the patient is an excellent resource in these circumstances.



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**Informed Consent**

Feminizing/masculinizing hormone therapy may lead to irreversible physical changes. Thus, hormone therapy should be provided only to those who are legally able to provide informed consent. This includes people who have been declared by a court to be emancipated minors, incarcerated people, and cognitively impaired people who are considered competent to participate in their medical decisions (see also Bockting et al., 2006). Providers should document in the medical record that comprehensive information has been provided and understood about all relevant aspects of the hormone therapy, including both possible benefits and risks and the impact on reproductive capacity.

**Relationship between the Standards of Care and Informed Consent Model Protocols**

A number of community health centers in the United States have developed protocols for providing hormone therapy based on an approach that has become known as the Informed Consent Model (Callen Lorde Community Health Center, 2000, 2011; Fenway Community Health Transgender Health Program, 2007; Tom Waddell Health Center, 2006). These protocols are consistent with the guidelines presented in the WPATH *Standards of Care, Version 7*. The *SOC* are flexible clinical guidelines; they allow for tailoring of interventions to the needs of the individual receiving services and for tailoring of protocols to the approach and setting in which these services are provided (Ehrbar & Gorton, 2010).

Obtaining informed consent for hormone therapy is an important task of providers to ensure that patients understand the psychological and physical benefits and risks of hormone therapy, as well as its psychosocial implications. Providers prescribing the hormones or health professionals recommending the hormones should have the knowledge and experience to assess gender dysphoria. They should inform individuals of the particular benefits, limitations, and risks of hormones, given the patient's age, previous experience with hormones, and concurrent physical or mental health concerns.

Screening for and addressing acute or current mental health concerns is an important part of the informed consent process. This may be done by a mental health professional or by an appropriately trained prescribing provider (see section VII of the *SOC*). The same provider or another appropriately trained member of the health care team (e.g., a nurse) can address the psychosocial implications of taking hormones when necessary (e.g., the impact of masculinization/feminization on how one is perceived and its potential impact on relationships with family, friends, and coworkers). If indicated, these providers will make referrals for psychotherapy and for the assessment and treatment of co-existing mental health concerns such as anxiety or depression.

The difference between the Informed Consent Model and *SOC, Version 7* is that the *SOC* puts greater emphasis on the important role that mental health professionals can play in alleviating gender dysphoria and facilitating changes in gender role and psychosocial adjustment. This may include a comprehensive mental health assessment and psychotherapy, when indicated. In the Informed Consent Model, the focus is on obtaining informed consent as the threshold for the initiation of hormone therapy in a multidisciplinary, harm-reduction environment. Less emphasis is placed on the provision of mental health care until the patient requests it, unless significant mental health concerns are identified that would need to be addressed before hormone prescription.

## Physical Effects of Hormone Therapy

Feminizing/masculinizing hormone therapy will induce physical changes that are more congruent with a patient's gender identity.

- In FtM patients, the following physical changes are expected to occur: deepened voice, clitoral enlargement (variable), growth in facial and body hair, cessation of menses, atrophy of breast tissue, increased libido, and decreased percentage of body fat compared to muscle mass.

- In MtF patients, the following physical changes are expected to occur: breast growth (variable), decreased libido and erections, decreased testicular size, and increased percentage of body fact compared to muscle mass.

Most physical changes, whether feminizing or masculinizing, occur over the course of two years. The amount of physical change and the exact timeline of effects can be highly variable. Tables 1a and 1b outline the approximate time course of these physical changes.

TABLE 1A: EFFECTS AND EXPECTED TIME COURSE OF MASCULINIZING HORMONES [A]

| Effect | Expected Onset[B] | Expected Maximum Effect[B] |
|---|---|---|
| Skin oiliness/acne | 1-6 months | 1-2 years |
| Facial/body hair growth | 3-6 months | 3-5 years |
| Scalp hair loss | >12 months[C] | variable |
| Increased muscle mass/strength | 6-12 months | 2-5 years[D] |
| Body fat redistribution | 3-6 months | 2-5 years |
| Cessation of menses | 2-6 months | n/a |
| Clitoral enlargement | 3-6 months | 1-2 years |
| Vaginal atrophy | 3-6 months | 1-2 years |
| Deepened voice | 3-12 months | 1-2 years |

[A] Adapted with permission from Hembree et al.(2009). *Copyright 2009, The Endocrine Society*.
[B] Estimates represent published and unpublished clinical observations.
[C] Highly dependent on age and inheritance; may be minimal.
[D] Significantly dependent on amount of exercise.

TABLE 1B: EFFECTS AND EXPECTED TIME COURSE OF FEMINIZING HORMONES [A]

| Effect | Expected Onset[B] | Expected Maximum Effect[B] |
|---|---|---|
| Body fat redistribution | 3-6 months | 2-5 years |
| Decreased muscle mass/ strength | 3-6 months | 1-2 years[C] |
| Softening of skin/decreased oiliness | 3-6 months | unknown |
| Decreased libido | 1-3 months | 1-2 years |
| Decreased spontaneous erections | 1-3 months | 3-6 months |
| Male sexual dysfunction | variable | variable |
| Breast growth | 3-6 months | 2-3 years |
| Decreased testicular volume | 3-6 months | 2-3 years |
| Decreased sperm production | variable | variable |
| Thinning and slowed growth of body and facial hair | 6-12 months | > 3 years[D] |
| Male pattern baldness | No regrowth, loss stops 1-3 months | 1-2 years |

[A] Adapted with permission from Hembree et al. (2009). *Copyright 2009, The Endocrine Society*.
[B] Estimates represent published and unpublished clinical observations.
[C] Significantly dependent on amount of exercise.
[D] Complete removal of male facial and body hair requires electrolysis, laser treatment, or both.

The degree and rate of physical effects depends in part on the dose, route of administration, and medications used, which are selected in accordance with a patient's specific medical goals (e.g., changes in gender role expression, plans for sex reassignment) and medical risk profile. There is no current evidence that response to hormone therapy – with the possible exception of voice deepening in FtM persons – can be reliably predicted based on age, body habitus, ethnicity, or family appearance. All other factors being equal, there is no evidence to suggest that any medically approved type or method of administering hormones is more effective than any other in producing the desired physical changes.

## Risks of Hormone Therapy

All medical interventions carry risks. The likelihood of a serious adverse event is dependent on numerous factors: the medication itself, dose, route of administration, and a patient's clinical characteristics (age, co-morbidities, family history, health habits). It is thus impossible to predict whether a given adverse effect will happen in an individual patient.

The risks associated with feminizing/masculinizing hormone therapy for the transsexual, transgender, and gender nonconforming population as a whole are summarized in Table 2. Based on the level of evidence, risks are categorized as follows: (i) likely increased risk with hormone therapy, (ii) possibly increased risk with hormone therapy, or (iii) inconclusive or no increased risk. Items in the last category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Additional detail about these risks can be found in Appendix B, which is based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (Dahl, Feldman, Goldberg, & Jaberi, 2006; Ettner, Monstrey, & Eyler, 2007).



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TABLE 2: RISKS ASSOCIATED WITH HORMONE THERAPY. BOLDED ITEMS ARE CLINICALLY SIGNIFICANT

| Risk Level | Feminizing hormones | Masculinizing hormones |
|---|---|---|
| Likely increased risk | **Venous thromboembolic disease**[A]<br>Gallstones<br>Elevated liver enzymes<br>Weight gain<br>**Hypertriglyceridemia** | **Polycythemia**<br>Weight gain<br>Acne<br>Androgenic alopecia (balding)<br>Sleep apnea |
| Likely increased risk with presence of additional risk factors[B] | Cardiovascular disease | |
| Possible increased risk | **Hypertension**<br>Hyperprolactinemia or prolactinom[A] | Elevated liver enzymes<br>**Hyperlipidemia** |
| Possible increased risk with presence of additional risk factors[B] | **Type 2 diabetes**[A] | **Destabilization of certain psychiatric disorders**[C]<br>**Cardiovascular disease**<br>**Hypertension**<br>**Type 2 diabetes** |
| No increased risk or inconclusive | **Breast cancer** | Loss of bone density<br>**Breast cancer**<br>**Cervical cancer**<br>**Ovarian cancer**<br>**Uterine cancer** |

[A] Risk is greater with oral estrogen administration than with transdermal estrogen administration.
[B] Additional risk factors include age.
[C] Includes bipolar, schizoaffective, and other disorders that may include manic or psychotic symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone.

## Competency of Hormone-Prescribing Physicians, Relationship with Other Health Professionals

Feminizing/masculinizing hormone therapy is best undertaken in the context of a complete approach to health care that includes comprehensive primary care and a coordinated approach to psychosocial issues (Feldman & Safer, 2009). While psychotherapy or ongoing counseling is not required for the initiation of hormone therapy, if a therapist is involved, then regular communication among health professionals is advised (with the patient's consent) to ensure that the transition process is going well, both physically and psychosocially.

With appropriate training, feminizing/masculinizing hormone therapy can be managed by a variety of providers, including nurse practitioners and primary care physicians (Dahl et al., 2006). Medical visits relating to hormone maintenance provide an opportunity to deliver broader care to a population that is often medically underserved (Clements, Wilkinson, Kitano, & Marx, 1999; Feldman, 2007; Xavier, 2000). Many of the screening tasks and management of co-morbidities associated with long-term hormone use, such as cardiovascular risk factors and cancer screening, fall more uniformly within the scope of primary care rather than specialist care (American Academy of Family Physicians, 2005; Eyler, 2007; World Health Organization, 2008), particularly in locations where dedicated gender teams or specialized physicians are not available.

Given the multidisciplinary needs of transsexual, transgender, and gender nonconforming people seeking hormone therapy, as well as the difficulties associated with fragmentation of care in general (World Health Organization, 2008), WPATH strongly encourages the increased training and involvement of primary care providers in the area of feminizing/masculinizing hormone therapy. If hormones are prescribed by a specialist, there should be close communication with the patient's primary care provider. Conversely, an experienced hormone provider or endocrinologist should be involved if the primary care physician has no experience with this type of hormone therapy, or if the patient has a pre-existing metabolic or endocrine disorder that could be affected by endocrine therapy.

While formal training programs in transgender medicine do not yet exist, hormone providers have a responsibility to obtain appropriate knowledge and experience in this field. Clinicians can increase their experience and comfort in providing feminizing/masculinizing hormone therapy by co-managing care or consulting with a more experienced provider, or by providing more limited types of hormone therapy before progressing to initiation of hormone therapy. Because this field of medicine is evolving, clinicians should become familiar and keep current with the medical literature, and discuss emerging issues with colleagues. Such discussions might occur through networks established by WPATH and other national/local organizations.

## Responsibilities of Hormone-Prescribing Physicians

In general, clinicians who prescribe hormone therapy should engage in the following tasks:

1. Perform an initial evaluation that includes discussion of a patient's physical transition goals, health history, physical examination, risk assessment, and relevant laboratory tests.

2. Discuss with patients the expected effects of feminizing/masculinizing medications and the possible adverse health effects. These effects can include a reduction in fertility (Feldman & Safer, 2009; Hembree et al., 2009). Therefore, reproductive options should be discussed with patients before starting hormone therapy (see section IX).

3. Confirm that patients have the capacity to understand the risks and benefits of treatment and are capable of making an informed decision about medical care.

4. Provide ongoing medical monitoring, including regular physical and laboratory examination to monitor hormone effectiveness and side effects.

5. Communicate as needed with a patient's primary care provider, mental health professional, and surgeon.

6. If needed, provide patients with a brief written statement indicating that they are under medical supervision and care that includes feminizing/masculinizing hormone therapy. Particularly during the early phases of hormone treatment, a patient may wish to carry this statement at all times to help prevent difficulties with the police and other authorities.

Depending on the clinical situation for providing hormones (see below), some of these responsibilities are less relevant. Thus, the degree of counseling, physical examinations, and laboratory evaluations should be individualized to a patient's needs.

## Clinical Situations for Hormone Therapy

There are circumstances in which clinicians may be called upon to provide hormones without necessarily initiating or maintaining long-term feminizing/masculinizing hormone therapy. By acknowledging these different clinical situations (see below, from least to highest level of complexity), it may be possible to involve clinicians in feminizing/masculinizing hormone therapy who might not otherwise feel able to offer this treatment.



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### 1. Bridging

Whether prescribed by another clinician or obtained through other means (e.g., purchased over the internet), patients may present for care already on hormone therapy. Clinicians can provide a limited (1-6 month) prescription for hormones while helping patients find a provider who can prescribe long-term hormone therapy. Providers should assess a patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated (Dahl et al., 2006; Feldman & Safer, 2009). If hormones were previously prescribed, medical records should be requested (with the patient's permission) to obtain the results of baseline examinations and laboratory tests and any adverse events. Hormone providers should also communicate with any mental health professional who is currently involved in a patient's care. If a patient has never had a psychosocial assessment as recommended by the *SOC* (see section VII), clinicians should refer the patient to a qualified mental health professional if appropriate and feasible (Feldman & Safer, 2009). Providers who prescribe bridging hormones need to work with patients to establish limits as to the duration of bridging therapy.

### 2. Hormone therapy following gonad removal

Hormone replacement with estrogen or testosterone is usually continued lifelong after an oophorectomy or orchiectomy, unless medical contraindications arise. Because hormone doses are often decreased after these surgeries (Basson, 2001; Levy, Crown, & Reid, 2003; Moore, Wisniewski, & Dobs, 2003) and only adjusted for age and co-morbid health concerns, hormone management in this situation is quite similar to hormone replacement in any hypogonadal patient.

### 3. Hormone maintenance prior to gonad removal

Once patients have achieved maximal feminizing/masculinizing benefits from hormones (typically two or more years), they remain on a maintenance dose. The maintenance dose is then adjusted for changes in health conditions, aging, or other considerations such as lifestyle changes (Dahl et al., 2006). When a patient on maintenance hormones presents for care, the provider should assess the patient's current regimen for safety and drug interactions and substitute safer medications or doses when indicated. The patient should continue to be monitored by physical examinations and laboratory testing on a regular basis, as outlined in the literature (Feldman & Safer, 2009; Hembree et al., 2009). The dose and form of hormones should be revisited regularly with any changes in the patient's health status and available evidence on the potential long-term risks of hormones (See *Hormone Regimens,* below).

**4. Initiating hormonal feminization/masculinization**

This clinical situation requires the greatest commitment in terms of provider time and expertise. Hormone therapy must be individualized based on a patient's goals, the risk/benefit ratio of medications, the presence of other medical conditions, and consideration of social and economic issues. Although a wide variety of hormone regimens have been published (Dahl et al., 2006; Hembree et al., 2009; Moore et al., 2003), there are no published reports of randomized clinical trials comparing safety and efficacy. Despite this variation, a reasonable framework for initial risk assessment and ongoing monitoring of hormone therapy can be constructed, based on the efficacy and safety evidence presented above.

## Risk Assessment and Modification for Initiating Hormone Therapy

The initial evaluation for hormone therapy assesses a patient's clinical goals and risk factors for hormone-related adverse events. During the risk assessment, the patient and clinician should develop a plan for reducing risks wherever possible, either prior to initiating therapy or as part of ongoing harm reduction.

All assessments should include a thorough physical exam, including weight, height, and blood pressure. The need for breast, genital, and rectal exams, which are sensitive issues for most transsexual, transgender, and gender nonconforming patients, should be based on individual risks and preventive health care needs (Feldman & Goldberg, 2006; Feldman, 2007).

### Preventive care

Hormone providers should address preventive health care with patients, particularly if a patient does not have a primary care provider. Depending on a patient's age and risk profile, there may be appropriate screening tests or exams for conditions affected by hormone therapy. Ideally, these screening tests should be carried out prior to the start of hormone therapy.

### Risk assessment and modification for feminizing hormone therapy (MtF)

There are no absolute contraindications to feminizing therapy *per se*, but absolute contraindications exist for the different feminizing agents, particularly estrogen. These include previous venous thrombotic events related to an underlying hypercoagulable condition, history of estrogen-sensitive neoplasm, and end-stage chronic liver disease (Gharib et al., 2005).

Other medical conditions, as noted in Table 2 and Appendix B, can be exacerbated by estrogen or androgen blockade, and therefore should be evaluated and reasonably well controlled prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Clinicians should particularly attend to tobacco use, as it is associated with increased risk of venous thrombosis, which is further increased with estrogen use. Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of feminizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

**Risk assessment and modification for masculinizing hormone therapy (FtM)**

Absolute contraindications to testosterone therapy include pregnancy, unstable coronary artery disease, and untreated polycythemia with a hematocrit of 55% or higher (Carnegie, 2004). Because the aromatization of testosterone to estrogen may increase risk in patients with a history of breast or other estrogen dependent cancers (Moore et al., 2003), consultation with an oncologist may be indicated prior to hormone use. Co-morbid conditions likely to be exacerbated by testosterone use should be evaluated and treated, ideally prior to starting hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009). Consultation with a cardiologist may be advisable for patients with known cardio- or cerebrovascular disease.

An increased prevalence of polycystic ovarian syndrome (PCOS) has been noted among FtM patients even in the absence of testosterone use (Baba et al., 2007; Balen, Schachter, Montgomery, Reid, & Jacobs, 1993; Bosinski et al., 1997). While there is no evidence that PCOS is related to the development of a transsexual, transgender, or gender nonconforming identity, PCOS is associated with increased risk of diabetes, cardiac disease, high blood pressure, and ovarian and endometrial cancers (Cattrall & Healy, 2004). Signs and symptoms of PCOS should be evaluated prior to initiating testosterone therapy, as testosterone may affect many of these conditions. Testosterone can affect the developing fetus (Physicians' Desk Reference, 2011), and patients at risk of becoming pregnant require highly effective birth control.

Baseline laboratory values are important to both assess initial risk and evaluate possible future adverse events. Initial labs should be based on the risks of masculinizing hormone therapy outlined in Table 2, as well as individual patient risk factors, including family history. Suggested initial lab panels have been published (Feldman & Safer, 2009; Hembree et al., 2009). These can be modified for patients or health care systems with limited resources, and in otherwise healthy patients.

# Clinical Monitoring during Hormone Therapy for Efficacy and Adverse Events

The purpose of clinical monitoring during hormone use is to assess the degree of feminization/masculinization and the possible presence of adverse effects of medication. However, as with the monitoring of any long-term medication, monitoring should take place in the context of comprehensive health care. Suggested clinical monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009). Patients with co-morbid medical conditions may need to be monitored more frequently. Healthy patients in geographically remote or resource-poor areas may be able to use alternative strategies, such as telehealth, or cooperation with local providers such as nurses and physician assistants. In the absence of other indications, health professionals may prioritize monitoring for those risks that are either likely to be increased by hormone therapy or possibly increased by hormone therapy but clinically serious in nature.

**Efficacy and risk monitoring during feminizing hormone therapy (MtF)**

The best assessment of hormone efficacy is clinical response: Is a patient developing a feminized body while minimizing masculine characteristics, consistent with that patient's gender goals? In order to more rapidly predict the hormone dosages that will achieve clinical response, one can measure testosterone levels for suppression below the upper limit of the normal female range, and estradiol levels within a premenopausal female range but well below supraphysiologic levels (Feldman & Safer, 2009; Hembree et al., 2009).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs of cardiovascular impairment and venous thromboembolism (VTE) through measurement of blood pressure, weight, and pulse; heart and lung exams; and examination of the extremities for peripheral edema, localized swelling, or pain (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

**Efficacy and risk monitoring during masculinizing hormone therapy (FtM)**

The best assessment of hormone efficacy is clinical response: Is a patient developing a masculinized body while minimizing feminine characteristics, consistent with that patient's gender goals? Clinicians can achieve a good clinical response with the least likelihood of adverse events by maintaining testosterone levels within the normal male range while avoiding supraphysiological

levels (Dahl et al., 2006; Hembree et al., 2009). For patients using intramuscular (IM) testosterone cypionate or enanthate, some clinicians check trough levels while others prefer midcycle levels (Dahl et al., 2006; Hembree et al., 2009; Tangpricha, Turner, Malabanan, & Holick, 2001; Tangpricha, Ducharme, Barber, & Chipkin, 2003).

Monitoring for adverse events should include both clinical and laboratory evaluation. Follow-up should include careful assessment for signs and symptoms of excessive weight gain, acne, uterine break-through bleeding, and cardiovascular impairment, as well as psychiatric symptoms in at-risk patients. Physical examinations should include measurement of pressure, weight, pulse, and skin; and heart and lung exams (Feldman & Safer, 2009). Laboratory monitoring should be based on the risks of hormone therapy described above, a patient's individual co-morbidities and risk factors, and the specific hormone regimen itself. Specific lab monitoring protocols have been published (Feldman & Safer, 2009; Hembree et al., 2009).

## Hormone Regimens

To date, no controlled clinical trials of any feminizing/masculinizing hormone regimen have been conducted to evaluate safety or efficacy in producing physical transition. As a result, wide variation in doses and types of hormones have been published in the medical literature (Moore et al., 2003; Tangpricha et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). In addition, access to particular medications may be limited by a patient's geographical location and/or social or econonomic situations. For these reasons, WPATH does not describe or endorse a particular feminizing/masculinizing hormone regimen. Rather, the medication classes and routes of administration used in most published regimens are broadly reviewed.

As outlined above, there are demonstrated safety differences in individual elements of various regimens. The Endocrine Society Guidelines (Hembree et al., 2009) and Feldman and Safer (2009) provide specific guidance regarding the types of hormones and suggested dosing to maintain levels within physiologic ranges for a patient's desired gender expression (based on goals of full feminization/masculinization). It is strongly recommend that hormone providers regularly review the literature for new information and use those medications that safely meet individual patient needs with available local resources.

**Regimens for feminizing hormone therapy (MtF)**

Estrogen

Use of oral estrogen, and specifically ethinyl estradiol, appears to increase the risk of VTE. Because of this safety concern, ethinyl estradiol is not recommended for feminizing hormone therapy. Transdermal estrogen is recommended for those patients with risks factors for VTE. The risk of adverse events increases with higher doses, particular those resulting in supraphysiologic levels (Hembree et al., 2009). Patients with co-morbid conditions that can be affected by estrogen should avoid oral estrogen if possible and be started at lower levels. Some patients may not be able to safely use the levels of estrogen needed to get the desired results. This possibility needs to be discussed with patients well in advance of starting hormone therapy.

Androgen reducing medications ("anti-androgens")

A combination of estrogen and "anti-androgens" is the most commonly studied regimen for feminization. Androgen reducing medications, from a variety of classes of drugs, have the effect of reducing either endogenous testosterone levels or testosterone activity, and thus diminishing masculine characteristics such as body hair. They minimize the dosage of estrogen needed to suppress testosterone, thereby reducing the risks associated with high-dose exogenous estrogen (Prior, Vigna, Watson, Diewold, & Robinow, 1986; Prior, Vigna, & Watson, 1989).

Common anti-androgens include the following:

- Spironolactone, an antihypertensive agent, directly inhibits testosterone secretion and androgen binding to the androgen receptor. Blood pressure and electrolytes need to be monitored because of the potential for hyperkalemia.

- Cyproterone acetate is a progestational compound with anti-androgenic properties. This medication is not approved in the United States because of concerns over potential hepatotoxicity, but it is widely used elsewhere (De Cuypere et al., 2005).

- GnRH agonists (e.g., goserelin, buserelin, triptorelin) are neurohormones that block the gonadtropin releasing hormone receptor, thus blocking the release of follicle stimulating hormone and luteinizing hormone. This leads to highly effective gonadal blockade. However, these medications are expensive and only available as injectables or implants.

- 5-alpha reductase inhibitors (finasteride and dutasteride) block the conversion of testosterone to the more active agent, 5-alpha-dihydrotestosterone. These medications have beneficial effects on scalp hair loss, body hair growth, sebaceous glands, and skin consistency.

Cyproterone and spironolactone are the most commonly used anti-androgens and are likely the most cost-effective.

### Progestins

With the exception of cyproterone, the inclusion of progestins in feminizing hormone therapy is controversial (Oriel, 2000). Because progestins play a role in mammary development on a cellular level, some clinicians believe that these agents are necessary for full breast development (Basson & Prior, 1998; Oriel, 2000). However, a clinical comparison of feminization regimens with and without progestins found that the addition of progestins neither enhanced breast growth nor lowered serum levels of free testosterone (Meyer III et al., 1986). There are concerns regarding potential adverse effects of progestins, including depression, weight gain, and lipid changes (Meyer III et al., 1986; Tangpricha et al., 2003). Progestins (especially medroxyprogesterone) are also suspected to increase breast cancer risk and cardiovascular risk in women (Rossouw et al., 2002). Micronized progesterone may be better tolerated and have a more favorable impact on the lipid profile than medroxyprogesterone does (de Lignières, 1999; Fitzpatrick, Pace, & Wiita, 2000).

## Regimens for masculinizing hormone therapy (FtM)

### Testosterone

Testosterone generally can be given orally, transdermally, or parenterally (IM), although buccal and implantable preparations are also available. Oral testosterone undecenoate, available outside the United States, results in lower serum testosterone levels than non-oral preparations and has limited efficacy in suppressing menses (Feldman, 2005, April; Moore et al., 2003). Because intramuscular testosterone cypionate or enanthate are often administered every 2-4 weeks, some patients may notice cyclic variation in effects (e.g., fatigue and irritability at the end of the injection cycle, aggression or expansive mood at the beginning of the injection cycle), as well as more time outside the normal physiologic levels (Jockenhövel, 2004). This may be mitigated by using a lower but more frequent dosage schedule or by using a daily transdermal preparation (Dobs et al., 1999; Jockenhövel, 2004; Nieschlag et al., 2004). Intramuscular testosterone undecenoate (not currently available in the United States) maintains stable, physiologic testosterone levels over approximately 12 weeks and has been effective in both the setting of hypogonadism and in FtM individuals (Mueller, Kiesewetter, Binder, Beckmann, & Dittrich, 2007; Zitzmann, Saad, & Nieschlag, 2006). There is evidence that transdermal and intramuscular testosterone achieve similar masculinizing results, although the timeframe may be somewhat slower with transdermal preparations (Feldman, 2005, April). Especially as patients age, the goal is to use the lowest dose needed to maintain the desired clinical result, with appropriate precautions being made to maintain bone density.

Other agents

Progestins, most commonly medroxyprogesterone, can be used for a short period of time to assist with menstrual cessation early in hormone therapy. GnRH agonists can be used similarly, as well as for refractory uterine bleeding in patients without an underlying gynecological abnormality.

**Bioidentical and compounded hormones**

As discussion surrounding the use of bioidentical hormones in postmenopausal hormone replacement has heightened, interest has also increased in the use of similar compounds in feminizing/masculinizing hormone therapy. There is no evidence that custom compounded bioidentical hormones are safer or more effective than government agency-approved bioidentical hormones (Sood, Shuster, Smith, Vincent, & Jatoi, 2011). Therefore, it has been advised by the North American Menopause Society (2010) and others to assume that, whether the hormone is from a compounding pharmacy or not, if the active ingredients are similar, it should have a similar side-effect profile. WPATH concurs with this assessment.

# IX
# Reproductive Health

Many transgender, transsexual, and gender nonconforming people will want to have children. Because feminizing/masculinizing hormone therapy limits fertility (Darney, 2008; Zhang, Gu, Wang, Cui, & Bremner, 1999), it is desirable for patients to make decisions concerning fertility before starting hormone therapy or undergoing surgery to remove/alter their reproductive organs. Cases are known of people who received hormone therapy and genital surgery and later regretted their inability to parent genetically related children (De Sutter, Kira, Verschoor, & Hotimsky, 2002).

Health care professionals – including mental health professionals recommending hormone therapy or surgery, hormone-prescribing physicians, and surgeons – should discuss reproductive options with patients prior to initiation of these medical treatments for gender dysphoria. These discussions should occur even if patients are not interested in these issues at the time of treatment, which may be more common for younger patients (De Sutter, 2009). Early discussions are desirable, but not always possible. If an individual has not had complete sex reassignment surgery, it may be possible to stop hormones long enough for natal hormones to recover, allowing the production of mature

gametes (Payer, Meyer III, & Walker, 1979; Van den Broecke, Van der Elst, Liu, Hovatta, & Dhont, 2001).

Besides debate and opinion papers, very few research papers have been published on the reproductive health issues of individuals receiving different medical treatments for gender dysphoria. Another group who faces the need to preserve reproductive function in light of loss or damage to their gonads are people with malignances that require removal of reproductive organs or use of damaging radiation or chemotherapy. Lessons learned from that group can be applied to people treated for gender dysphoria.

MtF patients, especially those who have not already reproduced, should be informed about sperm preservation options and encouraged to consider banking their sperm prior to hormone therapy. In a study examining testes that were exposed to high-dose estrogen (Payer et al., 1979), findings suggest that stopping estrogen may allow the testes to recover. In an article reporting on the opinions of MtF individuals towards sperm freezing (De Sutter et al., 2002), the vast majority of 121 survey respondents felt that the availability of freezing sperm should be discussed and offered by the medical world. Sperm should be collected before hormone therapy or after stopping the therapy until the sperm count rises again. Cryopreservation should be discussed even if there is poor semen quality. In adults with azoospermia, a testicular biopsy with subsequent cryopreservation of biopsied material for sperm is possible, but may not be successful.

Reproductive options for FtM patients might include oocyte (egg) or embryo freezing. The frozen gametes and embryo could later be used with a surrogate woman to carry to pregnancy. Studies of women with polycystic ovarian disease suggest that the ovary can recover in part from the effects of high testosterone levels (Hunter & Sterrett, 2000). Stopping the testosterone briefly might allow for ovaries to recover enough to make eggs; success likely depends on the patient's age and duration of testosterone treatment. While not systematically studied, some FtM individuals are doing exactly that, and some have been able to become pregnant and deliver children (More, 1998).

Patients should be advised that these techniques are not available everywhere and can be very costly. Transsexual, transgender, and gender nonconforming people should not be refused reproductive options for any reason.

A special group of individuals are prepubertal or pubertal adolescents who will never develop reproductive function in their natal sex due to blockers or cross gender hormones. At this time there is no technique for preserving function from the gonads of these individuals.

X

# Voice and Communication Therapy

Communication, both verbal and nonverbal, is an important aspect of human behavior and gender expression. Transsexual, transgender, and gender nonconforming people might seek the assistance of a voice and communication specialist to develop vocal characteristics (e.g., pitch, intonation, resonance, speech rate, phrasing patterns) and non-verbal communication patterns (e.g., gestures, posture/movement, facial expressions) that facilitate comfort with their gender identity. Voice and communication therapy may help to alleviate gender dysphoria and be a positive and motivating step towards achieving one's goals for gender role expression.

## Competency of Voice and Communication Specialists Working with Transsexual, Transgender, and Gender Nonconforming Clients

Specialists may include speech-language pathologists, speech therapists, and speech-voice clinicians. In most countries the professional association for speech-language pathologists requires specific qualifications and credentials for membership. In some countries the government regulates practice through licensing, certification, or registration processes (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada).

The following are recommended minimum credentials for voice and communication specialists working with transsexual, transgender, and gender nonconforming clients:

1. Specialized training and competence in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients.

2. A basic understanding of transgender health, including hormonal and surgical treatments for feminization/masculinization and trans-specific psychosocial issues as outlined in the *SOC*; and familiarity with basic sensitivity protocols such as the use of preferred gender pronoun and name (Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).



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3. Continuing education in the assessment and development of communication skills in transsexual, transgender, and gender nonconforming clients. This may include attendance at professional meetings, workshops, or seminars; participation in research related to gender identity issues; independent study; or mentoring from an experienced, certified clinician.

Other professionals such as vocal coaches, theatre professionals, singing teachers, and movement experts may play a valuable adjunct role. Such professionals will ideally have experience working with, or be actively collaborating with, speech-language pathologists.

## Assessment and Treatment Considerations

The overall purpose of voice and communication therapy is to help clients adapt their voice and communication in a way that is both safe and authentic, resulting in communication patterns that clients feel are congruent with their gender identity and that reflect their sense of self (Adler, Hirsch, & Mordaunt, 2006). It is essential that voice and communication specialists be sensitive to individual communication preferences. Communication – style, voice, choice of language, etc. – is personal. Individuals should not be counseled to adopt behaviors with which they are not comfortable or which do not feel authentic. Specialists can best serve their clients by taking the time to understand a person's gender concerns and goals for gender role expression (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia).

Individuals may choose the communication behaviors that they wish to acquire in accordance with their gender identity. These decisions are also informed and supported by the knowledge of the voice and communication specialist and by the assessment data for a specific client (Hancock, Krissinger, & Owen, 2010). Assessment includes a client's self-evaluation and a specialist's evaluation of voice, resonance, articulation, spoken language, and non-verbal communication (Adler et al., 2006; Hancock et al., 2010).

Voice and communication treatment plans are developed by considering the available research evidence, the clinical knowledge and experience of the specialist, and the client's own goals and values (American Speech-Language-Hearing Association, 2011; Canadian Association of Speech-Language Pathologists and Audiologists; Royal College of Speech Therapists, United Kingdom; Speech Pathology Australia; Vancouver Coastal Health, Vancouver, British Columbia, Canada). Targets of treatment typically include pitch, intonation, loudness and stress patterns, voice quality, resonance, articulation, speech rate and phrasing, language, and non-verbal communication (Adler et al., 2006; Davies & Goldberg, 2006; de Bruin, Coerts, & Greven, 2000; Gelfer, 1999; McNeill, 2006; Oates & Dacakis, 1983). Treatment may involve individual and/or group sessions. The frequency and duration of treatment will vary according to a client's needs. Existing protocols for voice and

communication treatment can be considered in developing an individualized therapy plan (Carew, Dacakis, & Oates, 2007; Dacakis, 2000; Davies & Goldberg, 2006; Gelfer, 1999; McNeill, Wilson, Clark, & Deakin, 2008; Mount & Salmon, 1988).

Feminizing or masculinizing the voice involves non-habitual use of the voice production mechanism. Prevention measures are necessary to avoid the possibility of vocal misuse and long-term vocal damage. All voice and communication therapy services should therefore include a vocal health component (Adler et al., 2006).

## Vocal Health Considerations after Voice Feminization Surgery

As noted in section XI, some transsexual, transgender, and gender nonconforming people will undergo voice feminization surgery. (Voice deepening can be achieved through masculinizing hormone therapy, but feminizing hormones do not have an impact on the adult MtF voice.) There are varying degrees of satisfaction, safety, and long-term improvement in patients who have had such surgery. It is recommended that individuals undergoing voice feminization surgery also consult a voice and communication specialist to maximize the surgical outcome, help protect vocal health, and learn non-pitch related aspects of communication. Voice surgery procedures should include follow-up sessions with a voice and communication specialist who is licensed and/or credentialed by the board responsible for speech therapists/speech-language pathologists in that country (Kanagalingam et al., 2005; Neumann & Welzel, 2004).

# XI
# Surgery_

## Sex Reassignment Surgery Is Effective and Medically Necessary

Surgery – particularly genital surgery – is often the last and the most considered step in the treatment process for gender dysphoria. While many transsexual, transgender, and gender nonconforming individuals find comfort with their gender identity, role, and expression without surgery, for many others surgery is essential and medically necessary to alleviate their gender dysphoria (Hage



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& Karim, 2000). For the latter group, relief from gender dysphoria cannot be achieved without modification of their primary and/or secondary sex characteristics to establish greater congruence with their gender identity. Moreover, surgery can help patients feel more at ease in the presence of sex partners or in venues such as physicians' offices, swimming pools, or health clubs. In some settings, surgery might reduce risk of harm in the event of arrest or search by police or other authorities.

Follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Gijs & Brewaeys, 2007; Klein & Gorzalka, 2009; Pfäfflin & Junge, 1998). Additional information on the outcomes of surgical treatments are summarized in Appendix D.

## Ethical Questions Regarding Sex Reassignment Surgery

In ordinary surgical practice, pathological tissues are removed to restore disturbed functions, or alterations are made to body features to improve a patient's self image. Some people, including some health professionals, object on ethical grounds to surgery as a treatment for gender dysphoria, because these conditions are thought not to apply.

It is important that health professionals caring for patients with gender dysphoria feel comfortable about altering anatomically normal structures. In order to understand how surgery can alleviate the psychological discomfort and distress of individuals with gender dysphoria, professionals need to listen to these patients discuss their symptoms, dilemmas, and life histories. The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments.

Genital and breast/chest surgical treatments for gender dysphoria are not merely another set of elective procedures. Typical elective procedures involve only a private mutually consenting contract between a patient and a surgeon. Genital and breast/chest surgeries as medically necessary treatments for gender dysphoria are to be undertaken only after assessment of the patient by qualified mental health professionals, as outlined in section VII of the *SOC*. These surgeries may be performed once there is written documentation that this assessment has occurred and that the person has met the criteria for a specific surgical treatment. By following this procedure, mental health professionals, surgeons, and of course patients, share responsibility for the decision to make irreversible changes to the body.

It is unethical to deny availability or eligibility for sex reassignment surgeries solely on the basis of blood seropositivity for blood-borne infections such as HIV or hepatitis C or B.

## Relationship of Surgeons with Mental Health Professionals, Hormone-Prescribing Physicians (if Applicable), and Patients (Informed Consent)

The role of a surgeon in the treatment of gender dysphoria is not that of a mere technician. Rather, conscientious surgeons will have insight into each patient's history and the rationale that led to the referral for surgery. To that end, surgeons must talk at length with their patients and have close working relationships with other health professionals who have been actively involved in their clinical care.

Consultation is readily accomplished when a surgeon practices as part of an interdisciplinary health care team. In the absence of this, a surgeon must be confident that the referring mental health professional(s), and if applicable the physician who prescribes hormones, are competent in the assessment and treatment of gender dysphoria, because the surgeon is relying heavily on their expertise.

Once a surgeon is satisfied that the criteria for specific surgeries have been met (as outlined below), surgical treatment should be considered and a preoperative surgical consultation should take place. During this consultation, the procedure and postoperative course should be extensively discussed with the patient. Surgeons are responsible for discussing all of the following with patients seeking surgical treatments for gender dysphoria:

- The different surgical techniques available (with referral to colleagues who provide alternative options);
- The advantages and disadvantages of each technique;
- The limitations of a procedure to achieve "ideal" results; surgeons should provide a full range of before-and-after photographs of their own patients, including both successful and unsuccessful outcomes;
- The inherent risks and possible complications of the various techniques; surgeons should inform patients of their own complication rates with each procedure.

These discussions are the core of the informed consent process, which is both an ethical and legal requirement for any surgical procedure. Ensuring that patients have a realistic expectation of outcomes is important in achieving a result that will alleviate their gender dysphoria.

All of this information should be provided to patients in writing, in a language in which they are fluent, and in graphic illustrations. Patients should receive the information in advance (possibly via the internet) and given ample time to review it carefully. The elements of informed consent should always be discussed face-to-face prior to the surgical intervention. Questions can then be answered and written informed consent can be provided by the patient. Because these surgeries are irreversibile, care should be taken to ensure that patients have sufficient time to absorb information fully before they are asked to provide informed consent. A minimum of 24 hours is suggested.

Surgeons should provide immediate aftercare and consultation with other physicians serving the patient in the future. Patients should work with their surgeon to develop an adequate aftercare plan for the surgery.

## Overview of Surgical Procedures for the Treatment of Patients with Gender Dysphoria

**For the male-to-female (MtF) patient, surgical procedures may include the following:**

1. Breast/chest surgery: augmentation mammoplasty (implants/lipofilling);

2. Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty;

3. Non-genital, non-breast surgical interventions: facial feminization surgery, liposuction, lipofilling, voice surgery, thyroid cartilage reduction, gluteal augmentation (implants/lipofilling), hair reconstruction, and various aesthetic procedures.

**For the female-to-male (FtM) patient, surgical procedures may include the following:**

1. Breast/chest surgery: subcutaneous mastectomy, creation of a male chest;

2. Genital surgery: hysterectomy/ovariectomy, reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses;



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3. Non-genital, non-breast surgical interventions: voice surgery (rare), liposuction, lipofilling, pectoral implants, and various aesthetic procedures.

## Reconstructive Versus Aesthetic Surgery

The question of whether sex reassignment surgery should be considered "aesthetic" surgery or "reconstructive" surgery is pertinent not only from a philosophical point of view, but also from a financial point of view. Aesthetic or cosmetic surgery is mostly regarded as not medically necessary and therefore is typically paid for entirely by the patient. In contrast, reconstructive procedures are considered medically necessary – with unquestionable therapeutic results – and thus paid for partially or entirely by national health systems or insurance companies.

Unfortunately, in the field of plastic and reconstructive surgery (both in general and specifically for gender-related surgeries), there is no clear distinction between what is purely reconstructive and what is purely cosmetic. Most plastic surgery procedures actually are a mixture of both reconstructive and cosmetic components.

While most professionals agree that genital surgery and mastectomy cannot be considered purely cosmetic, opinions diverge as to what degree other surgical procedures (e.g., breast augmentation, facial feminization surgery) can be considered purely reconstructive. Although it may be much easier to see a phalloplasty or a vaginoplasty as an intervention to end lifelong suffering, for certain patients an intervention like a reduction rhinoplasty can have a radical and permanent effect on their quality of life, and therefore is much more medically necessary than for somebody without gender dysphoria.

## Criteria for Surgeries

As for all of the *SOC*, the criteria for initiation of surgical treatments for gender dysphoria were developed to promote optimal patient care. While the *SOC* allow for an individualized approach to best meet a patient's health care needs, a criterion for all breast/chest and genital surgeries is documentation of persistent gender dysphoria by a qualified mental health professional. For some surgeries, additional criteria include preparation and treatment consisting of feminizing/masculinizing hormone therapy and one year of continuous living in a gender role that is congruent with one's gender identity.

These criteria are outlined below. Based on the available evidence and expert clinical consensus, different recommendations are made for different surgeries.

The *SOC* do not specify an order in which different surgeries should occur. The number and sequence of surgical procedures may vary from patient to patient, according to their clinical needs.

**Criteria for breast/chest surgery (one referral)**

Criteria for mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Criteria for breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

## Criteria for genital surgery (two referrals)

The criteria for genital surgery are specific to the type of surgery being requested.

Criteria for hysterectomy and ovariectomy in FtM patients and for orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled.
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before the patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these procedures for medical indications other than gender dysphoria.

Criteria for metoidioplasty or phalloplasty in FtM patients and for vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country;
4. If significant medical or mental health concerns are present, they must be well controlled;
5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).
6. 12 continuous months of living in a gender role that is congruent with their gender identity;



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Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

Rationale for a preoperative, 12-month experience of living in an identity-congruent gender role:

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery. As noted in section VII, the social aspects of changing one's gender role are usually challenging – often more so than the physical aspects. Changing gender role can have profound personal and social consequences, and the decision to do so should include an awareness of what the familial, interpersonal, educational, vocational, economic, and legal challenges are likely to be, so that people can function successfully in their gender role. Support from a qualified mental health professional and from peers can be invaluable in ensuring a successful gender role adaptation (Bockting, 2008).

The duration of 12 months allows for a range of different life experiences and events that may occur throughout the year (e.g., family events, holidays, vacations, season-specific work or school experiences). During this time, patients should present consistently, on a day-to-day basis and across all settings of life, in their desired gender role. This includes coming out to partners, family, friends, and community members (e.g., at school, work, other settings).

Health professionals should clearly document a patient's experience in the gender role in the medical chart, including the start date of living full time for those who are preparing for genital surgery. In some situations, if needed, health professionals may request verification that this criterion has been fulfilled: They may communicate with individuals who have related to the patient in an identity-congruent gender role, or request documentation of a legal name and/or gender marker change, if applicable.

## Surgery for Persons with Psychotic Conditions and Other Serious Mental Illnesses

When patients with gender dysphoria are also diagnosed with severe psychiatric disorders and impaired reality testing (e.g., psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated. Reevaluation by a mental health professional qualified to assess and manage psychotic conditions should be

conducted prior to surgery, describing the patient's mental status and readiness for surgery. It is preferable that this mental health professional be familiar with the patient. No surgery should be performed while a patient is actively psychotic (De Cuypere & Vercruysse, 2009).

## Competency of Surgeons Performing Breast/Chest or Genital Surgery

Physicians who perform surgical treatments for gender dsyphoria should be urologists, gynecologists, plastic surgeons, or general surgeons, and board-certified as such by the relevant national and/or regional association. Surgeons should have specialized competence in genital reconstructive techniques as indicated by documented supervised training with a more experienced surgeon. Even experienced surgeons must be willing to have their surgical skills reviewed by their peers. An official audit of surgical outcomes and publication of these results would be greatly reassuring to both referring health professionals and patients. Surgeons should regularly attend professional meetings where new techniques are presented. The internet is often effectively used by patients to share information on their experience with surgeons and their teams.

Ideally, surgeons should be knowledgeable about more than one surgical technique for genital reconstruction so that they, in consultation with patients, can choose the ideal technique for each individual. Alternatively, if a surgeon is skilled in a single technique and this procedure is either not suitable for or desired by a patient, the surgeon should inform the patient about other procedures and offer referral to another appropriately skilled surgeon.

## Breast/Chest Surgery Techniques and Complications

Although breast/chest appearance is an important secondary sex characteristic, breast presence or size is not involved in the legal definitions of sex and gender and is not necessary for reproduction. The performance of breast/chest operations for treatment of gender dysphoria should be considered with the same care as beginning hormone therapy, as both produce relatively irreversible changes to the body.

For the MtF patient, a breast augmentation (sometimes called "chest reconstruction") is not different from the procedure in a natal female patient. It is usually performed through implantation of breast prostheses and occasionally with the lipofilling technique. Infections and capsular fibrosis are rare complications of augmentation mammoplasty in MtF patients (Kanhai, Hage, Karim, & Mulder, 1999).

For the FtM patient, a mastectomy or "male chest contouring" procedure is available. For many FtM patients, this is the only surgery undertaken. When the amount of breast tissue removed requires skin removal, a scar will result and the patient should be so informed. Complications of subcutaneous mastectomy can include nipple necrosis, contour irregularities, and unsightly scarring (Monstrey et al., 2008).

## Genital Surgery Techniques and Complications

Genital surgical procedures for the MtF patient may include orchiectomy, penectomy, vaginoplasty, clitoroplasty, and labiaplasty. Techniques include penile skin inversion, pedicled colosigmoid transplant, and free skin grafts to line the neovagina. Sexual sensation is an important objective in vaginoplasty, along with creation of a functional vagina and acceptable cosmesis.

Surgical complications of MtF genital surgery may include complete or partial necrosis of the vagina and labia, fistulas from the bladder or bowel into the vagina, stenosis of the urethra, and vaginas that are either too short or too small for coitus. While the surgical techniques for creating a neovagina are functionally and aesthetically excellent, anorgasmia following the procedure has been reported, and a second stage labiaplasty may be needed for cosmesis (Klein & Gorzalka, 2009; Lawrence, 2006).

Genital surgical procedures for FtM patients may include hysterectomy, ovariectomy (salpingo-oophorectomy), vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, and phalloplasty. For patients without former abdominal surgery, the laparoscopic technique for hysterectomy and salpingo-oophorectomy is recommended to avoid a lower-abdominal scar. Vaginal access may be difficult as most patients are nulliparous and have often not experienced penetrative intercourse. Current operative techniques for phalloplasty are varied. The choice of techniques may be restricted by anatomical or surgical considerations and by a client's financial considerations. If the objectives of phalloplasty are a neophallus of good appearance, standing micturition, sexual sensation, and/or coital ability, patients should be clearly informed that there are several separate stages of surgery and frequent technical difficulties, which may require additional operations. Even metoidioplasty, which in theory is a one-stage procedure for construction of a microphallus, often requires more than one operation. The objective of standing micturition with this technique can not always be ensured (Monstrey et al., 2009).

Complications of phalloplasty in FtMs may include frequent urinary tract stenoses and fistulas, and occasionally necrosis of the neophallus. Metoidioplasty results in a micropenis, without the capacity for standing urination. Phalloplasty, using a pedicled or a free vascularized flap, is a lengthy, multi-stage procedure with significant morbidity that includes frequent urinary complications and

unavoidable donor site scarring. For this reason, many FtM patients never undergo genital surgery other than hysterectomy and salpingo-oophorectomy (Hage & De Graaf, 1993).

Even patients who develop severe surgical complications seldom regret having undergone surgery. The importance of surgery can be appreciated by the repeated finding that quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2006).

## Other Surgeries

Other surgeries for assisting in body feminization include reduction thyroid chondroplasty (reduction of the Adam's apple), voice modification surgery, suction-assisted lipoplasty (contour modeling) of the waist, rhinoplasty (nose correction), facial bone reduction, face-lift, and blepharoplasty (rejuvenation of the eyelid). Other surgeries for assisting in body masculinization include liposuction, lipofilling, and pectoral implants. Voice surgery to obtain a deeper voice is rare but may be recommended in some cases, such as when hormone therapy has been ineffective.

Although these surgeries do not require referral by mental health professionals, such professionals can play an important role in assisting clients in making a fully informed decision about the timing and implications of such procedures in the context of the social transition.

Although most of these procedures are generally labeled "purely aesthetic," these same operations in an individual with severe gender dysphoria can be considered medically necessary, depending on the unique clinical situation of a given patient's condition and life situation. This ambiguity reflects reality in clinical situations, and allows for individual decisions as to the need and desirability of these procedures.

# XII

# Postoperative Care and Follow-up

Long-term postoperative care and follow-up after surgical treatments for gender dysphoria are associated with good surgical and psychosocial outcomes (Monstrey et al., 2009). Follow-up is important to a patient's subsequent physical and mental health and to a surgeon's knowledge about the benefits and limitations of surgery. Surgeons who operate on patients coming from long



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distances should include personal follow-up in their care plan and attempt to ensure affordable local long-term aftercare in their patients' geographic region.

Postoperative patients may sometimes exclude themselves from follow-up by specialty providers, including the hormone-prescribing physician (for patients receiving hormones), not recognizing that these providers are often best able to prevent, diagnose, and treat medical conditions that are unique to hormonally and surgically treated patients. The need for follow-up equally extends to mental health professionals, who may have spent a longer period of time with the patient than any other professional and therefore are in an excellent position to assist in any postoperative adjustment difficulties. Health professionals should stress the importance of postoperative follow-up care with their patients and offer continuity of care.

Postoperative patients should undergo regular medical screening according to recommended guidelines for their age. This is discussed more in the next section.

# XIII

# Lifelong Preventive and Primary Care

Transsexual, transgender, and gender nonconforming people need health care throughout their lives. For example, to avoid the negative secondary effects of having a gonadectomy at a relatively young age and/or receiving long-term, high-dose hormone therapy, patients need thorough medical care by providers experienced in primary care and transgender health. If one provider is not able to provide all services, ongoing communication among providers is essential.

Primary care and health maintenance issues should be addressed before, during, and after any possible changes in gender role and medical interventions to alleviate gender dysphoria. While hormone providers and surgeons play important roles in preventive care, every transsexual, transgender, and gender nonconforming person should partner with a primary care provider for overall health care needs (Feldman, 2007).

## General Preventive Health Care

Screening guidelines developed for the general population are appropriate for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. However, in areas such



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as cardiovascular risk factors, osteoporosis, and some cancers (breast, cervical, ovarian, uterine, and prostate), such general guidelines may either over- or underestimate the cost-effectiveness of screening individuals who are receiving hormone therapy.

Several resources provide detailed protocols for the primary care of patients undergoing feminizing/masculinizing hormone therapy, including therapy that is provided after sex reassignment surgeries (Center of Excellence for Transgender Health, UCSF, 2011; Feldman & Goldberg, 2006; Feldman, 2007; Gorton, Buth, & Spade, 2005). Clinicians should consult their national evidence-based guidelines and discuss screening with their patients in light of the effects of hormone therapy on their baseline risk.

## Cancer Screening

Cancer screening of organ systems that are associated with sex can present particular medical and psychosocial challenges for transsexual, transgender, and gender nonconforming patients and their health care providers. In the absence of large-scale prospective studies, providers are unlikely to have enough evidence to determine the appropriate type and frequency of cancer screenings for this population. Over-screening results in higher health care costs, high false positive rates, and often unnecessary exposure to radiation and/or diagnostic interventions such as biopsies. Under-screening results in diagnostic delay for potentially treatable cancers. Patients may find cancer screening gender affirming (such as mammograms for MtF patients) or both physically and emotionally painful (such as Pap smears offer continuity of care for FtM patients).

## Urogenital Care

Gynecologic care may be necessary for transsexual, transgender, and gender nonconforming people of both sexes. For FtM patients, such care is needed predominantly for individuals who have not had genital surgery. For MtF patients, such care is needed after genital surgery. While many surgeons counsel patients regarding postoperative urogenital care, primary care clinicians and gynecologists should also be familiar with the special genital concerns of this population.

All MtF patients should receive counseling regarding genital hygiene, sexuality, and prevention of sexually transmitted infections; those who have had genital surgery should also be counseled on the need for regular vaginal dilation or penetrative intercourse in order to maintain vaginal depth and width (van Trotsenburg, 2009). Due to the anatomy of the male pelvis, the axis and the dimensions

of the neovagina differ substantially from those of a biologic vagina. This anatomic difference can affect intercourse if not understood by MtF patients and their partners (van Trotsenburg, 2009).

Lower urinary tract infections occur frequently in MtF patients who have had surgery because of the reconstructive requirements of the shortened urethra. In addition, these patients may suffer from functional disorders of the lower urinary tract; such disorders may be caused by damage of the autonomous nerve supply of the bladder floor during dissection between the rectum and the bladder, and by a change of the position of the bladder itself. A dysfunctional bladder (e.g., overactive bladder, stress or urge urinary incontinence) may occur after sex reassignment surgery (Hoebeke et al., 2005; Kuhn, Hiltebrand, & Birkhauser, 2007).

Most FtM patients do not undergo vaginectomy (colpectomy). For patients who take masculinizing hormones, despite considerable conversion of testosterone to estrogens, atrophic changes of the vaginal lining can be observed regularly and may lead to pruritus or burning. Examination can be both physically and emotionally painful, but lack of treatment can seriously aggravate the situation. Gynecologists treating the genital complaints of FtM patients should be aware of the sensitivity that patients with a male gender identity and masculine gender expression might have around having genitals typically associated with the female sex.

# XIV

# Applicability of the Standards of Care to People Living in Institutional Environments

The *SOC* in their entirety apply to all transsexual, transgender, and gender nonconforming people, irrespective of their housing situation. People should not be discriminated against in their access to appropriate health care based on where they live, including institutional environments such as prisons or long-/intermediate-term health care facilities (Brown, 2009). Health care for transsexual, transgender, and gender nonconforming people living in an institutional environment should mirror that which would be available to them if they were living in a non-institutional setting within the same community.

All elements of assessment and treatment as described in the *SOC* can be provided to people living in institutions (Brown, 2009). Access to these medically necessary treatments should not be denied on the basis of institutionalization or housing arrangements. If the in-house expertise of health professionals in the direct or indirect employ of the institution does not exist to assess

and/or treat people with gender dysphoria, it is appropriate to obtain outside consultation from professionals who are knowledgeable about this specialized area of health care.

People with gender dysphoria in institutions may also have co-existing mental health conditions (Cole et al., 1997). These conditions should be evaluated and treated appropriately.

People who enter an institution on an appropriate regimen of hormone therapy should be continued on the same, or similar, therapies and monitored according to the *SOC*. A "freeze frame" approach is not considered appropriate care in most situations (Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW, 2002). People with gender dysphoria who are deemed appropriate for hormone therapy (following the *SOC*) should be started on such therapy. The consequences of abrupt withdrawal of hormones or lack of initiation of hormone therapy when medically necessary include a high likelihood of negative outcomes such as surgical self-treatment by autocastration, depressed mood, dysphoria, and/or suicidality (Brown, 2010).

Reasonable accommodations to the institutional environment can be made in the delivery of care consistent with the *SOC*, if such accommodations do not jeopardize the delivery of medically necessary care to people with gender dysphoria. An example of a reasonable accommodation is the use of injectable hormones, if not medically contraindicated, in an environment where diversion of oral preparations is highly likely (Brown, 2009). Denial of needed changes in gender role or access to treatments, including sex reassignment surgery, on the basis of residence in an institution are not reasonable accommodations under the *SOC* (Brown, 2010).

Housing and shower/bathroom facilities for transsexual, transgender, and gender nonconforming people living in institutions should take into account their gender identity and role, physical status, dignity, and personal safety. Placement in a single-sex housing unit, ward, or pod on the sole basis of the appearance of the external genitalia may not be appropriate and may place the individual at risk for victimization (Brown, 2009).

Institutions where transsexual, transgender, and gender nonconforming people reside and receive health care should monitor for a tolerant and positive climate to ensure that residents are not under attack by staff or other residents.



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# XV

# Applicability of the Standards of Care to People With Disorders of Sex Development

## Terminology

The term *disorder of sex development* (DSD) refers to a somatic condition of atypical development of the reproductive tract (Hughes, Houk, Ahmed, Lee, & LWPES1/ESPE2 Consensus Group, 2006). DSDs include the condition that used to be called *intersexuality*. Although the terminology was changed to *DSD* during an international consensus conference in 2005 (Hughes et al., 2006), disagreement about language use remains. Some people object strongly to the "disorder" label, preferring instead to view these congenital conditions as a matter of diversity (Diamond, 2009) and to continue using the terms *intersex* or *intersexuality*. In the *SOC*, WPATH uses the term *DSD* in an objective and value-free manner, with the goal of ensuring that health professionals recognize this medical term and use it to access relevant literature as the field progresses. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

## Rationale for Addition to the SOC

Previously, individuals with a DSD who also met the *DSM-IV-TR's* behavioral criteria for Gender Identity Disorder (American Psychiatric Association, 2000) were excluded from that general diagnosis. Instead, they were categorized as having a "Gender Identity Disorder - Not Otherwise Specified." They were also excluded from the WPATH *Standards of Care*.

The current proposal for *DSM-5* (www.dsm5.org) is to replace the term *gender identity disorder* with *gender dysphoria*. Moreover, the proposed changes to the *DSM* consider gender dysphoric people with a DSD to have a subtype of gender dysphoria. This proposed categorization – which explicitly differentiates between gender dysphoric individuals with and without a DSD – is justified: In people with a DSD, gender dysphoria differs in its phenomenological presentation, epidemiology, life trajectories, and etiology (Meyer-Bahlburg, 2009).

Adults with a DSD and gender dysphoria have increasingly come to the attention of health professionals. Accordingly, a brief discussion of their care is included in this version of the *SOC*.

## Health History Considerations

Health professionals assisting patients with both a DSD and gender dysphoria need to be aware that the medical context in which such patients have grown up is typically very different from that of people without a DSD.

Some people are recognized as having a DSD through the observation of gender-atypical genitals at birth. (Increasingly this observation is made during the prenatal period by way of imaging procedures such as ultrasound.) These infants then undergo extensive medical diagnostic procedures. After consultation among the family and health professionals – during which the specific diagnosis, physical and hormonal findings, and feedback from long-term outcome studies (Cohen-Kettenis, 2005; Dessens, Slijper, & Drop, 2005; Jurgensen, Hiort, Holterhus, & Thyen, 2007; Mazur, 2005; Meyer-Bahlburg, 2005; Stikkelbroeck et al., 2003; Wisniewski, Migeon, Malouf, & Gearhart, 2004) are considered – the newborn is assigned a sex, either male or female.

Other individuals with a DSD come to the attention of health professionals around the age of puberty through the observation of atypical development of secondary sex characteristics. This observation also leads to a specific medical evaluation.

The type of DSD and severity of the condition has significant implications for decisions about a patient's initial sex assignment, subsequent genital surgery, and other medical and psychosocial care (Meyer-Bahlburg, 2009). For instance, the degree of prenatal androgen exposure in individuals with a DSD has been correlated with the degree of masculinization of gender-related *behavior* (that is, *gender role and expression*); however, the correlation is only moderate, and considerable behavioral variability remains unaccounted for by prenatal androgen exposure (Jurgensen et al., 2007; Meyer-Bahlburg, Dolezal, Baker, Ehrhardt, & New, 2006). Notably, a similar correlation of prenatal hormone exposure with gender *identity* has not been demonstrated (e.g., Meyer-Bahlburg et al., 2004). This is underlined by the fact that people with the same (core) gender identity can vary widely in the degree of masculinization of their gender-related behavior.



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# Assessment and Treatment of Gender Dysphoria in People with Disorders of Sex Development

Very rarely are individuals with a DSD identified as having gender dysphoria *before* a DSD diagnosis has been made. Even so, a DSD diagnosis is typically apparent with an appropriate history and basic physical exam – both of which are part of a medical evaluation for the appropriateness of hormone therapy or surgical interventions for gender dysphoria. Mental health professionals should ask their clients presenting with gender dysphoria to have a physical exam, particularly if they are not currently seeing a primary care (or other health care) provider.

Most people with a DSD who are born with genital ambiguity do not develop gender dysphoria (e.g., Meyer-Bahlburg et al., 2004; Wisniewski et al., 2004). However, some people with a DSD will develop chronic gender dysphoria and even undergo a change in their birth-assigned sex and/or their gender role (Meyer-Bahlburg, 2005; Wilson, 1999; Zucker, 1999). If there are persistent and strong indications that gender dysphoria is present, a comprehensive evaluation by clinicians skilled in the assessment and treatment of gender dysphoria is essential, irrespective of the patient's age. Detailed recommendations have been published for conducting such an assessment and for making treatment decisions to address gender dysphoria in the context of a DSD (Meyer-Bahlburg, in press). Only after thorough assessment should steps be taken in the direction of changing a patient's birth-assigned sex or gender role.

Clinicians assisting these patients with treatment options to alleviate gender dysphoria may profit from the insights gained from providing care to patients without a DSD (Cohen-Kettenis, 2010). However, certain criteria for treatment (e.g., age, duration of experience with living in the desired gender role) are usually not routinely applied to people with a DSD; rather, the criteria are interpreted in light of a patient's specific situation (Meyer-Bahlburg, in press). In the context of a DSD, changes in birth-assigned sex and gender role have been made at any age between early elementary-school age and middle adulthood. Even genital surgery may be performed much earlier in these patients than in gender dysphoric individuals without a DSD if the surgery is well justified by the diagnosis, by the evidence-based gender-identity prognosis for the given syndrome and syndrome severity, and by the patient's wishes.

One reason for these treatment differences is that genital surgery in individuals with a DSD is quite common in infancy and adolescence. Infertility may already be present due to either early gonadal failure or to gonadectomy because of a malignancy risk. Even so, it is advisable for patients with a DSD to undergo a full social transition to another gender role only if there is a long-standing history of gender-atypical behavior, and if gender dysphoria and/or the desire to change one's gender role has been strong and persistent for a considerable period of time. Six months is the time period of full symptom expression required for the application of the gender dysphoria diagnosis proposed for *DSM-5* (Meyer-Bahlburg, in press).

## Additional Resources

The gender-relevant medical histories of people with a DSD are often complex. Their histories may include a great variety of inborn genetic, endocrine, and somatic atypicalities, as well as various hormonal, surgical, and other medical treatments. For this reason, many additional issues need to be considered in the psychosocial and medical care of such patients, regardless of the presence of gender dysphoria. Consideration of these issues is beyond what can be covered in the *SOC*. The interested reader is referred to existing publications (e.g., Cohen-Kettenis & Pfäfflin, 2003; Meyer-Bahlburg, 2002, 2008). Some families and patients also find it useful to consult or work with community support groups.

There is a very substantial medical literature on the medical management of patients with a DSD. Much of this literature has been produced by high-level specialists in pediatric endocrinology and urology, with input from specialized mental health professionals, especially in the area of gender. Recent international consensus conferences have addressed evidence-based care guidelines (including issues of gender and of genital surgery) for DSD in general (Hughes et al., 2006) and specifically for Congenital Adrenal Hyperplasia (Joint LWPES/ESPE CAH Working Group et al., 2002; Speiser et al., 2010). Others have addressed the research needs for DSD in general (Meyer-Bahlburg & Blizzard, 2004) and for selected syndromes such as 46,XXY (Simpson et al., 2003).

# References

Abramowitz, S. I. (1986). Psychosocial outcomes of sex reassignment surgery. *Journal of Consulting and Clinical Psychology, 54*(2), 183-189. doi:10.1037/0022-006X.54.2.183

ACOG Committee of Gynecologic Practice. (2005). Committee opinion #322: Compounded bioidentical hormones. *Obstetrics & Gynecology, 106*(5), 139-140.

Adler, R. K., Hirsch, S., & Mordaunt, M. (2006). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide*. San Diego, CA: Plural Pub.

American Academy of Family Physicians. (2005). *Definition of family medicine*. Retrieved August 10, 2009, from http://www.aafp.org/online/en/home/policy/policies/f/fammeddef.html

American Medical Association. (2008). *Resolution 122 (A-08)*. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/471/122.doc

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders DSM-IV-TR* (4th ed., text rev.). Washington, DC: Author.

American Speech-Language-Hearing Association. (2011). *Scope of practice*. Retrieved from www.asha.org

Anton, B. S. (2009). Proceedings of the American Psychological Association for the legislative year 2008: Minutes of the annual meeting of the council of representatives, February 22-24, 2008, Washington, DC, and August 13 and 17, 2008, Boston, MA, and minutes of the February, June, August, and December 2008 meetings of the board of directors. *American Psychologist, 64*, 372-453. doi:10.1037/a0015932

Asscheman, H., Giltay, E. J., Megens, J. A. J., de Ronde, W., van Trotsenburg, M. A. A., & Gooren, L. J. G. (2011). A long-term follow-up study of mortality in transsexuals receiving treatment with cross-sex hormones. *European Journal of Endocrinology, 164*(4), 635-642. doi:10.1530/EJE-10-1038

Baba, T., Endo, T., Honnma, H., Kitajima, Y., Hayashi, T., Ikeda, H., . . . Saito, T. (2007). Association between polycystic ovary syndrome and female-to-male transsexuality. *Human Reproduction, 22*(4), 1011-1016. doi:10.1093/humrep/del474

Bakker, A., Van Kesteren, P. J., Gooren, L. J., & Bezemer, P. D. (1993). The prevalence of transsexualism in the Netherlands. *Acta Psychiatrica Scandinavica, 87*(4), 237-238. doi:10.1111/j.1600-0447.1993.tb03364.x

Balen, A. H., Schachter, M. E., Montgomery, D., Reid, R. W., & Jacobs, H. S. (1993). Polycystic ovaries are a common finding in untreated female to male transsexuals. *Clinical Endocrinology, 38*(3), 325-329. doi:10.1111/j.1365-2265.1993.tb01013.x

Basson, R. (2001). Towards optimal hormonal treatment of male to female gender identity disorder. *Journal of Sexual and Reproductive Medicine, 1*(1), 45-51.

Basson, R., & Prior, J. C. (1998). Hormonal therapy of gender dysphoria: The male-to-female transsexual. In D. Denny (Ed.), *Current concepts in transgender identity* (pp. 277-296). New York: Garland Publishing, Inc.

Benjamin, H. (1966). *The transsexual phenomenon*. New York: Julian Press.

Besnier, N. (1994). Polynesian gender liminality through time and space. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 285-328). New York: Zone Books.

Bockting, W. O. (1999). From construction to context: Gender through the eyes of the transgendered. *Siecus Report, 28*(1), 3-7.

Bockting, W. O. (2008). Psychotherapy and the real-life experience: From gender dichotomy to gender diversity. *Sexologies, 17*(4), 211-224. doi:10.1016/j.sexol.2008.08.001

Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey & A. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 185-208). New York: The Haworth Press.

Bockting, W. O., & Goldberg, J. M. (2006). Guidelines for transgender care (special issue). *International Journal of Transgenderism, 9*(3/4).

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9*(3/4), 35-82. doi:10.1300/J485v09n03_03

Bolin, A. (1988). *In search of Eve* (pp. 189-192). New York: Bergin & Garvey.

Bolin, A. (1994). Transcending and transgendering: Male-to-female transsexuals, dichotomy and diversity. In G. Herdt (Ed.), *Third sex, third gender: Beyond sexual dimorphism in culture and history* (pp. 447-486). New York: Zone Books.

Bornstein, K. (1994). *Gender outlaw: On men, women, and the rest of us*. New York: Routledge.

Bosinski, H. A. G., Peter, M., Bonatz, G., Arndt, R., Heidenreich, M., Sippell, W. G., & Wille, R. (1997). A higher rate of hyperandrogenic disorders in female-to-male transsexuals. *Psychoneuroendocrinology, 22*(5), 361-380. doi:10.1016/S0306-4530(97)00033-4

Brill, S. A., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Berkeley, CA: Cleis Press.

Brown, G. R. (2009). Recommended revisions to The World Professional Association for Transgender Health's Standards of Care section on medical care for incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 11*(2), 133-139. doi:10.1080/15532730903008073

Brown, G. R. (2010). Autocastration and autopenectomy as surgical self-treatment in incarcerated persons with gender identity disorder. *International Journal of Transgenderism, 12*(1), 31-39. doi:10.1080/15532731003688970

Bullough, V. L., & Bullough, B. (1993). *Cross dressing, sex, and gender*. Philadelphia, PA: University of Pennsylvania Press.

Callen Lorde Community Health Center. (2000). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

Callen Lorde Community Health Center. (2011). *Transgender health program protocols*. Retrieved from http://www.callen-lorde.org/documents/TG_Protocol_Request_Form2.pdf

Canadian Association of Speech-Language Pathologists and Audiologists. http://www.caslpa.ca/

Carew, L., Dacakis, G., & Oates, J. (2007). The effectiveness of oral resonance therapy on the perception of femininity of voice in male-to-female transsexuals. *Journal of Voice, 21*(5), 591-603. doi:10.1016/j.jvoice.2006.05.005

Carnegie, C. (2004). Diagnosis of hypogonadism: Clinical assessments and laboratory tests. *Reviews in Urology, 6*(Suppl 6), S3-8.

Cattrall, F. R., & Healy, D. L. (2004). Long-term metabolic, cardiovascular and neoplastic risks with polycystic ovary syndrome. *Best Practice & Research Clinical Obstetrics & Gynaecology, 18*(5), 803-812. doi:10.1016/j.bpobgyn.2004.05.005

Center of Excellence for Transgender Health, UCSF. (2011). *Primary care protocol for transgender health care*. Retrieved from http://transhealth.ucsf.edu/trans?page=protocol-00-00

Chiñas, B. (1995). Isthmus Zapotec attitudes toward sex and gender anomalies. In S. O. Murray (Ed.), *Latin American male homosexualities* (pp. 293-302). Albuquerque, NM: University of New Mexico Press.

Clements, K., Wilkinson, W., Kitano, K., & Marx, R. (1999). HIV prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism, 3*(1), 2-17.

Cohen-Kettenis, P. T. (2001). Gender identity disorder in DSM? *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(4), 391-391. doi:10.1097/00004583-200104000-00006

Cohen-Kettenis, P. T. (2005). Gender change in 46,XY persons with 5α-reductase-2 deficiency and 17α-hydroxysteroid dehydrogenase-3 deficiency. *Archives of Sexual Behavior, 34*(4), 399-410. doi:10.1007/s10508-005-4339-4

Cohen-Kettenis, P. T. (2006). Gender identity disorders. In C. Gillberg, R. Harrington & H. C. Steinhausen (Eds.), *A clinician's handbook of child and adolescent psychiatry* (pp. 695-725). New York: Cambridge University Press.

Cohen-Kettenis, P. T. (2010). Psychosocial and psychosexual aspects of disorders of sex development. *Best Practice & Research Clinical Endocrinology & Metabolism, 24*(2), 325-334. doi:10.1016/j.beem.2009.11.005

Cohen-Kettenis, P. T., & Kuiper, A. J. (1984). Transseksualiteit en psychothérapie. *Tijdschrift Voor Psychotherapie, 10*, 153-166.

Cohen-Kettenis, P. T., Owen, A., Kaijser, V. G., Bradley, S. J., & Zucker, K. J. (2003). Demographic characteristics, social competence, and behavior problems in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology, 31*(1), 41-53. doi:10.1023/A:1021769215342

Cohen-Kettenis, P. T., & Pfäfflin, F. (2003). *Transgenderism and intersexuality in childhood and adolescence: Making choices*. Thousand Oaks, CA: Sage Publications, Inc.

Cohen-Kettenis, P. T., & Pfäfflin, F. (2010). The DSM diagnostic criteria for gender identity disorder in adolescents and adults. *Archives of Sexual Behavior, 39*(2), 499-513. doi:10.1007/s10508-009-9562-y

Cohen-Kettenis, P. T., Schagen, S. E. E., Steensma, T. D., de Vries, A. L. C., & Delemarre-van de Waal, H. A. (2011). Puberty suppression in a gender-dysphoric adolescent: A 22-year follow-up. *Archives of Sexual Behavior, 40*(4), 843-847. doi:0.1007/s10508-011-9758-9

Cohen-Kettenis, P. T., Wallien, M., Johnson, L. L., Owen-Anderson, A. F. H., Bradley, S. J., & Zucker, K. J. (2006). A parent-report gender identity questionnaire for children: A cross-national, cross-clinic comparative analysis. *Clinical Child Psychology and Psychiatry, 11*(3), 397-405. doi:10.1177/1359104506059135

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer III, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior, 26*(1), 13-26.

Coleman, E., Colgan, P., & Gooren, L. (1992). Male cross-gender behavior in Myanmar (Burma): A description of the acault. *Archives of Sexual Behavior, 21*(3), 313-321.

Costa, L. M., & Matzner, A. (2007). *Male bodies, women's souls: Personal narratives of Thailand's transgendered youth*. Binghamton, NY: Haworth Press.

Currah, P., Juang, R. M., & Minter, S. (2006). *Transgender rights*. Minneapolis, MN: University of Minnesota Press.

Currah, P., & Minter, S. (2000). Unprincipled exclusions: The struggle to achieve judicial and legislative equality for transgender people. *William and Mary Journal of Women and Law, 7*, 37-60.

Dacakis, G. (2000). Long-term maintenance of fundamental frequency increases in male-to-female transsexuals. *Journal of Voice, 14*(4), 549-556. doi:10.1016/S0892-1997(00)80010-7

Dahl, M., Feldman, J. L., Goldberg, J. M., & Jaberi, A. (2006). Physical aspects of transgender endocrine therapy. *International Journal of Transgenderism, 9*(3), 111-134. doi:10.1300/J485v09n03_06

Darney, P. D. (2008). Hormonal contraception. In H. M. Kronenberg, S. Melmer, K. S. Polonsky & P. R. Larsen (Eds.), *Williams textbook of endocrinology* (11th ed., pp. 615-644). Philadelphia: Saunders.

Davies, S., & Goldberg, J. M. (2006). Clinical aspects of transgender speech feminization and masculinization. *International Journal of Transgenderism, 9*(3-4), 167-196. doi:10.1300/J485v09n03_08

de Bruin, M. D., Coerts, M. J., & Greven, A. J. (2000). Speech therapy in the management of male-to-female transsexuals. *Folia Phoniatrica Et Logopaedica, 52*(5), 220-227.

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., . . . Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679-690. doi:10.1007/s10508-005-7926-5

De Cuypere, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R., . . . Monstrey, S. (2007). Prevalence and demography of transsexualism in Belgium. *European Psychiatry, 22*(3), 137-141. doi:10.1016/j.eurpsy.2006.10.002

De Cuypere, G., & Vercruysse, H. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH standards of care. *International Journal of Transgenderism, 11*(3), 194-205. doi:10.1080/15532730903383781

de Lignières, B. (1999). Oral micronized progesterone. *Clinical Therapeutics, 21*(1), 41-60. doi:10.1016/S0149-2918(00)88267-3

De Sutter, P. (2009). Reproductive options for transpeople: Recommendations for revision of the WPATH's standards of care. *International Journal of Transgenderism, 11*(3), 183-185. doi:10.1080/15532730903383765

De Sutter, P., Kira, K., Verschoor, A., & Hotimsky, A. (2002). The desire to have children and the preservation of fertility in transsexual women: A survey. *International Journal of Transgenderism, 6*(3), retrieved from http://www.wpath.org/journal/www.iiav.nl/ezines/web/IJT/97-03/numbers/symposion/ijtvo06no03_02.htm

de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. A. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism, 9*(3-4), 83-94. doi:10.1300/J485v09n03_04

de Vries, A. L. C., Doreleijers, T. A. H., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric adolescents. *Journal of Child Psychology and Psychiatry*. Advance online publication. doi:10.1111/j.1469-7610.2011.02426.x



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2459
9/20/11 9:43 PM

de Vries, A. L. C., Noens, I. L. J., Cohen-Kettenis, P. T., van Berckelaer-Onnes, I. A., & Doreleijers, T. A. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders, 40*(8), 930-936. doi:10.1007/s10803-010-0935-9

de Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., & Cohen-Kettenis, P. T. (2010). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*. Advance online publication. doi:10.1111/j.1743-6109.2010.01943.x

Delemarre-van de Waal, H. A., & Cohen-Kettenis, P. T. (2006). Clinical management of gender identity disorder in adolescents: A protocol on psychological and paediatric endocrinology aspects. *European Journal of Endocrinology, 155*(suppl 1), S131-S137. doi:10.1530/eje.1.02231

Delemarre-van de Waal, H. A., van Weissenbruch, M. M., & Cohen Kettenis, P. T. (2004). Management of puberty in transsexual boys and girls. *Hormone Research in Paediatrics, 62*(suppl 2), 75-75. doi:10.1159/000081145

Derrig-Palumbo, K., & Zeine, F. (2005). *Online therapy: A therapist's guide to expanding your practice*. New York: W.W. Norton & Co.

Dessens, A. B., Slijper, F. M. E., & Drop, S. L. S. (2005). Gender dysphoria and gender change in chromosomal females with congenital adrenal hyperplasia. *Archives of Sexual Behavior, 34*(4), 389-397. doi:10.1007/s10508-005-4338-5

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model. *Journal of Gay and Lesbian Psychotherapy, 8*(1/2), 41-67.

Di Ceglie, D., & Thümmel, E. C. (2006). An experience of group work with parents of children and adolescents with gender identity disorder. *Clinical Child Psychology and Psychiatry, 11*(3), 387-396. doi:10.1177/1359104506064983

Diamond, M. (2009). Human intersexuality: Difference or disorder? *Archives of Sexual Behavior, 38*(2), 172-172. doi:10.1007/s10508-008-9438-6

Dobs, A. S., Meikle, A. W., Arver, S., Sanders, S. W., Caramelli, K. E., & Mazer, N. A. (1999). Pharmacokinetics, efficacy, and safety of a permeation-enhanced testosterone transdermal system in comparison with bi-weekly injections of testosterone enanthate for the treatment of hypogonadal men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3469-3478. doi:10.1210/jc.84.10.3469

Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior*. New York: Plenum Press.

Drummond, K. D., Bradley, S. J., Peterson-Badali, M., & Zucker, K. J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology, 44*(1), 34-45. doi:10.1037/0012-1649.44.1.34



Standards of Care_1c.indd 78 2460 9/20/11 9:43 PM

Ehrbar, R. D., & Gorton, R. N. (2010). Exploring provider treatment models in interpreting the standards of care. *International Journal of Transgenderism, 12*(4), 198-2010. doi:10.1080/15532739.2010.544235

Ekins, R., & King, D. (2006). *The transgender phenomenon*. Thousand Oaks, CA: SAGE Publications Ltd.

Eklund, P. L., Gooren, L. J., & Bezemer, P. D. (1988). Prevalence of transsexualism in the Netherlands. *British Journal of Psychiatry, 152*(5), 638-640.

Eldh, J., Berg, A., & Gustafsson, M. (1997). Long-term follow up after sex reassignment surgery. *Scandinavian Journal of Plastic and Reconstructive Surgery and Hand Surgery, 31*(1), 39-45.

Emerson, S., & Rosenfeld, C. (1996). Stages of adjustment in family members of transgender individuals. *Journal of Family Psychotherapy, 7*(3), 1-12. doi:10.1300/J085V07N03_01

Emory, L. E., Cole, C. M., Avery, E., Meyer, O., & Meyer III, W. J. (2003). Client's view of gender identity: Life, treatment status and outcome. *18th Biennial Harry Benjamin Symposium,* Gent, Belgium.

Ettner, R., Monstrey, S., & Eyler, A. (Eds.) (2007). *Principles of transgender medicine and surgery*. Binghamton, NY: The Haworth Press.

Eyler, A. E. (2007). Primary medical care of the gender-variant patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (pp. 15-32). Binghamton, NY: The Haworth Press.

Factor, R. J., & Rothblum, E. (2008). Exploring gender identity and community among three groups of transgender individuals in the United States: MTFs, FTMs, and genderqueers. *Health Sociology Review, 17*(3), 235-253.

Feinberg, L. (1996). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman*. Boston, MA: Beacon Press.

Feldman, J. (2005, April). *Masculinizing hormone therapy with testosterone 1% topical gel.* Paper presented at the 19th Biennial Symposium of the Harry Benjamin International Gender Dysphoria Association, Bologna, Italy.

Feldman, J. (2007). Preventive care of the transgendered patient. In R. Ettner, S. Monstrey & E. Eyler (Eds.), *Principles of transgender surgery and medicine* (pp. 33-72). Binghamton, NY: The Haworth Press.

Feldman, J., & Goldberg, J. (2006). Transgender primary medical care. *International Journal of Transgenderism, 9*(3), 3-34. doi:10.1300/J485v09n03_02

Feldman, J., & Safer, J. (2009). Hormone therapy in adults: Suggested revisions to the sixth version of the standards of care. *International Journal of Transgenderism, 11*(3), 146-182. doi:10.1080/15532730903383757

Fenichel, M., Suler, J., Barak, A., Zelvin, E., Jones, G., Munro, K., . . . Walker-Schmucker, W. (2004). *Myths and realities of online clinical work, observations on the phenomena of online behavior, experience, and therapeutic relationships. A 3rd-year report from ISMHO's clinical case study group.* Retrieved May 24, 2011, from https://www.ismho.org/myths_n_realities.asp

Fenway Community Health Transgender Health Program. (2007). *Protocol for hormone therapy.* Retrieved from http://www.fenwayhealth.org/site/DocServer/Fenway_Protocols.pdf?docID=2181

Fisk, N. M. (1974). Editorial: Gender dysphoria syndrome--the conceptualization that liberalizes indications for total gender reorientation and implies a broadly based multi-dimensional rehabilitative regimen. *Western Journal of Medicine, 120*(5), 386-391.

Fitzpatrick, L. A., Pace, C., & Wiita, B. (2000). Comparison of regimens containing oral micronized progesterone or medroxyprogesterone acetate on quality of life in postmenopausal women: A cross-sectional survey. *Journal of Women's Health & Gender-Based Medicine, 9*(4), 381-387.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (Third ed.). Baltimore, MD: Johns Hopkins University Press.

Fraser, L. (2009a). Depth psychotherapy with transgender people. *Sexual and Relationship Therapy, 24*(2), 126-142. doi:10.1080/14681990903003878

Fraser, L. (2009b). Etherapy: Ethical and clinical considerations for version 7 of The World Professional Association for Transgender Health's standards of care. *International Journal of Transgenderism, 11*(4), 247-263. doi:10.1080/15532730903439492

Fraser, L. (2009c). Psychotherapy in The World Professional Association for Transgender Health's standards of care: Background and recommendations. *International Journal of Transgenderism, 11*(2), 110-126. doi:10.1080/15532730903008057

Garaffa, G., Christopher, N. A., & Ralph, D. J. (2010). Total phallic reconstruction in female-to-male transsexuals. *European Urology, 57*(4), 715-722. doi:10.1016/j.eururo.2009.05.018

Gelder, M. G., & Marks, I. M. (1969). Aversion treatment in transvestism and transsexualism. In R. Green, & J. Money (Eds.), *Transsexualism and sex reassignment* (pp. 383-413). Baltimore, MD: Johns Hopkins Press.

Gelfer, M. P. (1999). Voice treatment for the male-to-female transgendered client. *American Journal of Speech-Language Pathology, 8*(3), 201-208.

Gharib, S., Bigby, J., Chapin, M., Ginsburg, E., Johnson, P., Manson, J., & Solomon, C. (2005). *Menopause: A guide to management*. Boston, MA: Brigham and Women's Hospital.



Standards of Care_1c.indd 80 2462 9/20/11 9:43 PM

Gijs, L., & Brewaeys, A. (2007). Surgical treatment of gender dysphoria in adults and adolescents: Recent developments, effectiveness, and challenges. *Annual Review of Sex Research, 18*, 178-224.

Gold, M., & MacNish, M. (2011). *Adjustment and resiliency following disclosure of transgender identity in families of adolescents and young adults: Themes and clinical implications*. Washington, DC: American Family Therapy Academy.

Gómez-Gil, E., Trilla, A., Salamero, M., Godás, T., & Valdés, M. (2009). Sociodemographic, clinical, and psychiatric characteristics of transsexuals from Spain. *Archives of Sexual Behavior, 38*(3), 378-392. doi:10.1007/s10508-007-9307-8

Gooren, L. (2005). Hormone treatment of the adult transsexual patient. *Hormone Research in Paediatrics, 64*(Suppl 2), 31-36. doi:10.1159/000087751

Gorton, R. N., Buth, J., & Spade, D. (2005). *Medical therapy and health maintenance for transgender men: A guide for health care providers*. San Francisco, CA: Lyon-Martin Women's Health Services.

Green, R. (1987). *The"sissy boy syndrome" and the development of homosexuality*. New Haven, CT: Yale University Press.

Green, R., & Fleming, D. (1990). Transsexual surgery follow-up: Status in the 1990s. *Annual Review of Sex Research, 1*(1), 163-174.

Greenson, R. R. (1964). On homosexuality and gender identity. *International Journal of Psycho-Analysis, 45*, 217-219.

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2006). Parent's reactions to transgender youth's gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*(1), 3-16. doi:10.1300/J041v18n01_02

Grossman, A. H., D'Augelli, A. R., & Salter, N. P. (2006). Male-to-female transgender youth: Gender expression milestones, gender atypicality, victimization, and parents' responses. *Journal of GLBT Family Studies, 2*(1), 71-92.

Grumbach, M. M., Hughes, I. A., & Conte, F. A. (2003). Disorders of sex differentiation. In P. R. Larsen, H. M. Kronenberg, S. Melmed & K. S. Polonsky (Eds.), *Williams textbook of endocrinology* (10th ed., pp. 842-1002). Philadelphia, PA: Saunders.

Hage, J. J., & De Graaf, F. H. (1993). Addressing the ideal requirements by free flap phalloplasty: Some reflections on refinements of technique. *Microsurgery, 14*(9), 592-598. doi:10.1002/micr.1920140910

Hage, J. J., & Karim, R. B. (2000). Ought GIDNOS get nought? Treatment options for nontranssexual gender dysphoria. *Plastic and Reconstructive Surgery, 105*(3), 1222-1227.

Hancock, A. B., Krissinger, J., & Owen, K. (2010). Voice perceptions and quality of life of transgender people. *Journal of Voice*. Advance online publication. doi:10.1016/j.jvoice.2010.07.013

Hastings, D. W. (1974). Postsurgical adjustment of male transsexual patients. *Clinics in Plastic Surgery, 1*(2), 335-344.

Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L. J., Meyer III, W. J., Spack, N. P., . . . Montori, V. M. (2009). Endocrine treatment of transsexual persons: An Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 94*(9), 3132-3154. doi:10.1210/jc.2009-0345

Hill, D. B., Menvielle, E., Sica, K. M., & Johnson, A. (2010). An affirmative intervention for families with gender-variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy, 36*(1), 6-23. doi:10.1080/00926230903375560

Hoebeke, P., Selvaggi, G., Ceulemans, P., De Cuypere, G. D., T'Sjoen, G., Weyers, S., . . . Monstrey, S. (2005). Impact of sex reassignment surgery on lower urinary tract function. *European Urology, 47*(3), 398-402. doi:10.1016/j.eururo.2004.10.008

Hoenig, J., & Kenna, J. C. (1974). The prevalence of transsexualism in England and Wales. *British Journal of Psychiatry, 124*(579), 181-190. doi:10.1192/bjp.124.2.181

Hughes, I. A., Houk, C. P., Ahmed, S. F., Lee, P. A., & LWPES1/ESPE2 Consensus Group. (2006). Consensus statement on management of intersex disorders. *Archives of Disease in Childhood, 91*(7), 554-563. doi:10.1136/adc.2006.098319

Hunter, M. H., & Sterrett, J. J. (2000). Polycystic ovary syndrome: It's not just infertility. *American Family Physician, 62*(5), 1079-1095.

Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: The National Academies Press.

Jackson, P. A., & Sullivan, G. (Eds.). (1999). *Lady boys, tom boys, rent boys: Male and female homosexualities in contemporary Thailand*. Binghamton, NY: The Haworth Press.

Jockenhövel, F. (2004). Testosterone therapy-what, when and to whom? *The Aging Male, 7*(4), 319-324. doi:10.1080/13685530400016557

Johansson, A., Sundbom, E., Höjerback, T., & Bodlund, O. (2010). A five-year follow-up study of Swedish adults with gender identity disorder. *Archives of Sexual Behavior, 39*(6), 1429-1437. doi:10.1007/s10508-009-9551-1



Standards of Care_1c.indd 82 2464 9/20/11 9:43 PM

Joint LWPES/ESPE CAH Working Group, Clayton, P. E., Miller, W. L., Oberfield, S. E., Ritzen, E. M., Sippell, W. G., & Speiser, P. W. (2002). Consensus statement on 21-hydroxylase deficiency from the Lawson Wilkins Pediatric Endocrine Society and the European Society for Pediatric Endocrinology. *Journal of Clinical Endocrinology & Metabolism, 87*(9), 4048-4053. doi:10.1210/jc.2002-020611

Jurgensen, M., Hiort, O., Holterhus, P. M., & Thyen, U. (2007). Gender role behavior in children with XY karyotype and disorders of sex development. *Hormones and Behavior, 51*(3), 443-453. doi:0.1016/j.yhbeh.2007.01.001

Kanagalingam, J., Georgalas, C., Wood, G. R., Ahluwalia, S., Sandhu, G., & Cheesman, A. D. (2005). Cricothyroid approximation and subluxation in 21 male-to-female transsexuals. *The Laryngoscope, 115*(4), 611-618. doi:10.1097/01.mlg.0000161357.12826.33

Kanhai, R. C. J., Hage, J. J., Karim, R. B., & Mulder, J. W. (1999). Exceptional presenting conditions and outcome of augmentation mammaplasty in male-to-female transsexuals. *Annals of Plastic Surgery, 43*(5), 476-483.

Kimberly, S. (1997). I am transsexual - hear me roar. *Minnesota Law & Politics, June*, 21-49.

Klein, C., & Gorzalka, B. B. (2009). Sexual functioning in transsexuals following hormone therapy and genital surgery: A review (CME). *The Journal of Sexual Medicine, 6*(11), 2922-2939. doi:10.1111/j.1743-6109.2009.01370.x

Knudson, G., De Cuypere, G., & Bockting, W. (2010a). Process toward consensus on recommendations for revision of the DSM diagnoses of gender identity disorders by The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 54-59. doi:10.1080/15532739.2010.509213

Knudson, G., De Cuypere, G., & Bockting, W. (2010b). Recommendations for revision of the DSM diagnoses of gender identity disorders: Consensus statement of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 12*(2), 115-118. doi:10.1080/15532739.2010.509215

Kosilek v. Massachusetts Department of Corrections/Maloney, C.A. No. 92-12820-MLW (U.S. Federal District Court, Boston, MA, 2002).

Krege, S., Bex, A., Lümmen, G., & Rübben, H. (2001). Male-to-female transsexualism: A technique, results and long-term follow-up in 66 patients. *British Journal of Urology, 88*(4), 396-402. doi:10.1046/j.1464-410X.2001.02323.x



Standards of Care_1c.indd 83 2465 9/20/11 9:43 PM

Kuhn, A., Bodmer, C., Stadlmayr, W., Kuhn, P., Mueller, M. D., & Birkhäuser, M. (2009). Quality of life 15 years after sex reassignment surgery for transsexualism. *Fertility and Sterility, 92*(5), 1685-1689. doi:10.1016/j.fertnstert.2008.08.126

Kuhn, A., Hiltebrand, R., & Birkhauser, M. (2007). Do transsexuals have micturition disorders? *European Journal of Obstetrics & Gynecology and Reproductive Biology, 131*(2), 226-230. doi:10.1016/j.ejogrb.2006.03.019

Landén, M., Wålinder, J., & Lundström, B. (1998). Clinical characteristics of a total cohort of female and male applicants for sex reassignment: A descriptive study. *Acta Psychiatrica Scandinavica, 97*(3), 189-194. doi:10.1111/j.1600-0447.1998.tb09986.x

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299-315. doi:10.1023/A:1024086814364

Lawrence, A. A. (2006). Patient-reported complications and functional outcomes of male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 35*(6), 717-727. doi:10.1007/s10508-006-9104-9

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Clinical Practice Press.

Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of The World Professional Association for Transgender Health's standards of care. *International Journal of Transgenderism, 11*(2), 74-99. doi:10.1080/15532730903008032

Levy, A., Crown, A., & Reid, R. (2003). Endocrine intervention for transsexuals. *Clinical Endocrinology, 59*(4), 409-418. doi:10.1046/j.1365-2265.2003.01821.x

MacLaughlin, D. T., & Donahoe, P. K. (2004). Sex determination and differentiation. *New England Journal of Medicine, 350*(4), 367-378.

Maheu, M. M., Pulier, M. L., Wilhelm, F. H., McMenamin, J. P., & Brown-Connolly, N. E. (2005). *The mental health professional and the new technologies: A handbook for practice today*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Malpas, J. (in press). Between pink and blue: A multi-dimensional family approach to gender nonconforming chldren and their families. *Family Process*.

Mazur, T. (2005). Gender dysphoria and gender change in androgen insensitivity or micropenis. *Archives of Sexual Behavior, 34*(4), 411-421. doi:10.1007/s10508-005-4341-x

McNeill, E. J. M. (2006). Management of the transgender voice. *The Journal of Laryngology & Otology, 120*(07), 521-523. doi:10.1017/S0022215106001174



Standards of Care_1c.indd 84 2466 9/20/11 9:43 PM

McNeill, E. J. M., Wilson, J. A., Clark, S., & Deakin, J. (2008). Perception of voice in the transgender client. *Journal of Voice, 22*(6), 727-733. doi:10.1016/j.jvoice.2006.12.010

Menvielle, E. J., & Tuerk, C. (2002). A support group for parents of gender-nonconforming boys. *Journal of the American Academy of Child & Adolescent Psychiatry, 41*(8), 1010-1013. doi:10.1097/00004583-200208000-00021

Meyer, I. H. (2003). Prejudice as stress: Conceptual and measurement problems. *American Journal of Public Health, 93*(2), 262-265.

Meyer, J. K., & Reter, D. J. (1979). Sex reassignment: Follow-up. *Archives of General Psychiatry, 36*(9), 1010-1015.

Meyer III, W. J. (2009). World Professional Association for Transgender Health's standards of care requirements of hormone therapy for adults with gender identity disorder. *International Journal of Transgenderism, 11*(2), 127-132. doi:10.1080/15532730903008065

Meyer III, W. J., Webb, A., Stuart, C. A., Finkelstein, J. W., Lawrence, B., & Walker, P. A. (1986). Physical and hormonal evaluation of transsexual patients: A longitudinal study. *Archives of Sexual Behavior, 15*(2), 121-138. doi:10.1007/BF01542220

Meyer-Bahlburg, H. F. L. (2002). Gender assignment and reassignment in intersexuality: Controversies, data, and guidelines for research. *Advances in Experimental Medicine and Biology, 511*, 199-223. doi:10.1007/978-1-4615-0621-8_12

Meyer-Bahlburg, H. F. L. (2005). Gender identity outcome in female-raised 46,XY persons with penile agenesis, cloacal exstrophy of the bladder, or penile ablation. *Archives of Sexual Behavior, 34*(4), 423-438. doi:10.1007/s10508-005-4342-9

Meyer-Bahlburg, H. F. L. (2008). Treatment guidelines for children with disorders of sex development. *Neuropsychiatrie De l'Enfance Et De l'Adolescence, 56*(6), 345-349. doi:10.1016/j.neurenf.2008.06.002

Meyer-Bahlburg, H. F. L. (2009). Variants of gender differentiation in somatic disorders of sex development. *International Journal of Transgenderism, 11*(4), 226-237. doi:10.1080/15532730903439476

Meyer-Bahlburg, H. F. L. (2010). From mental disorder to iatrogenic hypogonadism: Dilemmas in conceptualizing gender identity variants as psychiatric conditions. *Archives of Sexual Behavior, 39*(2), 461-476. doi:10.1007/s10508-009-9532-4

Meyer-Bahlburg, H. F. L. (in press). Gender monitoring and gender reassignment of children and adolescents with a somatic disorder of sex development. *Child & Adolescent Psychiatric Clinics of North America*.



Standards of Care_1c.indd 85 2467 9/20/11 9:43 PM

Meyer-Bahlburg, H. F. L., & Blizzard, R. M. (2004). Conference proceedings: Research on intersex: Summary of a planning workshop. *The Endocrinologist, 14*(2), 59-69. doi:10.1097/01.ten.0000123701.61007.4e

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Carlson, A. D., Obeid, J. S., & New, M. I. (2004). Prenatal androgenization affects gender-related behavior but not gender identity in 5–12-year-old girls with congenital adrenal hyperplasia. *Archives of Sexual Behavior, 33*(2), 97-104. doi:10.1023/B:ASEB.0000014324.25718.51

Meyer-Bahlburg, H. F. L., Dolezal, C., Baker, S. W., Ehrhardt, A. A., & New, M. I. (2006). Gender development in women with congenital adrenal hyperplasia as a function of disorder severity. *Archives of Sexual Behavior, 35*(6), 667-684. doi:10.1007/s10508-006-9068-9

Meyer-Bahlburg, H. F. L., Migeon, C. J., Berkovitz, G. D., Gearhart, J. P., Dolezal, C., & Wisniewski, A. B. (2004). Attitudes of adult 46,XY intersex persons to clinical management policies. *The Journal of Urology, 171*(4), 1615-1619. doi:10.1097/01.ju.0000117761.94734.b7

Money, J., & Ehrhardt, A. A. (1972). *Man and woman, boy and girl*. Baltimore, MD: The Johns Hopkins University Press.

Money, J., & Russo, A. J. (1979). Homosexual outcome of discordant gender identity/role in childhood: Longitudinal follow-up. *Journal of Pediatric Psychology, 4*(1), 29-41. doi:10.1093/jpepsy/4.1.29

Monstrey, S., Hoebeke, P., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Blondeel, P., . . . De Cuypere, G. (2009). Penile reconstruction: Is the radial forearm flap really the standard technique? *Plastic and Reconstructive Surgery, 124*(2), 510-518.

Monstrey, S., Selvaggi, G., Ceulemans, P., Van Landuyt, K., Bowman, C., Blondeel, P., . . . De Cuypere, G. (2008). Chest-wall contouring surgery in female-to-male transsexuals: A new algorithm. *Plastic and Reconstructive Surgery, 121*(3), 849-859. doi:10.1097/01.prs.0000299921.15447.b2

Moore, E., Wisniewski, A., & Dobs, A. (2003). Endocrine treatment of transsexual people: A review of treatment regimens, outcomes, and adverse effects. *Journal of Clinical Endocrinology & Metabolism, 88*(8), 3467-3473. doi:10.1210/jc.2002-021967

More, S. D. (1998). The pregnant man-an oxymoron? *Journal of Gender Studies, 7*(3), 319-328. doi:10.1080/09589236.1998.9960725

Mount, K. H., & Salmon, S. J. (1988). Changing the vocal characteristics of a postoperative transsexual patient: A longitudinal study. *Journal of Communication Disorders, 21*(3), 229-238. doi:10.1016/0021-9924(88)90031-7

Mueller, A., Kiesewetter, F., Binder, H., Beckmann, M. W., & Dittrich, R. (2007). Long-term administration of testosterone undecanoate every 3 months for testosterone supplementation in female-to-male transsexuals. *Journal of Clinical Endocrinology & Metabolism, 92*(9), 3470-3475. doi:10.1210/jc.2007-0746

Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: A systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology, 72*(2), 214-231. doi:10.1111/j.1365-2265.2009.03625.x

Nanda, S. (1998). *Neither man nor woman: The hijras of India*. Belmont, CA: Wadsworth Publishing.

Nestle, J., Wilchins, R. A., & Howell, C. (2002). *Genderqueer: Voices from beyond the sexual binary*. Los Angeles, CA: Alyson Publications.

Neumann, K., & Welzel, C. (2004). The importance of voice in male-to-female transsexualism. *Journal of Voice, 18*(1), 153-167.

Newfield, E., Hart, S., Dibble, S., & Kohler, L. (2006). Female-to-male transgender quality of life. *Quality of Life Research, 15*(9), 1447-1457. doi:10.1007/s11136-006-0002-3

Nieschlag, E., Behre, H. M., Bouchard, P., Corrales, J. J., Jones, T. H., Stalla, G. K., . . . Wu, F. C. W. (2004). Testosterone replacement therapy: Current trends and future directions. *Human Reproduction Update, 10*(5), 409-419. doi:10.1093/humupd/dmh035

North American Menopause Society. (2010). Estrogen and progestogen use in postmenopausal women: 2010 position statement. *Menopause, 17*(2), 242-255. doi:10.1097/gme.0b013e3181d0f6b9

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12-23. doi:10.1080/00224490903062258

Oates, J. M., & Dacakis, G. (1983). Speech pathology considerations in the management of transsexualism-a review. *International Journal of Language & Communication Disorders, 18*(3), 139-151. doi:10.3109/13682828309012237

Olyslager, F., & Conway, L. (2007). On the calculation of the prevalence of transsexualism. Paper presented at the *World Professional Association for Transgender Health 20th International Symposium,* Chicago, Illinois. Retrieved April 22, 2010 from http://www.changelingaspects.com/PDF/2007-09-06-Prevalence_of_Transsexualism.pdf

Oriel, K. A. (2000). Clinical update: Medical care of transsexual patients. *Journal of the Gay and Lesbian Medical Association, 4*(4), 185-194. doi:1090-7173/00/1200-0185$18.00/1

Pauly, I. B. (1965). Male psychosexual inversion: Transsexualism: A review of 100 cases. *Archives of General Psychiatry, 13*(2), 172-181.

Payer, A. F., Meyer III, W. J., & Walker, P. A. (1979). The ultrastructural response of human leydig cells to exogenous estrogens. *Andrologia, 11*(6), 423-436. doi:10.1111/j.1439-0272.1979.tb02232.x

Peletz, M. G. (2006). Transgenderism and gender pluralism in southeast asia since early modern times. *Current Anthropology, 47*(2), 309-340. doi:10.1086/498947

Pfäfflin, F. (1993). Regrets after sex reassignment surgery. *Journal of Psychology & Human Sexuality, 5*(4), 69-85.

Pfäfflin, F., & Junge, A. (1998). Sex reassignment. Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961-1991. *International Journal of Transgenderism*. Retrieved from http://web.archive.org/web/20070503090247/http://www.symposion.com/ijt/pfaefflin/1000.htm

*Physicians' desk reference*. (61st ed.). (2007). Montvale, NJ: PDR.

*Physicians' desk reference*. (65th ed.). (2010). Montvale, NJ: PDR.

Pleak, R. R. (1999). Ethical issues in diagnosing and treating gender-dysphoric children and adolescents. In M. Rottnek (Ed.), *Sissies and tomboys: Gender noncomformity and homosexual childhood* (pp. 34-51). New York: New York University Press.

Pope, K. S., & Vasquez, M. J. (2011). *Ethics in psychotherapy and counseling: A practical guide* (Fourth ed.). Hoboken, NJ: John Wiley & Sons, Inc.

Prior, J. C., Vigna, Y. M., & Watson, D. (1989). Spironolactone with physiological female steroids for presurgical therapy of male-to-female transsexualism. *Archives of Sexual Behavior, 18*(1), 49-57. doi:10.1007/BF01579291

Prior, J. C., Vigna, Y. M., Watson, D., Diewold, P., & Robinow, O. (1986). Spironolactone in the presurgical therapy of male to female transsexuals: Philosophy and experience of the Vancouver Gender Dysphoria Clinic. *Journal of Sex Information & Education Council of Canada, 1*, 1-7.

Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism, 3*(3). Retrieved from http://www.WPATH.org

Rachlin, K. (2002). Transgendered individuals' experiences of psychotherapy. *International Journal of Transgenderism, 6*(1). Retrieved from http://www.wpath.org/journal/www.iiav.nl /ezines/web/IJT/97-03/numbers/symposion/ijtvo06no01_03.htm.

Rachlin, K., Green, J., & Lombardi, E. (2008). Utilization of health care among female-to-male transgender individuals in the United States. *Journal of Homosexuality, 54*(3), 243-258. doi:10.1080/00918360801982124

Rachlin, K., Hansbury, G., & Pardo, S. T. (2010). Hysterectomy and oophorectomy experiences of female-to-male transgender individuals. *International Journal of Transgenderism, 12*(3), 155-166. doi:10.1080/15532739.2010.514220

Reed, B., Rhodes, S., Schofield, P. & Wylie, K. (2009). *Gender variance in the UK: Prevalence, incidence, growth and geographic distribution.* Retrieved June 8, 2011, from http://www.gires.org.uk/assets/Medpro-Assets/GenderVarianceUK-report.pdf

Rehman, J., Lazer, S., Benet, A. E., Schaefer, L. C., & Melman, A. (1999). The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Archives of Sexual Behavior, 28*(1), 71-89. doi:10.1023/A:1018745706354

Robinow, O. (2009). Paraphilia and transgenderism: A connection with Asperger's disorder? *Sexual and Relationship Therapy, 24*(2), 143-151. doi:10.1080/14681990902951358

Rosenberg, M. (2002). Children with gender identity issues and their parents in individual and group treatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(5), 619-621. doi:10.1097/00004583-200205000-00020

Rossouw, J. E., Anderson, G. L., Prentice, R. L., LaCroix, A. Z., Kooperberg, C., Stefanick, M. L., . . . Johnson, K. C. (2002). Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the women's health initiative randomized controlled trial. *JAMA: The Journal of the American Medical Association, 288*(3), 321-333.

Royal College of Speech Therapists, United Kingdom. http://www.rcslt.org/

Ruble, D. N., Martin, C. L., & Berenbaum, S. A. (2006). Gender development. In N. Eisenberg, W. Damon & R. M. Lerner (Eds.), *Handbook of child psychology* (6th ed., pp. 858-932). Hoboken, NJ: John Wiley & Sons, Inc.

Sausa, L. A. (2005). Translating research into practice: Trans youth recommendations for improving school systems. *Journal of Gay & Lesbian Issues in Education, 3*(1), 15-28. doi:10.1300/J367v03n01_04

Simpson, J. L., de la Cruz, F., Swerdloff, R. S., Samango-Sprouse, C., Skakkebaek, N. E., Graham, J. M. J., . . . Willard, H. F. (2003). Klinefelter syndrome: Expanding the phenotype and identifying new research directions. *Genetics in Medicine, 5*(6), 460-468. doi:10.1097/01.GIM.0000095626.54201.D0

Smith, Y. L. S., Van Goozen, S. H. M., Kuiper, A. J., & Cohen-Kettenis, P. T. (2005). Sex reassignment: Outcomes and predictors of treatment for adolescent and adult transsexuals. *Psychological Medicine, 35*(1), 89-99. doi:10.1017/S0033291704002776

Sood, R., Shuster, L., Smith, R., Vincent, A., & Jatoi, A. (2011). Counseling postmenopausal women about bioidentical hormones: Ten discussion points for practicing physicians. *Journal of the American Board of Family Practice, 24*(2), 202-210. doi:10.3122/jabfm.2011.02.100194

Speech Pathology Australia. http://www.speechpathologyaustralia.org.au/

Speiser, P. W., Azziz, R., Baskin, L. S., Ghizzoni, L., Hensle, T. W., Merke, D. P., . . . Oberfield, S. E. (2010). Congenital adrenal hyperplasia due to steroid 21-hydroxylase deficiency: An endocrine society clinical practice guideline. *Journal of Clinical Endocrinology & Metabolism, 95*(9), 4133-4160. doi:10.1210/jc.2009-2631

Steensma, T. D., Biemond, R., de Boer, F., & Cohen-Kettenis, P. T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry.* Advance online publication. doi:10.1177/1359104510378303

Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Gender transitioning before puberty? *Archives of Sexual Behavior, 40*(4), 649-650. doi:10.1007/s10508-011-9752-2

Stikkelbroeck, N. M. M. L., Beerendonk, C., Willemsen, W. N. P., Schreuders-Bais, C. A., Feitz, W. F. J., Rieu, P. N. M. A., . . . Otten, B. J. (2003). The long term outcome of feminizing genital surgery for congenital adrenal hyperplasia: Anatomical, functional and cosmetic outcomes, psychosexual development, and satisfaction in adult female patients. *Journal of Pediatric and Adolescent Gynecology, 16*(5), 289-296. doi:10.1016/S1083-3188(03)00155-4

Stoller, R. J. (1964). A contribution to the study of gender identity. *International Journal of Psychoanalysis, 45*, 220-226.

Stone, S. (1991). The empire strikes back: A posttransexual manifesto. In J. Epstein, & K. Straub (Eds.), *Body guards: The cultural politics of gender ambiguity* (pp. 280-304). London: Routledge.

Tangpricha, V., Ducharme, S. H., Barber, T. W., & Chipkin, S. R. (2003). Endocrinologic treatment of gender identity disorders. *Endocrine Practice, 9*(1), 12-21.

Tangpricha, V., Turner, A., Malabanan, A., & Holick, M. (2001). Effects of testosterone therapy on bone mineral density in the FTM patient. *International Journal of Transgenderism, 5*(4).

Taywaditep, K. J., Coleman, E., & Dumronggittigule, P. (1997). Thailand (muang thai). In R. Francouer (Ed.), *International encyclopedia of sexuality*. New York: Continuum.

The World Professional Association for Transgender Health, Inc. (2008). *WPATH clarification on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A.* Retrieved from http://www.wpath.org/documents/Med%20Nec%20on%202008%20Letterhead.pdf

Thole, Z., Manso, G., Salgueiro, E., Revuelta, P., & Hidalgo, A. (2004). Hepatotoxicity induced by antiandrogens: A review of the literature. *Urologia Internationalis, 73*(4), 289-295. doi:10.1159/000081585

Tom Waddell Health Center. (2006). *Protocols for hormonal reassignment of gender.* Retrieved from http://www.sfdph.org/dph/comupg/oservices/medSvs/hlthCtrs/TransGendprotocols122006.pdf

Tsoi, W. F. (1988). The prevalence of transsexualism in Singapore. *Acta Psychiatrica Scandinavica, 78*(4), 501-504. doi:10.1111/j.1600-0447.1988.tb06373.x

Van den Broecke, R., Van der Elst, J., Liu, J., Hovatta, O., & Dhont, M. (2001). The female-to-male transsexual patient: A source of human ovarian cortical tissue for experimental use. *Human Reproduction, 16*(1), 145-147. doi:10.1093/humrep/16.1.145

van Kesteren, P. J. M., Asscheman, H., Megens, J. A. J., & Gooren, L. J. G. (1997). Mortality and morbidity in transsexual subjects treated with cross-sex hormones. *Clinical Endocrinology, 47*(3), 337-343. doi:10.1046/j.1365-2265.1997.2601068.x

van Kesteren, P. J. M., Gooren, L. J., & Megens, J. A. (1996). An epidemiological and demographic study of transsexuals in the Netherlands. *Archives of Sexual Behavior, 25*(6), 589-600. doi:10.1007/BF02437841

van Trotsenburg, M. A. A. (2009). Gynecological aspects of transgender healthcare. *International Journal of Transgenderism, 11*(4), 238-246. doi:10.1080/15532730903439484

Vancouver Coastal Health, Vancouver, British Columbia, Canada. http://www.vch.ca/

Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent transgender/gender-dissonant children. *Child and Adolescent Social Work Journal, 26*(2), 135-154. doi:10.1007/s10560-008-0158-5

Vilain, E. (2000). Genetics of sexual development. *Annual Review of Sex Research, 11*, 1-25.

Wålinder, J. (1968). Transsexualism: Definition, prevalence and sex distribution. *Acta Psychiatrica Scandinavica, 43*(S203), 255-257.

Wålinder, J. (1971). Incidence and sex ratio of transsexualism in Sweden. *The British Journal of Psychiatry, 119*(549), 195-196.

Wallien, M. S. C., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(12), 1413-1423. doi:10.1097/CHI.0b013e31818956b9



Standards of Care_1c.indd 91 2473 9/20/11 9:43 PM

Wallien, M. S. C., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 46*(10), 1307-1314. doi:10.1097/chi.0b013e3181373848

Warren, B. E. (1993). Transsexuality, identity and empowerment. A view from the frontlines. *SIECUS Report, February/March,* 14-16.

Weitze, C., & Osburg, S. (1996). Transsexualism in Germany: Empirical data on epidemiology and application of the German Transsexuals' Act during its first ten years. *Archives of Sexual Behavior, 25*(4), 409-425.

Wilson, J. D. (1999). The role of androgens in male gender role behavior. *Endocrine Reviews, 20*(5), 726-737. doi:10.1210/er.20.5.726

Winter, S. (2009). Cultural considerations for The World Professional Association for Transgender Health's standards of care: The Asian perspective. *International Journal of Transgenderism, 11*(1), 19-41. doi:10.1080/15532730902799938

Winter, S., Chalungsooth, P., Teh, Y. K., Rojanalert, N., Maneerat, K., Wong, Y. W., . . . Macapagal, R. A. (2009). Transpeople, transprejudice and pathologization: A seven-country factor analytic study. *International Journal of Sexual Health, 21*(2), 96-118. doi:10.1080/19317610902922537

Wisniewski, A. B., Migeon, C. J., Malouf, M. A., & Gearhart, J. P. (2004). Psychosexual outcome in women affected by congenital adrenal hyperplasia due to 21-hydroxylase deficiency. *The Journal of Urology, 171*(6, Part 1), 2497-2501. doi:10.1097/01.ju.0000125269.91938.f7

World Health Organization. (2007). *International classification of diseases and related health problems-10th revision*. Geneva, Switzerland: World Health Organization.

World Health Organization. (2008). *The world health report 2008: Primary health care - now more than ever*. Geneva, Switzerland: World Health Organization.

WPATH Board of Directors. (2010). *De-psychopathologisation statement released May 26, 2010.* Retrieved from http://wpath.org/announcements_detail.cfm?pk_announcement=17

Xavier, J. M. (2000). *The Washington, D.C. transgender needs assessment survey: Final report for phase two*. Washington, DC: Administration for HIV/AIDS of District of Columbia Government.

Zhang, G., Gu, Y., Wang, X., Cui, Y., & Bremner, W. J. (1999). A clinical trial of injectable testosterone undecanoate as a potential male contraceptive in normal Chinese men. *Journal of Clinical Endocrinology & Metabolism, 84*(10), 3642-3647. doi:10.1210/jc.84.10.3642

Zitzmann, M., Saad, F., & Nieschlag, E. (2006, April). *Long term experience of more than 8 years with a novel formulation of testosterone undecanoate (nebido) in substitution therapy of hypogonadal men.* Paper presented at European Congress of Endocrinology, Glasgow, UK, April 2006.

Zucker, K. J. (1999). Intersexuality and gender identity differentiation. *Annual Review of Sex Research, 10*(1), 1-69.

Zucker, K. J. (2004). Gender identity development and issues. *Child and Adolescent Psychiatric Clinics of North America, 13*(3), 551-568. doi:10.1016/j.chc.2004.02.006

Zucker, K. J. (2006). 'I'm half-boy, half-girl'': Play psychotherapy and parent counseling for gender identity disorder. In R. L. Spitzer, M. B. First, J. B. W. Williams & M. Gibbons (Eds.), *DSM-IV-TR casebook, volume 2* (pp. 321-334). Arlington, VA: American Psychiatric Publishing, Inc.

Zucker, K. J. (2010). The DSM diagnostic criteria for gender identity disorder in children. *Archives of Sexual Behavior, 39*(2), 477-498. doi:10.1007/s10508-009-9540-4

Zucker, K. J., & Bradley, S. J. (1995). *Gender identity disorder and psychosexual problems in children and adolescents.* New York: Guilford Press.

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., & Cantor, J. M. (2008). Is gender identity disorder in adolescents coming out of the closet? *Journal of Sex & Marital Therapy, 34*(4), 287-290. doi:10.1080/00926230802096192

Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (in press). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy*.

Zucker, K. J., & Lawrence, A. A. (2009). Epidemiology of gender identity disorder: Recommendations for the standards of care of The World Professional Association for Transgender Health. *International Journal of Transgenderism, 11*(1), 8-18. doi:10.1080/15532730902799946

Zucker, K. J., Owen, A., Bradley, S. J., & Ameeriar, L. (2002). Gender-dysphoric children and adolescents: A comparative analysis of demographic characteristics and behavioral problems. *Clinical Child Psychology and Psychiatry, 7*(3), 398-411.

Zuger, B. (1984). Early effeminate behavior in boys: Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease, 172*(2), 90-97.

Standards of Care_1c.indd 94 2476 9/20/11 9:43 PM

# APPENDIX A
## GLOSSARY

Terminology in the area of health care for transsexual, transgender, and gender nonconforming people is rapidly evolving; new terms are being introduced, and the definitions of existing terms are changing. Thus, there is often misunderstanding, debate, or disagreement about language in this field. Terms that may be unfamiliar or that have specific meanings in the *SOC* are defined below for the purpose of this document only. Others may adopt these definitions, but WPATH acknowledges that these terms may be defined differently in different cultures, communities, and contexts.

WPATH also acknowledges that many terms used in relation to this population are not ideal. For example, the terms *transsexual* and *transvestite* – and, some would argue, the more recent term *transgender* – have been applied to people in an objectifying fashion. Yet such terms have been more or less adopted by many people who are making their best effort to make themselves understood. By continuing to use these terms, WPATH intends only to ensure that concepts and processes are comprehensible, in order to facilitate the delivery of quality health care to transsexual, transgender, and gender nonconforming people. WPATH remains open to new terminology that will further illuminate the experience of members of this diverse population and lead to improvements in health care access and delivery.

**Bioidentical hormones**: Hormones that are *structurally* identical to those found in the human body (ACOG Committee of Gynecologic Practice, 2005). The hormones used in bioidentical hormone therapy (BHT) are generally derived from plant sources and are structurally similar to endogenous human hormones, but they need to be commercially processed to become bioidentical.

**Bioidentical compounded hormone therapy (BCHT):** Use of hormones that are prepared, mixed, assembled, packaged, or labeled as a drug by a pharmacist and custom-made for a patient according to a physician's specifications. Government drug agency approval is not possible for each compounded product made for an individual consumer.

**Crossdressing (transvestism):** Wearing clothing and adopting a gender role presentation that, in a given culture, is more typical of the other sex.

**Disorders of sex development (DSD):** Congenital conditions in which the development of chromosomal, gonadal, or anatomic sex is atypical. Some people strongly object to the "disorder" label and instead view these conditions as a matter of diversity (Diamond, 2009), preferring the terms *intersex* and *intersexuality*.

**Female-to-Male (FtM):** Adjective to describe individuals assigned female at birth who are changing or who have changed their body and/or gender role from birth-assigned female to a more masculine body or role.

**Gender dysphoria:** Distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth (and the associated gender role and/or primary and secondary sex characteristics) (Fisk, 1974; Knudson, De Cuypere, & Bockting, 2010b).

**Gender identity:** A person's intrinsic sense of being male (a boy or a man), female (a girl or woman), or an alternative gender (e.g., boygirl, girlboy, transgender, genderqueer, eunuch) (Bockting, 1999; Stoller, 1964).

**Gender identity disorder:** Formal diagnosis set forth by the *Diagnostic Statistical Manual of Mental Disorders, 4th Edition, Text Rev (DSM IV-TR)* (American Psychiatric Association, 2000). Gender identity disorder is characterized by a strong and persistent cross-gender identification and a persistent discomfort with one's sex or sense of inappropriateness in the gender role of that sex, causing clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Gender nonconforming:** Adjective to describe individuals whose gender identity, role, or expression differs from what is normative for their assigned sex in a given culture and historical period.

**Gender role or expression:** Characteristics in personality, appearance, and behavior that in a given culture and historical period are designated as masculine or feminine (that is, more typical of the male or female social role) (Ruble, Martin, & Berenbaum, 2006). While most individuals present socially in clearly male or female gender roles, some people present in an alternative gender role such as genderqueer or specifically transgender. All people tend to incorporate both masculine and feminine characteristics in their gender expression in varying ways and to varying degrees (Bockting, 2008).

**Genderqueer:** Identity label that may be used by individuals whose gender identity and/or role does not conform to a binary understanding of gender as limited to the categories of man or woman, male or female (Bockting, 2008).

**Male-to-Female (MtF):** Adjective to describe individuals assigned male at birth who are changing or who have changed their body and/or gender role from birth-assigned male to a more feminine body or role.

**Natural hormones:** Hormones that are derived from natural *sources* such as plants or animals. Natural hormones may or may not be bioidentical.

**Sex:** Sex is assigned at birth as male or female, usually based on the appearance of the external genitalia. When the external genitalia are ambiguous, other components of sex (internal genitalia, chromosomal and hormonal sex) are considered in order to assign sex (Grumbach, Hughes, & Conte,

2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). For most people, gender identity and expression are consistent with their sex assigned at birth; for transsexual, transgender, and gender nonconforming individuals, gender identity or expression differ from their sex assigned at birth.

**Sex reassignment surgery (gender affirmation surgery):** Surgery to change primary and/or secondary sex characteristics to affirm a person's gender identity. Sex reassignment surgery can be an important part of medically necessary treatment to alleviate gender dysphoria.

**Transgender:** Adjective to describe a diverse group of individuals who cross or transcend culturally-defined categories of gender. The gender identity of transgender people differs to varying degrees from the sex they were assigned at birth (Bockting, 1999).

**Transition:** Period of time when individuals change from the gender role associated with their sex assigned at birth to a different gender role. For many people, this involves learning how to live socially in "the other" gender role; for others this means finding a gender role and expression that is most comfortable for them. Transition may or may not include feminization or masculinization of the body through hormones or other medical procedures. The nature and duration of transition is variable and individualized.

**Transphobia, internalized:** Discomfort with one's own transgender feelings or identity as a result of internalizing society's normative gender expectations.

**Transsexual:** Adjective (often applied by the medical profession) to describe individuals who seek to change or who have changed their primary and/or secondary sex characteristics through femininizing or masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.

# APPENDIX B
## OVERVIEW OF MEDICAL RISKS OF HORMONE THERAPY

The risks outlined below are based on two comprehensive, evidence-based literature reviews of masculinizing/feminizing hormone therapy (Feldman & Safer, 2009; Hembree et al., 2009), along with a large cohort study (Asscheman et al., 2011). These reviews can serve as detailed references for providers, along with other widely recognized, published clinical materials (e.g., Dahl et al., 2006; Ettner et al., 2007).

# Risks of Feminizing Hormone Therapy (MtF)

**Likely increased risk:**

## Venous thromboembolic disease

- Estrogen use increases the risk of venous thromboembolic events (VTE), particularly in patients who are over age 40, smokers, highly sedentary, obese, and who have underlying thrombophilic disorders.
- This risk is increased with the additional use of third generation progestins.
- This risk is decreased with use of the transdermal route of estradiol administration, which is recommended for patients at higher risk of VTE.

## Cardiovascular, cerebrovascular disease

- Estrogen use increases the risk of cardiovascular events in patients over age 50 with underlying cardiovascular risk factors. Additional progestin use may increase this risk.

## Lipids

- Oral estrogen use may markedly increase triglycerides in patients, increasing the risk of pancreatitis and cardiovascular events.
- Different routes of administration will have different metabolic effects on levels of HDL cholesterol, LDL cholesterol and lipoprotein(a).
- In general, clinical evidence suggests that MtF patients with pre-existing lipid disorders may benefit from the use of transdermal rather than oral estrogen.

## Liver/gallbladder

- Estrogen and cyproterone acetate use may be associated with transient liver enzyme elevations and, rarely, clinical hepatotoxicity.
- Estrogen use increases the risk of cholelithiasis (gall stones) and subsequent cholecystectomy.

**Possible increased risk:**

Type 2 diabetes mellitus

- Feminizing hormone therapy, particularly estrogen, may increase the risk of type 2 diabetes, particularly among patients with a family history of diabetes or other risk factors for this disease.

Hypertension

- Estrogen use may increase blood pressure, but the effect on incidence of overt hypertension is unknown.
- Spironolactone reduces blood pressure and is recommended for at-risk or hypertensive patients desiring feminization.

Prolactinoma

- Estrogen use increases the risk of hyperprolactinemia among MtF patients in the first year of treatment, but this risk unlikely thereafter.
- High-dose estrogen use may promote the clinical appearance of preexisting but clinically unapparent prolactinoma.

**Inconclusive or no increased risk:** Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Breast cancer

- MtF persons who have taken feminizing hormones do experience breast cancer, but it is unknown how their degree of risk compares to that of persons born with female genitalia.
- Longer duration of feminizing hormone exposure (i.e., number of years taking estrogen preparations), family history of breast cancer, obesity (BMI >35), and the use of progestins likely influence the level of risk.

**Other side effects of feminizing therapy:**

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with feminizing hormone therapy.

Fertility and sexual function

- Feminizing hormone therapy may impair fertility.
- Feminizing hormone therapy may decrease libido.
- Feminizing hormone therapy reduces nocturnal erections, with variable impact on sexually stimulated erections.

**Risks of anti-androgen medications:**

Feminizing hormone regimens often include a variety of agents that affect testosterone production or action. These include GnRH agonists, progestins (including cyproterone acetate), spironolactone, and 5-alpha reductase inhibitors. An extensive discussion of the specific risks of these agents is beyond the scope of the *SOC*. However, both spironolactone and cyproterone acetate are widely used and deserve some comment.

Cyproterone acetate is a progestational compound with anti-androgenic properties (Gooren, 2005; Levy et al., 2003). Although widely used in Europe, it is not approved for use in the United States because of concerns about hepatotoxicity (Thole, Manso, Salgueiro, Revuelta, & Hidalgo, 2004). Spironolactone is commonly used as an anti-androgen in feminizing hormone therapy, particularly in regions where cyproterone is not approved for use (Dahl et al., 2006; Moore et al., 2003; Tangpricha et al., 2003). Spironolactone has a long history of use in treating hypertension and congestive heart failure. Its common side effects include hyperkalemia, dizziness, and gastrointestinal symptoms (*Physicians' Desk Reference*, 2007).

# Risks of Masculinizing Hormone Therapy (FtM)

**Likely increased risk:**

Polycythemia

- Masculinizing hormone therapy involving testosterone or other androgenic steroids increases the risk of polycythemia (hematocrit > 50%), particularly in patients with other risk factors.
- Transdermal administration and adaptation of dosage may reduce this risk

Weight gain/visceral fat

- Masculinizing hormone therapy can result in modest weight gain, with an increase in visceral fat.

**Possible increased risk:**

Lipids

- Testosterone therapy decreases HDL, but variably affects LDL and triglycerides.
- Supraphysiologic (beyond normal male range) serum levels of testosterone, often found with extended intramuscular dosing**,** may worsen lipid profiles, whereas transdermal administration appears to be more lipid neutral.
- Patients with underlying polycystic ovarian syndrome or dyslipidemia may be at increased risk of worsening dyslipidemia with testosterone therapy.

Liver

- Transient elevations in liver enzymes may occur with testosterone therapy.
- Hepatic dysfunction and malignancies have been noted with oral methyltestosterone. However, methyltestosterone is no longer available in most countries and should no longer be used.

Psychiatric

Masculinizing therapy involving testosterone or other androgenic steroids may increase the risk of hypomanic, manic, or psychotic symptoms in patients with underlying psychiatric disorders that include such symptoms. This adverse event appears to be associated with higher doses or supraphysiologic blood levels of testosterone

**Inconclusive or no increased risk:** Items in this category include those that may present risk, but for which the evidence is so minimal that no clear conclusion can be reached.

Osteoporosis

- Testosterone therapy maintains or increases bone mineral density among FtM patients prior to oophorectomy, at least in the first three years of treatment.
- There is an increased risk of bone density loss after oophorectomy, particularly if testosterone therapy is interrupted or insufficient. This includes patients utilizing solely oral testosterone.

Cardiovascular

- Masculinizing hormone therapy at normal physiologic doses does not appear to increase the risk of cardiovascular events among healthy patients.
- Masculinizing hormone therapy may increase the risk of cardiovascular disease in patients with underlying risks factors.

Hypertension

- Masculinizing hormone therapy at normal physiologic doses may increase blood pressure but does not appear to increase the risk of hypertension.
- Patients with risk factors for hypertension, such as weight gain, family history, or polycystic ovarian syndrome, may be at increased risk.

Type 2 diabetes mellitus

- Testosterone therapy does not appear to increase the risk of type 2 diabetes among FtM patients overall.

- Testosterone therapy may further increase the risk of type 2 diabetes in patients with other risk factors, such as significant weight gain, family history, and polycystic ovarian syndrome. There are no data that suggest or show an increase in risk in those with risk factors for dyslipidemia.

Breast cancer

- Testosterone therapy in FtM patients does not increase the risk of breast cancer.

Cervical cancer

- Testosterone therapy in FtM patients does not increase the risk of cervical cancer, although it may increase the risk of minimally abnormal Pap smears due to atrophic changes.

Ovarian cancer

- Analogous to persons born with female genitalia with elevated androgen levels, testosterone therapy in FtM patients may increase the risk of ovarian cancer, although evidence is limited.

Endometrial (uterine) cancer

- Testosterone therapy in FtM patients may increase the risk of endometrial cancer, although evidence is limited.

**Other side effects of masculinizing therapy:**

The following effects may be considered minor or even desired, depending on the patient, but are clearly associated with masculinization.

Fertility and sexual function

- Testosterone therapy in FtM patients reduces fertility, although the degree and reversibility are unknown.
- Testosterone therapy can induce permanent anatomic changes in the developing embryo or fetus.
- Testosterone therapy induces clitoral enlargement and increases libido.

Acne, androgenic alopecia

Acne and varying degrees of male pattern hair loss (androgenic alopecia) are common side effects of masculinizing hormone therapy.

# APPENDIX C
## SUMMARY OF CRITERIA FOR HORMONE THERAPY AND SURGERIES

As for all previous versions of the *SOC*, the criteria put forth in the *SOC* for hormone therapy and surgical treatments for gender dysphoria are clinical guidelines; individual health professionals and programs may modify them. Clinical departures from the *SOC* may come about because of a patient's unique anatomic, social, or psychological situation; an experienced health professional's evolving method of handling a common situation; a research protocol; lack of resources in various parts of the world; or the need for specific harm reduction strategies. These departures should be recognized as such, explained to the patient, and documented through informed consent for quality patient care and legal protection. This documentation is also valuable to accumulate new data, which can be retrospectively examined to allow for health care – and the *SOC* – to evolve.

### Criteria for Feminizing/Masculinizing Hormone Therapy (one referral or chart documentation of psychosocial assessment)

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental concerns are present, they must be reasonably well-controlled.

## Criteria for Breast/Chest Surgery (one referral)

Mastectomy and creation of a male chest in FtM patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Hormone therapy is not a pre-requisite.

Breast augmentation (implants/lipofilling) in MtF patients:

1. Persistent, well-documented gender dysphoria;
2. Capacity to make a fully informed decision and to consent for treatment;
3. Age of majority in a given country (if younger, follow the *SOC* for children and adolescents);
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Although not an explicit criterion, it is recommended that MtF patients undergo feminizing hormone therapy (minimum 12 months) prior to breast augmentation surgery. The purpose is to maximize breast growth in order to obtain better surgical (aesthetic) results.

## Criteria for genital surgery (two referrals)

Hysterectomy and ovariectomy in FtM patients and orchiectomy in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones).

The aim of hormone therapy prior to gonadectomy is primarily to introduce a period of reversible estrogen or testosterone suppression, before a patient undergoes irreversible surgical intervention.

These criteria do not apply to patients who are having these surgical procedures for medical indications other than gender dysphoria.

Metoidioplasty or phalloplasty in FtM patients and vaginoplasty in MtF patients:

1. Persistent, well documented gender dysphoria;

2. Capacity to make a fully informed decision and to consent for treatment;

3. Age of majority in a given country;

4. If significant medical or mental health concerns are present, they must be well controlled;

5. 12 continuous months of hormone therapy as appropriate to the patient's gender goals (unless the patient has a medical contraindication or is otherwise unable or unwilling to take hormones);

6. 12 continuous months of living in a gender role that is congruent with their gender identity.

Although not an explicit criterion, it is recommended that these patients also have regular visits with a mental health or other medical professional.

The criterion noted above for some types of genital surgeries – i.e., that patients engage in 12 continuous months of living in a gender role that is congruent with their gender identity – is based on expert clinical consensus that this experience provides ample opportunity for patients to experience and socially adjust in their desired gender role, before undergoing irreversible surgery.

# APPENDIX D
## EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who underwent sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer III, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment was not recorded. Study participants who were taking testosterone had typically being doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p<.001$). (A similar analysis was not done for genital surgery). In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 2000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990). Similar improvements were found in a Swedish study in which "almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning" (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

# APPENDIX E
## DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial *SOC* "work group" was established in 2006. Members were invited to examine specific sections of *SOC, Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the *SOC* as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International Journal of Transgenderism (IJT)*. Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1-4) in 2009, making them available for discussion and debate.

After these articles were published, a *Standards of Care* Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of *SOC, Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision – both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion – and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of *SOC, Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized it was circulated among the broader *SOC* Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revision. Two additional drafts were created and posted on the Google website for consideration by the broader *SOC* Revision Committee and the International Advisory Group. Upon completion of these three iteratations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

The plans are to disseminate this version of the *SOC* and invite feedback for further revisions. The WPATH Board of Directors decides the timing of any revision of the *SOC*.

## Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;

2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;

3. Working meeting of the Writing Group;

4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7* Revision Committee, and WPATH Board of Directors;

5. Costs of printing and distributing *Standards of Care, Version 7* and posting a free downloadable copy on the WPATH website;



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6. Plenary session to launch the *Standards of Care, Version 7* at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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# The dividing lines over Scotland's gender laws

By James Cook
Chief News Correspondent for The Nine

11 February 2020




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**The Scottish government is proposing to make it easier to legally change gender. Supporters say the plans are vital to ensure transgender people are treated with dignity - but one woman who used hormones and surgery to become a man, only to regret the decision, has described the proposed reforms as "dangerous".**

Sinead Watson says she didn't have any issues with her gender as a child.

It wasn't until she began to grow into a woman in her teens that a feeling of insecurity took hold, and she began to dislike her body and feel uncomfortable in her own skin.

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When she was in her early 20s, she told **BBC Scotland's The Nine**, she typed into Google "something along the lines of 'I'm a woman, I wish I was a man'."

The results page introduced Ms Watson to the concept of gender dysphoria, **defined by the NHS** as discomfort or distress caused by a mismatch between biological sex and gender identity.



Sinead Watson became Sean Watson but then regretted her decision

She says she read the list of symptoms - such as feeling a disconnect from one's body and resentment for one's sexual characteristics - and thought: "That's what I have."

After consulting her GP, Ms Watson was referred to the **Sandyford gender identity clinic** in Glasgow, one of four in Scotland (the others are in Edinburgh, Inverness and Aberdeen). It is also home to the nation's only such facility for children.

"I was very aware that I wasn't going to literally change my sex, but I thought if I could transform to such an extent that I passed and lived socially and legally as male [then] it would solve all the problems I had," she says.

Over the next few years, Sinead had counselling sessions at the Sandyford; changed her name to Sean; began taking testosterone; and finally, after two years on an NHS waiting list, had surgery to remove her breasts.

"After the double mastectomy in 2017, there was a period of bliss," she says. Soon though "the novelty of that wore off and I thought, you know, why do I still hate myself?"

For Ms Watson the three years since have been painful. She has now concluded that transitioning was a terrible mistake, that she did not in fact

have symptoms of gender dysphoria but individual physical and psychological issues which should, she says, have been diagnosed and treated as such.

For now Sinead remains, legally at least, Sean. She changed her gender on her passport and her driving licence but not her birth certificate and is now trying to figure out how to change them back.

Ms Watson says she has serious concerns about a proposed change in the Scotland's laws that would make it easier to change a birth certificate from male to female or vice versa, and potentially to lower the age at which you could do so from 18 to 16.

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## What are the laws?




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Protesters demonstrated outside Holyrood last June calling for reform of the Gender Recognition Act

Since 2005, trans people have been able to apply to a UK tribunal called the Gender Recognition Panel for a gender recognition certificate to allow them to amend their birth certificate (passports and driving licences can be changed more easily).

Typically, at present, successful applicants must obtain a diagnosis of gender dysphoria and must swear an oath that they have been living in their new gender for two years and that they intend to do so for the rest of their life.

They must provide one medical report outlining their diagnosis and a second detailing any relevant treatment or surgery. Other information, such as utility bills to prove how they have been living, can also be requested by the panel.

The Scottish government is **proposing to relax some of these requirements**, making the process "less onerous".

Under the proposals applicants would no longer need a clinical diagnosis or medical reports, and the two-year period would be reduced to three months. This would be followed, if an application was accepted, by three months for reflection before the gender recognition certificate was issued.

Cases would be handled by the Registrar General for Scotland, removing the need to apply to the panel.

Applicants would still have to swear an oath confirming that they intended to live permanently in their acquired gender, and making a false statement would be a criminal offence.

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Ms Watson regards some aspects of the proposed new legislation as "dangerous" and voices concerns that many more people will end up in her situation as the number of people transitioning rises.

She worries especially that young people are being pushed towards a diagnosis of gender dysphoria by a combination of well-meaning doctors and politicians, and the warm embrace of online trans communities.

"It's like social contagion," she says, recounting her own experience. The system was geared up to help her transition, she argues, but not to help her when she began to have doubts.

"I got next to no support off mental health professionals. They seemed very uncomfortable whenever I discussed transition regret. So I'm really fortunate that I have amazing loved ones that were there to help me. I probably wouldn't be here without them, to be honest."




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Sinead changed her gender on her passport

Ms Watson said she was particularly worried about the idea that the age limit for legally changing gender could be lowered to 16.

"If you don't actually have gender dysphoria and you go down that route you end up like me, where you've irreversibly changed your body with hormones and surgery and you feel humiliated, you feel ashamed of yourself and you feel completely betrayed by the people that allowed this to happen," she says.

NHS Greater Glasgow and Clyde, which runs the Sandyford, said the clinic follows internationally-agreed guidelines. Patients undergo full assessments by psychiatrists, sexual health doctors, psychologists and occupational therapists including multiple engagements over an extended period to ensure they fully understand the process.

It said treatment and support were tailored to individual needs, and patients were regularly referred to services outwith the clinic for other health needs, including mental health conditions.

How many people actually de-transition is in dispute. Ms Watson says she has spoken to "dozens and dozens" and is in a group chat with about 50 de-transitioners, although the nature of social media and a desire for anonymity makes it difficult to verify their stories.

**Academic research estimates** that the total number of people who have de-transitioned in Scotland is between 18 and 36, or between 1% and 2% of

those who transition.



Emily Frood: "Self harm, suicide - those kinds of things - are all too common in our community"

Similarly to Sinead, Emily Frood says she had no idea she was transgender until she was 17 years old.

She was born as a boy and had lived her childhood content with her sex until one day, "it suddenly kind of clicked".

"I'd never thought about it before… because I had no experience and knowledge of trans people," Ms Frood says, adding with a smile: "It is really bonkers."

Now 21, Ms Frood is in her final year of film and media studies at Queen Margaret University in Musselburgh, East Lothian, and her appearance has changed dramatically.

Not only is she wearing make-up and a colourful blouse but hormone therapy has stopped the growth of facial hair and redistributed muscle and fat, changing the shape of her body and the contours of her face.

Ms Frood, who hopes one day to win a seat in the Scottish Parliament for the Green Party, uses the personal pronoun "she" and calls herself a trans woman, but she describes herself as "non-binary" - meaning she does not identify as either male or female.

"For trans people," she says, "the lines get blurred a little."

"I personally don't identify fully with womanhood in a binary way, but kind of somewhere in between that. Just not man. If that makes sense."




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The current heated discussion about transgender rights suggests there are many people in the country for whom this does not in fact make sense.

"The kind of anti-trans rhetoric that comes up especially in newspapers and print media is horrendous," says Ms Frood.

Self-harm and suicide "are all too common in our community because the progression of our rights is framed as a debate", she says.

She regards critics who insist gender is an immutable biological fact defined by physical characteristics at birth as ill-informed at best.

"Anyone who has either studied more than higher grade biology or had any kind of introduction to sociology will understand that gender doesn't work like that and neither does sex," she says.





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For Ms Frood the proposed legislative changes are welcome but don't go far enough. An initial consultation included a recommendation that the Scottish government should recognise non-binary people in law but ministers now say they do not intend to do so.

"We were gutted, completely let down and it's quite shameful, to be honest," says Ms Frood.

"To see that result in a consultation response was incredible and for it to be totally ignored was devastating."

There is not a definitive figure for the number of transgender people in Scotland but an NHS report published in May 2018 cited an estimate of 0.5% of the population, or some 24,000 adults.

**The report** said the number of trans people accessing NHS gender identity services had risen sharply between 2014 and 2017.

From 2014 to 2015 the number of children aged 16 and below being referred with gender issues more than doubled from 63 to 128.

By the end of the period surveyed there was some indication that the rate of increase was slowing but published data is so scarce that it is hard to be sure.



James Morton says the current procedure can be humiliating

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For James Morton, manager of the Scottish Trans Alliance, a Scottish

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For James Morton, manager of the Scottish Trans Alliance, a Scottish government-funded project which campaigns for improved rights for transgender people, the changes, while not perfect, are a welcome step forward.

"I've gone through the gender recognition process myself and got a gender recognition certificate and it was really humiliating and really frustrating," he says.

Mr Morton says in his case a deeply intrusive psychiatric report was rejected as not detailed enough because, for example, he had not detailed what toys he played with as a child or revealed whether or not he had a sexual partner.

"What has that got to do with how I'm living my life?" he asks.

The government is also consulting on one proposal to reduce from 18 to 16 the age at which people can apply to legally change their gender and another to draw up guidance to "protect and promote" the rights of trans pupils in schools.



Rhona Hotchkiss: "My experience is that it is always an issue to have trans women in with female prisoners"

For Rhona Hotchkiss that is a worry.

"You can't buy a pack of cigarettes or drink a pint at 16, but you can make a decision that will affect the rest of your life," she says. "It just seems bizarre."

Ms Hotchkiss became interested in the debate about transgender rights when she was governor of Cornton Vale women's prison near Stirling.

"My experience is that it is always an issue to have trans women in with female prisoners," she says. This was not just because of what she describes as the occasional "physical or sexual threat" but also because "the very fact of the presence of a male-bodied person" among vulnerable women causes "distress

presence of a male-bodied person" among vulnerable women causes "distress and consternation".

Ms Hotchkiss says she accepts that calling trans women "male-bodied" may cause offence and says she has "no wish to disparage" anyone, but insists that most trans prisoners "have done nothing to change their physical appearance, or very little".

"The vast majority of women in prison have been traumatised by male violence, and they are threatened by having a male-bodied person in what is quite an intimate living space," she says.

Ms Hotchkiss says she has witnessed aggression from trans prisoners including threats to rape female staff and prisoners, but is not aware of anyone actually being attacked by a trans prisoner in Scotland.

At present a trans woman does not have a legal right to insist on being placed in a women's prison but the former governor says she is concerned that the current consultation may open up a path to that changing, making it harder, she argues, to keep women safe.

However, the Scottish Prison Service insists that acquiring a gender recognition certificate "does not and will not give a prisoner any new legal rights regarding the decisions that are made by the Scottish Prison Service about their accommodation".



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Ms Hotchkiss is one of a number of high profile lesbian, feminist activists who have attracted opprobrium for taking what other feminist activists see as the wrong side in this debate.

She says that her belief that "it is not possible for a man literally to become a

woman" has resulted in her being attacked online as "a racist, a fascist, a Nazi, a bitch" and "much worse words than that".

Mr Morton points out that transgender people have also been threatened with violence and even attacked.

"But I don't think there should be a competition," he adds. "It's unacceptable for anybody to be being abusive towards anybody else and I want all of that to stop."

He says most of the abuse is online and urges everyone involved in the debate to step away from Twitter, which he regards as a toxic forum.

Mr Morton argues that women are not going to be put at risk in prisons, insisting that the legal ability to keep a trans woman in a male facility or a transgender facility based on individual risk assessments will remain.

"There's usually only about 15 to 20 trans people in the Scottish prison system so it's not an unwieldy number of people to do in-depth, individualized assessments of," he says.

Mr Morton reckons there is a "moral panic" about transgender people which has echoes of the battle, 20 years ago, over Section 28 of the Local Government Act which prevented state schools from teaching that homosexual relationships were acceptable.

The **Scottish government consultation,** which has clearly generated passion, discomfort and even anger, closes on 17 March.

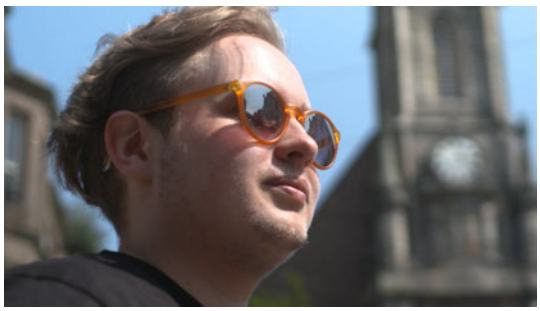
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Llywodraeth Cymru
Welsh Government

Advancing LGBTQ+ equality






# LGBTQ+ Action Plan for Wales

July 2021

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Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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# Draft LGBTQ+ Action Plan

## Ministerial Foreword

Everyone has the right to be safe, to be themselves and to lead lives free from discrimination. Equality and inclusion are core values of the Welsh Government and our commitment to social justice means that we must do all that we can to value diversity and protect and advance human rights in Wales. As we emerge from the Covid-19 pandemic, these values are even more central to creating a fairer, more prosperous and a more equal Wales. Support for lesbian, gay, bisexual, transgender and queer/questioning people (LGBTQ+) (with the + representing other identities including non-binary) is at the heart of this commitment.

We want Wales to be a nation, where everyone feels safe to be themselves, to be open about their sexual orientation, gender identity, gender expression and sex characteristics, at home, leisure or work without feeling threatened.

In the past few years alone we have made remarkable progress. We have pushed forward with curriculum reform, embedding LGBTQ+ inclusive education. We established a gender identity service to help our trans family be their true selves. We became the first nation in the UK to offer PReP (Pre-Exposure Prophylaxis, an anti-HIV drug) free on the NHS. We have supported Pride Cymru and our First Minister marched at the front of the parade. During Covid-19 we set up a bespoke LGBTQ+ venue grant and we enabled drag artists to access our freelancer fund.

But there is always more to be done. We recognise the very real struggles against disadvantage, inequality and discrimination experienced by LGBTQ+ people in Wales. We have been working closely with representatives of Wales' LGBTQ+ communities to develop this action plan. In January 2021 we established an Independent Expert Panel comprised of individuals with a depth of community-based, professional, organisational, academic and personal lived experience to help set out the next steps for advancing LGBTQ+ equality. In March, this panel presented their report including a strong set of recommendations which has formed the basis for this Action Plan. We are in no doubt that the draft LGBTQ+ Action Plan, is a better Plan than we would have managed without the advice, guidance and recommendations from the panel and the individuals who contributed their lived experiences.

This ambitious, cross-government LGBTQ+ Action Plan for Wales seeks to tackle the existing structural inequalities experienced by LGBTQ+ communities, to challenge discrimination and to create a society where LGBTQ+ people are safe to live and love authentically, openly and freely as themselves. This is our first plan to focus on responding to the specific needs, diversity and vulnerabilities of our LGBTQ+ communities. For the first time, we have brought together our existing commitments and set out how we intend to advance LGBTQ+ equality and inclusion, to make a real difference to the life chances, prospects, rights and outcomes for LGBTQ+ people, into the future.

We know that issues being faced by the LGBTQ+ community are often multidimensional: that is why this action plan has an unprecedented focus on intersectionality. It aligns closely with all of our work to advance human rights and reduce inequality relating to gender, disability, faith, age and race. Equality is for and means everyone in Wales, with no-one left behind.



**Mark Drakeford MS**

**First Minister**



**Jane Hutt MS**

**Minister for Social Justice**



**Hannah Blythyn**

**Deputy Minister for Social Partnership**

## Introduction

The Welsh Government is committed to safeguarding human rights for everyone – we want to enable all LGBTQ+ people in Wales to live as full lives as possible – to be healthy, to be happy and to be safe. We've come a long way in the past three decades when it comes to strengthening equality and human rights for lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ+) people in Wales and across the UK. Legislative change has meant that schools, organisations and public services are now doing much more to advance these rights and tackle LGBTQ+ bullying and discrimination. Equal marriage and adoption rights are now a reality for many and Section 28 (a law passed in 1988 that stopped councils and schools "promoting the teaching of the acceptability of homosexuality as a pretended family relationship) has been consigned to history. We have seen a huge shift in positive attitudes toward LGBTQ+ communities and for LGBTQ+ inclusion.

While these changes are to be celebrated, we've also witnessed a rise in anti-LGB and anti-trans attitudes and hostility in many parts of the world. The human rights of LGBTQ+ people are under continuing or renewed threat in many countries. We must recognise that disadvantage, inequality and discrimination remains a reality for many LGBTQ+ people living in Wales too. Many continue to face significant barriers to participating fully and equally in Welsh society. In a recent survey[1] Stonewall Cymru found that 78 per cent of LGBTQ+ people in Wales have avoided being open about their sexual orientation or gender identity for fear of a negative reaction from others. Furthermore, 46 per cent of LGBTQ+ people in Wales have experienced verbal harassment in the last year. Such findings show the distressing experiences that LGBTQ+ people continue to go through in Wales today and demonstrate how far we still have to go to achieve equality and for people to feel happy and safe just simply being who they are.

Even before a global pandemic, we knew that LGBTQ+ communities were more likely to experience inequalities across a range of outcome areas. For example, LGBTQ+ people are more likely than their heterosexual counterparts to:

- Report lower life satisfaction levels
- Experience poorer access to healthcare services
- Be a victim of bullying, discrimination and hate crime in school, the workplace or in their communities;
- Drink alcohol, smoke and engage in substance misuse, and,
- Suffer from poorer mental health including loneliness, depression and suicide.

This disadvantage is also further compounded when the specific needs and vulnerabilities of being LGBTQ+ intersects with other protected characteristics including age, race, gender,

[1] Stonewall Cymru was commissioned by the Welsh Government to author and publish a survey in summer 2020, to capture statistics on LGBTQ+ people in Wales's experiences. This survey also included the opportunity to capture individuals' recommendations for a future LGBTQ+ Action Plan. These suggestions have been reflected, and in some cases included directly, into the Expert Panel's recommendations. The survey was promoted on a number of social media channels from organisations across Wales (encompassing both LGBTQ+ and non-LGBTQ+ organisations). The survey received 532 responses

religion and disability[2]. The Covid-19 pandemic has laid bare and further exacerbated the structural inequalities faced by Wales' most marginalised and disadvantaged communities[3]. For LGBTQ+ people, in particular, the Expert Panel report has highlighted ongoing concerns in education, personal and community safety, health and social care, and the workplace. Their report also highlighted the need for improved strategic coordination on LGBTQ+ issues. Emerging international and domestic evidence also suggests LGBTQ+ people have faced additional barriers in being unable to access healthcare services or medication as a result of the Covid-19 pandemic and are at increased risk of violence, abuse, homelessness, lower employment, social isolation and loneliness[4]. This means there is a broad and deepening human rights crisis for LGBTQ+ people across the world, including Wales. The actions within this plan aim to address these problems, providing tangible action to be taken to improve the lives of LGBTQ+ people in Wales.

Progress can and never should be taken for granted and more work needs to be done for Wales to lead by example and safeguard the hard won freedoms of LGBTQ+ people. The Welsh Government's position is clear: LGBTQ+ rights are human rights. Our draft LGBTQ+ Action Plan signals our commitment to respecting, protecting and fulfilling the rights of LGBTQ+ people in Wales. The LGBTQ+ Action Plan will act as the coordinating framework for LGBTQ+ policy development across government. It will set out the concrete steps we will take to improve the lives of LGBTQ+ people, to challenge discrimination and to create a society where LGBTQ+ people are safe to live and to love authentically, openly and freely as themselves. The Plan is underpinned by the rights-based approach set out by the UN High Commissioner for Human Rights[5] and the UN Independent Expert on Sexual Orientation and Gender Identity (IESOGI)[6] and supports the realisation of rights guaranteed to LGBTQ+ people by the:

- Universal Declaration of Human Rights (UDHR)
- International Covenant of Economic, Social and Cultural Rights (ICESCR)
- International Covenant on Civil and Political Rights (ICCPR)
- United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- United Nations Convention on the Rights of the Child (UNCRC)
- United Nations Principles for Older Persons (UNPOP).

This approach ensures the plan will contribute strongly to the Welsh Government's fulfilment of its Public Sector Equality Duty functions, under section 149 of the Equality Act 2010. This plan will link to related work on gender, disability, race and other protected characteristics under this Act. We recognise the need to ensure our equality action plans work together. While this is the first policy framework to focus on the specific needs and vulnerabilities of LGBTQ+ people, it forms part of a wider approach to mainstream equality and strengthen human rights protections

[2] LGBT Foundation (2020) *Hidden Figures: The Impact of Covid-19 Pandemic on LGBT Communities in the UK*
[3] Welsh Parliament: ELGC Committee (2020) *Into sharp relief: inequality and the pandemic*
[4] EHRC (2020) *How coronavirus has affected equality and human rights*
[5] https://www.un.org/en/ga/search/view_doc.asp?symbol=A/HRC/29/23&referer=/english/&Lang=E
[6] https://www.ohchr.org/en/issues/sexualorientationgender/pages/index.aspx

for everyone. As such, it should be read alongside our Strategic Equality Plan, Race Equality Action Plan, Framework for Action on Disability, and Gender Equality Plan.

This national LGBTQ+ Action Plan has been established to help coordinate action by Welsh Government and other agencies. The plan sets out an overarching set of actions to improve the recognition of LGBTQ+ people and also includes a wide range of policy-specific actions relating to education, improving safety, housing, health and social care, and promoting community cohesion. The Welsh Government will continue to vocally defend and promote the rights and dignity of trans and non-binary people in Wales to enable them to take a full and equal role in Welsh society at all levels. For the first time, we have brought together our existing commitments and set out how we intend to advance LGBTQ+ equality and inclusion, to make a real difference to the life chances, prospects and outcomes for LGBTQ+ people, today and into the future.

## Key steps in the development of this Action Plan

The Welsh Government has worked collaboratively with a wide range of representatives from LGBTQ+ communities to inform the development of this draft Action Plan. In summer 2020, we commissioned Stonewall Cymru to carry out initial engagement with stakeholders to explore what important themes should be taken forward into a new LGBTQ+ Action Plan for Wales. Stonewall Cymru captured LGBTQ+ people's lived experiences via a survey (over 600 respondents) and a series of virtual focus groups. Some of the key messages from this engagement focused on tackling LGBTQ+ discrimination, improving safety and addressing health inequalities, particularly trans health.

In November 2020, the Welsh Government established an LGBTQ+ External Reference Group to provide advice and guidance and in January 2021, a smaller Independent LGBTQ+ Expert Panel was established to build on Stonewall Cymru's initial stakeholder engagement and provide strategic advice on advancing LGBTQ+ equality in Wales. The Independent Expert Panel chaired by Lu Thomas, comprised of people with a depth of community-based, professional, organisational, academic and personal lived experience, established the issues which must be addressed if we are to achieve substantial change and improved outcomes for all LGBTQ+ people in Wales. This panel was supported by workshops and sub-groups which considered many issues in more detail.

The Welsh Government also commissioned Stonewall Cymru to carry out further stakeholder engagement sessions to support the Independent Expert Panel's consideration of the intersectional experiences of LGBTQ+ people. The arrangements included virtual roundtable focus groups (representing LGBTQ+ young people, older people, disabled people and Black, Asian and Minority Ethnic people) and some additional discussions with organisations including the Wales TUC, WEN Wales and LGBT Helpline Cymru.

The Independent Expert Panel presented their report and recommendations to the then Deputy Minister and Chief Whip, Jane Hutt MS, in March 2021. They recommended that the LGBTQ+ Action Plan take an intersectional approach to address how disadvantage experienced by LGBTQ+ people frequently intersects with other protected characteristics, such as race and

disability, to compound structural inequalities and disadvantage. As a result, this draft Action plan pays particular attention to the diversity of LGBTQ+ people's specific needs and vulnerabilities, including those experiencing intersectional discrimination (for example trans and non-binary people, who are among the least accepted groups in society and generally experience more discrimination and violence than others in the LGBTQ+ communities).

Discrimination is also often multidimensional and here too the plan takes an intersectional approach in order to pave the way to sustainable and respectful changes in society. The Expert Panel report included a set of overarching recommendations focusing on the incorporation of human rights into domestic law, strategic coordination and integration of plans, and training, awareness-raising and capacity building. The report included thematic recommendations for a broad range of policy areas, including recognition of trans and non-binary people; safety; home and communities; health and social care; education and lifelong learning; workplace and supporting the Covid-19 response. These recommendations have formed the basis of the draft Action Plan.

**Language:** The Expert Panel has recommended that we should use the acronym LGBTQ+ in relation to this work. Both the panel and the Welsh Government recognise that there are different views and usages across our communities, and that practice is likely to change again in future.

## Overarching Aims

The overarching actions below provide a strategic and common thread which runs throughout the more specific actions that follow. They help to identify the commonalities shared by actions in the plan as a whole.

| | **Actions** |
|---|---|
| 1. | We will strengthen equality and human rights for LGBTQ+ people and we will seek to influence the UK Government to strengthen the protections afforded to trans and non-binary people under the law, including refugees and those seeking asylum. |
| 2. | We will ensure that the rights of LGBTQ+ people are recognised and mainstreamed across the public sector in Wales. |
| 3. | We will ensure that all public service workers understand LGBTQ+ needs, encouraging comprehensive, intersectional equalities training to be undertaken where necessary. |
| 4. | We will help to challenge heteronormative and cisnormative assumptions and will require public bodies to appropriately identify and record LGBTQ+ identities at the point of access. The needs of LGBTQ+ communities will be made visible in service design and population-level analysis; and we will encourage service design to be co-produced. |
| 5. | We will improve data collection, including intersectional data, to identify the discrimination and wellbeing disparities experienced by our LGBTQ+ communities. |
| 6. | We will formalise the Independent Expert Panel to guide, monitor and evaluate implementation of the plan. We will provide an annual progress update on the implementation of the plan. |

## Human Rights & Recognition

We will continue our support of LGBTQ+ people and ensure we continue to vocally defend and promote their rights and dignity to take a full and equal role in Welsh society. Research undertaken in preparing this Action Plan highlighted concerns from non-binary people over a lack of recognition both societally and in how they are reflected in the way services operate. In addition Trans people in Wales would like to see the Welsh Government go above and beyond the actions of the UK Government in protecting and furthering trans people's rights.

There is particular concern around the continuing practice of 'conversion therapy. 'We want every LGBTQ+ person to be treated with equal value, to be safe and to live authentically and openly as themselves, which is why the Programme for Government highlights that we will ban all aspects of LGBTQ+ conversion therapy that are within our current powers and seek the devolution of any necessary additional powers to enable us to achieve this. In addition, we will seek to devolve powers in relation to Gender Recognition and support our Trans community.

| | **Actions** |
|---|---|
| 7. | Continue to vocally defend and promote the rights and dignity of trans and non-binary people in Wales to take a full and equal role in Welsh society at all levels. |
| 8. | Provide recognition of non-binary people throughout devolved policy areas, including education, housing and health as far as possible under the law. |
| 9. | Seek to devolve powers in relation to Gender Recognition and support our Trans community. |
| 10. | Use all available powers to ban all aspects of LGBTQ+ conversion therapy and seek the devolution of any necessary additional powers. |
| 11. | Explore ways unnecessary personal identifications such as name, age and gender markers can be removed from documentation particularly in recruitment practices. |
| 12. | Provide LGBTQ+ people with a greater understanding of their human rights, what they mean, how they intersect, or when they have been infringed, as well as how to seek redress when this happens. |

## Ensuring LGBTQ+ People's Safety

Whilst there have been improvements in some areas, many LGBTQ+ people in Wales continue to feel unsafe and at a high risk of abuse or discrimination[7]. With recorded hate crime against LGBTQ+ people continuing to rise, most notably against trans people[8] (more than doubling since 2017 to 106 per cent), it is vital that action is taken to address this and guarantee the safety LGBTQ+ people in Wales. Although the majority of LGBTQ+ people in Wales do live fulfilling and positive lives, we also know that too many live in fear of discrimination and prejudice. The comprehensive outreach undertaken to support development of this Action Plan revealed that LGBTQ+ people in Wales continue to face discrimination at home and in their respective communities. Nearly half of survey respondents (46 per cent) stated they had been subjected to verbal harassment, 26 per cent had suffered online abuse or harassment and 13 per cent experienced the threat of physical or sexual harassment and violence in the last year. These findings show how much more must be done to make homes and communities in Wales safe for all. Having safe communities will allow LGBTQ+ people to thrive and live without fear.

| | **Action** |
|---|---|
| 13. | Work with Police and Crime Commissioners and Chief Constables to consider building on existing ongoing engagement activity with marginalised communities, to ensure that their relationship with the police is more reflective of their needs. This will include LGBTQ+, disabled communities and Black, Asian and Minority Ethnic communities. |
| 14. | Work with Police and Crime Commissioners and Chief Constables, along with other criminal and social justice partners, to review the under-reporting of LGBTQ+ hate crimes with the aim of acting to further improve the levels of reporting. |
| 15. | Work with the tech companies and media platforms to tackle hate crime and misinformation. |
| 16. | Engage with members of LGBTQ+, disabled and Black, Asian and Minority Ethnic communities to understand issues where there appears to be a lack of understanding amongst police call handlers and other front line staff. This should then inform work with Chief Constables to develop awareness raising inputs on specific issues related to hate crime, human rights and how those with protected characteristics are targeted. |
| 17. | Specifically target violence against women, domestic abuse and sexual violence (VAWDASV) in the LGBTQ+ community - to better understand the reasons for |

[7] LGBT in Wales - Hate Crime and Discrimination report, 2018, https://www.stonewallcymru.org.uk/system/files/lgbt_in_wales_-_hate_crime_stonewall_cymru.pdf

[8] Hate Crime Figures Available Online at: https://www.gov.uk/government/statistics/hate-crime-england-and-wales-2017-to-2018; https://www.gov.uk/government/statistics/hate-crime-england-and-wales-2018-to-2019; https://www.gov.uk/government/statistics/hate-crime-england-and-wales-2019-to-2020

| | Action |
|---|---|
| | historically low reporting from the community, ensuring all literature, messaging and awareness raising initiatives are inclusive, and where necessary specific to the LGBTQ+ community. Data collection from VAWDASV service providers, along with professional and public services, including police data should capture LGBTQ+ reporting, referrals, incidences etc. |

## Home & Communities

Wales is made up of diverse communities, languages, identities and cultures. LGBTQ+ people exist in all our communities: from rural and urban communities to communities of faith, culture and the arts. All people, however they identify or where they reside, should be able to feel a sense of belonging both to their community and to Wales.

| | **Action** |
|---|---|
| 18. | Support and resource LGBTQ+ community groups and organisations across Wales to combat regional inequalities that people experience when accessing services. Targeted intervention is also needed to increase the Welsh medium support services available to LGBTQ+ people. |
| 19. | Work with the youth work sector to find a longer term sustainable funding model for organisations, including in the voluntary sector, who provide support for a wide range of young people with differing backgrounds and needs, including support for LGBTQ+ young people. Future strategies including the work of the Interim Youth Work board should consider equality and diversity for all young people. |
| 20. | Utilise – and encourage the use of – LGBTQ+ awareness events in the annual calendar as opportunities to uplift LGBTQ+ voices, particularly from under-represented sections of the community. These include, but are not limited to, Pride events, LGBTQ+ History Month (February), IDAHOBIT (17 May), International Non-Binary Day (14 July), (Bi Visibility Day (23 September), Trans Day of Remembrance (20 November), and World AIDS Day (1 December).<br><br>Work with other public bodies to support bi people with shows of support, such as flying the bi pride flag. |
| 21. | Support Prides across Wales by sponsoring Pride Cymru, establishing a Wales-wide Pride Fund and appointing a Wales wide Coordinator |
| 22. | As part of the Democratic Renewal campaign we will provide access to diverse role models to promote participation in democracy including standing for office, at all levels, in Wales. |
| 23. | REPRESENTATION – Culture & Sport<br><br>• Reach out to LGBTQ+ individuals, groups and communities inviting them to support the design and development of holistic approaches across the Culture and Sport sectors in Wales, and building on the existing work of public bodies represented in the Public Body Equality Partnership.<br>• Improve LGBTQ+ representation in the Culture & Sport sectors in Wales at all levels, including at Board, workforce and volunteers' levels. |

| | Action |
|---|---|
| | • Use national and local collections in the Culture and Sport sectors in Wales to celebrate and share LGBTQ+ stories and histories, providing funding where appropriate.<br>• Consider how to provide greater focus on equality as part of skills development, work experience, volunteering, mentoring and apprenticeship opportunities. |
| 24. | CELEBRATION – Culture & Sport<br><br>• Celebrate the LGBTQ+ communities in Wales by developing our national and local collections, encouraging LGBTQ+ communities to collate and donate collections to local archives and museums, providing funding where appropriate.<br>• Use national and local collections to support Pride activity across Wales, including at Pride Cymru events and during Pride month.<br>• Public bodies in the Culture and Sports sectors in Wales will work with any future appointed Wales Pride Coordinator to maximise opportunities to celebrate diversity. |
| 25. | PARTICIPATION – Culture & Sport<br><br>• Work with Sport Wales and national governing bodies to address the findings of the review of Transgender Inclusion in Domestic Sport.<br>• Ensure workforces are engaged and aware of events and activities at local, regional and national level.<br>• Consider how to provide greater focus on equality as part of skills development, work experiences, volunteering, mentoring and apprenticeship activities and opportunities, providing funding where appropriate. |
| 26. | COHESION – Culture & Sport<br><br>• Collaborate across the culture and sport sectors to cascade and share good practice and learning. National, local and voluntary organisations will work cohesively to develop good practice that can be scalable and shared as appropriate, to ensure that best practice across the sectors is recognised and adopted wherever appropriate. |
| 27. | Examine how we can provide support to faith groups to create open and accessible environments for LGBTQ+ people, and to promote inter-community dialogue. |
| 28. | Strengthen LGBTQ+ representation on equality forums. |
| 29. | Ensure that all homelessness services sensitively capture people's sexual orientation and trans status to tailor appropriate and safe pathways. |
| 30. | Evaluate specific LGBTQ+ projects, such as the Ty Pride project, and gather best practices and principles to share with local authorities regarding LGBTQ+ homelessness. |
| 31. | Work with the UK Government to encourage sensitive identification of LGBTQ+ people throughout their asylum claim by making amendments to the ASF1 form and asylum case worker guidance. |

| | Action |
|---|---|
| 32. | Work with the UK Government and Clearsprings Ready Homes to encourage the development of LGBTQ+ only asylum properties in Wales, with necessary safeguarding and welfare considerations implemented. |
| 33. | Work with specialised LGBTQ+ asylum and refugee support services, such as Glitter Cymru and Hoops & Loops, to identify improvements to relevant policies and support organisational sustainability. |
| 34. | Ensure our commitments to making Wales a Nation of Sanctuary are inclusive of LGBTQ+ people. |
| 35. | Ensure that appropriate mental health support is provided to LGBTQ+ refugees and people seeking asylum. |

## Improving Health Outcomes

Outreach which informed the Actions within this Plan found that LGBTQ+ people in Wales continue to face significant inequalities when accessing health and social care services. The Expert Panel survey found that, whilst improvements are being made 85 per cent of responders indicated that there was no effect (69 per cent) or positive effect (16 per cent) when disclosing their LGBTQ+ identity to healthcare staff, and experiences of discrimination continue at an unacceptable rate. 22 per cent of survey responders indicated that they had been subject to inappropriate questions or curiosity when disclosing their sexual orientation or gender identity, whilst 18 per cent felt their specific healthcare needs were ignored or not taken into account and 12 per cent stating they had avoided treatment or accessing services for fear of discrimination or intolerant reactions. Research also suggests that LGBTQ+ people face distinct inequalities when accessing social care.[9] Previous reports show that LGBTQ+ disabled people continue to face discrimination on the basis of their sexual orientation and/or gender identity from those providing personal care.[10] Research on the experiences of LGBTQ+ older people in care homes has shown it is often noted that the needs of older people are not always met.[11] Each of these findings display that work must be done to ensure that LGBTQ+ people in Wales are safe and confident in accessing the health and social care system. There are also several areas where LGBTQ+ people are disproportionately affected, such as depression and suicidal thoughts, sexual health conditions and substance use.[12] We must take action to better understand and mitigate for these disproportionalities.

| **Action** | |
|---|---|
| 36. | Undertake targeted public health work to combat issues where LGBTQ+ people are disproportionately at risk, including substance use, sexual health and mental health. |
| 37. | Continue to ensure that maternity and fertility services are accessible and straightforward to use for LGBTQ+ people. |
| 38. | Work alongside NHS Wales, Social Care Wales and social care providers and commissioners to embed comprehensive and ongoing LGBTQ+ specific health and social care training to all staff. Health Inspectorate Wales and Care Inspectorate Wales should act to ensure compliance with best practice |
| 39. | Include consideration of the needs of LGBTQ+ people, including LGBTQ+ older people and younger people, in the process of reviewing our codes of practice and statutory guidance under the Social Services and Well-being (Wales) Act 2014, to link in with appropriate professional training. |

[9] Health and Social Care and LGBTQ Communities, House of Commons, Women and Equalities Committee - https://publications.parliament.uk/pa/cm201919/cmselect/cmwomeq/94/94.pdf
[10] LGBTQI+* Disabled People and self-directed social care support https://www.sscr.nihr.ac.uk/PDF/Findings/RF77.pdf
[11] Developing inclusive care homes for older people who identify as lesbian, gay, bisexual and trans (LGBTQ) https://www.bristol.ac.uk/policybristol/policy-briefings/inclusive-care-homes
[12] Stonewall, 2018, LGBTQ in Britain: Health Report: https://www.stonewall.org.uk/LGBTQ-britain-health

| Action | |
|---|---|
| 40. | Ensure any future review of mental health services takes account of the focus on and efficacy for LGBTQ+ people including young people. |
| 41. | Publish and act on a new HIV and Sexual Health Action Plan which includes a focus on prevention, education and equitable service provision. |
| 42. | Support the moves to tele-medicine for sexual health appointments and postal testing where possible and desired by the patient. |
| 43. | Commit to review the Gender Identity pathway for children and young people in Wales following the review in NHS England. |
| 44. | Continue to develop the Wales Gender Service with GPs able to initiate hormone therapy as part of the adult pathway. |
| 45. | Work with the Wales Gender Service to address public perception that there is disparity of access to gender identity services for non-binary people. |
| 46. | Consider establishing an NHS Wales-wide review on trans people's medical records, led by trans communities, to promote trans people's engagement with healthcare services, privacy, and quality of healthcare. |

## Education

In 2017, the Expert Sex and Relationships Education panel drew on a wide range of national and international research,[13] one of the key findings of the panel was that there was a gap between children and young people's lived experiences of relationships and sexuality (online and offline). Drawing on Stonewall Cymru's survey which found that there remains a lack of discussion in educational environments about sexual orientation and/or gender identity, with 44 per cent of those in education in the last three years stating that neither of these topics was discussed, the expert panel concluded that rarely is Relationship and Sexuality Education (RSE) LGBTQ+ inclusive, and provision is too heteronormative. These findings have been confirmed by teachers' own evaluative audits with their students in a recent professional learning programme with primary, secondary and special schools[14] – practices supported by the published commitment and promise of new statutory guidance for schools, in which LGBTQ+ inclusivity is an underpinning principle.[15]

Change is underway: while the LGBTQ+ people who engaged with Stonewall Cymru's outreach process were largely optimistic about the opportunities of the new Welsh curriculum,[16] specifically the commitment to teach inclusive RSE for all learners (age 3-16), concerns were raised around the implementation of the commitments on a truly inclusive curriculum.

| **Action** | |
|---|---|
| 47. | Provide strategic, comprehensive investment in professional learning and training on designing a fully LGBTQ+ inclusive curriculum. This should include delivering LGBTQ+ inclusive RSE for all. |
| 48. | Ensure that training must also act to empower professionals to adequately support LGBTQ+ young people and tackle homophobic, biphobic and transphobic bullying, by embedding a rights based approach. |
| 49. | Promote resources to help the families of LGBTQ+ young people, through Parenting. Give it time. |
| 50. | Provide statutory national trans guidance for schools and local authorities. |
| 51. | Continue to invest in hate crime prevention programmes across Wales. |
| 52. | Work with colleges and universities in Wales to ensure that they are LGBTQ+ inclusive environments for learners and staff, identifying and building on best practice. |

[13] Renold, E. and McGeeney, E. 2017a. The Future of the Sex and Relationships Education Curriculum in Wales. Wales: Welsh Government. AND Renold, E. and McGeeney, E. 2017b. Informing the Future of the Sex and Relationships Education Curriculum in Wales. Cardiff: Cardiff University.
[14] Renold, EJ., Ashton, M. and McGeeney, E. (2020) *CRUSH: Transforming Relationships and Sexuality Education.* Cardiff: Cardiff University. Available Online at: www.agendaonline.co.uk/crush/
[15] Welsh Government. 2020a. *Cross-cutting themes for designing your curriculum*. Hwb. [Online] Available at: https://hwb.gov.wales/curriculum-for-wales/designing-your-curriculum/cross-cutting-themes-for-designing-your-curriculum
[16] Welsh Government, Available Online at: https://hwb.gov.wales/curriculum-for-wales

| Action | |
|---|---|
| 53. | Consider options for the targeted funding of research into the experiences of the LGBTQ+ population of Wales. |

## Workplace

While progress has been made on making workplaces more equal, this remains dependent on the type of industry and the level of commitment shown by the employer. More and more organisations are taking pride in their commitment to LGBTQ+ staff, customers and service users. Yet, discrimination in the workplace remains widespread, requiring action and Government commitment to drive change. The outreach process found that whilst 45 per cent of people reporting that those in the workplace reacted only positively when aware they were LGBTQ+, 24 per cent reported un-permissible exposure of their LGBTQ+ identity in the workplace and 10 per cent recounted experiencing verbal harassment. Focus group attendees also stated that they experience workplace inequalities and discrimination, particularly those in more precarious employment. Workplaces in Wales have improved, yet we need to go further to eradicate discrimination and empower all those in employment to be themselves as well as championing the positive impact diversity can have in all types of organisation.

| | **Action** |
|---|---|
| 54. | With support from Trade Unions, create a more homogenised approach to private workplace training resources for workplaces to become more LGBTQ+ inclusive. |
| 55. | Provide a resource detailing employment protections as well as employer responsibilities for upholding the rights of trans staff working in the private sector. |
| 56. | Promote the importance of the collection of diversity data to businesses in Wales. |

## Covid-19 Response

Research conducted by the University College London and the University of Sussex into the lives of LGBTQ+ people in Britain during the coronavirus lockdowns has uncovered a mental health crisis among the LGBTQ+ community, with 69 per cent of respondents suffering depressive symptoms, rising to 90 per cent of those who had experienced homophobia or transphobia[17]. This evidence is supported by further research on the disproportionate impact of the pandemic on LGBTQ+ people, conducted by the United Nations Human Rights Office of the

[17] The mental health and experiences of discrimination of LGBTQ+ people during the Covid-19 pandemic: Initial findings from the Queerantine Study: https://www.medrxiv.org/content/10.1101/2020.08.03.20167403v1, 2020

High Commissioner[18], LGBT Foundation[19] and highlighted by Human Rights Watch[20] . These findings are reinforced by the results of a Welsh Government commissioned Stonewall Cymru survey, with many LGBTQ+ people in Wales reporting experiences of isolation as a result of Covid-19. This social isolation along with some being forced back into unsupportive or openly-hostile households, highlights the stark impact of coronavirus for LGBTQ+ people, and the need to recognise and consider their experiences when responding to the crisis. Evidence suggests the potential impact of Covid-19 is even more marked among certain LGBTQ+ groups such as older LGBTQ+ people, younger LGBTQ+ people, Black, Asian and Minority Ethnic LGBTQ+ people and LGBTQ+ disabled people"[21,22,23,24]

| | **Action** |
|---|---|
| 57. | Consider the distinct experiences of LGBTQ+ people including, explicitly LGBTQ+ children and young people as Wales comes out of lockdown and plan the post-COVID recovery. |
| 58. | Consider undertaking a thorough investigation into how LGBTQ+ people in Wales have been impacted by the Coronavirus pandemic. |

[18] United Nations Human Right – Office of the High Commissioner, 2020, Report on the impact of the Covid-19 pandemic on the human rights of LGBT persons, Available Online at: https://www.ohchr.org/EN/Issues/SexualOrientationGender/Pages/COVID19Report.aspx

[19] LGBT Foundation, 2020, Hidden Figures: The impact of the Covid-19 pandemic on LGBT communities in the UK, Available Online at: https://s3-eu-west-1.amazonaws.com/lgbt-website-media/Files/7a01b983-b54b-4dd3-84b2-0f2ecd72be52/Hidden%2520Figures-%2520The%2520Impact%2520of%2520the%2520Covid-19%2520Pandemic%2520on%2520LGBT%2520Communities.pdf

[20] Graeme Reid, 2020, Human Rights Watch: LGBTQ Inequality and Vulnerability in the Pandemic, Available Online at: https://www.hrw.org/news/2020/06/18/lgbtq-inequality-and-vulnerability-pandemic

21 Phillips, C. (2021). How covid-19 has exacerbated LGBTQ+ health inequalities. https://www.bmj.com/content/bmj/372/bmj.m4828.full.pdf

22 Ruprecht, MM; Wang, X; Johnson, AK; et al. (2020). Evidence of Social and Structural COVID-19 Disparities by Sexual Orientation, Gender Identity, and Race/Ethnicity in an Urban Environment. https://link.springer.com/article/10.1007/s11524-020-00497-9

23 Gato, J; Barrientos, J; Tasker, F; et al. (2021). Psychosocial Effects of the COVID-19 Pandemic and Mental Health among LGBTQ+ Young Adults: A Cross-Cultural Comparison across Six Nations. https://www.tandfonline.com/doi/full/10.1080/00918369.2020.1868186

24 LGBT Foundation. (2020). Hidden Figures: The Impact of the Covid-19 Pandemic on LGBT Communities in the UK. https://s3-eu-west-1.amazonaws.com/lgbt-website-media/Files/7a01b983-b54b-4dd3-84b2-0f2ecd72be52/Hidden%2520Figures-%2520The%2520Impact%2520of%2520the%2520Covid-19%2520Pandemic%2520on%2520LGBT%2520Communities.pdf

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27 Jan 2021

Dear Deputy Minister

**Call for cross-party discussions on proposed Stonewall Cymru LGBT Action Plan due 31 March 2021**

We are writing to ask you to join a non-partisan discussion on the LGBT+ Action Plan for Wales – due for release in 9 weeks' time. We believe this discussion is urgently needed, since the Action Plan may have severely detrimental consequences for the protected characteristic of sexual orientation.

We believe that the likely impending erosion of LGB rights is not intentional. After all, the Welsh Government has undertaken to ensure that advancing "equality for transgender and non-binary people will not erode the rights of women and other people with protected characteristics". This is an important and much appreciated aspiration, but complex to achieve. We would like to offer you our support in addressing these complexities. We know that you have recently been in correspondence with our sister organisation LGB Alliance Cymru, and also Ruth Dineen, and we would like to build on the ideas already shared with you.

You have outsourced the job of developing the LGBT Action Plan to Stonewall Cymru. We are sure that you did so in good faith. After all, over the decades, Stonewall built up a reputation as the leading UK LGB lobby group, whose reputation for fact-based argument and bridge building was second to none. Indeed, many of us in LGB Alliance helped to build it up and were proud to do so.

When Stonewall changed its mission in 2015, becoming what can best be called a gender identity lobbying organisation, it kept the same name. This has understandably given rise to confusion. It would have been helpful if, at the time, Stonewall had renamed itself as "Queer, Trans, Intersex People's Group" as this would make a clear statement of the group's priorities since 2015. It has been a heart-breaking blow for many of Stonewall's one-time LGB supporters, who feel the organisation has abandoned them.

Today's Stonewall promotes a very narrow view of sex and gender and does not represent LGB people as a whole. It insists that everyone has a "gender identity" that takes precedence over biological sex, and that anyone who challenges this doctrine is a bigot. This includes people who say they are only attracted to others of the same sex – in other words, the very homosexuals whose interests Stonewall once held dear. It is a sorry state of affairs, and almost incomprehensible to those hearing it for the first time.

You may not be aware of the two campaigns most heavily pushed by Stonewall right now. The first is that males should be allowed to compete with women at rugby. After extensive research and consultation last year with all rugby unions, World Rugby ruled the risks of injury to women were too high. Stonewall does not accept this and campaigns against the safety of women who play, many of whom are lesbians.

The second relates to the Judicial Review of the Gender Identity Development Services at the Tavistock and Portman clinic brought by Keira Bell and Mrs A in Oct 2020. One might expect Stonewall, theoretically an LGB campaigning group, to be standing up for young lesbian Keira Bell. The opposite is true. In the original hearing Stonewall formally requested to intervene on behalf of the Tavistock. This was rejected by the judges as Stonewall was unable to provide any additional evidence that the court did not already have. Yesterday we learned that Stonewall is applying for a second time to intervene – this time in the appeal by the Tavistock.

Here we have just two examples of the way Stonewall has "changed sides" if you like, and now campaigns directly against the interests of homosexuals – in both these cases they happen to be lesbians.

LGB Alliance, which now has 14 allied groups worldwide, was set up as a response to Stonewall's refusal to allow any dialogue on important issues of sex and gender. Stonewall believes we are "transphobic". We don't accept that it is "transphobic" to stress the importance of biological sex. We don't accept that it is "transphobic" to say a child can't be "born in the wrong body". Many LGB people hold these views. Instead of labelling and silencing we believe that people of different views need to talk.

We believe in freedom of speech as a central pillar of democracy. Expressing ideas that differ from those held by Stonewall Cymru should be allowed and encouraged in a democracy – not banned. We all know that the best way to learn is to listen to opposing views and develop and grow.

As a member of Stonewall Diversity Champions, the Welsh Assembly clearly has an established relationship with that organisation. However, by working solely with Stonewall, the Welsh Government is not receiving a plurality of views, and certainly not hearing from those who oppose gender identity theory.

We note that in your email to Ruth Dineen dated 18 December 2020, that "There will be opportunities for organisations and individuals to input to the plan during its development". We respectfully suggest that since Stonewall Cymru has been working on this plan since June 2020 this is too little and too late.

The Proposed Timeline of Work between the Welsh Government and Stonewall Cymru was agreed as follows:

> *"**End of June 2020** – scoping document to receive approval, enabling Stonewall Cymru to commence work on the terms laid out…*
>
> ***End of June – End of August** – Stonewall Cymru to undertake outreach and research. To provide key main findings to Welsh Government ahead of the summer recess for consideration.*
>
> ***March 2021** – Initial proposed final deadline for the publishing of LGBT Action Plan, up to this point Stonewall Cymru to engage with Welsh Government on specific elements of the plan"*

It seems to us that is not reasonable to ask for serious input at this late stage – with only 9 weeks to go. We therefore suggest that you "press pause" on the project while a cross-party group reviews the assumptions and ideology Stonewall Cymru are likely to have built into the draft plan. Clearly defined terms and a balance of rights will be needed to build broad acceptance of the plan amongst the electorate – and we can help with that.

We know that your Government is committed to evidence-based policy making. In LGB Alliance Cymru's recent letter to you and the First Minister, the group commended the Welsh Government for "using the best available scientific evidence in managing the country's response to the pandemic". It is important that the LGBT+ Action Plan commands respect, and that surely means it too must be based on evidence and not on a limited, doctrinaire ideology.

Our goal, like yours, is to ensure equality for all. By "equality" we mean social acceptance as well as equal protection under the law. To achieve that, it is essential to hear a range of views – to hear from all those likely to be affected by a national plan for equality. With that in mind, we are writing to you, and to Senedd members Leanne Wood and Laura Anne Jones, to ask you all to consider setting up a cross-party group to revisit the thinking behind the plan.

This is an important issue requiring careful scrutiny and open, thoughtful discussion. We would like to help in any way we can. We would be happy to host any initial meetings with you or with your officials to set the terms of reference of a cross-party group to address these issues.

Please let us know your thoughts. We look forward to hearing from you.

Kind regards

Kate Harris & Bev Jackson
LGB Alliance

# Extract of Interview with Jo Maugham of Good Law Project

Sunday, 2/27

https://www.youtube.com/watch?v=ig7PlK0PQ4Q

**SPEAKERS**
Jolyon Maugham, Katie Montgomery

**Katie Montgomery** 00:10
Hello, everyone, welcome to my latest interview. I think this is turning into a bit of a series, I probably need a proper name for it. For anyone who doesn't know, I am Katie Montgomery. I'm an internet dickhead who argues about trans rights. And I'm a trans woman. And today I am talking to Joe mom from good law project. I, Joe, for anyone who doesn't know who you are, would you like to just briefly introduce yourself?

**Jolyon Maugham** 00:37
Hi, Chris. You're typing everyone. Yes, I am a lawyer. So I was a queen's counsel, sort of senior trial lawyer. I used to argue tax cases. And I realized that actually, there were more useful and interesting things I could do with my life. So in 2016, I started

...

**Katie Montgomery** 13:33
It's yeah, it's definitely become like the cultural thing I was described as the trans panic. Like as in taking the name from the Satanic Panic, which also then like, the second version of that was the gay panic. And it's like, every generation, I guess, picks one thing, and the media blows it completely out of proportion, and it becomes the culture war issue, and you need to have an opinion on it. And suddenly, every single person in the UK has an opinion about whether how easy it should be for me to get a certificate so I can get married. Like, why it's just completely ridiculous. But people it's something that's new in like cultural awareness. And then there are it's also because like trans people existing and their rights is, like an affront to the patriarchy, that then becomes an issue. You know, it's the thing is the thing they can all talk about to radicalize people to being bigoted and supporting loads of attacks on women. Yeah, I won't I won't rant off onto this too much, because I want to talk more about good law project. So um, in in, like, around 2016, I guess is when I first started getting into following gender critical as like a thing. And since then, they've had these groups pop up like for Women Scotland or Fair Play for Women,  LGB Alliance, like all of these gender critical groups and lots of them and some individuals too. have followed this kind of model that they did with the all women shortlist, where they make some buzz, and they start a crowd funder. And then all of the right wing newspapers publish

about it over the same week. So they get loads of publicity. And they get donations in the region of 100,000 pounds. And then they do some court case. And quite a lot of them have been judicial reviews, which I didn't even know about that was until recently, and now I'm quite aware of it. As far as law things go. But suddenly, as a trans person, like, on the ground and watching this, I felt like that we have nothing, we were just standing there. And they were you know, firing all these shots, setters. And lots of them failed, but some of them start. And I just thought we need, like, where's r1? What's, what's going on here? And I kind of feel like good law project has taken that spot. Do you? Do you feel like it like, is that what I guess? Was your change of mind? Like, the sole reason that you decided to get into trans rights stuff with good law project or it but did you see this kind of like, really one sided thing going on, or?

**…**

**Katie Montgomery** 40:16
Yeah, I mean, it's just an irrational panic that's turned into a profitable Oh, it's conspiracy theory. And in some places, it's a cult and over, it's profitable, like some of these people are professional gender criticals. Now, and lots of these lawyers, I mean, some of these law firms from gender critical people have raked in a half million pounds. And so it's in their benefit to carry on suggesting these cases. So saying that talking to a lawyer who or crowdfunding for but you know, it's it is it shows the, the balance here, because if they lose the cases, then whatever, whereas if I lose them, potentially, it's, you know, my rights on the line. But anyway, so that, then you've got this thing on the waiting times. And you mentioned, you know, there's ridiculous waiting times, but there's a few more things coming up. And I, I think people Yeah, let's talk about the LGB Alliance, one, basically, this, LG, there's a lot of gender critical groups. But LGB Alliance are one of the most ridiculous, incompetent, plainly garbage groups and somehow they managed to get charity status. Which I, I feel like it'd be difficult for me to not describe whatever led to that as corruption i Not at all putting that on you saying that that's, that's just what I feel like because it is so utterly ridiculous like that there's so transparently just an anti trans group. But anyway, so you've got this case, coming up to challenge?

**Jolyon Maugham** 41:53
Yeah, I mean, I was accosted at a party, actually, by one of the founders of LGBA. A couple of weeks ago. I was there with a friend of mine, who I won't name her, when one of the founders of LGBA came over. And she said, I used to love all of your work, and I just don't understand why you're doing this against us. We're just protecting the rights of women, and in particular, lesbian women, you don't seem to be interested in what this means for lesbian women. And the woman I was with jumped in and said, Well, I'm a lesbian woman. And I think this is completely consistent with, with my understanding of the whole sphere, a lesbian woman, and bizarrely, I hadn't even known she was lesbian, I was very, very grateful to her for throwing herself under that particular bus. But yeah, that they're, they've they're very, they're very media savvy. They have  they seem to have enormous amounts of money. We know that vast amounts of money are coming into the UK from the Christian right. We don't know where that money is going, but it must be going somewhere. And if it isn't going in part to many of these crowdfunders. And many of these organizations that seem to spring up out of nowhere with very professional offers, I'd be pretty amazed. I had this discussion, actually with the LGBTA founder. And she said, Well, no all of our money comes from members of the public. And I said, Well, how do you

know? Because you don't know who is giving you money. Even if money comes into your Crowdfunder people have the option of telling you who they are

**Katie Montgomery** 44:02
It's self ID isn't it?

**Jolyon Maugham** 44:04
It's self ID that's right. And so you just have no way of knowing in truth, whether the money is being fed in in dribs and drabs from some huge Christian Right organisation from the States or from somebody who's genuinely concerned in the in the UK.

**Katie Montgomery** 44:26
There was one as well as these big like, attacks on law. There's been lots of different defamation and stuff cases going on around this as well. And there was there's also been cases about police misconduct, there's been lots of different things, and I can't remember exactly what it was, and I'm not going to say who it was, but a gender critical person had some law trouble and they needed money for some case. And they originally had a go against them and they appealed it and they went for them and then they didn't have any trouble. But in that thing the people were accusing them of taking money from the religious right and stuff, because that's the accusation that gender criticals was always get. And she was like, kind of like accidentally mask off said, You know what? I did have a religious right organization come and say that they would pay all of my fees, and we will have to and I turned them down. So if anyone says we've been funded by the right, they're lying. And I was like, but they wouldn't have come to me and offered me the money would they? They did offer you

**Jolyon Maugham** 45:32
Or the other people who, you know, lots of people around who have had that same offer and haven't said no. Yeah. Yeah, I mean, I'm definitely undoubtedly there's a huge avalanche of money from the history right coming into the UK and Europe as report after report after report that identifies that the number is in the billions of pounds. And, you know, the trans community in the UK does not have much support in the establishment, as you rightly point out, it's very, very difficult to get any newspaper to give people any sort of a hearing that alone are reasonable and sustainable one.

**Katie Montgomery** 46:09
Do we like have any trans QC's in the country that I was trans or any trans?

**Jolyon Maugham** 46:15
I'm not sure that I know, to be honest, there are a couple of trans barristers that I'm aware of there are almost there are very, very few QC's who are out as trans supporting less known knowns to the trans.

**Katie Montgomery** 46:37
So obviously, it'd be difficult to come up. But I guess, like the point is, like, we don't have any openly trans politicians, we don't have any openly trans, like, editors of newspapers. And there were very few trans journalists and very few trans like barristers and lawyers. And yeah, like, we don't have the

institutional power and not for sure, we have, you know, some trans allies. But there are so many gender critical people in these positions of power, and people who are sympathetic to their views. So, you've got some case coming up to I don't quite understand how you can challenge the charity status with the law, but

**Jolyon Maugham** 47:18
To become a charity, you have to meet certain legal thresholds. And those thresholds are about determining which groups exist fundamentally for the public good. And the question really, is whether LGBTA exists for the public good. Or is it a hate group, and I think it's a hate group. And there is a lot of evidence, it's a hat group. I'm very happy to say that here, as I've said it elsewhere. The LGB is a hate group, it does very little, that does not involve the pumping out of transphobic material, and some of it is quite revolting. They have compared being trans to being sexually interested in animals. I mean, it's really, really, really horrid stuff. And all of this stuff will go before the tribunal that hears the challenge to challenge the status. It's a very difficult challenge, because of a technical point around standing, the challenge has actually been brought by Mermaids. And the law seems to be that there are very narrow grounds upon which anyone can challenge the standing of a charity, we may need to appeal. And we will appeal if we lose the first instance, that the finding that finding that mermaids doesn't have standing. I mean, it's obviously it’s for Mermaids, not for us.

**Katie Montgomery** 48:42
this is something I was gonna ask about so recently about standing and send something only just heard about from good law project, because you had some ruling saying you didn't have standing, is that this case? Or is that another case?

**Jolyon Maugham** 48:53
That's a different case. There's a concept. It's very familiar to lawyers that you have to have a sufficient interest in an issue. Before you have before you can bring a challenge to it. And a court held in relation to a challenge to the failure of government to take into account the impacts of its recruitment policies on disabled people and ethnic minorities. That the Runnymede Trust did have standing. Runnymede was our co-claimant and because it was a better claim, we didn't have standing. So there's always a standing question floating around but it might be that the standing test the standing curb, if you'd like to challenge challenge whether or not a charity and be registered charity is a much higher hurdle than the general hurdle.

**Katie Montgomery** 49:47
So when they say you don't have legal standing, they mean in this case, they don't mean as you're not like you're no longer a practicing group, like go away.

**Jolyon Maugham** 50:00
That’s right, that’s right. It’s always sort of a context specific question.

**Katie Montgomery** 50:02
Yeah. Okay, cuz I like whenever you see anything like you saying you'd like public enemy number one, you've made a lot of enemies because you've attacked the Conservative government. And you've

attacked you know, the gender critical people and you've got lots of stuff going on. And so when anything comes out about Good Law Project or about you, even neutral, there's instant spin to say how this is your downfall. And I, the first I saw of it was gender critical. People saying good law project no longer have standing, which means they'll never be able to do another trans court case again. And this is this is it, this is the final, like straw on the camel's back or whatever. And then, now him you explain what standing is. That seems completely ridiculous, like,

**Jolyon Maugham** 50:45
It’s completely ridiculous. But the thing about the law is, it's not really a momentum sport, right? If everyone on Twitter rose up in unison, and said, Good Law Project doesn't have standing. That wouldn't matter. The question would be, as a matter of law does the Good Law Project have standing and the fact that everyone on Twitter agreed that we didn't, would be completely irrelevant. But that's that's kind of cheering and important to remember. When you read stuff about me and about us and about our likely success, we are very, very careful about the cases we take. And you can see that in the extraordinary success rate, we have particularly given that we choose to fight in the most difficult of areas.

TRANS

# Trades Union Congress, with 5.5 million members, comes out for trans rights while condemning LGB Alliance

VIC PARSONS | SEPTEMBER 17, 2020

SAVE FOR LATER



Trades Union Congress president Gail Cartmail. (Twitter/The_TUC)

**Portraying trans rights as dangerous to women and children is "reminiscent of homophobic lies of the past and we reject this", the Trades Union Congress (TUC) has said in a motion emphatically standing with trans and non-binary people.**

Condemning "anti-trans campaigners" as "deliberately stoking dissention between LGB and T sections of our communities", the TUC also strongly came out against anti-trans organisations in the UK.

Privacy

The "anti-trans LGB Alliance", t
existing rights of trans people".

The TUC is the federation of tr
48 affiliated unions. Its current general secretary is Frances O'Grady, with the socialist feminist Gail Cartmail as president.

It passed the motion in support of trans rights and called for a progressive reform of the Gender Recognition Act – the 2004 law that governs legal gender recognition for adult trans men and women – at its 2020 Congress this week.

The Congress also reaffirmed its "wholehearted commitment to trans rights".

In the motion, the TUC said it recognised that "transphobic attacks" in social and mainstream media are led by groups who want to roll back trans rights; that the Tories are using trans rights as "a wedge issue" to divide working-class people; and called out newspapers owned by Rupert Murdoch for "regularly promoting… myths and tropes about trans and non-binary people".

## TUC calls myth that trans rights threaten women 'reminiscent of homophobic lies of the past'.

The TUC also firmly stated its support for non-binary people, saying that "for all social purposes, trans women should be treated as women and trans men treated as men" and that "other gender identities (non-binary etc) are equally authentic".

"This is a social question rather than a scientific one," the TUC noted. "Past attempts to categorise human beings by purely scientific methods have often led to barbaric outcomes."

It added that "wilfully misgendering people is unacceptable" and that monitoring questions about sex or gender that rely on the gender binary are "discriminatory against non-binary people".

The TUC also noted that: "Transphobia is continuing during lockdown and beyond, clinic waiting times are increasing, and gender recognition reform is again delayed.

"Global campaigns by reactionary organisations including the Alliance Defending Freedom are supported by powerful evangelical and other conservative Christian institutions. These organisations are also homophobic, biphobic and against women's rights and they have financial resources to support legal cases.

"Many conservatives have tried to portray trans rights as a danger to women and also children. This is reminiscent of homophobic lies of the past and we reject this.

"These issues have been made more contentious by our society's deep gender segregation. We shoulc fight for all public places to be safe spaces."

The TUC follows the British Medical Association, the UK's trade union for doctors, in emphatically supporting the trans and non-binary community.

Privacy

The BMA on Tuesday ruled tha
their gender, in a motion that c
trans youth.

More: BMA, british medical association, gender recognition act, GRA Reform, lgb alliance, trades union congress, trans rights, tuc


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CONSORTIUM
for stronger lgbt+ communities

# Consortium Response to EHRC Statements

27th January 2022



CONSORTIUM
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Yesterday, 26 January 2022, the Equality and Human Rights Commission (EHRC) released two statements – in response to plans to legislate for a ban on conversion therapy in England and Wales, and Gender Recognition Act reform in Scotland.

We have seen incredible strength of feeling from our members, and Consortium share concerns about the statements made by the EHRC.

The statements released yesterday demonstrate an attempt to stall vital legislation, which LGBT+ people have already been waiting on for several years. These delays are unacceptable and undermine the rights of our communities. Any further attempt to further delay legislation in these areas after the extensive consultation which has already taken place is an attack on the rights of LGBT+ people.

Consortium joins with its Member organisations and allies in expressing enormous concerns about this development.

The public has been consulted extensively over many years on both the GRA reform in Scotland, as well as in England and Wales, and a ban on conversion therapy.

The EHRC statement appears to propose that legislation to ban conversion therapy should exclude gender identity. On 26 January 2021, Galop **published a report** that shows the shocking extent of abuse towards trans people in the name of conversion therapy.

Several other countries and states such as France, Canada and Victoria State in Australia have recently enacted an outright ban on conversion practices.

**Vic Valentine, manager of Scottish Trans notes that:** *"there have been comprehensive public consultations by the Scottish Government since 2017. The draft bill was fully consulted on a year ago, and everyone had their say. The EHRC itself responded to both public consultations, supporting reform. There will of course be much more detailed consideration of the bill as it goes through the Scottish Parliament."*

**Tim Hopkins, director of the Equality Network said:** *"The EHRC is not independent of government, but has its Board directly appointed by Liz Truss and the UK Government. We assume that their appointees are responsible for this letter and for failing to stand up for equality for trans people. We do not need UK Government appointees telling us in Scotland how to legislate in devolved areas Scottish Trans and we look forward to the Scottish Government proceeding with this legislation soon, as has been promised many times."*

We are truly disappointed by the EHRC's continued lack of engagement with LGBT+ communities.

In May 2021, Consortium, along with leaders from across the sector, wrote to the EHRC urging them to step up for our LGBT+ communities. We expressed frustration and disappointment that they were no longer using their powers to advance equality for LGBT+ people.

Since then, the situation has continued to deteriorate, with levels of LGBT+ hate crime rising and the UK sliding down the Rainbow Europe rankings of equality and social climate for LGBT+ communities. In January 2022, the Parliamentary Assembly of the Council of Europe named the UK alongside Hungary, Poland, the Russian Federation and Turkey as a country of specific concern in relation to attacks on LGBT+ rights.

In their own words, the EHRC exists as "an independent statutory body with the responsibility to encourage equality and diversity, eliminate unlawful discrimination, and protect and promote the human rights of everyone in Britain." The delays proposed within their latest statements are in conflict with this stated purpose and indicate a failure of the EHRC not just in working with LGBT+ communities, but in upholding their responsibilities as an independent statutory body.

We know this may be a highly distressing time. Please encourage your trans+ friends, colleagues and service users to be careful around social media and to prioritise protecting their mental health.

We stand with all trans and non-binary people – in defending their human rights, dignity and safety.

**We stand #TogetherWithTrans**

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**Please find below responses and letters to sign from our member organisations and allies:**

- Sign the Stonewall Open letter: Stand up for trans rights
- Gendered Intelligence press release on the EHRC
- LGBT Foundation – LGBT Foundation to sever all ties with the EHRC
- Statement from TransActual on EHRC
- Galop's statement on the EHRC's response to the conversion therapy consultation
- Sparkle – The National Transgender Charity's Public Response to Statements by the EHRC
- Trans in the City's Public Response to Statements by the EHRC
- A shameful act of trans exclusion: Mermaids' response to the EHRC
- Statement: akt supports lgbtq+ young people
- GIRES response to the EHRC comments on the proposed ban to conversion therapy
- Steph's Place – Investigation into Trans Hostile activities at the Equality & Human Rights Commission
- Intercom Trust: Statement on the Equality and Human Rights Commission's (EHRC) response to the conversion therapy consultation
- Ban Conversion Therapy Coalition Statement
- Trans Legal Project on Twitter

We urge everyone to respond to the government's **consultation on the conversion therapy** ban to ensure that our voices are heard. The consultation closes on 4th February. Advice and guidance on writing a response can be found here.

We welcome the opportunity to share statements from our members regarding this matter and will update this blog to include further statements from members. Consortium members wishing to share a statement should contact admin@consortium.lgbt. Thank you.

The EHRC statements can be found here:

- Conversion therapy consultation
- Scottish GRA Reform

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Posted in Consortium

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← First Pride event launches in Cannock Chase

Sparkle – The National Transgender Charity's Public Response to Statements by the EHRC →

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# EHRC asserts protections for religious and trans conversion therapy, calls for pausing GRA reform

by Mallory Moore , Meryl Links and Sarah Clarke
Thu Jan 27, 2022 (*updated: 12:21*)· 5542 words · 28 min
tags: EHRC UK Government State attacks on human rights

The UK Equality and Human Rights Commission (EHRC) published two statements pushing government bodies to hold back civil rights reforms affecting trans people. One of these was sent to the Scottish Cabinet, telling them to pause plans for reforming the Gender Recognition Act, citing the "polarised debate", and a lack of "detailed consideration" of the issues.

Scottish parliament has been through 2 rounds of consultation on GRA reform, and before the current chair was installed by the Conservative and Unionist party, the EHRC had made a clear recommendation in favour of reform of the GRA 2 years ago, where they made directly contradictory statements fully supporting GRA reform and recommending that current regulations should be greatly reduced.

The EHRC made a further submission to the UK Government conversion therapy consultation. This included suggestions that the government should consider allowing exceptions in cases where SOGI change efforts were "consensual" and bizarre claims that the terms "Conversion Therapy" and "Transgender" were ill defined (despite the fact that this proposal is currently at a consultation stage allowing expert bodies and human rights advocates to have input into defining specifically what sorts of practices should be banned). The EHRC made suggestions that a ban might interfere with minors' medical consent rights (known as *Gillick Competence*, a persistent target of

anti-rights groups for the fact it allows minors the right to abortion and contraceptives without parental consent) and directly recommended against banning "exploratory" therapy or efforts to "encourage" people to comply with religious doctrines around sexuality or gender identity. "Exploratory therapy" is an increasingly ambiguous term, which traditionally refers to to a range of valid therapeutic techniques. However increasingly, some therapists associated with the pro-conversion-therapy lobby have been using the term in a way that includes efforts to "explore" looking for a presumed psychic injury underlying trans gender identity, with a view to changing or ideally "curing" it into acceptance of the patient's registered sex at birth. The EHRC submission also urged that government make clear exceptions for "psychological medical healthcare" including "support to... reconcile a person to their biological sex where clinically indicated, including for children and young people aged under 18". This plainly falls under widely accepted definitions for "Conversion Therapy", otherwise known as Sexual Orientation and Gender Identity or Expression Change Efforts (SOGIECE).

Trans Safety Network responded:

> It is disappointing that only a day after the United Kingdom has been rebuked for its sliding LGBT human rights record, the EHRC is putting pressure on Scotland to hold back rather than move foward with reforms. We know that long delays and public debate have exacerbated rather than ameliorated public toxicity, giving more time for populist hate groups to demonise a minority. This is part of a trend of UK governmental bodies abdicating responsibility towards trans people . The EHRC's response to the UK government consultation of conversation therapy is also extremely concerning.
>
> Point 7 in particular appears to grant free-license to perform anti-transgender conversation therapy.
>
> There is already a wealth of evidence that Sexual Orientation and Gender Identity Conversion Efforts are extremely harmful and

> damaging practices. The UN's report on so-called conversion therapy outlines the harms these approaches cause..

## Other LGBTI+ and human rights organisations speaking out

The EHRC statements were also subject to unified outcry across the UK LGBT+ sector. *(If we have missed your organisation from the list of those mentioned here please get in touch with your statement so we can add you to the list.)*

End Conversion Therapy Scotland:

> We note with concern the EHRC letter released today. One point that we are particularly concerned about however, is the suggestion that individuals - including children - can give "voluntary and informed" consent to conversion practices.
>
> All forms of Conversion Therapy and Conversion Practices are based upon the prejudiced notion that being LGBT+ is undesirable and the pseudo-scientific notion that this can be "cured" or "fixed" through often abusive "treatment".
>
> We reiterate our position is that people cannot consent to abuse, torture, and the harm caused by practices that cannot deliver what they promise.
>
> Any ban on conversion therapy must be fully comprehensive.

National Transgender charity Gendered Intelligence said:

> Not only is this disgraceful for a Commission that claims to support equality, it is disrespectful to all survivors of abuse. We owe it to them – past and present – to stop making excuses and stamp out this practice now. According to the EHRC, “more detailed consideration is needed

> before any change is made to the provisions in the [Gender Recognition] Act." How much longer can we consider? We have been waiting five years and two consultations for the Government to fulfil its promises. How long is long enough? Every delay sends a message: transgender people don't count, transgender people aren't valued, transgender people don't deserve rights. Every postponement brings another wave of harassment and discrimination, fuelled by a government who refuse to support the marginalised and the vulnerable.

Trans led campaigning organisation TransActual said:

> TransActual expresses our disappointment at the EHRC's failure, once again, to understand that they need to protect the rights of trans people as well as everyone else... That the EHRC can be so out of line with established, mainstream international views on human rights is an ongoing alarming situation, and further reinforces our view that the Commission has not been fit for purpose for some time.

The Equality Network, a Scottish LGBTI organisation issued the following statement:

> Reform of gender recognition is one of the most consulted-on policies of all time with two comprehensive public consultations by the Scottish Government since 2017. The draft bill was fully consulted on a year ago, and everyone had their say. The EHRC itself responded to both public consultations, supporting reform... Tim Hopkins, director of the Equality Network said, "The EHRC is not independent of government, but has its Board directly appointed by Liz Truss and the UK Government. We assume that their appointees are responsible for this letter and for failing to stand up for equality for trans people. We do not need UK Government appointees telling us in Scotland how to legislate in devolved areas and we look forward to the Scottish Government proceeding with this

> legislation soon, as has been promised many times.

The Trans Legal Project said:

> Like many other LGBT+ organisations we are very frustrated and disappointed by what we have seen from the EHRC tonight. The UK trans community deserves much better than this. We will produce 3 threads on aspects of this. On Conversion Therapy, the EHRC has asked that proposals to legislate to protect trans people be paused. Amongst their incoherent reasons for this position, they implicitly refer to the Bell/Tavistock case – one that concerned consent to medical treatment, not conversion therapy. Further, the Court of Appeal completely demolished the High Court's decision in this case, leaving the law unchanged. Critically also, 20 health counselling and psychotherapy organisations – (ALL expert/major bodies) - banned Conversion Therapy in relation to gender identity in 2017. https://bacp.co.uk/events-and-resources/ethics-and-standards/mou/ Yet the EHRC talks of a 'lack of evidence' in this area. This is clearly rubbish.

Trans women's group Steph's Place said:

> At Steph's Place, we believe the EHRC are in disrepute.
>
> We have been investigating them for many months, sent dossiers to MP's and third parties.
>
> The information we have discovered will be made public very soon.
>
> Have faith.

Mermaids, a charity supporting families of trans children said:

> After years of toxic abuse stemming from the GRA "debate", we say no more. No more pathologising. No more ridicule. No more demonising. We're not asking for much: just respect and recognition, and to be left in peace to get on with living our very ordinary lives. So it's bitterly disappointing to see the EHRC seek to elongate what has been an exhausting and upsetting period of time for our community.
>
> We're extremely concerned to see our equality watchdog specifically suggest protection for trans people should be further delayed, when we know – and Government data illustrates - that trans people are also victims to this form of abuse. There can be no more heel-dragging.

National LGBT charity LGBT Foundation issued a statement saying:

> It is with great sadness and deep regret that LGBT Foundation is severing all ties with the EHRC. The Equality and Human Rights Commission released two statements today... These statements are extremely damaging and cannot be supported under any circumstances. We stand with our peers and are rightly horrified by today's events and reassure the LGBTQ+ community that we will continue to fight for equality and justice in the UK.

National LGBT charity Stonewall said:

> The EHRC has a statutory duty to enforce the Equality Act 2010 and protect equality and human rights across all nine protected characteristics, including sexual orientation and gender reassignment. These statements do the opposite, by actively standing in the way of improving the rights of trans people. The EHRC is also a UN-accredited National Human Rights Institution, and as such is expected to operate according to the 'Paris Principles', which include the commitment to promote and protect all

> human rights and to contribute towards a world where everyone, everywhere fully enjoys their rights.
> We believe today's statements by the EHRC violate these Principles.

Welsh LGBT group Pride Cymru said:

> Pride Cymru condemns the EHRC for its ill-informed and dangerous transphobic stance. Yesterday's statements by the EHRC show an organisation that is failing to discharge their stated aims and stand up for human rights. Its board has rejected sound and researched policy, and endorsed dog whistle transphobia. EHRC is effectively denying the human rights of trans people, influenced heavily by hate groups. We're troubled that the EHRC is no longer fit for purpose, under current leadership. We call on Welsh Government to be a beacon of hope, and deliver on its promises to the trans community.

The Amnesty UK Rainbow Network said:

> We will continue to advocate for the basic rights of our trans and non-binary family. Solidarity always.

National civil rights group Liberty said:

> Full LGBTQ+ equality in the UK is long overdue and so today's announcements from the Equality and Human Rights Commission are beyond disappointing. At a time when the Government is undermining the rights of everyone in the UK, from protest to equal access to voting, we need a regulatory body that stands up for rights and freedoms. The EHRC is doing the opposite. It is putting obstacles in the way of equality by adding further unnecessary delays to vital legislation and undermining the health and well-being of LGBTQ+ people in the process. For the EHRC to make such a damaging intervention calls in to question whether it is

> serving its purpose and Liberty supports the calls for the EHRC's status as a national human rights institution (NHRI) to be reviewed.

LGBT+ anti-abuse charity GALOP said

> Yesterday's statement from the EHRC makes it clear that they have not understood the reality of conversion therapy in the UK. Galop supports LGBT+ victims of this kind of abuse every day, and we have a number of concerns about the effects the EHRC's statement may have on protecting the people we work with. We do need a clear definition of so-called conversion 'therapy' in the upcoming ban – one that recognises the wide range of psychological, physical and sexual abuse that LGBT+ people are subjected to in an attempt to cure, change, or suppress our identities. We must ensure that the ban protects all victims from all backgrounds who are experiencing this abuse, in all its forms. There is no ban for LGBT+ people in the UK that does not include our trans and non-binary siblings. Conversion therapy must be banned because being LGBT+ is not an illness, therefore it is not possible to cure us. If that is true for LGB people, then it is true for trans and non-binary people. The report we launched yesterday showed that our trans and non-binary siblings are disproportionately affected by sexual violence intended to 'convert' or 'punish' them. Sexual violence is only one aspect of what conversion therapy looks like in the UK. It is vital that this ban protects the whole of the LGBT+ community – and leaves no one behind. LGBT+ people should continue to have access to affirming services that support them, and spaces for them to explore their identities. The important difference is that those spaces should not have a pre-determined outcome. Everyone should be supported to come to their own understanding of who they are, and no one should be forced to be someone they're not. We see the significant and long-term effects of so-called conversion therapy on the people we work with. We must not delay the

> implementation of this life-saving law – every day that passes without a ban leaves LGBT+ people unprotected.

The Rainbow Project, a Northern Irish LGBTQIA+ health and wellbeing group said:

> Yesterday's statements from the EHRC are an unwelcome and unwarranted attack on Trans equality. We believe that these two statements (one in response to the call for a ban on conversion therapy and the Gender Recognition Act in Scotland) are actively seeking to exclude Trans people from improved rights and important legal protections. Trans Rights are Human rights. The Comments from EHRC undermine their core purpose of promoting and upholding equality and human rights.

Ban Conversion Therapy Northern Ireland followed, agreeing:

> We support this - please read the thread below!
>
> Trans Rights are Human Rights.
>
> There can be no excuses, no delays and no loopholes in legislation around a ban on conversion therapy.

The Ban Conversion Therapy Coalition stated :

> It should be noted that this recommendation by the EHRC would place England and Wales as international outliers removed from the international consensus of states seeking to protect LGBTQ+ people from conversion practices. During the 4 years of delays, additional research periods and extended consultations that have occurred since the UK Government first promised to ban conversion practices, other countries and states such as France and Canada and Victoria State in Australia have moved ahead and outright banned conversion practices for sexual

> orientation and gender identity. No other comparable country, state, territory, region or city has passed a ban on conversion practices without including gender identity.

National umbrella body Consortium, who represent over 350 LGBT+ member organisations said:

> We have seen incredible strength of feeling from our members, and Consortium share concerns about the statements made by the EHRC.
>
> The statements released yesterday demonstrate an attempt to stall vital legislation, which LGBT+ people have already been waiting on for several years. These delays are unacceptable and undermine the rights of our communities. Any further attempt to further delay legislation in these areas after the extensive consultation which has already taken place is an attack on the rights of LGBT+ people.
>
> Consortium joins with its Member organisations and allies in expressing enormous concerns about this development.
>
> The public has been consulted extensively over many years on both the GRA reform in Scotland, as well as in England and Wales, and a ban on conversion therapy.
>
> The EHRC statement appears to propose that legislation to ban conversion therapy should exclude gender identity. On 26 January 2021, Galop published a report that shows the shocking extent of abuse towards trans people in the name of conversion therapy.
>
> Several other countries and states such as France, Canada and Victoria State in Australia have recently enacted an outright ban on conversion practices.
>
> We stand with all trans and non-binary people – in defending their human rights, dignity and safety.

Engender Scotland responded to the EHRC's letter saying:

> The EHRC has engaged in two consultation processes, and directly with the women's sector, confirming on numerous occasions its previous position. Namely, that the proposed changes to the GRA would have no impact on the existing exemptions in the Equality Act 2010.
>
> The authoritative interpretation of the law on single-sex spaces is set out in the EHRC's own guidance and the Code of Practice on the provision of single (or separate) sex services. This has most recently been robustly reinforced in May 2021, in R (on the application of Authentic Equality Alliance) v Commission for Equality and Human Rights, available here: https://bailii.org/ew/cases/EWHC/Admin/2021/1623.html
>
> The EHRC's letter provides absolutely no legal reasoning for such an abrupt change in their own position, and we ask them to urgently set out the legal basis underpinning this change, if this exists. ...
>
> We are concerned at the repeated attempts to derail the process of making minor reforms to the Gender Recognition Act, which will improve the lives of trans people in Scotland. This only serves as a distraction to the urgency of achieving women's equality in Scotland and will lead to a regression in human rights for all.

Trans In The City UK issued a statement saying:

> Trans In The City has spent several years attempting to engage with the UK Government in a positive conversation around its approach towards trans people.
>
> We have received very little response in our efforts. In the few cases they have responded, it has often been hostile...
>
> In light of this week's events, Trans In The City will not be supporting the Government's "Safe To Be

> Me" conference this summer.

Feminist Gender Equality Network posted a statement saying:

> Following the recent challenge to the UK from the Council of Europe for its inadequate protection of the LGBTI community, leading to an 'extensive and virulent' attack on their rights, it is hugely disappointing to see the Equality & Human Rights Commission (EHRC) supporting further delays to the Gender Recognition Act (GRA) reforms in Scotland. This is based on the views of a small but vocal minority who are actively working against the best interests of trans people.
>
> It is also very concerning to see the EHRC response to the UK Government Consultation on Banning Conversion Therapy, published yesterday. This states that the report lacks clear definitions of the terms 'conversion therapy' and 'transgender', but these both have very straightforward and specific meanings that the EHRC should be able to understand if qualified to comment on the issues in question.
>
> As an organisation defined by its dedication to human rights, the EHRC should be committed to supporting the rights of trans people over and above the ideological resistance of a minority of anti-trans campaigning organisations. The Feminist Gender Equality Network strenuously protest the EHRC attack on the rights of transgender people, and those of the wider LGBTQIA+ community.

The British LGBT Awards stated:

> These statements concerned plans to legislate a ban on conversion therapy in England and Wales, and also discussed the Gender Recognition Act in Scotland, in which the rights and protections of trans and non-binary people were notably absent.

> With countries such as France having recently banned all forms of this horrific practice, we know that a future free of conversion therapy is possible.
>
> We stand with the other organisations in our community that have come together not only to denounce the EHRC's statements, but also for their unfaltering support of the most vulnerable within our diverse family.
>
> Together we can fight this.

LGBT+ Labour issued a statement, saying:

> We share the LGBT+ community's concerns regarding the Equality and Human Rights Commission in the aftermath of their interventions on Wednesday. As Labour members, we are acutely aware of how crucial the proper functioning of the EHRC is. However, it can only be an effective body if it has the confidence of the communities it is supposed to advocate for...
>
> With their recent interventions it is clear that the EHRC has lost the confidence of the LGBT+ community, with LGBT Consortium, LGBT Foundation, Stonewall, the Equality Network, the Rainbow Project, Gendered Intelligence, Mermaids, the Ban Conversion Therapy Coalition, End Conversion Therapy Scotland, Ban Conversion Therapy NI, Amnesty U.K. Rainbow Network and Liberty, all condemning the EHRC's interventions. It is deeply concerning that such a wide variety of LGBT and human rights organisations are losing faith, to the extent that it's role as a National Human Rights Institution is being questioned.
>
> This is all the more worrying when the EHRC is due to be publishing guidance on the operation of single-sex spaces, the moral panic around which has created a deeply hostile environment for trans and non-binary people accessing essential services. The guidance is likely to be challenged and not viewed credibly by our

> communities if the EHRC cannot demonstrate engagement with the LGBT sector.

GIRES UK, a UK Charity supporting trans and gender diverse people, said:

> After reviewing this document, GIRES' trustees felt compelled to call attention to the attempt in this respose to legitimise a wide range of CT practices (as defined by The Cooper Report, which was produced by a cross-party group of MPs, peers, barristers, academics and other experts, chaired by Baroness Helena Kennedy, QC) by suggesting that they should fall outside of the definition to be used in legislation....
>
> It is difficult to imagine a trans-inclusive definition of CT that would not include attempts to "reconcile a person with their biological sex," as a prime example of CT. Indeed, this kind of language also repeats the pro-CT talking point that there is 'insufficent evidence' that CT harms trans people, which is false. Even if this were the true, the burden of proof that a medical intervention does not cause harm is on the provider (e.g. licencing medications), except where inaction has been shown to do harm (consider chemotherapy) – therefore, unless being trans in and of itself constitutes harm (it does not, but the EHRC seem to think it does), this argument does not undermine the necessity and appropriateness of a trans-inclusive CT ban...
>
> We are disappointed, but hardly surprised, by this latest example of the deteriorating quality of the EHRC's output and its ongoing capture by a deeply socially conservative 'gender critical movement'. Trans and gender-diverse people are not yet treated equitably under law, and long-standing human rights protections for trans people are under attack.

LGBT Youth Scotland open letter to Scottish cabinet on the EHRC statement:

> Following the EHRC's letter to you on the 26th of January 2022, we would like to share with you our reaction.
>
> The letter frankly hurt and angered us. After taking time to assess and manage our emotions, we have compiled our thoughts and feelings into this document.
>
> While this "debate" plays politics with our lives, our community experiences significant violence, not just in confined and gendered spaces but online, in the streets and everywhere we go. We believe this is indefensible.
>
> As we see it, the Scottish Government has a choice. It can choose to agree with the advice from the EHRC and continue to fall drastically behind on LGBTQ+ rights. Or it can choose to make meaningful and progressive change, something the Scottish Government was once proud to be at the forefront of and is ostensibly committed to in the current programme for government.
>
> No more waiting, no more consultations, it's already too late for too many. We have suffered enough. We have lost enough of our friends, family and people we never even had the chance to meet.

Manchester Pride issued the following statement:

> We're extremely concerned and disappointed to see the harmful statements released by the EHRC regarding the government's proposed legislation on 'conversion therapy' in England and Wales, and the proposed reform of Scotland's Gender Recognition Act.
>
> The EHRC's statements do not support the human rights of ALL LGBTQ+ people, nor do they promote and support the urgent need for further trans equality in the UK. Trans and non-binary lives are not up for debate.

> Just this week, the Council of Europe singled out and condemned the UK alongside Russia, Poland and Hungary for extensive and consistent attacks on LGBTQ+ human rights, and alarming levels of transphobic prejudice.
>
> Our Inclusivity Development Manager, Dr. Christoper Owen, is currently analysing the EHRC's documents with the view to providing the community with a full and thorough information resource, which we will release in the coming days.

Trans and LGBTQ related Consultancy My Genderation said:

> My Genderation is deeply concerned by the statements by the Equality And Human Rights Commission (EHRC) regarding the proposed GRA reform in Scotland and the proposed legislation on conversion therapy in England and Wales.
>
> The experiences and trauma our community has had to endure has been ignored and pushed aside, and the devastating effects of it only made worse by an institution which in its name should uphold and acknowledge our lives and experiences.
>
> In a film we released in 2013, an older trans man described his experiences of conversion and electro-shock therapy that he had to endure.
>
> His story is one of many, and even today trans people are subjected to modern conversion therapy, where their identities are diminished, suppressed and shamed.
>
> It's shameful and abhorrent that the EHRC chooses to ignore this, and for the government not to take a firm stance with trans people and their rights. The government and EHRC cannot continue to pride themselves of being supporters of LGBTQIA rights when their action, or lack thereof, has shown the complete opposite.

Rainbow Greens - a group of Scottish LGBT+ Green Party Members - said:

> We are disappointed that - after a series of appointments from the Tory Government - EHRC have backtracked on their previous policies to undermine the case for GRA reform and a conversion therapy ban.
>
> We do not have faith in them to uphold and protect equality and human rights.

UK Black Pride issued a statement on Twitter saying::

> We stand with our trans siblings and we join Stonewall in calling for the UN Office of the High Commissioner for Human Rights and the Global Alliance of National Human Rights Institutions to urgently review EHRC and ensure that trans people's rights are effectively supported.

Albert Kennedy Trust, a charity for homeless LGBT+ youth wrote:

> On 26 January 2022, the Equality and Human Rights Commission (EHRC) released two statements in response to legislative plans to ban conversion therapy in England and Wales, and Gender Recognition Act reform in Scotland. The statements and its recommendations represent a disappointing and continued disregard for our communities. The calls for delays in legislation is a move that prevents LGBTQ+ people from accessing improved rights and protections.
>
> Our report found that one in six LGBTQ+ young people were forced to commit sexual acts against their will by family members before they became homeless. Whilst not explicitly stated, many of these young people will have been subjected to some form of 'conversion' therapy. We are failing to protect these young people if we choose to delay legislation to end this abhorrent practice once and for all. 40 percent

> of our service users identify as trans or non-binary and our report showed how trans young people experiencing homelessness were more likely to have faced abuse.
>
> 74 percent of young trans people said their family members repeatedly belittled them to the extent that they felt worthless before they became homeless. The discrimination that trans young people face does not end when they leave home. One in five young trans people stated they faced discrimination when accessing support because they were trans, and the same number had experienced misgendering or deadnaming while accessing services. We should be looking at ways to improve support available to trans people not creating a sense of distrust in the community as to whether institutions will protect their human rights. We stand in solidarity with our community and will be signing an open letter with other LGBTQ+ organisations to the ERHC and we encourage others to do so.

Black Trans Alliance CIC wrote:

> Friends, Family and Allies - Please don't let the EHRC leave us behind. Help fight for #transequality Transgender flag Sign Stonewall's Open Letter! #transrights

Trans Radio UK wrote:

> Trans Radio UK is a community led organisation that cares deeply about the whole LGBTQ+ community. Proud to have presenters and listeners alike from all aspects of the community and beyond, we strive for equality and rights for all. Trans Radio UK are extremely saddened and concerned to have seen the latest harmful statements given by the EHRC. We stand firmly beside all the fantastic LGBTQ+ organisations who have also now condemned the EHRC statements.

> Trans Radio UK will continue to stand up and speak out against any acts of aggression towards the LGBTQ+ community, and will not condone any form of transphobia, wherever it may come from, no matter whether the public or the Government.
>
> #UnSafeToBeMe

LGBT training and guidance group Blossom LGBT said:

> We believe that everyone regardless of their gender identity or gender expression should be entitled to live safe and happy lives. We believe the actions by the EHRC are transphobic and raise concerns of the significant risk to wellbeing, health & lives of trans people in the UK.

Stonewall Housing published a statement saying:

> So-called Conversion Therapy is abuse. Every day we work with people who have experienced these barbaric practices and we know the real impact they can have on LGBTQ+ communities in the UK and throughout the world.
>
> EHRC's statement will have a significant detrimental effect on our service users, colleagues, friends and supporters.
>
> We stand in solidarity with so many of our partners in the LGBTQ+ sector and are proud to sign Stonewall's open letter calling for the inclusion and protection of trans rights.
>
> Stonewall Housing will not attend the 'Safe To Be Me' conference or any space that is not safe and inclusive of the trans community.

Amnesty International UK condemned the EHRC saying:

> On the recent statements published by the Equality and Human Rights Commission on the governments' consultation on conversion

> therapy, Amnesty International UK disagree unreservedly in the EHRC's assessment of separating protections for LGBTI people and specifically excluding trans people from initial legislation.
>
> These statements are actively damaging to the rights of trans and non-binary people in the UK, and we find them to be disappointing and deeply troubling.
>
> We encourage the UK and Scottish Governments' to continue to show commitment and leadership on human rights by delivering on their commitments to reforming the Gender Recognition Act and introducing a comprehensive legislative ban on conversion therapy that protects the whole of the LGBTI community, including those who are trans and non-binary.
>
> We stand in solidarity with our partners in the LGBTI sector.

Birmingham Pride issued the following statement:

> The two statements made this week by EHRC regarding the banning of 'conversion therapy' in England and Wales and the reform of the Gender recognition Act in Scotland effectively excludes the trans community from the protection and rights to which they are entitled.
>
> The UK, along with Russia, Hungary and Poland have been rightly accused of infringing the human rights of its LGBTQ+ communities and of transphobia by the Council of Europe. Having had sufficient time for consultation, the two statements ask for further, unnecessary delay. We have waited long enough. We call on Boris Johnson, Nicola Sturgeon to provide leadership and to recognise and protect the rights of the Trans community without further delay or hindrance.

@trans_safety · @transsafetynetwork

UK

# ‘Every major LGBT+ charity’ calls for disgraced equalities watchdog EHRC to be downgraded

LILY WAKEFIELD | FEBRUARY 11, 2022

SAVE FOR LATER



EHRC chair Baroness Kishwer Falkner. (Sky News)

Privacy

1209

2574

**show that the UK's Equality and Human Rights Commission (EHRC) is no longer "credible" or "fit for purpose".**

Over the last few weeks, evidence has been piling up against the supposedly independent equalities watchdog, as it recommended halting gender recognition reform in Scotland, and advised that a ban on trans conversion therapy be delayed.

Leaks have revealed how the EHRC has met with anti-trans lobby groups, and the body has seen an exodus of staff, with workers describing how it has become "transphobic" and "the enemy of human rights".




On Thursday (10 February), it was reported that the EHRC has worked on draft guidance advising that trans people who do not hold a Gender Recognition Certificate (which is more than 99 per cent of trans people) should be excluded from single-sex spaces. The EHRC has denied any knowledge of the draft, which was seen by *Vice World News* and, the outlet said, aligned with a second document seen by the Good Law Project.

The Good Law Project and Stonewall, along with many LGBT+ rights groups, is now calling for the EHRC to lose its 'A' status, meaning it would no longer be able to make representations at the UN Human Rights Council.

On Friday (11 February) Stonewall announced that it had submitted an extensive dossier of evidence to the UN and Ganhri, a human rights network which "strengthens NHRIs [National Human Rights Institutions] to operate in line with the Paris Principles".

NHRIs are expected to operate independently of government, and to receive an 'A' status from the UN, they must abide by the Paris Principles which outline the role and functions of such an institution.

In a statement, Stonewall said: "We believe that recent statements made by the Equality and Human Rights Commission (EHRC), Great Britain's NHRI, indicate that they can no longer be considered compliant with the Paris Principles, and are no longer fit for purpose as a National Human Rights Institution."

The submission of a 19-page dossier of evidence, the organisation said, was "prompted by the EHRC's recent, and significant, change in stance on the issue of trans rights".

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"The EHRC's stance seeks to strip trans people of legal protections, and pose a grave threat to the ability of trans people to participate in daily life with dignity and respect."

The dossier "outlines substantial evidence that reveals the numerous ways the EHRC now finds itself falling short of international standards", it said.

## Liz Truss is responsible for EHRC appointments

The commissioners of the EHRC are appointed by minister for women and equalities Liz Truss, herself widely criticised for killing reforms to the Gender Recognition Act. In 2020, Truss named Baroness Kishwer Falkner as chair of the commission.

Since her first interview after being appointed chair, Falkner has been open about her determination that the EHRC should protect "freedom of belief", including "gender critical" beliefs, and has said that it is "entirely reasonable" to question trans people's gender identity.

The EHRC is supposed to be independent, but Stonewall said its dossier "outlines a 'complete absence' of financial autonomy from the UK government, and cites 'excessive' governmental interference – including 'politically motivated' appointments to the chair and board, many of whom have repeatedly and publicly demonstrated their opposition to the expansion of human rights, and whose appointments have drawn widespread criticism from NGOs".

While its signatories "accept that UK Government policy changes based on their democratic mandate", NHRIs like the EHRC "should operate according to the principle of acting independently, free from political inference, and focus on upholding international human rights standards regardless of the politics of the day".

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Jo Maugham, director of the Good Law Project, wrote on Twitter: "The EHRC should lose its status as an 'A' rated UN Human Rights Institution and, I have some confidence, will.

"It has become a tool of government where it should be independent. Having that status removed would be an international humiliation that would, rightly, mark the disastrous nature of Liz Truss's tenure as notional equalities minister."

Trans rights group TransActual said in a statement: "The EHRC is walking away from its duties to uphold basic human rights for trans and non-binary people. It no longer commands our confidence, and we fear what it now intends.

"It will take some strong and swift actions to convince us that it is on our side, actions we no longer think it is capable of."

The EHRC told *PinkNews* in a statement: "We take all decisions impartially, based on evidence and the law, both in the UK and internationally. Our independence is guaranteed in statute.

"All appointments to our non-executive and executive roles are made through a fair, open and transparent recruitment process. The way the commission is governed and commissioners appointed is set out in the Equality Act and has not changed since the commission was established.

"Our statutory mandate and role as a National Human Rights Institution is to protect and promote equality and human rights for everyone – and that includes trans people.

"Where rights may conflict, our role is to advise on striking an appropriate balance. We uphold fairness for all, and our work is rigorous and impartial."

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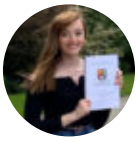
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CIVILSOCIETY news

# LGBT Foundation cuts ties with equalities watchdog

28 Jan 2022 News



**Sam Wait**
**114 articles**
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LGBT Foundation has severed all ties with the Equality and Human Rights Commission (EHRC), with the charity saying recent statements were “extremely damaging”.

EHRC had called for “more detailed consideration” on the proposed reforms to the Gender Recognition Act in Scotland.

Proposed reforms to the Gender Recognition Act in Scotland would simplify the process trans people go through to obtain legal recognition of their gender.

The process of gaining a Gender Recognition Certificate (GRC) can take up to five years. It requires a medical diagnosis of body dysphoria and that the trans individual live in their acquired gender for two years.

LGBT Foundation has said this causes trans people “unnecessary trauma”, and by not agreeing with the proposals to change them “EHRC can no longer call itself a true human rights organisation”.

In a second statement EHRC called for more research into conversion therapy, further delaying a proposed ban on the practice.

“It is with sadness and deep regret that LGBT Foundation is severing all ties with the EHRC,” LGBT Foundation said.

Stonewall, Mermaids, Pride Cymru and The Rainbow Project are among the LGBTQ+ charities that have openly disagreed with EHRC’s stance on the matters.

## ‘Attack on trans equality’

EHRC is a non-departmental public body that was established in 2007 to promote equality and non-discrimination laws in England, Scotland and Wales.

The equality regulator voiced several concerns about changing the criteria that allows an individual to have a GRC. It says this is because of the potential implications “relating to the collection and use of data, participation and drug testing in competitive sport, measures to address barriers facing women, and practices within the criminal justice system, inter alia”.

Stonewall responded by calling it an “attack on trans equality” and has created an open letter calling on the UK prime minister Boris Johnson and Scotland's first minister Nicola Sturgeon to stand up for trans rights. Within 24 hours, the letter has almost 2,000 signatures.

In its statement, Stonewall said: “We are deeply troubled by the approach that the EHRC is taking to trans people’s human rights. Their approach appears to focus on pleasing a noisy minority of anti-trans activists, rather than promoting human rights for all LGBTQ+ people.”

## ‘Heel dragging’ on progress

Trans and gender diverse charity Mermaids also released a statement on EHRC’s position: “We're extremely concerned to see our equality watchdog specifically suggest protection for trans people should be further delayed, when we know – and government data illustrates - that trans people are also victims to this form of abuse. There can be no more heel-dragging.”

Pride Cymru said it “condemns the EHRC for its ill-informed and dangerous transphobic stance” and argued the regulatory body’s position was endorsing “dog whistle transphobia”.

“We’re troubled the EHRC is no longer fit for purpose,” Pride Cymru continued.

Trans-led charity Gendered Intelligence also expressed outrage at EHRC’s statement: “We have been waiting five years and two consultations for the government to fulfil its promises. How long is long enough?

“Every delay sends a message: transgender people don’t count, transgender people aren’t valued, transgender people don’t deserve rights. Every postponement brings another wave of harassment and discrimination, fuelled by a government who refuse to support the marginalised and the vulnerable.”

## A significant change in position

Scottish National Party (SNP) leader Nicola Sturgeon expressed concern about EHRC’s calls to delay the process further yesterday.

“This actually represents a significant change in position of the Equalities and Human Rights Commission,” Sturgeon said.

When previous drafts of the Scottish Government’s consultations occurred in 2017 and 2019, EHRC largely agreed that the process of gaining a GRC was traumatic.

“This is a bill that is designed to simplify an existing process, to reduce the distress, the trauma and anxiety and often the stigmatisation that trans people suffer in our society,” Sturgeon said.

## LGB Alliance response

The LGB Alliance welcomed the EHRC’s decision.

The charity is the subject of a legal challenge about whether it should have been able to register as a charity, despite inflammatory language when discussing trans rights.

In a statement it said: “Yesterday, @EHRC wrote to the Scottish Government expressing concerns over plans for reform of the Gender Recognition Act. We are pleased to co-sign this joint statement today in support of the EHRC's stance, and urge @scotgov to reconsider.”

For more news, interviews, opinion and analysis about charities and the voluntary sector, sign up to receive the Civil Society News daily bulletin here.

**Contact us**

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# Stonewall response to EHRC statements on upcoming LGBTQ+ legislation

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BY STONEWALL STAFF

PUBLISHED 26 JANUARY 22

NEWS MEDIA STATEMENTS

Today's statements from the EHRC are an attack on trans equality and undermine EHRC's core purpose of regulating, promoting and upholding human rights.

We believe the EHRC is no longer fit for purpose. Sign our petition in support of trans rights.

The two statements – in response to plans to legislate for a ban on conversion therapy in England and Wales, and Gender Recognition Act reform in Scotland - effectively seek to exclude trans people from improved rights and protections.

They disregard findings from the UK Government's own research and the largest ever survey of LGBTQ+ people in the UK, as well as the expert opinion of the UN Independent Expert on Sexual Orientation and Gender Identity on conversion therapy and gender recognition.

In these statements the EHRC is calling for further delays to legislation that our communities have been waiting on for many years. In both cases the UK Government and Scottish Government have given ample opportunity for consultation.

And so **we urge both the Prime Minister of Great Britain and Northern Ireland, and First Minister of Scotland, to continue showing leadership to recognise and protect trans people, and progress rights for our communities by supporting these key pieces of legislation.**

We are deeply troubled by the approach that the EHRC is taking to trans people's human rights. Their approach appears to focus on pleasing a noisy minority of anti-trans activists, rather than promoting

human rights for all LGBTQ+ people.

The EHRC has a statutory duty to enforce the Equality Act 2010 and protect equality and human rights across all nine protected characteristics, including sexual orientation and gender reassignment. These statements do the opposite, by actively standing in the way of improving the rights of trans people.

The EHRC is also a UN-accredited National Human Rights Institution, and as such is expected to operate according to the 'Paris Principles', which include the commitment to promote and protect all human rights and to contribute towards a world where everyone, everywhere fully enjoys their rights.

We believe today's statements by the EHRC violate these Principles.

This comes as the UK is named as a country of concern in a resolution by the Council of Europe, in which the General Rapporteur on LGBT+ Rights raised concerns about the growth in "highly prejudicial anti-gender, gender-critical and anti-trans narratives which reduce the fight for the equality of LGBTI people to what these movements deliberately mischaracterise as 'gender ideology' or 'LGBTI ideology'."

Our communities need and deserve a stronger human rights institution. **Stonewall calls on the UN Office of the High Commissioner for Human Rights and the Global Alliance of National Human Rights Institutions to urgently review EHRC and ensure that trans people's rights are effectively supported by this institution.**

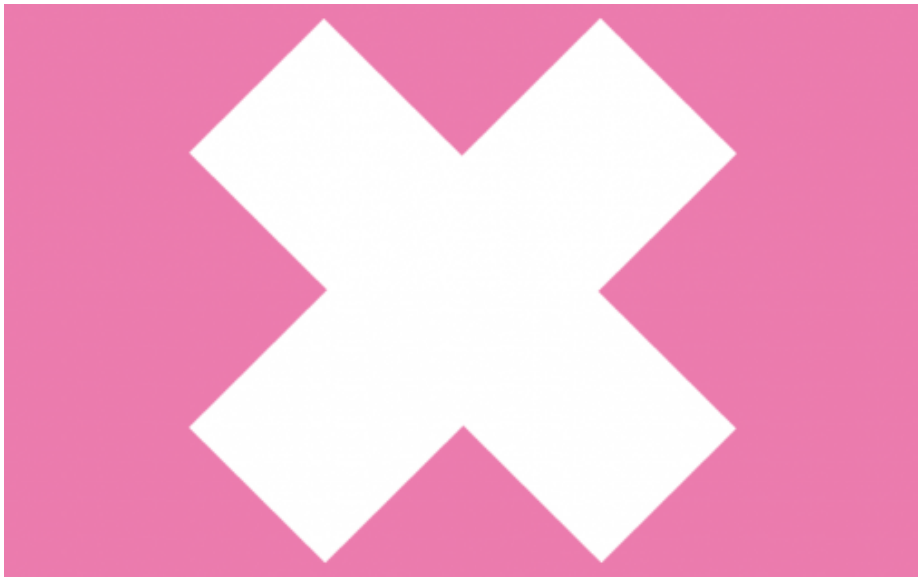
## We believe the EHRC is no longer fit for purpose. Sign our petition in support of trans rights.

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We'd love to show you how your support is helping LGBTQ+ people everywhere to thrive. We need your consent to share news, campaigns, events and ways in which you can further support this important work.

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# Organisations unite to praise the EHRC




Twenty different campaigning groups from across the UK have come together in a statement of response on the Equality and Human Rights Commission's recent communications – with the UK Government about conversion therapy and with the Scottish Government about reform of the Gender Recognition Act.

The EHRC has come under fire for its statements from groups that do not recognise that protecting human rights requires balancing the interests of people with different characteristics. Our statement praises them for sticking with their mandate of promoting everyone's human rights.

# to the EHRC intervention

The Equality and Human Rights Commission's response to the UK Government's Consultation on conversion therapy and its letter to the Scottish Government about reform of the Gender Recognition Act are a breath of fresh air.

The Commission has called for careful and respectful discussion of potential changes to the law and asked all Governments to take the time needed to ensure that definitions are clear, and that the policy is evidence-based.

The EHRC's mandate is to challenge discrimination, and to protect and promote everyone's human rights. LGB (lesbian, gay and bisexual) and women's grassroots organisations have for the last few years been raising the alarm at policies, advocated by gender identity activists, which only recognise the rights of one group.

Protecting human rights often means balancing the interests of people with different protected characteristics. Legislators and regulators must listen to the views of all and not favour a particular lobby or allow one group's interests to destroy the rights of others. As the EHRC have stated, the established legal concept of sex is a critical underpinning to all our rights; including those of LGB people, women and people who identify as transgender.

The EHRC has clearly listened to our voices. For this we thank the Commission. For our part we will continue to lobby all Governments to focus on what any good law requires – open debate, broad consultation, human rights impact assessments, clear language and proper regard for evidence.

**Signed**

LGB Alliance, Merched Cymru, Fair Play for Women, Transgender Trend, Conservatives for Women, AEA, Safe Schools Alliance, FiLiA, Sex Matters, LGB Alliance Cymru, Labour Women's Declaration Working Group, For Women Scotland, Lesbian Labour, LGB Alliance Scotland, Women's Equality Party Sex-Based Rights Caucus, Women Uniting, Lesbian Fightback, Liberal Voice for Women, Woman's Place UK, Green Feminists

Filed under Healthcare Legal system Updates

Tags: Conversion therapy, Equality and Human Rights Commission






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**31 January 2022**

# Statement in response to the EHRC intervention

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## Signed

LGB Alliance, Merched Cymru, Fair Play for Women, Transgender Trend, Conservatives for Women, AEA, Safe Schools Alliance, FiLiA, Sex Matters, LGB Alliance Cymru, Labour Women's Declaration Working Group, For Women Scotland, Lesbian Labour, LGB Alliance Scotland, Women's Equality Party Sex-Based Rights Caucus, Women Uniting, Lesbian Fightback, Liberal Voice for Women, Woman's Place UK, Green Feminists



**James Dreyfus** 🇺🇦 ✓
@DreyfusJames

2 day hangover.
TWO FLIPPING DAYS...
A magnificent conference by @ALLIANCELGB , respectful, reasoned debate. Gay men, lesbians, bi, trans & straight...ALL THERE!

Anyone who continues to try & sell you the huge LIE that this is a 'h*te group' is either being wilfully ignorant..1

12:16 PM · Oct 23, 2021 · Twitter for iPhone



**Michelle Shipworth**
@MShipworth

Replying to @DeirdreReneeNW @ProfAliceS and 4 others

I watched all the LGB Alliance conference speeches & have read huge amounts of the websites of SexMatters & FairPlayForWomen. Genuinely, there is no hate there. I see & hear compassion for all.

11:17 PM · Feb 23, 2022 · Twitter Web App



**Dr Viv Pointon, angry woman** 🇪🇺💜🤍💚🦕🦙
@VPointon

Replying to @Jebadoo2

I'm so grateful for the LGB Alliance. The conference felt like we'd been reborn.

7:33 PM · Dec 29, 2021 · Twitter for iPad



**WomenSpeakScotland**
@womenspeakscot1

This was worth waiting for! The final session from @ALLIANCELGB conference in October. Fantastic contributions from @simonjedge @jo_bartosch @JNHanvey @DreyfusJames - just brilliant. #SexNotGender




youtube.com
Session 4: The Way Forward
We've arrived at a point where, after decades of fighting for our rights as people who are same-sex attracted, we are no...

11:57 PM · Dec 18, 2021 · Twitter Web App



**David Bridle**
@Pomegranate2021

Thoughtful post-@ALLIANCELGB Conference piece for LGN by @RadFem_KatH: “Whilst seemingly harmless, the loss of our spaces in reality means more LGB people feel isolated, and cannot find others with whom they can discuss their experiences or find support…




3:54 PM · Oct 28, 2021 · Twitter Web App



**KatieW** 🦕🦕🦕🦕🦕🦕🏴
@adarcymraeg

Replying to @BluskyeAllison and @NessNag

Very Happy New Year Allison. Your fab speech at the LGBAlliance conference still rings in my ears, heartwarming and inspirational.xx

11:42 PM · Dec 31, 2021 · Twitter Web App



**Ellie Heretic KPSS**
@EllieHeretic

Replying to @Jebadoo2 and @treekahlo

I wasn't at the Conference, but I feel so much more optimistic, since.
It was lovely to see you all having a great time.
As a veteran of the fight for Gay Rights,
I feel proud to fight, alongside such intelligent, compassionate, brave, principled people

7:57 AM · Oct 24, 2021 · Twitter for iPad



**Mr Alex Bloodfire, Esq 💙🦕🦖 #SayNoToSelfID 🎄🎄**
@alexbloodfire

Replying to @DreyfusJames @DebbieHayton and @ALLIANCELGB

A massively brilliant conference from the pro LGB charity - LGB Alliance and I'm getting ready and prepared for LGB Alliance Conference 2022!!!

There was a good proper debate!

It was a pleasure to chat with you James!

8:19 PM · Oct 23, 2021 · Twitter Web App

**Riot Grrl**
@RiotGrrl19

Post the @ALLIANCELGB conference on Thursday it's reminded me how deeply important it is to NEVER backdown to bullies. Bullied all through my schooling life, those scars never leave. We know who the bullies are. 👊💥👊 Enough is enough! #IStandWithCeri 🔥🔥grahamlinehan.substack.com/p/ceri-black-t...




7:34 PM · Oct 23, 2021 · Twitter Web App

1235



**Tiberius Kirk** 🇬🇧
@TibbyKirk

@ALLIANCELGB Conference has been a triumph. A joyful, welcoming celebration of sex and same-sex issues with open, free and incredibly intelligent discussion and debate. Outstanding speakers that lay to waste any hint of hate within this noble, new organisation.

10:30 AM · Oct 23, 2021 · Twitter Web App



**Karldin**
@karldinmanfor

Replying to @ALLIANCELGB

Glad to see so many of my twitter mutuals attend your conference. You guys are doing really good, important work. Keep leading the way; you're inspiring people from all over the world to speak out and draw the line.

5:16 PM · Oct 22, 2021 · Twitter for Android


AliceB
@AYomTov
Sat on the train home after yesterday's brilliant @ALLIANCELGB conference, wearing my lovely new hoodie. No better testimony to the day than having a man go past and, seeing the logo, say "great day, wasn't it?" We are everywhere ...
9:44 AM · Oct 22, 2021 · Twitter for iPhone
94 Retweets
4 Quote Tweets
1,368 Likes



**Alexander Bramham** 🇬🇧🦕
@BramhamAlex

Replying to @AYomTov and @ALLIANCELGB

I just popped into a cafe morning after and bumped into two familiar faces. Message of inclusion, community and respect is winning.




10:54 AM · Oct 22, 2021 · Twitter for iPhone

**4** Retweets **127** Likes



**Emma Harriet Nicholson** @Baroness_Nichol · Oct 21, 2021

Today with Dr Az @ALLIANCELGB and @LesbianLabour and a huge crowd this morning at coffee break ☕☕☕☕☕



15 32 611



**Iris_I Am Woman** 🇪🇨 🇬🇧

@Ecuadorian_Mum

Replying to @Baroness_Nichol @ALLIANCELGB and @LesbianLabour

Such a happy picture. Hope you had a great time x

9:29 PM · Oct 21, 2021 · Twitter for iPad

**9** Likes

**Safe Schools Alliance**
@SafeSchools_UK

We had a fantastic day yesterday at @ALLIANCELGB conference. We feel really privileged to have been invited to attend & our spokeswoman be given the opportunity to speak about child #safeguarding. There was a fantastic line up speakers #LGBAlliance2021 #LGBT #edutwitter #WomenEd




12:11 PM · Oct 22, 2021 · Twitter for iPhone

**21** Retweets **169** Likes

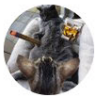


**Helen Saxby**
@helensaxby11

Congratulations on your successful conference LGB Alliance @ALLIANCELGB - from the pictures it looks like it was enthusiastic and joyful and all about the love 😘
#LGBAlliance2021

9:07 AM · Oct 22, 2021 · Twitter for Android

**4** Retweets **39** Likes



**FPL_Dave**🟥
@Klopps_mug

Lovely pictures from the LGB Alliance conference yesterday, it's a long time since Section 28 was over turned, but 2003 doesn't seem that long ago when written down. Today, they have a new fight and I stand with them

7:45 AM · Oct 22, 2021 · Twitter for Android



**Simone C. Bacchini.**
@curzio70

I wish @ALLIANCELGB the best for their conference today. Sorry I can't be there. You are now the only organisation in the U.K. fighting for the rights of lesbians, gays, and bisexuals and affirming the reality of sex and same-sex attraction. Bon courage!

7:44 AM · Oct 22, 2021 · Twitter for iPhone

**Truth and Beauty** 🦕👩‍🎨🐐
@trashalou

I am delighted the @ALLIANCELGB has rec'd this letter of support from Downing St and the presence of so many MPs. I note it sits in contrast w the public support of politicians for the FILiA conference the previous week.

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our "incredible hard work" from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇



10 DOWNING STREET
LONDON SW1A 2AA
www.gov.uk/number10

Head of the Direct Communications Unit

20 October 2021

**Gender Atheist** 🥬🥛🍆
@gayfeministally

Thank you @ALLIANCELGB team for putting together a brilliant #LGBAlliance2021 conference. Exactly the positive, energetic, loving event that we all needed. The venue was an inspired choice. Those of us who want both LGB rights and women's rights are inspired and strengthened. x

11:37 PM · Oct 21, 2021 · Twitter for Android

1242



**John James**
@JohnJamesTV

Congratulations on an historic conference @ALLIANCELGB!

The days of Stonewall speaking on behalf of lesbians, bisexuals and homosexuals are over.

LGB Alliance are here to stay x

#LGBAlliance2021 #LGBAlliance #LGBA

11:07 PM · Oct 21, 2021 · Twitter for iPhone

**22** Retweets **4** Quote Tweets **184** Likes



**Maureen O'Hara**
@OHaraMaureen9

Great speech from @jo_bartosch at LGB Alliance conference today:




thecritic.co.uk
The way forward | Josephine Bartosch | The Critic Magazine
Below is an extract from Jo Bartosch's speech at the LGB Alliance Conference, 21 October 2021 I want to talk about pride and about shame. I have never been...

10:28 PM · Oct 21, 2021 · Twitter for Android

1244



**Dr Viv Pointon, angry woman** 🇪🇺💜🤍💚🦕🦙
@VPointon

Absolutely amazing day at @ALLIANCELGB conference. Fabulous to talk to Rosie Duffield, Jo Cherry and James Dreyfus. And so many more familiar faces, friends old and new. The bonus was meeting Ann McManus, writer of Bad Girls.

9:57 PM · Oct 21, 2021 · Twitter for iPad

**2** Retweets **153** Likes



**Aphrodite Philomeddes**
@philomeddes

Today's @ALLIANCELGB conference was fab. Tanya Carter for @SafeSchools_UK gave a brilliant speech. Neale Harvey asked in whose interest is it to erode child safeguarding?
@jo_bartosch got a standing ovation and was a straight taking and fabulous as ever.
Great day.

9:35 PM · Oct 21, 2021 · Twitter Web App

**20** Retweets **1** Quote Tweet **143** Likes



**Ian Acheson**
@NotThatBigIan

Very interesting evening at the @ALLIANCELGB conference with @NoXYinXXprisons who is doing so much to protect women's rights in custody. Banging tunes too,  as the youth might say.

9:22 PM · Oct 21, 2021 · Twitter for Android

**1** Retweet **10** Likes



**Baron Stuart Rutherford** 🌻🇺🇦🦕💙🟩⬜🟪🦖🦋
@doodlewhale

Can we have an @ALLIANCELGB conference every day? I've cried tears, mostly of joy, reading the stories coming out of the event and seeing the huge support on and offline. I am awash with hope. 🌱

#LGBAlliance2021

8:57 PM · Oct 21, 2021 · Twitter for iPad

**1** Retweet **9** Likes



**deb** 💜🤍💚🇺🇦
@nomadawn68

To all the amazing women and men at the fabulous @ALLIANCELGB conference, hope you are having an absolute ball this evening 🎪🥂🍾🍻🎉
P.S. please look after @DreyfusJames he's a wild one 🕺
#LGBAlliance2021

8:19 PM · Oct 21, 2021 · Twitter for Android

**1** Retweet **24** Likes



**Neale Hanvey MP** ❤️🏴‍☠️✊ 

@JNHanvey

Delighted to finally catch up with the wonderful @DebbieHayton in person at @ALLIANCELGB conference today

#CourageCallsToCourageEverywhere




7:49 PM · Oct 21, 2021 · Twitter for iPhone

**57** Retweets **6** Quote Tweets **771** Likes

1248

2613



**Tony Guillan**
@TonyGuillan

What an inspiring day listening to inspiring people @ALLIANCELGB conference. Passion, and compassion, grounded in the biological and social realities faced by us all, differently. I wanted to say to the protesters - come in, and listen. There is another way #LGBAlliance2021




7:32 PM · Oct 21, 2021 · Twitter for Android

**11** Retweets **139** Likes



**Charlotte Edwards** 🦖🤍💜
@rafaellacj

So thrilled to meet @RosieDuffield1 at the @ALLIANCELGB conference!



7:16 PM · Oct 21, 2021 · Twitter for iPhone

**7** Retweets **341** Likes

1250



**Samira #IndyWales #EndFGM**
@abdisamira1

Congratulations to @ALLIANCELGB on their 1st conference. Hoping next year @LGBAllies_Cymru can hold one in Wales #LGBACymru2022 ✊🏾

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Well this is a good result for a day's work. "Boris Johnson backs Kathleen Stock and LGB Alliance"
>
> thetimes.co.uk/article/bcd547...

6:57 PM · Oct 21, 2021 · Twitter for iPhone



**Problem Being** 🏴‍☠️🇭🇰🇮🇱🇬🇧🇨🇦✡️
@BeingProblem

Replying to @ALLIANCELGB and @BluskyeAllison

So pleased you managed to have such a successful conference. I so wish. I could have been there with you.

6:52 PM · Oct 21, 2021 · Twitter for iPad



**LesbianStrength**
@StrengthLesbian

Congratulations to LGB Alliance for their wonderful conference.

6:46 PM · Oct 21, 2021 · Twitter for Android

**4** Likes

**Here to read**
@Soph33761225

@ALLIANCELGB amazing conference! What a line up! Such incredible speakers, so much positive energy and such a lot of hope for the future. Thanks for organising - here's to next year! #LGBAlliance2021

6:34 PM · Oct 21, 2021 · Twitter Web App

**1** Like



**Dr Sarah Rutherford**
@sarahrutherfor2

I had the pleasure of listening to these three politicians speak this afternoon @ALLIANCELGB conference showing that female solidarity extends beyond party lines. Thank you @JackieDP @RosieDuffield1 and @joannaccherry

> **Nicky Edwards** @NickyEdwards · Oct 21, 2021
> I'm really grateful to my sisters here @JackieDP @RosieDuffield1 and @joannaccherry looking out for each other in Parliament and beyond @ALLIANCELGB




6:30 PM · Oct 21, 2021 · Twitter for iPhone

**4** Likes

1253

**FiLiA**
@FiLiA_charity

What a conference!

Thanks to @ALLIANCELGB for making it possible.

#NoDebate is extinct

#LGBAConference #LGBA2021




5:22 PM · Oct 21, 2021 · Twitter for Android

**55** Retweets **221** Likes



**Sean McGrath**
@SeanMcG53

@ALLIANCELGB .. an excellent conference today at QE2 Westminster .. brilliant & inspiring speakers Joanna Cherry, Graham Linehan Maya Forstater..Sinead Watson..Allison Bailey ...thank you @BevjacksonAuth & Kate Harris... 👍👍👍🏳️‍🌈




5:08 PM · Oct 21, 2021 · Twitter for iPhone

**2** Likes



**slightlyatsea (Deb) 💙NHS**
@slightlyatsea

Love and support to everyone at the LGB Alliance conference today. ❤️

> **Sam Morgan** @CrunchAlias · Oct 21, 2021
> Replying to @PpoliticsForAll
> The LGB Alliance have had to put up with a torrent of abuse for not caving in to the redefine of homosexuality to homogenderality. They deserve praise for being the only remaining charity in the UK which officially supports and campaigns for homosexuals.

4:12 PM · Oct 21, 2021 · Twitter Web App

**1** Retweet **9** Likes



**Anne Jenkin**
@Baronessjenkin

Me too 👇 . @ALLIANCELGB conference great speakers and great atmosphere. Good to see half a dozen @Conservatives colleagues from @UKHouseofLords and @UKParliament there too.

> **Philip Hunt** @LordPhilofBrum · Oct 21, 2021
> Delighted to have joined this important conference twitter.com/LesbianLabour/...

4:12 PM · Oct 21, 2021 from London, England · Twitter for iPhone

**7** Retweets **35** Likes

**Genspect**
@genspect

Congratulations @ALLIANCELGB and best wishes for a productive conference today !

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our “incredible hard work” from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇



10 DOWNING STREET
LONDON SW1A 2AA
www.gov.uk/number10

Head of the Direct Communications Unit

20 October 2021

**Claire Fox**
@Fox_Claire

This #CancelCulture panel debate at @ALLIANCELGB conference is humbling and inspiring in England measure. Free speech really does matter. It's a visceral feeling in the room.

> **Claire Fox** @Fox_Claire · Oct 21, 2021
> Brilliant, shocking, funny and self-effacing speech by @Pomegranate2021 on how #CancelCulture works, how it fuels cowardice and disloyalty. BUT in the end, it can also inspire bravery, create new networks of solidarity, even spawn new journalism. We shall overcome.

3:46 PM · Oct 21, 2021 from London, England · Twitter for Android

**7** Retweets **46** Likes



**Pink_CarbonUnit**
@PCarbonunit

Listening to @Pomegranate2021 at the conference. I cannot believe the @THTorguk removed a VITAL HIV drive from @BoyzMagazine within moments of David's tweet neutrally welcoming @lgballiance!

It leaves an indelible mark on THT. As a HIV man of 21 years I will NEVER FORGIVE YOU.

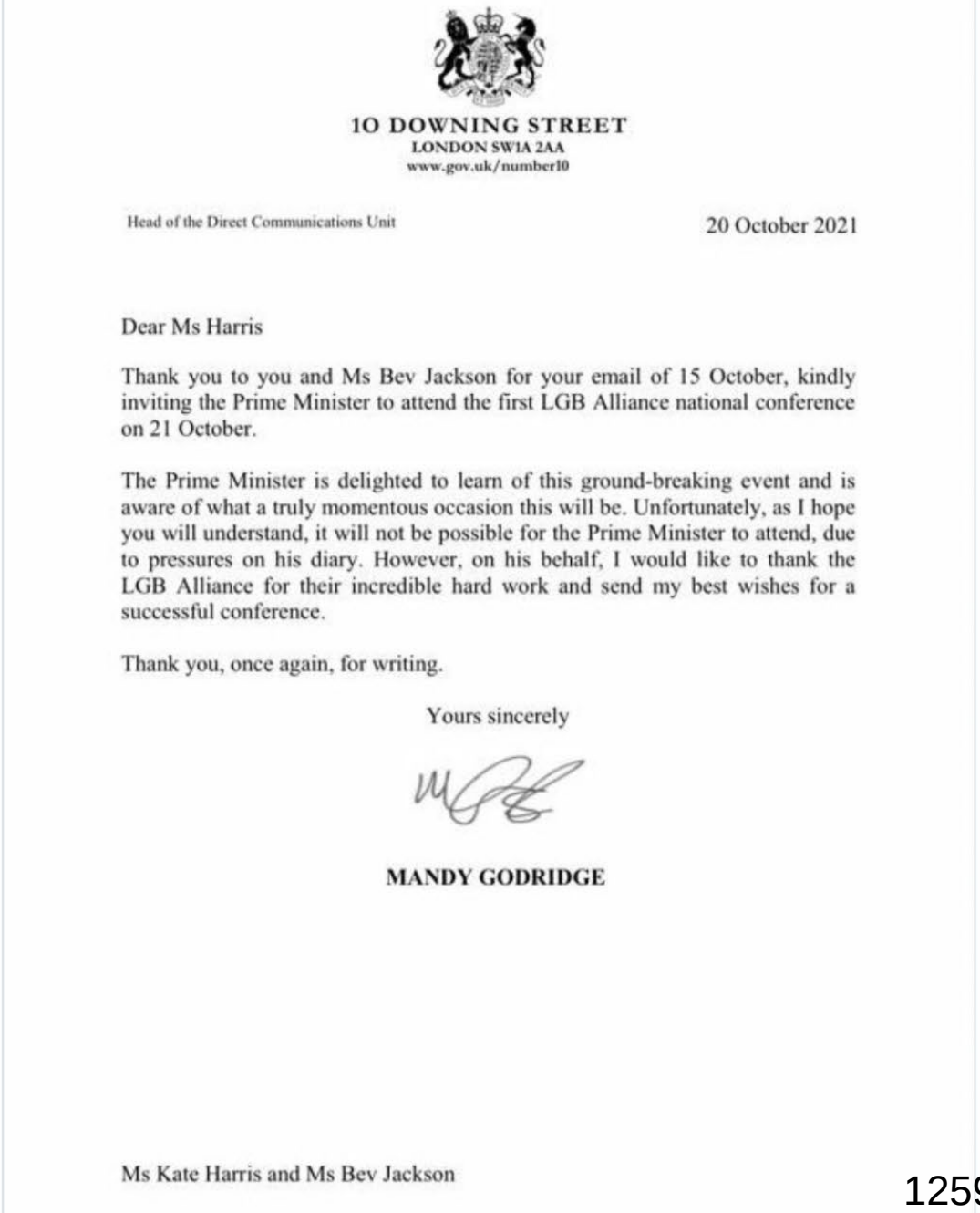
3:34 PM · Oct 21, 2021 · Twitter for iPhone

**24** Retweets **2** Quote Tweets **84** Likes

**Angela Richardson MP**
@AJRichardsonMP

I wish the LGB Alliance well as they hold their conference today.

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our “incredible hard work” from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇



10 DOWNING STREET
LONDON SW1A 2AA
www.gov.uk/number10

Head of the Direct Communications Unit

20 October 2021

Dear Ms Harris

Thank you to you and Ms Bev Jackson for your email of 15 October, kindly inviting the Prime Minister to attend the first LGB Alliance national conference on 21 October.

The Prime Minister is delighted to learn of this ground-breaking event and is aware of what a truly momentous occasion this will be. Unfortunately, as I hope you will understand, it will not be possible for the Prime Minister to attend, due to pressures on his diary. However, on his behalf, I would like to thank the LGB Alliance for their incredible hard work and send my best wishes for a successful conference.

Thank you, once again, for writing.

Yours sincerely

MANDY GODRIDGE

Ms Kate Harris and Ms Bev Jackson

1259



**Ruth Richards-Hill** ♿♀🏳️‍🌈🐾🇺🇦
@Tantrumfly

@BluskyeAllison is making the most incredible keynote speech at the @ALLIANCELGB conference 2021. I hope we will be able to get a copy online for those that could not attend

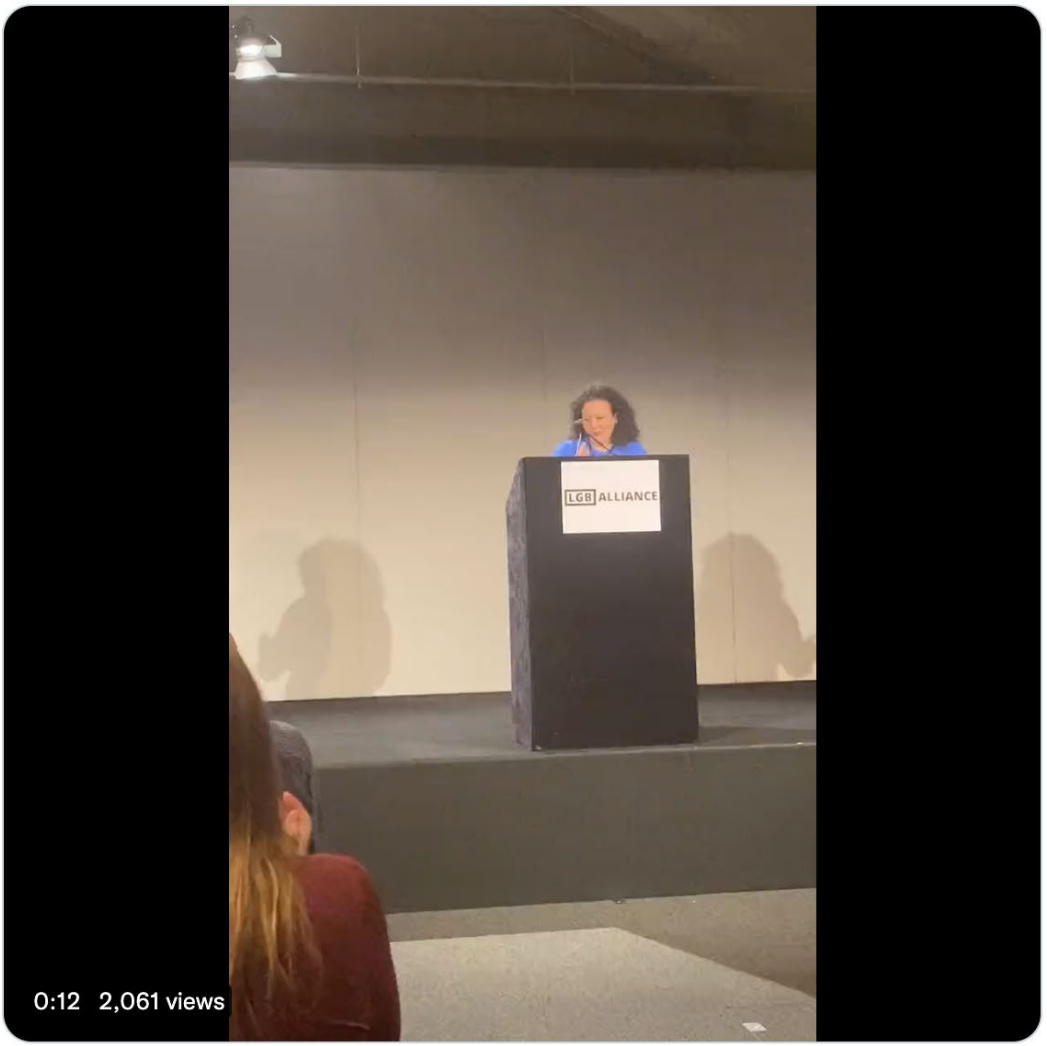
2:37 PM · Oct 21, 2021 · Twitter for iPhone

**5** Retweets **26** Likes



**Paola Diana**
@paoladiana_

What a pleasure to see the force of nature of @MForstater at #LGBAlliance2021 and a room full of incredibly amazing people fighting for human rights and freedom. What a huge success! Well done to @ALLIANCELGB for organising this much needed conference #sexnotgender




2:16 PM · Oct 21, 2021 · Twitter for iPhone

**14** Retweets **6** Quote Tweets **53** Likes

**LGB Alliance Australia**
@LGBAlliance_Aus

Sending all our support from the other side of the world, to the group who made our group possible. Best wishes @ALLIANCELGB for their inaugural conference today! Wish we could be there ourselves, but amazing to see such an incredible line-up of speakers and supporters.

2:14 PM · Oct 21, 2021 · Twitter Web App

**3** Retweets **45** Likes



**Hassan Mamdani**
@HassanMamdani

@ALLIANCELGB have put on a fantastic conference... inspiring, knowledgable, insightful speakers and a wonderful chance to meet so many people I've only interacted with on Twitter. Amazing atmosphere! Thanks @BevJacksonAuth, Kate, @TwisterFilm and the team #LGBAlliance2021

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> We appreciate the support of MPs and peers from all parties. Today, we are delighted and honoured to receive congratulations on our "incredible hard work" from the Prime Minister, @BorisJohnson as well as his best wishes for our conference. #LGBAlliance2021 👇
>
> 10 DOWNING STREET
> LONDON SW1A 2AA



**Liath Luachra**
@liath_luachra

Replying to @ALLIANCELGB

Beautiful flag design. Congratulations on getting your conference off the ground and on countering the blatant lies and mistruths being promulgated about your organisation. I would love to be there.

1:39 PM · Oct 21, 2021 · Twitter Web App



**Notorious VFT** 🌻
@ChunLisa

Replying to @Bjerkeley @PrideInSurrey and @KirstySNP

They speak for the LGB people who are there and who support them. I support LGB Alliance because I believe same-sex attraction is being demonised. If you don't feel that way, that's good for you. But we disagree, as do the hundreds of people at the conference today.

1:03 PM · Oct 21, 2021 · Twitter for Android

**14** Likes



**Allenomura**
@Allenomura

Truth about LGB Alliance: Who campaigns for what, then, and when. 👇

It's perfectly clear, demonstrable and uncomplicated, as truth often tends to be. Today is #LGBAlliance2021 Conference: the Alliance is here to stay! 👍 Well done to Bev & the team for stepping up so we can all 🗣️

> **LGB Alliance** @ALLIANCELGB · Oct 20, 2021
> 4./ Our critics then said we were hateful by breaking up a long-standing LGBT relationship. We didn't. Here's one of many Stonewall publications from before 2014. It's a Guide for Lesbians that gives information on How to Get Pregnant. 👇 stonewall.org.uk/resources/preg...
> Show this thread

12:53 PM · Oct 21, 2021 · Twitter Web App



**Brenda Ellis**
@sapphitweet

Replying to @joannaccherry @LesbianGayNews and @ALLIANCELGB

Sounds like you are all having a fantastic conference. Wish I could be there.

12:43 PM · Oct 21, 2021 · Twitter Web App

**14** Likes



**Joanna Cherry QC**
@joannaccherry

At @ALLIANCELGB conference listening to a fantastic panel event. Lucy Masoud firefighter & barrister says the new attack on same sex attraction is homophobia dressed up as progressive & inclusive. She won't be bullied back into the closet. #LGBAlliance2021




12:31 PM · Oct 21, 2021 · Twitter for iPhone

**234** Retweets **12** Quote Tweets **927** Likes

1265



**FirechildAmericano** ☕
@CathycoffeeUS

Replying to @ALLIANCELGB and @SpeechUnion

Best wishes for a peaceful and productive conference. Finally lesbians may have half a chance to be recognized

12:25 PM · Oct 21, 2021 · Twitter for Android



**Tiberius Kirk** 🇬🇧
@TibbyKirk

Replying to @Blackbox666 @Jebadoo2 and @ALLIANCELGB

I hope the LGBA conference evolves to include a new gay and lesbian pride march.

12:14 PM · Oct 21, 2021 · Twitter for iPhone

**4** Likes



**You know it makes sense** 💚🤍💜
@NeverTheSun23

Replying to @ALLIANCELGB

Hope you have a wonderful conference!

11:15 AM · Oct 21, 2021 · Twitter Web App



**Yvonne M**
@mcwhirr11

Replying to @ALLIANCELGB

Have a fantastic conference.  Im looking forward to updates.

11:12 AM · Oct 21, 2021 · Twitter for Android



**Susan B Mouse**💚🤍💜
@SusanBMouse1

Replying to @ALLIANCELGB

Wishing you a wonderful and powerful conference, I hope to join you next time. X

11:04 AM · Oct 21, 2021 · Twitter for iPhone



**SophieXY ♂KPSS**
@SophieXY44

I have major FOMO over the @ALLIANCELGB conference. I hope there will be videos aplenty!

10:59 AM · Oct 21, 2021 · Twitter for iPhone

**2** Retweets **93** Likes

**BenC42 #KPSS #SWS #NPBFC**
@BenC42

Solidarity to @LesbianLabour members attending the @ALLIANCELGB Conference in London. Definitely NOT a "hate group"!
Best regards - Ben
(@UKLabour member A618905)
Cc: @Keir_Starmer @AngelaRayner @AnnelieseDodds @lisanandy @DrRosena @jessphillips @Alison_McGovern @TaiwoOwatemi

> **LesbianLabour** @LesbianLabour · Oct 21, 2021
> Lesbian Labour here we go! #LGBAlliance conference




**Carol Cunningham** 🏴🏴🇮🇱✝️✡️🌻🌻🌻
@CarolM_CC

Replying to @ForwomenScot and @ALLIANCELGB

Have a great conference everyone 💜🤍💚

10:53 AM · Oct 21, 2021 · Twitter for iPhone



**Fran StaniFan** 🟥🐐💚🤍💜
@gladys3467

LGB Alliance making history with their first conference this weekend. Have a good one all of you, you've achieved so much in such a short time 💕💕

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Oh look there's light in the sky and our flags are up.





**Antonia Frances** 💙🦕
@antoniafrances

Replying to @ALLIANCELGB

Have a good conference everyone. You have some great speakers.

10:32 AM · Oct 21, 2021 · Twitter for iPhone

**1** Retweet **9** Likes



**Resist**
@L0V3Printworks

Replying to @LGBAlliance_USA @ALLIANCELGB and @BevJacksonAuth

#freetobelgb Love this! Wish I was there! Happy Conference kick-off @ALLIANCELGB

10:20 AM · Oct 21, 2021 · Twitter for Android

**3** Likes



**Emma Harriet Nicholson**
@Baroness_Nichol

Undoubtedly we are already doing that and this magnificent @ALLIANCELGB conference will propel our determined campaign much further on

> **seonaid dawn barber** @seonaidsnail · Oct 21, 2021
> Replying to @Baroness_Nichol and @ALLIANCELGB
> Hope u have fun n productive time -finding way forward to protect young people from maddening ideology

10:11 AM · Oct 21, 2021 · Twitter for iPhone

**3** Retweets **32** Likes



**Susan Dalgety**
@DalgetySusan

Replying to @ForwomenScot and @ALLIANCELGB

Have a great conference!

10:03 AM · Oct 21, 2021 · Twitter for iPhone

**7** Likes



**Niko**
@girltimeintl

Replying to @ALLIANCELGB

Love to see it 😍😍😍 Have a great conference!

9:59 AM · Oct 21, 2021 · Twitter Web App



**Wendy Stephenson**
@WendySteph

Replying to @ALLIANCELGB

Have a great conference. Solidarity!

9:46 AM · Oct 21, 2021 · Twitter for iPhone



**🦕 Enhehuanna 🌸**
@wrongthinkorg

Replying to @BramhamAlex and @ALLIANCELGB

Have a wonderful conference ❤️

9:44 AM · Oct 21, 2021 · Twitter for iPhone



**🦕🍒 Sisters KPSS**
@SistersOfAnne

@ALLIANCELGB Good luck with the conference today. Sorry we couldn't be there with you!

9:50 AM · Oct 21, 2021 · Twitter for iPhone



**Lizzie Morris 🏳️‍🌈 🦕**
@LizzieM70

Replying to @ALLIANCELGB

Have a fantastic conference. SO sorry I can't join you today.

9:44 AM · Oct 21, 2021 · Twitter Web App



**Julian Vigo**
@_JVigo

I am excited about today's @ALLIANCELGB conference. We've had many of the participants on the Savage Minds podcast and it warms my heart to see a truly grassroots movement come together in person. I wish I were there! @simonjedge @MForstater @HJoyceGender @ProfAliceS

9:40 AM · Oct 21, 2021 · Twitter Web App

**4** Retweets **63** Likes

**Sally Jackson**
@Blackbox666

Proud to be supporting @ALLIANCELGB at their first conference!




9:39 AM · Oct 21, 2021 · Twitter for iPhone

**73** Retweets **6** Quote Tweets **1,259** Likes



**Samantha** 🇺🇦💚🤍💜🦕🦕
@samanthasrants

Wish I was able to be at the @ALLIANCELGB conference to show my support in person but sadly all I can do is send my best wishes.

Have fun everyone ❤️

9:37 AM · Oct 21, 2021 · Twitter for Android




**Rachel Terfasaurus** 🦕🦕💚🤍💜🏝️
@raychilled

Have a wonderful day all attending @ALLIANCELGB conference #SexNotGender

> **Hybrid Transsexual Humanoid**🏳️‍🌈🏳️‍⚧️🌊 @JaeDQuinn · Oct 20, 2021
> I'm a transsexual and I support this. twitter.com/BuckAngel/stat...

9:29 AM · Oct 21, 2021 · Twitter Web App



**shelley charlesworth**
@charlesworth102

Fantastic to be here at this groundbreaking conference. #Free2Be#LGBAlliance 2021

9:15 AM · Oct 21, 2021 · Twitter for iPhone

**3** Likes

**LGB Alliance Deutschland**
@LGBAlliance_DE

The first LGB Alliance Conference in London has started. We wish all participants a successful and informative conference. Best regards from Germany!

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Oh look there's light in the sky and our flags are up.



**Martin in Yorkshire** 🇺🇦
@martinradio

Wishing everyone attending the @ALLIANCELGB conference a happy and productive day.

8:58 AM · Oct 21, 2021 · Twitter for Android

**Rick Westhorpe**
@YnYCae

Its the LGB Alliance Conference today. Really sad I can't be there, but sending love and gratitude for the brilliant work you do. xx

> **LGB Alliance** @ALLIANCELGB · Oct 21, 2021
> Please feel free to RT, spread the Truth and ...encourage people to follow us. Can we get to 46K by the end of our conference today? 👀🤞
> twitter.com/ALLIANCELGB/st...

8:47 AM · Oct 21, 2021 · Twitter Web App



**Lachlan Stuart** 🌹🗽🇺🇦
@Lachlan_Edi

Solidarity to all those organising and attending the @ALLIANCELGB conference in London today.

When they call us hateful bigots, remember, it's them sterilising gay youth, not us. Who would have thought we're back to asserting the normality of same sex love?




8:29 AM · Oct 21, 2021 · Twitter Web App

**68** Retweets **2** Quote Tweets **386** Likes



**Littlest HOMOsexual**
@HomoLittlest

Have a great @ALLIANCELGB conference. 👍❤️
Unable to attend because of work so I donated a ticket and will be there in spirit.
Remember truth is not hateful.
Thank you wonderful people for standing up for our hard won rights based on sex and same-sex attraction.

7:02 AM · Oct 21, 2021 · Twitter for Android

**8** Retweets **160** Likes



**LabourWomen'sDeclaration** 🐐 🐐
@LabWomenDec

Congrats to @ALLIANCELGB on their conference. Lots of us will be there & the rest cheering from afar. You'll find LWD leaflets & new banner at stall of our sister org @LesbianLabour. All supporters attending Plse say hi. Special cheers for any @UKLabour politicians speaking up!

> **LGB Alliance** @ALLIANCELGB · Oct 20, 2021
> 1./ What's the TRUTH about LGB Alliance? Our critics like to claim we're funded by extremists and, despite the fact we've many trans supporters, that we don't support trans rights, even although we do. So WHY do so many people believe the myths? 👇 pinknews.co.uk/2021/10/19/lgb...
> Show this thread

6:32 AM · Oct 21, 2021 · Twitter for iPhone

**44** Retweets **2** Quote Tweets **246** Likes



**Eve** 🦖🐈‍⬛🌱🐹🦋
@eve_eveander

Shout out to my lovely lesbian and gorgeous gay friends heading off to @ALLIANCELGB conference 😘😘😘

6:24 AM · Oct 21, 2021 · Twitter for iPhone

**2** Retweets **13** Likes



**Louisa Jones**
@FilmLecturer

Replying to @ALLIANCELGB and @Matt_Zeleo

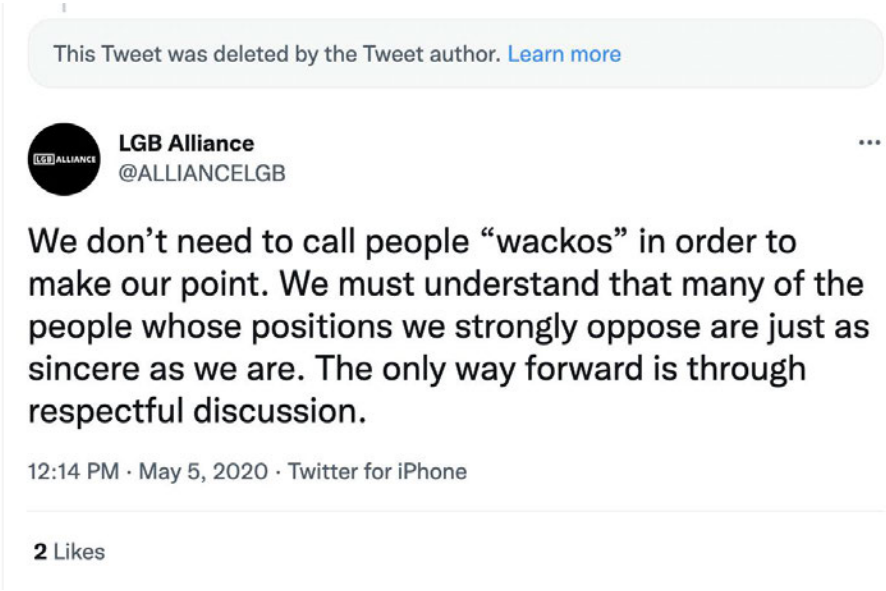
Wishing you all a great conference! X




8:10 PM · Oct 20, 2021 · Twitter for iPhone

**8** Likes

https://twitter.com/ALLIANCELGB/status/1257629704921718788




https://twitter.com/ALLIANCELGB/status/1340771183814471680



https://twitter.com/ALLIANCELGB/status/1286984156598149120



LGB Alliance
@ALLIANCELGB

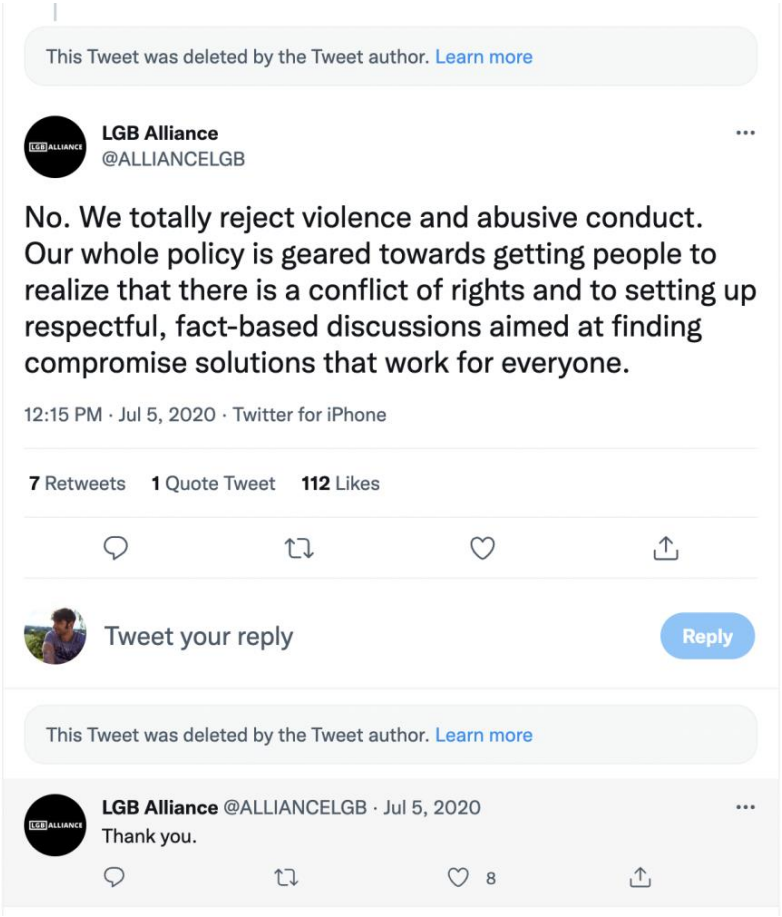
Replying to @BearCaeleb and @OwenJones84

We oppose any expressions on our threads that encourage or condone violence or that are abusive to those who oppose us. We do not believe anything can be gained in that way. Respectful dialogue is the only way forward.

12:18 PM · Jul 25, 2020 · Twitter for iPhone

**2** Likes

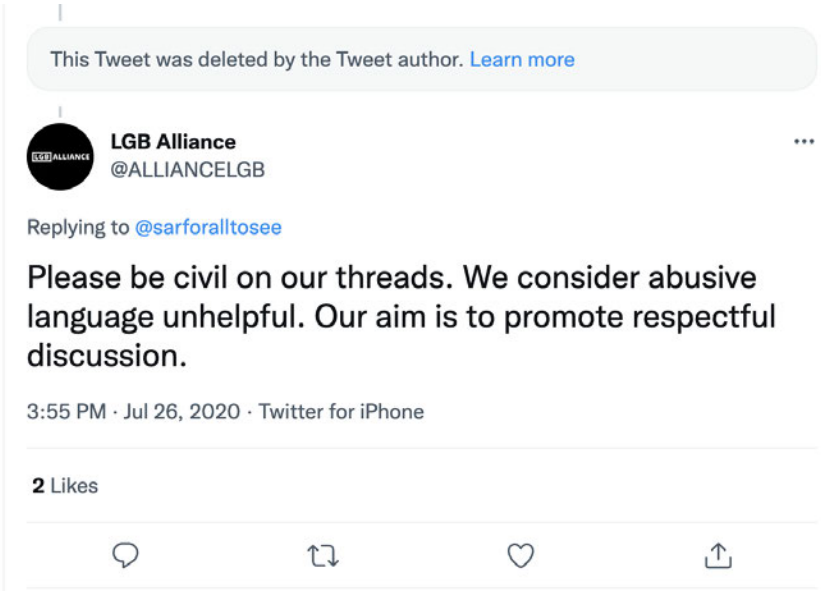
https://twitter.com/ALLIANCELGB/status/1279735756446195712



https://twitter.com/ALLIANCELGB/status/1287367138236407808




https://twitter.com/ALLIANCELGB/status/1287401186044383234



https://twitter.com/ALLIANCELGB/status/1287407208750362631




https://twitter.com/ALLIANCELGB/status/1300482665267761162



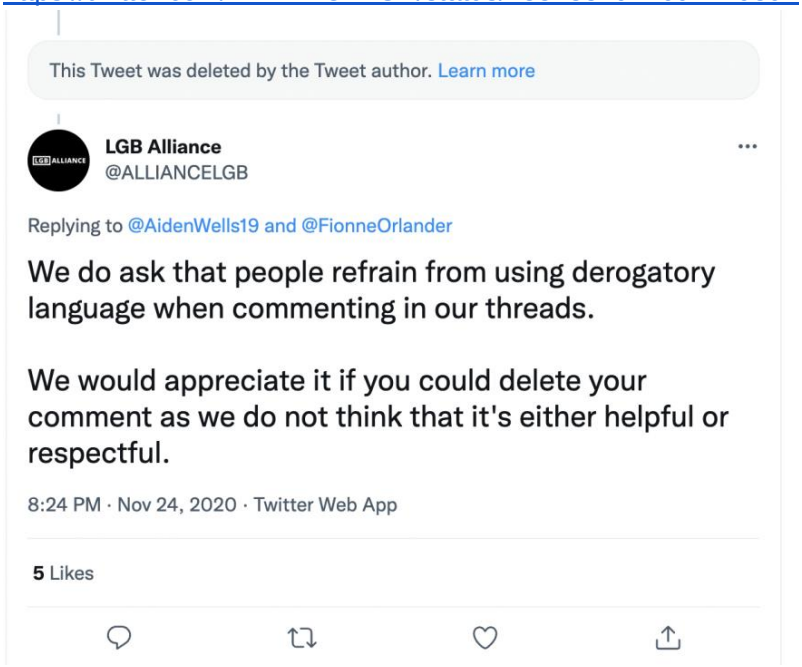
https://twitter.com/ALLIANCELGB/status/1313244516401504256



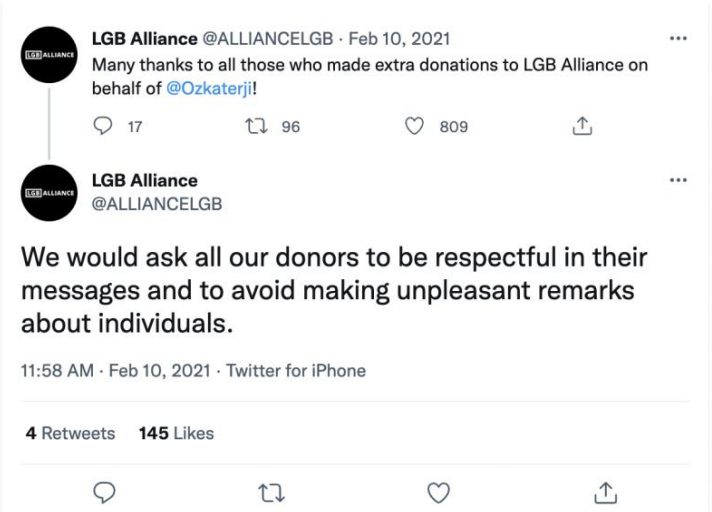

https://twitter.com/ALLIANCELGB/status/1328030580500525056



https://twitter.com/ALLIANCELGB/status/1331332941692219394




https://twitter.com/ALLIANCELGB/status/1359471757246296069





Critics say that giving the advice on puberty blockers to schools is 'disturbing'
KLAUS VEDFELT

# Transgender lobby group Mermaids urges puberty-blockers for 12-year-olds

Ewan Somerville and Sian Griffiths

Sunday September 15 2019, 12.01am, The Sunday Times

Share Save

Teachers have been told in a training session that some children as young as 12 who question their gender identity should be offered hormones to block puberty.

In a meeting with 20 teachers and pastoral staff at Newman University in Birmingham last December, a trainer for the transgender lobby group Mermaids said giving puberty blockers to gender-dysphoric children gave them "immense relief" and was "completely reversible".

The trainer, recorded by an audience member, said: "Puberty blocker medication doesn't make any changes, so [is] completely reversible. What it does is put a pause button on the pituitary gland and freezes puberty where it is. Not growth, just puberty. Take the blockers away and biological puberty will

recommence." She added that using blockers "does provide immense relief from the dysphoria" and argued that arrested development meant less need for physical intervention later "if they decide to go down that path".

This weekend the advice was attacked as "misleading and potentially dangerous" by an Oxford academic. The session is believed to be a blueprint for training by the group in schools nationally.

Michael Biggs, associate professor in sociology at St Cross College, Oxford, says the guidance could push children towards medical intervention. He cites research which found that most children prescribed blockers at a young age progressed to taking cross-sex hormones and surgery, which damage fertility.

ADVERTISEMENT

Biggs says he has unpublished evidence that after a year on blockers "children experienced increased psychological problems, including self harm. Mermaids is not giving pupils a

choice that they may just be gay or lesbian. Instead, it is diverted down a drastic path that ultimately ends in surgery. To be propagating such information to schools is disturbing."

Michael Conroy, who taped the footage and has worked in pastoral support in schools for 15 years, said he believed Mermaids was encouraging young people to think that they were "born in the wrong body . . . It's putting children at risk."

Mermaids said: "The information in our sessions is based on a wealth of international scientific study and 25 years of experience in this field. Since this training session in 2018, we have been funded by the Department for Education in a schools training programme overseen by the Government Equalities Office."

Last week a group of parents announced a lobbying organisation aimed at the NHS. One of them, a mother, told a public meeting that the gender reassignment of young people with autism or psychological problems was "state-sponsored sterilisation of the mentally disabled". Members of the group attended a governors' council of the Tavistock and Portman NHS Trust, which includes the Gender Identity Development Clinic for trans children. The mother said her 20-year-old, who identifies as a gay trans man and lives with other young people awaiting reassignment surgery, had ADHD with autistic traits diagnosed at the age of six.

She said her child fitted the description of "rapid onset gender dysphoria", whereby youngsters declare, often in clusters, that they are trans after exposure with their peers to suggestions they are "trapped in the wrong body".

Additional reporting: Joani Walsh

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**Mermaids**

**Questions**

**1 Do you have any comments on the proposal that applicants must live in their acquired gender for at least 3 months before applying for a GRC?**

Yes

**If yes, please outline these comments.:**

Mermaids notes the outdated notion of 'acquired' gender within the question and only uses this term in reference to current legislation. Any future legislation should refer either simply to one's 'gender' or 'affirmed gender'.

Mermaids welcomes that the draft Gender Recognition Reform (Scotland) Bill proposes to de-medicalise and streamline the current process for applying for legal gender recognition, replacing this with a more straight-forward, administrative process, based on the principle of self-determination.

However, we believe the requirement that an individual must state on a statutory declaration that they have been living as their gender for 3 months is arbitrary, unnecessary and does not help achieve the purpose of the Act. We do not know of any evidence that this waiting time is necessary and call for this requirement to be removed. What we do have is a significant amount of evidence around the detrimental effect of waiting on the mental health and wellbeing of trans populations. Although this research is generally in reference to treatment paths, it concurs with anecdotal evidence around gender recognition. In the Trans Mental Health Study 2012 (McNeil, J., Bailey, L., Ellis, S., Morton, J. and Regan, M.), people described waiting as 'devastating, frustrating, hoop jumping, waiting for permission to live, emotional torment, treading water, waiting for the world to catch up, in limbo' – we know how difficult it is for trans people feeling like they have to wait to live their lives. Far less research has been done specifically on waiting for a GRC, however there is research currently being conducted which will hopefully be published later this year.

Further, such a requirement would not be in line with Council of Europe Recommendations, that a system should be '…quick, transparent and accessible' [Paragraph 21 LGBT Recommendations CM/Rec 2010(5)]. One will be required to be able to afford to have a Statutory Declaration sworn (should it be done so by a notary public), as well as add an unnecessary 3 months to the process.

For completeness we want to be clear that we would not be in agreement with the Registrar General making further evidence provisions in relation to a 3 month lived experience within a GRA application. If it comes to light that such further provision could be made, we respectfully would request that we provide a further annexed response to this.

Mermaids recommends that a model of self-determination is the most appropriate, desirable and human rights conscious regime. This is supported by the notion that a

model of self-determination has already been successfully implemented in Norway, Malta, Belgium, Denmark, France, Portugal and Ireland. This is evidenced in the following report, which also shows the UK to be the only country of those reviewed without a model of self-determination http://www.trust.org/contentAsset/raw-data/8cf56139-c7bb-447c-babf-dd5ae56cd177/file

2 Do you have any comments on the proposal that applicants must go through a period of reflection for at least 3 months before obtaining a GRC?

Yes

**If yes, please outline these comments.:**

Mermaids recommends that there is no period of reflection for any applicant of any age because it contravenes the principle of self-determination that we believe must be at the centre of any new Legal Gender Recognition (LGR) system. A reflection period requirement bolsters a myth that trans, non-binary and gender diverse (TNBGD) people don't understand their identities or know what's best for themselves. For a TNBGD person, a decision to apply for a gender recognition certificate (GRC) will inevitably be following a period of self-reflection. An arbitrarily imposed 'reflection period' should not be bureaucratically imposed, but instead should be self-determined by the individual.

Requiring a state-imposed period of reflection not only invalidates a TNBGD's experience, it also unnecessarily elongates the LGR process. In line with Council of Europe Recommendations, LGR should be 'quick, transparent and accessible' [Paragraph 21 LGBT Recommendations CM/Rec 2010(5)]. This requirement does not satisfy this recommendation, but instead prolongs the length of time an individual must wait before having their gender legally recognised. All this time is a delay in the individual being recognised and dealt with as their true gender (this is especially true for Children and Young People (CYP)) and prolongs the length of time that their rights, including their right to privacy, are violated – this includes CYP.)

The requirement of a reflection period is often justified with reference to the theory of 'desistence'. This ignores the experiences of TNBGD people and is not appropriate within this discussion. While we encourage the government to take into consideration all evidence, Mermaids recommends a cautionary approach to evidence around. Newhook et al (2018) offer a critique of commonly cited desistence studies, highlighting methodological, theoretical, ethical and interpretive concerns. Attention should be directed towards research which focuses on how to support TNBGD people, as the evidence base around desistence will not assist in creating better systems for our TNBGD members of society (See [Dr B Vincent, PhD, 'Transgender Health: A Practitioners Guide to Binary and Non-Binary Trans Patient Care' (2018) Jessica Kingsley Publishers pp.121-124] for full discussion around desistence in CYP).

Further, through direct consultation with our service users it was suggested that the idea of a reflection period insinuates that someone is making a decision around their gender, which is the wrong approach: "…the idea that it is a 'decision' makes me so angry … why it is someone else's decision? People still get rejected on the basis of it

being someone else's decision and that it should not be the case. You should not have to prove yourself to anyone. Current law feels like the government are saying, "…you are not trans enough"." Anonymous, 15 year old trans youth, 2018

Mermaids recommends that any procedure is made accessible enough to allow for a quick reversion if necessary in acknowledgement that one's gender identity may indeed change in time, for people of any age.

Significantly, no other process for updating records, no matter how significant a change, requires a reflection period. This level of caution suggests updating a birth certificate is likely to have a negative impact on the person's life, even though all evidence points to the opposite. Further, this level of caution suggests that the law is reserving special rules for those who are planning on updating their gender records, which could be viewed as treating someone less favourably as a result of them being TNBGD.

We call on the Scottish Government to remove this requirement.

**3 Should the minimum age at which a person can apply for legal gender recognition be reduced from 18 to 16?**

No

**If you wish, please give reasons for your view.:**

Mermaids believes the minimum age should be lowered, but have no minimum age. Mermaids recommends that every trans, non-binary and gender diverse (TNBGD) CYP should have access and the option of Legal Gender Recognition.

The process of self-declaration should be available to anyone from 16 years and upwards. This is consistent with other laws in Scotland that state a person acquires their rights (eg to marry, gain employment, vote, and be held legally responsible for their actions) from the age of 16. It is also in line with the position of the World Professional Association on Transgender Health (WPATH) (2017) a non-profit interdisciplinary professional and educational organisation devoted to trans health, with goal to promote evidence based care, education, research, public policy and respect in trans health. WPATH advocates that gender recognition should be available to trans youth, including those under the age of the majority, see https://tgeu.org/wpath-2017-identity-recognition-statement/

We also recommend that a system of recognition should also be available to under 16s.

We say this within the context that a birth certificate is the only legally recognised form of identification for CYP under 17 without a passport, so often CYP under 17 need to use their birth certificate more than adults do, for example when changing schools. Being able to change their gender on their birth certificate is therefore particularly important to protect the privacy of children and young people under 17.

In summary Mermaids recommends that those CYP aged 16 and 17 years old should have automatic access to a self-declaration model application. The mechanism for under 16 year olds should be streamlined for those who have consent from at least one person with parental responsibility (PR), although PR consent would not be necessary should the young person have independent competence. Those without an unsupportive person with PR and lack of independent competence should have access to a safeguarded mechanism; we invite to work with the government and other stakeholders to develop a vision as to what this mechanism would look like. Any procedure must provide every CYP a life of dignity and autonomy, the right to privacy and the right to be heard and to take an active role in all administrative and judicial procedures that concern them.

Identity documents reflecting a person's gender identity are important for trans, non-binary and gender diverse (TNBGD) people's dignity, safety and access to human rights – this includes children. Nearly one-third (32%) of individuals who have shown IDs with a name or gender that did not match their presentation reported negative experiences, such as being harassed, denied services, and/or attacked; (James, S., Herman, J., Rankin, S., Keisling, M., Mottet, L. and Anafi, M. (2016) The Report of the 2015 U.S. Transgender Survey. Washington DC, National Center for Transgender Equality.)

Not providing TNBGD CYP with access to LGR creates unwanted experiences of having to come out, which often would not happen were the CYP to have a birth certificate (BC) that reflected as their true gender. TNBGD CYP people do not always have passports or driving licences; BCs can often be a CYPs only form of official personal identification. This often leads to a CYP, or their parent, having to explain why the BC has the incorrect gender marker on it which infringes on the right to privacy of that individual [Article 8, ECHR].

Through in-house consultations and statements from service users, we have listened to the life-experiences of our CYP who face problems in being recognised and respected for their gender within society without a birth certificate that reflects their true gender. We have received accounts of our service users being denied recognition in our schools, jobs and when accessing healthcare on the basis that their identity documents do not match their gender. This is unacceptable and exposes TNBGD CYP to distressing and humiliating situations that is impacting on their ability to learn, thrive and interact in full within society, which could be avoided through Gender Recognition Act (GRA) reform. Reforming the GRA to include all those below 18 years old with no age restriction can help end the discrimination that is currently taking place. Mermaids states this whilst acknowledging however that TNBGD CYP should have no extra difficulty interacting in society as their true gender without a GRC and we invite the Government to explore ways public bodies and society generally can be educated in this respect.

Not allowing a TNBGD CYP to correct their BC is also incompatible with other systems that allow TNBGD to change their gender marker. For example, trans binary CYP can change their gender marker on all other forms of ID including passports, education and NHS records without age-based restrictions. A change in law around LGR for CYP and the allowance of it would simply bring GRA law in line with how wider social systems are working. In respect of non-ninary CYP, GRA reform would

ensure wider social systems recognised these individuals also. Without a set of matching documents participation in society becomes very difficult. For many TNBGD CYP, the gendered information in these documents, including name and gender marker is a constant source of discomfort, discrimination and hate incidents/hate crimes. Mermaids believes that GRA reform can help make our TNBGD CYP more comfortable, mitigate the risk of discrimination against them and mitigate the risk of hate incidents/hate crimes.

Scotland should be careful not be deny a TNBGD CYP gender recognition on the ground that they are too young. Current legislation does not give our TNBGD CYP acknowledgement that they are right holders in their true gender. The Council of Europe asks member states dealing with minors' gender recognition procedures to "ensure that the best interests of the child are a primary consideration in all decisions concerning children". Explicit or implicit age restrictions may obstruct this best-interest-principle for CYP.

Further, such restrictions may violate non-discrimination provisions in the Convention on the Rights of the Child (UNCRC) [Art 3.1; Art 8.1; Art 12.1; Art 24 and Art 6.2], the Yogyakarta Principles [YP+10, Principle 32 http://yogyakartaprinciples.org/wp content/uploads/2017/11/A5_yogyakartaWEB-2.pdf], the European Convention on Human Rights [Art 8; Art 14] and the EU Fundamental Rights Charter [Art. 21]. The UNCRC requires states to respect the right of a child to be heard and to duly take into account their views, supported by the Council of Europe [CM/Rec (2012)2]; their evolving capacities must be taken into account also remembering that the age of a CYP does not determine the significance of their views. The UN Committee on the Rights of the Child has highlighted that the identity of the child includes characteristics such as gender identity and the right of the child to preserve his or her identity is guaranteed by the UNCRC [Article 8] and must be respected and taken into consideration in the assessment of the child's best interests.

The state talks about 'protecting' TNBGD CYP, but it needs to ensure that 'protection' is not only looked at from a cis-normative perspective. The state needs to reject a default position that not being trans (or, cisgender) as the safest position, when simply it is not for a trans person. Being TNBGD has been evidenced to subject an individual to an increased risk of depression [https://www.sciencedirect.com/science/article/pii/S0165032717324400] and specific research around not supporting TNBGD CYP with their gender can lead to an increase risk of isolation, distress, depression and suicide; [Olson Kristina R., Durwood L., DeMeules M., et al. (2015): Mental Health of Transgender Children Who Are Supported in Their Identities. Pediatrics. 2016;137(3): e20153223 accessible at: http://tinyurl.com/jn844dx ].

We ask the government to mitigate this risk by supporting TNBGD people with their identity through GRA reform. We have evidence that illustrates pushing an assigned gender on a young person can be extremely damaging and in some circumstances, fatal. The Stonewall School Report (2017) [https://www.stonewall.org.uk/school-report-2017], conducted with the University of Cambridge, found that more than four in five Trans young people (84 per cent) have self-harmed; more than two in five Trans young people (45 per cent) have attempted to take their own life; approximately nine in ten Trans young people (92 per cent) have thought about

doing it (Young Minds estimates that one in four young people have had these thoughts).
We invite the Scottish government to recognise TNBGD CYP for who they are and support them in being themselves. We believe that GRA reform is a form of social support, which has been repeatedly evidenced to have a strong positive correlation with the mental health and wellbeing of trans young people (McConnell et al, 2016; Aparicio-Garcia et al, 2018)

Making gender recognition accessible independent of age is becoming more pressing as more TNBGD CYP come out at an earlier age. The World Professional Association for Transgender Healthcare – WPATH – confirms that "increasing numbers of adolescents have already started living according to their gender identity upon entering high school" [deVries, Steensma, Doreleijers, & Cohen-Kettenis, 2010 in WPATH, Standards of Care Version 7 (2013)] and currently 8 states in Europe open gender recognition procedures for those below age of majority with no age restrictions
[https://tgeu.org/wp-content/uploads/2018/05/SideB_TGEU2018_Print.pdf]. It is also worth noting that the age for gender recognition has been lowered in Norway and Belgium (http://www.trust.org/contentAsset/raw-data/8cf56139-c7bb-447c-babf-dd5ae56cd177/file).

Mermaids believes that it is important to pay attention to practical aspects and ensure that no barriers are in place that might render a procedure inaccessible. Accessibility needs to be ensured for all TNBGD people who seek it, independent of gender identity or a non-binary identity, the person's medical, age or other protected characteristic status such as disability or race. If a TNBGD person cannot fulfil certain requirements for age, religious, health or other reasons, they should not be barred from having their gender identity recognised.

Through consultation with our service users there is an overwhelming support for there to be no age requirement as part of the future LGR application.We here provide you with some comments from our TNBGD CYP service users that support this assertion: " …there should not be an age limit because it takes away the agency of the children and instils the belief 'is it just a phase'. Changing the law would also means that there was recognition that trans young people do exist and there should be no age of credibility because this is prejudicial… changing the legislation would help get rid of the myth around young trans and non-binary people not existing and remove the barriers and make the system as simple as it is for cis gender… cis gender people do not have to prove their existence… any age limit on legal gender recognition would show an age limit to transgender people being believed to exist…" Anonymous, sister to a 16 year old trans young man, 2018

"…I find it offensive that my child has a name and gender marker that she has never identified with on her birth certificate. If my daughter is dead-named it can reduce her to tears and not being able to change her birth certificate makes it more likely that this will happen…" Anonymous, mother to 10 year old trans girl, 2018

***
"…I am frustrated that I can change everything apart from my birth certificate … I have to adapt to society rather than society adapt to me…" Anonymous, 16 year

old young trans man, 2018
***
"…privacy and dignity should be afforded to people of all ages and that someone shouldn't have to out themselves through the disclosure of documents…" Anonymous, 16 year old young trans man, 2018
***
"…I don't think parental support is an unnecessary thing… trans kids who want their gender changed on their birth certificate will want it so much that they won't want to change later on… there shouldn't be an age limit on anything …" Anonymous, 16 year old young trans woman, 2018
***
"…it would mean the state seeing me as valid and as a female which is in line with the government seeing me as a woman in all other walks of my life… it would also mean not having to out myself and I could be comfortable knowing that all pieces of ID will be consistent and uniformed. I think this would put trans young people at ease generally." Anonymous, 16 year old young trans woman, 2018
***
"…I still have a piece of paper that says I am female and the worst thing is that this isn't my fault. The law changing would mean that society would accept trans and non-binary people more – coming out as trans should not be a big deal…" Anonymous, 16 year old young trans man, 2018
***
"…I think society is scared and the legislation protects and reinforces that. Current legislation is working for the majority (I.e. cis people) and ignoring trans and non-binary people…" Anonymous, sister to young trans man, 2018

**4 Do you have any other comments on the provisions of the draft Bill?**

Yes

**If yes, please outline these comments.:**

1. Accessibility

a. Firstly, we would like to stress the importance of ensuring that the gender recognition process is more straightforward and accessible. Implementing a system based around the idea of self-declaration or similar would alleviate a huge emotional, mental, and financial burden for many trans people in Scotland, including CYP. Intervenable factors associated with suicide risk in transgender persons: a respondent driven sampling study in Ontario, Canada' Bauer et al (2015) found that "having one or more identity documents concordant with lived gender was significantly associated with reductions in past-year ideation and attempts, with the potential to prevent 90 cases of ideation per 1000 trans persons and 230 attempts per 1000 with ideation".

b. It would also bring the process of acquiring legal gender recognition in line with international human rights standards and European best practice. Resolution 2048 of the Parliamentary Assembly of the Council of Europe calls on all Member States to "develop quick, transparent and accessible procedures, based on self-determination, for changing the name and registered sex of transgender people on birth certificates,

identity cards … and other similar documents". We urge the Scottish Government to adhere to this resolution.
c. We call on the Scottish Government to ensure that no one is unfairly blocked from being able to apply for a Gender Recognition Certificate. For example, refugees and asylum seekers who may be blocked by the Scottish Government's proposal which limits those who can apply for a Gender Recognition Certificate to anyone with a birth or adoption certificate from Scotland, or anyone who is "ordinarily resident" in Scotland. We would ask the Scottish Government to clarify what is meant by "ordinarily resident", and to provide assurances that these criteria will not unfairly prevent anyone, particularly people without current, valid leave to remain who are in Scotland, from applying for a Gender Recognition Certificate.

2. Legal Recognition of Non-Binary Individuals

One key gap in this draft bill is the absence of legal gender recognition for non-binary people. This means that non-binary people have their existence invalidated every time they interact with the state, e.g. by accessing health services, applying for legal documents such as passports, or attending school or college. Under the current system, non-binary people are forced to conform to a binary gender category which is not representative of how they live and identify in their day to day lives. We herewith quote from James, S., Herman, J., Rankin, S., Keisling, M., Mottet, L. and Anafi, M. (2016) The Report of the 2015 U.S. Transgender Survey. Washington DC, National Center for Transgender Equality. "As a non-binary person, not being able to change my gender on any of my identification documents is really disheartening, dysphoria inducing, and kind of dehumanizing. I'm not allowed to be me."

We believe that the exclusion of non-binary people undermines the success of this Bill by denying equal rights of recognition for all gender diverse people this Act would apply to. Not having a process for non-binary people means that the process is completely and wholly inaccessible for a demographic of people. Case studies as written about by Sally Hines (Transgender Identities - Towards a Social Analysis of Gender Diversity, p. 103) discuss the argument for a system that recognises that not all citizens are able to, or wish to, define as male or female.

We stipulate that including a third, gender-neutral option on legal documents would be an uncomplicated proposal which would follow the precedent already set by a growing number of countries including Denmark, Malta, New Zealand, and parts of the USA, Canada, and Australia. Non-binary recognition is also advocated by WPATH (https://tgeu.org/wpath-2017-identity-recognition-statement/).

We urge the Scottish Government to acknowledge the existence of non-binary people in new gender recognition legislation through the inclusion of a third legal gender option.

3. Section 22

We have concerns about the Scottish Government's suggestion that they may introduce additional exceptions to Section 22 of the Gender Recognition Act. We do not believe that any additional exceptions are necessary. In particular, we believe that the example given of a potential additional exception – for HR staff to be able to

out trans applicants for jobs to other colleagues in their workplace – would seriously undermine trans people's human right to privacy, enshrined in Article 8 of the European Convention on Human Rights. We therefore strongly urge the Scottish Government not to include any additional exceptions to Section 22 of the Gender Recognition Act, and to ensure that trans people's privacy is protected by law throughout the gender recognition process.

4. Separate criminal offence

We also have concerns about the Scottish Government's proposal of creating a new criminal offence of making a false declaration in order to obtain a Gender Recognition Certificate. We believe that this new offence is unnecessary, given that the existing offence of making a false statutory declaration would fully cover any fraudulent applications for a Gender Recognition Certificate and would impose an identical penalty. This offence is particularly needless in light of the lack of evidence from any other jurisdictions that have introduced similar laws, or laws with an even lower evidential burden, of non-trans people applying to obtain legal gender recognition for fraudulent purposes, as already acknowledged by the Scottish Government throughout the consultation.

We therefore believe that creating this new offence would stigmatise the gender recognition process and by extension, trans people, by implying that the possibility of someone making a fraudulent application for a Gender Recognition Certificate is significant and concerning enough to warrant its own criminal offence.

We ask that the Scottish Government not to create this unnecessary and stigmatising criminal offence.

5. A person who has an interest in a Gender Recognition Certificate

We would like the Scottish Government to provide more clarity on its proposal that "a person who has an interest in a gender recognition certificate" could apply to the sheriff to have a GRC revoked on grounds of fraudulent application. The process of applying to have an individual's Gender Recognition Certificate revoked could potentially be open to abuse, for example by an unsupportive family member or ex-spouse. This is extremely concerning as it has the potential to cause great distress to trans people as well as undermining the purpose of the Bill, which is to provide recognition of Scottish citizens for who they genuinely are.

We would therefore ask that the Scottish Government imposes a clearly defined, sensible and limited definition of who "a person who has an interest in a gender recognition certificate" could apply to and we would welcome further conversation in this regard.

6. Fees

As applicants may have to pay to make the statutory declaration, they shouldn't be subject to further fees to make the application. Carpenter, Eppink and Gonzales (2020, Transgender Status, Gender Identity, and Socioeconomic Outcomes in the United States) found trans people to have lower employment rates, lower household

incomes and higher poverty, meaning fees could prevent people getting a GRC. Also, this can lead into a vicious cycle if people are not applying for jobs for fear of outing themselves with incongruent documentation, so remain unable to apply for a GRC, which would include all those under an age threshold should this be imposed, as well as those who identify outside of the binary.

**5 Do you have any comments on the draft Impact Assessments?**

Yes

**If yes, please outline these comments.:**

We agree with the EQIA which finds that the proposals won't have a detrimental impact on those who share a protected characteristic, particularly the protected characteristic of sex.

Further, trans, non-binary and gender diverse people's access to single-sex spaces and facilities is already covered by the Equality Act 2010, which will not change based on this Bill. Trans people have already been accessing a number of single-sex spaces and services in Scotland, under the Equality Act 2010, with no reported difficulties as far as we are aware.

The only thing that the Bill covers is how trans people's birth certificates are changed, which impacts the level of privacy they are entitled to, such as when they are getting a job or marrying, and how they are recognised after death. The accessibility of legal gender recognition does not have an inherent impact on access to single sex spaces, or anything else that does not require a birth certificate, and therefore will have no impact on other groups.

Guidance

# Plan your relationships, sex and health curriculum

Information to help school leaders plan, develop and implement the new statutory curriculum.

From:
Department for Education (/government/organisations/department-for-education)
Published
24 September 2020
Last updated
17 February 2022 —

## Applies to England

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- Creating a policy for the new curriculum
- Adapting an existing programme of study
- Deciding what to teach at primary and secondary level
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- Choosing resources
- Creating an inclusive classroom
- Ensuring content is appropriate
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- Right to request withdrawal
- Identifying teachers' needs
- Assessment and evaluation

This guidance is aimed at:

- headteachers and principals

- senior leadership teams
- teachers
- curriculum co-ordinators
- governing bodies and proprietors

It gives some basic principles to help school leaders plan and prepare for the new statutory curriculum. Schools have the flexibility to design their own curriculum to ensure it meets the needs of pupils and the community, as well as the statutory requirements.

Schools are required to teach:

- relationships education (all primary aged pupils)
- relationships and sex education (RSE) (all secondary aged pupils)
- health education (all pupils in state-funded schools only)

Ofsted school inspectors will evaluate the provision for relationships education, relationships and sex education and health education in line with the school inspection handbook (https://www.gov.uk/government/publications/school-inspection-handbook-eif) and in the context of this guidance.

Independent schools are required to teach personal, social, health and economic (PHSE) education.

Sex education at primary school is not compulsory but can be taught if a school decides that it is appropriate to do so.

All pupils should receive teaching on lesbian, gay, bisexual and transgender (LGBT) relationships during their school years. Secondary schools should include LGBT content in their teaching. Primary schools are strongly encouraged, and enabled, when teaching about different types of family, to include families with same sex parents.

Headteachers and teachers must read the statutory guidance (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education) in full. It contains information on what schools should do and sets out the legal duties you must meet.

## Creating a policy for the new curriculum

It is important to read the developing a policy (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#developing-a-policy) section of the statutory guidance to ensure you understand what you need to comply with.

All schools must have a written policy in place for the new relationships education and relationships and sex education curriculum.

Policies are typically approved by the governing body, or the appropriate body if that is not the governing body (for example, the trust board).

You will need to decide the outline of your curriculum and consult with parents and carers on the policy before finalising it.

The statutory guidance suggests typical sections you may wish to include in your policy such as:

- details of the content or scheme of work and when each topic is taught, taking the age of pupils into account
- who delivers relationships education or relationships and sex education
- whether you're using any external organisations to teach part of the curriculum
- how the policy has been produced, and how it will be kept under review, in both cases working with parents and carers, as set out in the advice on engaging parents with relationships education (https://www.gov.uk/government/publications/engaging-parents-with-relationships-education-policy)
- how the delivery of the content will be made accessible to all pupils, including those with special educational needs and disabilities (SEND)
- an explanation of the right to withdraw pupils from sex education classes
- requirements on schools in law, for example (where relevant), the Human Rights Act 1998 (https://www.legislation.gov.uk/ukpga/1998/42/contents), the Equality Act 2010 and the Education Act 1996 (https://www.legislation.gov.uk/ukpga/1996/56/contents)
- how often the policy is updated
- who approves the policy

Where parents and carers have complaints which cannot be resolved through informal discussion, you should ask them to follow your school's (curriculum) complaints policy.

## Integration to the whole school ethos

You should already have a statement of values and ethos. This may include personal qualities and behaviours you seek to foster.

Consider making a link between your values and ethos statement and your relationships, sex and health education policy.

## Adapting an existing programme of study

Many schools who are planning their curriculum for relationships education, relationships and sex education and health education will be doing so within a broader personal, social, health and economic (PSHE) education framework (https://www.gov.uk/government/publications/personal-social-health-and-economic-education-pshe).

You could choose to teach the new compulsory content within the PSHE education framework if this model meets the needs of your pupils. The new curriculum and your PSHE education framework do not need to be seen as separate subjects.

PSHE education remains non-statutory in maintained schools although the new subjects cover much of the content typically included in a PSHE education programme. PSHE education continues to be compulsory in independent schools, as set out in the Education (Independent School Standards) Regulations 2014 (http://www.legislation.gov.uk/uksi/2014/3283/schedule/made#:~:text=The%20Education%20%28Independent%20School%20Standards%29%20Regulations%202014%201,Quality%20of%20leadership%20in%20and%20management%20of%20schools).

Before you plan your new curriculum, you need to review your current curriculum plan in light of the statutory requirements. Your school may already have some provision in place that will support delivery. For example, a wider school ethos of inclusion and anti-bullying procedures.

## Deciding what to teach at primary and secondary level

The statutory guidance specifies:

- what topics need to be taught at primary level and secondary level

- what pupils should know by the end of each level

It does not break the curriculum up by key stage, year group or age. This is because decisions about when to teach topics will vary by school and context.

Use your knowledge of your pupils to choose whether to:

- introduce secondary requirements in primary with pupils who are ready (with parental consultation and consent)
- include primary requirements in secondary teaching where pupils have gaps in their understanding, to build their knowledge before they progress (this is likely to be needed as the new curriculum is introduced)

Try to identify what pupils already know at the start of a lesson or topic. Topics should be revisited, as necessary.

Consider working with your academy trust or local authority and local public health teams when embedding statutory relationships, sex and health education within your whole school ethos. They can work with you to help make sure:

- you are clear on what has been covered already, for example, what a secondary school pupil might have been taught in primary school
- teaching progresses smoothly from key stage to key stage
- you understand local health profiles of children and young people within the catchment area of the school, which can help you identify priorities in the curriculum
- you have a knowledge of the wider specialist support services (including sexual health services) available to children and young people in the area

Contact your local public health team to find out what tailored local support is available. The names of current local directors of public health (https://www.adph.org.uk/current-directors-of-public-health/) are available on the Association of Directors for Public Health website. You can also contact them through your local authority.

## Teaching these subjects

These subjects should be set in the context of a whole-school approach to supporting pupils to be safe, happy and prepared for life beyond school. It is important that as you begin to plan your curriculum, you are clear about your approach to pedagogy and connect to wider school approaches on how pupils learn to promote good progress.

The evidence and expert guidance on how children are best taught applies to these topics as to all others.

Teaching should:

- clearly explain the knowledge, facts and concepts needed
- provide adequate opportunities for pupils to recall the acquired knowledge, facts and concepts to develop an understanding of the topic

The training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) provide some examples of good practice and approaches you might consider when preparing to teach about individual subjects.

You can deliver a carefully sequenced and coherent curriculum, by:

- identifying the essential concepts, knowledge, skills and principles of the subject and providing an opportunity for all pupils to learn and master these critical components
- ensuring pupils' thinking is focused on key ideas within the subject
- working with experienced colleagues to accumulate and refine a collection of powerful analogies, illustrations, examples, explanations and demonstrations
- using resources and materials aligned with the school curriculum (for example, printed or online textbooks or shared resources designed by experienced colleagues that carefully sequence content)
- being aware of common misconceptions and discussing with experienced colleagues how to help pupils master important concepts

A good summary of what we know about effective pedagogy and how to apply it is in the Early Career Framework (https://www.gov.uk/government/publications/supporting-early-career-teachers).

## Planning your curriculum

The relationships education, relationships and sex education and health education curriculum complements several other curriculum subjects. You should look for opportunities to draw links between the subjects and integrate teaching where appropriate.

For example, it may be helpful to know:

- in secondary schools when relevant aspects of science (biology) are taught in relation to sex education
- in primary schools when relevant aspects of puberty are taught in science
- when and how physical education covers the benefits of an active lifestyle and cardiovascular exercise
- how content in computing relates to online and media topic
- when literary texts which touch on emotional aspects of relationships are studied in English

## Points to consider when planning your curriculum

When planning your curriculum, consider mapping out terms, years and key stages to help decide which topics you will cover and when. Also, consider whether there are topics which will need to be covered more than once as pupils grow in maturity.

You will also need to consider the most appropriate method for teaching certain topics. This could mean having:

- regular lessons – for example, a weekly or fortnightly slot in class taught by the class teacher
- a teacher or other appropriate adult in school who teaches a particular topic to all classes in turn
- additional whole school / key stage assemblies, either led by staff at school or by a carefully selected external speaker or expert - it's important to remember that assemblies should not be a substitution for timetabled lessons

It is possible that you may see an increase in disclosures as a result of teaching the new subjects. You should remind all staff members of the correct procedures to follow, should any disclosures from individual pupils be prompted by lessons in these subjects.

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

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## Using external agencies

External agencies (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements) can provide speakers, tools and resources to enhance and supplement the curriculum.

It is important when using external agencies to take particular care that the agency and any materials used are appropriate and in line with your school's legal duties regarding political impartiality, which you can find more information about in our guidance on political impartiality in schools (https://www.gov.uk/government/publications/political-impartiality-in-schools).

Schools are responsible for ensuring that speakers, tools and resources do not undermine the fundamental British values of democracy, the rule of law, individual liberty, and mutual respect and tolerance of those with different faiths and beliefs.

When deciding on the external agencies and resources to use, you should make appropriate checks to ensure that the agencies' approach to teaching relationships education, relationships and sex education and health education and the resources that they plan to use comply with:

- your school's policy
- the Teaching Standards
- the Equality Act 2010
- the Human Rights Act 1998
- the Education Act 1996

You should engage with agencies to ensure their approach to teaching about relationships education, relationships and sex education and health education is balanced and the resources they intend to use are age-appropriate and aligned to the developmental stage of the pupils being taught. Schools should exercise their judgement reasonably, in line with their legal responsibilities, in the selection of providers and resources to be used. You should exercise extreme caution when working with external agencies and proceed only if you have full confidence in the agency, its approach and the resources it uses.

Schools should not under any circumstances work with external agencies that take or promote extreme political positions or use materials produced by such agencies. More information on this, including examples of extreme political positions, can be found in guidance on political impartiality in schools (https://www.gov.uk/government/publications/political-impartiality-in-schools).

It is important to be clear about what you want from an external agency, tool or resource. You should consider the range of options available to ensure what you use is best suited and appropriate to your school and pupils and are of a high quality and sufficient value.

If you are using external speakers to deliver part of the curriculum, then it is important to make sure the expert and any tool or resource they might use meets the outcome of that part of the curriculum.

External experts and resources can also be useful for developing curriculum planning ideas, activities and identifying age-appropriate outcomes.

It is important that you review any case study material and look for feedback from others they have worked with.

You should be clear what they are going to say and what their position on the issues to be discussed are. You should ask to see any materials that external agencies may use in advance.

Make sure you know the named individuals who will be there, any need for Disclosure and Barring Service (DBS) checks and that there is an agreed protocol should any safeguarding issue arise, for example from a disclosure.

You should also conduct a basic online search (as parents and carers may do this). It is important that anything you or parents and carers would be concerned about is addressed beforehand.

Before a session with an external speaker, it is important to check protocols for taking pictures or using any personal data the external speaker may get from the session.

Remember teachers should not be afraid to say 'no', or in extreme cases stop a session. These are your pupils and you are responsible for what is said to them.

It is good practice for the teacher to be in the room, so they know what was discussed and can follow up with their pupils. They will also understand what has been discussed if a pupil makes a disclosure later.

## Choosing resources

There are many external resources (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#use-of-materials) available to support the delivery of your lessons, these include:

- lesson plans
- complete curriculum plans
- other classroom materials such as videos or posters

Any materials you intend to use should align with the teaching requirements set out in the statutory guidance.

Many organisations actively promote external resources to schools. It is important when choosing resources to take particular care that any materials used are appropriate and in line with your school's legal duties regarding political impartiality, which you can find more information about in our guidance on political impartiality in schools (https://www.gov.uk/government/publications/political-impartiality-in-schools).

Schools should not under any circumstances use resources produced by organisations that take extreme political positions on matters. This is the case even if the material itself is not extreme, as the use of it could imply endorsement or support of the organisation.

When deciding if a resource is suitable, you should consider if it:

- aligns to the teaching requirements set out in the statutory guidance
- would support pupils in applying their knowledge in different contexts and settings
- is age-appropriate - think about the age, developmental stage and background of your pupils
- is evidence-based and contains robust facts and statistics
- fits into your curriculum plan
- is from a credible source

It is also important to consider whether the resource is compatible with approaches to teaching which are known to be effective. These approaches are summarised in the Early Career Framework (https://www.gov.uk/government/publications/supporting-early-career-teachers). The resources you choose should deliver knowledge in a way that supports the building of pupils' confidence.

Resources should also be sensitive to pupils' experiences as some may have already been exposed or at risk of content being taught. You should ensure that resources do not exhibit any content that may provoke distress.

A series of DfE training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) are also available which subject leads can use to train other teachers.

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## Creating an inclusive classroom

You should consider what it is like for a diverse range of pupils to be taught about these topics and how individual pupils may relate to particular topics, including complex and sensitive subjects that might personally affect them.

These topics should help all pupils understand their physical and emotional development and enable them to make positive decisions in their lives.

The approach you take to planning and teaching these subjects should take account of those pupils who may be at different stages of cognitive development to their peers. For example, for some pupils in secondary schools, there may be a need to focus on primary content beyond age 11.

You should also make sure the framing of issues is appropriate and that additional time is taken to explain to parents and carers what will be taught and why.

Some pupils may have already been exposed to, or be at risk of exposure to, the experiences and content being taught. Developing a sensitive teaching style will be key to ensuring all pupils feel safe and supported in lessons and able to engage with the key messages.

As well as classroom teaching, you may want to consider other options including digital approaches, one-to-one discussions, teaching in small groups or targeted sessions for some pupils.

## Supporting pupils with additional needs

It is important to read the supporting pupils with special educational needs and disabilities (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#pupils-with-special-educational-needs) section of the statutory guidance.

Relationships education, relationships and sex education and health education must be accessible for all pupils and this is particularly important when you are planning teaching for pupils with special educational needs and disabilities (SEND).

Subject leaders should liaise with the class teacher and special educational needs co-ordinator (SENCO) to make sure:

- the needs of all pupils are met
- the curriculum is fully accessible
- education, health and care (EHC) plans are followed

If your school is a mainstream school, you should ensure that teaching is differentiated to support pupils with SEND to fully access the curriculum. This might include revisiting earlier topics or spending longer on a topic. Effective use of teaching assistants will support this.

You should also use your own expertise and knowledge to differentiate activities within lessons where needed.

Specialist resources can be used to support effective teaching. You can use the picture exchange communication system (PECS) to create resources or image-based books for pupils with SEND.

There are specific duties set out in:

- schedule 10 of the Equality Act 2010 (http://www.legislation.gov.uk/ukpga/2010/15/schedule/10) to support the participation of disabled pupils
- chapter 6 of the SEND code of practice (https://www.gov.uk/government/publications/send-code-of-practice-0-to-25), to support the participation of pupils with SEND

## The Equality Act 2010 and Public Sector Equality Duty

Schools are required to comply with relevant requirements of the Equality Act 2010 (https://www.legislation.gov.uk/ukpga/2010/15/contents). Chapter 1 of Part 6 of the Act applies to schools.

The content of the school curriculum is exempt from the duties imposed on schools by Part 6 of the Equality Act.

This means schools are free to include a full range of issues, ideas and materials in their curriculum. Schools are not required to equally weight all of the protected characteristics within the curriculum.

The Public Sector Equality Duty (https://www.equalityhumanrights.com/en/publication-download/public-sector-equality-duty-guidance-schools-england) (as set out in section 149 of the Equality Act 2010) requires all public authorities (including state-funded schools) in the exercise of their function, to have due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it

Relevant protected characteristics are:

- age
- disability
- gender reassignment
- pregnancy and maternity
- race
- religion or belief
- sex and sexual orientation

State-funded schools must ensure that the public sector equality duty is discharged when taking decisions.

Pupils should leave school with a proper understanding of the importance of equality and respecting and understanding differences. This includes differences in religion, belief, or sexual orientation.

The guidance for promoting fundamental British values (https://www.gov.uk/government/publications/promoting-fundamental-british-values-through-smsc) provides some helpful principles to guide practice.

## Ensuring content is appropriate

The safety of children is of paramount importance in school.

Teachers should be aware of age-inappropriate material on the internet. Great caution should be exercised before setting any assignment, in class or at home, that involves researching a subject where there is a high risk that a child could accidentally be exposed to age-inappropriate material, such as pornography. Particularly at primary level, you should be careful not to expose children to over-sexualised content.

Knowledge about safer sex and sexual health is important to ensure that young people are equipped to make safe, informed and healthy choices. This should be delivered in a non-judgemental, factual way and allow scope for young people to ask questions in a safe environment. Schools have the freedom to develop an age-appropriate, developmental curriculum which meets the needs of their young people, in consultation with parents and the local community.

You should be mindful of the law and legal requirements and be careful not to condone or encourage illegal political activity, including violent action against people, criminal damage to property, hate crime or terrorism, or the use of illegal drugs.

We are aware that topics involving gender and biological sex can be complex and sensitive matters to navigate. You should not reinforce harmful stereotypes, for instance by suggesting that children might be a different gender based on their personality and interests or the clothes they prefer to wear. Resources used in teaching about this topic must always be age-appropriate and evidence based. Materials which suggest that non-conformity to gender stereotypes should be seen as synonymous with having a different gender identity should not be used and you should not work with external agencies or organisations that produce such material. While teachers should not suggest to a child that their non-compliance with gender stereotypes means that either their personality or their body is wrong and in need of changing, teachers should always seek to treat individual students with sympathy and support.

You should work together with parents on any decisions regarding your school's treatment of their child, in line with the school's safeguarding policy and the statutory guidance on working together to safeguard children (https://www.gov.uk/government/publications/working-together-to-safeguard-children--2).

## Dealing with sensitive issues

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

What is sensitive or likely to give parents, carers or teachers cause for anxiety may vary according to the context of the school.

Conversations within your lessons should not lead to any type of bullying, ostracising or other forms of social or emotional harm. Pupils should be aware of this and lessons should be delivered in such a way to ensure this does not happen.

To help create a safe environment for pupils when teaching these topics, you should consider:

- setting ground rules for lessons, where needed, particularly around not sharing personal information (there is guidance on how to create ground rules in the individual subject training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education))
- stopping discussions if personal information is shared in lessons and following up with pupils later where needed
- not promising confidentiality if a pupil confides something concerning
- telling pupils they can ask for help and they will be taken seriously

## Managing a sensitive class discussion

Occasionally teachers may find that managing a whole class discussion is a useful stage in the teaching of a particular topic.

Whole class discussions can be a useful way to model listening respectfully to the views of others.

## Distancing techniques

You can avoid embarrassment and protect pupils' privacy by always depersonalising discussion, for example, using a case study to illustrate an issue.

Pupils can then talk about a fictional character in the case study without having to share personal information.

You should manage and lead discussions attentively. If the discussion is at risk of straying, you need to be prepared to redirect it back to intended topics.

It is generally not helpful to ask pupils to lead or chair discussions on sensitive topics as there can be a greater risk of going off-topic.

## Handling difficult questions

Teaching in these subjects should allow appropriate opportunities for pupils to ask questions to check and test their understanding.

Most questions will be relevant to what the teacher has explained, and general questions should be welcomed. Pupils should not feel penalised or censored for asking sensible or relevant questions, even if they are occasionally awkward.

Sometimes, pupils may ask questions which go beyond what the teacher has planned and may stray into sensitive territory.

There is no single way to address all such questions – some may be handled straightforwardly for the whole class to hear.

You should be mindful and explain to teachers that a question may occasionally raise a possible safeguarding concern, and the school's safeguarding process should be followed in such cases.

The individual subject training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) include advice on handling difficult questions.

### Primary level

Some questions may relate to sex education which the school may not be teaching, or not yet. These should generally not be answered in front of the whole class.

Strategies to handle such questioning could include offering a word outside the lesson, referring to another more senior member of staff or offering a simple 'holding' answer and mentioning the question to parents and carers at the end of the day.

> It is important to read the managing difficult questions (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/relationships-education-primary#managing-difficult-questions) section of the statutory guidance.

### Secondary level

Questions relating to sex education may come up anytime. There might be pupils whose parents or carers do not want them to receive sex education in school, therefore particular care should be taken when answering questions in front of these pupils.

Where a pupil who is withdrawn from sex education asks a question relating to sex education content, teachers should offer a brief 'holding response', usually via a senior member of staff and draw the issue to the attention of the pupil's parents and carers, unless there is a safeguarding concern and then the school's

safeguarding process should be followed in such cases.

For pupils who are not withdrawn from sex education, it may be appropriate to speak discreetly with the pupil asking the question at the end of the lesson to address their question or to ensure the answer is covered in subsequent teaching which is clearly designated as sex education.

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

## Right to request withdrawal

It is important to read the right to be excused from sex education (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#right-to-be-excused-from-sex-education-commonly-referred-to-as-the-right-to-withdraw) (also referred to as the right to withdraw) section of the statutory guidance to ensure you understand what you need to comply with.

You should be clear in your published policy when in the curriculum different aspects of sex education are taught.

The policy should state clearly that parents and carers have the right to request withdrawal from all or part of sex education. It should also tell them who to contact to make such a request - this will usually be the headteacher, in the first instance.

When a request is received, consider meeting with the parents and carers to:

- discuss the background to their request
- offer assurances about your school's approach
- set out the benefits of pupils accessing sex education in school

If parents and carers decline an invitation to a discussion, you must still process their request for withdrawal in the normal way.

If the parents still want withdrawal after such a discussion, unless there are exceptional circumstances, parents and carers' request should be granted until 3 terms before the pupil turns 16. For example, if the pupil's 16th birthday is in February of year 11, that point would be February in year 10.

At that point, if the pupil wishes to be taught sex education, you must ensure they receive it in one of those 3 terms and continue to be taught it while the child remains in school.

## Right to withdraw – pupils with special educational needs and disabilities (SEND)

In most cases, there should be no difference in the approach between SEND pupils (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#pupils-with-special-educational-needs) and other pupils.

However, in cases where the nature or degree of the pupil's special educational need or disability, possibly combined with their domestic or social circumstances, mean that they are demonstrably very likely to be at unusual risk from sexual activity or sexual exploitation, then your headteacher may judge that an exception should be made.

In such exceptional cases, your headteacher may decline a parental request for withdrawal (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/introduction-to-requirements#right-to-be-excused-from-sex-education-commonly-referred-to-as-the-right-to-withdraw).

It is important to read the safeguarding, reports of abuse and confidentiality (https://www.gov.uk/government/publications/relationships-education-relationships-and-sex-education-rse-and-health-education/delivery-and-teaching-strategies#safeguarding-reports-of-abuse-and-confidentiality) section of the statutory guidance.

## Record keeping and informing parents and carers

You should keep a record of all discussions with parents, carers and pupils concerning the right to withdraw, exceptions and decisions not to grant it.

Where possible, you should share records of all discussions with parents and carers to make sure all parties are clear about the decisions.

## Primary sex education (where taught)

**Primary schools are not required to teach sex education but must teach relationships education and have regard to the statutory guidance in full.**

Primary schools may already have age-appropriate sex education programmes in place. There is no need to change these if your curriculum is working well. However, sex education is outside the content defined for relationships and health education in primary schools.

You need to set out clearly in your policy if you are teaching sex education. You must also be aware of the parental right of withdrawal at primary. You should make it clear to parents and carers in your policy and set out a practical method for them to communicate to school if this is their wish. Stating clearly exactly what aspects of sex education are covered in what terms and years is helpful to allow parents and carers to make this decision.

Parents and carers cannot withdraw their child from:

- relationships education
- health education
- national curriculum science (https://www.gov.uk/government/publications/national-curriculum-in-england-science-programmes-of-study)

Read our advice on engaging parents and carers on relationships education (https://www.gov.uk/government/publications/engaging-parents-with-relationships-education-policy) which explains why it is important to engage with parents and carers, as soon as possible, and gives tips on how to do this.

## Identifying teachers' needs

## Teacher wellbeing

It is essential that teachers can maintain their own wellbeing when delivering the curriculum. There may be times that a topic triggers feelings or thoughts, including of historic, recent or current trauma.

It is important for school leaders to appreciate the different nature of these subjects, and be understanding of teachers' individual circumstances and the support they may need.

You may want to engage teachers in considering their own needs in advance.

It is important that teaching is balanced and not dependent on any personal views teachers may have. Teachers should operate at all times within the framework of their school's policy, the Teaching Standards (https://www.gov.uk/government/publications/teachers-standards) and comply with the Equality Act (https://www.legislation.gov.uk/ukpga/2010/15/contents). There is no obligation on teachers to offer information personal to themselves or to share personal views.

**Teachers are not required to answer personal questions asked by pupils and should consider, with the support of their school, how best to handle any such questions.**

## Teacher training

Teacher training activities may help your teachers feel supported. You might also consider activities that support teachers to reflect on their own values around the subject and consider ways to present an unbiased and evidence-based curriculum to pupils.

Use the teacher training modules (https://www.gov.uk/guidance/teaching-about-relationships-sex-and-health#train-teachers-on-relationships-sex-and-health-education) to train groups of teachers on the different topics within the curriculum.

## Assessment and evaluation

## Assessment

Schools should have the same high expectations of the quality of pupils' work in these subjects as for other curriculum areas. A strong curriculum will build on the knowledge pupils have previously acquired, including in other subjects, with regular feedback provided on pupil progress.

Lessons should be planned to ensure that all pupils of differing abilities are suitably challenged. You should identify and assess the needs of pupils who may require extra support or intervention.

Whilst there is no formal examined assessment for these subjects, you could use tests, written assignments or self-evaluations, to capture progress.

## Evaluation

Schools should continuously evaluate and review the implementation of relationships education, relationships and sex education and health education, to ensure the quality of provision.

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1. 17 February 2022
   Added a link to the guidance on political impartiality in schools.
2. 24 September 2020
   First published.

## Related content

- Relationships education, relationships and sex education (RSE) and health education: FAQs (/government/news/relationships-education-relationships-and-sex-education-rse-and-health-education-faqs)
- Relationships education, RSE and PSHE (/government/publications/relationships-education-rse-and-pshe)
- Relationships, sex and health education: guides for parents (/government/publications/relationships-sex-and-health-education-guides-for-schools)
- Engaging parents with relationships education policy (/government/publications/engaging-parents-with-relationships-education-policy)
- Pre-election guidance for schools and multi-academy trusts (/government/publications/pre-election-guidance-for-schools-and-multi-academy-trusts)

### Detailed guidance

- Teaching about relationships, sex and health (/guidance/teaching-about-relationships-sex-and-health)

### Explore the topic

- Personal, social, health and economic education (/education/personal-social-health-and-economic-education)

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# Major LGBTQ+ organisations spark international review of the EHRC

SEND SHARE SHARE EMAIL RSS

BY STONEWALL STAFF

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NEWS

## All of us need our human rights protected and upheld. This is a fundamental value that rises above the politics of the day.

That is why the United Nations has robust mechanisms in place internationally to ensure that National Human Rights Institutions (NRHIs) can operate independently of the changing priorities of any government.

These are known as the Paris Principles – the minimum standards required for NHRIs to meet to be considered effective and credible. For an NRHI to achieve an 'A' status, which allows them to participate at the UN Human Rights Council, they must be fully compliant with these principles.

We believe that recent statements made by the Equality and Human Rights Commission (EHRC), Great Britain's NHRI, indicate that they can no longer be considered compliant with the Paris Principles, and are no longer fit for purpose as a National Human Rights Institution.

This week, a coalition of LGBTQ+ and trans focused charities and human rights bodies, led by Stonewall and supported by the Good Law Project, wrote to the United Nations and the Global Alliance of National Human Rights Institutions (GANRHI) to formally submit evidence to support calls for a Special Review of the 'A' status of EHRC as Great Britain's National Human Rights Institution.

The submission is prompted by the EHRC's recent, and significant, change in stance on the issue of trans rights. Their recent statements on GRA reform in Scotland, and the conversion therapy ban in England and Wales, not only reverse their long-held positions, but are in stark contrast to international human rights standards. The EHRC's stance seeks to strip trans people of legal protections, and pose a grave threat to the ability of trans people to participate in daily life with dignity and respect.

> The 19-page submission outlines substantial evidence that reveals the numerous ways the EHRC now finds itself falling short of international standards.

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The 19-page submission outlines substantial evidence that reveals the numerous ways the EHRC now finds itself falling short of international standards. It outlines a ‘complete absence’ of financial autonomy from the UK Government, and cites ‘excessive’ governmental interference – including ‘politically motivated’ appointments to the Chair and Board, many of whom have repeatedly and publicly demonstrated their opposition to the expansion of human rights, and whose appointments have drawn widespread criticism from NGOs.

The signatories of this exercise accept that UK Government policy changes based on their democratic mandate.

However, the important point of NHRIs is that they should operate according to the principle of acting independently, free from political inference, and focus on upholding international human rights standards regardless of the politics of the day.

> The politicisation of GB's human rights body to take a determinedly anti-trans stance has placed trans people in the firing line.

The politicisation of the GB’s human rights body to take a determinedly anti-trans stance has placed trans people in the firing line.

But the EHRC’s attempt to create a hierarchy of human rights in Great Britain is a very real threat to everyone, particularly those of us protected by the Equality Act. That is why we have taken swift action to call for an international review, and domestically, we are calling for the Women & Equalities Select Committee to hold a review into the matter.

It is difficult to see how the EHRC can continue to hold its current status, given how compromised it appears to be, and how far from Paris Principles compliance it has drifted. We call on the UK Government to show leadership by ensuring we have a revived and truly independent EHRC that is fit for purpose.

## You can support our international efforts by campaigning here in the UK. Take action in support of trans rights.

## Signatories

Good Law Project

Liberty

Gendered Intelligence

TransActual

Mermaids

Trans in the City

GIRES

Sparkle

Trans Safety Network

LGBT Consortium

LGBT Foundation

Equality Network

LGBT Youth Scotland

Galop

Feminist Gender Equality Network

Steph's Place UK

The Outside Project

The Clare Project

Be: North

Spectra

CliniQ

Allsorts

Tonic Housing

Global Butterflies

## Quotes from signatories

"The EHRC is walking away from its duties to uphold basic human rights for trans and non-binary people. It no longer commands our confidence, and we fear what it now intends. It will take some strong and swift actions to convince us that it is on our side, actions we no longer think it is capable of." - **TransActual**

"As the UK's leading charity supporting trans people, we join Stonewall in calling on the UN to review the 'A' status of the Equality and Human Rights Commission. The EHRC's biased approach to trans rights raises big questions around its integrity and so-called 'independence'. The EHRC uses its 'A' status as evidence of its credibility on its website – a credibility that creates an authority which is currently contributing to the roll-back of trans rights in the UK. We ask for a thorough examination of the EHRC through the lens of the UN, because the public deserve an impartial watchdog, not one that drives government agendas." - **Mermaids**

"As independent human rights organisations we must uphold human rights equally, regardless of political whim or public opinion. The EHRC's recent announcements however, run contrary to this basic principle. Far from pushing UK governments to go further and strengthen equality and rights protections for LGBT people it is calling for UK governments to pause their plans. It has also made suggestions about conversion therapy which actively undermine the health and well-being of trans people in the UK right now. The departure from its purpose is as staggering as it is unacceptable. The EHRC's role as a National Human Rights Institution must be reviewed." - **Martha Spurrier, Director of Liberty.**

"The past years have seen LGBT and other human rights organisations lose faith in the EHRC to serve as an independent body, or one that works for the protection of our rights. It has shown again and again it will

take dangerous, swingeing moves against marginalised people if it deems it politically expedient to do so. This is doubly true, as the last few weeks have shown, for the trans and non-binary people whose rights it should be standing up for, not seeking to undermine." - **Gendered Intelligence**

“At GIRES, our aim is to ensure that national and international legislation and practice meet the needs of trans and gender diverse people. We call on EHRC and our Government to work with trans communities now, to call out prejudice and discrimination, improve our existing equality legislation, strengthen our fight for trans human rights, in the UK and elsewhere.” - **Cat Burton, GIRES Chair and Shaan Knan, GIRES Vice Chair**

"The EHRC is subject to a level of oversight and micro-management from the Department which is just not consistent with being a UN Human Rights Institution. They are supposed to be independent from Government but the EHRC looks much more like a tool of Government." - **Jolyon Maugham, Director of the Good Law Project**

“As a national LGBT+ specialist infrastructure and membership organisation, Consortium share the serious concerns raised by member organisations and allies about the direction of the EHRC. We are deeply troubled by the threat that the EHRC’s actions pose to the human rights of trans people. We stand with all trans and non-binary people – in defending their human rights, dignity and safety – In the UK and globally.” - **LGBT Consortium**

“A review of the EHRC is urgently needed. As a UN-accredited National Human Rights Institution, it should operate according to the ‘Paris Principles,’ which include the commitment to promote and protect all human rights and to contribute to a world where everyone, everywhere fully enjoys their rights. We believe the EHRC fail in this. Defending trans and non-binary people’s rights, dignity and safety is critical.” - **Rob Cookson, Deputy Chief Executive, LGBT Foundation**

“This submission clearly sets out our concerns about undue UK Government influence on the EHRC. The EHRC also seems to be riding roughshod over the arrangements that are in place to ensure proper consultation in Scotland on devolved matters including gender recognition reform.” - **Tim Hopkins, director of the Equality Network**

"We are supporting this submission, because as a feminist organisation with members worldwide and one committed to equality for everyone including trans people, we are concerned and disgusted by the activities of the EHRC and its failure to support the human rights of trans people in the UK. We believe the UN and the international community as a whole needs to take action against the EHRC's threat to human rights of many groups of people in the UK." - **Feminist Gender Equality Network**

“The way the EHRC is constituted makes it institutionally unfit for purpose. It is subject to unacceptable levels of political and financial control and thus cannot meaningfully be regarded as an independent reviewer of human rights within the UK. This follows serious shortcomings called out previously in the Women and Equality Select Committee report as well. EHRC has now advocated multiple policies which pose a serious threat to the human rights of trans individuals. We demand a complete overhaul.” - **Trans Safety Network**

“Galop has significant concerns about the EHRC's views on trans rights. As the largest organisation in the UK working directly with LGBT+ victims of abuse, we believe its current position will have serious negative impacts on those we support, and on our community as a whole.” - **Galop**

“Under the direction of Baroness Falkner, the Equality and Human Rights Commission has proved time and again that it is no longer fit for purpose, or global recognition as an independent human rights body. We stand with Stonewall and other LGBTQIA+ charities and human rights organisations in condemning the EHRC’s failure in its mission to “encourage equality and diversity, eliminate unlawful discrimination, and protect and promote the human rights of everyone in Britain”. - **Sparkle – The National Transgender Charity**

“Our concerns about EHRC’s change in approach in Scotland, resulting in the potential adverse impact on the human rights of young LGBTI people, are included within this submission. They are echoed in an open letter to Scottish Government by our Trans Rights Youth Commission who recently highlighted that “EHRC are meant to be defenders of our human rights” while clearly expressing their hurt and anger to this change in stance. We welcome this request to GANHRI and add our voice calling for a Special Review” - **Dr Mhairi Crawford, Chief Executive of LGBT Youth Scotland**

"With EHRC's complete reversal on their own positions they have shown that current leadership is actively hostile to trans people in the UK and cannot be considered fit for purpose as a human rights organisation." - **Gemma Dellbridge, Operations Director, Be Trans Support and Community**

“Government interference with the EHRC has led to it being unfit for purpose which we believe is strategic in the UK's escalating hostile environment towards marginalised communities. A special review by the UN will give hope to many that although this small island may appear adrift, we are seen and heard by much greater countries internationally.” - **Carla Ecola, Co-founder, The LGBTQI+ Outside Project**

“Spectra welcomes this rigorous and detailed initiative from Stonewall calling for a special review of the EHRC. Concerns with organisational independence from government together with the failure of the EHRC to attend to issues of trans equality have eroded the EHRC's reputation, underscoring the necessity of action.” - **Spectra**

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LGB Alliance
Kemp House
152-160 City Road
London, EC1V 2NX

Nadine Dorries
Minister for Mental Health, Suicide Prevention and Patient Safety
House of Commons
London SW1A 0AA

30 June 2020

Dear Minister,

**NHS-funded service for detransitioners**

We are writing to you on a matter of some urgency about the need for a new service to be provided by the NHS.

You are doubtless aware of the 4,400% increase in the number of girls seeking "gender treatment" at the Tavistock GIDS clinic over the past decade. You may also be aware that growing numbers of young women in their twenties are coming to realise that they made a mistake. They have beard growth, deep voices and in some cases have undergone double mastectomies, and now recognise that they are women. In many cases they have come to understand that they had in fact been struggling with an internalised resistance to their lesbian sexuality, often compounded by homophobia within their families. In case you may have missed it, this issue was covered in the recent Newsnight broadcast of 18 June.[1]

There is an unmet need for a service to help these young women – and indeed any young men who may be in a comparable situation. We cannot quantify this need since many of those concerned are suffering in solitude: there is nowhere for them to go. These individuals are often understandably reluctant to contact the service that caused their present situation. They often feel shame and embarrassment that the solution they had sought so eagerly turned out to be fool's gold. They are angry with the medical professionals who simply encouraged them to "transition" without helping them to explore the underlying factors, which, aside from sexual orientation, often involve abuse or autism and a range of other mental health issues.

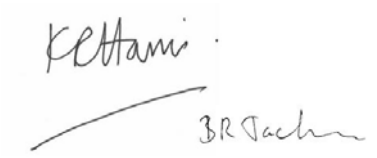
[1] https://www.youtube.com/watch?v=zTRnrp9pXHY&feature=youtu.be

Whether there are five, fifty or five hundred young women and men in need of a professional service to help them deal with what is undoubtedly a highly complex array of physical, mental and even legal difficulties, there is undoubtedly an unmet need that must be addressed. We feel that it is clearly the duty of the NHS, which caused the problems in the first place, to provide a service for people who find themselves in this extraordinarily distressing situation.

We are in contact with several highly experienced clinicians who will be more than happy to contribute their expertise to help you understand this problem more fully. We therefore urge you to reply as soon as possible with a view to arranging a meeting with these experts. In our view, this is the necessary first step towards addressing this urgent matter and exploring the parameters of the necessary new service.

In the appendix below, we attach a set of proposals drawn up by experts in the field.

Yours sincerely,



Kate Harris and Bev Jackson
LGB Alliance

**Appendix**

**Proposals for requirements for a service for detransitioners**

- This needs to be a primarily psychological service with access to specialist endocrinologists who may be required for consultation with hormonal/surgical matters.

- The therapy may comprise either individual or group-based therapy and should be a psychodynamic/attachment/supportive model and with reference to specific adaptations of therapeutic model. I would recommend reference to my papers (Hakeem) and chapters published outlining the specialist adaptations of psychotherapy for Gender Dysphoria. For a subset of patients additional psychoeducation on gender/sex, risk management and distress tolerance skills, *may* be required.

- Therapists should not have any particular aims in relation to the patient outcomes – biologically or identity-wise - but should be able to be available to provide a neutral exploratory thinking space without the patient feeling they are being pressurised into one particular solution or another.

- Therapists should be adequately trained in the therapy model they are delivering and robust individual and supervision should be available – with a particular focus on avoiding team dynamics impacting on individuals' ability to work with the client group.

- The service should be able to cater for those below the age of 18, who would usually be considered children and adolescents in mental health services, as well as patients over the age of 18, who would usually be considered adults, in addition to older adults.

- These services should not be part of a gender identity clinic but be separate in physical location and accountability.

- Ideally a broad range of outcome measures should be used: e.g. the GPRS outcome rating scale to show effectiveness of treatments offered.

- The service should be free to access for patients and ideally there should be no limits to the length of contact with services (over time it may be found that there is an optimal time required for the treatment in which case the time of the service may change).

- Due to the specialist nature of the service, this should be considered a national specialist funding initiative rather than set up at local level.

- Continued professional development of staff support and supervision would be essential for the staff due to the complexity and challenging nature of the work. External and objective clinical oversight should be built into the service design.

- The essential requirements for the therapists would be adequate training and expertise rather than having experienced gender dysphoria or transition or detransition themselves, although the involvement of 'experts by experience' or detransitioners themselves at the planning and delivery of the service would be extremely helpful.

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# What is a “normal” masculine chest? Findings from an anthropometric study of cisgender men and implications for transgender chest wall masculinization surgery.

Thursday, 11th April - 08:40: Surgeons Only Session I: trans men (Bramante 15)

***Tim van de Grift [1], Floyd Timmermans [1], Merel de Heer [1], Mark-Bram Bouman [1], Margriet Mullender [1]***

***1.*** *VU Medical Center*

**Background**

**Introduction:** Two aims of chest wall masculinization surgery in trans men are to remove feminine breast tissue and to place the nipple-areolar complex (NAC) in a masculine position. Yet, little is known of what is a “normal” masculine chest constitutes.

**Objective:** In order to improve surgical counseling and operative decision-making, the aim of this study was to collect normative data on breast volume and NAC position in cisgender men. Also, anthropometric chest characteristics were related to other physical characteristics.

**Methods**

**Methods:** Between September 2017 and December 2017, cisgender male volunteers from the VU University Medical Center and Medical School were approached to participate. Participants with preexisting thorax trauma or surgery were excluded. Data collection included standardized manual assessment and 3D photography of the thorax. From both sources, data on position of the NAC, umbilicus, sternal notch and axillary fold were collected. Also data on areolar size and shape were collected. In order to measure body type, chest circumference, waist-hip ratio and leg lengths were determined. Lastly, participants filled out a short survey on ethnicity, highest weight and sport habits. Descriptive statistic were performed after which a backwards selection multiple regression analysis was conducted to determine a prediction model for inter nipple distance and NAC position. Analysis of the prediction of chest volume is still in progress.

**Results and Conclusions**

**Results:** A total of 68 cisgender men participated in the study. Substantial variability in NAC position was observed: the absolute inter nipple distance ranged between 18.8 and 28.3 cm (M=22.6). Similarly, areolar diameters ranged between 1.3/1.8 and 4.2/3.9 cm (left/right, M=2.7) (Figure 1). The inter nipple distance was predicted by the chest circumference, umbilicus to anterior axillary fold length and Caucasian ethnicity. The relative NAC position was predicted by BMI, umbilicus to anterior axillary fold length and inner leg length. No statistically significant independent effects of other variables were observed. When testing the final NAC prediction model on the dataset, the model showed good internal validity (small discrepancies). No outcomes of similar analyses of breast volume have been produced yet.

**Conclusions:** The present study indicates that there is no such thing as a uniform “normal” masculine chest for everyone. However, the model showed good predictive value in the present data set, suggesting that masculine NAC position can be predicted adequately based on other body characteristics. These findings may assist clinicians in surgical decision-making and counseling trans men on the variability of the male thorax.

# Chest reconstruction and chest dysphoria in trans masculine minors and young adults

Thursday, 11th April - 08:45: Surgeons Only Session I: trans men (Bramante 15)

***Johanna Olson-Kennedy*** [1]

***1.*** *Children's Hospital Los Angeles/University of Southern California*

**Background**

As transgender visibility has increased over the past decade, growing numbers of transgender and gender non-binary youth are presenting at specialized clinics seeking care related to phenotypic gender transition. Despite the fact that the average age of referral is dropping, the developmental stage that most patients are in at the time of entry into medical care necessitates future surgical intervention to change undesired secondary sex characteristics. For those assigned female at birth who identify on the transmasculine spectrum, gender confirmation procedures commonly include male chest reconstruction. Chest dysphoria, the distress that arises from having a female chest contour, is a common clinical concern for transmasculine adolescents and young adults. While a decent body of literature exists examining the outcomes of transgender related surgeries in patients over the age of majority, no data has been published concerning the outcomes of these procedures among minors. Existing professional guidelines regarding surgical interventions lack clarity, and leave medical providers uncertain about referring minors for chest surgery. This pilot study aimed to quantify the impact of male chest reconstruction on chest dysphoria in this population and included the development of a "chest dysphoria" measure.

**Methods**

The chest dysphoria scale was developed by experienced clinicians and includes 17 Likert scale questions that span domains commonly impacted by chest distress. The domains include emotional well-being, physical well-being, recreational, occupational, social life and relationships was created and administered to 68 pre-surgical and 68 post-surgical transmasculine youth and young adults between the ages of 13 and 24 years. Higher composite scores on the scale correspond with greater chest dysphoria, with a range from 0 (lowest) to 51 (highest). Pre-surgical participants were asked about their desire for surgery, and the post-surgical survey queried satisfaction with surgery, side effects and desire for future surgeries related to gender dysphoria.

**Results and Conclusions**

Half of the 136 participants were post-surgical, thirty-three were minors (49% post-surgical) at the time of surgery. Chest dysphoria composite score mean was 29.6 for participants who had not yet undergone chest reconstruction, significantly higher than those who had undergone this procedure (3.3; $p<.001$). Among the non-surgical cohort, 64 (94%) perceived chest surgery as very important, and chest dysphoria increased by 0.33 points each month that passed between initiation of testosterone and the time of survey. The most common complication of surgery was loss of nipple sensation. Comparisons between the pre and post surgical groups across all domains are significant, and highlight the impact of chest dysphoria on those youth who have not undergone surgery. No youth reported regret about the procedure.

Results from the post-surgical cohort reflect the positive impact of male chest reconstruction witnessed in clinical settings, and might be useful for changing existing guidelines and recommendations for minors.

# Masculinizing chest surgery in trans male patient: does large breast always correlate with postoperative loss of nipple sensation ?

Thursday, 11th April - 08:50: Surgeons Only Session I: trans men (Bramante 15)

***Alexis Laungani*** [1], ***Oscar Manrique*** [1], ***Jorys Martinez-Jorge*** [1]

***1.*** *Mayo Clinic*

**Background**

For most trans men, breasts are the cause of significant dysphoria. Chest surgery is the first important step in achieving a more masculine look, thus relieving some dysphoria and helping one to fulfill the criteria of living in the assimilated gender prior to potential genital surgery. Several algorithms have been proposed to discuss the type of subcutaneous mastectomy depending on the breast size and the skin elasticity. For large breasts with poor skin elasticity, the described gold standard technique remains the double subcutaneous mastectomy incision with free nipple graft. The main burden of this technique is the postoperative complete loss of nipple sensation.

**Methods**

We present a technique combining a subcutaneous mastectomy with the principles of a breast reduction with wise pattern and inferior pedicle. In this technique, the preoperative markings are similar to those of a well-known classic wise pattern breast reduction and inferior pedicle. The new nipple position is evaluated by different means. The large inferior flap is completely de-epithelialized.

**Results and Conclusions**

Plastic surgeons who perform a lot of breast surgery for cisfemale patients have a very good understanding of vascular anatomy of the breast. With the improvement of mastectomies and preservation of the nipple areola complex by the general surgeons, it has become a necessity to adapt plastic surgery techniques. This knowledge can be used to better serve our transgender patient. We described a subcutaneous mastectomy technique that allows preservation of the nipple sensation and reproducible even in large breasts.

# Nipple sensation and appearance after chest wall reconstruction using the double incision mastectomy and inferior dermal flap technique. A prospective study from a single surgical center in a three year period.

Thursday, 11th April - 08:55: Surgeons Only Session I: trans men (Bramante 15)

***Ioannis Ntanos*** [1], ***Grit Dabritz*** [1]

***1.*** *North Manchester General Hospital*

**Background**

Many trans men express a preference to have nipple sensation preserved. This is due to the desire for functioning nipples as well as for sexual satisfaction. The inferior dermal flap technique appears to preserve nipple sensation in a large number of patients. All patients who wish to retain nipple sensation and have no contraindications are offered this technique in our unit.

**Methods**

Our service users are offered to complete a questionnaire six months after their operation at their final review appointment. The review included an interview regarding general health and physical well-being and a clinical examination. The date of surgery includes the period from October 2015 to February 2018 and date of review the period from April 2016 to August 2018.

**Results and Conclusions**

In total there were 66 bilateral and one unilateral case (total number of mastectomies 133). Nipple sensation was retained at least in one side in 87 mastectomies (65,41%) and bilaterally in 40 cases (60%). Nipple sensation was not retained in either side in 18 cases (27,27%). Qualitative parameters like response to cold and warmth was also reviewed with comparable results on both sides. The nipple appearance (user perception) was unchanged in 51 cases bilaterally (77.27%). No nipples were lost.

This surgical technique appears to have good results preserving nipple sensation in around two thirds of cases. It can safely be used in selective cases. Further studies are required to evaluate long-term nipple sensation and patient satisfaction.

# Masculine chest wall contouring in trans men: a personal approach

Thursday, 11th April - 09:00: Surgeons Only Session I: trans men (Bramante 15)

***Giulia Lo Russo*** [1], ***Sara Tanini*** [1]

***1.*** *Depertment of Plastic and Reconstructive Microsurgery, Careggi University Hospital, Florence Italy.*

**Background**

The anatomical features of the chest identify an individual as male or female and even the smallest details of these features determine the appropriate appearance for each gender . The main goal is to masculinize the chest by removing the female contour. Chest contour, scar placement, scar shape, scar length, nipple-areola position, nipple size and the areola size are the key points.After the introduction of news details to perfect the technical surgery and the final results we have decided to analyzed the satisfaction and the social, physical and psychological improvement of our patients following chest masculinization surgery. To do that we have used the Breast-Q modified and adapted to this surgical procedures and elaborated with a personalized web application.

**Methods**

Between July 2013 and June 2019, 100 trans men underwent surgical procedures to create a masculine chest-wall contour. In our study, we analizes the all patients who have undergone chest surgery, we determine our flow chart and we use the breast-q adapted to our population to valuated the results. Furthermore we have published an anatomical study and statistical analysis support to create a method for repositioning the NAC that is applicable in the operating room, is easy, practical and reproducible without the use of formulas and based on an easily identifiable landmark.

**Results and Conclusions**

The patients' survey revealed a high satisfaction rate with the aesthetic result. We use the double incision method for most of the cases, reserving the periareolar technique for the very small size breast.

The authors propose a new technical approach and indications for FtM transgender patients' surgery. A longer scar that emphasizes the pectoralis muscle, a smaller nipple and a resized and refaced areola are the key points of our technique to give a masculine appearance to the chest. Furthermore our anatomical study and statistical analysis support a consistent relationship between the position and shape of the NAC and the borders of the pectoral muscle. We have used this relationship to develop our "trick," which is easily applicable in the operating room to find the NAC position without using formulas and numbers. This method allowed us to place the NAC in a position very close to that of a typical male subject, and it permitted us to reduce the surgery time. The scars are permanent, but most of them will fade and the patients are enthusiastic with their new "male" chest appearance. The high level of satisfaction, the great aesthetic result and the low rate of complications suggest to us the use of this technique in even small and medium-size breasts.

# Combined total laparoscopic hysterectomy and bilateral salpingo-oophorectomy with subcutaneous mastectomy in trans men: does the order matter?

Thursday, 11th April - 09:05: Surgeons Only Session I: trans men (Bramante 15)

***Lian Elfering*** [1], ***Tim van de Grift*** [1], ***Mark-Bram Bouman*** [1], ***Norah Van Mello*** [1], ***Freek Groenman*** [1], ***Judith Huirne*** [1], ***Margriet Mullender*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

Subcutaneous mastectomy is the preferred gender affirming surgery in trans men and can be combined with a total laparoscopic hysterectomy with or without bilateral salpingo-oophorectomy (TLH ± BSO) in one single operation session. Research regarding the outcomes of this combined procedure technique is scarce and it is unknown if the order of the procedures matters when considering the rate(s) of complication. It is hypothesized that the rate of post-operative hematoma (or bleeding) after mastectomy may increase when mastectomy is performed first, due to the Trendelenburg position of the patient during TLH ± BSO.

**Methods**

Trans men who underwent bilateral subcutaneous mastectomy with TLH ± BSO between July 2012 and December 2017 in two hospitals in Amsterdam, The Netherlands, were identified. A retrospective chart review was performed, in which the order of procedures, peri- and post-operative bleeding and re-surgery were recorded. The primary outcome measures in this study were the incidence rate of post-operative bleeding and re-surgery of the breast needed.

**Results and Conclusions**

Two hundred and twelve trans men underwent combined mastectomy and TLH ± BSO. Of them, 34 (16.0%) developed a post-operative bleeding of the breast, 25 (16.4%) in the TLH/BSO-first group and 9 (15.0%) trans men in the mastectomy-first group (p = 0.88). Re-surgery of the breast during admission was needed in 21 patients (9.9%), n= 14 (9.3%) in the TLH/BSO-first group versus n = 7 (11.7%) in the mastectomy-first group (p = 0.60).

Conclusion: Based on these retrospective data is the order of procedures in combined mastectomy and TLH ± BSO not of influence on the post-operative bleeding of the breast or the incidence of re-surgery.

# Vaginal remnants after gender affirmation surgery in trans men

Thursday, 11th April - 09:10: Surgeons Only Session I: trans men (Bramante 15)

***Borko Stojanovic [1], Marta Bizic [1], Marko Bencic [1], Gradimir Korac [1], Svetlana Vujovic [2], Dragana Duisin [3], Dusica Markovic Zigic [4], Katarina Maksimovic [4], Marija Miletic [5], Milina Tancic-Gajic [5], Jasmina Barisic [6], Miroslav Djordjevic [1]***

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**Background**

Removal of female genitalia is usually the first and very important step in gender affirmation surgery (GAS) in trans men. Closure of the vagina in our center is performed by colpocleisis, minimally invasive and efficient procedure. However, rejuvenation of vaginal mucosa may lead to various complications in these patients.

**Methods**

Between January 2010 and March 2018, 15 trans men, aged 21–36 years (mean age 30.5) presented with symptoms due to vaginal remnants after GAS. They previously underwent one-stage GAS, that included hysterectomy with bilateral oophorectomy, vaginectomy (colpocleisis), metoidioplasty and urethral lengthening. Complications occurred 3 to 16 months (mean 7 months) after GAS, and included perineal cyst formation, persistent perineal or urethral discharge, and/or localized perineal inflammation. All patients underwent surgical repair using perineal approach. Complete excision of cystic vaginal remnant is performed, followed by perineoplasty and urethroplasty.

**Results and Conclusions**

The mean follow-up was 40 months (ranged from 6 to 105 months). Successful outcome was achieved in all cases. All patients were free of symptoms after surgery, with a normal male appearance of perineal region and without urethral discharge. There have been no sings of recurrence so far.

Vaginal remnant may occur as a complication of colpocleisis, performed as a part of GAS in trans men. Complete surgical repair is necessary to eliminate this complication, without recurrence.

# Vaginal colpectomy in transgender men; procedure and outcomes of a retrospective cohort study

Thursday, 11th April - 09:15: Surgeons Only Session I: trans men (Bramante 15)

***Charlotte Nikkels [1], Mick van Trotsenburg [2], Judith Huirne [1], Mark-Bram Bouman [1], Robert De Leeuw [1], Norah Van Mello [1], Brechje Ronkes [1], Freek Groenman [1]***

***1.*** *Amsterdam UMC, location VUmc,* ***2.*** *Universitätsklinikum St. Pölten-Lilienfeld*

**Background**

The individualized management of transgender men range from no physical changes to complete transition that includes hormonal therapy, mastectomy, hysterectomy, oophorectomy and genital surgery. Colpectomy, removal of the vaginal epithelium and closure of the introitus, may be performed because of a disturbed male self-image or vaginal discharge. Also risk reduction for fistula formation at the urethral-neo-urethral junction has become an important indication for performing colpectomy. Colpectomy via a vaginal/perineal approach is often thought of as a hazardous procedure due to its complexity and may lead to various complications such as bladder and bowel lesions, haemorrhage and fistula. The objective of this study is to describe our technique and report on the outcomes.

**Methods**

A single-center retrospective cohort study on all vaginal colpectomies was performed between January 2006 and April 2018.

**Results and Conclusions**

A total number of 143 vaginal colpectomies was performed. In 109 patients (76%) the procedure consisted of colpectomy only, while in 34 patients (23%) colpectomy was combined with other procedures. Mean length of the procedure was 132 minutes (±SD 62), median blood loss was 300 mL (IQR 250) and mean time of admission to the hospital was 3,6 days (±SD 1,9). In 15 patients (10%) per-operative major complications were reported and one per-operative minor complication (0,7%). Post-operative major complications were reported in 17 patients (12%) and post-operative minor complications in 50 patients (35%).

Conclusion: Vaginal colpectomy is a procedure with a high complication rate but advantages seem to outweigh disadvantages, both subjectively and objectively. In all but one no long-term sequelae were reported but the high complication rate and re-intervention rate should be discussed with patients who are considering to undergo this procedure. Future studies are needed to optimise the procedure and to determine the optimal approach and strategy.

# The effect of colpectomy on the lower urinary tract function in transgender men: a prospective cohort study

Thursday, 11th April - 09:20: Surgeons Only Session I: trans men (Bramante 15)

***Brechje Ronkes*** [1]***, Muhammed Al-tamimi*** [2]***, Garry Pigot*** [2]***, Norah Van Mello*** [2]***, Judith Huirne*** [2]***, Freek Groenman*** [3]***, Mark-Bram Bouman*** [2]

***1.*** *Amsterdam UMC, location VUmc,* ***2.*** *VU Medical Center,* ***3.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

**Background:**Many transgender men who opt for genital gender affirming surgery (GAS) express the wish to be able to void while standing. To enable this, the urethra has to be lengthened. Urethral lengthening is considered to a significant challenge that is associated with a high complication rates of urethral fistula and strictures. These complications can results in personal distress and impede the possibility to void while standing. To reduce urethral fistula rate, a colpectomy is increasingly performed to obtain sufficient vascularized tissue for neo-urethra coverage. In elderly assigned women at birth, performing a colpectomy is associated with chronic urinary dysfunction. However, no data is available on urinary tract function in transgender men that undergo colpectomy.
**Objective:**To assess the effect of colpectomy on the lower urinary tract function in transgender men.

**Methods**

**Methods:**We prospectively assessed the lower urinary tract (LUT) function (e.g. uroflowmetry, post-void residual volume, international prostate symptom score and voiding diary) in transgender men before, and three months after colpectomy. Colpectomy surgical technique, complications and reoperations were recorded.

**Results and Conclusions**

**Results:**Thirty transgender men underwent colpectomy. Of 30 patients, 13 underwent (robot assisted) laparoscopic colpectomy and 17 patients had a vaginal procedure. Additional patients will be included and the final data will be presented at the EPATH Symposium.
**Conclusion:**Based on the preliminary data, (1) a colpectomy seems to be associated with urinary dysfunction postoperatively, and (2) (robot assisted) laparoscopic colpectomy seems to result in less urinary complications in comparison to a vaginal procedure

# “Gender Confirming Surgery for trans men” - the Daverio all-in-one surgical concept -

Thursday, 11th April - 10:10: Surgeons Only Session II: trans men (Bramante 15)

***Paul Daverio*** [1]***, Andreas Steiert*** [2]***, Michael Krüger*** [2]

***1.*** *Swiss Medical network,* ***2.*** *MEOCLINIC BERLIN*

**Background**

Most centers for Gender Confirming Surgery perform female to male surgery in more than one stage, usually in the following steps: Mastectomy as a single procedure, sometimes with the Hysterectomy and Adnexectomy; Phalloplasty or Metaiodioplasty with or without Colpectomy. In this report we will introduce our All-in-One Concept in Female to Male Gender Confirming Surgery (FMGCS), regarding the feasibility in a realistic time slot of surgical duration in less then nine hours in order to avoid severe complications.

**Methods**

FMGCS is performed in an All-in-One Concept. The different parts of the surgery are split in different teams, working simultaneously. The All-in-One Surgery Concept includes the following surgery steps: Mastectomy, Colpectomy, complete Hysterectomy and bilateral Adnexectomy, proximal Urethroplasty and a microvascular Phalloplasty including a neopenile urethra as a tube-in-tube flap (Radial Forearm Free Flap, RFF). The arterial anastomosis is an end-to-side anastomosis with the femoral artery, the venous anastomosis is usually performed as an end-to-end anastomosis with saphena magna and accessories. The extended urethra allows to be shifted upwards in a new position to define the basis of the penoid together with the former clitoris. For sensitization of the penoid, a connection can be performed between the sensitive branches of the cutaneous antebrachii nerve of the RFF and the bilateral ilioinguinal nerves by fibrin glueing. The resulting cavum after Colpectomy is minimized and closed. The new scrotum is created by special preparation of the Labia Majora. The placement of an inflatable prosthesis is usually done after achieving of the sensitive penile innervation nine months after the All-in-One FMGCS.

**Results and Conclusions**

In more than 1000 cases of FMGCS, we performed 40% with the All-in-One surgical Concept. In the other FMGCS patients, the Mastectomy and the Hysterectomy had been done in a prior surgical procedure. We saw no severe complications based on the prolonged surgical approach. After twelve days, patients urinate in standing position and became outpatients two weeks after the operation. Most of them are back to work after four weeks. The low rate of complications will be discussed.

**Conclusion:**

Transgender surgery is a high specific surgery, belonging in expert’s hands. A FMGCS as an All-in-One surgical Concept is possible and safe. Most of the patients undergoing FMGCS are full time occupied in their business and career. For this reason, the downtime to get back in daily life is very important to realize the gender reassignment process. Finally, it is very relieving for the patients to conquer the FMGCS in only one surgical procedure, when they celebrate their “Man’s Birthday”, the day after surgery.

# Combination phalloplasty in trans men: surgical methods and complications

Thursday, 11th April - 10:15: Surgeons Only Session II: trans men (Bramante 15)

***Toshiyuki Watanabe*** [1]

***1.*** *Okayama University Hospital*

**Background**

Phalloplasty with radial forearm flap(RF flap) using tube within a tube style technique is standard. But if the patient refuses to be done with forearm flap to avoid a large scar on the forearm, or is in a Allen's test negative case, we'll do pedicled anterolateral thigh flap (ALT flap) using the tube within a tube technique, or do flap combination phalloplasty. But in some cases, pedicled ALT flap can not be used from the variation of the blood vessel or flap thickness. In these cases, we do combination phalloplasty using combined one flap for the urethra formation and another flap for reconstruction of the penile shaft.We present this concept of adaptation.

**Methods**

The combination phalloplasty is performed when the patient wants to avoid a large scar on the forearm or in a Allen's test negative case or pedicled ALT flap using the tube within a tube technique can not be used from the variation of the blood vessel or flap thickness. The method of combination phalloplasty is that a small radial forearm flap is used only for urethro-plasty and another flap for shaft plasty, and that when a radial forearm flap is not used, more than two flaps are used to reduce morbidity of the forearm. The kinds of flaps ever used are RF flap,pedicled ALT flap,pedicled SCIP flap,and pedicled groin flap.

**Results and Conclusions**

We performed combination phalloplasty in 17 patients. The clinical disadvantages of combination phalloplasty are the technical complexity of the plastic surgery procedure and prolonged surgical operation times. In some cases, it was impossible to reconnect the nerves because of technical difficulties. Combination phalloplasty has any advantages such as it can gain the selection of donor flaps, it can reduce the donor morbidity of forearm, it can be used for Allen' test negative case, and pedicled ALT flap can not be used from the variation of the blood vessel or flap thickness. And it has some disadvantages prolonged operation time and complexity of the operative procedure. Combination phalloplasty is alternative useful technique.

# Comparison of Radial Forearm Flap and Antero-Lateral Thigh Flap Phalloplasty: Analysis of 413 Cases

Thursday, 11th April - 10:20: Surgeons Only Session II: trans men (Bramante 15)

***Karel Claes*** [1]***, Stan Monstrey*** [2]***, Edward De Wolf*** [2]***, Salvatore D'Arpa*** [3]

***1.*** *University Hospital Ghent,* ***2.*** *Ghent University Hospital,* ***3.*** *Uz Gent*

**Background**

This study aims at comparing outcomes of anterolateral thigh (ALT) flap phalloplasty and of radial forearm flap (RFF) phalloplasty. ALT flap phalloplasty is gaining increasing popularity in gender confirming surgery. This is the largest series comparing ALT flap phalloplasty and RFF phalloplasty .

**Methods**

Four-hundred-thirteen phalloplasties were performed at a single institution between 2004 and 2016 (320 RFF, 93 ALT). Flap survival, urinary complications (fistulae and strictures), outcomes of erectile and testicular implants, number of secondary procedures required at the penis and at the donor site. PROMs were evaluated as well by administering a questionnaire to investigate QoL and aesthetic outcomes. Mean follow up was 51 months in the RFF group and 40 months in the ALT group.

**Results and Conclusions**

Rates of secondary procedures in the penis (45 vs 15 %) and in the donor site (16 vs 5 %) were significantly higher in the ALT group compared to the RFF group. In the RFF group there were significantly higher early fistula rates (31.6 vs 15.2 %) and significantly higher rates of patients wearing an implant (65.6 vs 42 %). No statistically significant differences were found in the rates of fistulas requiring surgery, stricture rates, flap revision rates and prosthesis-related complications rates. Even PROMs (responders: 37 RFF and 17 ALT patients) showed no statistically significant difference.

There seems to be no significant differences in terms of outcomes when comparing ALT phalloplasty with RFF phalloplasty. The ALT phalloplasty, which allows to avoid the forearm scar, can be considered as a valuable alternative to RFF phalloplasty. The drawbacks are the frequent need for a second flap for the urethra, higher rates of secondary touch ups at the penis and at the donor site. QoL and cosmetic outcomes were comparable. RFF patients request an erectile implant more often since sometimes the ALT is thick and rigid enough to allow sexual intercourse without an implant.

# An outcome analysis of the suprapubic pedicled phalloplasty in trans men diagnosed with gender dysphoria: a retrospective cohort analysis

Thursday, 11th April - 10:25: Surgeons Only Session II: trans men (Bramante 15)

***Marco Falcone*** [1]***, Massimiliano Timpano*** [2]***, Paolo Gontero*** [2]

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**Background**

Various techniques may be considered to address total phallic construction (TPC) in trans men diagnosed with gender dysphoria (GD). The gold standard approach is yet to be defined. The aim of our study is to report the surgical outcomes and the patient's reported outcomes (PRO's) after a suprapubic pedicled phalloplasty (SPP) in trans men with gender dysphoria.

**Methods**

From November 2008 to August 2018 a consecutive series of 42 trans men diagnosed with gender dysphoria underwent a sex reassignment surgery (SRS) in a single tertiary referral center. Patients were offered the choice between three different techniques: metoidioplasty, radial artery based forearm free-flap and SPP. A retrospective analysis focused on patients underwent a SPP was conducted extrapolating data from the clinical records. SPP was conducted as a multistage procedure, consisting in 3 stages a) TPC b) glans sculpting, urethral reconstruction and scrotoplasty c) penile prosthesis implantation. A descriptive analysis of the surgical outcomes and PRO's was conducted. Statistical analysis was performed using STATA version 12.0 for Mac package.

Duration of surgery, intra and postoperative complications and the hospital stay were selected as variables for the surgical outcomes. PRO's were extrapolated from a 4-item "ad hoc" created questionnaire administered through a telephone interview at 1 year follow-up.

**Results and Conclusions**

A total 23 patients were enrolled in the present study. The median age was 45 (IQR 35-49). The median BMI was 24 (IQR 22-26). The median follow-up was 88 months (IQR (16-102). The median operative time resulted 135 (IQR 120-215). A defatting of the flap was necessary in 13 patients (81.2%) as well as an umbilicus caudal repositioning which was needed in 5 patients (31.2%). Lateral rotational flap to close the abdominal defect were required in 7 patients (43.75%).

The median size of the flap turned out to be: length of 13 cm (IQR 12-13) and width of 12 cm (IQR 11-12). The median hospital stay was 5 days (IQR 4-6). Focusing on major postoperative complications a partial necrosis of phallus was detected in a single case (6.2%), as well as a seroma formation (6.2%). 18 patients completed the 3 stages of surgery and were therefore considered for PRO's analysis. 89% of patients declared to be fully satisfied of the TPC. 83% would recommend the procedure to someone else and 89% would undergo the same procedure again. 66% of patients could achieve an orgasm during sexual penetrative intercourses.

The SPP represents an acceptable option for TPC, with a low incidence of major complications and without disfiguring the donor skin site.

# The surgical technique and outcomes of secondary phalloplasty after metoidioplasty in transgender men: an international, multi-center case series.

Thursday, 11th April - 10:30: Surgeons Only Session II: trans men (Bramante 15)

***Muhammed Al-tamimi*** [1], ***Garry Pigot*** [2], ***Wouter Van Der Sluis*** [1], ***Miroslav Djordjevic*** [3], ***Romain Wiegert*** [4], ***Christopher Salgado*** [5], ***Sinikka Suominen*** [6], ***Kristin de Haseth*** [7], ***Marlon Buncamper*** [2], ***Maud Belanger*** [8], ***Richard Santucci*** [9], ***Mark-Bram Bouman*** [2]

***1.*** *Amsterdam UMC, location VU University Medical Center,* ***2.*** *VU Medical Center,* ***3.*** *School of Medicine, University of Belgrade, Belgrade, University Children's Hospital, Belgrade, Serbia,* ***4.*** *CHU Bordeaux,* ***5.*** *University of Miami Hospital,* ***6.*** *Helsinki University Hospital,* ***7.*** *VU,* ***8.*** *Gender Reassignment Surgery Montreal,* ***9.*** *Detroit Medical Center*

**Background**

Some transgender men express the wish to undergo Genital gender Affirming Surgery (GAS). Metoidioplasty and phalloplasty are procedures that are performed to reconstruct the neophallus. Disadvantages of metoidioplasty are: a relatively small neophallus, inability to have penetrative sex and often incapability to void while standing. Therefore, some transgender men opt to undergo a secondary phalloplasty after metoidioplasty. Phalloplasty consists of creating a neophallus using free and/or pedicled flaps. Literature on secondary phalloplasty is scarce.

**Methods**

Transgender men, wereretrospectively identified who underwent secondary phalloplasty after metoidioplastyin seven specialized gender surgery clinics. Pre-operative consultation,patient reason for secondary phalloplasty, surgical technique, peri-operativecharacteristics, complications , clinical and patient experienced outcomes were recorded.

**Results and Conclusions**

A total of 61 patients were identified. The main patient reasons to undergo secondary phalloplasty were: having a larger phallus (n=29), being able to have penetrative sexual intercourse (n=25) and/or to void from a standing position (n=15). The following free and/or pedicled flaps were used for secondary phalloplasty: free radial forearm flap (n=26), anterolateral thigh flap (n=15), latissimus dorsi flap (n=8), gracislis muscle flap (n=5), abdominal flap (n=4), groin flap (n=2) and the lateral upper arm flap (n=1). Intraoperative complications (revision of microvascular anastomosis) occurred in three (4,9%) patients. Direct postoperative complications (e.g., flap failure and wound infection) occurred in 21 (34,4%) patients. Urethral fistula occurred in 18 (32,7%) patients and strictures in 18 (32,7%) patients. The median (range) follow-up was 7 (0-39) years. Most patients were satisfied with the results. **Conclusion:** Secondary phalloplasty can be performed after metoidioplasty with complication rates to primary phalloplasty in transgender men. Proper preoperative consultation is necessary to help patients determine whether a metoidioplasty or phalloplasty is likely to meet their expectations and hopefully result in less converting procedures.

# A new coronaplasty technique in penile reconstruction

Thursday, 11th April - 10:35: Surgeons Only Session II: trans men (Bramante 15)

***Salvatore D'Arpa*** [1]***, Karel Claes*** [2]***, Casper Sommeling*** [3]***, Edward De Wolf*** [3]***, Ali Salim*** [4]***, Dries Opsomer*** [3]***, Stan Monstrey*** [1]

***1.*** *Uz Gent,* ***2.*** *University Hospital Ghent,* ***3.*** *Ghent University Hospital,* ***4.*** *Kaiser Permanente*

**Background**

The coronaplasty is an important step of the phalloplasty procedure as it creates a prominent coronal ridge and a constricted coronal sulcus, resulting in the transformation of a regular skin flap into a flap resembling a circumcised penis. The aim of this abstract is to describe our new coronaplasty technique that exploits opposing contracting forces of 2 different skin grafts to hold the shape of a thick, distally based skin flap, resulting in a natural looking neo-phallus.

**Methods**

A distally based flap is raised at the junction of the middle and distal thirds of the neo-phallus. The dissection continues until adequate mobilization is obtained, so the flap can stand almost perpendicular to the axis of the shaft. 2 separate full-thickness skin grafts are harvested and placed: the first at the raw undersurface of the flap, the second at the flap's donor site. To make the sulcus deeper and to define the ridge, the lower part of the graft placed on the undersurface of the distal flap is sutured with tacking sutures. Depending on the type of flap used this procedure can be done during the phalloplasty procedure itself (axial flaps) or at least 1 week later (perforator flaps).

**Results and Conclusions**

The new technique that we developed shows a more distinct coronal sulcus and coronal ridge, longlasting results, and a more aesthetically pleasing and natural-appearing glans penis. The harvested distal flap is progressively thicker and not folded, resulting in a more naturally looking ridge. The donor site is deeper than other techniques, creating a well-defined sulcus. By using 2 skin grafts the opposing force vectors increase the projection of the ridge and the deepness of the sulcus.

**Conclusion**

This technique results in a more prominent glans penis and is an important step in creating an almost naturally looking neo-phallus. This procedure can be applied to all different kind of flaps used for phalloplasty, both in an immediate or delayed fashion. As grafts are used, partial or complete graft lost can appear. Furthermore, attention must be paid not to incise the distal flap too deep so vascularity to the distal part of the flap will not be impaired. A continuous search to optimize the aesthetic outcome of the phalloplasty procedure is necessary and with this new coronaplasty technique we hope to raise attention and take another step toward creating "the real thing."

# SCIP Phalloplasty - Is it the aesthetic , cosmetic and functional way forward: KDAH series

Thursday, 11th April - 10:40: Surgeons Only Session II: trans men (Bramante 15)

***Sanjay Pandey*** [1]

***1.*** *Kokilaben Dhirubhai Ambani Hospital & Research Institute*

**Background**

Gender reaffirmation Phalloplasty is a complex surgical task. Successful creation of the penis must meet certain cosmetic and functional thresholds. The ideal neophallus should be sensate, hairless, and similar in color to the surrounding skin. It should have an inconspicuous scar, maintain rigidity for sexual intercourse, and allow for micturition upon standing with minimum donor site morbidity

We demonstrate our technique of using a SCIP flap for the same and its evolution over a period of 27 cases.

**Methods**

After appropriate psychiatric and endocrine evaluation, patients were counselled for surgery.

(Concomitant mastectomies/vaginectomies were also done when feasible)

The technical considerations of the surgery are demonstrated in the video.

The SCIP phalloplasty was the first part of a three stage process that involvedurethroplasty and insertion of a penile prostheses.

**Results and Conclusions**

The mean age of our patients was 28 years (21-39). There were no complications for 14 cases in our series; we saw a failure in 3 of them where the flap had to be debrided as the vascularity was hampered because of a narrow vessel, spasm or obesity. Two of them had prostheses related issues during the neourethra creation.

To conclude, the free radial forearm flap though established itself over time, has major problems like donor-site morbidity with large depressive scar after skin grafting, urethral fistulas, and need for microvascular anastomosis. A SCIP flap has the advantage of minimal donor-site morbidity with a concealed donor scar and no microvascular anastomosis aesthetic - realistic in dimensions with moderate sensations . Hence our advocacy for the same

# Pedicled sensate SCIP flap; a promising technique for phalloplasty.

Thursday, 11th April - 10:45: Surgeons Only Session II: trans men (Bramante 15)

***Kristin de Haseth*** [1], ***Floyd Timmermans*** [1], ***Lian Elfering*** [1], ***Marlon Buncamper*** [1], ***Matthijs Botman*** [1], ***Muhammed Al-tamimi*** [1], ***Mark-Bram Bouman*** [1], ***Wouter Van Der Sluis*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

The aim of the ideal neophallus is to create a phallus that resembles a penis as much as possible, has tactile and erogenous sensation, rigidity for penetrative sex and if desired the ability to void standing, while achieving low donor site comorbidity or non-stigmatizing scars. In order to achieve this goal multiple techniques have been developed.

Recently, our clinic has started using a new phalloplasty technique; a pedicled sensate superficial circumflex iliac perforator (SCIP) flap. This flap can be used as a single pedicled flap either without urethral lengthening or with urethral lengthening when combined with a contralateral SCIP flap or other tissue (local or free flap).

**Methods**

We started using this new technique as of March 2017. At the time of presentation in April 2019, we will have included more than 40 patients to present our results.

Flaps are designed on the perforators of the superficial or deep branch of the superficial circumflex iliac artery (SCIA) or a combination of both.

To pre operatively evaluate and identify the vascular status and anatomy prior to flap design, a hand held doppler is used. The flap is then designed based on the vascular course and local tissue surplus. Incision is made along the inferior border of the flap, where the proximal vascular pedicle is identified. Once the vascular pedicle is located and of adequate caliber, dissection continues in a retrograde fashion. The Th10, 11 or 12 nerve, which give sensate innervation to the raised skin area, is identified during the suprafascial dissection in the distal part of the flap, where it pierces the obliquus externus abdominis muscle. In order to gain maximum length, the nerve is then dissected toward its origin. If possible, a combination of the nerves is used for the flap reinnervation.

Once the flap is raised, it is tunneled subcutaneously to the genital region, where the acceptor site has been prepared. Neurorrhaphy is performed on one of the dorsal clitoral nerves. The neophallus is then tubularised either on itself or around the neo urethra. Post operatively, the sensitivity is evaluated by Semmes-Weinstein monofilament.

**Results and Conclusions**

**Results**

Our preliminary reports show there is an acceptable complication rate.There is however a higher flap-related complication rate in double flap phalloplasties were the SCIP flap is combined with another flap for urethral lengthening when compared to unilateral SCIP phalloplasties (without urethral lengthening).

All donor sites could be closed primarily. No complete sensibility has yet been established during the present follow up. However, most patients have reported the possibility to orgasm.

**Conclusion**

The SCIP flap yields thin, pliable tissue with minimal donor site morbidity, as well as a well concealed donor site scar with an acceptable (short term) complication rate. Most patients were able to reach an orgasm, probably

due to indirect stimulation of the buried clitoris. We expect that one year post operatively tactile sensation in the neophallus will be present, however this is yet to be objectified.

# The pedicled labia minora flap: a multicenter study on the clinical outcome of a novel surgical technique for urethral lengthening in transgender men undergoing phalloplasty.

Thursday, 11th April - 10:50: Surgeons Only Session II: trans men (Bramante 15)

***Muhammed Al-tamimi*** [1], ***Garry Pigot*** [1], ***Wouter Van Der Sluis*** [2], ***Tim van de Grift*** [1], ***Jeroen Van Moorselaar*** [2], ***Margriet Mullender*** [1], ***Miroslav Djordjevic*** [3], ***Borko Stojanovic*** [3], ***Kristin de Haseth*** [4], ***Brechje Ronkes*** [5], ***Mark-Bram Bouman*** [1]

***1.*** *VU Medical Center,* ***2.*** *Amsterdam UMC, location VU University Medical Center,* ***3.*** *School of Medicine, University of Belgrade, Belgrade, University Children's Hospital, Belgrade, Serbia,* ***4.*** *VU,* ***5.*** *Amsterdam UMC, location VUmc*

**Background**

The majority of transgender men that undergo phalloplasty express a strong desire to be able to void while standing. For this purpose the urethra has to be lengthened. A procedure which is considered to be the most challenging in phalloplasty with a high complication rate. Reconstruction of the pars fixa is considered a standard procedure and is performed using the labia minora. Reconstruction of the pars pendulans is significantly more difficult and many studies have been published in search of the ideal reconstruction technique. There are multiple surgical options for pars pendulans reconstruction: a tube-in-tube flap configuration, a second fasciocutaneous flap, use of full-thickness skin grafts or buccal mucosa. Each of these methods has its own disadvantages. We describe a novel technique with a pedicled labia minora flap (PLMF).

**Methods**

Between September 2007 and August 2018, 17 transgender men underwent phalloplasty with a PLMF for urethral lengthening at the Amsterdam UMC (VU university) in the Netherlands and the Belgrade University Hospital in Serbia. Patient demographics, surgical characteristics, neo-urethra characteristics (neo-urethra length, pars pendulans length and meatus localization), intra- and postoperative complications, pre-and postoperative voiding evaluation( e.g. uroflowmetry and voiding diary), the ability to void while standing postoperatively and hospitalization length were retrospectively identified from chart reviews. Labia minora hypertrophy was assessed by the surgeon (urologist or plastic surgeon) to determine surgical eligibility. The minimum required labia minora size to perform this technique was five centimeters in length from the base to the edge, and two centimeters in depth.

**Results and Conclusions**

The mean neo-urethral length was 15,6±2,6 centimeter, and the pars pendulans 9,6 ±2,5 centimeter. The neo-meatus was localized on top of the neophallus in 10 (58,8%) patients. No intraoperative complications occurred. Postoperative complications (within three weeks) occurred in 3 (17,6%) patients. Of those, two patients (11%) developed neo-urethral necrosis which was localized at the distal part of the pars pendulans. Urethral fistula formation occurred in 4 (23,5%) patients and strictures in 7 (41,1%) patients. Of 7 patients that developed an urethral stricture, 3 (17,6%) patients had only meatal stenosis. In 2 (11,7%) patients a (temporary) perineostomy had to be performed. **Conclusion:** The pedicled labia minora flap for urethral reconstruction in phalloplasty is a feasible surgical technique in a subset of transgender men that wish to void while standing. Advantages of this technique are a hairless urethra, more favorable urethral softness, preventing additional donorsite and being a single-stage procedure.

# Reconstructing the urethra in ALT flap phalloplasties: experience based on 93 cases.

Thursday, 11th April - 11:25: Round table: Reconstructing the urethra in ALT flap phalloplasties (Bramante 15)

***Salvatore D'Arpa*** [1], ***Karel Claes*** [2], ***Edward De Wolf*** [3], ***Nicolaas Lummen*** [3], ***Piet Hoebeke*** [3], ***Stan Monstrey*** [1]

***1.*** *Uz Gent,* ***2.*** *University Hospital Ghent,* ***3.*** *Ghent University Hospital*

**Background**

The anterolateral thigh (ALT) flap is becoming increasingly popular for phalloplasty as an alternative to the radial forearm flap (RFF) or other techniques. However, the ALT is often too thick to reconstruct the urethra with the tube-in-tube technique. Based on a 93 cases series, the largest reported so far, we aim at describing different options for urethral reconstruction in ALT phalloplasties and comparing their urinary outcomes.

**Methods**

Ninety-three ALT phalloplasties were performed between 2004 and 2016. In 7 cases the urethra was not reconstructed due to the presence of a urinary derivation. In the remaining 86 case the urethra was reconstructed with the tube-in-tube technique (n=5), with prelamination with a skin graft (n=8), with a free radial forearm flap (RFF) (n=39), with a pedicled superficial circumflex iliac artery perforator (SCIAP) flap (n=38), with a skin flap from a previous phalloplasty (n=6).

Indications were gender confirming surgery (n=79), severe penile insufficiency due to congenital malformation (n=11), amputation for cancer (n=1), multiple penile implant failures (n=1) or trauma (1).

**Results and Conclusions**

Fistulas rates were: : tube-in-tube ALT: 20%; pre-laminated ALT: 0%; free RFF: 27.6%; SCIAP: 23.7%; skin flap from previous phalloplasty: 16.7%.

Stricture rates were: tube-in-tube ALT: 20%; pre-laminated ALT: 87.5%; free RFF: 10.3%; SCIAP: 2.6%; skin flap from previous phalloplasty: 0%.

Voiding while standing was achieved in 91.86% of patients. The remaining patients have a temporary perineostomy and are awaiting completion of urethral reconstruction.

**Conclusion**

A skin flap lined urethra is, in our experience, the best option for urethral reconstruction in ALT phalloplasty. When this cannot be accomplished with the same ALT flap with the tube-in-tube technique due to excess flap thickness our first choices are the SCIAP or the RFF flaps. Due to the high stricture rates, flap prelamination has been abandoned. When there is existing penile skin, like in cases of an unsatisfactory previous phalloplasty, the penile skin could be tubed in to reconstruct the urethra.

# Welcome Address – EPATH board

Thursday, 11th April - 12:30: Plenary session I: Opening Session (Michelangelo Ballroom)

***Guy T'Sjoen*** [1]***, Joz Motmans*** [2]

***1.*** *Uz Gent,* ***2.*** *Ghent University Hospital, Center for Sexology and Gender*

**Background**

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**Methods**

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**Results and Conclusions**

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# Welcome Address – Host & Local Organizing Committee

Thursday, 11th April - 12:45: Plenary session I: Opening Session (Michelangelo Ballroom)

***Mario Maggi*** [1], ***Jiska Ristori*** [2], ***Alessandra Daphne Fisher*** [3]

***1.*** *Department of Experimental, Clinical and Biomedical Sciences Careggi University Hospital Florence,* ***2.*** *University of Florence,* ***3.*** *Department of Experimental, Clinical and Biomedical Sciences, Careggi University Hospital, Florence, Italy*

**Background**

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**Methods**

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**Results and Conclusions**

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# Sexual Intimacy, Gender Identity and 'Fraud'

Thursday, 11th April - 13:00: Plenary session I: Opening Session (Michelangelo Ballroom)

***Alex Sharpe*** [1]

***1.*** *Keele University*

**Background**

Despite a trajectory of reform, transgender people continue to face numerous problems in European societies: violence, workplace discrimination, inadequate healthcare … the list goes on (and on). However, and importantly, these and other material realities are underscored by a prior violence, what we might call an ontological wound. I am speaking here of the denial of gender identity. Many other concrete problems can be viewed as symptoms of this deeper refusal, at the level of civil society, if not the state, to recognise us as properly gendered, and therefore as fully human.

**Methods**

In order to illuminate this problem, my lecture will focus on an example from the UK, one that serves both to dramatise the problem and to emphasis the stakes for trans people. The example I will explore is one borne of material reality: the criminal prosecution of young trans and other gender non-conforming youth for not disclosing their gender histories prior to intimacy (*R v Gemma Barker* [2012] unrep; *R v Chris Wilson* [2013] unrep; *R v Justine McNally* [2013] EWCA Crim 1051; *R v Gayle Newland* [2015] unrep; *R v Kyran Lee* (Mason) [2015] unrep; *R v Jason Staines* [2016] unrep; *R v Gayle Newland* [2017] unrep). All of these defendants were convicted, most have received custodial sentences, and all have been placed on the Sex Offenders Register.

**Results and Conclusions**

The lecture will provide a series of arguments against the bringing of such prosecutions for what is, after all, desire-led intimacy. To that end, it will, in addition to considering privacy and non-discrimination rights, interrogate the key criminal law and philosophical concepts of consent, harm and deception, and will reveal the cisnormative frame through which each is constructed. Ultimately, the test of our humanity might best be gauged at such sites of desire and their disavowal, at the point where trans and cis bodies most intimately touch.

# Transgender prejudice in young, competitive sports people: The role of motivation to win and gender role beliefs

Thursday, 11th April - 14:30: Mental Health Session I: Social support, discrimination, prejudices and mental well being (Michelangelo Ballroom)

***Gemma Witcomb*** [1], ***Nessa Millet*** [1]

***1.*** *Loughborough University*

**Background**

Transgender people face many barriers to participating in sport and physical activity. At a recreational level, these may be related to inadequate facilities, body discomfort, and general transphobic discrimination. At the more competitive level, barriers may be more deeply rooted in the widely-held beliefs underpinning the institution of sport and the need for sex-segregation; that is beliefs around biology, strength, and fairness. Little previous literature has explored transgender prejudice among athletes. Thus, this study aimed to explore how cisgender competitive athletes view their transgender counterparts and to what extent transphobic attitudes are associated with gender role beliefs and differences in psychological factors that influence motivation and performance in competitive sport.

**Methods**

Participants (aged 18-30) were recruited from sports clubs and university sports teams within the UK and Ireland. Two hundred and thirty eight competitive sports people chose to participate, with 178 (59 cismales and 119 cisfemales; mean age = 21 years) completing an online questionnaire in full. The questionnaire contained demographic questions along with measures assessing individual differences in competitiveness and achievement behaviour (Sport Orientation Questionnaire), self-efficacy (General Self-Efficacy Scale), performance attribution (Controllability, Stability, Globality, and Universality Attributions), gender stereotypes (The Bem Sex- Role Inventory) and transphobia (Trans Prejudice Attitudes Scale).

**Results and Conclusions**

Cisgender male and female athletes did not differ in their levels of transphobia. When looking at the relationship between transphobia, psychological motivations in sport, and sex roles, correlational analyses revealed that transgender prejudice was positively associated with the achievement orientation *Win*, as well as with scores on the *Masculinity* measure of sex role beliefs. No other measures of psychological motivation and achievement were associated with transphobia. Subsequent regression analyses confirmed that transphobia was significantly predicted by both *Win Orientation* and *Masculinity*. This suggests that desire to win drives transphobia more than other psychological attributes and those who have more stereotypical beliefs about masculinity are likely to be less accepting of trans opponents.

**Conclusion:** The present study was unique in its inclusion of sports psychology theory within explanations for transgender prejudice. This study highlights how beliefs about gender and psychological motivation to win, irrespective of other psychological factors underpinning sporting performance, influence transphobia within a sporting context. Both of these may be illustrative of the deeply-rooted beliefs about gender, strength and fairness in sport. As trans people become more visible in sporting contexts, and policies change to promote inclusion, coaches and athletes will need to focus on challenging these beliefs in order to tackle transphobia within sport.

# A comparison of mental health symptomatology and levels of social support in young treatment seeking transgender individuals who identify as binary and non-binary

Thursday, 11th April - 14:45: Mental Health Session I: Social support, discrimination, prejudices and mental well being (Michelangelo Ballroom)

***Nat Thorne*** [1], ***Gemma Witcomb*** [2], ***Timo Nieder*** [3], ***Elena Nixon*** [1], ***Andrew Yip*** [1], ***Jon Arcelus*** [4]

***1.*** *The University of Nottingham,* ***2.*** *Loughborough University,* ***3.*** *UKE,* ***4.*** *The Nottingham Centre for Transgender Health*

**Background**

Previous research has consistently reported high rates of mental health symptomatology and lower social support in young treatment seeking transgender individuals. However, these studies have failed to distinguish between transgender people who identify within the gender binary and those who identify as non-binary. This study aimed to compare levels of mental health symptomatology (anxiety, depression, and non-suicidal self injury behavior) and social support of treatment seeking non-binary transgender young individuals with those self identified as binary transgender young individuals. All participants attended a national transgender health service in the UK during a 2-year period.

**Methods**

Data was gathered from individuals between the ages of 16-25 who were referred to a national transgender health service in the United Kingdom between June 2015 and June 2017. The data was gathered in the form of a questionnaire containing the measures. Age and gender identity descriptors were collected, as well as clinical measures of anxiety and depression (Hospital Anxiety and Depression Scale), self-esteem (The Rosenberg Self-Esteem Scale), non-suicidal self injury (Non-Suicidal Self injury: Treatment Related), and social support (Multidimensional Scale of Perceived Social Support).

**Results and Conclusions**

A total of 388 young people, aged 16–25 years, agreed participation; 331 (85.3%) identified as binary and 57 (14.7%) as non-binary. Analysis of the data showed the non-binary group experienced significantly more anxiety and depression and had significantly lower self-esteem than the binary group. There were no significant differences between groups in the likelihood of engaging in non-suicidal self injury behavior or levels of social support

**Conclusions:** Non-binary identifying treatment seeking transgender youth are at increased risk of developing anxiety, depression, and low self-esteem compared to binary transgender youth. This may reflect the even greater barriers and feelings of discrimination that may be faced by those whose identity does not fit the notion of binary gender that is pervasive in how society views both cis- and transgender populations.

# Coping with Stigma: Life Stories of Italian Transgender and Gender Nonconforming People

Thursday, 11th April - 15:00: Mental Health Session I: Social support, discrimination, prejudices and mental well being (Michelangelo Ballroom)

***Paolo Valerio*** [1], ***Anna Lisa Amodeo*** [1], ***Roberto Vitelli*** [1], ***Vincenzo Bochicchio*** [2], ***Cristiano Scandurra*** [1]

***1.*** *University of Naples Federico II,* ***2.*** *University of Calabria*

**Background**

A great amount of quantitative research has largely demonstrated that transgender and gender nonconforming (TGNC) people experience high rates of minority stress, against which they are able to exercise resilience and to use adaptive strategies buffering the negative effects of stress on health. Notwithstanding, qualitative investigations on how TGNC people subjectively experience minority stress are still scarce. Thus, the current study aims at qualitatively exploring how minority stress is subjectively experienced in a small group of Italian TGNC individuals participating in a focus group. Given the literature on stigma and coping in TGNC people (and informed by the minority stress theory), the main questions that guided this study were: (1) How do TGNC individuals subjectively experience social stigma towards them? (2) What impact does the social stigma have on TGNC individuals' health? (3) How do TGNC individuals cope with societal stigma?

**Methods**

The present study involved eight Italian TGNC participants born and living in Naples, a city in southern Italy. Regarding gender identification, 7 of them self-identified as transgender (5 trans women and 2 trans men). Only one self-identified as genderqueer and was assigned female at birth. Participants were aged from 20 to 30 years old (M = 25; SD = 5).

Participants were recruited through a snowball sampling procedure. They were sent a presentation letter of the study, in which objectives and methods were described in detail. In the letter, inclusion criteria to take part in the focus group were also reported, which were: 1) self-identifying as a TGNC person, 2) being aged between 20 and 30 years, and 3) being born and living in Naples. Before being included in the group, participants who voluntarily decided to take part in the study were invited to a meeting for the presentation of the study. At that meeting, a preliminary screening to exclude severe psychiatric disorders was performed with the participants' informed consent. All participants attending the meeting were recruited, as the screening showed no severe psychiatric disorders. The focus group was not conducted by the same authors who managed the initial meeting because they were well known to some of the participants.

All data were collected in accordance with the General Data Protection Regulation 679/2016, and the study was designed to respect all principles of the Declaration of Helsinki on Ethical Principles for Medical Research Involving Human Subjects.

Narratives were analyzed through deductive thematic analysis.

**Results and Conclusions**

The analysis generated four main categories: (1) family rejection, (2) visibility of the body, (3) negative effects of family violence on health, and (4) integration of TGNC identity.

Results offer an in-depth exploration of minority stress processes and adaptive strategies in TGNC people.

Suggestions for clinical practice and social policies are discussed.

# Relationship Between Suicide Attempt and Perceived Discrimination in People Diagnosed with Gender Dysphoria

Thursday, 11th April - 15:15: Mental Health Session I: Social support, discrimination, prejudices and mental well being (Michelangelo Ballroom)

***Zeynep Tuzun*** [1], ***Koray Başar*** [2]

***1.*** *Hacettepe University, Faculty of Medicine, Departmet of Pediatrics, Division of Adolescent Medicine,,* ***2.*** *Hacettepe University, Faculty of Medicine, Department of Psychiatry*

**Background**

Objective: It is known that people diagnosed with gender dysphoria (GD) may experience intense stress factors across their life course in many domains. Stress factors can place those individuals at high risk for negative mental health outcomes (1). In addition to experiencing a mental disorder, suicide attempt has also been associated with experience of discrimination and lack of social support (2, 3). The expectation of discrimination can lead to perceived discrimination beyond the actualized discrimination and can also cause negative mental health effects (4). High rate of suicide attempts was reported in a Turkish sample (5). The aim of this study was to investigate the relationship of perceived discrimination, social support, transition process features and lifetime history of suicide attempt in a clinical group of individuals diagnosed with gender dysphoria in Turkey.

**Methods**

Methods: Perceived Discrimination Scale (PDS), Multidimensional Scale of Perceived Social Support (MSPSS), Beck Hopelessness Scale (BHS) and self report forms related to demographic and transition-related information were administered to individuals (n=230) diagnosed with GD, who demanded assistance in gender-affirming processes in psychiatry outpatient clinic. History of suicide attempt, presence of lifetime and current mental disorders were evaluated with a clinical interview.

**Results and Conclusions**

Results: Of participants 65.2 % (n=150) were assigned female at birth and mean age of the sample was 24 years. Lifetime diagnosis of depression (% 64.4) and non-suicidal self injury (NSSI) (% 69.5) were significantly higher among participants with a lifetime history of suicide attempt. No significant gender differences were found for suicide attempts and NSSI. Participants with history of suicide attempt had higher scores indicating higher hopelessness ($p = .02$) and perceived personal discrimination ($p = .001$). Scores of MSPSS and perceived group discrimination scale were not different. Logistic regression analysis including the related variables in order to determine the predictors of suicide attempt, lifetime diagnosis of depression and perceived personal discrimination scores were found to be significantly associated.

Conclusion: Lifetime history of suicide attempt was associated with diagnosis of depression and perceived discrimination. It is considered important to address perceived discrimination and coping strategies during the assessment and follow-up of individuals diagnosed with gender dysphoria.

References

1. Arcelus J, Claes L, Witcomb GL, Marshall E, Bouman WP. Risk factors for non-suicidal self-injury among trans youth. The Journal of Sexual Medicine 2016, 13: 402-412.
2. Marshall E, Claes L, Bouman WP, Witcomb GL, Arcelus J. Non-suicidal self-injury and suicidality in trans people: A systematic review of the literature. International Review of Psychiatry 2016, 28(1): 58-69

3. Başar K, Öz G, Karakaya J. Perceived discrimination, social support, and quality of life in gender dysphoria. J Sex Med 2016, 13 (7) 1133-41
4. Yüksel Ş, Aslantaş Ertekin B, Öztürk M, Bıkmaz PS, Oğlağu Z (2016) A clinically neglected topic: Risk of suicide in transgender individuals. Arch Neuropschiatry 53: doi: 10.5152/npa.2016.10075.

# Gender-related psychological well-being, general life satisfaction and quality of life in non-binary transgender people: A case control study

Thursday, 11th April - 15:30: Mental Health Session I: Social support, discrimination, prejudices and mental well being (Michelangelo Ballroom)

***Beth Jones*** [1], ***Emma Haycraft*** [1], ***Walter Bouman*** [2], ***Jon Arcelus*** [2]

***1.*** *Loughborough University,* ***2.*** *University of Nottingham*

**Background**

To date, most transgender health research tends to group all transgender people under one category, failing to distinguish between non-binary and binary transgender people. Recent research has found that non-binary transgender people feel invisible in society and are more likely to experience transphobia in comparison to binary transgender people. This may affect mental health and life satisfaction among non-binary transgender people, although no research has explored this to date. It was therefore the aim of this study to explore mental well-being and life satisfaction among a community sample of adult non-binary transgender people and to compare these levels to controls (binary transgender people and cisgender people).

**Methods**

In total, 526 people from a community sample were recruited into the study from the United Kingdom. Of this sample, 97 were non-binary transgender people, 91 binary transgender people and 338. Participants were asked to complete an online questionnaire which included validated questionnaires related to mental well-being, life satisfaction and quality of life.

**Results and Conclusions**

Overall it was found that non-binary transgender people reported better mental health and life satisfaction in comparison to binary transgender people after controlling for age. This supports that non-binary and binary transgender people should be distinguished in research as they are not homogenous in relation to mental health and life satisfaction. However, this study also found that non-binary and binary transgender people both had poorer mental health and life satisfaction in comparison to cisgender people. Consequently, better support for mental health needs to be provided to transgender people (non-binary and binary) to close the mental health disparity between cisgender people.

# Symptoms of disordered eating among trans people seeking gender-affirming therapy in Sweden

Thursday, 11th April - 15:45: Mental Health Session I: Social support, discrimination, prejudices and mental well being (Michelangelo Ballroom)

***Amanda Gunnarsson*** [1], ***Ulrika Beckman*** [2], ***Attila Fazekas*** [3], ***Louise Frisén*** [4], ***Lotta Sandström*** [5], ***Nils Thelin*** [6], ***Fotios C Papadopoulos*** [1]

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**Background**

Several studies indicate that transgender individuals may be at higher risk of developing eating disorders than cisgender individuals. It is important to identify risk factors for disordered eating, as early identification and treatment is associated with better health outcomes. Our aim was to estimate the prevalence of eating disorder diagnoses and symptoms in a Swedish population of trans people seeking gender-affirming treatment and to examine which factors are associated with higher risk of disordered eating.

**Methods**

Baseline data on 196 transgender individuals was obtained from the Swedish Gender Dysphoria Study, a multicentre study where trans people 15 years or older with an ongoing healthcare contact for gender-affirming therapy are asked to participate. The data included basic sociodemographic and health variables, including self-reported somatic and mental health diagnoses, the Eating Disorder Examination Questionnaire (EDE-Q), Transgender Congruence Scale (TCS), Ritvo Autism and Asperger Diagnostic Scale (RAADS), Adult ADHD Self-Report Scale (ASRS) and Body Image Scale (BI-1). Eating disorder symptoms were assessed through global EDE-Q scores (n=172). Frequency analyses were made for the self-reported eating disorder diagnoses; factors related to eating disorder symptoms were examined through univariate analyses (Pearson correlations for the continuous and t-test or ANOVA for the categorical variables) followed by a multivariate linear regression model, with the EDE-Q as a continuous outcome measure.

**Results and Conclusions**

Out of the 196 participants, 7.1% (n=14) self-reported a lifetime diagnosis of any eating disorder; 2.6% (n=5) anorexia nervosa, 1.5% (n=3) bulimia nervosa and 4.1% (n=8) other eating disorder. This is to be compared with the reported Western lifetime prevalence in the general population of 1.29% for any eating disorder, 0.32% for anorexia nervosa and 0.90% for bulimia nervosa.

In the univariate analyses, factors with significant associations ($p<0.05$) with higher global EDE-Q score included higher score on the TCS, negative screening for autism spectrum disorder (ASD), positive ADHD screening, BMI, experienced trauma (psychological, physical and/or sexual), perceived discrimination, history of self-harm and/or suicidal attempt, as well as self-reported lifetime diagnosis of other psychiatric disorders than eating disorders, ASD or ADHD.

No statistically significant differences in EDE-Q were found in analyses with age, non-binary gender identity, civil status, sexual preference, previous gender-affirming treatment, age of onset for symptoms of gender dysphoria or age at menarche.

In the multivariate regression analysis, the following factors remained significant and independent correlates of symptoms of disordered eating: higher TCS scoring, higher BMI, positive ADHD screening and more perceived discrimination.

Our results suggest that there is a higher prevalence of eating disorders among trans people seeking gender-affirming therapy in Sweden than in the general population. A higher degree of gender incongruence, a higher BMI, positive ADHD screening and more perceived discrimination are independently associated with more symptoms of disordered eating in this cohort.

# Dismantling the barriers to accessing care for transgender/gender non-binary (TGNB) patients

Thursday, 11th April - 14:30: Mental Health Session Ib: country studies (Bramante 8)

***Peter Meacher*** [1], ***Asa Radix*** [2]

***1.*** *Callen-Lorde Community Health Center,* ***2.*** *Callen Lorde Community Health Center*

**Background**

It has been well documented that transgender/gender non-binary (TGNB) patients face barriers to accessing health-care, avoid healthcare and fare poorly in many metrics of health and wellness. Traditional healthcare systems are designed in a way that reinforces this inequity. Dismantling and redesigning new systems that break down such barriers is critical in any effort to improve health outcomes for this population.

Callen-Lorde is a federally qualified health center (FQHC) in New York City serving >5000 TGNB patients. For over two decades, TGNB care has successfully been provided using an Informed Consent model allowing for the rapid provision of hormone care. Hormones are usually provided within two weeks of a patient's first visit. Despite providing a trans-affirming medical setting some TGNB patients, especially those living with HIV, substance use and other chronic health conditions face challenges with retention in care.

**Methods**

Callen-Lorde has implemented an advanced access program that offers patients an alternative way to receive their care when the traditional appointment system does not work. This program, "FlexCare", allows patients same day access to full scope primary and TGNB care as well as expedited access to behavioral health services. The program is available 5 days a week and staffed by 2 medical providers who provide gender affirming services, including hormone treatment, in addition to comprehensive primary care, sexual health services, as well as specialist HIV and hepatitis C services.

**Results and Conclusions**

Our results show that FlexCare engages and retains TGNB patients in care at Callen-Lorde, including patients who would usually be driven from care by arduous barriers and competing demands. After initiating FlexCare we have observed improved health outcomes for patients who were previously lost to care, including achievement of viral suppression for those living with HIV, treatment of hepatitis C, and linkage to mental health and substance use programs. Results confirm that in combination these program designs reach populations most impacted by social determinants of health.

# Improvement in mental well-being in individuals diagnosed with gender dysphoria with psychosocial support and hormone therapy: a prospective study

Thursday, 11th April - 14:45: Mental Health Session Ib: country studies (Bramante 8)

***Koray Başar*** [1], ***Emre Mutlu*** [1]

***1.*** *Hacettepe University, Faculty of Medicine, Department of Psychiatry*

**Background**

Quality of life (QoL) and mental health indices have been reported to be worse than general population in people diagnosed with gender dysphoria (GD). Recent meta-analyses suggest improvement in both quality of life and mental health following hormone therapy. There are few prospective studies on the effects of hormone therapy, where the assessments before initiation and after 3-12 months of therapy were compared. The objective of this study was to investigate the change in QoL, mental health indices, and perceived discrimination in people diagnosed with GD by naturalistic longitudinal follow-up design. The follow-up consisted of two periods; an initial period of psychosocial assessment and support, second where hormone therapy was administered.

**Methods**

Individuals presenting to the psychiatry clinic requesting assistance for gender-affirming medical interventions were enrolled if they provided informed consent and diagnosed with GD. All participants (N=32, sex assigned at birth F/M= 27/5) were assessed at three points: initially following the first interview, later before initiation of the hormone therapy (median follow-up duration of 9 months; 3-80; IQR 8), and finally following hormone therapy (median duration of hormone use 14 months; 10-26, IQR 5). Quality of life (WHOQOL-BREF-TR), personal and group related perceived discrimination (Perceived Discrimination Scale, PDS), social support (Multidimensional Scale of Perceived Social Support, MSPSS), depressive symptom severity (Beck Depression Inventory, BDI), self-esteem (Rosenberg's Self-esteem Scale) were evaluated. Also sociodemographic and gender transition-related features were assessed via self-report forms.

**Results and Conclusions**

Participants' median age at first assessment was 24 years (18-39, IQR 6,5). Median total follow-up duration was 23.5 months (14-93, IQR 12). Eighteen participants (56.3%) had lifetime, ten (31.3%) had a current mental disorder diagnosis at the initial assessment. At the final assessment median duration of hormone use was 12 months, and 17 participants (%53.1) already had chest surgery.

Repeated measures ANOVA including three assessments revealed significant improvement in psychological (p=<.001), social (p=.011), and environmental (p=<.040) domains of WHOQOL-BREF-TR; decrease in BDI scores (p=.001); increase in MSPSS score (p=<.001); reduction in the scores of perceived discrimination against the individual (p=.005). Post-hoc tests indicated significant change with hormone therapy in all domains of QoL, whereas severity of depressive symptoms decreased and perceived social support from the family was increased significantly during the initial period of assessment and psychosocial support. Level of self-esteem was observed to improve significantly (p=.022) only during the first interval. Finally, perceived discrimination against the individual significantly decreased with each consecutive assesment.

When the effect of presence of mental disorder diagnosis at the initial interview was assessed in all above analyses, similar findings were obtained. The group without a diagnosis was shown to improve more only in social domain

of QoL (p=.012).

Findings of this prospective study confirms the beneficial effect of hormone therapy in people diagnosed with GD, and extends this improvement to the assessment and psychosocial support period preceeding the hormone therapy. Temporally distinguishable benefits shown in different periods and throughout the care provide evidence to the model of management provided in line with WPATH guidelines.

# A comparison of the presenting issues and desired outcomes of people with a non-binary gender identity, between those assigned male at birth and those assigned female at birth at the UK Charing Cross NHS Gender Identity Clinic

Thursday, 11th April - 15:00: Mental Health Session Ib: country studies (Bramante 8)

***Lucy Evans*** [1], ***Laura Scarrone Bonhomme*** [1], ***Craig Rypma*** [1], ***Christina Richards*** [1], ***Leighton Seal*** [1]

***1.*** *Charing Cross Gender Identity Clinic, Tavistock and Portman NHS Foundation Trust*

**Background**

In recent years, there has been an increase in the number of non-binary people attending gender specialist services. While there is an established body of evidence regarding binary-identified trans people, the research on non-binary gender is lacking. This study outlines the sorts of interventions non-binary people seek at the largest National Health Service (socialised healthcare) Gender Identity Clinic in the United Kingdom. Additionally, we examined the prevalence and differences in psychological presenting issues between non-binary people assigned male at birth and those assigned female at birth.

**Methods**

We have carried out a service evaluation reviewing case notes of a sample of 189 self-identified non-binary individuals attending the Charing Cross Gender Identity Clinic (GIC). The data has been collected over the period of a year via an electronic search of the clinic's records. The presenting issues and desired outcomes of non-binary individuals assigned male at birth (AMAB, N=47) were compared with non-binary individuals assigned female at birth (AFAB, N=142). The analysis was performed with SPSS software, using the Student's t-test for parametric data and chi-square analysis for nominal data. One-tailed significance was used and, due to the large number of data points, significance was taken at $p < 0.01$.

**Results and Conclusions**

From our sample we found a ratio of 3:1 AFAB vs. AMAB. Non binary people AFAB presented 4.6 years earlier than those AMAB (27.6 vs 32.2 years). With regards to gender identification, a higher proportion of people AFAB identify as non-binary masculine (63.4% vs 2.1%, $p < 0.001$) and a significantly higher proportion AMAB identified as non-binary feminine (51.1% vs 1.4%, $p < 0.001$). A higher proportion of people AFAB self-reported being asexual (22.5% vs 6.7%, $p < 0.011$).

When analysing reports of gender dysphoria and desired bodily changes through either hormone therapy, surgical interventions, or Speech and Language Therapy; we found that a higher proportion of people AFAB were found to want low-dose or time limited hormone treatment (37.3% vs. 19.1%, $p < 0.01$). A higher proportion of people AFAB were found to want changes to the chest contour (88.3% vs. 61.5%, $p < 0.001$). A higher proportion of people AMAB were found to want changes to body hair (87.9% vs. 46.3%, $p < 0.001$). A higher proportion of people AMAB were found to want changes to facial hair (93.3% vs. 51.7%, $p < 0.001$). A higher proportion of people AMAB were found to want changes to size of genitalia through hormone therapy (66.7% vs 36.8%, $p < 0.01$). A higher proportion of people AMAB were found to want genital reconstructive surgery (45.5% vs 12.7%, $p < 0.01$).

Based on birth assigned gender, we did not find significant difference in the prevalence of Eating Disorders, Autism Spectrum Condition, suicide attempts, or self-harming behaviour. We found a higher prevalence of Personality Disorders in non-binary people AFAB (9.9% vs 0.0%, $p<0.01$).

**Conclusions**

Based on birth assigned gender, we expected no significant differences in desire for physical changes or psychological presenting issues; however, we found several significant differences in the described parameters.

# Gender reassignment process, religion and ethnicity in Israel: social obstacles and dilemmas of Jewish and Arabs patients

Thursday, 11th April - 15:15: Mental Health Session Ib: country studies (Bramante 8)

***Elad Ofir*** [1]

***1.*** *Department of Plastic & Reconstructive Surgery, "Sheba" Medical institute*

**Background**

Some religions, such as Judaism, Islam and Christianity, have addressed the gender reassignment process (GRP) within the frame of their God-ordained laws by establishing certain moral and legal rules. Yet, modern developments in medicine have made the gender reassignment process possible.

Due to Israel's unique history, religion and ethnicity play a central cornerstone in shaping the Israeli society in many themes, including the transgender topic, enhancing the complexity of GRP and increasing the number of challenges faced by the patients and by medical staff as well.

Since 1986, according to the rule of Israeli ministry of health, Gender Reassignment Committee is the one to supervise the GRP in Israel.

During the last 3 years, since 2016, a diverse type of transgender people, from the religion and ethnic point of view, for example Jewish (religious, secular), Arabs (religious Muslims or religious Christians, and non-religious), Christians, Bedouins etc, underwent GRP in our department, Plastic and Reconstructive surgery in "Chayim Sheba" Medical Institute, Israel.

This is a 3 years review of trans GRP patients in Israel, exploring the relation between religion and ethnicity impact on the transgender's social dilemmas and social obstacles.

**Methods**

A 3-years review of trans GRP patients in Israel, analyzing retrospectively the demographic parameters and the main social barriers according to the transgender religion and ethnic perspective.

**Results and Conclusions**

**Results:**

According to our experience during the last 3 years, we observed more "social Abandonment" among the religious social group, Arabs and Jewish (each group having their own causes) which is characterized by transferring their center of life from their native environment to a different and new part of the country dealing with the GRP alone.

**Conclusions:**

One of the main conclusions is the need to clarify the transgender conceptualization in the religious communities, Jewish and Arabs, in order to decrease stress and increase mental well being so the transgender can understand better his feelings and in order to reduce the social pressure load and to enable an open dialog between the transgender and his close environment,on the one hand, and with the professional staff, including social workers, psychologists, psychiatrists etc, on the other hand.

An additional conclusion is the need to emphasis the importance in education to gender differences from an early age, mainly in the religious communities and also in smaller and more closed ethnic communities, so transgender pepole will talk about it more freely, and others will be able to understand them more easily.

Regarding to the medical follow during and after the GRP, we noticed that transgender people growing in more religious communities required more intensive and comprehensive follow-up (including new guidance about edu-

cation, employment, and dwelling place). The difficulty of living alone after being cut off from the previous society, puts them at greater risk of being exploited by others, and for such dangerous behaviors as drug addiction and prostitution.

# Accessing of physical interventions by age of first referral to a specialist gender service: Does age of first referral matter?

Thursday, 11th April - 14:30: Children & adolescents Session I: Outcomes of medical affriming therapies in transgender adolescents (Bramante 6)

***Una Masic*** [1], ***Polly Carmichael*** [1]

***1.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust*

**Background**

The presentation of children and adolescents adopting a gender other than their assigned gender at birth has undergone a shift, with more children and young people socially transitioning from an earlier age. This retrospective chart review aimed to assess whether age of first referral to a specialist gender service predicted subsequent accessing of hormone blocking physical interventions when the option was available. Within the UK, access to specialist services provides therapeutic support to children and adolescents experiencing distress around their gender and is required before hormone blocking interventions are sought within the National Health Service, thus understanding the choices made by these young people is useful to improve support for care pathways pursued.

**Methods**

A sample of 3052 young people referred to a specialist gender service (referred from 2-17 years old) from 2010 to 2018 who were eligible for hormone blocking treatment (therefore currently aged at least 14+ years old) were assessed to determine whether age of referral influenced subsequent accessing of hormone blockers when the child was at an age at which they would be able to access these blockers. For instance, some children may have been referred at age five but were at least 14 years old at time of analysis (and would therefore be known to the service for nine years). Age of first referral rather than age of onset of cross-gender identification was assessed to allow for accurate analysis due to data quality and the variability of reportage of age of onset for the young people attending the service. The range of young people accessing included post-pubescent as well as pre-pubescent children as hormone blocking treatment within the National Health Service is required before accessing cross-sex hormones in adolescents under the age of 18.

**Results and Conclusions**

Ordinal regression revealed age of first referral to the gender service significantly predicted subsequent accessing of hormone blockers. Further Chi-square analysis showed that those initially referred at age 12 and under were more likely to pursue blockers and those referred over 12 were less likely to pursue blockers. This pattern was similar across assigned males and assigned females (no effect of assigned gender).

**Conclusions**: Children and young people initially referred to a specialist gender service at a young age were more likely to access hormone blocking treatment when available in the present sample; whilst those referred over the age of 12 were less likely to subsequently access the blocker. This may have implications for therapeutic practice of exploration of gender diversity in young people. However the number of those 12 and under accounted for a smaller sample thus results must be interpreted with caution. Future research is required to further understand trajectories of gender diverse children and adolescents.

# Psychosocial health after gender affirming treatment in young adults diagnosed with Gender Dysphoria referred to the Hamburg Gender Identity Service: first follow-up results

Thursday, 11th April - 14:45: Children & adolescents Session I: Outcomes of medical affriming therapies in transgender adolescents (Bramante 6)

***Inga Becker*** [1], ***Saskia Fahrenkrug*** [1], ***Florentien Campion*** [1], ***Hertha Richter-Appelt*** [1], ***Claus Barkmann*** [1]

***1.*** *University Medical Center Hamburg*

**Background**

Gender-affirming medical treatment options for adolescents starting around the onset of puberty have been available in Germany for the past 12 years. However, the empirical evidence around the effects of puberty suppression (GnRHa) and gender-affirming hormones (GAH) on the overall well-being is still sparse. A few previous European studies have assessed the long-term effects in clinical samples, providing evidence that both GnRHa and GAH lead to overall improved psychosocial functioning. Therefore, the aim of the present study was to longitudinally assess the effects of different treatment conditions in a defined clinical sample of German transgender adolescents and young adults at follow-up.

**Methods**

The present study is the first longitudinal evaluation of the same clinical cohort sample, around 2 years after their first referral to the Hamburg Gender Identity Service for Children and Adolescents. Participants included the first *N*=75 adolescents and young adults (n=64 assigned female at birth/trans boys and *N*=11 male assigned at birth/trans girls; M age=15.5 at baseline, and 17.4 at follow-up) who were assessed at the Hamburg Clinic and participated at two time points of the research project. An original baseline sample of N=205 in total was contacted for the follow-up, after being considered eligible for medical treatment. Further inclusion criteria were an age starting from 11 years at baseline, the fulfillment of diagnostic criteria, and the wish to receive medical interventions.

Participants were assessed at two time points: at intake and at least 6 months after the first referral (up to 4 years later). Adolescents were then divided into five different follow-up treatment conditions (1. diagnostic stage/eligible for treatment (n=9); 2. psychosocial treatment/delayed eligible (n=12); 3. GnRHa only (n=11); 4. GAH only (n=32); and 5. GAH and surgery (mastectomy, n=11).

A general linear model (GLM) was applied with the following predictors: functioning at baseline, time since first referral to the Clinic, gender, and age. Main outcome measures were the psychosocial/global functioning (measured via self-report; YSR/ASR; and clinicians' report, CGAS), mental and physical dimensions of quality of life (Kidscreen), and body image/satisfaction(HBDS) at follow-up.

**Results and Conclusions**

None of the GLM analyses comparing the two time points achieved significant levels. However, when comparing the different follow-up treatment conditions by the means of contrast analysis, a linear pattern became apparent: the more advanced the treatment stage, the better the psychosocial functioning at follow-up. Only the treatment condition groups receiving GAH, or GAH and surgery, reached statistical significance, when compared with the diagnostic phase group. The present study thus provides evidence that GAH and surgery have a positive effect on the psychosocial outcomes in transgender adolescents compared to those who had not received any form of medical treatment, yet. However, the group receiving GnRHa did not achieve the same significant results at follow-up. Possible limitations and implications will be discussed. In line with previous studies, it seems important to

follow a multi-disciplinary approach, that not only includes medical treatment options during adolescence, but also tends towards the psychosocial or psychological needs of this specific group, in order to support the best possible treatment outcomes.

# Transgender youth and gender affirming hormones; a prospective 5-7 year follow up

Thursday, 11th April - 15:00: Children & adolescents Session I: Outcomes of medical affriming therapies in transgender adolescents (Bramante 6)

***Johanna Olson-Kennedy*** [1]

***1.*** *Children's Hospital Los Angeles/University of Southern California*

**Background**

Little data has been published about long term follow up of youth who initiated gender affirming hormones in adolescence and young adulthood. Between 2010 and 2012, a cohort of 101 youth experiencing gender dysphoria between the ages of 12 and 24 years were enrolled in a longitudinal observational study to understand their baseline mental and physiologic health and how it changed over time after initiating hormone therapy for the purpose of phenotypic gender transition. Baseline data from this cohort were published previously in 2015. These data represent those collected between 2017 and 2018 and reflect 5-7 year follow up examination of a large, multi-ethnic cohort of transgender youth in the United States seeking care for gender dsyphoria.

**Methods**

Self-identified transgender youth between the ages of 12 and 24 years presenting consecutively for care at the Center for Transyouth Health and Development (CTHD) at Children's Hospital Los Angeles between February 2011 and June 2013 were screened for participation in the study. The services provided by the clinic range from mental health counseling and referrals to family and youth support groups to hormonal intervention for those youth interested in a phenotypic transition, and referrals for appropriate surgical interventions. Eligibility criteria for the study included age between 12 and 24 years old, self-identification with an internal gender identity different than the one assigned at birth (based on genital anatomy), presence of gender dysphoria, desire to undergo phenotypic gender transition, naivety to gender affirming hormones or less than three months of previous hormone use, and ability to read and comprehend English. One hundred and one participants were initially enrolled into the study. Follow up data was collected and managed using electronic data capture tools (RedCap) which allowed participants to answer questions from remote locations. Additional items were added to the original survey regarding employment and education, follow up medical care, regret, surgical interventions, and finally, a happiness scale.

**Results and Conclusions**

Sixty-five participants completed follow up surveys over a six-month follow up window. Ninety eight percent (64/65) of the participants were currently taking gender affirming hormones, one participant had stopped after one year. While 61% of the participants reported thinking about killing themselves at some point in their life, only 19% had thought about it in the past three months. Thirty-six (63%) had undergone some surgical procedure to help bring their physical body into better alignment with their gender. Seventy-one percent of trans feminine participants reported "My life is okay, but not always what I would like it to be" (58.3%) and "I am generally contented and happy in my life" (12.5%). Among trans masculine participants, 73% reported "My life is okay, but not always what I would like it to be" (43.2%) and "I am generally contented and happy in my life" (29.7%). Ninety-six percent of the respondents reported they "never" have had any regret about starting hormones. Two participants reported "sometimes" having regret about starting hormones. Overall results are promising, and support access to gender affirming hormones for youth and young adults.

# Psychological well-being and self-image in children and adolescents diagnosed with gender dysphoria in relation to hormonal treatment.

Thursday, 11th April - 15:15: Children & adolescents Session I: Outcomes of medical affriming therapies in transgender adolescents (Bramante 6)

***Elise Ruysschaert*** [1]***, Justine Janssen*** [1]***, Jolien Laridaen*** [2]***, Karlien Dhondt*** [2]

***1.*** *Ghent University,* ***2.*** *Ghent University Hospital*

**Background**

Children and adolescents diagnosed with gender dysphoria may consult professionals for psychological and medical treatment. The objectives of these therapies are to relieve suffering and aid in the transition to the desired sex. In literature the majority of studies on this topic have reported on the psychological issues that transgender youth encounter; however, evidence of the effect of medical intervention on psychological well-being is scarce. Therefore, in this study we aim to clarify various aspects of psychological well-being and self-image in this population before and after different stages of medical treatment.

**Methods**

Participants were all patients recruited from the Pediatric Gender Clinic at the University Hospital of Ghent (UZ Ghent), Belgium. Patients considered for inclusion were strictly younger than 19 years old and diagnosed with gender dysphoria by an in-house child & adolescent psychiatrist and/or child psychologist. Patients were recruited at the following stages of transition: begin treatment hormonal suppression or begin treatment cross-sex hormones. The study's objective was communicated at a routine consultation with a hospital professional, either a psychologist, endocrinologist or psychiatrist, and by means of a telephone call. Subsequently, all patients and parents provided written informed consent. Data was obtained through an online survey, which included known questionnaires, such as the Utrecht Gender Dysphoria Scale (UGDS), the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults (GIDYQ-AA), the Body Image Scale (BIS), the Youth Self-Report (YSR), and the Self- Perception Profile for Adolescents (SPPA). The Dutch versions of these surveys were used. Patients completed the survey on two occasions: before (new) hormonal medication (puberty blockers or cross sex hormones) and at 4 months follow-up.

**Results and Conclusions**

During the study period, 177 children and adolescents were being treated at the Pediatric Gender Clinic at the University Hospital of Ghent, Belgium. Out of these patients, 53 individuals agreed to participate in the study at baseline. Due to incomplete responses or failure to follow-up 27 patients remained in the study after 4 months.
There were minor significant differences in study outcomes with regards to the medical therapy employed or to trans male vs trans female transitioning. There was a significantly higher prevalence of autism spectrum disorder in the study population compared to the general population in Belgium. Contrary to findings in literature, non-suicidal self-harming behavior or suicidal thoughts were not more prevalent in the study sample. When evaluating self-image, psychological functioning and the degree of gender dysphoria in the study population, analyses showed that the individuals were generally satisfied with themselves and their competences, with the exception of their appearance. Significantly higher scores were reported on the internalizing problem scale compared to the externalizing problem scale, although there was a tendency to express the behavior of the experienced gender.

# A follow up study of transgender adolescents who stopped their medical treatment with puberty suppression

Thursday, 11th April - 15:30: Children & adolescents Session I: Outcomes of medical affriming therapies in transgender adolescents (Bramante 6)

***Marijn Arnoldussen*** [1], ***Lieke Vrouenraets*** [2], ***Annelou de Vries*** [1], ***Thomas Steensma*** [1], ***Sabine Hannema*** [2], ***Irma Hein*** [3], ***Arne Popma*** [1], ***Martine De Vries*** [2]

***1.*** *VU Medical Center,* ***2.*** *Leiden University Medical Center,* ***3.*** *De Bascule*

**Background**

Since the 1970s, medical gender affirming treatment with hormones and surgeries has been an accepted treatment for transgender adults. However, there has been more reluctance concerning medical interventions including puberty suppression in young transgender children and adolescents. One of the reasons for this debate is the possibility that the gender identity of children may still change over time [1,2,3,4]. Furthermore, the capacity in children to make decisions with life-long consequences is limited and they are not legally allowed to provide informed consent [3]. There is a call for more research on the effect of puberty suppression on psychological and physical well-being to further explore the risks and benefits of the treatment and to make it more evidence-based [4]. Up until now, there are only a few follow-up studies that evaluated the effect of puberty suppression on mental-health related outcomes and there are no studies published that have investigated the considerations of adolescents who decided to stop their treatment with puberty suppression [5,6,7]. Puberty suppression is meant to create thinking time, nonetheless most adolescents seem to experience their treatment with puberty suppression as the first step into the transitioning of their gender [8,9]. Wiepjes et al. reported that only 1.9% of the adolescents who started treatment with puberty suppression after they applied for gender affirming treatment at the Amsterdam, eventually stopped this treatment [10]. Because reasons for stopping the medical treatment were not specified in this study and no other studies have focused on this subject yet, little is known about this group of adolescents. The aim of our study is to further improve the care for young transgender adolescents and to gain a better understanding of the development of their gender-identity. The objectives are to: 1) examine what the reasons were for the transgender adolescents to stop their medical treatment with puberty suppression; 2) examine how these adolescents further developed with regard to their gender-identity; 3) examine how these adolescents look back on their treatment with puberty suppression.

**Methods**

Semi-structured interviews will be conducted with the 10 adolescents who stopped puberty suppression to identify their considerations regarding the treatment.Themes that will be discussed are, among others, reasons for starting and stopping their treatment with puberty suppression, what their social environment thought of the treatment, the development of their gender-identity and how they look back on their treatment now. After transcribing the qualitative data, the main ideas for each question or topic will be formulated and eventually different themes will be identified. These themes will be described in a descriptive narrative.

**Results and Conclusions**

Preliminary results will be presented. We expect that by following up these adolescents, we will gain insight why adolescents who started puberty suppression did not continue and how these adolescent further developed with regard to gender-identity. In addition, we will gain insight in how these adolescents have experienced their period of puberty suppression use. We hope that these insights contribute in the further improvement of care for young

transgender children and adolescents.

# Puberty blocking in transgender adolescents: How well-informed and open to change are the choices made at young age?

Thursday, 11th April - 15:45: Children & adolescents Session I: Outcomes of medical affriming therapies in transgender adolescents (Bramante 6)

***Lieke Vrouenraets*** [1], ***Marijn Arnoldussen*** [2], ***Annelou de Vries*** [3], ***Sabine Hannema*** [1], ***Irma Hein*** [4], ***Thomas Steensma*** [3], ***Arne Popma*** [3], ***Martine De Vries*** [1]

***1.*** *Leiden University Medical Center,* ***2.*** *VU,* ***3.*** *VU Medical Center,* ***4.*** *De Bascule*

**Background**

In international clinical guidelines the treatment with puberty blockers (PB) is described as an extended diagnostic phase in which the pubertal adolescents are provided time to make a balanced decision regarding gender affirming medical treatments [1;2]. Even though treatment with PB is described as an extended diagnostic phase, many transgender adolescents seem to experience PB as the first 'necessary' medical step of a seemingly indisputable trajectory with permanent physical changes (through gender affirming hormones and/or surgeries) in the end. If treatment with PB is seen as the first step to take in gender affirming treatment, very young children (from the age of 10) make a decision with life-long consequences, which may include reduced opportunities for fertility. Most adolescents that start suppression, continue with the (partially) irreversible steps of sex hormones and surgeries. However, concerns have been raised about the risk of regret, as gender identity could fluctuate during adolescence [3]. Furthermore there are worries about the impact of PB on physical, cognitive and psychosocial development and the development of a consistent gender identity [4]. An important issue in this regard is whether minors at such young age are capable of making decisions about treatment with such consequences [5]. One of the eligibility criteria for adolescents for treatment with PB according to the international guidelines is that the adolescent should have sufficient mental capacity to give informed consent to this treatment [1]. Children's competence to consent to treatment is a major issue in pediatric ethics, especially when it concerns consent for far-reaching treatments with possible side-effects. Up until now, little is known regarding child's competence except that it often proved difficult to assess a child's competence in clinical settings [6;7]. Nor is there empirical evidence on transgender children's or adolescents' competence to consent to treatment with PB. The aim of our study is to improve the decision making process in transgender adolescents regarding PB. The objectives are to: 1) examine whether treatment with PB is considered an extended diagnostic phase or the first 'necessary' medical step in the gender affirming trajectory by transgender adolescents themselves; and 2) examine how transgender adolescents themselves consider their competence to consent to treatment with PB.

**Methods**

Semi-structured interviews will be conducted to identify considerations of transgender adolescents in the Netherlands regarding treatment with PB. About 10 to 15 adolescents who are treated with PB and gender affirming hormones will be interviewed looking back on their treatment. Data collection will continue as long as new information comes up (data saturation).

**Results and Conclusions**

Preliminary results of these interviews will be presented. With this study we expect insight into whether treatment with PB is considered an extended diagnostic phase or the first 'necessary' medical step in the gender affirming trajectory. Secondly we expect to present how adolescents think about their capacities to make decisions on PB

and gender affirming hormones and whether they have experienced this differently for the two respective medical interventions. Based on these results, recommendations for clinical care will be given.

# Sex Ratio of Transgender Adolescents: A Meta-Analysis

Thursday, 11th April - 14:30: Children & adolescents Session Ib: Characteristics of transgender adolescents (Bramante 7)

***Kenneth Zucker*** [1], ***Madison Aitken*** [2]

***1.*** *University of Toronto,* ***2.*** *Centre for Addiction and Mental Health*

**Background**

Beginning in the mid-2000s, there appeared to be a shift in the sex ratio of adolescents referred clinically for gender dysphoria, from one favoring birth-assigned males to one favoring birth-assigned females. This was documented empirically by Aitken et al. (2015), who provided evidence for this shift from two gender identity clinics housed at academic health science centers: one in Toronto, Canada and the other in Amsterdam, the Netherlands. In that study, the male:female sex ratio in Toronto changed from 2.11:1 (prior to 2006) to 1:1.76 (years 2006-2013); in Amsterdam, the corresponding sex ratios were 1.41:1 (prior to 2006) and 1:1.72 (years 2006-2013).

**Methods**

The present study tested the generalizability of these findings by examining the sex ratios in 44 samples of adolescents (ages 12-20 years), divided into three types: (1) representative samples of high school students who self-identified as transgender; (2) non-representative or convenience samples of adolescents diagnosed with gender dysphoria or who self-identified somewhere along the transgender spectrum, recruited from the community, facebook, etc; and (3) clinic samples of adolescents referred for gender dysphoria. We coded for sample type, age at assessment (M, 15.8 years), year of assessment (M, 2012.5), region (U.S./Canada; Europe/Scandinavia; Other), and the number of birth-assigned males and females in each sample.

**Results and Conclusions**

Across the three sample types ($N$=14,484), the male:female sex ratio (1:2.13) favored birth-assigned females in 39 of the 44 samples. In the 4 representative samples ($N$ = 2694), the sex ratio was 1:1.93; in the 17 non-representative community samples (n = 4459), the sex ratio was 1:2.24; in the 23 clinic-referred samples ($N$ = 7331), the sex ratio was 1:2.15. Within each sample type, a random effects meta-analysis showed significant heterogeneity ($I^2$ranged from 73.6-92.4%) (all $p$s < .0001). In a meta-regression analysis, we entered sample type, age at assessment, year of assessment, and region as the predictor variables (effect modifiers) and the proportion of birth-assigned females as the criterion variable. The representative sample type was used as the referent group. Year of assessment was significantly associated with a greater proportion of birth-assigned females in the samples at $p$ < .0001 (95% CI, .010-.029), indicating more birth-assigned females in more recent years. Compared to the representative samples, the non-representative samples had proportionately more birth-assigned females ($p$ = .0007, 95% CI, .066-.248), as did the clinic-referred samples ($p$ = .0208, 95% CI, .015-.184). Age at assessment and region were not significant predictors. The non-representative and clinic-referred samples did not differ significantly from each other ($p$ = .0661, 95% CI, -.003-.118).

The results of the present study confirmed the Aitken et al. findings of a birth-assigned female-biased sex ratio among adolescents referred clinically for gender dysphoria and a similar birth-assigned female-biased sex ratio in two other sample types: non-representative samples recruited from the community and representative samples of high-school students who self-identified as transgender. We discuss these data in relation to theory on the prevalence of gender dysphoria and why there appears to be a disproportionate percentage of birth-assigned females

who fall in the transgender spectrum.

# Experiences and needs of transgender young adults with a history of suicidality regarding mental healthcare

Thursday, 11th April - 14:45: Children & adolescents Session Ib: Characteristics of transgender adolescents (Bramante 7)

***Jennifer de Lange*** [1]***, Diana van Bergen*** [1]***, Laura Baams*** [1]***, Margaretha Timmerman*** [1]***, Henny Bos*** [1]

***1.*** *University of Groningen*

**Background**

Rates of suicidal ideation and suicide attempts among transgender people are high. In prior research between 45% and 56.1% of transgender respondents was found to report suicidal ideation (Grossman & D'augelli, 2007; Testa et al., 2017). The gender minority stress and resilience (GMSR) model posits that transgender persons experience unique stressors related to their gender identity or expression, such as victimization, rejection, non-affirmation, and internalized transphobia (Testa, Habarth, Peta, Balsam, & Bockting, 2015). Their unique needs are often not met by healthcare services (Grant et al., 2011). Support from parents seems to be an important protective factor for risk for suicide attempts (Mustanski & Liu, 2013). The aim of this research is to explore experiences and needs of transgender young adults with a history of suicidality concerning professional mental healthcare, informal support and online mental healthcare. In addition, we wish to explore experiences and needs of *parents* of transgender youth with a history of suicidality.

**Methods**

From June 2018 until November 2018 semi-structured qualitative interviews are conducted among transgender young adults (aged 18-35 years old) from the Netherlands, who have experienced suicidality in the past. In addition, interviews are conducted among parents of transgender youth who have experienced suicidality in the past. Participants are recruited through LGBT organizations, and advertisements on social media. Data from the interviews are analyzed using thematic analysis.

**Results and Conclusions**

Our preliminary results show that participants experienced an interplay of multiple factors that contributed to their suicidality. Results regarding experiences with informal support show that most participants received support from friends and less support from parents. Results regarding experiences with formal mental healthcare show that most participants were not satisfied with mental healthcare they received and wished that mental health professionals improved knowledge about transgender issues. Data collection is ongoing and there are no preliminary results of parents' experiences and needs yet. Results regarding factors that contributed to suicidality are in line with previous research that showed a role for GMSR factors in suicidal ideation in transgender people (Testa et al., 2017). Results of this study can be used in understanding how factors play a role in the development of suicidal thoughts in transgender young adults, and in understanding how mental healthcare is experienced.

# Children and adolescents referred to an Italian network of specialised gender clinics: gender presentation and psychological features.

Thursday, 11th April - 15:00: Children & adolescents Session Ib: Characteristics of transgender adolescents (Bramante 7)

***Angela Caldarera*** [1], ***Chiara Baietto*** [2], ***Giovanni Castellini*** [3], ***Chiara Dalle Luche*** [4], ***Alessandra Delli Veneri*** [5], ***Massimo Di Grazia*** [6], ***Alessandra Daphne Fisher*** [7], ***Massimo Lavaggi*** [4], ***Elisabetta Lavorato*** [8], ***Valeria Mazzilli*** [9], ***Maddalena Mosconi*** [10], ***Daniela Anna Nadalin*** [11], ***Valeria Pace*** [8], ***Luca Palleschi*** [12], ***Luca Quagliarella*** [8], ***Jiska Ristori*** [7], ***Anna Paola Sanfelici*** [11], ***Fabiana Santamaria*** [9], ***Patrizia Stella*** [11], ***Gianluca Tornese*** [6], ***Damiana Massara*** [13]

***1.*** *University of Torino,* ***2.*** *Struttura complessa Neuropsichiatria, Dipartimento di Scienze della Sanità Pubblica e Pediatriche, Presidio Infantile Regina Margherita AOU Città della Salute e Scienza di Torino,* ***3.*** *Department of Health Science, Careggi University Hospital,* ***4.*** *Consultorio Transgenere Torre del Lago,* ***5.*** *Università degli Studi di Napoli Federico Il,* ***6.*** *Institute for Maternal and Child Health - IRCCS "Burlo Garofolo",* ***7.*** *Department of Experimental, Clinical and Biomedical Sciences, Careggi University Hospital, Florence, Italy,* ***8.*** *U.O.C Psichiatria Universitaria- Dipartimento di Scienze Mediche di Base, Neuroscienze e Organi di senso- Az. Ospedaliero Universitaria Consorziale Policlinico di Bari,* ***9.*** *Azienda Ospedaliera Universitaria Federico II Napoli,* ***10.*** *"Area Minori" Servizio per l'Adeguamento tra Identità Fisica e Identità Psichica (SAIFIP), Azienda Ospedaliera S.Camillo-Forlanini, Roma,* ***11.*** *Health Centre Gender Dysphoria at Movement for Transsexual Identity-Agreement with Local Healthcare Unit, City of Bologna,* ***12.*** *Servizio per l'Adeguamento tra Identità Fisica e Identità Psichica (SAIFIP), Azienda Ospedaliera S.Camillo-Forlanini, Roma.,* ***13.*** *CIDIGEM (Turin University Hospital Gender Team - Italy)*

**Background**

A network of the Italian gender teams dealing with gender dysphoria in childhood and adolescence was established in 2012, within ONIG (Osservatorio Nazionale sull'Identità di Genere). In 2017 we presented the first data collected through a shared protocol of assessment and care: our results outlined a progressive increase in number of referrals, and the necessity of continuing in such systematic data collection. In addition, those results showed a difference between children with a cross-gender identification and children with a more fluid gender presentation, with the latters reporting higher rates of psychological suffering compared to the firsts. We will thus present the updated results of this multicentric study from to the Italian Network of Gender Clinics for Children and Adolescents, which involved the centers of Torino, Firenze, Torre Del Lago, Roma, Bologna, Napoli, Bari and Trieste. More specifically, we will outline: (1) the gender presentation and psychological features of these young people, and (2) the differences between cross-gender and non-cross gender identified referred children and adolescents in relation to psychological difficulties.

**Methods**

The shared assessment protocol includes a socio-demographic data sheet and a psychological case history form, filled out by the professionals working in each participating gender clinic, for children, adolescents and families of children consecutively referred to the centers. In addition to the demographic and social data, we analysed information about: preference for toys and activities in childhood, presence of gender-dysphoric feelings, age of onset and of coming out; feelings about pubertal development; education; perceived quality of family relations and of peer relations; bullying experiences; associated psychological difficulties; romantic experiences. Participants were divided in two subgroups: Cross-Gender Identified (CGI) and Non-Cross Gender Identified (non-CGI) children

and adolescents. Such distinction has previously been proposed by Kuvalanka, Weiner, Munroe, Goldberg, and Gardner (2017). Demographic characteristics of the group of participants, differences and association between variables were tested through descriptive and multivariate statistics through the software SPSS.25.

**Results and Conclusions**

Up until now (data collection is ongoing) we collected data on a total sample of 285 children and adolescents aged 3 to 17. The mean age of the group is 14.37 (SD= 3.21), although 83.7% of the group is aged 13-17; participants' assigned gender at birth was female for 52.3% of the group; 69.4% were assigned to the CGI group and 30.6% to the non-CGI group. The progressive increase of referrals across years we outlined in Belgrade, 2017 is confirmed, considering that, in two years, numbers have more than doubled. As regards differences between children and adolescents assigned to the CGI and non-CGI groups, our preliminary results show that, while rates of psychological suffering are higher in the non-CGI group, bullying experiences present a similar distribution in the two groups.

Our result indicate the importance of (1) studying the factors underlying the higher rate of psychological suffering among children and adolescents assigned to the non-CGI group, (2) outlining the role of protective factors for psychological wellbeing including peer relations, family acceptance, and (3) of implementing a non-binary informed model of care.

# Ethnicity and Gender Diversity in Children and Young People

Thursday, 11th April - 15:15: Children & adolescents Session Ib: Characteristics of transgender adolescents (Bramante 7)

***Ilham Manjra*** [1], ***Ian Russell*** [1], ***Nastasja De Graaf*** [1], ***Anna Hames*** [1], ***Claudia Zitz*** [1]

***1.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust*

**Background**

Little is known about how ethnicity, culture and religion influence and interact with gender identity development and experience. Understanding these relations is essential for gender specialist clinics in order to provide suitable care for those seeking support with their gender identity exploration, especially from black and minority ethnic (BME) cultures and backgrounds. However, data exploring the experience of individuals diagnosed with gender dysphoria from diverse ethnic backgrounds is almost non-existent.

**Methods**

The principal focus for this study was to report on the self-defined ethnicities of children and young people under 18 years old referred to United Kingdom's (UK) national Gender Identity Development Service (GIDS), and compare this ethnicity data set to the diverse population of the UK today and the populations seen in Child and Adolescent Mental Health Services (CAMHS) in the UK (as additional data sources). An evaluation of all available self-defined ethnicities retrieved from a patient demographic form was conducted for those GIDS referrals accepted between April 2016 and March 2017 (n = 856). Ethnicity data, collected as part of the standard GIDS assessment process, was obtained by the "16+1" NHS defined ethnicity list.

**Results and Conclusions**

Only 6.65% of the 856 referrals were from a BME background, an underrepresentation when compared to the national UK (14%) and CAMHS (15%) populations. To understand this figure, the White ethnicity group and the overall BME group were compared with each other in terms of the average number of appointments offered by the Service, the average number of attendances or cancellations by the young people, and the number of young people accessing physical treatment. In light of this data, the authors offer hypotheses around the potential barriers BME users may face in accessing and engaging with gender services.

The complex definitions of ethnicity, and the overall low BME numbers, make it difficult to generalise conclusions from the data. Therefore, the authors have used this opportunity to stimulate discussion about how ethnicity may interact with gender identity development and experience; the hypotheses presented may help future studies, with the aid of additional data sources, to supplement this much under-researched field.

# Healthcare provider needs and wishes for training on trans patients and clients in five European countries

Thursday, 11th April - 14:30: Social Sciences Session I: health care practices, training & ethics (Bramante 10)

***Aisa Burgwal*** [1]***, Joz Motmans*** [1]

***1.*** *Ghent University*

**Background**

In the past decade, an increasing number of publications have focused on transgender health. Transgender individuals experience a variety of challenges in gaining access to healthcare. Lack of training on the part of providers about how to deliver competent care to transgender people has been cited as contributing to this problem. This study presents a set of preliminary results regarding the wishes and needs of healthcare providers for training on trans people. The purpose of this study is to map the current state of knowledge and training on trans people among healthcare providers, their confidence in working with trans people, as well as their wishes for training.

**Methods**

Using an online, anonymous questionnaire, healthcare providers (ranging from surgeon to administrative staff) from five different European countries (Georgia, Poland, Serbia, Spain and Sweden) were questioned. The survey assessed different topics, ranging from experiences with training on trans people, wishes for training on trans people, knowledge about the organisation of healthcare to the evaluation of general and trans-specific healthcare.

**Results and Conclusions**

Quantitative data-analysis indicated that only half of all healthcare providers (52.4%) have had training about trans people. Half of all healthcare providers have average to very low confidence in working with trans people. Training was associated with significantly more confidence among healthcare providers, compared with providers who have had no training. Almost all healthcare providers want training in order to increase their level of competence in working with trans people. The majority preferred this training to be part of their mandatory professional development, provided by a trans- or LGBTI organisation and in the format of a course organised by a healthcare provider specialised in trans-specific healthcare. In terms of knowledge, almost one in four do not know where to refer to for trans-specific healthcare which they do not offer themselves (21.7%) or do not know any trans support groups (24.0%). 41.4% have no knowledge about the existence of a protocol for trans-specific care. As to conclude, the authors propose recommendations to guide curriculum developers and trainers in developing content and structure and to facilitate implementation of trainings.

# Improving mental health care: perspectives from care users and care providers

Thursday, 11th April - 14:45: Social Sciences Session I: health care practices, training & ethics (Bramante 10)

***Tim de Jong*** [1]***, Jos Vroege*** [2]

***1.*** *Parnassia Groep Academie / Atria Institute on gender equality,* ***2.*** *Parnassia Groep Academie / PsyQ*

**Background**

A Dutch survey (Keuzekamp, 2012) revealed that one out of three trans people searching mental health care experienced that the care provider wanted to give help but didn't have enough knowledge on the topic; 17% experienced that the care provider was not willing (or seemed not to be willing) to help; 5% met with a professional who refused to help. It is unknown whether these experiences also apply to clients of the Parnassia Groep.

The same study revealed that many trans people are confronted with mental health problems such as depression and anxiety. Unemployment rates are high, as well as the prevalence of discrimination, harassment and violent interaction. Trans people have difficulty finding mental health professionals with expertise on trans issues and often face trans-unfriendly attitudes from care providers.

These findings were reason for the Parnassia Groep Academie to initiate a qualitative research into the experiences of both care users and care providers regarding the quality of the treatment. The study is carried out by a researcher with experiential expertise (TdJ), to optimize the use of clients' perspectives.

**Methods**

In this study we tried to find answers to the following questions: How do care users and care providers evaluate the quality of the received care? What is going well and what can be improved?

Aspects that we focused on were: satisfaction with treatment, knowledge level of care providers, respectful treatment, the need for gender neutral toilets, experiences with group therapy for trans people, the added value of experiential experts, treatment location (travel time) , collaboration with gender identity clinics.

The qualitative study consisted of:

(1) Questionnaires filled in by adult trans people (and their partners) who undergo treatment and care providers.

(2) In-depth interviews with both adult care users and care providers.

**Results and Conclusions**

The questionnaires were completed by 51 persons: 25 clients of whom 6 were adolescents (18-23y), 26 care providers of whom 10 work with children and adolescents.

29 people were interviewed: 15 clients (of whom 8 received group treatment) and 14 care providers.

Preliminary results show that trans-sensitive care is meaningful for the care users. Expertise on transgender issues is highly valued, as well as respectful treatment as shown in a sensitive use of pronouns. Care providers express the need for more knowledge on trans issues, by ways of study, collegial exchange and easy available online information. Both care users and care providers wish more collaboration between mental health care and gender identity clinics. Treatment groups are valued highly by participants. More regional spread is wanted by some, as travel time can be an obstacle.

Success factors, critical remarks and suggestions made by both care users and care providers point the way to improve mental health care services. Needs of clients can be met by giving them a voice and working together towards the common goal of supplying trans-sensitive and high quality mental health care.

# What do Flemish health care providers know about transgender persons and transgender health care? A study into their knowledge, attitudes and experiences.

Thursday, 11th April - 15:00: Social Sciences Session I: health care practices, training & ethics (Bramante 10)

***Els Elaut*** [1]***, Sharon Bruggeman*** [2]***, Joz Motmans*** [2]

***1.*** *Ghent University Hospital,* ***2.*** *Ghent University*

**Background**

It is well known that transgender health care worldwide is being consulted by an increasing number of individuals (Arcelus et al, 2015). Flemish and Dutch population-based studies estimate the prevalence of transgender individuals between 0.6% and 1.1% (Van Caenegem, et al, 2015, Kuyper & Wijsen, 2013). In the Dutch-speaking part of Belgium, the Flemish government has already helped funding initiatives and websites such as www.transgenderinfo.be. At the same time, a lot of obstacles to health care remain. One third of transgender individuals reports a change in primary care physician due to a trans phobic reaction (Motmans, 2009). Also, psychologists are experienced as lacking sufficient knowledge on the topic and are being 'trained' by people consulting them (Bradford et al, 2013). While these situations lead to transgender persons being withheld appropriate physical or mental health care, a substantial group of health care providers (HCPs) (psychologists, primary care physicians, psychiatrists, counselors, etc) in Flanders do not always master the skills to be able to provide transfriendly health care in their curriculum.

**Methods**

The present study was inspired by the survey 'Overdiagnosed but underserved', performed by Transgender Europe (TGEU) in five European countries (Smiley et al, 2017). An online survey assessing the knowledge on (Transgenders Pediatric Survey, Turban et al, 2017), experience with, and attitude towards transgender individuals (Gender Belief Scale, Latka et al, 2009) was sent out by the main professional organizations of Flemish clinical psychologists, sexologists, psychiatrists, primary care physicians and counselors.

**Results and Conclusions**

We will report on the percentage of Flemish HCPs that report to have experience with transgender individuals consulting for health care. We expect the majority will have only limited experience with assisting transgender individuals in their clinical practice. Further, we assume a relationship between the extent of experience and HCPs' estimation of their own competences. Hence, we expect a majority to report a significant need for further information and training. We will also assess in which format and by whom HCPs want to receive training.

# Transition-related health risk behaviour in transgender sex workers in Antwerp

Thursday, 11th April - 15:15: Social Sciences Session I: health care practices, training & ethics (Bramante 10)

***Judith Van Schuylenbergh*** [1], ***Joz Motmans*** [1], ***Justine Defreyne*** [2], ***Anna Somers*** [1], ***Guy T'Sjoen*** [3]

***1.*** *Ghent University,* ***2.*** *Ghent,* ***3.*** *Uz Gent*

**Background**

Research indicates that a significant portion of transgender women are involved in sex work, which is mostly attributed to discrimination of transgender persons on the labour market. Transition-related health risk behaviour, such as uncontrolled hormone use, auto-medication and the use of silicone injections, may lead to several adverse health outcomes for transgender persons. Transgender sex workers are a vulnerable group within the transgender population, who might be at increased risk for these health risk behaviours because of economic marginalisation. However, European research into this topic and risk population remains largely absent. This study is the first exploring these risk behaviours in a European sample of transgender sex workers, as well as the association with their socio-demographic characteristics, their work and their migration pathways.

**Methods**

This study explores the prevalence of uncontrolled gender-affirming hormone use and silicone injections among transgender sex workers working in window-based sex work in the Antwerp red light district (Belgium), as well as their socio-demographic characteristics and migration pathways. In co-operation with two outreach organizations providing sexual health services to sex workers, a face-to-face survey was carried out among 46 transgender sex workers. Descriptive analyses of this survey sample were supplemented with 9 in-depth interviews with transgender sex workers, which were analysed using Grounded Theory.

**Results and Conclusions**

The population of transgender sex workers working in the Antwerp' red light district has specific socio-demographic characteristics: they are all assigned male at birth, 83% identifies as female and 76% is from Latin-American descent, mainly from Ecuador. However, a variety of migration pathways is cited, and 30% cites travelling internationally to work, which influences their access to healthcare. Transition-related health risk behaviours are prevalent: current uncontrolled hormone use rate is 32%, and a lot of participants do not follow regular hormone regimens. Engaging in sex work appears to be an important reason for this uncontrolled gender-affirming hormone use and auto-medication, as gender-affirming hormones frequently cause erectile dysfunction and an erection is often required when engaging in transgender sex work. Of all participants, 65% has had silicone injections in one or more parts of the body, and 43% of them cites health problems due to these injections.

**Conclusion**

When addressing this population's health risk behaviour, the specific characteristics of this largely invisible but highly vulnerable population should be taken in account, as well as their work and migration pathways. Access to health care and social services should be ensured, and culturally tailored health interventions that take into account their social context as well as their gender identity should be developed.

# The experiences of gender variant youth with autism spectrum disorders: parent perspectives on clinical services

Thursday, 11th April - 14:30: Social Sciences Session Ib: Family matters (Bramante 11)

***Walllace Wong*** [1], ***Veronique Nguy*** [2], ***Jaime Semchuk*** [2]

***1.*** *Diversity Emotional Wellness Center,* ***2.*** *University of British Columbia*

**Background**

Accumulating research indicates that children and adolescents with co-occurring autism spectrum disorders (ASD) and gender variance (GV) are identified at higher rates than would be expected by chance. The clinical assessment and treatment of this population can prove complex, due to the developmental aspects of ASD. Recently, clinical care guidelines for this population were developed by obtaining consensus among professional with expertise in the field. However, these guidelines lacked the contribution of the expertise afforded by those with lived experience. In order to better understand and provide effective clinical services for this population, it is important to learn about the perspectives of key stakeholders with an insider perspective, including youth and their caregivers. To date, only one published study has investigated the perspectives of mothers of GV youth with ASD. The present study seeks to expand upon this body of research by asking the following question: What are the experiences of parents of GV youth with ASD when accessing clinical services in Canada?

**Methods**

To investigate this research question, a semi-structured focus group interview was conducted in March 2018. Interview questions were developed collaboratively with members of the research team and a review of current literature. Participants were recruited from a community-based mental health clinic that provides gender health services in the Lower Mainland of British Columbia, Canada. Informed consent was obtained from all participants. The focus group included 6 parents of a youth with a diagnosis of ASD who identifies as GV (e.g. transgender, non-binary, gender fluid). The focus group was audio-recorded, transcribed, and analyzed for themes using qualitative thematic analysis. Emergent themes across the parent focus group were identified.

**Results and Conclusions**

While data is still being analyzed at the time of abstract submission, preliminary findings include themes related to parents' experiences of supporting their child with ASD through the process of gender identity consolidation, parents' experiences working with clinical professionals, and perceived needs related to clinical services. This research will contribute to the emerging body of literature related to youth with ASD who identify as GV. To our knowledge, this is one of the first few studies that explore the perspectives and experiences of parents within this population. These findings will help to inform recommendations for clinical professionals who support GV youth with ASD and their families.

# Surrogate mothers and brotherhood in trans youth communities

Thursday, 11th April - 14:45: Social Sciences Session Ib: Family matters (Bramante 11)

***Joz Motmans*** [1]

***1.*** *Ghent University*

**Background**

As in many countries, the amount of young trans people coming out to their true selves is increasing rapidly in Belgium in the last five years. More and more families with under aged children are looking for qualitative care for themselves and their children (over 100 new families entered the trans youth care facility at our university in the last year). Although trans care is provided and even more so, large part of this care is funded, the daily situation of many adolescent trans person is quite hard, since the broader social structures in which they live, such as school and leisure time clubs, are not trans inclusive. Recently we have witnessed a wave of suicides in the young trans community, for which in many cases, the lack of support from the birth parents is a key element.

In-depth interviews with trans youth (aged 12-24) as well as with parents (minimum 30 in total) are being conducted in 2018. Topics such as informing friends and family, as well as experiences with friendships and care providers, support networks, school …, are the focus of the research. Through the interviews we detected the role of "surrogate mothers" (how supportive mothers of trans youth support friends of their kids who lack this parental support) and the role of "brotherhood" (how friendship among trans men take the role of "big supportive brother") among trans youth. The discourses used point at the concept of 'families of choice', the commitment of chosen, rather than fixed, relationships and ties of intimacy, care and support (McCartney & Edwards, 2011). The results highlight how alternative supporting networks in trans communities and allies, are used to overcome the failure of families of origin and the state to respond adequately to the need of trans youth.

**Methods**

In-depth interviews with trans youth (aged 12-24, n=22)) as well as with parents (n=28) from 29 different families were conducted in 2018. Topics such as informing friends and family, as well as experiences with friendships and care providers, support networks, school …, were the focus of the research.

**Results and Conclusions**

Through the interviews we detected the role of "surrogate mothers" (how supportive mothers of trans youth support friends of their kids who lack this parental support) and the role of "brotherhood" (how friendship among trans men take the role of "big supportive brother") among trans youth. The discourses used point at the concept of 'families of choice', the commitment of chosen, rather than fixed, relationships and ties of intimacy, care and support (McCartney & Edwards, 2011). Also, different experiences regarding care and self-care were deteced among trans families. The results highlight how alternative supporting networks in trans communities and allies, are used to overcome the lack of families of origin and the state to respond adequately to the need of trans youth and their families.

# "…I'm not unaccepting, I'm just concerned…". Supporting trans youths' parents in Poland.

Thursday, 11th April - 15:00: Social Sciences Session Ib: Family matters (Bramante 11)

***Anna Kłonkowska*** [1]

***1.*** *University of Gdansk*

**Background**

The dominant notion of gender identity in Poland is strongly influenced by the essentialist paradigm and immersed in the Eastern European and Polish-centered gender roles' concepts. Gender and bodily diversity is being stigmatized and pathologized. Thus, not only trans individuals, but also parents of trans youth often experience social oppression and their parenting skills are being questioned by the social environment. This may cause self-accusations and influence the parents' attitudes towards their children's gender (dis)identity.

**Methods**

The paper features the outcomes of a qualitative study research project. The research, based on in-depth, intensive, semi-structured interviews collected in Poland among parents of trans youths, has been inspired by the author's experiences from facilitating support groups meetings: for trans persons, for the families of trans persons and from individual psychological-support sessions. Regarding the confidential nature of these meetings, none of the originating data have been used for the purpose of the research project. The research participants had been recruited through the snowball sampling method. All of the participants were informed of the scope and purpose of the study. The interviews were conducted in Polish, recorded and transcribed personally by the author of this paper.

**Results and Conclusions**

The results of the research present the attitudes of trans youths' parents in Poland towards their children's gender (dis)identity: the initial reactions to their children's coming-out; personal emotions and feeling; the process of reframing and reworking their stances; responses to the social environment's expectations and the impact of stereotypically defined Eastern European and Polish-centered gender roles; concerns regarding upbringing a trans child in a conservative society and under the current political circumstances in Poland; attitudes towards specific Polish practices (unfavorable to parents) regarding the legal gender recognition. The outcomes of the collected interviews also indicate the parents' hints regarding the ways in which adolescent trans persons can mitigate the guardians' angst and psychological distress and – as a consequence – reinforce the parents' insight into their children's feelings, amplify the capability of supporting their children and coping with the adverse social environment. The conclusions reflect on the counselor's role in supporting the trans youths' parents in reference to the aforementioned concerns and circumstances.

# Influence of the transition on partner relations: What makes a relationship survive?

Thursday, 11th April - 15:15: Social Sciences Session Ib: Family matters (Bramante 11)

***Gillian Lentferink*** [1]***, Eva-Marijn Patty-Stegemann*** [1]***, Mark Hommes*** [1]***, Arjan Bos*** [1]

***1.*** *Open University of the Netherlands*

**Background**

The transition of transgender individuals can bring about fundamental changes, not only for the transgenders themselves but also for the people close to them. This is especially so for their spouses, since the change of gender often reaches the core of the relationship and can have a direct impact on their own (sexual) identity (Geurtsen, 2016; Patty-Stegemann, Hommes & Bos, 2017). Empirically based studies on the impact of a transition on relationships and the experiences of spouses are scarce (Coolhart, Ritenour & Grodzinski, 2018). In this paper we present a qualitative study on the impact of the transition on the relationship with the spouse. In this study we focused on specific situations concerning the transition (e.g. coming-out, pace of the transition, changing sexuality and sexual identity and -orientation, feelings of loss) in view of more general aspects of relation quality (e.g. communication, commitment, self-verification and trust). Furthermore we investigated how both trans- and cis gender partners cope with the challenges they encounter during this process, and aspects they consider important for the 'survival' and the quality of the relationship.

**Methods**

We conducted 18 separate in-depth interviews, with transgender individuals and partners from 9 couples of whom one of the partners transitioned (sometimes partially) during the relationship. The transitioning partners were 6 trans women and 3 trans men. The non-transitioning partners were all cis-gender, 8 women and 1 man. Participants were recruited through networks of transgender people and leaflets in waiting rooms of transgender health institutions in the Netherlands. Despite our effort to find ex-partners of split-up couples, all couples that participated were still together after the transition.

A semi-structured interview protocol was used. The interviews lasted 90 minutes on average.

**Results and Conclusions**

During the presentation we will highlight the main outcomes of this study. This includes the timing of the coming-out and its impact on trust; the importance of communication in negotiating the pace of the transition; feelings of loss and grief and the way couples dealt with changes in sexuality, sexual orientation and sexual attraction.

Although the amount of relationship commitment prior to transition varied over the couples, most of them expressed a strong commitment to the relationship afterwards. Relationship commitment may well have been an important criterion for participating in this study, so we must be careful to generalize the results. Nevertheless the participants in this study show how their relationships survived and often even grew stronger during the intense process of the transition of one of the partners. Their experiences can help others in the same situation.

Although the participating couples ended up well, the study also revealed their wish for more professional help during the transition in coping with the impact of it. The outcomes of this study may serve as a basis for quantitative research and can be used to develop theory- and evidence based support programs targeting trans couples.

# Hidden trans woman and her marriage and sex life

Thursday, 11th April - 15:30: Social Sciences Session Ib: Family matters (Bramante 11)

***Sahika Yüksel*** [1], ***Berna Ozata*** [2], ***Eren Yildizhan*** [3]

***1.*** *Istanbul University,* ***2.*** *Bakirkoy Mental Health Hospital,* ***3.*** *Bakirköy Mental Health State Hospital*

**Background**

Sex is considered a private matter between partners. Sex reassignment surgery (SRS) is a procedure that is becoming increasingly common.

Some trans individuals conceal their trans individuality and transformation they have undergone after the gender transition in places where transphobia is high. Therefore some individuals, who collaborated with us in their transition preparation period, tend to evade meeting us after the sex reassignment surgery. This means that we may have a limited opportunity to observe how trans individuals experience their new identities. In this presentation a trans woman will be discussed whom we followed up, 7years.

**Methods**

36 years old, married, 5 years ago she had 5 SRSs. She sought help with emotional and sexual problems. DSM-IV-TR Axis I Disorders , Self Esteem Scale, Arizona Sexual Experiences Scale (ASES) were administered before transition and 5 years after SRS.

**Results and Conclusions**

Ayşe has been perceived female by her husband and her family members. Her gender transition was kept a secret. Ayse met BPD and past PTSD diagnosis. She has been working as a switchboard operator, has moderate income. During her childhood she was exposed to physical abuse by her father. At the age of 19 she left home.

Ayşe's husband Hasan did not mention any problems. He said that he came only because his wife asked for it. Though no complete clinical examination was made, Hasan was diagnosed as being schizoid. Their emotional and sexual story was obtained only through Ayşe.

Ayşe was a person with sexual drive before and after SRS. She is happy with the SRS and identity change.

The clinical evaluation indicates positive development after SRS in terms of psychological condition. ASES Score: 13 (Before SRS and after SRS).

**Conclusion:** Studies confirm SRS improves the lives of transgender people, although this doesn't necessarily extend to the sexual functioning. Ayşe is happy living as a married woman yet she has sexual problems with her husband. It was found out that Hasan in general showed a lack of interest and was limited in terms of his social relationships. This affected their relationship negatively. On the other hand, these observations were a kind of advantage, considering the fact that Hasan either did not know or pretended not to know anything about his wife's trans history.

Ayşe is a trans woman living on her own who has been ostracized and exposed to violence by her own family. She faces the risk of losing her job and being subjected to violence by her environment. Being a married woman supports her image as a heterosexual woman.

In some marriages sexual satisfaction and intimacy does not serve as the most crucial factor in the establishment and maintenance of a relationship. Her status as being married to Hasan, a quiet person who does not question the existing situation, has reinforced the security of Ayşe's life.

Sexual satisfaction and function are closely related but are not the same thing and many transgender people may compromise to some extent on functionality if it means/provides greater sexual satisfaction.

# Breast augmentation in trans women receiving hormone treatment: prevalence and satisfaction

Thursday, 11th April - 14:30: Endocrinology Session I: Gynaecology and Fertility (Bramante 14)

***Christel De Blok*** [1], ***Annemieke Staphorsius*** [1], ***Chantal Wiepjes*** [1], ***Frank Niessen*** [1], ***Jan Maerten Smit*** [1], ***Prabath Nanayakkara*** [1], ***Martin Den Heijer*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

Trans women receiving gender-affirming hormone treatment (HT) often experience their breast development as modest and disappointing. Therefore, they sometimes choose to undergo breast augmentation besides HT. However, the prevalence of breast augmentation in trans women and their considerations in the decision to undergo breast augmentation are unknown. This study aimed to gain more insight in these factors as well as the prevalence of possible health complications related to breast implants in trans women receiving HT.

**Methods**

All transwomen who visited the outpatient clinic of the VU University Medical Center, Amsterdam, the Netherlands, and started HT before August 2018, were invited to participate. These transwomen received an anonymous questionnaire with questions regarding whether or not they underwent breast augmentation, what the reasons for this decision were, and whether they experienced (health) complaints of their breast implants.

**Results and Conclusions**

Results: A total of 3,074 trans women received a questionnaire, of which up to now, 934 (30.4%) were returned (725 filled out questionnaires, 209 return to sender). Reasons for return were that the trans woman had moved (n=155), was deceased (n=15), or other (n=39). Of the trans women who filled out the questionnaire, 291 (40%) had breast implants and 433 (60%) had not. The trans women who did have a breast augmentation were older at time of the survey (median 54 (IQR 45-63) vs 45 (IQR 29-57) years), were slightly younger when they started HT (median 34 (IQR 23-45) vs 36 (IQR 24-47) years), and therefore used HT for a longer period of time (median 17 (IQR 8-26) vs 4 (IQR 2-11) years) than trans women without breast implants. Nearly 80% of the trans women who underwent breast augmentation were satisfied with the result. However, 24% of the trans women with breast implants experienced local inconvenience and 21% experienced subjective systemic health complaints, such as tiredness, concentration disorders, or myalgia. Breast augmentation was performed before the start of HT in 8 trans women. The other trans women underwent breast augmentation after a median of 2 years of HT (range 1-42). Of the trans women without breast implants, 290 (67%) trans women considered a breast augmentation. Reasons not to undergo breast augmentation included 'happy with the breast growth gained with HT' (n=85), 'awaiting further breast growth with HT' (n=54), 'financial limitations' (n=80), 'afraid of complications' (n=19), and other reasons (n=43).

Conclusions: In this study, 40% of the trans women underwent breast augmentation besides HT. Trans women who underwent breast augmentation were older at time of the survey and used HT for a longer period of time than trans women who did not undergo breast augmentation. Although most trans women were satisfied with the results of the breast augmentation, approximately one fifth to a quarter of the trans women with breast implants also experienced health complaints which they attribute to their implants. These findings might help trans women in their consideration whether or not to undergo breast augmentation.

# Fertility preservation uptake and sperm banking success among adolescent registered male at birth

Thursday, 11th April - 14:45: Endocrinology Session I: Gynaecology and Fertility (Bramante 14)

***Elena Monti*** [1]***, Raheala Wafa*** [2]***, Alice Roberts*** [1]***, Sara Klecxewski*** [3]***, Kirpal Adu-Gyamfi*** [4]***, Sandra Walton-Betancourth*** [1]***, Elizabeth Williamson*** [2]***, Gary Butler*** [1]

***1.*** *Gender Identity Development Service adolescent endocrine clinic, University College London Hospital,* ***2.*** *Fertility and Reproductive Medicine Unit, University College London Hospital,* ***3.*** *Gender Identity Development Service adolescent endocrine, University College London Hospital,* ***4.*** *Gender Identity Development Service adolescent endocrine clinic and Reproductive Medicine Unit, University College London Hospital*

**Background**

GnRH analogue (GnRHa) and subsequent oestrogen treatments are offered to adolescent registered male at birth (RMAB) who finds medical treatment beneficial. Side effects include impairments in gonadal histology that may cause infertility or biological sterility. Current guidelines encourage professionals to address potential infertility risk and fertility preservation options with transgender youth and their families before starting these treatments. The aim of this study was to examine fertility preservation uptake and rate of sperm banking success among RMAB seen in our adolescent endocrine clinic.

**Methods**

This is a retrospective study on the young people with *a gender dysphoria diagnostic code*in the Identity Development Service (GIDS) liaison adolescent endocrine clinic (EC). Between 2015 and 2017, 179 RMAB were referred to the GIDSEC. Fertility counselling was documented. Young people could also choose to opt for professional fertility clinic counselling.

**Results and Conclusions**

60 RMAB (34%) requested referral to the fertility laboratory. Mean age at referral was 16.4 (±1.9 years). Group 1: 13 RMAB < 15 years (13.4 ±0.8); Group 2: 47 ≥15 years (17.2 ±0.9).

-RMAB opted for professional fertility counselling: Group 1: 11 (85%), Group 2: 36 (75%)

The majority did so before any medical intervention (11 in group 1 and 33 in group 2); few while on GnRHa (2 in group 1 and 13 in group 2); 1 in group 2 was on oestrogen.

-RMAB uptake of fertility preservation: Group 1: 10 (77% of the total 13); Group 2 :28 (58% of the 47). Mean number of visit was1.9 (±1.1 SD) in group 1 and 1.4 (±0.6 SD) in group 2.10 (69%). The majority weren't sure of the future use of the sample (69% in group 1 and 38% in group 2).

-The results of Sperm banking respectively in group 1 and 2 were (considering that 4 RMAB from group up 2 are on the waiting list):

→successful in 7 (54% of the 13 referred) and 26 (54% of the 47 referred) →

→unsuccessful in 2 (15%) and 7 (15%)

→declined in 2 (15%) and 8 (17%)

In summary this cohort of RMAB had a good rate of sperm banking success, regardless of their age. Interestingly lack of clarity regarding the future use of sperm samples among young participants decreased as the group got

older. If fertility preservation is handled sensitively in young RMAB, a high success rate can be obtained and should therefore be considered early in the transition process. Developmentally appropriate fertility counselling is essential and specific pathways and guidelines are needed.

# Chances for fertility preservation in trans women diagnosed with gender dysphoria in a German multi-center setting

Thursday, 11th April - 15:00: Endocrinology Session I: Gynaecology and Fertility (Bramante 14)

***Florian Josef Schneider*** [1], ***Bettina Scheffer*** [1], ***Nina Neuhaus*** [2], ***Stefan Schlatt*** [2], ***Sabine Kliesch*** [3]

***1.*** *Department of Clinical and Surgical Andrology, Center of Reproductive Medicine and Andrology, University of Münster,* ***2.*** *Institute of Reproductive and Regenerative Medicine, Center of Reproductive Medicine and Andrology,* ***3.*** *Department of Clinical and Surgical Andrology, Center of Reproductive Medicine and Andrology*

**Background**

Persons diagnosed with gender dysphoria (GD) undergo cross-sex hormone therapy (CSHT) until the day of gender confirming surgery (GCS). In Germany, interdisciplinary centers for treating GD are rare, hence there are challenges in service delivery according to the standards of the WPATH, especially concerning fertility preservation. Auer *et al.* (2017) reported, however, that 70% of German persons diagnosed with GD had the wish to have children, but fertility methods are hardly being pursued. Especially since we could show that 21% of trans women showed qualitatively normal spermatogenesis on the day of GCS (Schneider et al. 2015), testicular sperm extraction techniques could offer a chance for fertility preservation. The aim of this study is to present the results of hormonal and testicular evaluation in a multi-center setting over 6 years in order to set up a future concept for fertility preservation methods in trans women diagnosed with GD.

**Methods**

Between 02/2012 and 06/2018 268 trans women diagnosed with GD could be included. In total 354 testicular tissues and 226 questionnaires about CSHT from 268 persons could be obtained on the day of GCS. The patients were included from three German clinics with different treatment regimens. 48 persons took CSHT until GCS, 178 stopped the therapy 2 weeks before and another 40 4-6 weeks before GCS. Testicular tissue was evaluated according to Bergmann&Kliesch. Gonatropins and serum testosterone was measured with commercial ELISA and estradiol with immunofluorometric assays.

**Results and Conclusions**

Most of the patients (*N*=168) took cyproterone acetate (CPA) and estrogens as CSHT. The average dosage of CPA was 23,63 mg/d (min 0,25 mg/d, max 150 mg/d) for an average period of 29,15 months (min 5 months, max 169 months). Mean serum testosterone was 8,86 nmol/l (SD 8,6 nmol/l) and mean serum estradiol was 195,9 pmol/l (SD 382,4 pmol/l) on the day of GCS. Mean testicular weight was 11,35 g (SD 4,6 g). According to Bergmann/Kliesch 39 testicular tissues showed complete spermatogenesis, 63 meiotic arrest, 95 spermatogonial arrest, 38 Sertoli-Cell-Only syndrome and 3 tubular shadows. None of the patients from the three cooperating clinics pursued fertility preservation.

In the same period another 12 trans women presented in our clinic for councelling, including fertility preservation. Three of them successfully cryopreserved semen specimen with terato- and normozoospermia.

Sperm cryopreservation of semen can be offered before and during CSHT if sex gonadotropins, sex hormones and testicular size suggest spermatogenic activitiy and if the persons are not challenged psychologically by masturbation. Otherwise testicular sperm extraction could be offered prior to or during CSHT. The evaluation of the testicular tissue revealed in 16% of patients at least qualitatively intact spermatogenesis and thus offer the chance for positive sperm retrieval with TESE procedures. Even in younger patients at the peri- or prepubertal stages immature

testicular tissue could be offer to be cryropreserved experimentally following our Androprotect® protocols. Trans women should be counceled regarding fertility preservation options. Research activities can be enhanced to better understand the needs for and to improve fertility preservation options at the different stages of the gender confirming process.

# Influence of cross-sex hormone therapy on testicular peritubular myoid cells from persons diagnosed with gender dysphoria on the day of gender confirming surgery

Thursday, 11th April - 15:15: Endocrinology Session I: Gynaecology and Fertility (Bramante 14)

***Jennifer Dabel*** [1], ***Laura Heckmann*** [1], ***Joachim Wistuba*** [1], ***Stefan Schlatt*** [1], ***Sabine Kliesch*** [2], ***Nina Neuhaus*** [1], ***Florian Schneider*** [1]

***1.*** *Institute of Reproductive and Regenerative Medicine, Center of Reproductive Medicine and Andrology,* ***2.*** *Department of Clinical and Surgical Andrology, Center of Reproductive Medicine and Andrology*

**Background**

Little is known about the influence of cross-sex hormone therapy (CSHT) on testicular peritubular myoid cells (PMC) in persons diagnosed with gender dysphoria (GD). In Germany, anti-androgens such as cyproterone acetate (CPA) in combination with different forms of estrogens are used to achieve physical adaption in trans women diagnosed with GD before gender confirming surgery (GCS). CPA is a testosterone antagonist and leads to downregulation of the hypothalamic-pituitary-gonadal axis. Effective treatment leads to suppression of spermatogenesis coming along with regressed and degenerated tubules. Alterations of PMCs caused by CSHT are barely investigated. α-smooth muscle actin (SMA) is a marker protein for the differentiation status of PMCs and its expression is mediated by androgens.

The aim of this study was to assess the influence of CSHT on PMCs based on expression analysis of SMA.

**Methods**

30 testicular tissues from trans women diagnosed with GD (16-57 years;  38.3 years) were collected on the day of GCS. CSHT included CPA (10-12mg) and estrogens. The most advanced germ cell type was determined for each tubule. Immunohistochemical staining was performed for SMA and each tubule on one section per patient was evaluated semi-quantitatively. Intact tubules were assigned to one of the following categories: 100%, >50%, <50% or 0% of SMA-positive PMCs. Furthermore, thickness of the tubular wall, including the basal membrane, was measured. Testicular tissue from adult men with qualitatively intact spermatogenesis (n=5) served as controls.

**Results and Conclusions**

The 30 testicular tissues contained in total 7.330 cross sections of tubules and half of these contained germ cells at different stages of differentiation. Importantly, the most advanced germ cell type of the tubules was highly heterogeneous within the individual samples. Regarding the staining pattern of SMA, the number of tubules with 100% stained PMCs was highest in controls with normal spermatogenesis and reduced in patient samples (45% of tubules with elongated spermatids; 22% spermatogonia; 7% Sertoli cell-only and 1% of tubular shadows). In contrast, the proportion of 0% stained PMCs was lowest in controls and increased in samples with impaired spermatogenesis (0% of tubules with elongated spermatids; 7% Sertoli cell-only and 55% of tubular shadows). Comparison of tubular wall thickness revealed significantly thinner walls in tubules of the controls (7.02µm±2.12µm) compared to the walls of the samples (14.92µm ± 6.26µm; p≤0.0001). The thickening increased with suppressed spermatogenesis and walls of tubular shadows (22.95µm ± 7.35µm) were significantly thicker compared to tubules containing elongated spermatids (10.65µm ± 2.11µm; p≤0.0001), spermatogonia (12.92µm ± 2.46µm; p≤0.0001) or Sertoli cell-only (16.48µm ± 2.46µm; p≤0.05).

In conclusion, the CSHT leads to variable degree of degeneration of seminiferous tubules in the testis. The results in-

dicate a decreased SMA-expression in tubules with suppressed spermatogenesis. The thickening of the tubular wall correlates with spermatogenesis and increased with suppression of spermatogenesis. The findings of decreased SMA expression and a thickening of tubular wall correspond with findings in infertile men with impaired spermatogenesis (Schell *et al*., 2010, Volkmann *et al*., 2011). More research is needed to correlate the degeneration of the tubular walls with CSHT and endocrine profiles.

# Transgender men and pelvic pain

Thursday, 11th April - 15:30: Endocrinology Session I: Gynaecology and Fertility (Bramante 14)

***Rixt Anna Catharina Luikenaar MD*** [1]

***1.*** *Rebirth Obgyn/ Luikenaar and Crane, Center for Transgender Surgery*

**Background**

It has become apparent that transgender men, either early or later in their transition often struggle with painful cramping and pain after orgasm. This can be so debilitating that it can lead to the request for a hysterectomy (which is generally less often performed on trans men in the USA
compared to Europe). Transgender men also suffer from conditions more often seen in menopause as vaginal atrophy, desquamous vaginitis and even lichen planus. This leads to vaginal discharge and painful intercourse. Conservative options for treatment (empiric) of discharge and/or pain include estrogens (especially in transgender men without ovarian tissue), anti-estrogens or GnRH analogues (in transgender men with ovarian tissue and irregular bleeding), nsaids, or a vaginal combination of steroid/clindamycin and estradiol cream. Transgender men also have an increase in cuff cellulitis after hysterectomy which typically leads to painful cramping and discharge 5 days to two weeks after hysterectomy.

**Methods**

x

**Results and Conclusions**

This presentation will discuss possible reasons of pelvic pain in transgender men with an intact uterus and ovaries.

# Ultrasonographic changes in ovary after exposure to exogenous testosterone: A Mexican Cohort of Transgender Men

Thursday, 11th April - 15:45: Endocrinology Session I: Gynaecology and Fertility (Bramante 14)

***Esmeralda Román Mar [1], Mitzi Zaira Fong Ponce [2], Luis Carlos Joya Fierro [1], Arnulfo González Cantú [3], Maria Elena Romero [4], Andrea González Rodríguez [2]***

***1.*** *Condesa Specialized Clinic,* ***2.*** *Clinica Especializada Condesa,* ***3.*** *Eurarya PharmaCite,* ***4.*** *Muguerza Alta Especialidad*

**Background**

According to multiple medical guidelines of hormone therapy (HT) in people with gender incongruence (GI), the transgender men (TGM) have a long-term indication of testosterone as long as there is no medical contraindication.(1)(2) There are only few long-term studies on the effects of androgens, the majority is reported at the histopathological samples in ovarian and breast tissue, but there are no reports of ultrasonographic changes in ovaries.(3)

The Condesa Specialized Clinic (CSC) has had a health care program for transgender people since 2009, offering free mental health assessments, diagnosis and treatment for Human Immunodeficiency Virus / Sexually Transmitted Disease (HIV/STD) and HT. Before starting cross sex hormone therapy (CSHT), different laboratory and imaging are requested, including complete blood count, glucose, lipid profile, liver function tests, hormonal profile and breast and testicular ultrasound in transgender women (TGW) and breast and pelvic ultrasound for TGM in order evaluate medical conditions that could be aggravated by HT

**Methods**

**Objective:** To describe ultrasonographic changes in the ovaries of TG who use long-term exogenous testosterone.

**Materials and Methods** The CSC has registered 504 TGM from September 2009 to August 2018, of which 310(61.5%) are under CSHT. A retrospective study was conducted that included 71(22.9%) TGM who were under HT in a period from 2009 to 2018, between 16 to 24 years old to fit the young people definition of the World health organization; with pelvic ultrasound before and after the treatment, with basal hormone profiles. They were treated with testosterone enanthate 250 mg injection each 21 to 15 days to achieve testosterone values in the male range (320 to 1000 ng/dL). The ultrasound equipment used was type SA 600.

**Statistical Analysis**

In descriptive statistics we used mean, median and standard deviations for continous variables, and proportions for categorical variables. To analyze longitudinal data, we used linear mixed effects models. The missing values were handled with multiple imputation (predictive mean matching). Statistical significance were defined as p value < 0.05. R software version 3.4 was used for statistical analysis.

**Results and Conclusions**

**Results:** The mean age of 21(+/- 2.2 SD) years old. The average body mass index (BMI) was high of 26(+/- 5 SD). No severe metabolic disorders were detected. The table 3 (Lineal mixed effects model) shows that the mean ovary volume reduce with every year of testosterone therapy (p value <0.001). The effect of time in mean ovary volume was of 1 $cm^3$ (0.23 se) by year.

**Conclusions:** Use of exogenous testosterone for a long-time alters both the function and the morphological characteristics of the ovaries; is considerable ovary volume reduction within a year of treatment and continuously during the treatment.This is the first report in TGM with reduction of ovarian size by pelvic ultrasound with 36 months

follow up. The next step is to elucidate the mechanism of ovarian volume reduction and its histopathological correlation in transgender men who are being submited to oophorectomy.

# Human rights perspective to trans-specific health care post ICD-11

Thursday, 11th April - 14:30: Law Session I: Human Rights in Trans Matters (Bramante 9)

***Constantin Cojocariu*** [1], ***Leo Mulio*** [2]

***1.*** *Transgender Europe (TGEU),* ***2.*** *TGEU*

**Background**

Trans people continue to experience significant health disparities, reporting worse physical and mental health compared to the general population.[1] This cannot come as a surprise in the context where on the one hand trans people are subjected to psychiatrization and pathologization when seeking legal recognition to their gender identity, and on the other hand are often denied of access to their desired trans-specific health care (also gender affirming care) or health insurance coverage of such care. This push-pull dynamic harms the trust that trans people are able to put into the medical world.

Trans people are still too often forced to undergo medical examinations, tests, diagnosing, hormonal treatment and even sterilization to access legal gender recognition (LGR).[2] In a number of European countries invasive procedures, such as sterilisation, are a requirement for legal gender recognition, but at the same time not covered by public insurance. [3] Only a handful of European countries ensure that public insurance covers most gender affirming healthcare services.

**Methods**

The presentation will look at the recent European and UN related human rights standards that can be used to eradicate the paternalistic and abusive practices that trans people are subjected within or with help of medical world.

Firstly, I shall discuss the legality of so-called medical criteria in the LGR processes from the human rights perspective. What did the human rights discourse say until the 2017 decision of the European Court of Human Rights in the French cases and what does it say now? Where does the border of legality run for different medical procedures and treatments that state demand trans people to undergo as the prerequisite for new ID-papers? Since 2017 the sterilisation requirement is considered a human rights violation, but does that include hormonal treatments that may in time also lead to sterility?

Secondly, the presentation shall identify norms in human rights law[6] that can protect a trans person from a state that continues to pathologize trans identities after the adoption of ICD-11. Until there is case law from international courts banning psychiatric diagnoses of trans people on the basis of gender identity, what are the possible human rights strategies that could challenge pathologization and the state induced pressure to undergo medical examination?

**Results and Conclusions**

In the private relationship between patient and medical institution, where the state should have no extensive interference, imposing outdated laws of gender normalisation and trans pathologization cannot be viewed as in accordance with the human rights law. The presentation will attempt to answer the question on how can human rights be used to contest the often paternalistic approaches in trans-specific healthcare and instead protect a trans person from the discrimination and gender biases that hinder the access to quality health care.

# TGEU Guide: Human Rights Principles in Trans-specific Healthcare

Thursday, 11th April - 14:45: Law Session I: Human Rights in Trans Matters (Bramante 9)

***Richard Köhler*** [1], ***Leo Mulio*** [1]

***1.*** *Transgender Europe*

**Background**

The revision of the trans-related diagnoses in the International Classification of Diseases Version 11 provides an unmissable opportunity to introduce care pathways within national health systems that are based on informed consent, overcoming psychiatric assessments and gatekeeping. This poses the question how human rights based trans-specific healthcare can be implemented in practice. While specific solutions will differ from country-to-country TGEU has set to develop the key human rights principles which should underpin the Europe-wide provision of and access to depathologized trans-specific healthcare.

**Methods**

In developing the human rights guidelines, TGEU has been undertaking desk research, legal analysis, and brought together individuals with expertise in healthcare, including trans activists, healthcare professionals, and human rights advocates. TGEU will present the output of the process, explaining its development, giving a detailed overview of how the principles should be used to shape the delivery of trans-specific healthcare. It is also a great opportunity to discuss and explore the ways in which trans activists can use them in their healthcare advocacy.

**Results and Conclusions**

The human rights principles underpinning trans-specific healthcare are intended to enable the design of depathologized healthcare provision that upholds the human rights of trans people and genuinely facilitates access to care. The principles can be applied practically in the design, implementation and monitoring of services that center trans people's autonomy.

# After the WHO, is there any future left for the Gender Identity Clinic?

Thursday, 11th April - 15:00: Law Session I: Human Rights in Trans Matters (Bramante 9)

***Stephen Whittle*** [1]***, Sarah Rutherford*** [2]

***1.*** *The Manchester Law School, Manchester Metropolitan University,* ***2.*** *Depts. of Nursing and Health Professions, Manchester Metropolitan University*

**Background**

This paper is a reflective analysis of recent changes in diagnostic methodologies and the potential of what those changes could mean in law, for the role and purpose of the Gender Identity clinical system.

The history of Europe's current health and wellbeing provision for transgender identified people has been embedded within the paternalism and related values of the traditional psychiatric outpatient clinic. It is acknowledged that some clinicians have discussed, even tried to change their practice in light of the challenges presented by the de-psychopathologisation campaign by trans people. However, our recent research (2017-2018) undertaken across Europe demonstrates the continuing perpetuation of practices that are clinically questionable. More directly related to the question in this paper, however, since the changes in the WHO's classification of gender identity related diagnoses, many of those practice are in the author's view now very clearly contrary to the human rights of the transgender patient, as contained in the European Convention on Human Rights. Secondly, recent and proposed changes in European states to gender recognition laws, will doubly engage many of those practices and clearly outlaw them in relation to patient's rights under national laws and the European Charter of Fundamental Freedoms.

**Methods**

Qualitative Research into current practice within Gender Identity Clinics was undertaken with groups of people who are themselves marginalised within the Transgender Community,. Five Focus groups were held, in Spain, Sweden, Northern Ireland, the UK, and the Netherlands. This was combined with individual requests to know minority group members for information about current clinical experiences across the larger Europe; the 47 member states of the Council of Europe. A further series of individual long interviews were held with over 150 'successful' trans people across the wider Europe. These were all taped, translated and transcribed so that it was possible to review different aspects of individual's clinical pathways. All participants were asked to relate their clinical experience, and in particular focus on where healthcare had been positive and respectful of their gender identity, so as to avoid the natural bias that comes with such research; wherein participants 'tell the worst', thinking that is what researchers are looking for.

A black letter law analysis of human rights law was undertaken, and how they relate specifically through treaties, national laws, and case law to transgender patients and their clinical care experiences in Gender Identity Clinics and more general healthcare. These two bodies of data were interrelated by the simple method of looking the individual experiences of clinical care, and relating those to the individual rights that exist in law.

**Results and Conclusions**

Human Rights can be claimed against the state, and organisations performing duties on behalf of the state, including most Healthcare providers who provide services as part of the state's obligations under the WHO Constitution. The research found European states generally fail in meeting their obligations to provide transgender healthcare.

Specifically Gender Identity services persistently contravene patient rights. Our conclusions: the GIC is a redundant clinic, .alternatives do exist and this research demonstrates they should exist.

# Christine Goodwin v UK : The Transpersons Case which demonstrates that a Consensus among Member States is not necessary for a Far Reaching Judgement from the European Court of Human Rights: Can a Lesson be emulated in the Area of Same-Sex Marriage?

Thursday, 11th April - 15:15: Law Session I: Human Rights in Trans Matters (Bramante 9)

***Frances Hamilton*** [1]

***1.*** *Northumbria University*

**Background**

The European Court of Human Rights ('European Court') has demonstrated an inconsistent approach to the use of consensus as a standard in its leading case law concerning the treatment of individuals falling under the LGBTQ banner. In some high profile areas such as same-sex marriage the European Court has refrained from ruling in favour of the applicants. From the European Courts' leading judgments concerning same-sex marriage (most noticeably *Schalk and Kopf v Austria* (App. No. 30141/04)) it seems that it is only consensus, leading to a wide Margin of Appreciation ('MoA') (otherwise known as area of discretion awarded to Member States), which prevents the European Court recognising same-sex marriage. Early case law before the European Court also followed a similar approach. Transpersons' rights were denied on the basis of a lack of consensus, and a subsequent finding that a wide MoA was deemed necessary (*Rees v UK*(1987) 9 EHRR 56). However famously transpersons' rights were transformed before the European Court in the case of *Christine Goodwin v UK* (Appliction 28957/95, Judgment of 11th July 2002). This included a right for transpersons to marry according to their affirmed gender. The European Court is to be applauded in making a clear commitment to a 'dynamic and evolutive approach' in order to 'render [the European Convention's] rights practice and effective, not theoretical and illusory' (Christine Goodwin v UK paragraph 74). However, further analysis of the European Courts' case law demonstrates that no clear explanation was given as to how the European Court justified this change in approach. By the time the far reaching judgment in *Christine Goodwin v UK* was taken, there had been very little progress in the number of European countries recognising transpersons' rights over the sixteen year period since the earlier *Rees* judgement. The European Court's wording in *Christine Goodwin v UK* was also confusing as they used multiple different terminologies including 'emerging consensus' and a 'continuing international trend' and reference was also made to judgments from courts outside Europe including those from Australia and New Zealand.

**Methods**

Doctrinal desk based research.

**Results and Conclusions**

The *Christine Goodwin* judgment has been heavily criticised by academics, as an example of judicial policy making. It also creates difficulties for those wishing to determine when a consensus will be deemed to have been reached in other areas such as same-sex marriage, where consensus does seem to be determinative. In this piece I argue that the Goodwin case is an important example of a leading judgment by the European Court in case law concerning LGBTQ groups where consensus is not deemed as essential. As such this is an example which could be followed in other areas. Instead the protection of sexual minorities should be seen as more important. Alternatively the European Court should at least clarify in other areas when a consensus will be deemed to have been reached.

# Long-term effect of speech therapy in transgender women

Thursday, 11th April - 14:30: Voice Session I: Transgender women (Bramante 12)

***Marjan Cosyns*** [1]***, Lore Plantefève-castryck*** [1]***, Elia Vermeulen*** [1]***, John Van Borsel*** [1]

***1.*** *Ghent University*

**Background**

For transgender women, speech therapy is the treatment of choice to feminize the voice. However, research on therapy outcomes is rather scarce. This retrospective study aimed to examine the effect of speech therapy in transgender women who finished their therapy at least one year ago. The study distinguishes itself from other studies by sample size and the use of a multidimensional voice assessment including perceptual, objective and self-rating measures.

**Methods**

Participants were 21 transgender women ranging in age between 20 and 72 years (mean = 46, SD = 14.3) recruited from the database of the Speech and Hearing Department of the Ghent University Hospital, Belgium. They finished their speech therapy between 2 and 30 years ago (mean = 6, SD = 3.8) and none underwent pitch raising surgery. Voice assessment comprised perceptual evaluation (GRBASI), aerodynamic measurements (MPT, VC, PQ, s/z ratio), acoustic analysis (F0, jitter, shimmer, DSI, AVQI), voice range profile, and self-rating (VAS, TVQ). Findings were compared to measurements conducted before therapy and immediately post-therapy. In addition, 10 lay men and 10 lay women were asked to rate the femininity of the participants on a VAS.

**Results and Conclusions**

A repeated measures ANOVA followed by post hoc tests revealed that recent findings and measurements conducted immediately post-therapy were significantly higher than measurements conducted before therapy. There was no significant difference between recent findings and measurements conducted immediately post-therapy.

Speaking F0 ranged between 135 and 207 Hz with an average of 157 Hz (SD = 15.6) and differed significantly from normative values for persons assigned male at birth (i.e., 122 Hz) and persons assigned female at birth (i.e., 212 Hz). This in-between position was confirmed during the listener experiment which resulted in a mean score of 48.8 or a voice that is located between male and female. Further, it seemed that duration of discharge had a significant positive impact on mean F0.

It can be concluded that speech therapy has a positive effect on the voice of trangender women and that this effect can be maintained over time.

# Acoustic and perceptual effects of articulation exercises in trans women

Thursday, 11th April - 14:45: Voice Session I: Transgender women (Bramante 12)

***Evelien D'haeseleer*** [1], ***Kim Bettens*** [1], ***Paul Corthals*** [1], ***Marjan Cosyns*** [1]

***1.*** *Ghent University*

**Background**

Differences in formant frequencies contribute to gender perception and are therefore targeted in speech therapy for transgender persons. The vowel chart area (/a/, /i/, /u/) in Dutch is larger in female speakers. Articulation exercises using a cork between the front teeth enlarges articulation movements and hypothetically results in a larger vowel chart area. Articulation exercises for lip spreading hypothetically result in changes in the vowel formants.
The purpose of this study is to measure the impact of articulation exercises using a cork and articulation exercises for lip spreading on the formant frequencies of vowels and listeners perceptions of femininity in trans women.

**Methods**

Samples of continuous speech during reading are recorded before and after the cork articulation exercises and before and after exercises for lip spreading. Speech samples are analyzed using PRAAT. In the study, trans women (*N*=20) will be included. Data collection of the study will continue until January 2019 and results will be analyzed in February-March 2019. For each speech sample, the vowel formant frequencies (F1, F2, F3) and the vowel chart area will be determined. Secondly, a listeners experiment will be organized using naive female and male listeners rating the audio samples of continuous speech. For the listening experiment a combination of masculinity/femininity ratings (using a VAS) and gender identification (male voice versus female voice) will be used.

**Results and Conclusions**

The preliminary results of 4 included trans women show an increase of F2 (in Hz) of /a/ and /i/ and an increased F2 contrast /i-u/ in all participants indicating more frontal-dorsal tongue placement after the cork exercise. The results of the total group and the results of the listeners experiment will be analyzed and presented in April 2019.

# Investigating the validity and reliability of the Turkish version of the transsexual voice questionnaire (TVQMtF).

Thursday, 11th April - 15:00: Voice Session I: Transgender women (Bramante 12)

***Aysenur Taskin*** [1], ***Fatma Esen Aydınlı*** [1], ***Koray Başar*** [2], ***Taner Yılmaz*** [1], ***Esra Özcebe*** [1]

***1.*** *Hacettepe University,* ***2.*** *Hacettepe University, Faculty of Medicine, Department of Psychiatry*

**Background**

In a comprehensive voice evaluation battery, self-perception measures of the participants is quite important. Self-perception instruments help professionals understand the importance of disability for the individual. There are many self-perception instruments available in Turkish such as voice handicap index or voice-related quality of life index. However, a specific method of self-assessment measure developed for transgender women has not yet been translated into Turkish.

The aim of this study was to establish the Turkish version of the Transsexual Voice Questionnaire for transgender women ($TVQ^{MtF}$-TR) and to examine its validity and reliability.

**Methods**

The Turkish translation and adaptation of the $TVQ^{MtF}$ was performed according to the translation procedure of the World Health Organization. The questionnaire was translated by an expert fluent in both languages from English to Turkish, this translation was reviewed by a group of experts familiar with this population and fluent in both languages and the initial Turkish draft was obtained. Following back translation to English, both forms of the questionnaire were reviewed by all translators for inconsistencies. Following last modifications by whole group of translators, the final form was sent for approval to the researchers who have developed the original scale. Finally a preliminary study was made with a small sample of transgender women to assess the comprehensibility of the scale.

The validity and the reliability of the scale will be assessed with a mixed sample of transgender women, a group referred from the psychiatry clinic where they present for medical assistance in gender affirmation, and another group referred from a local association of transgender people. In order to assess the validity, the design of the original study was slightly modified. Transgender women providing consent will be enrolled in two groups based on their self-assesment of the change in their gender expression; one group with participants who consider themselves to express their gender identity in more than two soical domains longer than two years, and the other group with participants who don't fulfill these criteria. Twenty-five participants from each group, constituting a final sample size of 50, will be enrolled. $TVQ^{MtF}$-TR and the scale of femininity of the voice will be filled by all participants. Significance level is set as p=.05. Statistical analyses will be performed using SPSS 20.0.

**Results and Conclusions**

The internal consistency reliability of the questionnaire will be evaluated determined with Cronbach-alpha value, the item-total correlation will be calculated for all items, in whole sample. Test-retest reliability will be assessed from total scale scores administered three weeks apart by all participants, using Pearson correlation test. $TVQ^{MtF}$-TR scores of the two groups will be compared with the Mann-Whitney U test. The correlation between the $TVQ^{MtF}$-TR scores and the scale of femininity of the voice scores will be calculated for construct validity and the significance will be examined with Spearman correlation test.

The translation procedures have been completed and the data gathering period has been started. In the current

presentation, the preliminary findings on the validity and the reliability of TVQ$^{MtF}$-TR will be presented.

# Feedback of trans women regarding voice therapy

Thursday, 11th April - 15:15: Voice Session I: Transgender women (Bramante 12)

***Ioanna Georgiadou*** [1]

***1.*** *Nottingham Centre for Transgender Health*

**Background**

Voice therapists working with trans clients who wish to feminize their voice aim to record vocal parameters before and after therapy in order to quantify progress. Despite the multitude of studies documenting the outcomes of acoustic and perceptual voice differences and quality of life differences, no study reports on the opinion of the clients themselves regarding the most helpful techniques/exercises, after undergoing voice feminization therapy. During the course of voice feminization therapy, voice therapists use a variety of vocal techniques and exercises in order to facilitate desired voice change.

The aim of this study was to examine the opinions of trans women regarding the most helpful voice exercises/techniques after undergoing voice feminization therapy.

**Methods**

Forty-nine trans women completed an 'end of voice therapy questionnaire' developed for this study after participation in 5 one-to-one voice feminization sessions. The questionnaire included 1) scaling questions that rated the SLT's skills and competence and 2) open-ended questions regarding a) most helpful voice exercises/techniques, b) least helpful exercises/techniques and c) additional comments. The present study presents findings for 2a) most helpful voice exercises/techniques.

**Results and Conclusions**

The data revealed that participants found the following exercises/techniques to be most helpful in feminizing their voice: 1) resonance/tuning exercises (21/49, 42.86%), 2) Praat voice analysis recordings (16/49, 32.65%), 3) Intonation exercises (14/49, 28.57%), 4) Vowel elongation exercises (10/49, 20.41%), 5) Warm-up exercises (10/49, 20.41%), 6) Phone conversation exercises (3/49, 6.12%), 7) Tailored exercises (3/49, 6.12%), and 8) Posture/breathing exercises (2/49, 4.08%). This study suggests that resonance/tuning exercises seem to be among the ones that clients have found to be most beneficial during voice feminization. This is a pilot study and results should be interpreted with caution. A planned larger-scale clinical study will provide a better assessment of the views held by trans women regarding voice exercises.

# Femininity in voices of transgender women after pitch-raising surgery studied with a listening evaluation

Thursday, 11th April - 15:30: Voice Session I: Transgender women (Bramante 12)

***Victoria Kelly*** [1], ***Elin Emtedal*** [2], ***Isabelle Pano*** [2], ***Ulrika Nygren*** [3], ***Maria Södersten*** [3]

***1.*** *Karolinska University Hospital, Functional Area Speech & Language Pathology, SE-171 76 Stockholm, Sweden,* ***2.*** *Karolinska Institutet, Department of Clinical Science, Intervention and Technology, Division of Speech and Language Pathology, SE-171 77 Stockholm,* ***3.*** *Karolinska University Hospital*

**Background**

Some transgender women need pitch-raising surgery after feminizing voice therapy. Criteria for surgery at Karolinska University hospital are a) if a patient has difficulties to raise or b) maintain a speaking pitch in a female range, or c) if the pitch drops to a very low male range during involuntary phonation such as sneezing or coughing. Results from a previous study from our hospital showed that pitch-raising surgery, performed with cricothyroid approximation or glottoplasty, did raise pitch into a female range and that this result was stable over time (Kelly et al, 2018). To further examine the clinical relevance of surgery, a study was conducted with the purpose to investigate if the voices were perceptually rated more feminine after surgery. The rationale for this is that it is of importance for patients to be perceived by others in congruence with their self-perceived gender, and the voice is a strong gender marker.

**Methods**

As part of the clinical assessment the patients' voices are audio-recorded in a sound-treated booth following standard procedures before and after voice therapy, pre- and post-surgery, and at least at 12 months follow-up. Voice samples from 20 patients (pre- and post-surgery and at follow-up), and from 5 ciswomen and 5 cismen were randomized to comprise a listening test. In order to calculate intra-judge reliability approximately 20 % of the samples were duplicated. A group of 45 naïve listeners rated the voices using the five categories "very male" "rather male" "gender neutral" "rather female" or "very female" from the Transsexual Voice Questionnaire$^{MtF}$ (TVQ$^{MtF}$).

**Results and Conclusions**

Results showed that the perceived femininity in the trans women's voices had increased somewhat after surgery. Before surgery 10 % of the trans women's voices were perceived as "rather female". One month after surgery 42 % of the trans women's voices were perceived as "rather female" with a decrease to 28 % at follow-up one year after surgery. Totally the results showed that the majority of the voices were perceived as "rather male" (55 %) before surgery, "rather female" (42 %) after surgery and gender neutral (50%) at follow-up. When looking at the whole material we found that 30 % of the ratings went from either "very male" or "somewhat male" before surgery to "rather female" after surgery or at follow-up. None of the voices were rated "very female" after surgery. It should be remembered that patients who do get surgery are the ones who have not gained successful results after feminizing voice therapy. The results should be interpreted in the light of this. It was concluded that more information is needed about predictors for successful results after pitch-raising surgery.

# National Swedish quality register for transgender health. Data from people assigned male at birth registered by speech and language pathologists

Thursday, 11th April - 15:45: Voice Session I: Transgender women (Bramante 12)

***Maria Södersten*** [1], ***Ulrika Nygren*** [1]

***1.*** *Karolinska Institutet, Department of Clinical Science, Intervention and Technology, Division of Speech and Language Pathology and Karolinska University Hospital, Functional Area Speech & Language Pathology*

**Background**

In Sweden there is a tradition of using national quality registers in healthcare. In 2013 the planning of a national quality register for the transgender population started. An interdisciplinary steering group, including a patient representative, has been working to develop infrastructure for data collection and questionnaires together with the Register Center South. Data includes information from assessments, different gender-confirming treatments and lifelong follow-up regarding quality of life. The speech language pathologists (SLP) were the first professional group to start registering data in 2017. During the first year, information was collected from 190 registrations from six SLP-units related to gender teams at university hospitals. The purpose of this presentation is to give overall information about data recorded so far for the people assigned male at birth (AMAB).

**Methods**

It is possible to collect data at the first visit to the SLP, after voice therapy and at follow-up. Information regarding waiting time from referral to the first visit, patient's assigned sex at birth, diagnosis for gender incongruence, hormonal treatment, background factors relevant for voice use such as employment, vocal load, hearing and previous voice training were registered. Furthermore information about recording routines in the voice clinic and computer programs used for acoustic analyses were collected, as well as results from questionnaires and acoustic analysis.

**Results and Conclusions**

Of the registrations, 92 were from patients assigned male at birth and 87 of those were from a first visit. Only those data will be presented. There was a large variation regarding waiting time after referral from the psychiatrist to the first visit to the SLP from a few days to 10 months. Seventy-nine of the patients were diagnosed with Transsexualism (F64.0) according to ICD-10. One patient had not received any diagnosis yet, and 12 had received the diagnoses Other gender identity disorders (F64.8) or Gender identity disorder, unspecified (F64.9). A majority of the patients (77/87) had been recorded in a sound treated booth following clinical standard routines. Mean fundamental frequency ($f_o$), measured from habitual speech, was for the group 132 Hz (range 84 to 226 Hz) and $f_o$ mode 126 Hz (range 81 to 216 Hz). Less than half of the patients had filled in the Transsexual Voice Questionnaire$^{MtF}$ (38/87) with an average score of 71 and median score of 76 (range from 34 to 113). In conclusion: The register will be a valuable source of information for data collected prior feminizing voice therapy and for comparison with data after voice therapy when more data are available in the future.

# Perception of the femininity of the face and satisfaction with the results after one year of the FGCS: relationship with subjective well-being

Thursday, 11th April - 14:30: Surgeons Only Session III: trans women (Bramante 15)

***Marina Rodríguez*** [1], ***Fermín Capitán-Cañadas*** [1], ***Javier G. Santamaría*** [1], ***Zoe Barossi*** [1]

***1.*** *FACIALTEAM*

**Background**

The perception of facial gender is a construct that has been studied for decades. People quickly perceive and extract information from another face, such as identity, emotional state, gender, race, and age, among others. For this reason, it is essential for transgender women to have significantly more feminine features on their faces, and not be misgendered.

During the last decade, numerous well-being investigations have been carried out that have considerably broadened the conceptual map of this construct. Ryff suggested a multidimensional model of psychological well-being composed of six dimensions: self-acceptance, positive relationships with other people, autonomy, control of the environment, purpose in life, and personal growth. Self-acceptance is one of the central criteria of well-being.

When working on facial surgery, satisfaction with the results is significant to evaluate the effectiveness of operation and the positive effect of surgery on transgender women.

**Methods**

This descriptive, longitudinal and correlational study aims to unite these variables and study the relationship between them. A sample of 82 patients after a year of undergoing Facial Gender Confirmation Surgery (FGCS) is analyzed. The variables measured are the perception of the femininity of the face before surgery, one year after surgery and the measure of satisfaction with the results. Also, the pre and post measure of perceived well-being is included.

**Results and Conclusions**

According to the results, a positive and significant relationship can be observed between general satisfaction with surgery and the perception of femininity of the face at 12 months. There is also an increase in the score between the perception of femininity of the pre- and post face, with a rise in the second compared to the first. The measure of personal well-being at 12 months postop correlates in a positive and significant way with the perception of femininity of the face at 12 months and the satisfaction of the results. Likewise, an increase in the pre and post well-being score is also noted. The satisfaction with the outcomes is high in a significant number of patients.

Conclusions:

We can conclude that satisfaction of our patients with the outcomes of the FGCS is very high after a year from the surgery. In addition, satisfaction with the results is closely related to the perception of femininity of the face.

# Facial Feminization Surgery for transgender patients using 3D preoperative planning, osteotomy guides and Piezosurgical device: surgical technique and results.

Thursday, 11th April - 14:35: Surgeons Only Session III: trans women (Bramante 15)

***Sarra Cristofari*** [1], ***Marc Revol*** [2]

***1.*** *Tenon hospital- University Paris 6,* ***2.*** *hopital tenon- university paris 6*

**Background**

Facial feminization surgery (FFS) for transgender male to female patients often includes remodeling of the frontal and chin bones. Piezoelectric surgery is known to provide less bone tissue loss and less vascular and soft tissue damages. Preoperative three-dimensional (3D) planning is considered to allow more surgical precision, and a gain of peroperative time. We propose to retrospectively analyze our cases of FFS with frontal craniotomy or/and genioplasty using preoperative 3D planning, osteotomy guides and piezoelectric surgery.

**Methods**

All patients operated on for frontoorbital or chin FFS using bone section guides were analyzed, including surgery performed with or without piezosurgery. Perioperative outcomes were retrospectively reviewed. Postoperative patient satisfaction was evaluated using a satisfaction questionnaire.

**Results and Conclusions**

Twenty six patients were included. Frontoorbital or chin bone section guide were proper and usefull in all cases. In the piezosurgery group, operating time was shorter comparing to the classic non piezosurgery group using rotating instruments for the bone section. Frontal osteotomies lines were thinner and more precise in the piezosurgery group, with less damages of the underlying frontal sinus mucosa. No postoperative complications such as hematoma or infection were observed. Cosmetic results were good for all patients.

In conclusion, frontoplasty or genioplasty in FFS can be safely and properly performed with piezoelectric device, using preoperative 3D planning and osteotomy guide.

# Lower jaw contouring techniques in Facial Gender Confirmation Surgery

Thursday, 11th April - 14:40: Surgeons Only Session III: trans women (Bramante 15)

***Luis Capitán*** [1]***, Carlos Bailón*** [1]***, Raúl J. Bellinga*** [1]***, Javier G. Santamaría*** [1]***, Daniel Simon*** [1]

***1.*** *FACIALTEAM*

**Background**

Among the different surgical techniques included in the Facial Gender Confirmation Surgery (FGCS) spectrum, those aimed at the modification of the lower jaw are the least developed in the scientific literature. However, the modification of this structure is, together with the forehead reconstruction and rhinoplasty, one of the most demanded procedures by the male to female transgender patient.

**Methods**

In this study we present the different clinical indications and diagnosis, as well as the surgical techniques that allow the modification of the lower jaw in FGCS.

**Results and Conclusions**

The clinical evaluation of the lower facial third is an essential part of understanding what characteristics give the face its masculinity and may, therefore, lend themselves to surgical modification. The general aims of this treatment are to decrease the transversal jaw dimension, to modify or soften the gonial angles, to contour the jawline and to change the volume, format and position of the chin. In this presentation we describe the different approaches and the surgical techniques we carry out in the lower jaw and chin, illustrated by pictures, surgical videos and clinical results.

# Management of complications in Facial Gender Confirmation Surgery: the forehead reconstruction

Thursday, 11th April - 14:45: Surgeons Only Session III: trans women (Bramante 15)

***Luis Capitán*** [1]***, Carlos Bailón*** [1]***, Raúl J. Bellinga*** [1]***, Javier G. Santamaría*** [1]***, Daniel Simon*** [1]

***1.*** *FACIALTEAM*

**Background**

The management of complications is of extreme importance in Facial Gender Confirmation Surgery (FGCS). Despite the fact that this is a highly predictable surgery, it is not without complications, which can prolong the postoperative period and compromise the final result.

**Methods**

We present our experience in the diagnosis and treatment of the primary complications associated with the forehead reconstruction, either conducted via coronal approach or hairline approach.

**Results and Conclusions**

This study describes the most significant complications and the medical and surgical alternatives linked to the forehead reconstruction technique, either during the surgical time, the immediate recovery period or in the mid to long term follow-up period. An in-depth knowledge of these complications in FGCS, as well as of the treatment alternatives, is essential to guarantee the patients an adequate management of the same and therefore a more predictable and reliable surgery.

# Developing a training program in Facial Feminization Surgery: a pilot experience

Thursday, 11th April - 14:50: Surgeons Only Session III: trans women (Bramante 15)

***Fermín Capitán-Cañadas*** [1], ***Daniel Simon*** [1], ***Luis Capitán*** [1]

***1.*** *FACIALTEAM*

**Background**

During the confirmation process, a complex and extended transition period is usually required that involves numerous diagnostic processes, medical-surgical treatments and extensive psychological care. One of these medical-surgical treatments, facial surgery – popularly known as Facial Feminization Surgery (FFS) – has steadily gained importance and is emerging as a key element in the complex transition process, primarily for male to female transgender patients. In the last decade, we have worked towards the advancement of FFS, including its consolidation within current transgender healthcare protocols.

The professional and surgical development of this discipline, together with the growing demand by patients, has made it necessary to create specific training programs. To this end, we have developed the **Facial Feminization Surgery Training Program**, destined principally for experienced specialists whose objective is to build highly specialized gender units that will ultimately provide FFS training within their own institutions.

**Methods**

The FFS Training Program offers a higher degree of specialization for any plastic, maxillofacial, craniofacial or ENT surgeon that wants to amplify their knowledge in the field of FFS, allowing them to accelerate the learning curve and provide treatment with quality criteria. The program has been specifically designed to cover every facet of FFS, including theoretical sessions, live surgeries and a cadaver lab at the IAVANTE facilities, Advanced Multifunctional Centre for Simulation and Technological Innovation located in Granada, Spain. The program has been accredited by WPATH and by the European Accreditation Council for Continuing Medical Education (EACCME®).

**Results and Conclusions**

We present our experience with the FFS Training Program. The principles on which the program has been based have been slowly evolved through a process of incremental improvement over the course of 1,194 facial gender surgery patients in our center, from August 2008 to September 2018. As far as we are aware, there is no such FFS-specific training program anywhere in the world. Eventually, the training program could become a landmark in the integration of FFS within the surgical transition protocol, educating and training future FFS surgeons on principles such as good medical practice, appropriate diagnosis and specific surgical skills. In summary, best practices and methods for better results. As one of the fastest growing areas within plastic surgery, dissemination of education in gender surgery is essential to improving patient outcomes and spurring on new innovations.

# Psychological strain and social support in transgender women after gender confirmation surgery

Thursday, 11th April - 14:55: Surgeons Only Session III: trans women (Bramante 15)

***Jochen Hess*** [1], ***Anja Breidenstein*** [2], ***Yasmine Hess*** [3], ***Cordelia Kaspar*** [1], ***Alexander Henkel*** [1], ***Stephan Tschirdewahn*** [1], ***Martin Teufel*** [2], ***Sefik Tagay*** [2], ***Boris Hadaschik*** [1]

***1.*** *Department of Urology, Pediatric Urology and Urological Oncology, University Hospital Essen,* ***2.*** *Department of Psychosomatic Medicine and Psychotherapy, University Hospital Essen, Germany,* ***3.*** *Department of Oncology, Kliniken Essen Mitte*

**Background**

According to literature subjective postoperative overall satisfaction rates of approximately 80% can be expected. Surgical results and complications have an effect on satisfaction and QoL. Likewise it can be affected by other preexisting circumstances like psychological distress and social support within the transition process.

**Methods**

In total 158 trans* women (median age 49.5 years), who had undergone gender confirmation surgery (GCS) at the Department of Urology of the University Hospital Essen between 1995 and 2015, were surveyed using open questions and validated questionnaires. Median time since surgery was 6.6 years.

**Results and Conclusions**

Nearly all participants (96.8%) perceived themselves as female or rather female. Satisfaction with life in general, with outward appearance and sexual life was high (86.2%, 86.6% and 65.4% respectively) with a distinct subjective improvement after GCS in 87.9%, 85.9% and 51.3% respectively. General as well as trans*-specific QoL revealed a significant improvement within transition process (each $p<0.001$). However when compared to a German control sample health-related QoL was significantly reduced (physical QoL: $p=0.012$, mental QoL: $p<0.001$). At the time of interrogation nearly half of women (46.5%) lived in a firm relationship of whom 43.5% were allied with the same partner since coming out. The women in the study population were more satisfied with their relationship (according to PFB-K) compared to women of a non transgender cohort (mean 20.6 versus 18.4[T1] , $p<0.001$). Anticipated social support (F-SozU) did not differ between transgender subjects and non transgender controls. Subjects showed significantly elevated levels of psychological distress on all subscales of the SCL-27 ($p<0.001$) except for the subscale vegetative symptoms ($p=0.051$) with the global symptom index being significantly higher when compared to a control sample ($p<0.001$). The majority of participants (78.2%) experienced psychotherapeutic supervision helpful. Overall subjective satisfaction is high after GCS in our cohort. Though we found a distinct improvement general and trans*-specific QoL during transition process participants still scored less in health-related QoL compared to a non transgender control group. Participants were more satisfied with their relationship but anticipated social support did not differ between transgender subjects and controls. Psychotherapeutic supervision was helpful for most subjects.

# Robotic Vaginoplasty: An Alternative to Penile Inversion Vaginoplasty in Cases of Insufficient Skin, Vaginal Stenosis, and Rectovaginal Fistula

Thursday, 11th April - 15:25: Invited Session: Robotic Vaginoplasty

***Loren Schechter*** [1], ***Ervin Kocjancic*** [1], ***Slawomir Marecik*** [2]

***1.*** *The University of Illinois at Chicago,* ***2.*** *Advocate Lutheran General Hospital, Park Ridge, Il & Cook County Hospital, Chicago, Il*

**Background**

Robotic vaginoplasty using either intestine or peritoneum represents an alternative to traditional penile inversion vaginoplasty in cases of: 1) insufficient local tissue, 2) post-operative vaginal stenosis, and 3) rectovaginal fistula. The authors present a video describing their algorithm and operative technique for intestinal and peritoneal vaginoplasty in these challenging clinical scenarios.

**Methods**

Case selection depends upon the clinical requirements. If a full-length vaginal canal is required or concomitant repair of a rectovaginal fistula is planned, an intestinal vaginoplasty is recommended. Alternatively, if only partial vaginal reconstruction is performed (ie construction of an apical cap for deepening of the vaginal canal), a peritoneal vaginoplasty is offered.

A two-team approach to both intestinal and peritoneal vaginoplasty is described. The plastic surgery team operates from the position of the perineum, and either the colorectal team or urology team operate trans nabdominally using the DaVinci Robot. When performing an intestinal vaginoplasty, a hybrid approach involving laparoscopic mobilization of the sigmoid colon and pelvic dissection with the DaVinci Robot is utilized. When performing a peritoneal vaginoplasty, robotic-only mobilization of the peritoneum is performed.

**Results and Conclusions**

Intestinal vaginoplasty offers the possibility of lubrication through endogenous mucus production. However, mobilization of the sigmoid colon may be difficult, and malodorous discharge and inflammation of the neovaginal lining may occur. Peritoneal vaginoplasty is technically less complex, avoids bowel surgery, but only allows reconstruction of an apical cap (approximately 4-7 cm).

# Case Report: Laparoscopic assisted bowel vaginoplasty and transperineal recto-vaginal fistula repair in a trans woman following primary inverted-penoscrotal vaginoplasty.

Thursday, 11th April - 16:15: Surgeons Only Session IV: trans women (Bramante 15)

***Konstantinos Georgas*** [1], ***Gennaro Selvaggi*** [1], ***Mattias Block*** [2], ***Jonas Bengtsson*** [2], ***James Bellringer*** [3]

***1.*** *Plastic Surgery Department, Sahlgrenska University Hospital, Gothenburg,* ***2.*** *Department of Surgery, Colorectal Unit, Sahlgrenska University Hospital/Östra, Gothenburg,* ***3.*** *Department of Gender Surgery, Parkside Hospital, Wimbledon*

**Background**

Iatrogenic recto-vaginal fistula is one of the most serious complications following gender affirmation genital surgery in trans women. The treatment methods include conservative approach, antibiotic therapy, stoma creation, and delayed surgical repair. The surgical procedure consists of repair and/or excision of the fistula after adequate rectum mobilization. Usually, secondary bowel vaginoplasty is not performed together with the primary fistula repair, but is executed some months later.

**Methods**

This report describes the case of a 29-year old trans woman who undergone inverted-penoscrotal vaginoplasty and presented with a iatrogenic recto-vaginal fistula following the initial surgery. More specifically, the primary inverted-penoscrotal vaginoplasty was performed in August 2017; at day 5 postoperatively a scrotal flap necrosis was noticed, and at day 6 a recto-vaginal fistula became evident. CT and MRI with rectal contrast were performed. A 3 mm large recto-vaginal fistula was found. The patient underwent a colostomy creation 9 days after the primary operation. Eight months later, a laparoscopic assisted transperineal rectal repair, simultaneously with an ileal vaginoplasty was performed. To date, the follow-up is free of complications, and the patient is satisfied of the additional lubrication achieved with the ileal vaginoplasty. Colostomy closure surgery is planned for October 2018.

**Results and Conclusions**

This is the first case described in the literature of a laparoscopic assisted rectal repair using a perineal pull-through method of the rectum and excision of the fistula, with simultaneous ileal bowel vaginoplasty. The success of this approach shows the possibility of combining the fistula repair (following a primary inverted- penoscrotal vaginoplasty) and a bowel vaginoplasty at the same time. Bowel vaginoplasty and delayed recto-vaginal fistula repair, performed by a multidisciplinary surgical team including colorectal surgeons, plastic surgeons and urologists can successfully resolve the serious recto-vaginal complication and, at the same time, lead to a satisfactory result following the requested gender affirmation genital surgery.

# Gender affirmation surgery (gas) in trans women: penectomy – what does it involve?

Thursday, 11th April - 16:20: Surgeons Only Session IV: trans women (Bramante 15)

***Marta Bizic*** [1], ***Borko Stojanovic*** [1], ***Marko Bencic*** [1], ***Gradimir Korac*** [1], ***Svetlana Vujovic*** [2], ***Dragana Duisin*** [3], ***Dusica Markovic Zigic*** [4], ***Katarina Maksimovic*** [4], ***Marija Miletic*** [5], ***Milina Tancic-Gajic*** [5], ***Miroslav Djordjevic*** [1]

***1.*** *School of Medicine, University of Belgrade, Belgrade, University Children's Hospital, Belgrade, Serbia,* ***2.*** *Faculty of medicine, University of Belgrade, Clinic of endocrinology, diabetes and diseases of metabolism, Belgrade genfer team,* ***3.*** *Psychiatry Clinical Center,* ***4.*** *Department of Psychiatry, Clinical/Hospital Center "Dr Dragisa Misovic", Belgrade,* ***5.*** *Clinic for Endocrinology, Diabetes and Metabolic Diseases, Clinical Centre of Serbia, Faculty of Medicine, University of Belgrade, Belgrade, Serbia*

**Background**

Penile inversion technique is a gold standard for genital reconstruction in trans women. Remnants after removal of corpora cavernosa can cause significant bulging, pain and therefore compromise sexual intercourse.

**Methods**

Our study group included 287 primary "penile inversion" vaginoplasty patients and 42 re-do patients aged from 23 to 56 years who underwent GAS in our Center. In primary GAS "penile disassembly" technique was used with complete dissection of the neurovascular bundle on the dorsal side with the glans cap and urethra on the ventral side of the penis. Total anatomical dissection of corpora cavernosa as far as their attachments to the pubic bones, with identification and ligation of cavernosal arteries, was performed as complete penectomy. Space was created between the urethra, bladder and rectum, and neovagina was formed and placed inside the pelvic cavity using penile inversion technique Urethra was shortened to create female-like urethral orifice, while clitoris was created from dorsal part of the penile glans. Scrotal folds were used to create labia majora. In re-do patients, pharmacological erection was induced by prostaglandine E1 so that the corpora cavernosa remnants were identified and carefully dissected from the surrounding structures with the attention not to injure urethra or neurovascular bundle.

**Results and Conclusions**

Follow-up period ranged from 12-90 months (mean 43 months). In all 329 patients corpora cavernosa were completely removed to their attachments to the pubic bones. None of the patients reported pain or bulging during arousal, postoperatively. Vaginal sexual intercourse was possible in all patients.

Removal of complete erectile tissue is of the utmost importance for functional and esthetically acceptable female genitals in trans women. Complete penectomy to the attachments to the pubic bones is the only real penectomy and must be performed in all patients to prevent postoperative painful erections caused by corpora cavernosa remnants.

# Sensitivity before and after gender confirming surgery on the glans penis and neoclitoris - a preliminary report from an ongoing study.

Thursday, 11th April - 16:25: Surgeons Only Session IV: trans women (Bramante 15)

***Hannes Sigurjonsson*** [1], ***Vera Perrin*** [2], ***Matilda Almblad*** [1]

***1.*** *Karolinska University Hospital,* ***2.*** *Karolinska Institutet*

**Background**

Gender confirming surgery (GCS) is a cornerstone in the surgical treatment of gender dysphoria. Reconstructing the genitalia with tactile and erogenous sensitivity is crucial in GCS. The female clitoris has long been regarded as the stimulatory focus point in order to achieve orgasm, making the creation of a neoclitoris a vital part of the surgery. The clitoral flap is harvested as a W-shaped skin flap with its neurovascular pedicle from the proximal, dorsal part of the glans penis. Long-term follow up reports have shown high ability of the transgender women to reach orgasm after GCS but are limited to a few studies. To our knowledge, no previous study has compared the sensitivity before and after GCS in transgender women. The aim was to compare the tactile and vibratory sensitivity before, 1 and 12 months after GCS, on the glans penis and neoclitoris, respectively. Furthermore, the aim was to evaluate if the neoclitoris sensitivity was in line with that in ciswomen and to study if the patients were able to achieve orgasm after GCS.

**Methods**

Ten transgender women have been included so far. They were investigated regarding sensitivity preoperatively and one month postoperatively on the glans penis and neoclitoris, respectively. Tactile and vibratory sensitivity measurements were performed with Semmes-Weinstein monofilaments and Bio-Thesiometer, respectively. A control group of ten ciswomen were investigated regarding genital sensitivity. The patients received questions concerning orgasm function one month postoperatively.

**Results and Conclusions**

The patient's median age were 26.5 years. The median tactile and vibratory thresholds for the transgender women's glans penis were 24.0 g/mm$^2$and 0.26 µm, respectively. One month postoperatively the median tactile threshold of neoclitoris was 18.1 g/mm$^2$ and the vibratory threshold 0.25 µm (no significant change: p=0.313 and 0.469, respectively). The control group's median tactile and vibratory thresholds of the clitoris were 1.4 g/mm$^2$ and 0.04 µm, respectively. The tactile and vibratory sensitivity thresholds of the control group of ciswomen's clitoris were significantly lower than the thresholds of neoclitoris (p = 0.001 and p = 0.010, respectively). One patient achieved an orgasm one month postoperatively, out of two who had tried. The tactile and vibratory sensitivity seemed to be preserved one month after GCS. At this time, the sensitivity of neoclitoris was significantly inferior to the sensitivity of the control group.

# Refinements of vaginoplasty in Okayama University

Thursday, 11th April - 16:30: Surgeons Only Session IV: trans women (Bramante 15)

***Yuzaburo Namba*** [1]

***1.*** *Okayama University Hospital*

**Background**

Sex reassignment surgery in trans women is classified roughly into a flap vaginoplasty and a colon vaginoplasty. We have developed some kinds of flaps in vaginoplasty. So I would like to report the utility of the current pudendal-groin flap method comparing with the conventional penile flap inversion method and also report our experience of a colon vaginoplasty assisted with a laparoscope.

**Methods**

At first we adopt a peno-scrotal combined flap in vaginoplasty. Secondary we refined it to M-shaped perineo-scrotal bilobed flap method. And now we ordinarily use a pudendal-groin flap. We started a colon vaginoplasty assisted with a laparoscope in 2012. Thereafter we have adopted flap vaginoplasty in the case whose colon couldn't be used for medical reasons, who refused to use a colon and who didn't want to have sexual affair. Almost ninety percentage patients selected a colon vaginoplasty in the past three years.

**Results and Conclusions**

We could cover the whole vaginal cavity without a skin graft in all patients with a pudendal-groin flap. And there was no particular problem such as a flap necrosis in the postoperative course. In colon vaginoplasty cases some patients complaint bowel problems such as chronic diarrhea. But, such complains disappeared within three or six months. All patients were recognized excessive discharge of colon fluid. But it decreased extremely within three months.

The penile flap inversion method is the global standard for vaginoplasty in trans women. But, the penile flap is used not only to resurface the vaginal cavity, but also to cover the perineal area. So in a short penis case such as an Asian trans women we have to add a skin graft to resurface the deep part of vaginal cavity. The grafted skin may become constricted and the vagina might become narrow and short as the result. Ideally, a reconstructed vagina should be fully lined with a hairless flap without a skin graft in a flap vaginoplasty. The peno-scrotal combined flap can't cover the whole vaginal cavity in a short penis case. So we adopt an M-shaped perineo-scrotal bilobed flap which doesn't include a penile part. But, it isn't enough for full resurface in an atrophic scrotum case who had been done castration. Finally we develop a pudendal-groin flap which looks like a seed leaf can easily resurface all vaginal cavity even in a small penis or an atrophic scrotum case. In a sigmoid-colon vaginoplasty assisted with laparoscope the operation time is not so prolonged than the conventional open method and the hospitalization period is shortened. The operative scar is minimal and the texture of the reconstructed vagina is very similar to the natural one. The satisfaction level of the sexual partner is higher than the flap vaginoplasty. At the present moment I think this procedure should be selected as the first choice.

# Is a different approach needed for creation of clitoral hood and labia minora in penile inversion vaginoplasty in circumcised trans women?

Thursday, 11th April - 16:35: Surgeons Only Session IV: trans women (Bramante 15)

***Karel Claes*** [1], ***Dries Opsomer*** [2], ***Katherine Gast*** [3], ***Lisa Ramaut*** [1], ***Edward De Wolf*** [2], ***Stan Monstrey*** [4]

***1.*** *University Hospital Ghent,* ***2.*** *Ghent University Hospital,* ***3.*** *University of Wisconsin, School of Medicine and Public Health,* ***4.*** *Uz Gent*

**Background**

Gender dysphoria, the incongruence between anatomic sex and gender identity is estimated to affect 1% of the population. Creation of a feminine vulva remains a technical challenge for surgeons, especially in circumcised patients. Techniques for creation of a clitoral hood and labia minora during a single stage penile inversion vaginoplasty are not well described in the literature. We present a vulvoplasty technique with creation of both a clitoral hood and labia minora using a dorsal glans pedicled flap with prepuce skin in uncircumcised patients or distal shaft skin in circumcised patients.

**Methods**

A retrospective case review was performed of all penile inversion vaginoplasties performed by senior author (S.M.) between 2014 and 2016. History of circumcision, use of full thickness skin grafts (FTSG) to lengthen vault, necrosis of labia minora, and any revisionary surgery was recorded.

**Results and Conclusions**

A total of 161 single stage penile inversion vaginoplasty operations were performed using the described technique from 2014–2016. All patients were evaluated by the multidisciplinary gender team of the Gent University hospital prior to surgery and met standards of care established by World Professional Association of Transgender Health (WPATH). The majority, 97.5 % of patients, required FTSG to lengthen the vaginal vault. Creation of clitoral hood and labia minora was achieved in all patients. The overall early revisionary surgery rate was 4.3% (n=7) with six patients undergoing drainage of a hematoma and one patient needing a revisionary labiaplasty for dehiscence and skin necrosis. The overall late corrective surgery rate was 27.3% (n=44). Nine patients (5.6%) needed a revision for urethral stricture causing diversion of the urinary stream. All other late revisions took place because the patients desired minor aesthetical refinements of the labia (n=35 or 21.7%). Average length of follow-up was 29 months. Age, hormonal therapy time, Body Mass Index, smoking and diabetes were the investigated risk factors for postoperative complications but no significant correlations were found. In circumcised patients, distal penile shaft skin is used in absence of prepuce skin and survives on random blood supply through the circumcision scar. Labia majora are fashioned from the scrotal skin. Remaining penile shaft skin is inverted to construct the introitus and vaginal apex is lined with full thickness skin graft from excess scrotal skin. Postoperative genital aesthetics were excellent.

**Conclusions:**

Creation of the clitoral hood and labia minora during penile inversion vaginoplasty is achievable in both circumcised and uncircumcised patients with excellent aesthetic results and low revisionary surgery rate.

# Fistularepair and Redo-Vaginoplasty as One-Step Procedure in Trans women

Thursday, 11th April - 16:40: Surgeons Only Session IV: trans women (Bramante 15)

***Julia Bohr*** [1]***, Pier Francesco Alesina*** [2]***, Susanne Krege*** [1]

***1.*** *Kliniken Essen-Mitte, Dep. of Urology,* ***2.*** *Kliniken Essen-Mitte, Dep. of General- and Visceral Surgery*

**Background**

In Recto-neovaginal fistulas following rectal injury in vaginoplasty patients and physicians face two main issues: loss of stool continence and in many cases loss of neovaginal depth due to infection and/or inability to dilate. Fistula repair takes time and may need several operative interventions. But once the fistula is closed, redo-vaginoplasty is more difficult to perform due to scar tissue and high risk of additional rectal lesions followed by potential new fistula.

Sigmoid vagina is established as a technique for primary and secondary vaginoplasties. As a pediculed flap it provides good quality tissue after transferred to vaginal space. In this study we want to evaluate the outcome of fistula repair and re-do vaginoplasty using a sigmoid segment as a one-step procedure.

**Methods**

Inclusion criteria were: State after primary vaginoplasty with rectal injury, presence of recto-neovaginal fistula, and need for secondary vaginoplasty.

Surgical technique was performed as follows: At first space for neovagina was dissected on the rectoprostatic fascia accompanied by resecting all remaining scar tissue. Then the peritoneal fold was opened to build a passage for the sigmoid segment. Sigmoid segment was prepared and mobilized laparoscopically. Then fistula was closed by double-layer suture. Now sigmoid segment was finally positioned, while mesenteric part was placed directly on fistula as an additional seal. Mucosa was then attached to the perineal skin. No stent was placed into vagina. Patients were allowed to dilate carefully with semi-rigid stent of 20 mm diameter max. Colostomy was left left for at least 3 month. It was removed after sufficient proof of fistula firmness. Firmness was tested radiologically and clinically.

**Results and Conclusions**

Three patients in our population were matching the inclusion criteria. All patients had received a colostomy previously.

All three patients came out with a successful closure of fistula. Patient 1 had the colostomy removed 6 month after surgery, patient 2 after 6 month also, patient 3 after 3 month. There was no recurrence of fistula observed. Outcome of all sigmoid segments was satisfying, meaning no shrinkage, shortening, perfusion disorders, or infections were observed. Patients are all satisfied with vaginal depth of at least 20cm each. Width at patient 2 is 24mm, and at patient 3 22mm, but is still not in a final state due to short interval after surgery; for patient 1 it was 24mm at time point of colostomy removal, actual width is unknown.

One-step fistula repair and redo-vaginoplasty using a sigmoid segment seems to be a safe and efficient technique in trans women after failed primary vaginoplasty and rectal injury. It combines a sufficient fistula closure using mesenteric tissue as an additional seal, and a sufficient forming of a new neovagina. In opposite to free skin grafts, perfusion of the sigmoid segment is self-sustaining and not dependent on early revascularization, which may fail especially in fistula-zones. Furthermore, a one step procedure avoids the risk of a re-injury of the rectum in future

surgeries. But since patient number in this study is very small, further investigation and greater patient population is needed to proof these results.

# Sex reaffirming surgery for trans women using the combined technique leads to increased quality of life in a prospective study

Thursday, 11th April - 16:45: Surgeons Only Session IV: trans women (Bramante 15)

***Nikolaos A. Papadopulos*** [1], ***Dmitry Zavlin*** [2]

***1.*** *Department of Plastic Surgery and Burns, Alexandroupoli University General Hospital, Democritus University of Thrace, Alexandroupoli,* ***2.*** *1.Institute for Reconstructive Surgery, Houston Methodist Hospital, Weill Cornell Medicine, Houston, Texas*

**Background**

The authors' previous research showed that various plastic surgical procedures can increase a patient's quality of life in its different aspects. In a prospective setting, they evaluated whether sex reaffirming surgery has similar effects for trans women compared to baseline data before sex reassignment surgery.

**Methods**

All 39 trans women who underwent their sex reaffirming surgery between October of 2012 and January of 2014 received one set of questionnaires preoperatively (time 0) and approximately 6 months -on Life Satisfaction, Modules (German version) questionnaire, the Freiburg Personality Inventory, the Rosenberg Self-Esteem Scale, and the Patient Health Questionnaire, which were compared to available norm data.

**Results and Conclusions**

The mean age was 38.6 years. The majority of the trans women found in the Questions on Life Satisfaction, Modules (German version), especially for the items "partnership," "ability to relax," "energy," "freedom from anxiety," "hair," "breast," and "penis/vagina" ($p < 0.01$). Furthermore, they appeared more emotionally stable ($p = 0.03$), showed higher self-esteem ($p = 0.01$), and showed much lower depression/anxiety ($p < 0.01$).

Conclusions: The positive findings were confirmed with the results from prior retrospective studies. However, medical literature focuses largely on surgical and functional satisfaction and not overall quality of life. In addition, standardized questionnaires are used rarely and solely retrospectively, with the risk of recall bias. The increased quality of life of transgender women post-operatively endorses sex reaffirming surgery as a valuable option for these persons.

# OMtFSFI: operated Male To Female Sexual Function Index. Development and validation of the first questionnaire to assess sexual function after gender reassignment surgery for trans women.

Thursday, 11th April - 16:50: Surgeons Only Session IV: trans women (Bramante 15)

***Francesca Vedovo [1], Lisa Di Blas [2], Chiara Perin [3], Nicola Pavan [1], Marta Zatta [4], Stefano Bucci [1], Girolamo Morelli [5], Andrea Cocci [6], Augusto Delle Rose [6], Simone Caroassai Grisanti [6], Giorgio Gentile [7], Fulvio Colombo [7], Luigi Rolle [8], Massimiliano Timpano [8], Paolo Verze [9], Lorenzo Spirito [9], Francesco Schiralli [10], Carlo Bettocchi [10], Alessandro Palmieri [9], Vincenzo Mirone [9], Carlo Trombetta [1]***

***1.*** *Department of Urology, Azienda Sanitaria Universitaria Integrata di Trieste,* ***2.*** *Department of Life Sciences, University of Trieste,* ***3.*** *Clinical Psychology Unit, AIED, Pordenone,* ***4.*** *Infectious Diseases Unit, Azienda Sanitaria Universitaria Integrata di Trieste, Italy,* ***5.*** *Department of Urology, University of Pisa,* ***6.*** *Department of Urology, University of Florence,* ***7.*** *Andrology-Unit, Dept. of Gynecology and Urology, University Hospital of S.Orsola, Bologna,,* ***8.*** *Dept. of Urology, AO Città della Salute e della Scienza, University of Turin,* ***9.*** *Dept. of Urology, University of Naples, Federico II,* ***10.*** *Urology, Andrology and Kidney Transplantation Unit, Department of Emergency and Organ Transplantation, University of Bari*

**Background**

The available literature does not provide any questionnaire to evaluate sexual function after gender reassignment surgery for trans women. The assessment of sexual function in these patients is routinely performed by using tools designed for assigned women at birth, such as the Female Sexual Function Index (FSFI). Such a limit leads to a suboptimal evaluation, especially in domains like lubrication and dyspareunia. Moreover, FSFI scores in trans female patients often are similar to those observed in non-transsexual women with sexual dysfunction. We aim at developing validate new questionnaire, the operated Male to Female Sexual Function Index (oMtFSFI) in order to assess sexual function in patients who underwent gender reassignment surgery.

**Methods**

A panel of experts in gender dysphoria (4 uro-andrologists, 3 psycho-sexologists) defined salient content areas to be explored (genital self-image, desire, arousal, lubrication, orgasm, satisfaction and sexual pain). Ten trans women were administered the questionnaire in order to check its face validity. Their suggestions helped the expert revising the initial version. The revised oMtFSFI questionnaire presents 18 items and was applied in the present study. oMtFSFI with FSFI, Back Depression Inventory II and SF-36 questionnaires were web-based administered to 125 operated trans women, recruited during follow-up visits in 7 italian centres and to 80 women who provided self-ratings.

**Results and Conclusions**

65 trans women and 57 cisgender women completed the study. trans women and cisgender women did not differ in their age (mean 38.5 SD 9.3 versus 37.7 SD 11.5 years old). trans women underwent reassignment surgery up to 19 years before (mean 5.1). Principal component analysis performed on the self-ratings provided by MtFs on the oMtFSFI items yielded a 3-domain structure: Sexual Dissatisfaction, Sexual Pain and Genital self-image. The same structure emerged when data from the whole group were analysed. For trans women, Cronbach Alphas ranged from 0.64 to 0.93 for the three domains. After controlling for age and years from surgery, clear convergent associations with FSFI scales were found for Sexual Dissatisfaction and Sexual Pain but not for Genital Self-image; BDI did not

account for additional variance. These results support the reliability and psychometric validity of the oMtFSFI in the assessment of key dimensions of transgender women sexual function. Further studies are needed to develop a diagnostic cut-off scores for a potential classification of operated trans women's sexual dysfunction.

# Exploring the needs, expectations, and realities of mental healthcare for transgender adults: A grounded theory study on experiences in Sweden.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Debra Beight*** [1], ***Markus Larsson*** [1]

***1.*** *Lund University*

**Background**

Transgender persons experience a disproportionate representation in adverse mental health conditions globally. In Sweden there are tangible efforts to improving mental healthcare overall, but as a minority population, transgender persons still struggle with meeting their mental healthcare needs. While social factors such as stigma and discrimination act as catalysts for this burden, there is an absence of understanding the role of mental healthcare for this population and how mental healthcare services are being utilized.

The aim of this study was to gain an in-depth understanding of the mental healthcare needs for transgender persons in Sweden, that are both related and unrelated to the transition process. More specifically this study sought to explore the strategies employed by transgender persons to address their own concerns of mental health issues and mental healthcare. This gives insight into the role of mental healthcare and the ways care was navigated by trans persons.

**Methods**

Methods: Nine in-depth, semi-structured interviews were conducted with persons who identified as transgender or gender non-binary, at some stage of transition in Sweden. Data was collected, analyzed, and interpreted using constructivist ground theory.

**Results and Conclusions**

Results:Three categories emerged from the analysis of the data, Objectification vs. Subjectivity, Constructing the Narrative, and Reflections of Care that illustrate the dual tensions at play in transgender visibility, communication with mental healthcare professionals, and expectations of care. Six subcategories further delineate the specific forces at work in tension with one another that construct the mental healthcare experiences for trans persons.

Conclusion: Increased knowledge and visibility of transgender persons is needed to adequately serve the mental healthcare needs for this population. Currently there are barriers that inhibit transgender persons from getting the mental healthcare assistance desired and needed, as they do not view the healthcare system as safe space within which to receive care. As steps are being taken to de-pathologize transgender identities, momentum should be continued to create space for trans persons in society that enables unencumbered mental health assistance.

# Effect of Cross-sex Hormone Treatment on Autistic Traits in Treatment-Seeking Transgender Adults: A Longitudinal Study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Anna Nobili*** [1], ***Cris Glazebrook*** [2], ***Megan Cable*** [2], ***Walter P Bouman*** [3], ***Jon Arcelus*** [1]

***1.*** *University of Nottingham - Nottingham Centre for Transgender Health,* ***2.*** *University of Nottingham,* ***3.*** *Nottingham Centre for Transgender Health*

**Background**

***Background***

Cross-sectional studies using validated scales suggest that transgender assigned females at birth have an increased risk of scoring above the cut-off for probable autism. However, the extent to which elevated levels of autistic traits reflect a stable clinical condition, rather than heightened social anxiety associated with transgender status, is unclear. This study aims to explore the impact of Cross-sex Hormone Treatment (CHT) and transition to experienced gender on levels of autistic traits in transgender adults.

**Methods**

***Methods***

Transgender adults attending a transgender health service (n=91) were included in this longitudinal study if they had completed a measure of autistic traits (AQ-short) pre-CHT and one year post-treatment. We assessed levels of anxiety using the HADS anxiety sub-scale at the same time points. Repeated measures ANOVA was used to determine the relationship between birth-assigned sex and change in AQ-short scores, with change in anxiety as a covariate.

**Results and Conclusions**

***Findings***

Change in levels of autistic traits after treatment was positively associated with change in levels of anxiety ($r= 0.46$, $p<0.001$), particularly in assigned males ($r=0.58$, $p<0.001$). However, there was no overall change in levels of anxiety or AQ-short scores post-treatment.

Controlling for change in anxiety and age, we found a significant interaction between birth-assigned sex and change in level of autistic traits ($p<0.05$). Transgender participants assigned female at birth tended to increase their AQ-short scores post-treatment, with transgender birth assigned males reducing their scores slightly. The only significant simple main effect showed that transgender birth assigned females had higher AQ-short scores compared to birth assigned males post-treatment.

***Interpretation***

Findings suggest that high levels of autistic traits in transgender males are maintained following transition to the experienced gender. There is some evidence that the disparity in levels of autistic traits between transgender birth-assigned males and birth-assigned females increases following testosterone treatment, providing some support for the extreme male brain theory of autism.

# Establishing the gender health clinic for children and adolescents in Slovenia

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Maja Drobnic Radobuljac*** [1], ***Mojca Sostaric Zvonar*** [1], ***Irena Rahne Otorepec*** [1], ***Peter Zajc*** [1], ***Tadej Battelino*** [2]

***1.*** *University Psychiatric Hospital Ljubljana,* ***2.*** *University Children's Hospital*

**Background**

Slovenia is a small European country with 2.6 million inhabitants. It opened its first child and adolescent psychiatry gender health clinic in October 2016. The team comprised of a group of gender health psychiatrists, a clinical psychologist and a child and adolescent psychiatrist in cooperation with a pediatric endocrinologist, a gynecologist and a plastic surgeon. The health care team is cooperating closely with the local CAMHS as well as the non-governmental organizations. The aim of the present paper was to assess the characteristics, specific needs and corresponding management of the clinic population.

**Methods**

A retrospective chart review was performed for all the children or adolescents (C/A) admitted to the clinic from October 2016 to March 2018. All the C/A and/or their parents signed informed assents/consents prior to enrollment. The use of users' data was confidential by the managing clinicians. The data gathered were: age, chromosomal, gonadal, hormonal, or genital sex characteristics, birth assigned sex, gender identity, parent support, as assessed by family interview, desired procedures, specific psychopathology (assessed by clinical psychological examination).

**Results and Conclusions**

Twelve users were enrolled. Of these, 11 were adolescents, one was a gender affirmed female with two children, who needed counseling for her developing children. Of the adolescents, in two the chromosomal, gonadal, hormonal and genital sex was male and in nine, female, their birth assigned sex was corresponding. Two of them were showing signs of developing gender identity incongruent with their birth assigned sexes and their parents needed consultation, the remaining were diagnosed with gender dysphoria and wished to enter the gender confirmation process. Their average age was 16,9 years (min 11, max 17).

In clinical psychological assessment their intellectual capacities were mostly average, they exhibited a higher degree of gender dysphoria and lower self-concept (especially physical) as compared to the reference group. When drawing a person, they had drawn the perceived gender first (Male and Female). In personality assessments, there was a trend towards perceptual disturbances (weaker reality-testing), heightened level of thought disorders and ego impairment in the majority of users. In addition, they also showed greater body concerns (preoccupations with bodily functions), signs of anxiety and dysphoric affect. In some cases, these were signalling for dystimic, deprivating underlying feelings as symptoms of depression.

Three of the families were supportive of their experience at the time of inclusion and required only minor counseling with regards to the procedures, the rest were non-accepting and were offered family therapy sessions. At the time of writing seven users were in continuous consultation process, three have completed diagnostic assessment, three have officially changed names, two have completed family therapy and begun with hormonal treatment, one of them is waiting for mastectomy. In one of the patients removal from the family was suggested due to extremely neglecting and abusing reactions from parents.

The service experienced a relatively high demand in a newly opened area. Rapid changes in the management of C/A

with diagnosed gender dysphoria require highly specialized team of experts cooperating with legislation authorities and non-governmental organizations.

# Klinefelter Syndrome in a patient diagnosed with Gender Dysphoria

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Cherng Jye Seow*** [1]

***1.*** *Tan Tock Seng Hospital*

**Background**

The prevalence of chromosomal abnormalities appears to be slightly higher in the transgender population compared to the general population. This illustrates a patient with Klinefelter Syndrome diagnosed during the initial evaluation of gender dysphoria.

**Methods**

A 21 year old university undergraduate was diagnosed with gender dysphoria by the psychiatrist and referred for gender affirming therapy. She expressed feelings of anxiety and depression over her birth assigned gender and the feelings were not relieved with fluoxetine treatment. She was keen to be started on cross hormonal therapy with an intent for gender reassignment surgery eventually. On examination, she was tall at 1.84 meter, her weight was 70.4kg and BMI 20.8. She had long limbs, gynaecomastia and small testes of 4ml bilaterally. Baseline laboratory results: Testosterone level was low at 5nmol/L (RI: 8.6-29), FSH and LH elevated at 42.8 IU/L (RI: 1.5-12.4) and 33.2 IU/L (RI: 1.7-8.6) respectively. History did not suggest any etiologies of primary hypogonadism such as previous testicular trauma, cryptorchidism, varicocele, previous radiation, medication intake or mumps infection. Cytogenetics test revealed XXY karyotype. The diagnosis of Klinefelter Syndrome was conveyed to the patient. Treatment options were discussed and she was eventually initiated on estrogen and anti-androgen therapy (Spironolactone) with development of secondary sexual characteristics and much improvement in her mood disorder. Her triglyceride level was elevated (3.2 mmol/L) but there were no other evidence of metabolic syndrome. Her vitamin D level and bone mineral densitometry was normal. She opted for lifestyle interventions for the hypertriglyceridemia. There are plans for gender reassignment surgery in the near future.

**Results and Conclusions**

Klinefelter syndrome is the most common congenital cause of primary hypogonadism occurring in 1 in 1000 live people assigned male at birth. The diagnosis is rarely made at birth with most patients diagnosed after puberty. It may predispose to gender dysphoria although the mechanism is not clearly elucidated. A retrospective study examining the karyotypes of 368 transgender individuals revealed the prevalence of abnormal karyotypes to be 3.19% among trans women and 0.85% among trans men.

Cohort studies showed a markedly increased standardised mortality ratios for diabetes mellitus, pulmonary embolism and peripheral vascular disease. There is also a higher incidence of mediastinal tumours and breast cancer and earlier onset of osteoporosis as well as learning difficulties and behavioural dysfunction.

Although routinely investigating for Klinefelter syndrome with karyotyping may not be cost effective, the diagnosis of Klinefelter syndrome allow for earlier intervention such as regular screening for metabolic disorders, prescription of diet and exercise programs and cancer prevention awareness and this may lead to improved clinical outcome for the patient.

# The Mental Health Aspects of Barriers to Primary Care for Transgender Patients

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Jake Bush*** [1]***, Christopher Blackwell*** [2]***, Steven Talbert*** [2]

***1.*** *University of West Florida,* ***2.*** *University of Central Florida*

**Background**

In the last few years, public attention and research have been drawn to health disparities within the transgender community. This has occurred as a consequence of increasing acceptance and visibility of LGBTQ persons in society and emerging science highlighting health needs that are specific to this population. Three national surveys reported on multiple barriers to healthcare for transgender and gender non-conforming participants, along with frequencies of health disparities. Data from these assessments showed transgender and gender non-conforming participants had higher rates of discrimination and barriers to health care compared to lesbian, gay, bisexual, and HIV-infected participants. Specific barriers identified by transgender or gender non-conforming participants included concerns regarding healthcare providers' knowledgeable of their healthcare needs, being treated differently directly related to their gender identity or expression, refusal of care, and lack of mental health and substance abuse support groups. Other specific factors that can affect health were issues with mistreatment and violence, economic hardship, harmful effects on physical and mental health, and a compounding impact with discrimination. There were higher rates of psychological distress in the last month compared to the general population (i.e., 39% vs. 5%). Suicide attempts were substantially higher compared to the general population for both lifetime occurrence and the last year (i.e., nine times the rate of the general population and twelve times the rate of the general population, respectively). Investigation of the specifics of transgender primary care is validated by the overall national increase of the population to access to primary care as a consequence of the *Affordable Care Act* coupled with scholarly evidence that substantiates transgender barriers to primary care. While it is imperative to note sexual orientation and gender identity assume no relationship, sexual minority groups may have had, or continue to have, similar difficulties with primary care.

**Methods**

A comprehensive review of the state of the science was undertaken with a focus on LGBT populations. The databases MEDLINE, PsycINFO, GenderWatch, Social Abstract, CINAHL with Full Text, and Cochrane Database of Systematic Reviews were searched for relevant articles. A total of 14 articles were analyzed.

**Results and Conclusions**

The major barriers identified from the literature related to communication, provider-patient relationships, and environmental influences. Patients perceived acceptance or communication of LGBTQ acceptance from their healthcare providers verbally, nonverbally, through body language or symbols. Patients may have angst or reluctance to seek medical attention based on previous healthcare experiences. LGBTQ patients tend to bring preconceived notions of expected stigma, prejudice, or other negative feelings (that may or may not have been informed from previous healthcare experiences), into every healthcare encounter. Both, primary care providers and LGBTQ patients have a responsibility of open communication. Largely, primary care providers expressed openness to caring for their LGBTQ patients.

Specific recommendations applicable to the clinical setting include those aimed at reducing obstacles related to communication, provider-patient relationships, and environmental influences. Directives for future research include larger and more diversified/representative sampling and provider-focused inquiries aimed at identifying specific etiologic forces that contribute to transgender health disparities and barriers to primary care services.

# Adult attachment, trauma and Reflective Function in adults with GD diagnosis: a longitudinal study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Sarah Finzi*** [1], ***Giulia Di Fini*** [1], ***Chiara Michela Crespi*** [2], ***Valentina Mineccia*** [2], ***Maria Teresa Molo*** [3], ***Fabio Veglia*** [1]

***1.*** *Department of Psychology, University of Turin,* ***2.*** *CIDIGEM (Turin University Hospital Gender Team - Italy),* ***3.*** *Fondazione Carlo Molo ONLUS*

**Background**

The study of trauma and associated symptoms in clinical samples and sexual minorities is essential for setting up effective treatment plans. Previous studies highlighted a high percentage of traumatic experiences in the autobiographical narratives of individuals with GD diagnosis. Other authors propose that GD can constitute a traumatizing or re-traumatizing condition for the individual throughout their developmental history. Attachment Theory may offer new ways of understanding the role of trauma in individuals with GD diagnosis, especially in order to offer clinical interventions. Literature has not yet explored the role of parents' difficulties in mirroring the child's gender variance and, only partially, the role of past attachment experiences in adults with GD diagnosis.

Moreover, few studies have investigated the possible difficulties in mentalization processes as well as the possible change in the levels of Reflective Function (RF) along the gender transition process.

In the first part of the study we aimed to examine if and how gender transition process influences the continuity of the attachment states of mind and RF level. In the second part we chose to deepen the analysis by investigating the prevalence of different types of adverse childhood experiences and their impact on adults with a GD diagnosis, compared to a cisgender control group, in terms of resolved/unresolved states of mind with respect to attachment and presence of dissociative symptoms.

**Methods**

In the first part of the study (the) Adult Attachment Interview (AAI) was administrated to 20 adults referred to a Gender Clinic in Turin (C.I.D.I.Ge.M.) immediately after the GD diagnosis and after the Gender Affirming Surgery. RF was coded according to the RF Scale from (the) AAI transcripts. In the second part we added the Adverse Childhood Experiences Questionnaire (ACE) and the Dissociative Experiences Scale (DES), testing another group of 50 adults with GD diagnosis. A control sample of cisgender was recruited and paired according to age, sex assigned at birth and education.

**Results and Conclusions**

Data after the GD diagnosis revealed a high percentage of insecure attachment with frequent signs of unresolved loss or trauma. Sample with a GD diagnosis registered a higher exposure to adverse childhood experiences (especially humiliation and threats), higher scores related to derealisation/depersonalization symptoms and a lower RF level than the control group. After the surgical transition we found an improvement both in the AAI coherence scale and RF scoring: the most important RF indicators were the awareness of the nature of mental states and family dynamics, as well as a revision of thoughts and emotions.

These findings underline that the gender transition may involve effects on subjective and intersubjective mirroring processes associated to the new sense of self body congruity. Understanding the role of mentalization and trauma in the life of individuals diagnosed with GD is useful in order to improve the clinical intervention.

# Trans and non-binary people in forensic settings: Demographics and treatment considerations

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Christina Richards*** [1]

***1.*** *Tavistock and Portman NHS Foundation Trust*

**Background**

The Charing Cross Gender Clinic in the Tavistock and Portman NHS Foundation Trust, along with the Nottingham Center for Transgender Health, see the majority of trans and non-binary people with forensic histories in the UK who are seeking assistance with their gender.

The usual assessment process for hormones and surgeries is complicated by some people presenting to services for reasons other than their gender; some who have significant mental health factors which complicate assessment; and some people whose offending makes assessment more complex - both in terms of the logistics and nature of the assessment.

Further, there is little information available about the number and nature of the people with forensic histories who are being seen in gender clinics, and the concomitant associated service needs.

**Methods**

An audit of all current patients at the Charing Cross Gender Clinic was carried out to identify the number of people with forensic histories, and the demographics of those people, including the type and nature of their offending. Audit approval was granted on 10/09/2018 by the NHS Trust Audit department.

**Results and Conclusions**

Results of this ongoing audit will be presented at the conference.

In addition, details will be given of the specific nature of assessment for this client group, including differentials which should be considered, the sensitivities of which estate people should be accommodated in, and a consideration as to the nature of the multidisciplinary team engaged - including multi-agency involvement.

# GIST (Gender Identity Skills Training): Pilot Training Programme for Clinicians in Ireland

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Aileen Murtagh*** [1], ***Vanessa Lacey*** [2], ***Natasha Prescott*** [3], ***Anne Kehoe*** [4], ***Angela Joy*** [5]

***1.*** *St Patricks University Hospital, Dublin,* ***2.*** *TENI,* ***3.*** *GIDS,* ***4.*** *CAMHS,* ***5.*** *HSE*

**Background**

GIST is an Irish publically-funded initiative developed to upskill clinicians in working with gender diverse and dysphoric youth. This is particularly important in the absence of a national specialist service in Ireland.
An Irish survey (McNeil et al 2013) of trans people revealed that 69% and 79% had at least one negative experience in a mental health and general health service respectively. 38% were told that the clinicians themselves lacked knowledge of trans-healthcare. Provision of training to Irish staff was recommended.

**Methods**

GIST is a three day training package, comprising two days of didactic lectures and interactive sessions in addition to one day of facilitated case discussion. The organizing committee involved collaboration between national and international clinicians, the Irish public health service Health Service Executive (HSE) and the national non-profit organization TENI (Transgender Equality Network Ireland). Dr Thomas Steensma, Centre of Expertise on Gender Dysphoria, Amsterdam was the international lead. Dr Natasha Prescott, GIDS, UK also collaborated on this project. Topics covered included assessment, exploration and psycho-social support, co-occurring mental health issues and neuro-developmental conditions, outcomes, transitions, service provision, fertility and sexual health. Speakers representing a variety of disciplines were involved, including Psychology, Psychiatry, Paediatric Endocrinology and Nursing, in addition to Health & Education Manager and Education & Family Support Officer from TENI.

**Results and Conclusions**

43 delegates registered. Half of the delegates were Psychologists (51%), mostly Clinical Psychologists (n=16). Nursing (16%) and Psychiatrists (14%) accounted for almost a third of attendees.

26 attended the full 3 day training, 15 attended 2 days with 2 delegates attending 1 day. For those who didn't attend the third day of case discussion, for the majority (n=8) case discussion was not relevant to their current work e.g. educational psychologists, sexual health clinic staff and youth advocates.

A pre-and post-quiz was completed to evaluate baseline knowledge and knowledge accrued during training. An average score of 5.9 was obtained in pre-quiz out of a max score 10. Almost 50% of respondents in the pre-quiz thought an endocrinologist only should discuss fertility implications of hormones. Average score of 9 in the post-quiz.

The course was internally and externally evaluated. CPD accreditation obtained from College of Psychiatrists of Ireland and Psychological Society of Ireland. The external evaluator contacted delegates a month post-training to evaluate application of skills to clinical practice.

22 delegates completed the internal evaluation form. 23% had no prior experience with gender diverse youth. 41%

had worked with less than 5 gender diverse youth. 22% had worked with 5-10 youth. 14% had worked with more than 10 youth. 95% rated training as excellent and 5% as good. 95% indicated they were more or much more confident in using appropriate terms and language with gender diverse youth.

In summary, GIST is a publically funded three-day training initiative which involved collaboration between the Irish public health service, national and international clinicians and a national non-profit organization. Delegates attending had varied levels of prior experience working with gender diverse youth. Feedback is promising with a national roll-out of training under consideration.

# Influence of Internalized Transnegativity on Depression, Anxiety, and Suicidal Tendency in Trans Populations: A Systematic Review

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Marc Inderbinen*** [1], ***Jens Gaab*** [2], ***Kristin Schaefer*** [3], ***David Garcia Nuñez*** [4]

***1.*** *University of Basel, Department of Psychology,* ***2.*** *Department of Psychology, Division of Clinical Psychology and Psychotherapy, University of Basel,* ***3.*** *Department of Plastic, Reconstructive & Aesthetic Surgery and Hand Surgery, Basel University Hospital, University of Basel,* ***4.*** *Center for Gender Variance, Basel University Hospital, University of Basel*

**Background**

Trans individuals face stigmatization in virtually all cultures. Discrimination and victimization heavily impact the lives of trans populations and may cause adverse mental health outcomes. Based on the Gender Minority Stress Modell (GMSM), studies show that self-stigmatization of trans individuals could play an important role in this process. At the same time, there are resilience factors that contribute to the reduction of the negative consequences of the social exclusion of trans persons.

The goal of this systematic review is to examine the influence of the most proximal gender minority stressor, namely internalized transnegativity (IT), on depression and anxiety as well as suicidal tendency in trans people. Further the identification of protective factors for the development of anxiety and depression as well as suicidal tendency in trans populations is also subject of this systematic review.

**Methods**

This review was done systematically and accordingly to the protocol of the PRISMA statement. After the search in five large electronic databases in January 2018 and the following screening and selection procedure eleven quantitative articles were found eligible for analyses.

**Results and Conclusions**

The results are drawn from a sample of 5.511 self-identified trans individuals. Twelve instruments were used assessing psychopathological symptomology as well as seven measuring IT. While six studies found direct effects of IT on depression and anxiety, two found indirect effects via rumination and psychological distress. Four articles described the positive association between IT and suicidal tendency. The mediational role of depression, respectively perceived burdensomeness and thwarted belongingness between IT and suicidal tendency, was shown in two articles. Positive affect toward community was identified as protective factor against depression and anxiety by four studies.

The need for a paradigm shift within psychiatric and psychological practice towards explaining trans persons' experiences of stigmatization in society and its consequences is long overdue and important for the mental health of this population. Thereby, the yet understudied concepts of the GMSM as well as the psychosocial approach of self-stigma hold the potential to shed light on the underlying factors of trans people's risk for impaired mental health.The high explanatory value of the concept of IT as well as its importance for clinical work is emphasized. Further research addressing IT and its consequences is needed.

# HIV and sex work in a large sample of European transgender and non-binary persons

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Judith Van Schuylenbergh*** [1], ***Joz Motmans*** [1], ***Guy T'Sjoen*** [2]

***1.*** *Ghent University,* ***2.*** *Uz Gent*

**Background**

HIV prevalence rates have been estimated high for transgender persons, especially transgender women. Studies indicate that transgender women have been disproportionally represented in the sex industry, which has been mostly attributed to discrimination on the labour market. However, for European transgender persons, HIV prevalence, involvement in sex work (SW) and correlates remain largely unknown. Hence, the aim of this study is to estimate the prevalence of HIV and the involvement in SW, and identify factors associated with the involvement in SW in a large non-clinical sample of European transgender persons, thereby including not only transgender women, but also transgender men and non-binary persons, who have been largely neglected in transgender HIV and SW research.

**Methods**

This study investigates HIV prevalence and engagement in SW in transgender and non-binary persons from 6 European countries, using data from two large online surveys: the TGEU Trans Health Survey (2017, conducted in Georgia, Serbia, Sweden, Poland and Spain, N=850) and the Trans in Belgium survey (2017, N=413), both open for self-identified transgender persons aged 16 and older and widely disseminated online and offline by several transgender organisations. Data of both surveys, of which the sexual health section and all other relevant measures were set up in exact the same way, were merged into one dataset, obtaining a sample size of 1263 participants. Descriptive and bivariate analyses were conducted to explore HIV prevalence, HIV testing behaviour and involvement in SW. Bivariate and multivariate binary logistic regressions were conducted to investigate associations of lifetime involvement in SW with gender identity, passability, age, education and economic stress.

**Results and Conclusions**

Of all participants, 65,2% states knowing their current HIV status, of which 1,6% states being HIV positive (n=13). This is 1% of the total sample. Of all participants, 6,8% was ever engaged in SW and 2,9% was engaged in SW during the last 12 months. Of all participants with positive HIV status, nine had a history of SW. Participants ever involved in SW stated significantly more knowing their HIV status ($X^2$=12,302; p<0,001), and had significantly more recently had an HIV test than persons never involved in SW ($X^2$=69,377; p<0,001).

Lifetime engagement in SW is associated with **gender identity** ($X^2$=27,760, p<0,0001). For transgender women, engagement in SW was estimated at 11,8%, compared to 3,5% for transgender men and 4,9% for non-binary persons. Lifetime engagement in SW is also associated with **age**and **economic stress**. A variety of reasons for engaging in SW is mentioned.

**Conclusion**

This study is the first exploring HIV and SW in a large sample of European transgender persons. HIV prevalence rates found within this sample are considerably lower than other self-reported prevalence rates found in current literature on transgender persons and HIV. However, transgender persons' involvement in SW – transgender women as well as transgender men and non-binary persons - is estimated considerably higher in this study than involve-

ment in SW for cisgender women in Western Europe. Though associated with economic stress, reasons for involvement in SW appear complex and varied. More research is needed in this area.

# The Transgender Partner Project

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Melanie Verbeke*** [1], ***Joz Motmans*** [2], ***Myrte Dierckx*** [3]

***1.*** *Ghent University Hospital,* ***2.*** *Ghent University,* ***3.*** *Uz Gent*

**Background**

Partners and former partners of trans people may need tailored support from someone who is familiar with 'trans' as a topic. The Transgender Infopunt (Belgium) realized it was not catering sufficiently to the needs of partners with regard to support and peer contact. Especially former partners are in need of support on more 'neutral' grounds, i.e. outside the trans care context.

Endowed by the Flemish government, a project aimed to address professional and peer support related needs among partners and former partners of trans people. After three years, the transgender partner project has been evaluated.

**Methods**

The project offers support for partners and former partners on two levels. The first level concerns individual support: one-on-one peer contact. The staff member (Transgender Infopunt) selects the candidates, (former) partners of trans persons who voluntarily want to provide emotional support to other partners. These candidates get a professional training to become experts by experience. Afterwards, the staff member sets up the profiles of the experts by experience. Partners in need can be matched to experts by experience. The staff member organises a first contact and assesses the follow-up. The staff member is permanently available for the experts by experience in case of questions, emotional issues etc. Twice a year, intervision meetings have been organised for the experts by experience. The second level concerns group support: peer contact in group. Transgender Infopunt organises support meetings, exclusive for partners and former partners, on neutral locations in several regions. In this way, a safe environment can be guaranteed.

**Results and Conclusions**

In total, 20 experts by experience have been trained, and have been matched to 44 partners in need. 31 support group meetings have been organized for an average of 5 attendees. The project has reached 85 (former) partners.

An evaluation survey aimed to evaluate the experiences of the experts and partners participating in the project. Various interesting results can be highlighted: First, results show that (former) partners feel supported. Second, the one-on-one contact and support meetings complement each other. Third, three key words can be distinguished: recognition, security and understanding.

The method has succesfully been tested in other target audiences (parents of trans youth).

As we speak, the government demands to anchor the project structurally within a larger organization.

# Are two scans better than one? Scan-rescan reliability on structural neuroanatomical measures in transgender persons

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Sven Mueller*** [1], ***Behzad Sorouri khorashad*** [2], ***Freya Acar*** [1], ***Anna Hudson*** [1], ***Behnaz Khazai*** [3], ***Ali Talaei*** [2]

***1.*** *Ghent University,* ***2.*** *Mashhad University of Medical Sciences,* ***3.*** *University of Southern California*

**Background**

One important issue to establish whether the brains of transgender persons resemble those of their gender identity or their sex assigned at birth is the issue of power and low sample sizes. Given that an increase in sample size is often not possible, we assessed whether collecting two anatomical MRI scans in a row would improve signal and reliability to mitigate the power issue. This is an important issue as presently available findings are highly discrepant. A second issue is that most MRI findings have been presented in Western samples and potential cultural differences have not been addressed.

**Methods**

To this goal, two back-to-back within session structural MRI scans for each participant of the following four groups were acquired: transgender women (TW, n = 40), transgender men (TM, n = 40), cisgender men (CM, n = 30) and cisgender women (CW, n = 30) all of whom participated in a study in Mashhad, Iran. Regional grey matter volume, cortical surface area, and cortical thickness were assessed using the FreeSurfer pipeline focusing on 10 *a priori* regions of interest (ROI) previously reported to differ between transgender and cisgender persons.

**Results and Conclusions**

Analyses showed that acquiring a second scan increased the power of measurement in all ROI but particularly in bilateral frontal poles, bilateral accumbens, and putamen. Generally speaking, findings in transgender persons were more consistent with sex assigned at birth in the probed ROI in brain volume and surface area. No significant differences emerged for cortical thickness between groups. Finally, results in the Iranian sample were generally very similar to those reported previously in Western samples. The results further suggest that a simple time and cost effective measure to improve signal to noise ratio in populations with low prevalence rates is a second anatomical scan when structural MRI is of interest.

# Detransition rates in a national UK Gender Identity Clinic

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Skye Davies*** [1]***, Stephen McIntyre*** [1]***, Craig Rypma*** [1]

***1.*** *Charing Cross Gender Identity Clinic, Tavistock and Portman NHS Foundation Trust*

**Background**

Detransitioning refers to the process whereby people who have undergone gender transition later identify or present as the gender that was assigned to them at birth. Transgender people may also go on to retransition, that is, to identify or present with a different transgender identity. Detransition and retransition may involve a change in identity, social presentation, legal documentation, or physical interventions. Most previous studies indicate very low rates of detransition. Some people who do not detransition, may still feel regret related to their transition. The aim of this study was to investigate treatment outcomes in a UK National Health Service (NHS) adult gender identity clinic by examining the rates of and reasons for detransition and regret.

**Methods**

Patient assessment reports created between August 1st 2016 to August 1st 2017 were scanned electronically for words related to detransition or regret. The reports that were retrieved in the search were reviewed by study authors to identify evidence that patients had detransitioned or expressed regret related to their transition. Data extraction included patients' age, gender identity, gender assigned at birth, and descriptions of their detransition or regret.

**Results and Conclusions**

Of the 3398 patients who had appointments during this period, 16 (0.47%) expressed transition-related regret or detransitioned. Of these 16, one patient expressed regret but was not considering detransitioning, two had expressed regret and were considering detransitioning, three had detransitioned, and ten had detransitioned temporarily. The reasons stated by patients for their regret or detransition included: social factors, reporting physical complications, and changing their mind about their gender identity and identifying as their gender assigned at birth. The 16 patients consisted of 11 trans women, two trans men, two cis men, and one person assigned male at birth who said their gender identity was "trans".

Study findings are consistent with previous research showing low rates of detransition. Detransition was most often prompted by social difficulties rather than changes in gender identity or physical complications and was most often temporary. Only three patients made a long-term detransition. Strengths of this study include our use of an electronic search to efficiently scan a large number of patient records and our investigation of reasons for regret and detransition. Limitations of this study include that it only provides a snapshot of current rates of detransition and regret and relied on self-reported experiences of patients who may not have disclosed information relevant to this study in their appointments. These results suggest that current practices at the clinic are related to very low rates of detransition and regret. Future studies in gender identity clinics may investigate factors that predict detransition in a larger sample of patients.

# Health, well-being and social inclusion of transgender immigrants and asylum seekers

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Letizia De-Coll'*** [1]

***1.*** *Il Grande Colibrì*

**Background**

Migrant transgender population is characterized by **specific needs for the very condition**of being a migrant or a refugee as a result of discrimination of sexual identity, that hold a distinct help request (Chàvez, 2011), deserving of an appropriate response.

It denotes a **double vulnerability**, which results in doubling exposure to discrimination: those linked to immigration or asylum seeking stigmas and those linked to one's sexual identity. These discriminations can be perpetrated both by the host community and by that of other asylum seekers and refugees (UNCHR, 2015).

As for the hosting community, transgender migrants, asylum seekers and refugees are liable to being **discriminated during the whole process of social inclusion** against while they are **looking for a job and/or accommodation**.

**Methods**

Is a qualitative research: bibliographic about the employment status, social exclusion and invisibility of Transgender immigrant people (Kedde, Van Berlo, 2011; Geijtenbeek, Plug, 2015;Namaste, 2000; Goderie et al. 2002; Luit, 2013; Van der Pijl et al., 2018) and interview to the general supervisor of 'Il Nido del Colibrì' in Piacenza, Mr Valeriano Scassa

**Results and Conclusions**

A couple of studies (Holland:2010,2015) show how the "prejudice" works on the job's field: indeed, half of the interviewed pool tells to have lost their job due to their gender identity (Kedde, Van Berlo, 2011), moreover, whereas a transgender person would find a job, there is a pay gap with the cisgender male population (Geijtenbeek, Plug, 2015).

These disadvantageous labour conditions seem to lead particularly those who don't have a legal status (Namaste,2000;Goderie et al.2002;Luit,2013; Van der Pijl et al.,2018) and many of them are forced into prostitution or sex work for economic sustenance (Van der Pijl Y. et al., 2018). Although work as sex worker is a regular source of income and it helps them to pay for their transgender-related healthcare needs (Namaste 2000), engaging with sex works could increase risks of **mental distress** and **social exclusion**.

The employment discrimination forces many transgender migrants/refugees to live their lives at the at the margins of society; moreover, it puts them "simultaneously in a vulnerable and quite often **invisible position**" (Van der Pijl Y. et al., 2018: p. 6).

The general supervisor of 'Il Nido del Colibrì' reports about the differences between residing in villages or urban areas: "1) As it occurs in the countryside of Piacenza, the exclusion of transgender community is a matter of evidence and it does not depend on either the race or being involved in sex work; refugee and migrant people just live according to the model once they get to this place. 2) the people who are not out of the closet in their native countries do not have enough reasons to change their condition; they tend to reiterate the same actions".

In conclusion, given the complexity of conceiving the phenomenon, we **refer to the need to expand scientific research on the subject**, as to provide **adequate services** to the T, Q and + population of immigrants and asylum

seekers, **thus facilitating their improved access to health and community resources.**

# Shame and Alienation as Mediators between Discrimination and Mental Health in a Group of Italian Transgender and Gender Nonconforming People

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

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**Background**

Transgender and gender nonconforming (TGNC) people are a highly stigmatized population facing systematic violence and oppression because of their gender nonconformity. Anti-TGNC discrimination leads to negative mental health outcomes, such as depression and anxiety. Nevertheless, how psychological processes through which anti-TGNC discrimination affects health and protective factors buffer this relation still remain under researched. As an extension of the Minority Stress Model, the Psychological Mediation Framework (PMF) might help understanding these processes, as it postulates that stress is an initial starting point that leads to negative mental health outcomes through psychological mediators. Within the PMF, the current study analyzed the role of the internalized transphobia (i.e. shame and alienation) as a mediator between anti-TGNC discrimination and mental health, considering resilience as the individual-level coping mechanism buffering this relationship.

**Methods**

One hundred forty-nine Italian TGNC individuals (75 trans women and 74 trans men), ranged in age from 18 to 63 (M = 33.18, SD = 10.96), participated in an online survey assessing socio-demographic information, experiences with discrimination, internalized transphobia (i.e., shame and alienation), resilience, and mental health measures (i.e., anxiety and depression). All the study's hypotheses were tested using Structural Equation Modeling (SEM) in Mplus 7.2.

**Results and Conclusions**

The results suggest that both indicators of internalized transphobia (i.e., shame and alienation) mediate the relationship between anti-TGNC discrimination and depression, while only alienation mediates the relationship between anti-TGNC discrimination and anxiety. Furthermore, the results suggest that the indirect relation between anti-TGNC discrimination and anxiety through alienation is conditional on low and moderate levels of resilience. Findings have important implications for clinical practice and psycho-social interventions to reduce stigma and stress caused by interpersonal and individual stigma.

# Both peer relations and family functioning predict psychosocial functioning in transgender adolescents: results from a German clinical cohort study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

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***1.*** *University Medical Center Hamburg*

**Background**

Transgender adolescents who fulfill diagnostic criteria for Gender Dysphoria (GD) often face various associated social but also emotional and behavioral difficulties (measured via the CBCL/YSR; also referred to as psychosocial functioning). Both peer relations and family connectedness/relationships have been identified as one of the main factors that predict psychological difficulties in transgender adolescents. However, their impact on psychosocial functioning has not been compared, directly. In a marginalized group like youth diagnosed with GD, it seems crucial to identify factors that possibly impact the development of psychological functioning to further adapt therapeutic and societal approaches, and therefore, better accommodate their unique needs.

**Methods**

In the present cross-sectional study, psychosocial functioning measured via the Youth Self-Report (YSR), peer relations (measured via the YSR peer relations scale; PRS), and general family functioning (measured via the MFAD) data from *N* = 180 clinically referred adolescents (to the Hamburg Gender Identity Service between 2013 and 2017) were analyzed. All included participants completely fulfilled diagnostic criteria for a gender dysphoria diagnosis (DSM criteria A and B) and had not received any form of medical treatment yet.

**Results and Conclusions**

Transgender adolescents presented significantly more internalizing and higher YSR global problem scores than the German norm reference group before undergoing any kind of treatment at the Hamburg Gender Identity Service. Externalizing problems were above the norm for adolescents with a female sex assigned at birth, but within the standard range for adolescents with a male sex assigned at birth. Multiple regression analysis revealed that, next to poor peer relations, lower general family functioning (or: lower degrees of familial support) were highly significant predictors for lower psychological functioning outcomes.

Overall, adolescents with poorer peer relations, poorer general family functioning, advanced age, and a female sex assigned at birth showed more behavioral and emotional problems, or lower psychosocial functioning. Thus, the present study confirms the important role the social environment - both peers and family support - play with regard to the mental health outcomes in this group. Consequently, incorporating the family and social environment into Transgender Healthcare seems crucial in order to adequately tend to the needs of adolescents with GD.

# Describing non-binary identities – a systematic review

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Nat Thorne*** [1], ***Walter Bouman*** [2], ***Andrew Yip*** [1], ***Jon Arcelus*** [3]

***1.*** *The University of Nottingham,* ***2.*** *The Nottingham Centre for Transgender Health,* ***3.*** *University of Nottingham*

**Background**

Within the last two decades, a new concept in gender variance has emerged. Non-binary identities, and the multiple descriptors which lay under this catch-all term, are best described as identities which fall somewhere between or outside of the gender binary of male and female. The over-arching aim of this literature review is to summarise the ways in which non-binary identities have been described within scholarly research and how that definition has evolved through the last fifty years of gender research within the field of psychology.

**Methods**

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISRM) (Moher, Liberati and Tetzlaff, 2006) guidelines were followed to undertake this systematic review. Publications between 1st January 1960 and August 2018 were included in the search. The search engines used were: Web of Science, Science Direct and PubMed. A search following an identical inclusion criteria was also carried out within the archives of the International Journal of Transgenderism. Further papers were identified via the reference list of papers identified through the search of these key terms. In addition, further key terms were added as they were discovered via the search. Books were also included in this search as many key identifiers were found to have been mentioned in books before they were used in peer reviewed papers.

**Results and Conclusions**

Psychological Androgyny in the 1970s and 80s can be seen as a starting point towards the non-binary identities we see today. Other terms such as bigender and gender variant have been used between now and then and today, there seems to be no clearly defined umbrella term, with non-binary and genderqueer being the main descriptors for identities that lay outside of male and female.

**Conclusions:** So far, a consensus on terminology has not been found and the terms genderqueer and non-binary are used both interchangeably and in opposition to each other. However, there is a large range of descriptors underneath the disputed umbrella term which cover an equally wide range of gender identities.

# The use of hormone blockers to suppress puberty in trans children and adolescents. A qualitative study of perceptions and experiences of trans adult women.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Guido Giovanardi [1], Paola Morales [1], Alexandro Fortunato [1], Marta Mirabella [1], Luca Chianura [2], Anna Maria Speranza [1], Vittorio Lingiardi [1]***

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**Background**

In recent years, the use of gonadotropin-releasing hormone (GnRH) analogues in gender diverse adolescents to suppress puberty has been adopted by an increasing number of specialised gender clinics, generating controversial debate. Following an overview of the difficulties associated with this heterogeneous group of adolescents and a discussion of the arguments for and against the suspension of puberty, this contribution presents a qualitative research developed interviewing older gender diverse people about their experiences with hormone therapy (HT) and their opinion about the suppression of puberty. The main aim of the research is to explore thoughts and experiences of gender non-conforming adults regarding the psychological aspects of hormonal treatments, including the controversial issue of puberty suppression.

**Methods**

A semi-structured interview for gender diverse adults was constructed. The interview explored the personal history of trans individuals with regard their gender identity, their experiences with HT, and their opinions about the use of GnRH analogues to suppress puberty in gender diverse children and adolescents. Interviews' transcripts have been analysed with the method of Consensual Qualitative Research (CQR).

**Results and Conclusions**

Ten trans adult women were interviewed (mean age: 36.8). Several themes emerged, among those: experiences with their gender diversity, relationship with the specialised services, experiences with puberty and bodily changes, associated psychological problems, sexuality and affective relationships before and after treatments. Regarding suppression of puberty, we found a lack of consensus, reflecting a general debate upon this delicate topic. With this study we gave voice to an under-represented group in previous research regarding the use of GnRH analogues to suppress puberty in trans individuals, collecting first hand insights on a debated treatment, recommended by professional international guidelines.

# Use of GnRH agonists for Gender Dysphoria is rising at exponentially higher rates compared to Precocious Puberty

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Priya Phulwani*** [1], ***Whei Ying Lim*** [1]

***1.*** *Connecticut Children's Medical Center*

**Background**

Background: Gonadotropin releasing hormone agonists (GnRHa) are used in the hormone management of adolescents with a diagnosis of gender dysphoria to stop the production of endogenous estrogen or testosterone. This is often done before starting the intended hormonal transition and discontinued once the intended hormone has reached goal levels. At times GnRHa are used even after the intended cross hormone has been started to continue suppressing the endogenous hormone. For example to stop unwanted menses that are persistent (despite goal testosterone levels) or to lower persistently high levels or action of testosterone (despite goal estrogen levels and androgen blockers). Currently in USA, GnRHa use in treatment of gender dysphoria is still an "off-label" use that does not have FDA approval. Meanwhile GnRHa use to halt central precocious puberty is an FDA approved indication. Available formulations in the USA are leuprolide acetate injection or histrelin acetate implant

**Methods**

Aims:

1. To evaluate the overall use of GnRHa in a pediatric endocrinology clinic for adolescents with a diagnosis of gender dysphoria versus precocious puberty.
2. Compare the trends in use of leuprolide versus histrelin for each diagnosis.

Methods:

Retrospective analysis was conducted of deidentified medical records of adolescents started on GnRHa from January 2015 to September 2018, at the Connecticut Children's Medical Center general pediatric endocrinology clinic. There were 10 health providers- all prescribed GnRHa for precocious puberty, one provider prescribed GnRHa for Gender Dysphoria.

**Results and Conclusions**

Results and conclusions:

We saw a rise of GnRHa used for gender dysphoria relative to central precocious puberty over the past 3.75 years. In 2015, 36% of adolescents who were prescribed GnRHa had a diagnosis of gender dysphoria, as compared to about 52% in 2016 and 2017, and already 63% in only nine months of 2018.

Histrelin use has increased for Gender Dysphoria versus precocious puberty in 2018. In 2015, 2016 and 2017, between 41 to 44% of adolescents diagnosed with Gender Dysphoria were on Histrelin as compared to 80% in first 9 months of 2018. Since the numbers of these prescriptions for Gender Dysphoria is rising it is important for pharmaceutical companies in the USA to seek the FDA approval of GnRHa for this indication.

# Health demands and adherence of transgender people attended in the Andalusian Gender Team ( AGT), Spain, period 2000-2015.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Isabel Esteva de Antonio*** [1]***, Maricruz Almaraz*** [2]***, Juana Martínez-tudela*** [3]***, Trinidad Bergero*** [3]***, Javier Collado*** [4]***, Federico Soriguer*** [2]***, Francisco Giraldo*** [4]***, GIDSEEN Group*** [5]

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**Background**

***Introduction***:Knowing the type of demand and the adherence in Gender Identity Units is important for designing the healthcare processes for sexual reassignment **(SRP)** and for allocate resources within the public health system in Spain.***Objective*:** To describe frequency of people visited in Andalusian Gender Team (AGT) between the years 2000-2015; characteristisc of demand (psychological support, hormonal treatment or surgical genitoplasties and/or gonadectomies (SGG). It´s quantified the adherence, regrets of gender dysphoria and no eligibles cases for treatment, adjusted by trans women and trans men.

**Methods**

***Sample and Method***: retrospective study of the records and data of the total demands in AGT between 2000-2015: 1600 people ( andalusian residents, 1067). Subjects were classified as: inadherent, no eligibility and missing cases in follow up.

**Results and Conclusions**

***Results*:** 20% are no adherent (1,6 trans women/trans men). The follow up include 854 cases; ratio trans women/trans men 1,6. 15% minors from 5 to 17 years. In adults more than 90% demands the whole SRP; 51% underwent gonadectomy (217 trans women and 229 trans men), 20% trans women/7% trans men are missing postgonadectomies. Not eligibles 78 cases, ratio 2/1 (7,3% from the total sample.1% of adults experience regret, desisters in minors group are more than 60%. Demands per year increase specially in minors age.

# Basal Serum Testosterone Concentrations in Young Transgender Men Predicts Months Needed of Testosterone Treatment to Achieve Amenorrhea

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

*Mitzi Zaira Fong Ponce* [1], *Esmeralda Román Mar* [1], *Arnulfo González Cantú* [2], *Maria Elena Romero* [3], *Erika González de la Mora* [1], *Luis Carlos Joya Fierro* [1], *Andrea González Rodríguez* [1]

**1.** *Clinica Especializada Condesa,* **2.** *Eurarya PharmaCite,* **3.** *Muguerza Alta Especialidad*

**Background**

In the male transgender population Menstrual bleeding can be a source of mental distress, depressive symptoms and self-harming behaviors may peak during menstrual bleeding[1]. There are a few publications that studied testosterone effect inducing amenorrhea; these studies report amenorrhea within one to twelve months[2].
Objetive to Find predictor variables to achieve amenorrhea in transgender men in testosterone therapy.

**Methods**

At Specialized Clinic Condesa in Mexico city, They are 504 transgender men register of which 310 transgender are on active treatment. 73 transgender men were retrospective analyzed from the year 2009 to 2018, between the ages of 16 to 24 years to fit the Young people definition of the World health organization; with pelvic ultrasound before and after the treatment, with Basal hormone profiles and within treatment . They were initially treated with 250 mg of testosterone enanthate every 15 or 21 days. The dose was adjusted every 3 months according to serum testosterone concentration.
In descriptive statistics we used mean, median and standard deviations for continuous variables, and proportions for categorical variables. Linear regression models were used to predict the months and testosterone application to reach amenorrhea. This models were validated with 10 folds cross validation, and RMSE was reported. In order to detect a threshold with high specificity to reach amenorrhea, we use Receive Operator Curve analysis. the analysis was made with RV 3.4 Software

**Results and Conclusions**

the serum levels of testosterone can predict the applications of testosterone ( p value 0.001), and months to reach amenorrhea (p value 0.05) with an inverse relationship (estimate -1.41, -1.08). At higher levels of basal serum testosterone, less applications or months of therapy were needed to have amenorrhea (Cross validation root mean square error). The area under the curve of testosterone in ROC analysis was of 0.63. Serum levels of testosterone higher than 0.8 have an specificity of 100% to detect patients with amenorrhea in the first month of therapy.
Prior studies have reported amenorrhea induced by testosterone therapy at various fixed dosages [3,4]. In this study testosterone dose is not correlated to time needed to induce of amenorrhea but the inicial dose is the mayority of cases the same. Basal testosterone concentrations are highly correlated with induction of amenorrhea; the higher the basal serum concentrations fewer months needed to achieve amenorrhea with cutoff 0.8 ng/ml of serum testosterone. This is the first study with this finding. Hyperandrogenemia in cisgender women was the cutoff value of testosterone concentrations > 0.5 ng/ml in early follicular phase or progestin induced bleeding. In the transgender males with hyperandrogenia before testosterone treatment, just one dose of testosterone is needed to induced amenorrhea. The endometrium of PCOS patients (polycystic Ovarian syndrome) that are characterized by endoge-

nous hyperandrogenemia exhibits increased AR expression levels. Androgens exert an anti-proliferative role in the endometrium[5]. This could explain why the endometrium in the patients with endogenous hyperandrogenism is more responsive to testosterone administration. Prospective studies are needed to explore the effect of long term testosterone treatment on endometrial milleu.

# Every (binary) person likes to be someone's object of desire

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Annalisa Anzani*** [1]***, Antonio Prunas*** [1]

***1.*** *University of Milano-Bicocca*

**Background**

*Objective*Object of desire self-consciousness (ODSC) is described as the perception of one's own sexual and romantic desirability, and emerged as more relevant in women compared to men (Bogaert & Brotto, 2014). The construct reflect how we believe others view us and not necessarily an accurate representation of another's view, but it is still relevant in terms of sexual functioning. The following study is aimed to investigate differences in ODSC themes in the sexual fantasies of individuals with different gender identities.

**Methods**

A total of 228 self-identified cisgender (147 women and 81 men) and 65 transgender (20 binary and 45 non-binary) participants completed a sexual fantasies questionnaire (SFQ; Bogaert, VIsser, Pozzebon, 2015) that include a subscale of ODSC themed fantasies. A measure of objectified body consciousness was also included (McKinley & Hyde, 1996).

**Results and Conclusions**

Gender differences in ODSC themes are at odds with previous studies. No significant difference in the endorsement of ODSC fantasies was found between cisgender men and women in our sample. Cisgender and nonbinary identified people showed differences and a significant higher endorsement of ODSC fantasies was found in the former. Objectified body consciousness showed a correlation with ODSC themes in sexual fantasies, without any gender identity differences. ODSC themes in sexual fantasies appeared not to be characteristic exclusively of women's sexual functioning. In our sample, no significant differences emerged in sexual fantasies between cisgender men and women and binary transgender people.

# Transgender people accessing healthcare system in Northern Italy: prevalence, characteristics and needs.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Annalisa Anzani*** [1]***, Antonio Prunas*** [1]

***1.*** *University of Milano-Bicocca*

**Background**

Although there are several gender clinics in Italy offering medical and psychological assistance for transgender and gender variants children, adolescents and adults, there are no collective data available on the prevalence of GD in Italy and only a few studies describing the characteristics and needs of clients attending the clinics in the country. The aim of this study is to provide a description of clients admitted to a gender clinic in Milan (Northern Italy) throughout a year (2017).

**Methods**

Data were collected on all clients at their first admission at the gender clinic of Milan (Niguarda Ca' Granda Hospital) between January 2017 to January 2018. Every patient was invited to complete a questionnaire to collect data about their gender identity development, previous consultations with gender specialists or mental health professionals, and a sociodemographic form.

**Results and Conclusions**

A total of 55 new clients were admitted at the clinic in the reported timeframe, 48 (22 assigned male at birth and 25 assigned female at birth) of them accepted to participate in the study and signed the informed consent. In terms of identity labels, the majority of the sample identified as trans woman (*N*=10 assigned male at birth) or trans man (*N*=15 assigned female at birth), the remaining clients as woman (*N*=5), man (*N*=7), and transgender (*N*= 8). No participants identified as gender-queer/non-binary. 36,4% of clients assigned male at birth had already taken hormonal treatment (not necessarily under medical supervision) and had undergone cosmetic surgery, compared to 12,5% of clients assigned female at birth who were under hormonal treatment. As for the specific reasons for consultation, 86,4% of clients assigned male at birth and 91,7% of clients assigned female at birth were looking for hormonal treatments, 27,3% of clients assigned male at birth and 66,7% of clients assigned female at birth were seeking for surgery; 50% of the total sample expressed the need for psychological support and psychotherapy.

Our results suggest a trend reversal in the prevalence of clients assigned female and male at birth accessing gender clinics and also that clients who identify as genderqueer and non-binary are still under-represented in clinical settings.

# How many patients attending a large UK gender clinic are non-binary?

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Jess Gran*** [1]***, Andrew Davies*** [1]***, Vikinjeet Bhatia*** [1]

***1.*** *Gender Identity Clinic. Charing Cross. London*

**Background**

Background: The London Gender Identity Clinic, is a large, national gender clinic. Like gender services across the UK and Europe, we have anecdotally been receiving more referrals for patients who have non-binary gender identities (an identity that is other than male or female). Non-binary people's visibility has been increasing in recent years, and the London Gender Identity Clinic has been developing the service and treatment pathways to meet the needs of non-binary patients. However we do not have precise figures on what proportion of our patient population identifies as non-binary, which is important in service planning and delivery.

Aims: To find out how many patients self-identified as non-binary at their first assessment in May 2017 - January 2019; the age of this population; and what proportion of new patients identified as non-binary compared with binary male and female.

**Methods**

This clinical audit consists of a survey of the clinical population using an existing data set, routinely collected for clinical purposes. Data from initial assessment reports over a 20 month period was pulled to look at what proportion of new patients identified as non-binary, binary male, and binary female. Age and sex assigned at birth were also examined.

**Results and Conclusions**

The results show that 7% of the new patients assessed in this time self-identified as non-binary. This compares with 51.7% of new patients who identified as feminine, and 40.8% who identified as masculine. A very small proportion (0.5%) were unsure of their gender identity at the time of their initial assessment.

# Changes in muscle strength and muscle cross-sectional area following cross-sex hormone treatment

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Anna Wiik*** [1], ***Mats Holmberg*** [1], ***Tommy Lundberg*** [1], ***Mats Lilja*** [1], ***Daniel Andersson*** [1], ***Stefan Arver*** [1], ***Thomas Gustafsson*** [1]

***1.*** *Karolinska Institutet*

**Background**

Many biological differences seen in men and women are driven by relative differences in estrogen and testosterone levels. In transgender individuals, gender-affirming treatment includes inhibition of endogenous sex hormones and subsequent replacement with the cross-sex hormones. Yet, the effect of this treatment on functional muscle strength and mass remains poorly described.

The aim of the current study was to assess the effects of an altered sex hormone pattern on muscle strength and cross-sectional area.

**Methods**

Twelve transgender individuals, 6 trans women and 6 trans men who had been accepted to start gender-affirming medical intervention, were recruited. Knee extensor and flexor muscle strength was assessed using isokinetic dynamometry at three different angular velocities (0, 60 and 90 °/s). The assessments were made at four time points: (T1) before treatment initiation, (T2) four weeks after initiated gonadal hormonal down regulation but before hormone replacement, (T3) three months after hormone replacement therapy and (T4) eleven months after hormone replacement therapy. The cross-sectional area and radiological density of the thigh muscles were assessed by CT scans performed bilaterally at the midpoint of femur of each subject at baseline and after 11 months of cross-sex hormone treatment.

**Results and Conclusions**

Muscle area increased 17% in trans men ($p<0.001$) with an 8% increase in radiology density after eleven month of cross-sex hormone treatment. No change was seen in trans women. There were significant ($P<0.05$) group x time interactions at each angular velocity. Thus, while the trans men increased their strength over the four time points, strength levels were generally maintained in the trans women. When averaging the three strength tests, knee extension (16%) and knee flexion (34%) strength increased from T1 to T4 in trans men. The corresponding changes in the trans women group were -6% and 0%, respectively.

CONCLUSIONS: These results show that ~1 year of cross-sex hormone treatment results in increased muscle strength in trans men. Cross-sectional area and radiological density is also increased after testosterone treatment. However, trans women maintain their strength levels as well as cross-sectional area and radiological density throughout the treatment period. We conclude that the altered sex hormone pattern induced by gender-affirming treatment differentially affect muscle strength in trans men vs. trans women.

# Need for assistance and experiences with actual health care offers to the trans* population in Norway.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Esben Esther Benestad*** [1], ***Elsa Almås*** [1], ***Silje-Håvard Bolstad*** [1], ***Tor-Ivar Karlsen*** [1], ***Alain Giami*** [2]

***1.*** *University of Agder,* ***2.*** *INSERM / Université Paris-Saclay*

**Background**

This presentation reveals some results from the Norwegian part of the project: "Trans Health and Citizenship: International comparisons". The project is developing in France (INSERM – CESP), Brazil (Instituto de Medicina Social, State University of Rio de Janeiro), Denmark (Aalborg University), Italy (Sinapsi, University Federico II of Napoli), Norway (Dept of Health Sciences, Agder University), and Portugal (ISCTE-IUL, University of Lisboa.
The presentation is meant as part of the symposium:Access to health care among trans population in Europe

**Methods**

The same instruments of research elaborated in the French protocol were adapted and translated into Italian, Norwegian, Danish and Portuguese.
The questionnaire was translated and culturally adapted to Norwegian, using a forward-backward translation procedure. The Norwegian research group assessed the first translation together with a group of trans* people from different organizations and did semantic adjustments to the items. The final version was tested on a reference group of trans* people before used in the survey. The survey consisted of 129 items, aimed to register data on socioeconomic status, gender transition, health, sexuality and discrimination. The anonymous survey was performed digitally through an open website from April 5$^{th}$through August 1$^{st}$2018 and obtained 538 respondents.

**Results and Conclusions**

This presentation focus on the respondents' experiences on different levels of the Norwegian Health Care System (*NHCS*). As is relevant for mental health, the results include a major group (64%) who have felt discriminated by professionals in the *NHCS*, and a corresponding group that hesitates to seek health care in fear of being discriminated. Many (58%) have sought organizations or websites for gender incongruent people in order to find medical information and knowledge of rights (51%). We see a great variety of medical interventions. A minor number (8%) had had alterations to their genitals, while (56%) received hormonal treatment. Out of those who have received genital adjustments 61% had this done in Norway, 39% went abroad. Nevertheless, the majority (75%) had had their assessment at Oslo University Hospital (OUH) which has a national monopoly to treat individuals they diagnose as F64.0. Individuals that fall outside their criteria have no formalized offer. Professionals outside OUH offer assistance, but to be paid by the patients themselves or by their caretakers. Difficulties concerning affordable access to health care institutions, including gender affirming processes, access to hormonal treatment, surgery, psychological counseling, etc. raise fundamental questions concerning the way the *NHCS*is organized. The presentation will demonstrate the respondents' satisfaction (16% satisfied) with the offer given at the OUH and discuss how the*NHCS*can assist this group better.

Health care services to gender incongruent individuals in Norway is dissatisfactory both concerning clients' satisfaction and their experiences of discrimination from health care personnel. The *NHCS'*sgoal is equal access on equal terms to health care for all including gender variant individuals. This is not met in the present situation. It

seems that many are forced to seek more costly care elsewhere.

# Ability, not gender: A qualitative investigation of competitor's and spectator's attitudes and opinions of Limitless - an all-gender inclusive strength competition.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Han Newman*** [1], ***Gemma Witcomb*** [1]

***1.*** *Loughborough University*

**Background**

The number of people identifying as transgender or non-binary is increasing worldwide. While these individuals continue to face stigma and discrimination, often perpetuated by misrepresentations in the media, there is a gradual acceptance that sex assigned at birth (based on physical sexual characteristics) may not match the gender with which a person identifies. While this acceptance is positive and has influenced developments such as proposed reforms to the Gender Recognition Act, it does raise a number of important issues that are more difficult to reconcile. One of these is participation in sport and the premise of fairness, on which the need for sex-segregation is often based and which serves to undermine trans and non-binary people's rights to participate. This study sought to explore competitor's and spectator's attitudes and opinions of an all-gender inclusive strength competition, *Limitless*, that took place in May 2018 in the UK. This event organised competitors by ability, not gender, and aimed to provide a sporting opportunity that was fully inclusive to all.

**Methods**

Ten semi-structured interviews were conducted after the Limitless event, with both competitors (n=6: 1 non-binary, 1 genderfluid, 3 cisfemales, 1 cismale; mean age = 38.8 years) and spectators (n=4 cisfemales; mean age = 34.3 years). The interview asked participants questions related to their participation/interest in the event, the perceived success of the event, their understanding or experiences of barriers to participation related to gender identity, and their opinions on how sport can be more inclusive of trans identities. Data was transcribed verbatim and analysed using thematic analysis.

**Results and Conclusions**

A number of themes were identified that highlight the complexity of such events and challenging the gender binary within sport. Whilst the theme of *support* was strong, with an overall positive response from both competitors and spectators who described it as a successful event with an inclusive, supportive atmosphere, a counter theme that emerged was of an awareness of *marginalisation*, since it was recognised that the limited number of individuals taking part highlighted the non-mainstream nature of the event. *Challenging the binary* was a positive theme that arose, with all participants supportive of less sex-segregated sport, but again this was accompanied by the themes of *blind acceptance*, *fear for women's achievements*, and *overwhelming challenge*, with many of the participants admitting having never even thought about the issue, identifying potential challenges with attempting to address sex-segregation in sport and lack of awareness of how challenges could be overcome.

Conclusion: Sport remains one of the biggest institutions that upholds the gender binary and as such is a major player in how gender and gender identity are viewed in society. While this all-gender inclusive event was very positive, it highlighted the many misconceptions and challenges that accompany discussions around gender identity and sport. Increasing attention needs to be paid to organising events that are inclusive of all gender identities in order to increase normalisation, promote inclusive participation for all, and as a vehicle for social change.

# The experience of gender transition for partners of transgender individuals

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Ellen Marshall*** [1], ***Sally Robbins-cherry*** [2], ***Cris Glazebrook*** [3], ***Jon Arcelus*** [3]

***1.*** *The University of Nottingham,* ***2.*** *Nottingham Centre for Transgender Health,* ***3.*** *University of Nottingham*

**Background**

Very little is known about the partners of transgender individuals and their experience during the partner's medical or social gender transition. It has been reported that around half of relationships do not survive through an individual's gender transition due to the unique stressors associated with this process (Meier, Sharp, Michonski, Babock & Fitzgerald, 2013). Despite these stressors, partners of transgender individuals feel they do not have adequate support.

The aim of the current study is to explore the experiences and support needs of partners of transgender individuals.

**Methods**

A qualitative methodology using semi-structured interviews focused on the partner experience, as well as the experience of perceived support received during their partner's transition. Eligible participants are individuals, over the age of 18, who have been partnered with a transgender individual at some point during their gender transition (medical or social). Participants are recruited through social media (e.g. Facebook, Twitter) and transgender support organisations, as well as through health services. Data is analysed using thematic analysis.

This study is still in progress, currently eight participants have been recruited. It is anticipated recruitment will continue, aiming towards 15-20 participants.

**Results and Conclusions**

Current data suggests that being in a relationship with a transgender individual during their gender transition is a complex experience and specific support for partners is required. Four emerging themes from the data include: (1) A Unique Experience, Secondary to their Partner, (2) A Learning Experience, (3) Experiencing Unpredictable Reactions from Others, (4) Personal support required.

As the study is still in progress, analysis is on-going therefore for the final findings additional themes may be added. The initial analysis suggests the three first themes define the type of personal support required and this will be further determined upon additional analysis.

The themes that have emerged so far indicate the complex experience for partners and show the importance of acknowledging partners in the gender transition process. Based on this, sharing experiences within a personal network, education, and couple therapy would benefit partners of transgender individuals.

# A holistic approach on the mental health of trans adolescents in high-discrimination social environments: The case of Greece

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Elena Olga Christidi*** [1], ***Nancy Papathanasiou*** [1]

***1.*** *Orlando LGBT+*

**Background**

There is a multitude of evidence showcasing the deleterious effects of dicrimination on trans adolescents' mental health (for a recent review, Valentine & Shipherd, 2018). Although Greece has passed the legal gender recognition legislation in autumn 2017 for adults, trans adolescents still face multiple obstacles and system-wide discrimination. There is no legal provision for trans adolescents younger than 15 years that want to change their documents. Adolescents 15-18 years old with parental consent have to be examined by a multidisciplinary team of experts that will approve their application in order to complete the legal procedure. Regarding mental health, trans adolescents in most cases face malpractice, abusive and transphobic attitudes when they contact mental health experts. In the school context there is no clear legislation or any guidelines on how to include and create a safe environment for trans students. As a result we have multiple reports for transphobic bullying and discrimination from students and teachers alike. In this social setting, parents of trans adolescents in the best case don't know how to support their child and in the worst become part of the problem, internalizing transphobic beliefs and attitudes.

**Methods**

In order to respond to the above, we propose a multi-faceted holistic approach, addressing social and school support networks, using all available resources that can also be reproduced in similar contexts. These resources cover:

-affirmative mental health support and empowerment for adolescents and parents, through consulting and psychotherapy. To this end, we coordinate and supervise the national LGBTQI+ helpline that also offers in vivo sessions and empowerment groups for trans adolescents in an LGBTQI+ youth organization (Colour Youth),

-psychosocial support (eg. information about medical, legal or other services), through networking with the LGBTQI+ community and specialized health experts in the NHS,

-connection and networking with the LGBTQI+ community, in order to facilitate peer socializing and the creation of safe spaces for youth and parents, to share their experiences, and

-training and interventions in schools for teachers and students, either as intervention and crisis management (eg. a case of transphobic bullying after a student's coming out) or as training on gender identity issues, mental health aspects, and human rights, appropriately structured to address the classroom or the parents or teachers associations.

**Results and Conclusions**

Greece is an example of a country trying to move forward, while facing tremendous conservatism and transphobia. We will offer good practices in cases of interventions and we will discuss positive outcomes and challenges that have emerged applying the above, in the light of a changing and difficult social environment.

# Transgender persons in Malta: a healthcare system that cares unconditionally

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Claire Axiak*** [1]

***1.*** *Ministry of Health*

**Background**

Malta is considered a trailblazer in the field of LGBTIQ rights throughout Europe and beyond. In early 2018 the Health Ministry developed an ambitious plan to develop a trans-inclusive healthcare system based on the standards of care issued by WPATH, the World Professional Association for Transgender Health.

**Methods**

A gender clinic has been established that offers such care through a multidisciplinary clinical team consisting of specialists in endocrinology, urology, gynaecology, plastic surgery, psychiatry and paediatrics (in the case of children and adolescents) together with a psychologist, social worker, speech language pathologist and nurse working in a dedicated gender clinic. Transgender persons who desire state-funded hormonal or surgical treatment or other medical care are referred to this multidisciplinary team. Any referred individuals are initially assessed by a specialist nurse whose role is to optimise the chance of a successful transition and to identify comorbid clinical conditions for further management by members of the multidisciplinary team. The initial assessment consists of a series of interview questions regarding sociodemographic data, gender identity, treatment throughout life, conditions related to gender identity, stigma and rejection, distress, disability, medical history, substance use, social life, economic factors, present concerns and sexual function. The specialist nurse then carries out a further assessment for comorbid clinical conditions for further management, if necessary, by the multidisciplinary team, such as transvestism, anxiety, depression, psychosis and body dysmorphophobia.

Assessment for eligibility and readiness for progression through gender transition is considered on an individual basis on the advice and decisions taken by the multidisciplinary team following the initial assessments by the specialist nurse. For hormonal treatment or chest/breast surgery eligibility is determined by the ability to give informed consent after the person is informed of anticipated effects and risks. For lower surgery eligibility is determined by the ability to give informed consent after the person is informed of the limitations and associated complications of required procedures, following a period of social transition and two independently signed referrals (one of whom by a psychiatrist). In all cases, the patient's readiness for the consolidation of gender identity and mental stability is monitored regularly.

**Results and Conclusions**

After gender confirmation surgery, the patient and sometimes their partner or family may have ongoing or new concerns, whether emotional, interpersonal, intrapersonal, sexual or social. Since postoperative care including psychotherapy may be linked with a favourable outcome, a care plan for periodic follow-up by the multidisciplinary team is established for each patient to ensure overall care and support following hormone therapy or surgery.

The establishment of the Gender Clinic in Malta does not in anyway mean that transgender persons are considered to be sick and in need of treatment but on the contrary recognizes that since such persons typically face great challenges due to social stigmas and barriers, the State should as a bare minimum go out of its way to ensure that they access the best treatment with the least inconvenience.

# Identities Mediated: The Role of the Internet for Transgender Youth

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Riana Patel*** [1], ***Miriam Hillyard*** [2]

***1.*** *MSc Psychology Student, Birkbeck, University of London,* ***2.*** *Clinical Research Fellow in Addictions, Institute of Psychiatry, Psychology and Neuroscience, King's College London*

**Background**

Use of the internet by young people has become ubiquitous in the developing world and its role in identity formation is a critical yet nascent area of research. For the transgender youth population, use of the internet and digital tools has the potential to combat mental health issues which may be experienced by this population, such as suicidality, substance abuse, and dysphoria. In particular, social media use can provide an avenue for expression that, in its virtuality, can go beyond the bodily limits of identity expression and manifest social connections at a scale that surpasses the immediate community. Resources relating to gender identity and information relating to peer experience of being transgender are easily accessed digitally.

**Methods**

We conducted a thematic literature review on transgender youth, internet use, and mental health in order to understand this changing research landscape and current areas of focus. Search terms included combinations of "trans*", "youth", "child", "adolescent", "internet", "cyberbullying", "victimisation" and "social media" to aggregate themes.

**Results and Conclusions**

The relationship between sociality and identity emerged from two perspectives: social media use as a means of self-expression and the potential for cyberbullying as a contributor to psychological distress. We first consolidate what is known about online victimisation and and child and adolescent mental health by translating concepts such as trauma and violence into the digital sphere. Expressing oneself online presents opportunities for cyberbullying by other internet users, such as trolling, a form of digital violence endemic to digital contexts involving intentional elicitation of a negative reaction by anonymous or known viewers. Digital 'self-harm' has been observed, where anonymous comments that involve aggressive messages (in one case, encouraging the recipient to kill themselves) are actually sent by the original recipient. Finally, psychological distress can occur simply by browsing sites and content that dispute, mock, or otherwise undermine trans identities. Thus, it is important to analyse the context of the online space to understand the particular effects in terms of this violence or trauma. Following this, we make use of adjacent literature from sociological and media research to understand the contemporary experience of self-expression as a site for further and future clinical research, using theoretical insights from the social sciences that seek to dismantle the idea that online contexts are wholly separate and occur in a vacuum from offline counterparts. Increasingly, we must understand that these contexts are interwoven to better understand how transgender youth might experience mental health issues in their everyday lives. Such future areas of transgender youth research identified include those that are less developed, including the notion of resilience which has been a topic of considerable interest in other psychiatric and psychological literature. The potentials and pitfalls of the internet, especially social media, are key to understanding the contemporary transgender youth experience for those who access it, as it has become part of the fabric of everyday life.

# Integrated fertility counseling of trans women prior to semen cryopreservation within the genderteam

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Ilona Voorn - de Warem*** [1]***, Iris de Nie*** [2]***, Norah Van Mello*** [3]

***1.*** *Amsterdam UMC, location VU University Medical Center,* ***2.*** *VU,* ***3.*** *VU Medical Center*

**Background**

Gender-affirming hormonal treatment (HT) and sex assigning surgery for gender dysphoria in trans women has a negative impact on fertility. Cryopreservation of sperm cells seems an obvious way to preserve fertility options for the future. However it is known that the uptake of fertility preservation is low among trans women, especially the young ones. A number of reasons can be of importance: progress of transition, inability to masturbate, lack of knowledge about the effect of HT on fertility options. It is known that the quality of semen may be poor, possibly due to specific life style factors such as tight underwear and tucking. Depending on the semen quality future assisted reproductive treatment (ART) options may become possible, i.e. minimal invasive insemination or IVF/ICSI.
Counselling on possible effects of life style factors may optimize semen quality and therefor increase the chance of biological parenthood in the future.
Our goal was to create awareness among trans women and caregivers for fertility preservation for trans women before starting HT and/or surgery.

**Methods**

From 2017 onward we started with a dedicated out-patient setting within The Center of Expertise on Genderdysforia (CEG), VUmc, The Netherlands. Trans women were referred by their psychologist to our gynecologist and after intake counselled by a dedicated nurse who was well educated about gender dysphoria and fertility preservation.
There was a 30-minute consultation to inform the transwoman about their fertility options. The information given varied from very practical: “what to expect in a fertility clinic” to lifestyle-advise (the effect of tucking, taping, masturbation-frequency and intoxications on the quality of the semen). A trans woman specific information leaflet on semen preservation was created.
During weekly hosted multidisciplinary meetings for the genderteam, we created awareness for the optimal timing of fertility counseling and preservation.
We contacted fertility clinics in the country to educate them about the sensitivity and importance of the subject for our trans women.
During the process of semen preservation the nurse was the contact person for the trans omen, colleagues of the CEG but also for the collaborating fertility clinics.

The transwoman records and results were updated with feedback on the results of the quality and quantity of the semen. If the transwoman was satisfied by the results, the nurse would coordinate the continuation of the transition by referral to the endocrinologist or surgeon.

**Results and Conclusions**

In the period between January 2017 and July 2018, 208 trans women were counseled in the VUmc about options for fertility preservation. Eventually 156 of these 208 trans women proceeded with sperm banking.
This dedicated strategy has led to optimizing the informed consent of trans women before cryopreservation of

semen. Trans women were referred during the diagnostic process and had more time to optimize the semen quality. There was coordination of the fertility preservation process, feedback on the future ART options and guidance of the transition progress for trans women.
Integrated fertility preservation counseling of trans women by a dedicated nurse within the gender care optimizes chances in fertility outcome and reduces the delay in transition.

# Clinical psychological assessment of gender variant people in gender affirmation process: case report

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Mojca Sostaric Zvonar*** [1]

***1.*** *University Psychiatric Hospital Ljubljana*

**Background**

World Professional Association of Transgender Health (WPATH) released the last Standards of Care (SoC) in 2012. Clinical guidelines suggest that all people with transgender and gender nonconforming identities should have the option to be treated in a safe environment and to be given thorough, in-depth assessment, which includes different therapies, if needed – for example: primary care, gynaecological and urological care, reproductive care, voice therapy and mental health care (assessment, counselling, therapy). Psychological evaluation, which includes psychodiagnostic services of clinical psychologists, is needed especially in children and adolescents diagnosed with gender diversity/dysphoria. Apart from gender dysphoria evaluation, the assessment should also include emotional, intellectual and social evaluation. Clinical psychological report could be a part of the referral letter, which must also pinpoint coexisting mental health concerns, diagnosis, past and current treatment, if this is relevant for the client.

**Methods**

Two cases are represented: both clients gave the informed consent prior to enrolment.
Clinical psychological examination was performed in two different sessions. The third session was optional and was aimed at giving feedback to the client. Interviews and battery of clinical psychological instruments (tests, projective techniques, questionnaires and inventories) were used. Clinical psychological report was prepared and further interventions were suggested.

**Results and Conclusions**

CASE 1: An 18 years old client; birth assigned sex is female, has a strong wish for transition (hormones, breast surgery). Self-injury, suicidal ideations and unstable emotionality are in past anamnesis, but currently no such tendencies are evident. The client had weak social network and no familiar support. Clinical psychological examination revealed gender dysphoria and cognitive-emotional specifics, suggesting borderline personality functioning. Clinical psychological report was prepared. Individualized interventions plan was outlined and client‘s family members invited for family consultation. Client was advised to start individual trans-affirmative psychotherapy during the gender affirmation process and was considered relatively stable after 8 months to begin with hormonal therapy which he had been taken since then. He gradually decided to attend trans-affirmative group psychotherapy for TGNC clients. In 3 years time from the first admission into gender affirmative process he has changed legal gender from female to male and has recently undergone SRS. He has stable relationship with female partner and has improved relationship with his family.
CASE 2: A 30 years old client; birth assigned sex is male, has 2-years lasting wish to change gender (hormones, genital surgery). In age of 17, the client has been hospitalized, diagnosed with schizophrenia and has been treated with antipsychotic (clozapine) since then. Psychological clinical assessment was showing limited reality testing capacities, paranoid tendencies, cognitive deficits and other specifics, suggesting schizophrenic disorder. The clinical psychological report pinpointed the need for psychiatric monitoring. Evaluation and supportive interventions were

also suggested before starting with hormones. After 2 years the client started with hormonal therapy and was planning SRS. Recently s(he) came with a re-transition wish, explaining that in real life (s)he can not feel comfortable as a woman and is regretting the decision for changing the legal gender. S(he) stopped taking hormones and started dressing as a man.

# The Individual Treatment Progress Score – Introducing a new measure to acknowledge individual treatment biographies in trans individuals seeking for gender-affirmative medical interventions

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Andreas Koehler*** [1], ***Timo Nieder*** [1]

***1.*** *University Medical Center Hamburg-Eppendorf*

**Background**

To date, the majority of research with trans individuals seeking for gender-affirmative medical interventions (GAMI) assumes a pre-defined clinical pathway, starting with assessment and mental health care, followed by hormone therapy (HT) and finalized by genital reconstructive surgery (GRS). Therefore, previous research on psychosocial and clinical outcomes primarily focused on the comparison of means between different treatment stages, e.g. HT vs. GRS (Murad et al., 2010; White Hughto & Reisner, 2016). However, both empirical and clinical evidence suggests, that individual intentions to undergo GAMI are more diverse than previously assumed (e.g. Beek, et.al., 2015; Koehler et al., 2018). Some trans individuals require few interventions only and therefore would be inconsistent with the predefined treatment path ending with GRS. The reasons for individual treatment requests appear to be manifold. Besides diverse (e. g., non-binary) gender identifications, poor aesthetic outcomes and a high risk of medical complications, especially in GRS, were identified as important factors (Beek et al., 2015). Moreover, for some trans individuals, few GAMI might be sufficient to reduce gender incongruence/gender dysphoria significantly and ensure an increase in mental health and quality of life. This might be especially true for non-binary individuals.

**Methods**

Therefore, we introduce the Individual Treatment Progress Score (ITPS; Koehler et al., 2018) as an alternative approach to measure treatment progress in healthcare research with trans individuals. Contrary to previous approaches, it acknowledges individual treatment biographies not fitting a pre-defined treatment pathway that was assumed in research so far.

**Results and Conclusions**

The ITPS is calculated by adding together the numbers of received and planned GAMI per participant. This sum constituted a score of 100% on the ITPS. Afterwards, the number of received treatments is converted into percentages for each participant. Therefore, individual participants or participant groups could be compared regarding their treatment, while still addressing the variations in the number of interventions both relevant to individual participants and available for each sex. To make the ITPS more comprehensive, additional information (e. g. treatment satisfaction, aesthetical outcome) could be entered in the calculation.

The ITPS has already been used in recent studies and achieved good results (Eyssel et al., 2017; Koehler et al., 2018; Koehler et al., in press; Mayer et al., in prep.). It has been shown, that the ITPS explained a significant amount of variance and served as a promising approach to measure the treatment progress in research with trans individuals. Since the ITPS does not assume a pre-defined end of GAMI, it opens up the possibility to examine individual requests with regard to transition-related care in a comparable way. As it does not need preconceptions of a hypothetical treatment progress, the ITPS provides additional information on the diversity of the sample and therefore might be more inclusive.

# Androgen Blockers: The Bane of Spironolactone in Trans women.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Pei Shan Yeo*** [1]

***1.*** *Tan Tock Seng Hospital*

**Background**

Transgender women are treated with a combination of estrogen and androgen blockers. Androgen blockers are used to reduce the action of circulating levels of testosterone. Spironolactone, a mineralo-corticoid antagonist, is typically chosen as a first-line agent as it is cheap and readily available in our country. It works by directly blocking the action of androgens at their receptors. The typical daily recommended dose is 100 to 300mg/day of Spironolactone to achieve significant effects. However, Spironolactone primarily serves as an anti-hypertensive agent by acting as a diuretic. It can hence result in hypovolemia and hypotension. We describe 2 trans women who experienced significant frank hypotension resulting in hospital admission for volume resuscitation.

**Methods**

This is a retrospective analysis of 2 patients who suffered from frank hypotension due to Spironolactone.

**Patient A**

Patient A was a 21 year old trans woman. She had a history of chronic glomerulonephritis manifesting with proteinuria but was not known to be hypertensive. She was lean with a height of 1.59m and weighed 49kg, a body mass index (BMI) of 19.0 kg/$m^2$. The patient was treated with Estrofem 4mg daily and Spironolactone 200mg daily. Her baseline blood pressure (BP) was 110 to 120mmHg systolic. After starting Spironolactone therapy, she reported intermittent giddy spells. She subsequently experienced a near-syncope episode with frank hypotension of BP 70/40mmHg. The patient was admitted for aggressive hydration. Spironolactone dose had to be reduced and eventually stopped. An alternative androgen blocker, Cypoterone, had to be administered. The patient initially expressed apprehension to change as Cypoterone is more expensive. She is currently managed on Estrofem 4mg daily and Cypoterone 12.5mg daily. There has since been no recurrence of hypotension.

**Patient B**

Patient B was a 21 year old trans woman. She had a history of depression and Marfan's syndrome. She had stable mild aortic root dilatation managed on Losartan 25mg daily. She was underweight, with a height of 1.78m and weighed 50.5kg, a BMI of 15.9 kg/$m^2$. She was initially managed with Estrofem 4mg daily and Spironolactone 50mg daily. The patient developed an episode of syncope while exercising. On arrival of the paramedics, frank hypotension with BP of 79/60mmHg, was noted. She suffered from acute kidney injury (AKI) from dehydration and was admitted for intravenous hydration. We faced challenges in her management as she did not achieve satisfactory androgen blocking effects and yet suffered from hypotension with AKI on this dose of Spironolactone. The patient also expressed discouragement from the lack of feminising effects with her hormonal therapy. The patient had since been switched to Cypoterone 12.5mg OM and kept on Estrofem 4mg daily.

**Results and Conclusions**

It is important to consider the blood-pressure lowering effect of Spironolactone when trying to achieve anti-androgenic effects in transwomen. It can even result in hospitalisation. In such patients, an alternative agent,

such as Cyproterone, needs to be considered.

# Sexual information processing and vaginal pressure sensation in post-surgical trans women

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Mathilde Kennis*** [1], ***Marieke Dewitte*** [1], ***Felix Dücker*** [1], ***Guy T'Sjoen*** [2], ***Alexander Sack*** [1]

***1.*** *Maastricht University,* ***2.*** *Uz Gent*

**Background**

Several studies have indicated that in general, trans women are sexually active after GCS, but there is no research on how they experience vaginal pressure (as experienced during penetration) compared to ciswomen. It is relevant to study whether women experience vaginal sensations after GCS as pleasant or rather unpleasant, particularly because sexual wellbeing is strongly related to general happiness. This is essential information for trans women who are considering GCS, but also for sex therapists who work with this population. The study of vaginal sensation may offer valuable information for the evaluation of current surgery protocols and techniques. Additionally, most research on sexuality takes a medical approach and focuses on sexual function and frequency without taking into account the underlying mechanisms that determine sexual arousal responding. Drawing on the sexual information processing model, several processes can be distinguished, namely attention, appraisal and approach-avoidance motivation regarding sexual stimuli. Using a series of implicit tasks, gender differences in these three processes have been established in a cisgender population. In order to better understand sexual wellbeing and functioning after GCS, it is relevant to investigate how these mechanisms operate in trans women and to clarify their relation to sexual wellbeing and functioning after GCS.

**Methods**

To investigate sensation and evaluation of vaginal pressure in a sample of 15 post-surgical transwomen (at least 6 months after GCS) and 15 age-matched ciswomen, a recently developed instrument, the Vaginal Pressure Inducer (VPI), will be used. This device can be inserted into the (neo)vagina, and it resembles a small inflatable balloon that can be gradually filled with warm water to increase vaginal pressure. We examine the effect of sexual versus neutral stimulation (watching video clips) on the appraisal of vaginal pressure and on the vaginal pressure threshold. The same sample will perform three tasks on sexual information processing. We will investigate attention using a Posner-task, appraisal of sexual stimuli using an adaption of the Implicit Association Test (IAT), and approach-avoidance motivation using a Stimulus Response Compatability (SRC) task.

**Results and Conclusions**

Data collection is ongoing. The results will address a huge gap in the literature on sexual functioning after GCS. The conclusions will go beyond simply examining (the link between) sexual outcome variables. Instead, we focus on the processes that determine these sexual outcome variables and can explain their interrelations. By decomposing the process of sexual information processing in trans women, we could potentially identify clinically relevant processes that show maladaptive or dysfunctional features among this population.

# Hypothalamic volumes in cisgender and transgender youth

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Dominique Troost*** [1], ***Nikos Makris*** [2], ***Baudewijntje Kreukels*** [3], ***Dick Veltman*** [4], ***Julie Bakker*** [5], ***Elseline Hoekzema*** [1], ***Sarah Burke*** [1]

***1.*** *Leiden University,* ***2.*** *MGH, Harvard Medical School,* ***3.*** *VU Medical Center,* ***4.*** *Amsterdam UMC, location VU University Medical Center,* ***5.*** *University of Liege*

**Background**

Transgender individuals may be diagnosed with gender dysphoria (GD)[1], a marked and persistent incongruence between one's birth-assigned sex and experienced gender. Our understanding of the neurobiological basis of GD is limited. Histological studies found that the hypothalamus, a brain structure that links the endocrine and nervous systems, is sexually dimorphic in cisgender (cis) individuals[2, 3, 4]. Moreover, the central nucleus of the bed nucleus of the stria terminalis (BnST) was found to be of cis-female size and neuron number in a group of transgender (trans) women[2]. Consequently, Swaab proposed that sexual differentiation of the genitals and the brain occurs separately in utero, such that one could be born with female brain structures in a male body, and vice versa[5]. Although morphological neuroimaging studies have provided some *in vivo* evidence in favour of the brain sexual differentiation hypothesis[6,7], the histological studies cannot be replicated with the current technology using magnetic resonance imaging (MRI). Automated segmentation of the hypothalamus from MRI data is technically problematic, because of the absence of clear white matter demarcations defining the borders of the hypothalamus. Therefore, the present study used a novel, semi-automated segmentation method[4] to investigate sex differences in hypothalamic volumes in a large group of cis and trans youth during various hormonal/pubertal stages. Thereby, we aim to chart the effects of sex, GD diagnosis, puberty (suppression), and cross-sex hormone treatment on differences in hypothalamus volumes.

**Methods**

By the end of the year, we will have segmented the hypothalamus on MR T1-weighted images of a total of 139 cisgender participants (75 cis women; 7 – 23 years old), of which 37 were scanned twice (1 year between scans) and 167 transgender participants [92 trans men (male gender identity, female sex assigned at birth); 7 – 22 years old], of which 75 were treatment-naïve, 59 received puberty-suppressant medication, and 33 received cross-sex hormone treatment. Fourty-eight transgender participants were scanned at least twice during different treatment stages. A total of 401 MRI scans will be analysed. Based on anatomical landmarks, the hypothalamus was divided into seven sub-segments: anterior-inferior, anterior-superior, tuberal-inferior, tuberal-superior, posterior, the region of the BnST, and the medial preoptic region.

**Results and Conclusions**

Preliminary analyses of 20 cis men and 21 cis women adolescents revealed significant sex differences in total hypothalamus volumes and in volumes of the posterior and tuberal sub-regions. Cis men had significantly larger hypothalamus volumes than cis women. At the conference, we will present how hypothalamic volumes of the transgender groups compare to sex- and age-matched cisgender control groups, highlighting potential effects of the hormonal interventions.

**References**

[1]American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders* (Fifth edition).

[2]Zhou, J. N. et al. (1995) *Nature* doi:10.1038/378068a0

[3]Kruijver, F. P. M. et al. (2000) *Journal of Clinical Endocrinology & Metabolism*. doi:10.1210/jcem.85.5.6564

[4]Makris, N. et al. (2013)*NeuroImage*doi:10.1016/j.neuroimage.2012.12.008

[5]Swaab, D. F. et al. (2009). *Functional Neurology, 24(1)*, 17 – 28.

[6]Hoekzema, E. et al. (2015) *Psychoneuroendocrinology*. doi:10.1016/j.psyneuen.2015.01.016

[7]Guillamon, A. et al. (2016) *Archives of Sexual Behavior*. doi: 10.1007/s10508-016-0768-5

# The effects of cross sex hormone therapy on sleep in transgender adolescents

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Laura Jacxsens*** [1], ***Gianni Faelens*** [1], ***Karlien Dhondt*** [1]

***1.*** *Ghent University*

**Background**

Cross sex hormone therapy is started at the age of sixteen in the transition process of adolescents diagnosed with gender dysphoria in our pediatric gender clinic. The final aim of the cross sex hormones is to induce body characteristics of the desired sex. In the field of sleep medicine, researchers are already convinced about the impact of hormones on sleep quality and the circadian sleep/wake rhythm. From a clinical approach, some adolescents indeed experience more difficulties to sleep once they started cross sex hormone therapy. The aim of this pilot study is to identify the potential side effects of cross sex hormones on sleep homeostasis and the circadian sleep/wake rhythm.

**Methods**

Adolescents who are diagnosed with genderdysphoria and were planned to start cross sex hormone therapy were invited to participate in the study. Sleep questionnaires were used to assess sleep quality and quantity: the Pediatric Daytime Sleepiness scale, the Pittsburgh Sleep Quality Index and the Morningness-Eveningness Questionnaire/Self-Assessment. All adolescents who were included in the study received a regularly contact (every 2-3 months) and coaching sessions as a part of their transition process. The questionnaires were completed before cross sex hormonal treatment and four months after. Sleep quality in adolescents diagnosed with gender dysphoria was compared with adolescents in a general population as well as the impact of cross sex hormonal treatment after 4 months in our study group.

**Results and Conclusions**

This is the first study that is looking at the impact of hormonal treatment on sleep in adolescents diagnosed with gender dysphoria. Since this is a new pilot study, participants are still being included at this moment to enlarge the study power. We will be able to present the complete results at the conference.

# Frequency of Testosterone-Induced Erythrocytosis and Associated Predictive Factors on Transgender Males

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Jesús Pérez-Luis*** [1], ***Beatriz Gómez- Álvarez*** [2], ***Patricia Guirado- Peláez*** [2], ***Esther Gómez- Gil*** [3], ***GIDSEEN Group*** [4]

***1.*** *Universidad de La Laguna. Hospital Universitario de Canarias.,* ***2.*** *Hospital Universitario de Canarias,* ***3.*** *Hospital Clinic de Barcelona,* ***4.*** *(Gender Identity Group of the Spanish Society of Endocrinology)*

**Background**

Testosterone therapy (TTh) may produce various side effects, particularly erythrocytosis, with short-acting testosterone (T) injections presenting the greatest risk compared to other presentations. Other factors that may contribute to the development of erythrocytosis are smoking habit and obesity. The effect of TTh on erythrocytic mass is possibly mediated by supraphysiologic T levels. Erythrocytosis can be deleterious because increases blood viscosity which may lead to thromboembolic complications.

Aim: to study the frequency of erythrocytosis induced by TTh and its predictive factors on transgender males in the Gender Unit of our hospital.

**Methods**

A retrospective study on transgender males on TTh for at least 3 months was conducted. Age, age of treatment initiation, months on treatment, weight, height, BMI, waist and hip perimeters, waist-hip ratio, percentage of body fat (according to standards for males), hematocrit, total T, estradiol, SHBG, FSH, LH, PRL levels at the last visit as well as the highest hematocrit (MaxHt) value during follow-up were recorded. In addition, T formulation (short-acting IM injections: T cypionate; extended-release IM injections: T undecanoate; and transdermal gels), smoking status, and previous hysterectomy and mastectomy procedures were also documented. A hematocrit value ≥ 50 % was consider erythrocytosis and ≥ 53 % was an indication for phlebotomy.

**Results and Conclusions**

140 trans men were included: (M±EEM, min-max) age (29.29±0.82, 15-62 years); age of treatment initiation (24.06±0.70, 14-54 years); months on treatment (63.07±4.11, 4-276); weight (70.27±1.28, 40-117 kg); height (162.10±0.48, 146-179 cm); BMI (26.72±0.49, 14.9-49 kg/m2); waist perimeter (85.45±1.12, 59-121.5 cm); hip perimeter (98.53±0.87, 74.5-136 cm); waist-hip ratio (0.87±0.01, 0.72-1.13); body fat % (29.40±0.71, 9-49); hematocrit (46.93±0.34, 37.0-59.3 %); MaxHt (48.44±0.32, 26.7-55.1 %); total T (5.13±0.35, 0.2-22.7 ng/ml); SHBG (23.89±1.44, 5.3-139.6 nmol/l); estradiol (38.34±1.50, 20-107 pmol/ml); FSH (19.33±2.96, 0.1-214 mUI/ml); LH (9.84±1.41, 0.1-73.7 mUI/ml) and PRL (12.30±0.83, 2.83-83.2 ng/ml) levels.

The number of smokers, those undergone hysterectomy and mastectomy were 51, 76 and 80 respectively. According to T formulation there were: 9 on transdermal T gels, 100 on short acting IM T injections and 31 on extended-release IM T injections. Hematocrit and MaxHt were ≥ 50 % in 31 and 46 persons (33 %), and ≥ 53 % in 5 and 14 (10%) persons respectively.

Hematocrit (47.73± 0.45 vs 45.96±0.50 %, P=0.01) and MaxHt levels (49.69 ± 0.35 vs 46. 96 ± 0.52 %, P=0.0001) were higher in hysterectomised persons, while in smokers only MaxHt was higher (49.03 ± 0.42 vs 48.10 ± 0.45 %, P= 0.006). On the other hand, nor hematocrit nor MaxHt were related to T formulation, mastectomy or BMI. Both hematocrit and MaxHt correlated positively with themselves, age of treatment onset, waist perimeter and waist-hip

ratio. Moreover, there was no difference in the total testosterone levels measured between the three T preparations.

In conclusion, in our series, the percentage of transgender males with erythrocytosis was high (33 %), and 10% of them required phlebotomy at some point. Hematocrit values were independent of the BMI and the type of T preparation possibly due to the small number of individuals in two of the three treatment groups.

# Trans* Adolescents need Time to become Women and Men. The Task of Psychotherapy with Trans* Adolescents becoming Young Adults

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Wilhelm F. Preuss*** [1]***, Julia Schweitzer*** [2]

***1.*** *Private Practitioner after having been active as a transgender specialist at the Institute of Sex Research, University Clinic Hamburg-Eppendorf from 1992 - 2017,* ***2.*** *Clinic for Child an Youth Psychiatry, Psychotherapy and Psychosomatic Medicine, University Clinic, Hamburg-Eppendorf, Germany*

**Background**

Development takes time. Three case vignettes show that trans*-adolescents need individual periods for their transition, often reaching into early adulthood: 1. the case of a young trans* woman without psychopathology. Her individual psychosexual development would have been blocked if she had not undergone cross hormonal treatment at the age of fifteen and sex reassignment at nineteen. 2. the case of a fifteen-year-old assignned female by birth who demanded testosterone. Her child and youth psychotherapist rightly considered hormone treatment to be premature. Only when the patient was nineteen years old did he turn out to be a trans*man and the hormonal treatment could be started. 3. the case of a young trans* girl who had to be hospitalized due to the comorbidity of severe depression when she was sixteen. Close cooperation between her child and youth psychoanalyst and myself (in the position of a transgender specialist) was necessary. After the depression subsided, the patient underwent sex reassignement surgery when she was nineteen with a good outcome.

**Methods**

Presentation of three case vignettes.

**Results and Conclusions**

Since trans* developments in adolescence can reach into young adulthood, the referral to an adult transgender specialist should be planned in good time and addressed early in psychotherapy. On the basis of the three case vignettes, four principles of development-oriented psychotherapy are proposed which are important for working with trans* adolescents.

# Spanish research productivity by the multidisciplinary units in the field of gender dysphoria

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Esther Gomez-Gil*** [1]***, Marti Flo Csefkó*** [2]***, Isabel Esteva de Antonio*** [3]***, María Fernández Rodríguez*** [4]***, GIDSEEN Work Group*** [5]

***1.*** *Catalonia Gender Unit. Psychiatric Department, Hospital Clinic. Barcelona,* ***2.*** *CRAI. Biblioteca de Campus Clínic. University of Barcelona,,* ***3.*** *Andalusian Gender Unit, Endocrinology Service, University Regional Hospital. Málaga,* ***4.*** *Asturias Gender Unit, Mental Health Center La Magdalena. Hospital Universitario San Agustín, Avilés, Asturias, Spain,* ***5.*** *Spanish Society Gender Identity and Sexual Differentiation Group*

**Background**

Spanish biomedical research on gender dysphoria or transsexualism has been possible after the inclusion of their healthcare in the National Health Service, and has increased with the development of the gender units. We aimed to analyze the scientific contributions (publications and books) from Spanish gender units (Andalucía, Aragón, Asturias, Cataluña, Canarias, Castilla y León, Comunidad Valenciana, Madrid, Navarra and País Vasco) providing the gender dysphoria-related literature.

**Methods**

PubMed, IME (Indice Médico Español), and Google Schoolar databases were used to retrieve publications with the following key words with title: “transsexualism” OR “gender dysphoria” OR “sex reassignment” , in order to identify all original research studies, letters to the editor, editorials, books and case reports, published between 1999 and 2018, from all Spanish professionals working on multidisciplinary gender units. Book chapters, congress presentations and thesis were excluded. The year of publication, authors, language, main topic of interest, and number of citations were extracted. The number of citations was extracted from the Scopus database. The quantity and quality of research were assessed by the number of total publications and citation analysis.

**Results and Conclusions**

The total research output was 132 original articles and 4 books. There was a progressively increase in the number of publications, with three peaks in 2006, 2015 y 2017. One third was published in English. The units with leading positions were Catalonia, Andalusia and Madrid Gender Units. Half were cohort studies. The highest productivity order was in the fields of psychology and mental health, endocrinology, surgery and etiology/biological bases. The highest average citations were reported in the fields of neuroimaging and genetic. The annual impact factor rose progressively with the years. In conclusion, Spanish research in the field of gender dysphoria has rose progressively, and in the last years has reached an international influence, and a contribution to the advances in the medical knowledge on this topic.

# My menstruation is not female

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Natasa Jokic-Begic*** [1], ***Anita Lauri Korajlija*** [1], ***Marina Grubic*** [2]

***1.*** *Department of Psychology, University of Zagreb,* ***2.*** *Department of Pediatrics, Clinical Hospital Centre, Zagreb*

**Background**

In general, society continues to view menstruation strictly as an experience of cisgender women. Consistent with this perspective, previous studies examining attitudes toward menstruation have primarily been conducted with cisgender individuals. On the whole, this research demonstrates generally negative attitudes in which men's attitudes are typically more negative than those of women. Little is known about the attitudes and experiences of transgender individuals toward and with menstruation. However, although there has been little or no work on this topic by social scientists or healthcare providers, there is a wealth of information in the form of blogs or videos posted by transgender authors describing their personal experiences with menstruation.

**Methods**

The aim of this study was to gather information about the attitudes toward and experiences with menstruation among transgender men. Using a mixed methodology, qualitative data was collected from transgender persons and online resources. Firstly, online sources of information about the experiences of trans men with menstruation were analyzed. Data about personal experiences with menstruation, levels of distress experienced as a result of menstruation and attitudes towards menstrual suppression were also collected with a group of transmen from Croatia.

**Results and Conclusions**

While participants reported mixed attitudes toward menstruation, they expressed generally positive attitudes toward menstrual suppression. The experience of trans men highlighted five main sources of distress: the first period is usually a very distressful event; menstruation is a "taboo" subject that could not be openly discussed with anybody; feelings of "menstruation shame"; hygiene during menstruation; and using public toilets. Positive attitudes stemmed from feelings of "slowing down" and calmness during menstruation. These perspectives were similarly reflected in the personal experiences described by the authors of online blogs and videos. The implications of these findings towards future research will be discussed.

# Review of the reasons cited by GPs who refuse to prescribe medications recommended by the London Gender Identity clinic

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Rebecca MacGregor Legge*** [1], ***Leighton Seal*** [2]

***1.*** *St George's university,* ***2.*** *Tavistock and Portman NHS Foundation Trust*

**Background**

Introduction: Transgender medicine is a rapidly expanding field and GPs have historically played a vital role in prescribing hormones therapies for those with gender incongruence. Despite this, some GPs are refusing to prescribe medication recommended by the Gender Identity Clinic (GIC) in London. This problem is persisting despite the GMC guidance that prescribing is the GPs responsibility. The aim of this audit was to establish reasons why GPs are refusing and if there were factors that made refusal more likely

**Methods**

Method: 53 patients whose GPs had refused them prescriptions were identified and information about comorbidities, drug recommendation and reasons for refusal were collected. These were then compared against 53 controls matched for age and gender.

**Results and Conclusions**

Results: Refusal to prescribe hormones is uncommon (1.1%). The most common reasons cited by GPs were lack of knowledge or experience (35.5%), they felt it was a specialized area of medicine (26.6%) and that it was flagged as an amber drug by their local CCG (12.7%). Estrogen was significantly less likely to be refused than other drugs (20.6% vs 34.2%, p=0.007). People on the autistic spectrum were significantly more likely to be refused prescriptions (11% vs 0% p=0.012). On average the time from recommendation by the GIC to GP refusal to reply by the GIC was 86 days. With further correspondence, 87% of patients had been prescribed hormones in primary care.

Discussion: These results show that most GPs will prescribe hormones, often through simple reassurance by the endocrine team and quoting the GMC guidance. Delays are exacerbated by community pharmacy advice from CCGs who often unnecessarily classify transgender medications as amber drugs. Moving forward, the NHS must work towards clearer endocrine advice in primary care to ensure timely and effective treatment for transgender patients

# Effects of testosterone therapy on lipid profile in trans men during a 6-month prospective clinical study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Milina Tancic-Gajic*** [1], ***Miomira Ivovic*** [1], ***Ljiljana Marina*** [1], ***Zorana Arizanovic*** [1], ***Marija Miletic*** [1], ***Dragana Duisin*** [2], ***Dusica Markovic Zigic*** [3], ***Miroslav Djordjevic*** [4], ***Marta Bizic*** [4], ***Borko Stojanovic*** [4], ***Aleksandar Milosevic*** [5], ***Katarina Maksimovic*** [3], ***Gradimir Korac*** [4], ***Ivana Krstic*** [6], ***Svetlana Vujovic*** [1]

***1.*** *Clinic for Endocrinology, Diabetes and Metabolic Diseases, Clinical Centre of Serbia, Faculty of Medicine, University of Belgrade, Belgrade, Serbia,* ***2.*** *Clinic for Psychiatry, Clinical Center Serbia, Belgrade,* ***3.*** *Department of Psychiatry, Clinical/Hospital Center "Dr Dragisa Misovic", Belgrade,* ***4.*** *School of Medicine, University of Belgrade, Belgrade, University Children's Hospital, Belgrade, Serbia,* ***5.*** *Faculty of Medicine, University of Belgrade, Belgrade, Serbia,* ***6.*** *Faculty of Law, University of Belgrade*

**Background**

Recent systematic review showed that testosterone therapy in transgender men was associated with modest increases in b*ody mass index (*BMI) and low-density lipoprotein (LDL) cholesterol and decreases in high density lipoprotein (HDL) cholesterol. Less consistent results were noted for total cholesterol and triglycerides.

**Methods**

This was the prospective clinical study. The aim of our work was to assess the changes of lipid profile in trans men during the first 6 months of gender affirming therapy with testosterone. The study included young adult trans men from Belgrade gender team database. We examined anthropometric parameters and lipid profile before and during a 6-month therapy by intramuscular injection of testosterone enenthate, 250mg every 2 weeks.

**Results and Conclusions**

Sixteen trans men, aged 27.69 ±5.84, completed the study.During 6 months of testosterone therapy there was a significant increase of body weight (63.96±10.85 vs. 67.2±10.02kg, $p<0.05$) and body mass index (23.21±3.56 vs. 24.48±3.07kg/$m^2$, $p<0.05$), without a significant increase of waist circumference (80.54±10.6 vs. 82.85±8.51cm, $p>0.05$) and without a significant decrease of hip circumference (99.00±8.1 vs. 98.00±6.87cm, $p>0.05$). We found a significant decrease of HDL (1.78±0.48 vs. 1.39±0.39mmol/l, $p<0.05$), without significant changes of cholesterol (4.8±1.14 vs. 4.70±0.98 mmol/l, $p>0.05$), LDL (2.73±1,09 vs. 2.88±0.82 mmol/l, $p>0.05$), triglycerides (1.33±0.79 vs. 2.56±1.04 mmol/l,$p>0.05$), Apolipoprotein B (ApoB) (0.98±0.33 vs. 0.93±0.24g7l, $p>0.05$), Apolipoprotein A1 (ApoA1) (1.58±0.29 vs. 1.38±0.27g/l, $p>0.05$) and Lipoprotein(a) (Lp (a)(0.16±0.17 vs. 0.7±0.05g/l, $p>0.05$).

Short term testosterone therapy in transgender men was associated with increases in BMI and with decreases in HDL-cholesterol. Long-term studies are needed to assess the long-term cardiometabolic risks of testosterone therapy in trans men.

# Forthcoming study: The impact of medical treatments on non-binary and genderqueer patients

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Lotta Tynkkynen*** [1], ***Tuisku Katinka*** [1], ***Liisa Lempinen*** [1], ***Kaisa Kettula*** [1]

***1.*** *Helsinki University Hospital*

**Background**

The amount of patients seeking help for gender identity disorder has been growing rapidly and in line with this there has been an increasing number of non-binary and genderqueer patients hoping to get medical treatments to help their gender dysphoria. It is recommended (WPATH, 2011) that the evaluation of the need for medical treatments should be based on the distress caused by gender dysphoria and not on specific diagnoses, thus also non-binary and genderqueer patients should be given medical treatments if there are no physical or psychiatric hindrances. However, contrary to binary transgender patients, there is lack of longitudinal evidence on the impact the medical treatments have on non-binary and genderqueer patients. The aim of this study is to investigate the impact the medical treatments have on the gender dysphoria, mental well-being and life-satisfaction of non-binary and genderqueer patients.

**Methods**

All of the transgender patients, both binary and non-binary, starting at the Gender Identity Clinic in Helsinki University Hospital during year 2019 will be included in the study, which is expected to be around 400 patients. During the psychiatric evaluation period, which in Finland lasts about 1-2 years, the patients will be given questionnaires concerning their gender identity, gender dysphoria, physical and mental well-being and social functioning, which will be part of the register data of the patients. The register data includes also information on the progress of the evaluation period, possible psychosocial treatments during the evaluation period (i.e. psychotherapy) and finally the possible diagnosis given and information on the patients' desire for medical treatments. All of the patients with stable, longitudinal transgender identity, unresolved gender dysphoria, and adequate judgement, realistic treatment goals, sufficient mental and physical health will be referred to the desired medical treatments.

The patients will be reached again via mail after 5 years and after 10 years from the beginning of their evaluation period and again questions concerning their gender identity, distress caused by gender dysphoria, functional capacity, quality of life, physical and mental well-being will asked. Also questions on the possible medical treatments received will be asked; i.e. how satisfied patients are with the treatments and what are the experienced advantages and disadvantages of the treatments. Also information on possible sick leaves, disabilities and rehabilitations will be collected from the national registers.

**Results and Conclusions**

This study will be one of the first studies to longitudinally examine the impact of medical treatments on the well-being of non-binary and genderqueer patients. This study is very important and current as also according to DSM-V and ICD-11 the division between binary and non-binary and genderqueer patients should no longer be as significant marker for the medical treatments as the distress caused by the experienced gender dysphoria.

# Observational study on socio-demographic features and psychiatric coexisting problems in subjects with gender dysphoria diagnosis attending cidigem for sex-change from 2005-2015

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Anna Gualerzi*** [1], ***Flavia Capirone*** [2], ***Claudia Schettini*** [2], ***Donato Munno*** [1]

*1. Department of Neurosciences, Mental Health, Division of Psychiatry, AOU Città della Salute e della Scienza, Turin on behalf of CIDIGEM (Turin University Hospital Gender Team – Italy), 2. CIDIGeM, AOU Città della Salute e della Scienza, Turin on behalf of CIDIGEM (Turin University Hospital Gender Team - Italy)*

**Background**

Despite being recognized as an unfavorable prognostic factor for Sex Reassignment Surgery (SRS) and for long-term psychosocial adjustment in gender dysphoria, psychiatric coexisting disorders have rarely been assessed with standardized diagnostic instruments. The aim of this study is to investigate socio-demographic features and to assess current and lifetime psychiatric coexisting problems in subjects diagnosed with Gender Dysphoria (GD).

**Methods**

Our sample was composed by 300 subjects (207 trans women, 93 trans men; mean age= 33,72± 10,69 years) attending CIDIGeM – a Public Health Service for persons diagnosed with GD in Turin, Italy – in order to enter the programme for Sex Reassignment Surgery, from January 2005 to October 2015. All patients have been comprehensively evaluated independently by two mental health professionals, qualified to work with adults with GD diagnosis, and all patients fulfilled the criteria for GD according to the DSMIV-TR/DSM-5.

Socio-demographic features have been assessed by analyzing patient medical records, while coexisting psychiatric disorders have been evaluated via Semi-Structured Clinical Interview (SCID I-II) and Global Assessment Functioning (GAF).

Statistical analysis was conducted using SAS version 9.3 Institute Inc., Cary, NC, USA. Between–group comparisons of categorical variables were performed using chi-square analysis. The significance level was set at $p< 0,05$.

**Results and Conclusions**

We have found differences among the socio-demographic features analyzed in the two subgroups (trans women and trans men), such as sex ratio, age and sexual orientation, but only in family relationships, history of prostitution and sexual abuse they were statistically significant ($p< 0,05$). A positive correlation was found between higher rate of prostitution, older age and lower level of education. Almost half of our sample (46,0%) reported positive psychiatric anamnesis. The current comorbidity is positive on Axis I in 49,2% of the subjects, mainly for anxiety disorders, mood disorders and adjustment disorders, while on Axis II in 24,6% of the subjects, mainly for Cluster B personality disorders; 83% of subjects reported GAF values ≥ 61. Between-group differences regarding psychiatric coexisting problems did not differ significantly.

According to our results, we found a higher levels of Axis I and II psychiatric coexisting disorders in patients with a GD diagnosis than the general population. For us, these disorders are often a psychological reaction to GD condition, and rarely a contraindication for SRS, if the patient is under good psychopathological control. These coexisting conditions should be optimally managed prior to, or concurrent with, treatment of Gender Dysphoria, as confirmed by the WPATH International Standards of Care.

The lack of comparison before and after SRS is the main shortcoming of this study, nevertheless this has been a significant opportunity to investigate the socio-demographic features and the prevalence of psychiatric coexisting disorders in our patients before SRS. Our preliminary data on prevalence of psychiatric coexisting disorders before and after SRS in trans women show that presence of past mental health concerns does not adversely affect the post-operative outcome.

Our sample does not represent all transgender persons, but only the subjects with a GD diagnosis seeking for professional treatment, according to Standards of Care.

# Gender identity development in children and young people: A systematic review of longitudinal studies

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Hannah Stynes*** [1], ***Georgina Mann*** [2], ***Veronica Ranieri*** [1], ***Talen Wright*** [1], ***Una Masic*** [2], ***Claudia Zitz*** [2], ***Eilis Kennedy*** [1]

***1.*** *Tavistock and Portman NHS Foundation Trust,* ***2.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust*

**Background**

This review formed part of a multiphase research project designed to explore outcomes and predictors of outcome in children and young people referred to gender identity development services in the UK.

The visibility of young people with diverse gender identities has increased exponentially in recent years, accompanied by growing volumes of referrals to specialised gender services. This has reinforced the need for providers to accommodate new service users in a timely manner whilst also providing ethical, evidence based care. Accordingly, the body of research informing best practice is continually developing.

Prospective longitudinal research is of particular value, as it facilitates understanding of developmental trajectories and outcomes related to intervention and support. Thus far, no systematic review has been conducted looking at these types of studies with young people. The aim of the present study was to review the characteristics and key findings of these studies, describe measurement tools and identify ways to improve the rigour of future methodological approaches.

**Methods**

We systematically searched Embase, Medline, PsycInfo, PsycArticles and Science Direct, and manually searched journals and reference lists for peer reviewed literature in the English language.

We included prospective longitudinal studies which measured children and young people of <18 years at baseline and were published between January 2000 and May 2018. Excluded were retrospective, cross-sectional, experimental and case studies.

We extracted data on study characteristics including aims, study setting, recruitment method, sample size, age range at baseline and follow up, diagnostic criteria applied, demographics, variables assessed, and information on follow up. Additionally, the measures used in these studies to assess gender and psychosocial outcomes were presented.

A quality assessment tool was also applied.

**Results and Conclusions**

After initial searching, 3096 records were retrieved. Following screening and eligibility checks 14 papers describing 12 prospective studies were selected for inclusion.

Studies were conducted in 5 countries, mainly utilising small clinically referred samples of children diagnosed with Gender Identity Disorder (DSM-IV-TR and earlier). Few studies included very young children (<8yrs) and length of follow up varied considerably. Outcomes of interest included gender identity, sexual orientation, emotional and behavioural functioning, and psychiatric issues[EK1] . Whilst there was some consistency in the use of measurement tools, there are likely to be issues with validity given recent changes to DSM & ICD.

Overall, the review found a need for innovation in methods of following up gender variant children and young people.

# The quality of body image in a sample of trans women and biological features: effects of the gender affirming hormonal treatment.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Chiara Michela Crespi*** [1], ***Domiziana Magistri*** [1], ***Fabio Lanfranco*** [1], ***Paolo Riccardo Brustio*** [2], ***Giovanna Motta*** [1]

***1.*** *CIDIGEM (Turin University Hospital Gender Team - Italy),* ***2.*** *NeuroMuscularFunction | Research Group School of Exercise and Sport Sciences, Department of Medical Sciences, University of Torino*

**Background**

In gender dysphoria (GD) most diseases origin from the experienced feelings toward one's own body and particularly the gender identity is not congruent to the birth assigned sex.

Thus, the sexual physical characteristics are perceveid as not congruent to the gender experienced.

The aims of this retrospective study were: 1) to assess the effect of gender affirming hormonal treatment and of anthropometric and clinical parameters (hormonal levels, Body Mass Index (BMI), breast development…) on the quality of body image and 2) to evaluate the quality of the body image before the beginning of continouos gender affirming hormone treatment (T0) and 8-12 months afterwards (T1).

**Methods**

The sample was composed by 51 trans women who attended the University Hospital Gender Team of Turin (CIDIGeM) requesting a transition program and genital reconstructive surgery.

Every subject filled the WHOQOL-100 questionnaire before the gender affirming hormone therapy and at least 8 months afterwards to evaluate the quality of body image. The WHOQOL- investigated some specific areas of body satisfaction such as self-esteem, sexual satisfaction and in particular the body image in order to be able to draw conclusions on how much hormone therapy could improve this condition.

**Results and Conclusions**

Preliminary data showed that there are significant differences between T0 and T1 in all subscales, in particular in the body image subscale. No significant relationship in quality of the body image was found in subjects who performed also surgical procedures. In particular subjects who underwent the augmentation mammoplasty did not show a better body image quality than those who did not.

in conclusion, these preliminary data suggest that the gender affirming hormone therapy seems to be the main factor that alleviates gender dysphoria and improves the quality of body image.

# Suppressing puberty by GnRHa: Unresolved concerns

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Heino Meyer-Bahlburg*** [1], ***Christoph Anacker*** [2], ***Walter Bockting*** [2], ***Christine Denny*** [2], ***Anke Ehrhardt*** [2]

***1.*** *NYS Psychiatric Institute & Vagelos College of Physicians & Surgeons of Columbia University,* ***2.*** *NYS Psychiatric Institute & Columbia University*

**Background**

Puberty suppression, preferably by Gonadotropin Releasing Hormone Analogues (GnRHa) has become a standard treatment for early adolescents diagnosed with gender dysphoria (GD) (Hembree et al., 2017; Lopez et al., 2018). Follow-up studies agree that the treatment is effective regarding physical outcomes (Schagen et al., 2016; Klaver et al, 2018) and that individuals dagnosed with GD react very favorably, with reduction of behavioral/emotional problems and depression as well as improvement in global functioning (Chew et al., 2018).

As the adolescent brain is still sensitive to the organizational effects of sex steroids (Sisk, 2017) and has been shown to undergo significant reorganization during puberty (Giedd et al., 2015), the question arises whether puberty suppression lets the individual miss this sensitive period of brain reorganization, and what the long-term consequences may be. This paper is intended to summarize the current status of evidence for indicators of adverse side effects of puberty suppression on brain development and to identify related research needs.

**Methods**

This review draws on publications (found via a systematic search of PubMed) concerning long-term aftereffects of puberty suppression in non-human mammals and in individuals with central precocious puberty (CPP) or GD. Primary measures of adverse GnRHa-treatment outcomes of interest include structural and functional brain imaging variables as well as indirect indicators of such, e.g., selected neuropsychological findings.

**Results and Conclusions**

Animal models: Studies of the effects of prolonged GnRHa treatment in juvenile sheep have shown sex-specific impacts on emotion and behavior regulation (Wojniusz et al., 2011), impairment of long-term spatial memory (Hough et al., 2017a) which persisted after GnRHa discontinuation (Hough et al., 2017b), sex-specific effects on gray-matter and amygdala volume (Sex on Brain European Research Group - SOBER, et al., 2013), and on sex-biased gene expression of the amygdala (Nuruddin et al., 2013).

Children with CPP: Two modest-sized studies showed impairment of Wechsler IQ of about ½ standard deviation, affecting especially the Performance IQ (Mul et al., 2001; Wojniusz et al., 2016; Hayes, 2017).

Adolescents with GD: A case study showed a significant drop in working memory, which did not reverse after GnRHa treatment ended (Schneider et al., 2017). In a study of a small sample, GnRHa treatment did not affect executive functioning in terms of the Tower-of-London task (Staphorsius et al., 2015).

In conclusion, the very limited findings from sheep studies as well as from small human samples raise significant concerns about possible long-term adverse side effects of prolonged GnRHa treatment on brain development. Urgently needed are: (a) systematic studies of GnRHa effects on the developing brain in animal models that are more closely guided by the evidence regarding brain organization during puberty; (b) corresponding (preferably prospective) studies of pertinent behaviors and underlying brain structure and function in human clinical samples undergoing GnRHa treatment.

# From preventing isolation to promoting social relations: a play therapy group for gender diverse children.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Chiara Baietto [1], Laura G. Terrana [1], Filippa D. Campagna [2], Angela Caldarera [3], Benedetto Vitiello [2]***

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**Background**

Within the Pediatric Hospital Regina Margherita (Torino) there is a specialized center for gender diverse children and their families. Our model of care is characterized by a multi-professional, supportive approach. Gender diverse children may experience social difficulties, from isolation to rejection and victimization (Menvielle, 2012). Among our work tools, we offer a group activity for children, aimed at encouraging social interaction and fighting the feeling of loneliness. Since 2016 we have been running a play therapy group involving children referred to our clinic. We will thus present the pilot project, and the preliminary results observed in a group of children from October 2017 to March 2019.

**Methods**

A child psychiatrist assesses if the group activity is suitable for the child, and invites him/her, upon consent of the parents, to participate. The group is open to their siblings as well. This project is the result of an art therapy group started in 2016, monitored by the NPI doctors, psychologists, educators, whose activities involved the use of clay. The project grew over time. In 2017, in agreement with the participants, the main activity of the group was changed. Until now, ten children (five being assigned female at birth and five male), aged 4-12, have taken part in the project. All children attend school, two of them adopting cross-gender clothing. Half of the children reported feeling very isolated and being harassed from peers outside the group. One child reported anti-conservative ideation and another one committed suicide attempt. Considering that the main aim of this activity is to support social interaction in order to prevent or decrease social difficulties, we chose to set a process evaluation strategy focused on these dimensions. This was done by using a qualitative approach (a short semi-structured interview with the child about the group and the experience of social interactions within and outside the group) and integrating this with the use of quantitative measures (the Social Problems and Peer Relation Scales of CBCL, and the PED-QL). The data collection is ongoing.

**Results and Conclusions**

In 2016 the art therapy workshop involved the use of clay, encouraging the children to invent and articulate a story. Each child invented their character's storyline and appearance. In 2017 the individual storylines were woven together into a general story. This was later turned into a book and finally turned into a short film, that was watched with the families in September 2018. The activity has regularly taken place every two weeks with a two-hours session. No dropouts occurred.

As regards the results, for the quantitative measures data collection is in progress, and we will have a first set of data in March 2019; during the short semi-structured interview the children reported a feeling of inclusion, a higher confidence in the possibility of experiencing and building good relationships with others. This pilot experience promises to be an important opportunity of individual development and promotion of well-being for gender diverse

children and their families.

# Assessing capacity to consent in trans youth with learning difficulties.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Stephanie Darroch*** [1], ***Fiona Lambert*** [1]

***1.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust*

**Background**

The decision to begin on medical pathways such as hormone blocker treatment or gender affirming hormones can have potential lifelong consequences for a young person. For example, some of the effects of hormone treatment such as changes to voice or development of breast tissue can be irreversible. And treatment pathways can have a permanent impact on fertility. Therefore, it is essential that young people can demonstrate the ability to give informed consent to treatment pathways. There are concerns that the ability to give informed consent may be compromised in young people who present to services with learning difficulties. A review of studies (Goldsmith et al, 2008) suggests that capacity to consent is greater in people with higher cognitive ability and verbal skills. As such it may be beneficial to include an assessment of cognitive functioning when assessing the capacity to consent in trans youth with learning difficulties.

**Methods**

This presentation will discuss the ethical, legal and practical implications of assessing the capacity to consent in trans youth with learning difficulties. These issues will be discussed in relation to two case studies of young people who presented to our service. Both had a documented history of learning difficulties. However, there was little information in the referral to our service about the extent of these difficulties. A cognitive assessment using the Weschler Abbreviated Scale of Intelligence was carried out to highlight the relative strengths and weaknesses in cognitive performance for each. The results of the assessment and the implications for informed decision making are discussed.

**Results and Conclusions**

Assessing capacity to consent to treatment can be a complex process in young trans people with learning difficulties. Including an assessment of people's cognitive strengths and weaknesses can help in assessing the capacity to consent in trans youth with learning difficulties.

# Being Kind of Different

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Laura Charlton*** [1], ***Tom Matthews*** [1], ***Jo Charsley*** [1]

***1.*** *Tavistock and Portman NHS Foundation Trust*

**Background**

Identity development for young people is markedly affected by social experiences and good mental health is associated with a sense of feeling connected to others. Compassion-focused therapy (CFT) explores how perceived and anticipated social rejection can create shame-based difficulties with far-reaching consequences, affecting the way in which young people relate to themselves and others. This poster will outline how a compassion - focused framework could be useful in understanding some of the difficulties that face gender diverse young people.

**Methods**

The poster will outline clinical themes and very brief case examples to demonstrate the particular applicability of using the CFT approach within the context of gender diversity. We will consider how to use this approach in a contextually sensitive way.

**Results and Conclusions**

Compassion-based interventions can be considered for use with gender diverse young people as a way of understanding the development and impact of shame-based difficulties. Through the development of a 'compassionate mind', young people are supported to interact with the world from a compassionate position, so to respond the sense of internal and external threat they experience.

# What it's all about? The influence of gender identity and treatment progress on the desire to participate in decision-making, psychotherapy and aftercare of trans persons.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Toby Mayer*** [1]***, Andreas Koehler*** [2]***, Jana Eyssel*** [2]***, Timo Nieder*** [2]

***1.*** *Friedrich-Schiller-Universität Jena,* ***2.*** *University Medical Center Hamburg-Eppendorf*

**Background**

Transition-related treatments are increasingly being offered by interdisciplinary transgender healthcare centres (ITHCCs), which focus on patient satisfaction. Updates to manuals and treatment guidelines which emphasis patient self-determination, relaxed requirements for psychotherapy and recognition of nonbinary and genderqueer (NBGQ) identities mean increasing numbers of trans individuals with a wide range of gender identities and treatment desires are presenting for treatment at ITHCCs. However, questions are raised as to how trans individuals view their role in decision-making, psychotherapy and aftercare treatments.

Additionally, research in the field of transgender health is also being revamped to reflect the numerous transition pathways associated with various genders, including the creation of a new measurement tool called the individual treatment progress score (ITPS; Köhler et al., 2017).

Objective of the current study was to gain insight into how trans individuals may differ in their desire to participate in decision-making processes, psychotherapy, and aftercare depending on the treatment progress and gender identity to improve patient satisfaction at ITHCCs and validate functionality of the ITPS.

**Methods**

Data regarding transition progress and 13 treatment-related desires were collected via an online study from a non-clinical sample consisting of 415 trans individuals (52% assigned female at birth), aged 16-76 (M = 38.12). Of participants, 18.3% identified with various NBGQ identities. Participants had progressed 60.77% (*SD* = 35.21) through their transitions at the time of data collection.

Main outcome measures were differences in participants' desire to participate in decision-making processes, psychotherapy, and aftercare according to transition progress (no treatment experience, early vs. later stages of transition as measured by the ITPS) and gender identity (male vs. female sex assigned at birth and binary vs. NBGQ gender).

**Results and Conclusions**

All participants ($p$ = .005), especially participants assigned male at birth ($p$ < .001), significantly differed in their desired level of participation in decision-making, with individuals without treatment experience desiring less participation in decision-making processes regarding aspects of their treatment. NBGQ participants assigned male at birth in the early stages of transition had significantly more desire for psychotherapy during the transition process ($p$ = .008) than participants of the same identity in later transition stages. All participants ($p$ = .003) and the binary participants in particular ($p$ = .003), significantly differed in their desire for aftercare treatments at ITHCCs, with individuals without treatment experience indicating a stronger desire.

This study highlights the changing desires for participation in decision-making, psychotherapy and aftercare of trans individuals at various stages of the transition process, particularly at treatment start, and based on gender identity. Health professionals working at ITHCCs should expect a wide range of desires from trans patients and ad-

just treatment approaches accordingly to increase patient satisfaction. Additionally, results confirm the superiority of the ITPS for measuring transition progress.

# The U.K endocrine pathway of care for young transgender patients. The A - Z as told by the gender identity nurse specialists

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Paul Carruthers*** [1]

***1.*** *The endocrine gender development service - Leeds Teaching Hospitals*

**Background**

The Leeds Teaching Hospitals Northern Gender Identity Development Clinic is a supra regional centre for young people with a diagnosis of gender dysphoria. The service is jointly run with the Tavistock and Portman NHS Foundation Trust and University College London Hospital NHS Foundation Trust. We provide a highly specialised service for young people (up to 18 years of age) who are experiencing gender dysphoria and who have major concerns about their physical development through puberty. The young people are referred to the endocrine service following extensive assessments undertaken by the Tavistock Team. This poster will provide an insight into the service the UK provides and the extensive support the clinical nurse specialists input into the lives of these patients and their families.

**Methods**

/

**Results and Conclusions**

Viewers of the poster will learn about biochemical testing/parameters, bone scanning, fertility options along with the treatment pathway the UK NHS provides

# Recalled pre-school activities among adults diagnosed with gender dysphoria who seek gender affirmative treatment – an Iranian study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Sepideh Kazemi*** [1], ***Mostafa Sadr*** [2], ***Behzad Sorouri Khorashad*** [2], ***Ali Talaei*** [2]

***1.*** *Psychiatry and Behavioral Sciences Research Centre, Mashhad University of Medical Sciences,* ***2.*** *Mashhad University of Medical Sciences*

**Background**

The aim of this study was to examine the association of recalled childhood gender nonconformity and gender dysphoria.

**Methods**

Pre-school Activities Inventory was used to assess childhood play behavior in 72 trans women, 92 trans men, 100 control women, and 75 control men.

**Results and Conclusions**

Trans women scored as significantly more feminine than control women, whereas a non-significant difference was found between control men and trans men: the latter recalled more masculine play behavior. The results show that transgender people, during childhood, exhibit great amounts of nonconforming play behaviors. This nonconformity can be a source of stigma, victimization, and mental distress; hence, parents, teachers, and care givers should be familiar with childhood gender nonconformities and be prepared to deal with them.

# Preferences in gender affirming treatment and fertility preservation among trans people in Sweden

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Lovisa Rasmusson*** [1], ***Ulrika Beckman*** [2], ***Attila Fazekas*** [3], ***Louise Frisén*** [4], ***Lotta Sandström*** [5], ***Nils Thelin*** [6], ***Alkistis Skalkidou*** [7], ***Fotios C Papadopoulos*** [1]

***1.*** *Department of Neuroscience, Psychiatry, Uppsala University, Uppsala, Sweden.,* ***2.*** *Lundström Gender Identity Clinic, Södra Älvsborgs Hospital, Alingsås,* ***3.*** *Gender identity service, Department of psychiatry, University hospital, Lund, Sweden,* ***4.*** *Department of Clinical Neuroscience, Karolinska Institutet, Stockholm,* ***5.*** *Department of clinical sciences, Psychiatry, Umeå University,* ***6.*** *Division of Psychiatry, University Hospital. Linköping, Sweden,* ***7.*** *Department of Women's and Children's Health, Uppsala University*

**Background**

The number of people seeking gender affirming treatment has increased profoundly in recent years. A younger age at presentation and a higher prevalence of a non-binary gender identity are reported among those seeking gender affirming treatment. Moreover, a major legislative change took place in Sweden in 2013, when the sterilization was no longer obligatory in order to apply for legal sex change. Little is known about the treatment choices of trans people seeking gender affirming treatment in Sweden after 2013. In this study, the aim was to describe the preferences in gender affirming treatment and examine their association with sociodemographic factors.

**Methods**

Data was obtained from the Swedish Gender Dysphoria Study (SKDS), a multicenter study where trans patients 15 years or older with an ongoing health care contact for gender affirming therapy are asked to participate. The participants are asked to fill out several web-based surveys in a longitudinal setting. 196 people with baseline data were included. Twenty people having already undergone gender affirming surgery were excluded from the analyses with a surgical outcome measure, leaving 176 for further analysis. We defined individuals stating that their preferred pronoun was "they" ("hen" in Swedish) or other than "she, he or they" as having a nonbinary gender identification.

**Results and Conclusions**

Our study population consisted of 73 birth assigned males (aM) (37%) and 123 birth assigned females (aF) (63%). 97 % aM patients stated that they wanted to have or already had gender affirming hormone treatment, while the respective percentage for breast augmentation was 56 %, for vaginoplasty 89 %, for other feminizing surgery 86 % and 84 % for fertility preservation. Among female-assigned aF, the respective percentages were 98 % for hormonal treatment, 95 % for mastectomy, 65 % for trans masculine genital surgery, 67 % for hysterectomy and/or salpingo-oophorectomy, 19 % for other trans masculine affirming surgery and 26 % for fertility preservation.

Non-binary pronoun (n=21) was associated with a lower desire for top surgery (OR=0.21, 95%CI 0.06-0.75) and external genital surgery (OR=0.12, 95%CI 0.03-0.44). Gynophilic (OR=4.40, 95%CI 1.56-12-45) and ambiphilic (OR= 11.14, 95%CI 1.78-69.84) sexual preferences were linked to higher desire for external genital surgery. Being more content with physical appearance was associated with lower desire for top surgery (OR=0.98, 95%CI 0.95-1.00). Less social support was associated to lower desire for internal genital surgery (OR=0.37, 95%CI 0.16-0.86). Those who had come further in their social transition had lower desire for other types of surgery (OR=0.26, 95%CI 0.09-0.74). Already having biological children was associated with lower desire for fertility preservation (OR=0.13, 95%CI 0.03-0.64).

**Conclusions**

The majority desired both hormonal and surgical gender affirming treatment. More aM desired fertility preservation. Our findings support the idea that more trans people would benefit from feminizing facial surgery funded by public health care. A nonbinary gender identity and certain sociodemographic characteristics were associated with a lower interest in gender affirming treatment.

# On the way to trans-inclusive healthcare and free legal gender recognition in the Central Asia

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Irina Karagapolova*** [1], ***Irina Lenskaya*** [2]

***1.*** *Labrys LGBT NGO, Kyrgyzstan,* ***2.*** *Kazakhstan Republic Mental Health Center*

**Background**

For the recent times the situation in the Central Asian countries Kyrgyzstan and Kazakhstan was the following. There was no any official regulation of the medical-social care for transgender people in Kyrgyzstan. In Kazakhstan such regulation existed but with some discriminative requests according legal gender recognition. In the last several years due to the efforts of trans community in collaboration with alies from healthcare system the situation is changing rapidly.

**Methods**

In the frame of trans advocacy the partnership of trans activists and Ministry of healthcare representatives is formed in Kyrgyzstan and Kazakhstan. Due to that partnership the Standards of medical-social care are worked out and confirmed in Kyrgyzstan. That Standards not only regulate care process but alleviate access to legal gender recognition also. Such achievments lead to initiation of the revision of rather discriminative regulation in the neighbouring Kazakhstan. Now the working group exists, which is forming the new regulation of care in Kazakhstan. In plans there is to change the law which demands the obligate surgical interposition.

**Results and Conclusions**

Now in Kyrgyzstan and Kazakhstan there are some achievments in medical-social care and some chellenges also. In Kyrgyzstan medical-social care regulation appeared but there is no training for practical specialists. Such issues should be incorporated into the educational programs. In Kazakhstan there must be installed new regulation of care. And specialists of healthcare system are faced with the task to influence the legislation changes and to exclude the obligatory surgical interposions for legal gender recognition in Kazakhstan.

# All treatments from a single source or rather spread over several locations: Does the setting make a difference? A comprehensive review

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Andreas Koehler*** [1]***, Peer Briken*** [1]***, Timo Nieder*** [1]

***1.*** *University Medical Center Hamburg-Eppendorf*

**Background**

To be able to live according to their gender identity and to prevent or minimise gender incongruence (GIC) and/or gender dysphoria (GD), transgender individuals might require a multidisciplinary set of gender-affirmative medical treatments (GAMT). Therefore, transgender healthcare (THC) is primarily focusing on medical interventions (e. g., hormone treatment, breast and genital surgery) in order to reduce GIC/GD and to improve quality of live as outcomes.

Cohort studies, case-control-studies or other follow-up studies assessing the effect of GAMT hardly analysed a potential effect of different settings (e. g., if patients received all treatments from a single source or rather spread over several locations) on the outcome. This is especially relevant since there are both THC services with a decentralized structure (e. g., selected GAMTs are conducted by different medical institutions) and specialised clinics with a centralized, interdisciplinary THC structure (e. g., GAMTs are provided from a single source).

First empirical analyses showed substantial differences between transgender individuals within centralized and decentralized THC structures, e. g., regarding substance abuse (Horvath, et al., 2014). However, there is a clear lack of systematic research exploring the effect of the THC setting in which GAMT are provided on the outcome. From a clinical point of view, GIC/GD is considered rare, with high expectations that are claimed towards THC. Therefore, THC is expected to be based on trained healthcare professionals with scientific expertise. Moreover, networking between healthcare providers, patients and their loved ones, and support groups is often demanded as a method of quality assurance (Eyssel et al. 2017). Centralized THC structures seem to more likely meet those requirements and are more easily able to ensure a highly sophisticated THC system.

**Methods**

The present study aims to review the empirical literature of follow-up studies with a special focus on information about the THC setting: All treatments from a single source or rather spread over several locations? Therefore, the authors search electronic databases (Medline, Embase, PsycInfo, Web of Science and Scopus) for follow-up studies (and reviews on follow-up studies) with a special focus on information about the THC setting.

**Results and Conclusions**

A potential effect of the THC setting on the various outcome measures of the included studies will be analysed. Implications for the improvement of THC settings will be discussed.

# Counselling transgender clients- specific cultural and ethic issues from Croatian perspective

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Iva Žegura*** [1]

***1.*** *University Psychiatric Hospital Vrapče*

**Background**

Past and present status of LGBT issues in Croatian psychological profession reflects this invisibility of LGBT persons in society more generally. Until 2000, topics related to sexual health, gender identity and sexual orientation, together with issues concerning human rights were almost never mentioned during university undergraduate and postgraduate education and therapy training. There are no specific guidelines aimed toward an affirmative psychological approach from the side of professional association and professional chamber. The stigma affecting minorities based on sexual orientation and gender diversity is mentioned in very few (if any) handbooks, reviews, research papers on the health and mental health of LGBT people in Croatia.

**Methods**

The examples of the impact of the specific cultural background and trans-phobia will be given through examples form the clinical psychologist's practice with transgender clients in Croatian mental health system.

**Results and Conclusions**

The vacuum that currently exists in the Croatian scientific literature is often filled with popular universal answers or plain advice, but more dangerously with quasi-scientific interpretations based on personal prejudice of professionals. This approach causes great damage to the personality development, health, well being and general adaptive functioning of people who are affected by these practices. The effect is doubled as these quasi-scientific approaches have a deleterious impact on the psychological profession. There os a clear need for more integrative and comprehensive scientific research on human sexuality and gender identity. Psychologists should be familiar with scientific facts, evidence-based practices and the professional position on sexuality and gender identity issues. The continuous education of professionals should be ensured as to provide adequate professional help when clients contact them with issues relating to sexual identity and/or gender identity. Professionals in particular should be very careful, responsible, competent and ethical when dealing with issues related to sexual orientation and gender diversity, which still represent a great source of polemics, although this, at least in the professional sphere, should not be the case.

# Primary care experience of gender diverse young people and their families in the United Kingdom.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Susie Green*** [1]

***1.*** *Mermaids*

**Background**

Transgender health is a relatively new area of health care and as a consequence few doctors have good knowledge of the health needs of the transgender population. This is mainly apparent at primary care level, which many people need to access in order to be referred to the appropriate gender service. In addition, with a complex and unclear process regarding shared care between gender services and primary care service, many patients find themselves in the middle of a very unclear pathway of care.

**Methods**

**Method:** A questionnaire survey developed specifically for this project was sent to parents and young people who are members of the parents and youth groups provided by Mermaids.

**Results and Conclusions**

A total of 76 people replied the survey questionnaire. Most of the respondents (93%) were parents of transgender young people (76.3 % (n=58) 15.7% were transgender people of 18 years or above). Five young people under 18 (6.5%) also responded the questionnaire. The experience of 34 people (44.7%) was described as positive and of 22 (28.9%) as negative. The rest of the respondents had mixed experiences. Some of the comments related to their lack of experience in transgender health. Shared care with their gender clinic was identified as one of the main issues. A total of 14 (18.4%) respondents described their GP as refusing to share their/their child's care, 11 (14.4%) responded described their GP granting partial shared care and 18 (23.6%) of them explained that their GP was happy to provide shared care with their gender clinic.

The shared care requested related to hormone blockers (23; 30.2%), cross sex hormones (8; 10.5%) and both (14; 18.4%). Those having positive experiences with their primary care GP described that although their GP was not knowledgeable about transgender health, they were very willing to learn, they searched for information, and they got information from Mermaids. Negative feedback related to not wanting to share care with a private clinician; referring them to child and adolescent mental health services first; not using preferred name; and/or not believing that there was a need to refer them to the gender service.

Unanimously most respondents would like their GP to have more knowledge about transgender health with only 13% (n=10) of respondents saying that their GP had some knowledge of transgender health.

**Conclusion:** Clarity regarding pathways of treatment prescription for gender diverse young people is necessary in the NHS. Education to primary care doctors is vital in order to improve the care of gender diverse young people and their families. Medical schools should consider adding transgender health as part of their curriculum.

# Psychopathology tied gender dysphoria with environmental distress conditions

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Laura Gallardo [1], Emilia Gómez Hoyos [1], Maria Antonia Maniega Rubio [1], Esther Delgado García [1], Aurelia Villar Bonet [2], Esther Gómez- Gil [3], Ruth González Collantes [1], Fernando Uriben Ladrón De Cegama [1], Daniel De Luis Román [1]***

***1.*** *Universitary Clinic Hospital of Valladolid,* ***2.*** *Univertsity Clinic Hospital of Valladolid,* ***3.*** *Hospital Clinic de Barcelona*

**Background**

**Introduction:** Nowadays, the psychological evaluation in gender dysphoria is being questionable. Some members of the transgender associations refered not to need this kind of evaluation and psychological follow-up; but the endocrinologist need to know that the gender change is a real desire and not a delusion.

On the other hand, in clinical practice we detected that an important percentage of patients had presented environmental distress conditions that could influence the process of gender affirmation and increase the possibility of presenting psychopatology during this change.

**Objective:** To describe the psychopathology and the enviromental distress conditions of the transgender population.

**Methods**

**Material and Methods:** We undertook a retrospective study of all patients attended by Castilla and Leon Gender Unit from 2015 to 2018. We evaluated sex assigned at birth, desired gender, environmental stress conditions and psychological variables.

**Results and Conclusions**

**Results:**42 patients. Age: from 10 to 55. trans women: 19 and FTM trans men: 23.

Depression: 15 (35.71%) (trans women: 8; trans men: 7).

Anxiety: 40 (95.24%) (trans women: 19; trans men: 21).

Behaviour disorders: 13 (30.95%) (trans women: 6; trans men: 7).

Suicidal attemps: 4 (9.52%). Suicidal ideas: 4 (9.52%)

Environmental distress conditions: 32 (76.19%) sexual abuse/assault: 2; social assault:4; domestic violence: 11, divorce: 3; death of close family members: 6

**Discussion:**

Regarding with the reference population without gender incongruence, the incidence of environmental distress conditions were higher. These environmental distres could predispose to an increased risk of psychopathology associated during the gender affirmation process. Therefore, we consider it necessary to evaluate psychology before and during the sex reassignment process.

# Combined hysteroannessiectomy and mastectomy in trans women: complication rates, operative times and relations with hormonal treatment. Single centre experience.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Tommaso Dragone*** [1], ***Roberto Zizzo*** [2], ***Luca Petruzzelli*** [1], ***Paolo Petruzzelli*** [3], ***Paolo Bogetti*** [4], ***Elisabetta Baglioni*** [5], ***Michela Chiadò Fiorio Tin*** [2], ***Giovanna Motta*** [6], ***Fabio Lanfranco*** [7]

***1.*** *Department of Emergency Surgery, Città della Salute e della Scienza, University Hospital, Turin.,* ***2.*** *Gynecology and Obstetrics, Department of Surgical Sciences, Città della Salute e della Scienza, University Hospital, Turin.,* ***3.*** *Gynecology and Obstetrics, Department of Surgical Sciences, Città della Salute e della Scienza, University Hospital, Turin.CIDIGEM (Turin University Hospital Gender Team - Italy),* ***4.*** *Department of Reconstructive and Aesthetic Plastic Surgery, Città della Salute e della Scienza, University Hospital, Turin. CIDIGEM (Turin University Hospital Gender Team - Italy),* ***5.*** *Department of Reconstructive and Aesthetic Plastic Surgery, Città della Salute e della Scienza, University Hospital, Turin (Italy).,* ***6.*** *Division of Endocrinology, Diabetology and Metabolism Department of Medical Sciences, University Hospital, Turin.,* ***7.*** *Division of Endocrinology, Diabetology and Metabolism Department of Medical Sciences, University Hospital, Turin on behalf of CIDIGEM (Turin University Hospital Gender Team - Italy)*

**Background**

*SRS*(*Sex Reassignment Surgery*) is an important step for *trans women*, since it is known to help the patients to live more easily in their gender role and to significantly increase quality of life, but it cannot disregard a previous minimal period of hormonal tretament. Nowadays, there are no precise indications regarding SRS' procedures for trans women. Furthermore, such surgery is burdened by high complication and re-intervention rates: long-term testosterone administration could affect some *SRS'*aspects for subjects who decide to then undergo surgery.

**Methods**

We have considered a sample of 60 transwomen referring to CIDIGeM who underwent hysteroannessiectomy and mastectomy between 2004 and 2018. We then collected data about 1) surgical technique 2) complications 3) re-interventions 4) operative times 5) duration of postoperative hospitalization. We have then searched eventual correlations with the following variables: duration of Testosterone treatment, pre-surgical serum Testosterone and Oestradiol levels, age and BMI.

**Results and Conclusions**

**Results.**Median age at surgery was 30 years (interquartile range: 24-37,5), median duration of androgenic therapy before *SRS*was 32 months (IQR: 27,25-38,75) and median BMI 23,91kg/m2 (IQR: 21,8-28,05).

Combined procedure of hysterectomy, bilateral annessiectomy and mastectomy in one single operative setting was performed in 54 trans women (90%) with a median time of 290 min (IQR: 232,5-335). The median postoperative stay was 5 days (IQR: 4-7). The majority of patients (97%) underwent *laparoscopically assisted vaginal hysteroannessiectomy*(LAVH) with complication rates of 0% (less than in the literature) and median operative time of 80 min (IQR: 61,5-90). Two main mastectomy techniques were performed (50% *Free Nipple Graft*and 37% *Round Block*) without significant differences regarding complications. The most frequent early complication was breast hematoma (9 cases, 17%, according to the literature), 31 patients (57%) presented late complications, mostly of aesthetic nature, such as adipo-cutaneous excesses (35%), scar alterations (16,5%), *minus*(10%), nipple necrosis (7%) and 1 abscess. 34 patients (63%) required reoperation for early (7%), late (46%) or both type of complications (9%). Finally, 48% of the patients later performed urological reconstructive surgery. Mastectomy duration was found longer than literature's

data, with a significant correlation with higher BMI (p=0,01); hematomas' incidence showed a weak correlation to lower BMI (p=0,04) and late complications to higher BMI (p=0,05). No significant relations with duration or levels of hormonal treatment were found.

**Conclusions**. Combined histeroannessiectomy and mastectomy in a single operating session is confirmed as safe, feasible and valuable procedure for trans women paying particular attention to mastectomy procedure and aesthetic results that are the main cause of reoperation.

On the basis of data collected Testosterone long-term administration do not affect in a significative way nor the duration nor the outcomes of SRS surgeries, in which individual characteristics (BMI) seem to play a pivotal role.

# Patient Reported Outcome Measures (PROMS): Trans Male people have improved emotional quality of life after chest contouring surgery

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Chloe Wright*** [1]***, Grit Dabritz*** [2]

***1.*** *Royal Bolton Hospital,* ***2.*** *North Manchester General Hospital*

**Background**

The aim of this study was to examine whether masculinising chest contouring surgery (CCS) leadsto an improvement in Health-related quality of life (HRQoL) in trans men. There are no published studies that have quantified the direct impactof CCS on HRQoL in this group. The Short Form 36 (SF-36) is a widely validatedgeneric measure of HRQoL. We have used the SF-36v2 acute recall survey toassess the impact of CCS on HRQoL in trans men.

**Methods**

A prospective longitudinal cohort study of all consecutive trans male patients having CCS over a six-month period was performed. NRES ethical approval was obtained. The SF-36 was administered pre-op and at 2-4 weeks post-op. Data was collected on age, body mass index (BMI), surgical technique and weight of breast tissue excised. SF-36 scores were compared using the paired t-test.

**Results and Conclusions**

30 patients were recruited. The mean age and BMI were 23 years (SD:0.78) and 24 kg/$m^2$(SD: 0.65) respectively. Surgical technique: 24 (80%) dermal flaps, 5 (17%) periareolar and 1 (3%) nipple-grafts. The median unilateral weight of breast tissue excised was 281g (range: 24-671g).

Post-op(median 23 days, IQR 2 days), statistically significant improvements were seen in the SF-36 domains of General Health(p=0.011), Social Functioning (p=0.004),Vitality (p=0.001), Role emotional (p=0.029) and Mental Health (0.008). No deteriorations were seen in any domains. There was a statistically significant improvement in overall emotional HRQoL of 15.5 points (scale: 0-100, S.D: 10.7,p=0.005) and no deterioration in physical HRQoL (p= 0.65).

Conclusions

This data showsthat masculinising CCS leads to significant improvements in the general andmental health, social functioning and vitality as well as in emotionalwell-being in trans men in the early post-op period, despite the physicalimpact of recent surgery. Longer term results are required to examine the enduranceof these improvements and to support causation between CCS and improved HRQoL.

# None fits all – A single centre surgical experience of non-binary persons

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Grit Dabritz*** [1], ***Kathryn Williams*** [1], ***Ioannis Ntanos*** [1]

***1.*** *North Manchester General Hospital*

**Background**

Over the last years there has been an increase in the referrals of non-binary persons for defeminising chest surgery. This is a heterogeneous group of people who have different needs and requirements from chest surgery. This overview is to summarise our experience and demonstrates the factors in our assessment process.

**Methods**

A prospective date collection with review of notes regarding presentation, used names and pronouns, use of testosterone and expectations from surgery

**Results and Conclusions**

Twelve persons who identified as non-binary were assessed in our unit between December 2016 and October 2018. One of these now identifies as trans male and has been excluded from further analysis. Eight have had surgery, three are on the waiting list. Six who had surgery attended a six-month postoperative follow-up appointment and were satisfied with their decision to have surgery. Two did not attend. Three presented in a feminine, four in a masculine and four in an androgynous fashion. Two used their given female names, one a masculine, five a neutral and three a unisex name. Two used female pronouns (the same individuals who used their given female names), nine used neutral pronouns. Six used testosterone, some of them a reduced dose, five did not. Eight requested a male chest, two a prepubertal chest and one a completely flat chest without nipples.

All non-binary persons who returned for follow-up after having undergone chest surgery in our unit are happy with their decision at six months postoperatively. However surgical decision-making and treatment remains a challenge in this group. Surgeons cannot rely on the same factors that are considered when offering masculinising chest surgery to trans males. It requires an even closer working relationship with the referring psychiatric team to ensure that the correct surgical treatment is offered. Challenges to service provision include registration of gender and appropriate inpatient accommodation. Improved networking will help to establish standards for surgical care of non-binary persons. More data needs to be collected in order to develop a pathway for this group.

# Gender affirming surgery without urethral lengthening in transgender men. Surgical and urological outcomes.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Garry Pigot [1], Muhammed Al-tamimi [1], Jakko Nieuwenhuijzen [2], Brechje Ronkes [3], Wouter Van Der Sluis [2], Mark-Bram Bouman [1], Margriet Mullender [1]***

***1.*** *VU Medical Center,* ***2.*** *Amsterdam UMC, location VU University Medical Center,* ***3.*** *Amsterdam UMC, location VUmc*

**Background**

Transgender men generally report an improved quality of life and satisfactory sexual function after Genital gender Affirming Surgery(GAS), e.g., phalloplasty and metoidioplasty. Traditionally, one of the main goals of genital GAS in transgender men is to achieve the ability to void while standing. To enable this, the urethra has to be lengthened. Common urethral complications after neo-urethra reconstruction are urethral fistulas and strictures. These complications often lead to (multiple) reoperations and may impede the possibility to void while standing. Therefore, at the VU University Medical Center, we offer (since 2004) the possibility to undergo genital gender affirming surgery(GAS) without urethral lengthening for those patients who do not need to void while standing or do not want to bear the burden of the neourethral complications and secondary surgery . The native urethral meatus is then re-localized and a perineal urethrostomy is performed to preserve the ability to void in sitting position.

**Objective:**To describe the surgical and urological outcomes after genital GAS without urethral lengthening in transgender men.

**Methods**

A prospective cohort study of transgendermen who underwent genital GAS without urethral lengthening from January 2004 toJanuary 2018 at the VU University Medical Center, Amsterdam, The Netherlands.Surgical outcomes and urological outcomes were recorded.

**Results and Conclusions**

**Results:**Genital surgery without urethral lengthening was performed in 68 patients. Of 68 patients, no (0%) patients developed an urethral fistula and 7 (10%) patients developed an urethral meatus stenosis . Mean surgery duration was 108(±41) minutes in the metoidioplasty (MET) group, 290(±73) minutes in the anterolateral thigh(ALT) flap phalloplasty group and 218 (±42) minutes in the superficial circumflex iliac artery perforator (SCIP) flap phalloplasty group. Mean hospital stay was five days after MET, seven days after ALT flap phalloplasty and six days after SCIP flap phalloplasty.

**Conclusion:** Genital GAS without urethral lengthening in transgender men is an eligible option with lower surgical complications and good urological outcomes, favorable surgery duration and hospital stay.

# Patient satisfaction after bilateral mastectomy and chest reconstruction with double incisions using the inferior dermal flap technique

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Grit Dabritz*** [1], ***Ioannis Ntanos*** [1]

***1.*** *North Manchester General Hospital*

**Background**

Our surgical unit offers a technique of masculinising chest contouring that preserves nipple sensation in more than 60% of cases. This study aims to evaluate patient satisfaction with the appearance of the chest and scars six months after surgery

**Methods**

All patients that underwent the above-mentioned chest wall contouring technique for gender affirmation were offered to complete a satisfaction survey 6 months after their operation. The questions included: 1. Overall satisfaction 2. Scar appearance 3. Chest wall appearance fully clothed (a), with t-shirt (b) and topless (c) 4. Effect on masculinity 5. Effect on overall well-being 67 questionnaires were reviewed (66 bilateral and a unilateral mastectomy). For the first three questions there was a choice of answers between very satisfied-satisfied-little dissatisfied-dissatisfied and the last two had a 'yes' and 'no' option.

**Results and Conclusions**

Overall satisfaction was recorded as "Satisfied" or "Very Satisfied" in 66 cases (98%). Satisfaction regarding scar appearance was 10% (Satisfied) and 30% (Very satisfied). When questioned about chest wall appearance, the "very satisfied" option remained the most frequent answer, from 97% when fully clothed to 56.7% when topless. There were no "Dissatisfied" answers.

82% of participants reported an improved feeling of masculinity while 86.5% reported an improvement in their wellbeing.

**Conclusion:**

Chest wall reconstruction with double incisions (inferior dermal flap technique) appears to result in high patient satisfaction with the appearance of the chest as well as in an improvement in the feeling of masculinity and well-being. The questionnaire was offered six months after surgery and a further improvement in chest wall and scar appearance is likely once healing is complete at around 2 years post-surgery. Long term follow up is therefore recommended.

# Hematoma development site after male-type thoracoplasty for trans male ; clinical study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Toru Sakurai*** [1]

***1.*** *Gyotoku general HOSPITAL*

**Background**

Many of trans men have a strong discomfort in female breasts, trying to obtain the outline of the male type chest wall, which is the original form of yourself, by holding the breast with a band. However, it is difficult to obtain a satisfactory male-type chest wall contour only with breast compression. So, they desire plastic surgery to make the breast a male type chest wall. Surgical treatment is effective for obtaining male-type chest walls, which are their original shapes, reducing mental stress and increasing sexual happiness.For male type thoracoplasty for trans men, it is safe to obtain good results by determining the surgical method using an algorithm depending on the morphology of the breast. However, it is also clear that various complications occur at a certain rate. Among the complications, one of the most serious complications requiring reoperation is hematoma.

**Methods**

With research approval at the Okayama University Hospital Ethics Committee approval was obtained and a retrospective study was conducted (Study No. 1808-030). Twenty-seven patients who underwent male type thoracoplasty under general anesthesia diagnosed as trans men at the Okayama University Hospital gender center from 2006 to 2016, targeted 12 cases with hematoma. In the initial surgery, 277 cases, two plastic surgeons performed left and right mastectomy and nipple and areola reduction, J - VAC Reservoirs® (A Johnson &. Johnson Company) 15 Fr was inserted subcutaneously on each side After the operation, pressure cramping with chest band and tape from the chest wall was performed. There were 262 cases of group 1 and 15 cases of group 2. In 12 of 277 cases, hematoma was observed in 4.3%, group 1 was 11 cases and group 2 was 1 case.

Postoperative hematoma was observed and 12 cases requiring surgery were examined for age, BMI, history of hormone treatment, operation time,intraoperative bleeding volume, smoking history, bleeding site, time to onset of hematoma, physical examination.

**Results and Conclusions**

Postoperative hematoma was found in 12 patients (4.3%) of 227 trans men who underwent a male type thoracoplasty at our hospital. Postoperative hematoma was examined retrospectively. The time to onset of hematoma was 11.1 ± 10.2 hours on average after surgery. The main blood vessels that caused bleeding were the head side skin flap region where visual confirmation was difficult and the perforator blood vessels from the pectoralis major muscle. There was no significant difference between the onset of hematoma and the resected breast volume($P > 0.05$). And there was a significant correlation between hematoma and operation time.

# Multiple-staged buccal mucosa metoidioplasty for trans men diagnosed with gender dysphoria: preliminary results from a single center cohort study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Massimiliano Timpano*** [1], ***Marco Falcone*** [1], ***Paolo Gontero*** [1]

**1.** *Urology Departement, Città della Salute e della Scienza, Univeristy of Turin on behalf of CIDIGEM (Turin University Hospital Gender Team - Italy)*

**Background**

Various techniques may be considered to address sex reassignment surgery (SRS) in trans men diagnosed with gender dysphoria (GD). Among them metoidioplasty represents a valuable option. Urethral reconstruction represents the weakest issue of this technique.

**Methods**

From September 2016 to August 2018 a consecutive series of 8 trans men diagnosed with GD underwent a metoidioplasty in a single tertiary referral centers as the last step of a SRS. Metoidioplasty was conducted as a multiple-staged procedure: 1) urethral lengthening and dorsal buccal mucosa grafting to reconstruct the urethral plate 2) tabularization of the urethral plate, vaginectomy and scrotoplasty with rotational labia majora flaps 3) bilateral testicular prosthesis implantation. A retrospective analysis was conducted extrapolating data from the clinical records. A descriptive analysis of the surgical outcomes and PRO's was conducted. Statistical analysis was performed using STATA version 12.0 for Mac package.

Duration of surgery, intra and postoperative complications and the hospital stay were selected as variables for the surgical outcomes. PRO's were extrapolated from a 4-item "ad hoc" created questionnaire administered through a telephone interview at 1 year follow-up.

**Results and Conclusions**

A total of 8 patients were enrolled in the present study. The median age was 32 (IQR 30-39). The median BMI was 20 (IQR 19-23). The median follow-up was 14 months IQR (8-20). The median operative time resulted 70 minutes (IQR 50-80) for 1$^{st}$ step, 120 minutes (IQR 100-155) for the 2$^{nd}$ step and finally 35 minutes (IQR 28-45) for the last step. The median urethral lengthening obtained was of 3.5 cm (IQR 2-4). A tabularization of the urethral plate on a size 14 Ch stent was possible in all cases. No major intraoperative complications were detected. The median hospital stay was 2 days (IQR 2-3) for 1$^{st}$ step, 5 days (IQR 3-6) for 2$^{nd}$ step and finally 1 day (IQR 1-2) for last step. A single case of the persistence of a minor urethral fistula on a penile urethra requiring surgical excision was detected. No urethral stenosis were detected. All the patients completed the 3 stages of surgery and were therefore considered for PRO's analysis. 87.5 % of patients declared to be fully satisfied of the TPC. 87.5% would recommend the procedure to someone else and 75% would undergo the same procedure again. Erogenous sensations were perceived by all patients during sexual intercourses.

The multiple-staged buccal mucosa metoidioplasty may represent a valuable option for SRS minimizing urethral postoperative complications.

# Salvage of partial or total phalloplasty flap loss in transgender men: a retrospective study of 17 cases.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Muhammed Al-tamimi*** [1], ***Wouter Van Der Sluis*** [1], ***Garry Pigot*** [1], ***Marlon Buncamper*** [1], ***Jan Maerten Smit*** [1], ***Haye Winters*** [1], ***Mark-Bram Bouman*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

Transgender men experience a good quality of life and report satisfactory sexual function after phalloplasty. Often, transgender men express the wish to be able to void while standing and/or to be able to engage in penetrative sexual intercourse. To enable this, the urethra has to be lengthened and an erectile prosthesis implanted in the neo-phallic shaft. Examples of fasciocutaneous flaps that can be used to reconstruct a neo-phallus shaft are: free radial forearm flap(FRFF), free or pedicled anterolateral thigh (ALT) flap, fibula flap, (pedicled) abdominal flaps, groin/SCIP flap and the latissimus dorsi (LD) flap. There are multiple surgical option for urethral reconstruction; a tube-in-tube flap configuration, use of full-thickness skin grafts, buccal mucosa or use of a second fasciocutaneous flap. Possible complications of pedicled or free flap phalloplasty compromise anastomotic occlusion, due to venous, arterial or combined thrombosis, resulting in partial or total flap failure. These complications are rare, but can cause major discomfort, emotional distress and impede the possibility to void while standing and/or to have penetrative sexual intercourse.

**Methods**

Retrospective analysis of medical records of all transgender men who underwent phalloplasty from January 1989 to January 2018 at the VU University Medical Center, Amsterdam, The Netherlands

**Results and Conclusions**

179 transgender men underwent phalloplasty. Partial or total phalloplasty flap loss occurred in 17(9.4%) patients. Total phalloplasty flap failure, shaft and neo-urethra, occurred in 10 (5.6%) patients. Seven (4%) partial flap losses, shaft or neo-urethra, occurred in double flap phalloplasties of which four (1%) were neo-urethra loss and three (0.8%) neo-phallic shaft loss . As salvage surgery we performed a secondary modified FRFF, SCIP flap or ALT flap.

**Conclusion:**Partial or total phalloplasty flap loss in transgender men is a rare, but serious complication causing major discomfort, functional loss and emotional destress. Salvage after flap loss is a difficult procedure and necessitating a multidisciplinary approach. Successful salvage of the phalloplasty can be performed using a secondary pedicled or free flap.

# Evaluation of psychological variables in a sample of patients who choose to submit to a facial gender confirmation surgery

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Marina Rodríguez*** [1], ***Fermín Capitán-Cañadas*** [1], ***Javier G. Santamaría*** [1], ***Zoe Barossi*** [1]

***1.*** *FACIALTEAM*

**Background**

Facial Gender Confirmation surgery (FGCS) is a surgical procedure that seeks to harmonize the bone structure of the skull of transgender patients (trans women) to bring it closer to the structure typically considered feminine. Much has been studied about this type of population, but almost always modulated by genital reassignment surgery, and there is little scientific evidence on psychological variables present in FGCS.

**Methods**

This descriptive and correlational study aims to join new research to establish the psychological basis of this type of surgery and study its involvement at the emotional level in transgender patients.

This study analyzes a sample of 438 patients who are going to undergo this type of surgery. The variables measured are depression, anxiety, perceived social support, coping with other previous operations, the perception of face femininity and personal well-being, using subscales of validated questionnaires and Likert-type questionnaires generated ad hoc for the study.

**Results and Conclusions**

Patients do not usually have high scores in depression or anxiety and have a good perception of well-being in general. According to the results, a negative and significant relationship can be observed between some of the variables studied such as the perception of femininity of the face and expectations, or well-being with depression and anxiety. Besides, a positive and significant relation can be observed among others variables such as the perception of femininity of the face with perceived well-being.

Conclusions:

The psychological profile of these patients is not pathological, but we can see that the emotional state of the patient is related to how the woman perceives her face and in turn to the expectations before surgery. For this reason, we conclude that FGCS is essential for the emotional well-being of the patient.

# Correlation of masculinity/femininity dimensions and gender in/congruence with personality treats and measures of personality in trans persons

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Jasmina Barisic*** [1], ***Dragana Duisin*** [1], ***Marko Kalanj*** [2], ***Miroslav Djordjevic*** [3], ***Marta Bizic*** [3], ***Svetlana Vujovic*** [4], ***Gradimir Korac*** [3], ***Borko Stojanovic*** [3]

***1.*** *Clinic for Psychiatry, Clinical Center of Serbia, Belgrade,* ***2.*** *Institute for Mental Health, Belgrade,* ***3.*** *School of Medicine, University of Belgrade, Belgrade, University Children's Hospital, Belgrade, Serbia,* ***4.*** *Clinic for Endocrinology, Diabetes and Metabolic Diseases, Clinical Centre of Serbia, Faculty of Medicine, University of Belgrade, Belgrade, Serbia*

**Background**

Research in the literature is mostly focused on the assessment of femininity/masculinity dimensions, personality profiles and psychopathological features (presence/absence of personality disorders) in trans persons. The aim of this research is to study the assessment of all aforementioned aspects by inclusion of level of personality organization using the using the Kernberg model (neurotic, borderline or psychotic personality organization) and to evaluate their correlation and significance in preparation for gender affirming medical treatments.

**Methods**

The total study sample (N=37) comprised of 10 trans women and 27 trans men (mean age 23,65 ± 6,36 years) during the period prior to medical transitional phase. Research was done in the Cabinet for Transgender States Clinic for Psychiatry Clinical Center of Serbia, Belgrade. The following assessment instruments were applied: Transgender Congruence Scale, Traditional Masculinity-Femininity scale (TMF), Millon Clinical Multiaxial Inventory (MCMI – III) and Inventory of Personality Ogranization (IPO). The small sample size and non-normal distribution of test scores have limited statistical analyses to use non-parametic methods.

**Results and Conclusions**

Distributions of traditional masculinity-femininity dimensions differed across groups, with an extreme scew towards traditional femininity in the trans female group, while scores in the trans male group heavily scewed towards traditional masculinity, but with a more equal distribution in the middle ranges of the scale. Traditional masculinity was moderately negatively correlated with the body discomfort subscale of the Transgender Congruence Scale. Higher gender congruence was moderately associated with depressive personality traits, strongly associated with compulsive personality traits, while lower gender congruence was moderately associated with self-defeating personality traits and strongly associated with more severe personality trait (borderline and schizotypal). Lower gender congruence was moderately associated with greater use of lower level of defences, with the strongest association for low appearance congruence subscale. No significant associations between gender congruence and reality testing or identity diffusion scales were found.

The clinical importance of the results obtained in this research is to determine on an individual basis the type and timing of medical treatment in the process of gender affirmation treatment. Patients may benefit from supportive treatment when lower level of defence mechanisms are present. A higher degree of gender incongruence, compulsive personality features, and higher levels of defence mechanisms represent better predictive factors for successful medical gender affirming medical interventions. Limitations of this research include a small sample size.

# The wisdom of a body that talks: body-psychological techniques in the transition pathways.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Chiara Dalle Luche*** [1], ***Roberta Rosin*** [2]

***1.*** *Consultorio Transgenere Torre del Lago,* ***2.*** *scuola di specializzazione psicoterapia funzionale*

**Background**

The present poster proposes the journey faced by transgender people in light of the Functional Psychology model, in which attention is given at the Integrated Systems as well as the body. The body, primary source of discomfort and reluctance, further becomes the true resource from where to start to modify, with coherence, the meaning of one's own existence.

Clinical pathways will be proposed, in which the therapies considering the Contact and the capacity to re-feel and rediscover those Basic Experiences of the Self that have deteriorated will result clear and coincident. Some therapeutic failures are indeed determined by those psychotherapies that conceal all the dimensions of the Self; to define a differential diagnosis and to support a natural propensity toward transition, verbal awareness would be insufficient. Body-psychotherapeutic techniques sustain that being touched is fundamental in transgender people, whom manifest their discomfort and, at times, rejection toward life through the body. The awareness of an integrated Self cannot exclude all the different levels, the body level considered as it becomes a manifestation visible to the world. Aim: how much the Functional Body-psychotherapy model, which sees the body dimension as a standing point, is efficient in the different pathways of transition.

**Methods**

The Adult Assessment Form and the Adult Diagnostic Form were used: both allow to draw up the *Therapeutic Project*, a clear and precise project with which is possible to intervene onto the complex reality of the Self, with its numerous variables, at the level of the basic Functioning. Techniques through which it is possible to intervene upon the basic Functioning were used, correlated to *Functions*such as Voice, Movements, Posture, the Neurovegetative System, the Muscular tone, the Sensorial and Perceptive System, the Neuroendocrine System and their general regulators, as Respiration, Imagination and essential Thoughts.

**Results and Conclusions**

The pathway that every person has to face is an ad hoc one, each person has its own therapeutic pathway. From the results, it emerges a greater awareness of oneself. Furthermore, the acceptance of oneself at the psychic, social and body level is highlighted. Nothing works in solitarily: A thought, for example, directly communicates with the Endocrine and Immune System as well as with the Neurovegetative one and, as a consequence, with the Central and Peripheral Nervous System. Placing ourselves in this complex perspective, thus looking at the coherence or non-coherence of the signals resulting from the different exchanges among these Systems, we would be able to be truly efficient and precise while in therapy.

During the transition pathway, every professional has to take charge for the whole Self. It is important to consider the person and the time required to properly assimilate the modifications exerted upon the Basic Functioning and Integrated Systems of the person in question (e.g. The Hormonal therapy disrupts a person physiological balance and more). The request to transition is a profound one, and requires attention toward its complexity.

# The unique needs of the transgender patient during their perioperative care

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Luis Tollinche*** [1], ***Michael Long*** [2], ***Zil Goldstein*** [3], ***Asa Radix*** [4], ***Chasity Walters*** [1], ***Cindy Yeoh*** [1]

***1.*** *Memorial Sloan Kettering Cancer Center,* ***2.*** *Marian University,* ***3.*** *Mount Sinai,* ***4.*** *Callen Lorde*

**Background**

An estimated 25 million people identify as transgender worldwide, approximately one million of whom reside in the United States. The increasing visibility and acceptance of transgender people makes it likely that they will present in general surgical settings, therefore perioperative healthcare providers must develop the knowledge and skills requisite for the safe management of transgender patients in the perioperative setting.

Extant guidelines, such as those published by the World Professional Association for Transgender Health (WPATH) (The World Professional Association for Transgender Health) and the UCSF Center of Excellence for Transgender Health, serve as critical resources to those caring for transgender patients. However, they do not address their unique perioperative needs.

**Methods**

Through expansive literature review, examination of our institution's experience, combined with collaboration with institutions that have well established programs in the New York City (USA) area, we composed a manuscript encompassing current recommendations on comprehensive care for the transgender patient in the perioperative setting.

**Results and Conclusions**

It is essential that anesthesia providers develop the knowledge and skills necessary for safely managing transgender patients in the perioperative setting. This review provides an overview of relevant terminology, the imperative for the provision of culturally sensitive care, and guidelines for preoperative, intraoperative, and postoperative management of the transgender patient.

Facilitating easy access and coordination of various subspecialty services such as endocrinology, anesthesiology, psychotherapy, psychiatry and social work, ultimately promotes the perioperative care and recovery of the transgender patient. However, to achieve this consequential imperative, providers need to be properly educated and vetted in the care of the transgender patient.

Appropriate training for clinicians caring for this population requires both health information education and sensitivity training especially in light of the stigmas and misconceptions associated with the transgender community. Such training needs to begin early in the education of healthcare providers. For instance, many medical students have inadequate training in LGBT health and particularly in transgender medicine. Residency training provides a time and opportunity for these gaps to be addressed. Program directors should ensure that topics in transgender healthcare are included in the residency training curriculum, addressing cultural competency and standards of care for hormone therapy and gender confirmation surgeries.

This serves as a comprehensive guide, and additionally sheds light on an important subject matter to stimulate much needed attention and research in a field that has long been overlooked and neglected because of social stigmatization.

# Sexual experiences of transgender adolescents before treatment – results from a German clinical cohort study

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Marie Louise Stübler*** [1], ***Inga Becker*** [1]

***1.*** *University Medical Center Hamburg*

**Background**

Research shows that transition-related medical healthcare is associated to positive sexual satisfaction outcomes in transgender adults, and a better psychosocial functioning in adolescents. So far, little information on the sexual behavior and sexual health of transgender youth is available. One other study has assessed the sexual and romantic experiences of this group of individuals before gender-affirmative treatment.

**Methods**

The present study assessed the sexual experiences of $N$ = 126 transgender adolescents (average age 15.6 years) that were referred to the Hamburg Gender Identity Service (between 2013 and 2016) before they underwent any sort of medical gender-affirming treatment, and fulfilled diagnostic criteria for Gender Dysphoria. Next to gender, age, and social transition status, sexual experiences such as falling in love, romantic relationships, sexual fantasies, masturbation, intimate experiences (petting), sexual intercourse, and sexual orientation (attraction) were assessed via a self-reported questionnaire. The analyses included gender/age group comparisons and comparisons with regard to the degree to which adolescents had transitioned socially.

**Results and Conclusions**

Although the majority of the adolescent sample (aged 11 to 18) reported falling in love (85%), having a serious relationship (65%) or sexual fantasies (60%), physical-sexual experiences with a partner were reported much less often: Less than half of the sample reported experiences with masturbation or intimate sexual experiences with another person, and only 13.5% reported having had sexual intercourse. Older adolescents (15 to 18 years of age) and those who had already undergone a social transition had comparatively more sexual experiences than younger adolescents (11 to 14 years) and those who still lived predominantly in their previous gender role.

Similar to the first previous study on this topic, and compared to adolescents from the same aged German norm population, transgender adolescents do not seem to make the same age-appropriate physical and partner-associated sexual experiences: Although both romantic relationships and sexual lust are reported by the majority of adolescents, transgender adolescents did not seem to undergo important sexuality associated developmental milestones. These findings manifest the importance that transitioning socially and receiving gender affirming medical support of this transition might play for the psychosexual development, as well as the psychotherapeutic protective space that allows the discussion of sexuality related issues.

# Long-term systematic follow-up of a national cohort of children and adolescents diagnosed with gender dysphoria - protocol presentation.

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Mette Ewers Haahr*** [1], ***Wivi Elisabeth Rasmussen*** [1], ***Anne Katrine Pagsberg*** [1], ***Katharina Main*** [1], ***Birte Smidt*** [1], ***Annamaria Giraldi*** [1]

***1.*** *Region Hovedstadens Psykiatri*

**Background**

From January 2016 The National Board of Health in Denmark approved of a treatment program of children and adolescents diagnosed with gender dysphoria. Healthcare for these children and adolescents is centralized nationwide, making this a unique cohort to study.

**Methods**

The aims of this project are

a) to describe the population regarding social, demographic, and psychiatric parameters of children and adolescents diagnosed with gender dysphoria (<18 years) in Denmark

b) to follow the cohort over 2, 5, and 10 years to assess the effects and possible side-effects of the treatment of gender dysphoria

c) to characterize the persons who regret treatment initiation and to define potential risk factors for desisting

We hypothesize that

a) children and adolescents diagnosed with gender dysphoria are at greater risk of psychiatric morbidity and/or being in the autistic spectrum compared to the background population

b) they have a higher risk of social problems, school-avoidance, bullying and lower general well-being before and during the gender transition period compared to the background population

c) the treatment of the gender dysphoria will improve the general well-being and eliminate all or some of the psychopathology

d) that the expected few individuals who desist, have a higher risk of being within the autistic spectrum compared to population of children and adolescents diagnosed with gender dysphoria

This project is a both retrospective and prospective longitudinal study of a single center national cohort and will include all children and adolescents consecutively referred to medical treatment due to gender dysphoria starting from January 2016. We will also follow-up on individuals, who do not pursue the wish for treatment or was not characterized as transgender after assessment.

Data will be collected at baseline and at follow-up at times 2, 5 and 10 years after initiation of hormone treatment. The outcomes measured will be history of gender incongruence and dysphoria, early or late onset, binary or non-binary gender status, age of social transition, age of name-change in registry, any psychiatric diagnosis, suicidal ideation and attempts, cognitive profile, general well-being, schoolattendance, social abilities, development of sexuality, externally and internally experienced transphobia, minority stress, and demographics including family sup-

port or rejection, parental social status, any parental issues, and parental educational level

**Results and Conclusions**

Approximately 250 children have already been treated in Denmark since January 2016, and these will be included in the retrospective study and also invited to participate in the follow-up study. For the prospective study we will include the approximately 90 children referred per year, leading to an intake period of 2-4 years for the prospective study to reach around 250 included children to be
followed-up systematically.

**Conclusions**

Results of the project will be published in leading peer-reviewed journals and communicated to the patients and their advocacy groups.

# External stressors on families of trans and non-binary youth: Preliminary results from Trans Youth CAN!

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Greta Bauer*** [1], ***Joe Raiche*** [2], ***Cindy Holmes*** [3], ***Julie Temple Newhook*** [4]

***1.*** *Western University, London,* ***2.*** *University of Calgary,* ***3.*** *University of Victoria,* ***4.*** *Memorial University*

**Background**

**Purpose:** Trans and non-binary youth may experience external stressors from gender-related social exclusion by family, friends, school or community. Additional stressors may be known only to parents or caregivers who try to shield their children from the words or actions of others. Similarly, youth may shield their parents/caregivers, producing different experiences of external stress for youth and parents/caregivers. Stressors include a range of experiences, such as being told one is a bad parent, having another family refuse to let their children come to the trans or non-binary youth's home, having to challenge school or extracurricular policies, investigation by child welfare authorities, or being asked not to participate in a religious organization.

**Methods**

**Materials and Methods:** We developed the Stressors on Families of Trans Youth Checklist (SFTYC) to capture information on 16 types of trans-related external stressors on families of trans and non-binary youth. It was derived from clinician, researcher, and parent report, with revision based on separate trans and non-binary youth and parent feedback groups (in English and French); group participants identified additional stressors and confirmed content validity. Youth and parent-caregiver versions of the SFTYC were administered in English or French as part of baseline data collection for Trans Youth CAN!, a pan-Canadian cohort study of youth referred for puberty suppression and/or hormone therapy. Eligible youth were aged from puberty to 15 years, and were attending their first visit after referral for puberty suppression and/or hormone therapy at one of eight clinics. Youth surveys were administered by a trained interviewer, and parent/caregiver surveys were self-completed.

**Results and Conclusions**

**Results**: We will present preliminary results from youth and parent/caregiver surveys, including: 1) frequencies of experience for specific types of external stressors among youth and (separately) parents/caregivers; 2) a matched comparison of experiences reported by youth and their parents/caregivers; 3) an analysis of the number of stressor types reported, and; 4) an exploration of whether numbers or types of stressors varied by youth's age, binary or non-binary gender identity, immigration history, or other sociodemographic factors.

**Conclusion**: We present new results characterizing external stressors experienced by families of trans and non-binary youth from both youth and parent/caregiver perspectives.

# Sources of support for trans and non-binary youth entering clinical care: Preliminary results from Trans Youth CAN!

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Margaret Lawson*** [1]***, Daniel Metzger*** [2]***, Emily Nunez*** [3]***, Cindy Holmes*** [4]***, Julie Temple Newhook*** [5]

***1.*** *Ottawa University,* ***2.*** *BC Children's Hospital, Vancouver,* ***3.*** *Western University, London,* ***4.*** *University of Victoria,* ***5.*** *Memorial University*

**Background**

**Purpose:** Social support can prevent or modify responses to stress that affect health and well-being. Furthermore, integration into social networks is hypothesized to promote recognition of self-worth, as well as sense of purpose, belonging, and security. There is developing evidence that transgender (trans) and non-binary youth who are supported through family, healthcare, community, and school are more likely to experience a similar range of mental health and well-being as the rest of their cisgender peers. This study aims to describe and characterize the level and nature of support trans and non-binary youth seeking gender-affirming care receive from their parents/caregivers, other family members, friends, classmates, teachers, and community groups and leaders.

**Methods**

**Materials and Methods:**Analyses were conducted using baseline survey data from Trans Youth CAN!, a pan-Canadian cohort study of youth referred for puberty suppression and/or hormone therapy. Eligible youth were aged from puberty to 15 years, and were attending their first visit after referral for puberty suppression and/or hormone therapy at one of ten clinics. Previously validated measures of support include the MOS Social Support Survey, Family Connectedness Scale, and School Connectedness Scale. The baseline survey also contains new measures developed by the research team which were derived from clinician, researcher, and parent report, with revisions based on separate English and French trans and non-binary youth and parent feedback groups. These new measures examined support for preferred pronoun(s); family, school and community support for gender identity and expression; parental support of youth receiving gender-affirming care; sources of social support; and use of LGBT2Q youth support groups.

**Results and Conclusions**

**Results**: We present preliminary results from youth baseline surveys, including frequencies for each measure of support, an analysis of the number of sources of social support reported, and an exploration of whether the quantity, quality, or nature of support varied by youth's age, binary or non-binary gender identity, Indigenous status, or immigration history.

**Conclusion**: Our results describe the ways that trans and non-binary youth perceive and receive support from friends, family, school, and community, with family and real-life, non-trans friends providing them with their greatest support. Education is needed to empower primary care providers, teachers, community members, and cultural/ethnic and faith communities to support trans youth. It is encouraging that strong parental support for gender identity and expression was associated with higher gender positivity and lower gender distress.

# The experiences of parents/caregivers accompanying gender diverse and trans children and youth attending speciality clinics: stories of gender affirming care project

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Annie Pullen Sansfacon*** [1]***, Shuvo Ghosh*** [2]***, Stephen Feder*** [3]***, Margaret Lawson*** [3]***, Jennifer Ducharme*** [4]***, Cindy Holmes*** [5]***, Julie Temple Newhook*** [6]***, Frank Suerichgulick*** [7]***, Valeria Kirichenko*** [7]

***1.*** *Ph.D., University of Montreal, School of Social Work,* ***2.*** *McGill University,* ***3.*** *Ottawa University,* ***4.*** *University of Manitoba,* ***5.*** *University of Victoria,* ***6.*** *Memorial University,* ***7.*** *University of Montreal*

**Background**

Over the past 5 years in Canada, clinicians have observed an increased number of gender diverse and trans children and youth (GDTCY) accessing clinics for gender affirming care and support (Lawson et al. 2017). That GDTCY are usually accompanied by their families (parents and caregivers) when accessing care provides a unique opportunity to integrate them into the treatment team. GDTCY have better health and social outcomes when strongly supported by their parents/caregivers (Katz-Wise et al. 2018). To optimize this, it is essential that we learn more about family experiences in supporting their GDTCY and in overcoming challenges and barriers to accessing services (Pullen Sansfaçon et al. 2015). *Stories of Gender-Affirming Care: Learning from Children, Youth and their Families*is one of the first qualitative research projects that aims to develop a deeper understanding of GDTCY and their parents/caregiver perspectives on the strengths and challenges within their experience of a gender-affirming care setting. This paper presents the findings on parent/caregiver experiences in accompanying their GDTCY and accessing care at Canadian clinics offering gender-affirming care to pre-pubertal, pubertal and post-pubertal youth.

**Methods**

A Grounded Theory methodology and a social determinants of health framework were used for the project. 36 semi-structured interviews and socio-demographic questionnaires were completed with parent/caregiver of a GDTCY between the age of 8 and 17 at one of the following three clinics: Meraki Health Centre, the Children's Hospital of Eastern Ontario and the Health Sciences Centre in Winnipeg. Participants were recruited through purposive sampling. Data were analyzed through open and then axial coding to identify emerging themes in their narratives.

**Results and Conclusions**

Preliminary analysis of parents/caregivers narratives revealed five themes: the importance of support groups for parents/caregivers and GDTCY, the complex yet essential process of recognizing and accepting the child's gender identity, parents' experiences with clinic staff, parents' unmet needs (e.g. counselling) and the central role played by clinics as a gateway to other services needed to support the GDTCY and the family. Findings emphasize the importance of accessible services within the clinics to support the GDTCY's overall gender journey and improve their access to other services.

**Conclusions**

This study contributes to better understanding of the experiences of parents/caregivers who accompany their GDTCY for clinical care and contributes to building knowledge in an emerging field. These insights are necessary to shape services and ultimately better support GDTCY in their clinical care.

**References:**

Katz-Wise, S. L., Ehrensaft, D., Vetters, R., Forcier, M., & Austin, S.B. (2018): Family Functioning and Mental Health of Transgender and Gender-Nonconforming Youth in the Trans Teen and Family Narratives Project, The Journal of Sex Research, DOI: 10.1080/00224499.2017.1415291

Lawson, M., Bauer, G., Bonifacio, J., Couch, B., Ducharme, J., Ghosh, S., Massarella, C., Metzger, D., Mokashi, A., Pacaud, D., for the Trans Youth CAN! Research Team (2017): Poster at CPATH, Vancouver, Canada 2017.

Pullen Sansfaçon, A., Robichaud, M. J., & Dumais-Michaud, A. A. (2015) The experience of parents who support their children's gender variance. Journal of LGBT Youth, 12, 39–63.

# Mental health in gender incongruent individuals below 20n years in Norway

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Elsa Almås*** [1], ***Esben Esther Benestad*** [1], ***Silje-Håvard Bolstad*** [1], ***Tor-Ivar Karlsen*** [1], ***Alain Giami*** [2]

***1.*** *University of Agder,* ***2.*** *INSERM*

**Background**

"Trans Health and Citizenship: International comparisons" is a project developing in France (INSERM – CESP), Brazil (Instituto de Medicina Social, State University of Rio de Janeiro), Denmark (Aalborg University), Italy (Sinapsi, University Federico II of Napoli), Norway (Dept of Health Sciences, Agder University), and Portugal (ISCTE-IUL, University of Lisboa.

This presentation reveals some results from the Norwegian part of the project, and is part of the symposium: Access to health care among trans population in Europe.

**Methods**

The questionnaire was translated and culturally adapted to Norwegian, using a forward-backward translation procedure. The Norwegian research group assessed the first translation together with a group of trans* people from different organizations and experienced clinicians in the field, and did semantic adjustments to the items. The final version was tested on a reference group of trans* people before used in the survey. The survey consists of 129 items, aimed to register data on socioeconomic status, gender transition, health, sexuality and discrimination. The anonymous survey was performed digitally through an open website from April 5$^{th}$through August 1$^{st}$2018 and obtained 538 respondents.

**Results and Conclusions**

This presentation focuses on the youngest group of respondents, 88 individuals under 20 years of age. The youngest group differ little from the total group on the question concerning being diagnosed for a mental disease: 51,7 percent versus 56 percent. Only 7.1 percent in the youngest group, compared to 14percent in the total group have been diagnosed with a neuropsychiatric disease. 66 percent in the total group versus 63,8 percent in the youngest group have received treatment for psychological problems. 75 percent in the youngest group compared with 46 percent in the total group report having self-harmed on purpose. In the total group, 30 percent report that they often have had suicidal thoughts, In the youngest group the percent is 33,9. 29 percent in the total group report that they have tried to commit suicide, almost all of these (93 percent) report that this happened before they started bodily adjustment. The youngest group report slightly less shame than the total group: 33,3 percent versus 39 percent. 17,3 per cent in the youngest group and 15 percent in the total group report that they still often feel shame.

The data show that the youngest group is not very different from the total group when it comes to psychological problems and feeling of shame. The data show that suicidal thoughts decreases after bodily adjustments. Contrary to many other reports, there are less individuals in the youngest group in this study who report neuropsychiatric diseases.

The results indicate that there is a large, but stable proportion of psychological problems in individuals with gender incongruency. The decrease in suicidal thoughts after treatment indicate that treatment should be offered as soon as it is safe to do so. Self-harm in the youngest group need to be studied further, but can be interpreted as a result of the despair that also can lead to suicidal thoughts, suicide attempts, and unfortunately also probably to successful

suicides in young transgender people.

# Pathology reports in a group of trans women after gender-confirming surgery

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Tommaso Dragone*** [1], ***Luca Petruzzelli*** [2], ***Paolo Petruzzelli*** [3], ***Paolo Bogetti*** [4], ***Elisabetta Baglioni*** [4], ***Chiara Manieri*** [5], ***Giovanna Motta*** [6], ***Fabio Lanfranco*** [1]

***1.*** *CIDIGEM (Turin University Hospital Gender Team - Italy),* ***2.*** *Department of Emergency Surgery, Città della Salute e della Scienza, University Hospital, Turin,* ***3.*** *Gynecology and Obstetrics, Department of Surgical Sciences, Città della Salute e della Scienza, University Hospital, Turin,* ***4.*** *Department of Reconstructive and Aesthetic Plastic Surgery, Città della Salute e della Scienza, University Hospital, Turin (Italy),* ***5.*** *University of Turin(Italy), Department of Medical Sciences, Division of Endocrinology, Diabetology and Metabolism.,* ***6.*** *Division of Endocrinology, Diabetology and Metabolism Department of Medical Sciences, University Hospital,*

**Background**

Testosterone treatment has a pivotal role in the gender-affirming treatment for trans women before and after hysteroannessiectomy and mastectomy, according to the Endocrine Society guidelines (Hembree et al., 2017).
Trans women represent an excellent model to evaluate by one side the effects of long-term androgenic treatment on different tissues (ovaries, uterus, breast). It is still matter of debate whether prolonged testosterone treatment in subjects who refuse surgery is safe on the long term.

**Methods**

We collected data from 60 transwomen, referring to CIDIGEM (Turin University Hospital Gender Team. Italy), who underwent hysteroannessiectomy and mastectomy between 2004 and 2018.
We evaluated the pathology reports of surgical specimens of ovaries, uterus, breast and we correlated them with the following variables: age, BMI, duration of androgenic treatment, serum testosterone and estradiol levels i) at baseline, ii) 1 year after the initiation of hormonal treatment, and iii) immediately before surgery.

**Results and Conclusions**

Testosterone treatment had a median duration of 32 months (25 th and 75 th percentile: 27,25-38,75 months). Mean testosterone and estradiol levels registered were respectively i) 0,53 ng/ml and 80,1 pg/ml at baseline ii) 5,13 ng/ml and 47,35 pg/ml 1 year after, and iii) 4,5 ng/ml and 46,5 pg/ml before surgery. Median age at surgery was 30 years (25 th and 75 th percentile: 24-37,5).
Pathology reports revealed increased ovarian volumes in 37,5% comparing to female population with same age.
Concernig ovaries, we reported 63% of cystic follicles,20% of corpora lutea, 38% corpora albicantia, 7% of scleroatrophy . One case of ovarian endometriosis was collected.
Uterine volumes fell within the normal range of nulliparous population. A proliferative endometrium was found in 59% of the sample and endometrial atrophy in 41%. Endometrial polyps and uterine leiomyomas were found in 10% and 23% of trans women, respectivetely.
At examination of breast tissue, focal or extended increase of fibrous tissue was observed in 89% of the patients.
No malignant tissues were observed.
No correlations between testosterone and oestradiol levels in different periods of transition and histological reports were observed. Higher BMI was found in trans women with endometrial atrophy (p=0,01) Older age was correlated to the presence of uterine leiomyomas (p <0,001).

Our data confirmed that prolonged testosterone administration in trans women is oncologically safe. In fact, no malignant findings were observed in our patients in the follow up period.
Whereas testosterone treatment on breast and ovaries has well known effects (breast tissue atrophy and ovarian polycystosis), as described in literature, testosterone effects on the endometrium remain poorly understood.
Therefore, these findings are particularly important to trans women who do not undergo gender-confirming surgery: physicians should inform their transgender patients about the importance of a regular and prolonged clinical follow up.

# Religion, Spirituality and Wellbeing for Trans People

Thursday, 11th April - 18:30: Plenary Session II (Michelangelo Ballroom)

***Susannah Cornwall*** [1]

***1.*** *University of Exeter*

**Background**

This keynote lecture introduces some historical and contemporary responses to trans people from various faith traditions prevalent in Europe, including Christianity, Judaism and Islam, and asks whether and how religion and spirituality may be positive sources of wellbeing for trans people today. It identifies barriers to good spiritual care provision within healthcare systems, and explores how these may be overcome.

**Methods**

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**Results and Conclusions**

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# Depathologisation: opportunities and challenges

Thursday, 11th April - 19:00: Plenary Session II (Michelangelo Ballroom)

***Dinah Bons*** [1]

***1.*** *Transgender Europe*

**Background**

Depathologisation is currently the greatest opportunity to improve transpeople's health and well-being. For it to become a reality many agents musttake action: governments, insurers, institutions and professionals. We are atcrucial time: the WHO has taken a clear position to end stigmatisation throughwrongly coding trans identities as mental illnesses, countries and regions arepassing depathologising legislation and healthcare protocols are beingdeveloped. On the other rising populist sentiments across Europe put pressure ontrans people and might distort the historic chance to revolutionize how wethink trans-specific healthcare. TGEU will briefly offer an overview of thecurrent situation in Europe, potential obstacles and give an inspiring outlookof progress that is also taking place.

**Methods**

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**Results and Conclusions**

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# Becoming myself

Thursday, 11th April - 19:30: Plenary Session II (Michelangelo Ballroom)

***Vladimir Luxuria*** [1]

***1.*** /

**Background**

Member of Parliament of the 15th Legislature during the Prodi government, she was the first transgender person to be elected to the parliament of a European state. She promoted and was the first to sign the bill of law on transgender rights, and has been committed to LGBT+ rights for many years with the Circolo di Cultura Omosessuale Mario Mieli, where she has served as artistic director since 1993. During this time she was responsible for creating the renowned Muccassassina event, which today still represents a cult event for LGBT+ friendly nightlife in the Capital, and which over the years has hosted international artists of the caliber of David LaChapelle, Grace Jones, Rupert Everett and Alexander McQueen. In July 2012 she gave a talk at the Global LGBT Workplace Summit, an international debate on employment organised in London by OUT and EQUAL, a US organisation engaged in securing workplace equality for the LGBT community. An undisputed commentator on major newspapers and the most important national television programs, she has also written novels and was awarded the Premio Margutta for literature in 2011.

**Methods**

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**Results and Conclusions**

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# The Year in Review - Mental Health

Friday, 12th April - 09:00: Plenary Session III: The Year in Review (Michelangelo Ballroom)

***Tim van de Grift*** [1]

***1.*** *VU Medical Center*

**Background**
Invited plenary

**Methods**
Invited plenary

**Results and Conclusions**
Invited plenary

# The Year in Review: Children and Adolescents

Friday, 12th April - 09:15: Plenary Session III: The Year in Review (Michelangelo Ballroom)

***Jiska Ristori*** [1]

***1.*** *Department of Experimental, Clinical and Biomedical Sciences, Careggi University Hospital, Florence, Italy*

**Background**

Transgender health care issues in children and adolescents are an increasing matter of interest anddebate at both a clinical and research level. Since these topics are continously changing, the evaluation process and managment of gender diverse youth (andtheir families) need to be regularly reviewed and updated in order to garanteeproper care.

The aim of this presentation is to update the main issues regarding the care of transgender children and adolescents since the last EPATH meeting in 2017.

**Methods**

An electronic search ofliterature was conducted using the following main search engines: ScienceDirect,Scopus, and PubMed from May 2017 to January 2019. In particular, the followingsearch terms were entered: gender dysphoria, gender incongruence, transgender, and gender variant. These terms were associated with terms relating to child ,adolescent, youth, mental health, diagnosis, using the AND operator.

**Results and Conclusions**

Several studies were identified. Review articles were not included. In particular, updated data focused on: (1) Changes in diagnostic criteria and debate on the existence of a diagnosis in childhood; (2) Epidemiology; (3) Studies on the proper health care needs of transgender adolescents/children and their families, and (4) Assessment and treatment protocols.

The main results previously underlined in the Results section will be discussed during the presentation, also in light of futher updating process.

# The Year in Review: Social Sciences

Friday, 12th April - 09:30: Plenary Session III: The Year in Review (Michelangelo Ballroom)

***Sally Hines*** [1]

***1.*** *University of Leeds*

**Background**
This talk will highlight the emerging themes of trans – focused work in the Social Sciences.

**Methods**
Beginning with an overview of concluding points from the 2017 review, the talk will move on to consider key shifts at the levels of the substantive, methodological and conceptual. In addition to addressing published work, the talk will examine Research Council funded projects and postgraduate research on topics around gender diversity.

**Results and Conclusions**
In conclusion, the talk will position the Social Sciences as a rich and productive discipline through which to engage with central social questions around shifting gendered identities, expressions, experiences and cultures.

# The Year in Review: Endocrinology

Friday, 12th April - 09:45: Plenary Session III: The Year in Review (Michelangelo Ballroom)

***Gary Butler*** [1]

***1.*** *Gender Identity Development Service adolescent endocrine clinic and Reproductive Medicine Unit, University College London Hospital*

**Background**

This review will highlight the key diagnostic, therapeutic and outcome measure endocrine publications since the last EPATH in both adolescents and adults.

**Methods**

N/A

**Results and Conclusions**

N/A

# The Year in Review: Voice and Communication

Friday, 12th April - 10:00: Plenary Session III: The Year in Review (Michelangelo Ballroom)

***Maria Södersten*** [1]

***1.*** *Karolinska University Hospital*

**Background**

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**Methods**

Systematic library searches were performed in the databases Pubmed, Web of Science, and CINAHL using two combined blocks of Mesh terms. The first block contained words related to “transgender” and the second block to words such as “voice, “speech” and” “communication”. The search was limited to the period 2017-2019.

**Results and Conclusions**

In the first broad search > 600 articles were found in Pubmed and Web of Science. Using a more strictly search strategy, 40 relevant articles were found. Focus of the studies were assessment and outcome measures for trans masculine and trans feminine persons’ voice and communication, results after feminizing voice therapy, and after pitch-raising surgery. The scientific levels of the studies, in what countries they were performed, and the most important results will be reported. Two text books in the field of transgender and non-binary people’s voice and communication were published.

# The Year in Review: Surgery

Friday, 12th April - 10:15: Plenary Session III: The Year in Review (Michelangelo Ballroom)

***Marta Bizic*** [1]

***1.*** *School of Medicine, University of Belgrade, Belgrade, University Children's Hospital, Belgrade*

**Background**

Surgical treatment of gender affirmation (GA) is often the last step in one individual's gender transition. The requirements for surgical treatment include referral letters from two board certified mental health professionals and hormonal treatment under the control of an endocrinologist. Surgical sterilization is still required in some countries to complete bureaucratic requirements for document change, but is no longer proposed for trans men by WPATH SOC7. Since the last EPATH meeting, the surgical approach is evolving in sense to satisfy functionality and aesthetics in patients receiving GA surgery. One stage approach is appreciated by patients and surgeons, but some techniques like phalloplasty require multistaged treatment.

**Methods**

Electronic search of literature was used for articles published from May 2017 till July 2018.

**Results and Conclusions**

The majority of papers is regarding genital affirmation surgeries.

# The Year in Review - Law

Friday, 12th April - 10:30: Plenary Session III: The Year in Review (Michelangelo Ballroom)

***Peter Dunne*** [1]

***1.*** *University of Bristol*

**Background**

*This keynote presentation provides an overview of legislative, judicial and academic developments in the field of trans rights since 2017. The keynote focuses on the intersection of law, gender identity and medicine. It will address important reforms and new legal arguments on various medico-legal questions, including involuntary sterilization, pathologization and trans parenthood. The keynote aims to give attendees a critical insight into the ways in which - both in Europe and beyond - the relationship between trans rights and medicine is evolving*

**Methods**

N/A

**Results and Conclusions**

N/A

# Prospective evaluation of self-reported aggression after initiation of gender affirming hormones in transgender people

Friday, 12th April - 11:30: Mental Health Session II: Miscellaneous (Michelangelo Ballroom)

***Justine Defreyne*** [1], ***Guy T'Sjoen*** [2], ***Walter Bouman*** [3], ***Nicola Brewin*** [4], ***Jon Arcelus*** [3]

***1.*** *Ghent University,* ***2.*** *Uz Gent,* ***3.*** *University of Nottingham,* ***4.*** *The Nottingham Centre for Transgender Health*

**Background**

Although research on the relation between testosterone and aggression in humans is inconclusive, guidelines (including the World Professional Association for Transgender Health Standards of Care, edition 7) have warned for an increase in aggression in transgender men upon testosterone administration. However, these guidelines are based on scarce evidence. The aim of the present study was to prospectively examine whether exogenous testosterone therapy increases aggression in transgender men and whether it decreases aggression in transgender women on antiandrogen plus estrogen therapy.

**Methods**

Every transgender person invited for assessment at a national transgender health clinic in the United Kingdom during a 3-year period (2012-2015) completed self-report measures for interpersonal problems, including levels of aggression (Inventory of Interpersonal Problems [IIP-32]), symptoms of anxiety and depression (Hospital Anxiety and Depression Scale [HADS]), social support (Multidimensional Scale of Perceived Social Support), and experiences of transphobia before and 1 year after the initiation of gender-affirming hormonal therapy. Correlations between prospective scores for the IIP-32 factor "too aggressive" and prospective levels of sex steroids, prospective psychological(HADS), and baseline psychosocial measurements were tested.

**Results and Conclusions**

Results of 140 people (56 transgender men, 84 transgender women) were analyzed. A prospective increase in scores for the factor "too aggressive" of the IIP-32 in transgender men 1 year after being treated with testosterone treatment or a decrease of the IIP-32 aggression scores in transgender women 1 year after gender affirming hormonal therapy was not found. However, a positive correlation was found between increasing HADS anxiety scores and increasing scores for the IIP-32 "too aggressive" score in the entire study population and a positive correlation with lower support from friends in transgender women.

We conclude that patients and hormone-prescribing physicians can be reassured that the long-term administration of testosterone in transgender men does not increase aggressive behavior. This is the 1st prospective study to assess the effect of gender-affirming hormonal care on aggression. Limitations included the use of different laboratories, the use of a patient-reported outcome measure, and the lack of aggression subtypes. Testosterone therapy was not associated with an increase in levels of aggression in transgender men, antiandrogen and estrogen therapy was not associated with a decrease in aggressive behavior in transgender women. Other psychological and/or social factors, such as anxiety levels, appear to contribute to self-reported aggression in transgender people.

# Sleep quality and dream contents in gender dysphoria.

Friday, 12th April - 11:45: Mental Health Session II: Miscellaneous (Michelangelo Ballroom)

***Alessandro Neirotti*** [1], ***Maria Chiara Villa*** [1], ***Chiara Michela Crespi*** [1], ***Giovanna Motta*** [1], ***Alessandra Giordano*** [2], ***Valentina Mineccia*** [1], ***Fabio Lanfranco*** [1], ***Alessandro Cicolin*** [2]

***1.*** *CIDIGEM (Turin University Hospital Gender Team - Italy),* ***2.*** *Sleep Disorder Center, Department of Neurosciences, University of Torino, AOU Città della Salute e della Scienza, Torino, Italy*

**Background**

Gender dysphoria (GD) is characterized by a mismatch between perceived gender and birth assigned sex. Sleep is important for health, especially mental health. Indeed, several studies prove a relationship between sleep and psychiatric disorders. Subjects with a GD diagnosis are characterized by a high prevalence of associated psychopathologies, in particular anxiety, mood disorders, and suicidality. Some authors assert that GD is due to a body image distortion, but few studies discuss this point of view. According to Domhoff continuity hypothesis, stating that dreams reflect the same thoughts and concerns we have in waking life, it is reasonable to use dream reports coded by Hall and Van de Castle method to evaluate body image and self-perception modifications in conditions involving body misperception. The aims of this study were: 1. to evaluate, in a sample of subjects diagnosed with GD, both the sleep quality and the possible related conditions, such as anxiety, depression and body image dissatisfaction; 2. to evaluate dream contents and their variations during the transition program; 3. to compare the dream contents in trans women and trans men with reference data.

**Methods**

The sample was composed by 101 subjects diagnosed with GD: 36 recruited during diagnostic evaluation (T0), 33 during gender affirming hormone treatment (T1), and 32 after surgery (T2).
All subjects were asked to fill a week-long dream report form, and 4 questionnaires were administered to evaluate: 1. body image (Body Image Concern Inventory; BICI); 2. anxiety (State-Trait Anxiety Inventory Y1-Y2; STAI Y1-Y2); 3. depression (Beck Depression Inventory II; BDI-II); 4. sleep quality (Pittsburgh Sleep Quality Index; PSQI).
Oneiric contents were analyzed using the coding system invented by Hall and Van de Castle, via a data entry system called DreamSAT.

**Results and Conclusions**

BICI mean value at T0 was higher than in the Italian population, but we noticed a decrease during hormone treatment, reaching a score similar to the Italian population at T1 and T2. BDI-II results showed a decrease of depressive symptoms between T0 and T1, with lower mean values for trans women at T2. Regarding STAI Y1 results, no significant differences between state anxiety level in different subgroups were found whereas STAI Y2 showed differences at T2 between trans men and trans women and significant lower values after surgery. Every subgroup except trans women at T2 had a mean PSQI value over 5, that indicates a poor sleeper; trans men subjects had a significantly lower sleep quality than trans women at T2. Analysis of dream contents showed differences between different treatment phases, and both trans women and trans men were significantly different in some categories (according to Hall and Van de Castle system) from reference data referred to both genders. In conclusion, we found significant differences in every score, between different phases, different genders or both.

# An initiative to combine MRI data in transgender persons to examine structural brain differences: preliminary findings from the ENIGMA transgender persons working group

Friday, 12th April - 12:00: Mental Health Session II: Miscellaneous (Michelangelo Ballroom)

***Sven Mueller*** [1], ***Paul Thompson*** [2], ***Eileen Luders*** [3], ***For The Enigma Transgender*** [4]

***1.*** *Ghent University,* ***2.*** *University of Southern California,* ***3.*** *University of Auckland,* ***4.*** *Persons Working Group*

**Background**

Previous Magnetic Resonance Imaging (MRI) studies of neuroanatomical differences in transgender persons have consistently identified specific regions that may differ between transgender and cisgender persons. However, with regards to directionality, findings in these regions have been rather mixed, possibly because of small sample sizes, differences in scanner strength, or cultural differences. To mitigate this problem, the ENIGMA transgender persons working group (a subgroup of the ENIGMA [Enhancing Neuro Imaging Genetics through Meta-Analysis] MRI initiative) was founded collating and sharing previously collected MRI data across sites. This presentation will introduce the ENIGMA transgender persons working group and present preliminary findings on brain anatomy.

**Methods**

Structural MRI data from 10 centers from 9 different countries with a total combined sample size of 894 scans including cisgender men and women and transgender men and women (all adults) were all locally preprocessed (with 3 exceptions) with freesurfer version 5.3. The data were then combined and analysed at the group chair's site in Ghent with SPSS.

**Results and Conclusions**

Generally speaking, the results of structural anatomical measures (grey matter volume, cortical surface area, and cortical thickness) suggest that the brains of transgender persons are mostly consistent with sex assigned at birth with some differences in variations in patterns across measurements. The benefits of large scale MRI mega-analyses across sites are discussed in unraveling the neuroanatomical correlates of gender identity.

# Gender non-binary people's experiences in trans care

Friday, 12th April - 12:15: Mental Health Session II: Miscellaneous (Michelangelo Ballroom)

***Aisa Burgwal*** [1]***, Joz Motmans*** [1]

***1.*** *Ghent University*

**Background**

Genderqueer and non-binary (GQNB) people (people who do not identify with the gender they were assigned at birth and are also outside the gender binary of male or female) remain largely invisible in health care research. Quantitative data analysing their experiences in health care settings is generally lacking. So far, GQNB people remain largely invisible in health care research in general, as well as in trans-related health research. As to existing literature, there is research showing that non-binary people have poorer health than binary transgender people do, whereas other literature sometimes shows that the binary trans population has worse health than the genderqueer and non-binary population. In any case, genderqueer and non-binary genders are often unknown to, or misunderstood by, health care professionals working with trans people, and this may serve as a reason to refuse access to transition related treatment. The aim of this study is to compare GQNB respondents with binary trans people in five European countries on different health-related topics, such as self-rated health, general well-being, suicide, access to care, and so forth.

**Methods**

An online anonymous survey targeted at self-identified trans persons aged 16 years or older was conducted in five countries (Georgia, Poland, Serbia, Spain and Sweden). The survey included (amongst others) questions regarding: (1) demographics, (2) background regarding gender and sexual identity, including level of openness, reactions, social support, trans-specific care, (3) general and mental health, including suicidal ideation and attempts, and (4) experiences in health care settings, including discrimination.

**Results and Conclusions**

The GQNB group rated their overall health significantly more often as bad in comparison to trans men and trans women and showed significantly higher rates of having a chronic problem, illness or disability. When looking at well-being, non-binary respondents also appeared to have much more often a depressive or low mood than trans respondents. Gender non-binary respondents did not differ significantly from trans binary respondents on lifetime suicidal thoughts nor in lifetime attempts. However, when asked about suicidal thoughts within the last 12 months significantly more GQNB people reported to have had suicidal thoughts than the trans binary respondents have. In contrast with trans men and trans women, only a small proportion of the GQNB group ever sought psychological or medical help for their gender identity and more GQNB people indicated to have ever delayed going to the doctor. In addition, GQNB respondents who wanted to access trans care services significantly more often than trans men or trans women did not know where to go. Furthermore, they significantly more often evaluated health care as bad. This study highlights the need to increase awareness on the differences between non-binary trans respondents and binary trans respondents, especially within health care research and services, because it appears that not only non-binary people more negatively evaluate health care, also their health is significantly worse than the health of trans binary respondents.

# Exploring gender congruence and body satisfaction in non-binary transgender people

Friday, 12th April - 12:30: Mental Health Session II: Miscellaneous (Michelangelo Ballroom)

***Beth Jones*** [1], ***Walter Bouman*** [2], ***Emma Haycraft*** [1], ***Jon Arcelus*** [2]

***1.*** *Loughborough University,* ***2.*** *University of Nottingham*

**Background**

Binary transgender people access gender affirming medical interventions to alleviate gender incongruence and increase body satisfaction. Despite the increase in non-binary transgender people, this population are less likely to access transgender health services compared to binary transgender people. No research has yet explored *why* by exploring levels of gender congruence and body satisfaction in non-binary transgender people. Therefore, it was the aim of this study to compare levels of gender congruence and body satisfaction in non-binary transgender people to controls (binary transgender people and cisgender (non-trans) people).

**Methods**

In total, 526 people from a community sample in the United Kingdom took part in the study (97 non-binary, 91 binary and 338 cisgender). Participants were asked to complete an online survey about gender congruence and body satisfaction.

**Results and Conclusions**

There were differences in gender congruence and body satisfaction between non-binary and binary transgender people. On sex specific parts of the body (i.e., chest, genitalia and secondary sex characteristics), non-binary transgender people reported significantly higher levels of gender congruence and body satisfaction compared to binary transgender people. However, there was no difference in congruence and satisfaction with social gender role between the two transgender groups (non-binary and binary). Cisgender people reported significantly higher levels of gender congruence and body satisfaction compared to transgender people (non-binary and binary).

There are differences in gender congruence and body satisfaction between non-binary and binary transgender people. Consequently, the gender affirming medical interventions that non-binary transgender people wish to access in order to increase their gender congruence and body satisfaction may be different from that desired by binary transgender people. The implications of this research are that transgender health services need to be more inclusive of non-binary transgender people and their treatment needs, which may differ from those who identify within the binary gender system.

# Mental state decoding among transgender adults

Friday, 12th April - 11:30: Mental Health Session IIb: symposium: The intersection of gender diversity and autism (Bramante 8)

***Anna van der Miesen*** [1]***, Behzad Sorouri Khorashad*** [2]***, Annelou de Vries*** [3]

***1.*** *Amsterdam UMC,* ***2.*** *Mashhad University of Medical Sciences,* ***3.*** *VU Medical Center*

**Background**

Previous studies have reported on co-occurring characteristics of autism spectrum disorder (ASD) and gender dysphoria (GD). One key cognitive characteristic of ASD is difficulty in mentalizing, i.e. attributing and recognizing mental states in oneself or others. Until now it is unknown if mentalizing is altered in transgender individuals.

**Methods**

We administered the Reading the Mind in the Eyes test, an advanced test of mental state decoding, in 164 transgender adults (mean age = 25.04, SD= 5.88; 92 birth-assigned females and 72 birth-assigned males) compared to 545 cisgender adults (mean age = 25.8, SD = 6.17; 282 women and 263 men).

**Results and Conclusions**

Analyses revealed that transgender individuals scored significantly lower than cisgender individuals ($p$ = .008, $d$ = -0.238), particularly on recognizing mental states with a negative valence ($p$ < .001, $d$ = -0.39). Patterns of differences between transgender birth-assigned males and females were the same as those between cisgender men and women. As this is the first study to report on advanced mental state decoding in transgender individuals, findings suggest that decreased mental state decoding may be associated with GD across birth-assigned genders. Clinically, our results underscore the importance of paying attention to decreased mentalizing when working with transgender individuals.

# Clinicians' perspectives on the co-occurrence of gender dysphoria and autism spectrum disorder: a pilot study

Friday, 12th April - 11:45: Mental Health Session IIb: symposium: The intersection of gender diversity and autism (Bramante 8)

***Coralie Fuchs*** [1]

***1.*** *VU Medical Center*

**Background**

The co-occurrence of a diagnosis of gender dysphoria (GD) and autism spectrum disorder (ASD) is an area of inquiry by researchers with the vast majority of publications reporting an increase in (symptoms of) ASD in individuals diagnosed with (symptoms of) GD and vice versa. All clinicians may therefore encounter individuals with the sometimes challenging co-occurrence of ASD and gender identity questions. But how comfortable are these clinicians in assessing and/or working with individuals with both GD and ASD and what is their approach? In current literature not much is known on this topic, therefore this pilot study investigates the perspectives of clinicians on co-occurring GD and ASD.

**Methods**

A questionnaire with both multiple choice as well as open ended questions was used to assess the views of clinicians working with individuals with (symptoms of) GD and ASD on their feelings of competence, their ideas and hypotheses on the co-occurrence, the topics they consider important to discuss during assessment, and their professional needs in improving their approaches. This pilot study included 44 mental health professionals working with different age-groups.

**Results and Conclusions**

While none of the participants worked in a specialized gender identity service, all had at least some experience with assessment of individuals with (symptoms of) GD and 95.5% had at least some experience with individuals diagnosed with ASD. A total of 72.7% had experience with assessment of individuals diagnosed with ASD for (symptoms of) GD. A total of 22.7% of clinicians would discuss similar topics with neurotypical as well as with individuals diagnosed with ASD. But there were also clinicians (22.7%) who had no idea which topics they should discuss with individuals diagnosed with ASD. Others mentioned that they would take specific aspects of ASD during the counseling into account such as rigid thinking, problems with abstract thinking, and the difficulties during social transition and treatment. Of the clinicians, 51.2% considered themselves competent to talk about gender/GD with individuals diagnosed with ASD because of experience and specific education. A total of 23.3% felt incompetent and 25.6% felt as well competent and incompetent. Being an expert in the separate fields of ASD or GD alone doesn't seem to be enough for clinicians to feel competent in working with individuals with co-occurring ASD and GD. Clinicians assessing and treating individuals with ASD stated that they want to broaden their knowledge of the current state of literature and the different views that exist on co-occurring GD-ASD. Being well-equipped with these scientific findings would enable the clinicians to adapt their clinical guidance on a case to case basis, thereby improving the assessment and care for individuals with co-occurring ASD and GD. During the symposium, clinical implications and future research on this topic will be discussed.

# Gender-referred adolescents with autism spectrum disorders

Friday, 12th April - 12:00: Mental Health Session IIb: symposium: The intersection of gender diversity and autism (Bramante 8)

***Riittakerttu Kaltiala-Heino*** [1], ***Marja Työläjärvi*** [1]

***1.*** *Tampere University Hospital*

**Background**

Research suggests overlap between autism spectrum disorders and gender dysphoria. The present study explored the psychosocial characteristics and development of gender-referred adolescents with ASD.

**Methods**

The subjects were 106 adolescents consecutively admitted to one of the two gender identity services for minors in Finland. Retrospective chart review was carried out. Data was collected to a structured data collection form focusing on mental health and adolescent development.

**Results and Conclusions**

Of 106 adolescents (15 assigned boys at birth and 91 assigned girls ) consecutively referred to one of the two gender identity services in the country, 19 (18%) presented with ASD, 2 (13%) of those assigned boys and 17 (19%) of those assigned girls. Those with ASD were slightly younger than those without ASD (M age=16.5 (SD=1.0) vs. 16.9 (SD=0.9) years, p=0.05). Pubertal timing was comparable between the ASD and neurotypical groups. Those individuals with ASD more commonly reported gender dysphoria in childhood (24% vs. 4%, p=0.03). The adolescents with ASD had more commonly been loners in childhood (56% vs. 30%, p=0.04) and were more commonly socially isolated at the time of the gender identity assessment (61% vs. 35%, p=0.04), but they did not distinguish from others regarding experiences of bullying. The individuals with ASD less commonly had experiences of dating or steady relationships (33% vs. 71%, p=0.007) and had less commonly experienced kissing (24% vs. 69%, p=0.001) or intimate sexual contact with a partner (11% vs. 44%, p=0.005). Individuals with ASD displayed or had more commonly a history of suicidal and self-harming behaviour (74% vs. 49%, p=0.05) and psychotic episodes (37% vs. 8%, p=0.003) but did not differ from the neurotypical group regarding depression, anxiety, ADHD, conduct disorder or substance use. After the first line assessments, a greater proportion of the adolescents with ASD compared to the neurotypical adolescents were not immediately eligible for medical treatments of gender dysphoria due to severe psychiatric problems (84% vs. 40%, p=0.002).

Conclusion: Gender-referred adolescents with autism spectrum disorder display delays of adolescent development that are typical for autism, and this poses a challenge to assessing identity development.

# Autistic traits in young people presenting to the Gender Identity Development Service: prevalence and trajectories over time

Friday, 12th April - 12:15: Mental Health Session IIb: symposium: The intersection of gender diversity and autism (Bramante 8)

***Sophie Landa*** [1]

***1.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust*

**Background**

Several papers have explored the prevalence of the co-occurrence of autism spectrum condition (ASC) and gender dysphoria in children and adolescents. For example, drawing on samples from gender identity clinics for children and young people, findings include: 7.8% of young people meet criteria for ASC (de Vries et al., 2010); and over 40% of young people score in the clinical range on a screening tool for ASC (Skagerberg et al., 2015; Vanderlaan et al., 2015). In the context of this rapidly evolving field, it is important that clinicians and researchers have up to date information of the prevalence of ASC in young people attending gender services, including changes over time in the presentations of young people with autistic traits.

**Methods**

This paper will use quantitative methodology to analyse recent routine clinical data on autistic traits collected at the Gender Identity Development Service, as measured by the Social Responsiveness Scale. It will explore the prevalence of autistic traits and whether profiles on the Social Responsiveness Scale are related to birth assigned sex and other relevant factors such as social and psychological functioning. Changes in presentations over time will be investigated, including changes in Social Responsiveness Scale scores for young people referred to GIDS from 2012-2013 and 2016-2017.

**Results and Conclusions**

Non-significant differences were found in SRS scores between the two time-points. SRS scores were found to be significantly higher in individuals who were birth assigned female, with significantly more of these individuals scoring within the clinical range. Higher scores on the SRS were significantly associated with lower levels of social and psychological functioning as measured by the CGAS. The implications of these findings will be discussed with reference to clinical practice at the Gender Identity Development Service and child and adolescent mental health services, making broader links to neurodevelopmental theories of autism symptomatology. Areas for future research indicated by these results will be considered, including potential limits of screening tools as a method to understand autistic traits in young people who have additional psychosocial needs.

# Are persons diagnosed with gender dysphoria and autism spectrum disorder treated in a different way compared to persons diagnosed with gender dysphoria without autism spectrum disorder? Results from clinical chart data and a self-assessment questionnaire.

Friday, 12th April - 12:30: Mental Health Session IIb: symposium: The intersection of gender diversity and autism (Bramante 8)

***Gunter Heylens*** [1], ***Simonne Holst*** [1], ***Mileen Mellemans*** [1], ***Els Elaut*** [1], ***Karlien Dhondt*** [1]

***1.*** *Department of Sexology and Gender in Ghent, University Hospital Ghent, Belgium*

**Background**

Several studies have suggested that gender dysphoria (GD) and autism spectrum disorder (ASD) co-occur more often than by chance both in children and adolescents as in adults (Van der Miesen et al, 2016; Glidden et al, 2016; Heylens et al, 2018). Wether the link between GD and ASD is real, or merely due to e.g. variety in methodology, social deficits related to non-ASD psychosocial challenges associated with GD,... is unclear (Turban et al, 2018).

With regard to the effect of co-occurent ASD in persons with GD on gender affirming treatment (GAT), even less is clear. Strang et al (2016) suggest there may be a more extended diagnostic period and clinical decisions may proceed more slowly, although this has never been investigated.

To our knowledge, this is the first study to explore the impact on clinical decision making of co-occurent ASD in persons diagnosed with GD attending a gender clinic. A second aim was to gain information regarding the perception of genderdsyphoric persons towards their treatment trajectory.

**Methods**

To explore the first research question, clinical chart data were used. A group of persons ($N$ = 30) diagnosed with GD and ASD has been compared to a control group ($N$ = 502) consisting of individuals diagnosed with gender dysphoria, but without ASD. Statistical methods has been used to find out whether GAT differed significantly in the first group compared to the second group.

Information on the perception of persons diagnosed with GD and ASD towards their treatment trajectory, was gained through a self-constructed questionnaire. The questionnaire was filled out by 13 of the 30 patients. This questionnaire consisted of 10 questions, of which 7 questions were attended to the patients, and 3 to family or relatives.

**Results and Conclusions**

Since data analysis is still ongoing at present, results regarding the first research question are not yet available. As an exemple of the results collected from the self-constructed questionnaire: On the question whether the ASD diagnosis has affected their treatment trajectory, 61.8 % answered that they did not think this was the case. The large majority (91.7%) of family or relatives perceived a positive evolution with regard to psychosocial well-being.

Preliminary results show that, at the subjective level, persons diagnosed with both GD and ASD are overall positive regarding the course of their GAT. Further data analysis will reveal how co-occurring ASD in persons diagnosed with GD affects the treatment trajectory. These findings can be important to optimalize the care for patients diagnosed with GD and ASD.

# A psychological support group for parents as intervention tool in the care of families with gender diverse children.

Friday, 12th April - 11:30: Children & Adolescents Session II: Transgender adolescents and their families (Bramante 7)

***Angela Caldarera*** [1]***, Sarah Davidson*** [2]***, Laura G. Terrana*** [3]***, Filippa D. Campagna*** [4]***, Benedetto Vitiello*** [4]***, Chiara Baietto*** [3]

***1.*** *University of Torino,* ***2.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust,* ***3.*** *Struttura complessa Neuropsichiatria, Dipartimento di Scienze della Sanità Pubblica e Pediatriche, Presidio Infantile Regina Margherita AOU Città della Salute e Scienza di Torino,* ***4.*** *Struttura complessa Neuropsichiatria, Dipartimento di Scienze della Saità Pubblica e Pediatriche, Presidio Infantile Regina Margherita AOU Città della Salute e Scienza di Torino*

**Background**

In Torino, within the Pediatric Hospital Regina Margherita, a specialized service for gender diverse children, adolescents and their families was set up in 2009. The service grew up across years, and operates with a multi-professional approach, focused on supporting psycho-social wellbeing of the referred young people and families. Parenting a gender diverse child may be a challenging experience according to different studies and approaches (Gregor, Hingley-Jones, & Davidson, 2014; Riggs & Due, 2015), and the possibility of working in group with other parents showed positive effects (Di Ceglie, & Thümmel, 2006; Menvielle, 2012).

**Methods**

We set up a psychological support group for mothers and fathers of gender diverse children and adolescents who attend the Service. The group meetings, led by a child psychiatrist and a clinical psychologist, are held on a monthly basis. In order set a process evaluation, we prepared two documents to be administered to the participant parents: (1) a short form where to report the relevant themes that come out across the sessions, and (2) a semi-structured feedback questionnaire, including four items with answers on a Likert scale, and five open-ended questions about helping and difficult aspects of the participation to the group, adapting the questionnaire from the form proposed in Di Ceglie and Thümmel, 2006. We presented the study to the parents group in September 2017 and ask to those who agreed to participate to fill-in the short-form about the main themes relevant to them across the sessions after six months (March 2018), and to fill-in the semi-structured questionnaire in September 2018. 12 parents accepted to participate. Answers to the Likert scales were analyzed through descriptive statistics (SPSS.25), and answers to the open-ended question were analyzed through a thematic approach.

**Results and Conclusions**

As regards the short-form administered after six months, parents report themes relevant to all of them, related to the importance of sharing experiences with others and the hope; the process of inner change about the way they deal with gender identity issues and the way they feel in the relation with their children; the possibility of looking at their child as a complex human being with many characteristics, and not exclusively defined by gender behavior and identification; the enrichment they felt in going beyond a binary view of gender.

As regards the feedback questionnaire, all participants reported high levels of perceived help from the participation to the group in understanding their child's gender identity; in meeting other parents; in feeling less isolated; and in the change of approach in dealing with the child gender identity issues. Our results showed that the participation in the group made it possible for the parents to achieve a better understanding and thus acceptance of the situation, and to improve the relation parents-children. The psychological support group, with respect to this group of partic-

ipants, was a useful tool in the clinical work with the children diagnosed with gender dysphoria and their families.

# Siblings' matters: the impact of coming out in siblings' relationships

Friday, 12th April - 11:45: Children & Adolescents Session II: Transgender adolescents and their families (Bramante 7)

***Maddalena Spirito*** [1], ***Patrizia Petiva*** [1]

***1.*** *Polo Clinico e di Ricerca di Torino*

**Background**

While the scientific literature about gender variant children and adolescents focuses mainly on the child diagnosed with gender dysphoria and on the parental couple, less attention is payed to the siblings and their relational dynamics.

Siblings are considered too often exclusively depending on their gender variant brother's/sister's condition, as satellites which gravitate around Dysphoria Planet. Instead, the fraternal relationship is an important support for the family system.

In one of our articles (Petiva, Spirito, 2015) we defined the coming-out of the gender variant adolescent as a developmental crisis which involves the entire family system. During this phase, the whole family is emotionally involved. For the adolescent, the family can represent a crucial source of competences, encouragement and resilience.

**Methods**

Our methodology uses mainly an integrative approach and the Asen and Fonagy's model.

Families have access to the psychotherapeutic treatment, a ten-sessions path completely free, through two hospital team. The connection between the parts is guaranteed by scheduled meetings.

In this case study, based on the analysis of the clinical process during family therapy, we took into consideration 12 families, which showed these characteristics:

- Average age of the adolescent: 16 years old
- Siblings' average age : 13, 6 years old
- Trans men: 7
- Trans women: 4
- 1 case wasn't part of diagnostic parameters

Families signed informed consent and a document describing data use according to the new European regulation.

Our team is composed of 4 systemic psychotherapists with specific training about developmental psychology and atypical gender identity development.

**Results and Conclusions**

In the last two years part of our work has been focused on the siblings system after the coming-out.

As regards the temporal dimension, we observed the modification of the relational dynamics within and outside the family system since the coming-out. In this time frame the siblings' system, as well as the whole family system, redefines its internal dimension and its relationships towards other reference points (parents, school, society). Moreover, it faces loss processing, and accomplishes acceptance and support tasks.

Helping siblings to express and comprehend their emotional states in a safe and empathic environment is indispensable during this phase.

Parents can sometimes express strong opposition about the involvement of their other children during therapeutic sessions. In their opinion, the child, especially if younger than the gender variant adolescent, should be left cau-

tiously at home in order to protect him/her from traumatic disclosures or because he/she couldn't understand the situation. In these cases, we noticed some behavioral patterns: a strong involvement into the parent/child relationship; fear for the loss of parental authority; experiences of exclusion. Consequently, when we work with siblings we carefully avoid unintentional rivalry between therapists and parents.

As regards the relationship between siblings, the older can be a reference point for the younger gender variant child, especially regarding friendship dynamics. Conversely, the family system tends to exclude the younger siblings from the dynamics started by the coming-out of the older one. As a consequence, younger siblings can experience social difficulties, transgressive behaviors, bullying episodes towards peers.

# Evaluation of GenderEd.ie, an online education programme to support families of trans young people in the Republic of Ireland

Friday, 12th April - 12:00: Children & Adolescents Session II: Transgender adolescents and their families (Bramante 7)

***Danika Sharek*** [1]

***1.*** *Genio*

**Background**

When a young person identifies as trans(gender), this may raise issues for the entire family. The literature has suggested that access to appropriate education and information may positively impact on families of trans young people. However, there is a lack of robust evidence about the impact of such education programmes. This study aimed to contribute to the evidence base and this presentation details the results of a mixed methods evaluation of an online education programme titled '*GenderEd.ie*'. *GenderEd.ie* is an eight-module online education programme which aims to provide basic information to families of trans young people in the Republic of Ireland. It was designed in collaboration with professionals, families, and trans young people.

**Methods**

The evaluation employed a convergent, mixed methods approach to evaluate the education programme. Quantitative surveys were collected at two time points (pre-education programme and post-education programme) to assess the impact of the education programme on a number of areas including: trans-related knowledge, self-reflection and insight, family communication, family problem-solving, self-efficacy, and views of gender identity. In-depth, semi-structured, qualitative interviews were conducted to explore families' experiences with the programme, its perceived impact, and their recommendations for improving it. In total, eight family members completed the pre-education programme and post-education programme surveys and eight family members participated in interviews.

**Results and Conclusions**

Statistically significant changes were found in terms of overall scores on trans-related knowledge from pre-education programme to post-education programme, and on six of the individual knowledge topics. No statistically significant changes were found on any of the other measures. Interview participants described the positive aspects of the programme, including that it was easy-to-use and accessible, with comprehensive trans-related information. The majority of interview participants reported learning something new from the programme; however, they reported fewer soft skills gained from the programme.

The findings from this study add to the evidence base about the impact of an education programme on families' trans-related knowledge. The study was limited by the use of non-probability convenience sampling methods based on a small, non-representative sample of those most likely to be supportive of a trans family member. The findings have implications in terms of theory, policy, service development, and education and practice. The study also highlights a number of opportunities for future research. In conclusion, this study has demonstrated that an education programme designed and developed through participatory methods has the potential to help positively support families and trans young people.

# Trans youth and their families, very first data in French-speaking Switzerland

Friday, 12th April - 12:15: Children & Adolescents Session II: Transgender adolescents and their families (Bramante 7)

***Adèle Zufferey*** [1]***, Denise Medico*** [2]***, Gabriel Galantino*** [3]***, Annie Pullen Sansfacon*** [4]

***1.*** *M.Sc., Agnodice Foundation,* ***2.*** *Ph.D., Université du Québec à Montréal (UQAM), département de sexologie,* ***3.*** *M.A. cand., Université du Québec à Montréal (UQAM), département de sexologie,* ***4.*** *Ph.D., Université de Montréal (UdM), School of Social Work*

**Background**

Introduction

Trans youth pose an emerging social and medical question in the French speaking part of Switzerland. There is total lack of knowledge on their lives, well-being, vulnerability and needs. Medical institutions are just beginning to address the growing demand from families and youth.

Aim of the study

This study aims at providing understanding of how and what are the experiences of trans youth and their families in the area of health, family support, school and social integration.

**Methods**

Methodology

A qualitative grounded theory methodology was adapted from a Canadian research on trans youth to Swiss culture and context. We conducted 20 semi-directive interviews. Ten French-speaking Swiss families participated and interviews were performed separately with parents and youth (8 to 21). Data were analysed horizontally by themes and vertically by family.

**Results and Conclusions**

Results

Our results show that families are in distress and have the feeling they have to fight for their children to obtain access to medical care. One of the main issues is the lack of knowledge and non-supportive practices they meet in medical institutions. Notwithstanding the fact that the parents are supportive and have to inform or even teach medical staff, some mistreatment by psychotherapists, psychiatrists and nurses in psychiatric institutions are reported. The experiences in school settings, broader family and with other youth are contrasted and associated by parents with a positive social change. Nevertheless, youth show a greater degree of mental distress, suicidal tendencies, automutilation and school drop off.

Conclusion

This study indicates that access to more supportive and affirmative healthcare is the actual key issue for trans youth and their families.

# Attitudes towards sexual rights of transgender people

Friday, 12th April - 11:30: Social Sciences Session II: FISS Symposium: Attitudes and stigma towards transgender people in Italy (Bramante 10)

***Stefano Eleuteri*** [1]***, Marco Silvaggi*** [2]***, Margherita Colombo*** [3]***, Valentina Fava*** [4]***, Chiara Malandrino*** [4]***, Cristina Rossetto*** [5]***, Chiara Nanini*** [6]***, Sara Simone*** [7]***, Irene Melis*** [6]***, Cinzia Artioli*** [8]***, Simona Gabriella Di Santo*** [9]

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**Background**

Only recently the importance of Sexual Rights (SR) has been discussed at the international level and the issue has recently entered into public debate. In addition SR of both trans women and trans men appear to be far behind those of other minorities, probably because of the lack of knowledge among people, which often causes unfounded prejudices. Aim of this study was to analyze the level of agreement of Italian people with the SR of transgender people and to verify if some characteristics of the population, such as gender, being from northern or southern region, age, being male or female, undergraduates, non-believer or churchgoers, were associated with a lower SR recognition.

**Methods**

An online anonymous questionnaire was realized to collect demographic data and information about the level of agreement/disagreement (on a 6-point likert scale), with statements regarding the right for trans women and trans men, to show in public their own sexual identity, to practice a satisfying sexuality, to marry, to adopt a child. Non-parametric statistics were used for data analysis.

**Results and Conclusions**

979 people (703 women and 276 men, mean age 35,44 ± 11,69) fulfilled the questionnaire. 12% of the sample declared to be against the marriage for both trans women and trans men and against the adoption by couples were one of the partner is a trans women and in the case of trans men the percentage arise to 28%. On the characteristics of respondents that affect the recognition of SR: Be female, graduated, younger than 30, non-believer or not church going and non-eterosexual, with respect to males, heterosexuals, under-graduated, believer church going, was correlated to a major recognition of the right to satisfying sexuality ($p<.05$) to marry ($p<.05$) and to adopt for both MtoF and FtoM ($p<.05$). These sociodemographic characteristics are also linked to lower intolerance toward SR of homosexual and bisexual orientation. Finally, people from northern Italy declared higher accordance with the sexual right to freely show their own sexual identity in public by trans women and trans men ($p<.05$). Conclusions SR recognition seems heavily affected by some characteristics of people among which instruction, age and religiosity gender and sexual orientation. This could drive the next diffusion of SR policies in addressing specific educational interventions to those categories of people at greater risk of intolerance toward SR.

# Microaggressions towards sexual minorities in early-career psychologists

Friday, 12th April - 11:45: Social Sciences Session II: FISS Symposium: Attitudes and stigma towards transgender people in Italy (Bramante 10)

***Antonio Prunas*** [1], ***Annalisa Anzani*** [1]

***1.*** *University of Milano-Bicocca*

**Background**

In Western culture, overt forms of discrimination have become increasingly less accepted and socially desirable, leaving space for more subtle forms of discrimination. Nadal (2012; 2013) refers to the construct of microaggression to explore these kind of experiences in LGBT people. The present study aims at investigating to what extent these subtle forms of prejudice are perpetrated by mental health professionals, in their clinical interaction with a fictitious trans client.

**Methods**

We recruited a sample of students graduated in psychology (N=84). They were asked to listen to an audiofile of a woman (trans vs. lesbian vs. straight) introducing herself during the first session with a therapist. Their task was simply to write down from five to ten questions they would have asked the client in order to form a clinical impression. After that, three different raters evaluated independently all the written material produced and rated from 0 to 1(0=no microaggression; 0.5=possible microaggression; 1=microaggression) the presence of subtle aggressions in every statement.

**Results and Conclusions**

30,9% of the sample produced at least one microaggressive question (rated as such by at least two out of three raters). Averaging the total score of microaggressions for every participant, no difference was found comparing participants in the lesbian client condition and those in the trans client condition. Our results suggest that early-career psychologists are not immune to subtle forms of prejudice, like microaggressions, that have negative consequences for minorities (Testa, 2012; Bockting et al., 2013). The transgender population and the other sexual minorities already undergo a higher amount of stress in their daily life (Bockting, 2013). Psychologists and other healthcare professionals, that are expected to provide support in a non-judgemental environment, should be properly trained and educated about the specific needs of minorities, with the purpose of not perpetrating the experiences of discrimination and harassment LGBT people are exposed to in their lives.

# Attitudes towards children's gender-related behavior in a group of Italian parents: socio-demographic correlates and association with parental ratings of boys' and girls' rule-breaking behavior.

Friday, 12th April - 12:00: Social Sciences Session II: FISS Symposium: Attitudes and stigma towards transgender people in Italy (Bramante 10)

***Angela Caldarera*** [1], ***Maria Teresa Molo*** [2], ***Eva Gerino*** [1], ***Luca Rollé*** [1], ***Lorenzo Curti*** [1], ***Piera Brustia*** [1]

***1.*** *University of Torino,* ***2.*** *Fondazione Carlo Molo ONLUS*

**Background**

Research on parental attitudes towards children's gender-related behavior showed a parents' differential treatment of girls versus boys (McHale, Crouter, & Whiteman, 2003), and a negative association between felt pressure to conform to gender norms and psychological adjustment of the children (Egan & Perry, 2001). Ruble (2008) as well underlined how the conformity to stereotypes may not necessarily be healthy. The literature also showed the importance of cultural context in these issues, and the need of conducting research about this issue among different countries (Turner, & Gervai, 1995). Nevertheless, to this day, a quantitative study about this issue on Italian families has not been published yet. This study aims to (1) test socio-demographic correlates of parental attitudes surrounding children's gender behavior; (2) test the relation between such attitudes and parental ratings of children's behavioral difficulties.

**Methods**

After receiving the approval of the University Bioethics Committee we recruited mothers and fathers of 464 children, aged 6-12 (M=9.55; SD=1.85). Parents filled in, upon informed consent, a set of questionnaires including a socio-demographic form, the Sex-Biased Parenting Style Scale (SB, Turner & Gervai, 1995), and the Child Behavior Checklist 6-18 (CBCL, Achenbach & Rescorla, 2001). The Italian version of the SB scale was created with the translation/back-translation method (Cronbach's alpha .84).

We tested demographic characteristics of the group of participants, differences and association between variables through descriptive and multivariate statistics; as regards reported levels of children's behavioral difficulties, the predicting role of parental traditionality was tested through a simple linear regression model. All analyses were performed by using the software SPSS.25.

**Results and Conclusions**

Mothers showed lower levels of traditionality compared to fathers ($t$=4.46, $p$<.001); differences between attitudes traditionality towards boys and towards girls were not significant. A One-way ANOVA confirmed the effect of education on levels of traditionality of attitudes towards children's gender-behavior both for fathers $F(5,456) = 5.76$, $p$<.001 and for mothers, $F(5,454) = 8.40$, $p$<.001.

Correlations between levels of traditionality of parental attitudes and parental ratings of children's behavioral difficulties showed a positive association between SB and the Rule-Breaking Behavior Scale of CBCL only in the girls subgroup for fathers ($r$=.19, $p$<.01) and mothers ($r$=.30, $p$<.01). The regression model, with the Rule-Breaking Behavior Scale as a dependent variable and levels of traditionality as predictor, was significant only for girls both in the fathers group ($F(2,233)= 4.54$; $p$<0.01) and the mothers group ($F(2,233)= 11.42$; p<0.001). Results showed that parental levels of traditionality predicted paternal (β=.19, p<.01) and maternal ratings (β=.30, p<.01) of girls' Rule-Breaking Behavior.Our findings indicate a complex relation between parental attitudes towards children's gender-related behavior, education level and sex assigned at birth (both of parents and of children) which needs to be further ex-

plored with interactional models. In addition, our results raise the need of understanding, through future studies, whether traditionality has an influence on the way parents appraise child behavior, or children with more traditional parents tend to react with more rule-breaking behavior to the felt pressure to conform to gender stereotypes.

# The impact of negating or transcending gender on our relationship with a Trinitarian God and the Church

Friday, 12th April - 11:30: Social Sciences Session IIb: representation, religion and phenomenology (Bramante 11)

***Shanon Ferguson*** [1]

***1.*** *Roehampton University*

**Background**

The gender binary is firmly fixed in Western thought but where did it come from? With the biological/medical information now available we are much more aware that physical bodies are more nuanced than a simple either/or (male or female) and that sex/gender differences can be found as much between the ears as between the legs. So why do we still cling so tightly to the idea of a gender binary?

In the first book of the Old Testament for Christians and the Pentateuch for Jews (Genesis), we are given two accounts of how humans were created and these texts are used to provide endless support for the subordination of women, the complementarity of the sexes, and heteronormativity.

A great deal of weight is placed upon the notion that people are made in the image of God and this is linked in Scripture with being male or female. This proves to be a hurdle for those who understand their gender as either neither male nor female or both male and female. Research has shown that feeling you are not made in God's image and have no place in Scripture or the Church can have a serious impact on a person's mental health and spiritual well being.

**Methods**

20 interviews were conducted with people who self-identify as non-binary and were brought up in a European Christian environment. 18 of the participants were recruited through groups that the researcher already had a relationship with, such as ILGA Europe, the European Forum of LGBT Christian Groups, the Metropolitan Community Church, and Bar Wotever. The remaining 2 participants heard about the research through either an existing participant or another researcher.

11 of the participants also currently attend church though none of them attend the denomination they attended as children. All but one follow some form of spiritual practice.

These interviews led the research in keeping with grounded theory. The interviews were semi-structured allowing the participants to tell their own stories.

**Results and Conclusions**

These are still under investigation but preliminary findings show that non-binary people have a deep desire for a spiritual connection and that this is important for their mental well being. Finding themselves in Scripture and valued by God are important factors. Understanding eunuchs as possibly trans or intersex and having a place in the realm of God and the ability to teach others about identity was also important. A critical finding was the importance placed upon being part of a church community and what is needed to feel truly welcome - participation and visibility. I am still researching Scripture and how the church has and is addressing gender in all its manifestations.

# Self-stigma, psychological distress and regular-, spiritual-, and religious coping among transgender people in the Netherlands

Friday, 12th April - 11:45: Social Sciences Session IIb: representation, religion and phenomenology (Bramante 11)

***Nico De Reus*** [1]***, Mark Hommes*** [2]***, Arjan Bos*** [2]

***1.*** *Open University / VUMC,* ***2.*** *Open University of the Netherlands*

**Background**

Transgender people face minority stressors like stigmatization and victimization (Testa et al., 2012; Boza & Perry, 2014). Being stigmatized may lead to self-stigmatization. This includes the fear for stigmatization, as well as the potential internalization of negative beliefs and feelings associated with the stigmatized condition (Bos, Pryor, Reeder, & Stutterheim, 2013). Self-stigma causes psychological distress and can lead to psychopathology (Herek, Saha, & Burack, 2013). Self-stigma can also negatively influence existential fulfillment and meaning making (Ehrlich-Ben Or et al., 2013; Hasson-Ohayon et al., 2014)

Spiritual and religious coping strategies among transgender people, are an underexposed theme. Spirituality refers to the connectedness to the moment, to oneself, to others, to nature and to a larger meaning or presence like 'the significant' or 'the sacred' (De Jager Meezenbroek et al., 2012). Religion is to be understood as a special expression of spirituality (Puchalski, 2012). Concerning regular coping styles, research suggests that active emotion-focused coping and avoidant coping are associated with the influence of self-stigma on psychopathological symptoms (Man, 2013). The present study examined the relationships between self-stigma and psychological distress and the mediating influence of spiritual-, and religious-, and regular coping strategies, among transgender people in The Netherlands.

**Methods**

We conducted a cross-sectional survey among 128 adult transgender persons. Participants were recruited through transgender associations and leaflets in waiting rooms of various gender teams in the Netherlands.

Self-stigma was measured by means of the Internalized Stigma of Mental Illness scale (Boyd Ritsher, Otilingam, & Grajales, 2003) and the Transgender Identity Survey (Bockting, 2017). Psychological distress was measured using the Symptoms Check List 90-R (Arrindell & Ettema, 2005), while regular coping has been measured using the Utrecht Coping List (Schreurs, van de Willige, Brosschot, Tellegen, & Graus, 1993). To measure spiritual coping and religious coping the Spirituele Attitude en Interesse Lijst (De Jager Meezenbroek et al., 2012) and the *Brief* RCOPE (Pargament, Feuille, & Burdzy, 2011) were used.

Ethical approval for this study was obtained by the ethics board of the Open University.

**Results and Conclusions**

Self-stigma was positively related to psychological distress. Active emotion-focused coping and active problem focused coping did not mediate this relationship nor did (positive or negative) religious coping. Avoidant coping was positively associated with both self-stigma and psychological distress and did mediate the relationship between self-stigma and psychological distress. Spiritual coping also mediated this relationship: self-stigma was negatively associated with spiritual coping, which in turn was negatively associated with psychological distress.

Self-stigma appears to have a detrimental impact on the psychological well-being of transgender people. More research on the determinants of self-stigma and the effect of coping strategies in this group is recommended, including spiritual coping as a way of countering self-stigma influence.

Finally, theory and evidence based interventions should be developed to reduce stigmatization and self-stigmatization of transgender people (Bos et al., 2013). In these interventions spiritual coping deserves attention.

# Queer Rebel, Human Rights and Guardianship: What do these discourses tell us about clinical work with gender diverse youth?

Friday, 12th April - 12:00: Social Sciences Session IIb: representation, religion and phenomenology (Bramante 11)

***Claudia Zitz*** [1]

***1.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust*

**Background**

Recent approaches of systemic psychotherapy, commonly known as family therapy, are predicated on values of social justice and human rights. Most systemic writing on gender diverse youth sees therapy as a political stance, arguing the need to explore socio-political contexts. The affirmative approach features strongly in the systemic literature. Paying attention to socio-political contexts and their contribution towards systemic psychotherapy, this research explored which discourses were drawn on during a public parliamentary debate on transgender youth equality in the UK. This debate was part of a lengthy consultation on transgender experience in the UK by the 'Women's and Equalities Committee' which went on to make recommendations to the government. Uniquely, the debate consisted of participants from a range of positions, including politicians, a clinician and trans activists.

**Methods**

Trans communities have repeatedly expressed their preference for qualitative research in the context of historically pathologising research (Staunton, Tacconelli & Rhodes, 2009). Therefore, this research used Foucauldian discourse analysis, which is situated within a post-positivist and social constructionist epistemology. It pays attention to how language constitutes subjectivity and the researcher's self-reflexivity.

The parliamentary debate of the women's and equalities committee in 2015 on transgender youth was transcribed and discourses of gender identity were identified and analysed according to Willig's six stages of Foucauldian discourse analytic research.

**Results and Conclusions**

The research identified a number of aligning and conflictual discourses of gender identity in relation to gender diverse youth:

1. Essentialist self discourse
2. Medical discourse
3. Queer rebel discourse
4. Human rights discourse
5. Neoliberal discourse

In addition, discourses of adolescence were pervasive. These included:

1. Bio-psycho-social discourses of adolescence
2. Guardianship discourse

Some discourses, such as the essentialist account, centred around validating the existence of young people's deeply felt gender identity in a battle to be recognized as intelligible human subjects. They highlighted the need to see

young people's essentialist accounts as embedded within historical contexts of oppression. The queer rebel discourse offered challenges to institutional normativity and taken for granted knowledge. Together, the queer rebel, human rights, neoliberal and medical discourses were used in powerful ways to argue for medical interventions for gender diverse youth. Most of these discourses, with the exception of the medical discourse, challenged gender clinics as institutions and advocated for an informed consent model. However, discourses of adolescence which were marked by uncertainty and vulnerability, such as the guardianship discourse and the psychological discourses of adolescence, offered a counterpoint to the call for medical interventions. These discourses emphasised a developmental trajectory and were subjugated discourses during the debate.

Overall, these findings highlight the importance of attuning to socio-political-historical contexts when working with gender diverse youth. Some discourses pointed towards the need to question (cis/hetero)-normative practices of therapy, teaching and supervision within the field. Others suggested that current affirmative models contain no discourses of adolescence, such as accounts of uncertainty and vulnerability, and may need to be tailored more specifically to gender diverse youth.

# First name choice as part of the transition process: a phenomenological approach

Friday, 12th April - 12:15: Social Sciences Session IIb: representation, religion and phenomenology (Bramante 11)

***Dana Pamfile*** [1]***, Céline Bourquin*** [1]***, Pascale Pecoud*** [1]***, Friedrich Stiefel*** [1]

***1.*** *CHUV - Lausanne Unversity Hospital*

**Background**

First name choice in transgender and gender diverse people is part of the social transition process and is considered to be an important step in affirming gender identity. For example, chosen name use is showed to be linked to reduced depressive symptoms, suicidal ideation and behaviour among transgender youth, researchers found. But even if name change is associated with reduced mental health risk, many trans and gender diverse people are unable to use their chosen name for legal or interpersonal reasons. Choosing and legally changing name can also represent a part of a subjectivation process, as the chosen name may become the metaphor of who a person is meant to be.

**Methods**

This qualitative research was designed according to Interpretative Phenomenological Analysis (IPA); IPA is a widely used approach in medical psychology which, through an in-depth interpretation of individual narratives, allows conceptualising the essence of how people give meaning to an experience and understand the world around them. Participants were recruited from the Gender Dysphoria Consultation in Liaison Psychiatry Unit in Lausanne University Hospital. Persons who were followed-up at Gender Dysphoria Consultation were informed about the ongoing study by their liaison psychiatrist; written information about the aims of the study was provided; the first author contacted them by phone once they expressed their consent to participate. A written consent was also signed. A sample of nine transgender persons, both trans-women and trans-men, was constituted. Data collection was based on a semi-structured questionnaire which was designed for the study and verbatim reports of the interviews were analysed. The aim of the analysis process using IPA is to detect the main themes and their interconnections in order to formulate an interpretative hypothesis; in the final stage of the research, the hypothesis will be discussed in a focus group with two psychiatrists experts in order to reach an agreement on the clinical relevance of the results.

**Results and Conclusions**

Current preliminary analysis shows that the name choice process in transgender people might be seen as the result of the interlacement between the sense of self-continuity, the perceived body metamorphosis under hormonotherapy and surgery, the desire to break with a painful experience and the opportunity to integrate the complex transition experience in the family dynamics.

# Bone mineral density assessment in a group of trans men and trans women after gender affirming surgery

Friday, 12th April - 11:30: Endocrinology Session II: Monitoring (side-)effects of hormonal treatment (Bramante 14)

***Giovanna Motta*** [1], ***Marco Barale*** [1], ***Massimo Procopio*** [1], ***Chiara Manieri*** [1], ***Fabio Lanfranco*** [2]

***1.*** *University of Turin(Italy), Department of Medical Sciences, Division of Endocrinology, Diabetology and Metabolism.,* ***2.*** *University of Turin(Italy), Department of Medical Sciences, Division of Endocrinology, Diabetology and Metabolism on behalf of CIDIGEM (Turin University Hospital Gender Team - Italy)*

**Background**

Sex steroids play a pivotal role in bone growth and bone density maintenance in both sexes (Almeida et al., 2017). Gender affirming treatment and hormonal replacement therapy after gender confirming surgery in trans women and trans men have an impact on body composition, bone mass and bone density (Hembree et al., 2017; Van Caenegem and T'Sojen, 2015).

Bone health is a critical issue in transgender health care. However, conflicting results on bone turnover parameters have been reported up to now, and only a few studies have evaluated the effects of hormonal replacement therapy after gender confirming surgery on bone metabolism (Hembree et al., 2017).

Aim of our study was to evaluate the effects of hormonal replacement therapy on bone metabolism in a population of transgender persons, after gender confirming surgery.

**Methods**

Thus, we retrospectively measured lumbar spine bone mineral density (BMD), using dual energy X-ray absorptiometry (DXA), and hormonal levels in a group of 57 trans women and 31 trans men referring to the gender dysphoria outpatient clinic (CIDIGEM) of our Institution.

All trans women were evaluated during estrogen replacement therapy (ERT) and all trans men during testosterone replacement therapy (TRT), at least 2 years after gender confirming surgery.

All causes of secondary osteoporosis were ruled out. Patients' compliance to ERT was defined according to medical history and to hormonal assays.

**Results and Conclusions**

Prevalence of low bone density, as defined by a Z-score ≤ -2 according to DXA criteria (Watts et al., 2013), was 40.4 % in transgender women (group 1) and 6,4% in transgender men (group 2).

In group 1 serum 17- β estradiol levels were significantly lower (34.7 ± 36.2 pg/ml vs 67.7 ± 40.2 pg/ml; $p<0.001$) and a higher prevalence of low compliance to ERT was recorded (82% vs 29%, $p < 0.0001$) compared to trans women with normal bone mineral density (Z score >-2). More in details, for 17β estradiol serum levels ≤ 50 pg/ml, low compliance was independently correlated with low bone mass (OR 9.89, $p<0.01$).

On the contrary, in group 2 no associations between lumbar spine Z-score levels and 25 OH vit D or LH levels, BMI, age, smoking habit, and duration of TRT after surgery were observed.

In conclusion, in trans women low BMD is significantly associated with a low compliance to ERT. Major efforts have often to be made in order to keep trans women under ERT after gender confirming surgery. Such efforts are necessary to prevent osteoporosis in trans women, as emphasized by the latest version of Endocrine Society Guidelines. In trans men the lower prevalence of low BMD could be explained by the protective effect of testosterone

on bone, mediated by peripheral conversion to estradiol.

# Lipid profile changes during long term gender affirming therapy in trans women

Friday, 12th April - 11:45: Endocrinology Session II: Monitoring (side-)effects of hormonal treatment (Bramante 14)

***Marija Miletic*** [1], ***Milina Tancic Gajic*** [1], ***Miomira Ivovic*** [1], ***Zorana Arizanovic*** [1], ***Milos Stojanovic*** [1], ***Svetlana Vujovic*** [1]

**1.** *Faculty of medicine, University of Belgrade, Clinic of endocrinology, diabetes and diseases of metabolism, Belgrade genfer team*

**Background**

**Background**Individuals with gender incongruence receive gender affirming therapy which is fundamental to sex reassignment. Although numerous studies have examined the effects of long-term hormone therapy in cisgender adults, less is known about the long-term effects of gender affirming HT in transgender adults.

**Aims** The aim of our study was to assess changes in the fasting serum lipid profile during gender affirming hormone therapy in Male to Female individuals in a long-term follow-up.

**Methods**

**Methods** Retrospective longitudinal study included 17 individuals with gender incongruence (male assigned at birth) in the Clinic for Endocrinology, Clinical Center of Serbia, Belgrade, from 1989 to 2017. A diagnosis of trans-sexualism was confirmed at 26.1 +7.1 years of age. Mean body mass index : 24.1+3.9 kg/m2. Median duration of therapy was 15.4 + 4.0 years. Orally administered estrogens were the mainstay of therapy. Socio-demographical, anthropometric and laboratory data were collected. Outcomes of interest included cholesterol, LDL, HDL, TRG. Not any patient was lost during a follow up. Data are shown as mean (±standard deviation) .Comparisons between means were done by *Sign test* for paired items. $P \leq 0.05$ was considered statistically significant. Statistical analysis was performed with SPSS Statistics 17.0 software (SPSS Inc.,Chicago, IL). The local Ethics Committee approved the study.

**Results and Conclusions**

**Results** In MtoF individuals , analysis showed no significant difference in total cholesterol, LDL and HDL. TRG levels worsened over time ( 1.91+ 0.84 to 2.12+0.9 mmol/l), but not in a statistically significant manner. There was a highly significant difference in weight and body mass index ( p = 0.04)

**Conclusion**During long term gender affirming therapy in Male to Female individuals, there was no significant deleterious effect in lipid profile, except of worsening trygliceride levels and gaining weight, which could not be attributed only to androgen deprivation and estradiol therapy.

Gender affirming therapy administration to transgender individuals is acceptably safe in the short and medium term. However, potentially adverse effects in the longer term are still unknown. The data of surrogate markers of cardiovascular disease leave room for a cautious optimism. Making priority of long term follow up studies could lead us to, urgently needed, true insight.

# Does gender affirming hormone therapy affect liver transaminase levels? Results from ENIGI

Friday, 12th April - 12:00: Endocrinology Session II: Monitoring (side-)effects of hormonal treatment (Bramante 14)

***Laurens Van De Bruaene*** [1], ***Justine Defreyne*** [1], ***Guy T'Sjoen*** [2]

***1.*** *Ghent University,* ***2.*** *Uz Gent*

**Background**

Severe liver dysfunction is mentioned as a medical risk associated with testosterone therapy in the Endocrine Society guidelines.

**Methods**

This prospective cohort study was part of the European Network for the Investigation of Gender Incongruence (ENIGI). We assessed serum transaminase levels (AST, ALT) over 36 months, starting upon first administration of hormonal therapy (HT). For logistical reasons, data from Ghent (Belgium) only was selected for this explorative substudy. Liver dysfunction (LD) was described as serum transaminase levels >3x upper limit, severe liver dysfunction (SLD) as >5x upper limit. Data were analyzed cross-sectionally and prospectively, taking into account possible confounders (age, BMI, smoking, alcohol, other biochemical parameters, etc.)

**Results and Conclusions**

At baseline, serum transaminase levels were reported in 392 cases (205 TW, 187 TM) and serum transaminase levels were higher in transwomen (TW) (ALT: 18.0U/L [14.0 – 26.0], AST: 20.0U/L [17.0 – 24.0]) compared to transmen (TM) (ALT: 15.0U/L [12.0 – 21.0, AST: 19.0U/L [16.0 – 22.0], P<0.001 and P=0.001, respectively).

During hormone therapy (HT), in TW both ALT and AST levels decreased during the first three months of HT (ALT: -3.0U/L, 95%CI -5.5 – -0.442, P=0.022, AST: -4.1U/L, 95%CI -5.2 – -2.9, P<0.001), remaining stable thereafter. In TM, AST levels increased during the first year (+4.3U/L, 95%CI +0.6 – +8.0, P=0.024), remaining stable thereafter, whereas ALT levels remained stable throughout the investigated time period.

None of the TW had serum AST levels suggestive for LD, although serum ALT levels above 3x the upper limit of normal for cisgender women were reported in 3 TW on HT. Two TM presented with SLD after 9 and 12 months of HT, hormone treatment remained unchanged while transaminase levels returned to lower values.

Over the entire study population, cross-sectional analysis revealed a positive relationship between serum ALT and AST levels and BMI (ρ=0.260, P<0.001 and ρ=0.063, P=0.004), hematocrit (ρ=0.132, P<0.001 and ρ=0.222, P<0.001), serum triglyceride levels (ρ=0.152, P<0.001 and ρ=0.104, P<0.001), total cholesterol levels (ρ=0.177, P<0.001 and ρ=0.186, P<0.001), serum LDL levels (ρ=0.191, P<0.001 and ρ=0.152, P<0.001) and a negative correlation with HDL% (ρ=-0.194, P<0.001 and ρ=-0.073, P=0.001). In addition, higher serum ALT levels were positively correlated to number of pack year (ρ=0.063, P=0.006).

In TW on HT, serum AST levels were positively correlated to serum LH (ρ=0.127, P<0.001) and FSH (ρ=0.149, P<0.001) levels and serum ALT levels were negatively correlated to serum SHBG levels (ρ=-0.105, P=0.001). In TM taking testosterone, serum LH and FSH levels were negatively correlated to serum AST levels (ρ=-0.109, P=0.002 and ρ=-0.137, P<0.001). Serum transaminase levels were not correlated to serum oestradiol or testosterone levels in both TW and TM.

HT leads to a change in absolute serum transaminase levels, towards the experienced gender, appearing over the first 3-12 months. LD and SLD are rare in TM (LD and SLD 0.8%), and TW (LD 0.6%). Cross-sectionally, higher

serum transaminase levels were not correlated to serum levels of sex steroids, although serum gonadotropins were correlated with transaminase levels. Other variables, such as BMI and serum lipids may contribute to elevated serum transaminase levels.

# Transgender heart – Testosterone influences

Friday, 12th April - 12:15: Endocrinology Session II: Monitoring (side-)effects of hormonal treatment (Bramante 14)

***Svetlana Vujovic*** [1], ***Miomira Ivovic*** [1], ***Milina Tancic Gajic*** [1], ***Ljiljana Marina*** [1], ***Zorana Arizanovic*** [1], ***Milos Stojanovic*** [1], ***Marija Miletic*** [1], ***Dragana Duisin*** [1], ***Dusica Markovic Zigic*** [1], ***Miroslav Djordjevic*** [2]

***1.*** *Faculty of medicine, University of Belgrade, Clinic of endocrinology, diabetes and diseases of metabolism, Belgrade genfer team,* ***2.*** *Faculty of medicine, University choldren hospital*

**Background**

Testosterone regulates cardiac action, potential, calcium homeostasis and has effects on endothelial cells in women's heart. It increases repolarizing potassium + current density and protect against arrhythmia in women. Myocardial response to acute ischaemia is gender dependent (apoptotic rate, Bax expression, cardiac function, myocardial healing, remodelling). The greatest density of androgen receptors in male is in the heart. Acute application of testosterone increases intracellular calcium in cardiac myocytes eliciting voltage by IP3 receptors. Phosphalamban , regulator of cardiac contraction, expression is increased in males. Androgen receptor overexpression in myocytes increases mitochondrial enzymes activity and oxygen consumption, induces vasodilatation and increases blood flow. Testosterone influences lipid metabolism, insulin sensitivity and blood pressure in both sexes. Common drugs effects, treating cardiovascular diseases, depend on gender specific polymorphic variants in genes including MDR1, APOZ, ACE, preproendothelin-1, microsomal triglyceride transfer protein. AIM of this study was to follow up during 15 years dynamic changes of 24 hour blood pressure monitoring, lipid levels, insulin sensitivity and hormonal changes in trans men.

**Methods**

SUBJECTS AND METHODS: 30 trans men participated study after completely exploration by psychiatrist who confirmed diagnosis. On the beginning of the study they were 26.6 +/-2.1 years old and BMI was 22.5+/- 2.0 kg/$m^2$.During the first year of therapy they received Testosterone enanthate 250 mg per 2 weeks, and after that on 3 week interval , in combination with dihydrotestyosterone gel on clitoris locally twice daily first year of therapy.
Cholesterol, HDL, LDL, triglycerides, apoA, apoB, Lp(a), FSH, LH, estradiol, prolactin, DHEAS, androstendione, 17 OH progesterone, testosterone, fT4, TSH, as well as oral glucose tolerance test with 75 gr of glucose and insulin and glycaemia detectiona on 0.30.60.90.120. minute, were performed prior to threrapy, during 6. month and 15 years later. 24 hour blood pressure monitoring was performed during the same intervals.

**Results and Conclusions**

RESULTS Significant increase of BMI was detected during 6 months (22,5 +/-2.0 vs.24.3 +/- 2.4 kg/$m^2$and reached 25.6 +/- 2.3 kg/$m^2$ 15 years later. All 24 hour blood pressure variables increased during 15 years expressed by before vs.15 years later: 112.4 +/-12.3/66.7 +/- 9.4 mmHg (day) , heart rate 78.2 +/- 3.2 vs. 83.3 +/- 4.2 /min (day) . During night values are:103.3 +/-5.6 /56.9 +/-5.6 vs. 107+/- 6.6 /65.5 +/- 6.0 mmHg, heart rate 62.4 +/- 4.3 vs.66.1 +/- 4.7 /min. Lipid levels increased, as well as insulin resistance. Fifteen years later 15% of FMT used antihypertensive drugs, 30% anxyolitics, 15% had diabetes and 15% hyperthyroidism.
CONCLUSION Gender differences, including differences in heart size volume, pumping activity in combination with endocrine and metabolic changes, as well as life style, may play key factor for the aging process. Does the heart characteristics , female or male, depend on receptor density, or gonadal steroid amonuts or philosophy of life

on this Planet continuously changing polarities?

# Shift in gender incongruence among children and adolescents: current situation in Norway

Friday, 12th April - 11:30: Law Session II: National Topics and Perspectives (Bramante 9)

***Anne Waehre*** [1]***, Martina Schorkopf*** [1]***, Linda David*** [1]***, Dirk Louis Schorkopf*** [1]

***1.*** *Oslo University Hospital*

**Background**

Following the creation of the Norwegian Gender Team for Children and Adolescents in May 2017 the necessity for an update on the current general situation of gender incongruence became apparent. The recent change (1st of July 2016) in Norwegian law regarding gender recognition allowed first insights into decision making frequencies among young patients regarding their legal gender status.

**Methods**

Since the initiation of the Norwegian Gender Team for Children and Adolescents, data from more than 300 patients has been collected to get an overview about the situation of gender incongruence among children and adolescents in Norway. Structured quantitative retrospective chart reviews and qualitative analysis of case files were applied. In addition, we also studied the number of cases among children and adolescents that realized the opportunity to change their legal gender status within 16 months after the new law came into effect.

**Results and Conclusions**

Current evaluation shows a dramatic increase of referrals since 2012. Observed is also a notable shift towards birth assigned girls in need of support regarding their gender incongruence, resulting into an inversion of observed birth-assigned gender frequencies around 2014. More than double of patients among the age group 13-17 were birth-assigned girls. The latter group was also notably overrepresented regarding signs or diagnosis of ASD (autism spectrum disorder) and other complex psychiatric symptoms, similar to what has already been observed in other Scandinavian and European countries. The current results suggests psychological monitoring and case-specific guidance of patients in their development going well beyond simplified gender incongruence treatment aspects.

About 40% of children and adolescents that were referred to the Gender Team for Children and Adolescents took the opportunity to change their legal gender status 16 months after the introduction of the novel gender recognition law. The decision making towards a change in legal status was partly gender specific: While the probability to change to female gender did not change markedly with patient age, there was a consistent increase in probability (Wald Chi-Square 8.846, p=0.005) in changing the legal gender status with age in birth-assigned girls. When taking age, bullying and previous trauma experience into account, there was a four-times higher probability in male-birth-assigned patients to change their legal gender status as compared to patients of the same gender not having reported previous bullying assaults. Future studies need to evaluate whether these observations might indicate a potential necessity for more attention regarding bullying in trans girls.

# “Torture Isn’t Therapy”: The Legality of Transgender Reparative Therapy

Friday, 12th April - 11:45: Law Session II: National Topics and Perspectives (Bramante 9)

***Florence Ashley*** [1]

***1.*** *McGill University*

**Background**

In 2015, the Canadian province of Ontario passed a law prohibiting “any treatment that seeks to change the sexual orientation or gender identity of a person under 18 years of age.” This law, which was widely described as a ban on reparative therapy, led to the closure of the CAMH Child Youth and Family Gender Identity Clinic, which practiced the psychotherapeutic approach to pre-pubertal youth care. Although a number of jurisdictions have since banned or attempted to ban reparative therapy, the overwhelming majority have no legislative measures in place which explicitly protect trans youth against therapies which aim at changing their gender identities and make them align with the gender they were assigned at birth, despite WPATH considering such therapeutic approaches unethical. In this presentation, the author inquires into the law’s ability to palliate the lack of explicit protections through general statutes on professional responsibility and through disciplinary mechanisms provided by licensing bodies.

**Methods**

Using a doctrinal and jurisprudential method which draws on notions of professional liability, disciplinary law, and the right to equality while situating them within of contemporary scientific knowledge and standards of practice, the presenter argues that laws of general application may be used to sanction the practice of reparative therapy by licensed professionals even in the absence of explicit prohibition.

**Results and Conclusions**

The juridical avenues provided by professional liability and disciplinary law empower victims of reparative therapy as well as trans advocates to seek judicial redress against the practice. It also provides professional association with legal tools which they can use to pursue their mandates of protecting trans patients by emitting guidelines as well as engaging in disciplinary procedures against practitioners of reparative therapy. In light of many legislatures’ unwillingness to prohibit reparative therapy, professional liability and disciplinary law may provide a viable alternative in the fight against this unethical practice. Insofar as both forms of law are intended to protect patients from unethical and out-of-date practices, trans health advocates should consider making use of them in opposing reparative therapy.

# The limits to gender self-determination in a stereotyped legal system: lessons from the 2017 Belgian Gender Recognition Act

Friday, 12th April - 12:00: Law Session II: National Topics and Perspectives (Bramante 9)

***Pieter Cannoot*** [1]

***1.*** *Ghent University*

**Background**

On 1 January 2018 the new Belgian Gender Recognition Act (GRA) entered into force. The GRA replaced the 2007 Act on Transsexuality and abolished all medical requirements for legal gender recognition. Transgender persons have therefore become able to have their official birth sex registration changed in their self-defined gender identity, without having to undergo a psychiatric assessment, sex reassignment surgery and sterilisation. By adopting the GRA, Belgium became the 5th European country and the 7th worldwide to enable legal gender recognition solely on the basis of self-declaration. However, the GRA not only abolished conditions for legal gender recognition but also introduced new so-called procedural guarantees to prevent (identity) fraud and 'light-hearted' applications. This contribution analyses the 2017 GRA in the light of the international and European human rights standards regarding gender identity. It specifically studies the scope of the recognition of gender self-determination in the GRA, the lingering paternalism towards transgender persons, and the unchallenged cisnormativity and binary normativity of the GRA and the legal system as a whole.

**Methods**

The research made use of Belgium as a case study of a European State with a constitutional tradition, that is a member of both the Council of Europe (CoE) and the European Union (EU). A theoretical qualitative analysis of the main domestic and foreign legal literature and case law was used. This legal analysis was informed by (post-structuralist) feminist scholarship, critical legal studies and queer theory. All three perspectives share post-structuralist viewpoints which proved to be instrumental to the analysis of how the Belgian legal system deals with the autonomy rights of transgender persons, especially with regard to its adherence to stereotypes regarding gender identity and gender diversity.

**Results and Conclusions**

The paper argues that the Belgian legislator failed to conceptually implement the logical consequences of the recognition of the right to gender self-determination and therefore embedded the GRA in a stereotyped legal system which still limits the human rights of transgender persons.

# Situation on the mental health services for transgender people in Ukraine

Friday, 12th April - 12:15: Law Session II: National Topics and Perspectives (Bramante 9)

***Nikita Karimov*** [1], ***Olga Semenova*** [1]

***1.*** *Insight NGO*

**Background**

The population of Ukraine is more than 40 million people, of which, according to the average world statistics, more than 50 thousand people belong to transgender people. Misunderstanding of the principles and importance of mental health theme is a huge social issue in Ukraine.

Special difficulty of rendering assistance for transgender people in Ukraine is not only the lack of a modern and systematized practice on this issue, but also the general lack of legislative mechanisms governing the provision of assistance and the work of health professionals for transgender clients.

Through the past years transgender people in Ukraine experienced a lot of difficulties in access to the qualitative mental health services. In particular, legal gender recognition procedure still requires the F64.0 diagnosys which interferes with social adaptation and violates the human rights. In this presentation we will describe an overall situation on the LGR procedure and access to the mental health services for transgender people in country.

**Methods**

Presentation with analytical data and case study.

**Results and Conclusions**

General overview of gained experience and approaches to providing mental health care and assistance to transgender people in Ukraine. Analysis of assistance in conditions of limited institutional support.

Mental health situation issues:

- Unified clinical protocol for medical care transgender people;
- Difficulties with access to paid help;
- Social stigma of referring to experts in the field of mental health: psychologist = psychiatrist = diagnosis of “psycho”;
- Specificity of conducting face-to-face meetings and access to public spaces for transgender people;
- Specificity of conducting face-to-face meetings and access to public spaces for transgender people;
- Lack of referral program for crisis help;
- Lack of relevant education and training programs for psychotherapists on gender identity and sexuality issues;
- Lack of ethic code among psychotherapists;
- Existence of forced correction approach.

# A thin line between protection and isolation: the denial of human dignity of transgender prisoners in Italian penal institutions

Friday, 12th April - 12:30: Law Session II: National Topics and Perspectives (Bramante 9)

***Giuseppe Zago*** [1]

***1.*** *Northumbria University*

**Background**

The Italian prison system is regulated on the basis of gendered and hypermasculine institutionalised dynamics, which perpetuate forms of discrimination particularly affecting queer, trans and gender non-conforming individuals. In particular, the gender binary divide of the prison population, along with a general sex prohibition policy, appears informed on what Rubin has called the "sex/gender" system (Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality, 1993), a traditionalist standard where only two genders, male and female, with specific essentialist roles, are recognised.

Indeed, the National Prison Service either classifies prisoners according to their sex at birth, or places transgender individuals in special sections usually located in male prisons in the aim of guaranteeing their security. Such arrangement ends up aggravating transgender inmates' prison conditions as compared to the general prison population, as they struggle accessing medical treatment or participating to activities organised by the prison staff. Ultimately, protection turns into daily isolation, invisibility and transphobic practices.

In April 2018, 58 declared transgender people were hosted in 10 special sections in different institutions (2018 Annual Report to Parliament of the Italian Ombudsman on the Rights of prisoners or people deprived of their liberty): this relatively small number is still disproportionate in light of the overall prison population, probably depending on the precarious and discriminatory conditions transgender people suffer even outside prison. Furthermore, many other individuals who do not identify as male or female, but are not placed in special sections, do not figure in official statistics.

**Methods**

The findings of this paper are based on the analysis of Italian law and jurisprudence, with special attention to the provisions introduced with the reform of the Law on Prisons that entered into force in October 2018. Moreover, the study of black letter law was undertaken by considering the data analysis of 14 semi-structured interviews recorded by the author with gay, lesbian and transgender prisoners that were held in three Italian prisons during the period July – August 2018.

**Results and Conclusions**

Conversations with queer prisoners highlighted main concerns of transgender inmates in terms of sexuality, intimacy, access to services and healthcare. They also gave a picture of the hurdles they face in entertaining relationships with other prisoners.

Interviews with gay and lesbian prisoners contributed to represent the sensitive relational dynamics among different groups within the queer minority. Particularly, data show that the situation of trans women in male prisons raises different issues if compared to the lives of trans men in female penal settings.

Overall, the conditions of imprisonment of queer and transgender inmates are problematic to say the least, raising doubts concerning their treatment conformity with the constitutional principles of rehabilitation as main aim of

imprisonment, and respect of human dignity.
The participants' sample, although small in size, allowed observing some major problems affecting non-cisgender, non-heterosexual minorities during imprisonment, which are only partially addressed by current national legislation, *in primis* the allocation procedure based on an unrealistic essentialist paradigm.

# Acid Reflux: A Silent Barrier to Transgender Voice Modification

Friday, 12th April - 11:30: Voice Session II (Bramante 12)

***Celia Stewart*** [1], ***Irene Kling*** [2]

***1.*** *New York University,* ***2.*** *Adelphi University*

**Background**

As speech-language pathologists, we recognize that the voice modification process is a complex one, and we must consider not only the sound of the voice and its underlying physiology, but the risk factors that often undermine the trans speaker's progress. These factors may include allergies, hearing loss, side effects from medications, and acid reflux. This last and pervasive risk factor can be the bane of the clinician and the client because chronic backflow of gastric acid into the throat often leads to changes in vocal fold tissue that negatively affect voice production. Transgender speakers, who experience chronic reflux, may complain of morning roughness with prolonged warm-up time, limited pitch and loudness ranges, difficulty maintaining vocal consistency in their desired range, and deterioration of voice quality during speech as well as singing. They may complain of excessive and intractable mucus, throat tickle, and the need for frequent throat clearing. When left untreated, mucosal changes, laryngeal soreness and tightness, and chronic cough may further compromise voice production and quality of life.

**Methods**

Management of acid reflux has increasingly become the purview of the voice clinician. However, the literature regarding the effectiveness of lifestyle changes (e.g., cessation of smoking, consumption of alcohol, timing and amount of eating, position during sleep, etc.) is inconclusive. In a review of over 20,184 articles from 1990 to 2018 only four factors consistently showed a significant decrease in the symptoms of reflux: regular mealtimes, time between eating and reclining, sleeping position, and elevation of the torso during sleep.

**Results and Conclusions**

Given the inconsistencies in the literature, the frequency of acid reflux, and its significant impact on progress, how, then, does the voice clinician effectively manage this often-omnipresent problem, and minimize its effect on the successful modification of the voice? In our presentation we will explore the options available to the client and the clinician to effectively cope with the consequences of acid reflux as they apply to voice modification.

# Trans Voice and Communication: Service users' satisfaction and self-rated outcomes with the delivery of voice feminisation therapy

Friday, 12th April - 11:45: Voice Session II (Bramante 12)

***Christella Antoni*** [1]***, Rhiannon Grébert*** [2]***, Carol Fairfield*** [3]

***1.*** *Christella Antoni Voice and Speech Services, London,* ***2.*** *Gender Identity Clinic, Daventry,* ***3.*** *University of Reading*

**Background**

There is a marked dearth of research on the delivery of voice modification therapy, particularly that which goes beyond the level of single service providers. The recent development of the Trans and Gender Diverse Voice and Communication Therapy Competency Framework (Royal College of Speech and Language Therapists, 2018) means the training and training needs of speech and language therapists (SLTs) in this field have received focused attention. It therefore seems extremely timely that how this therapy is delivered - on a structural level - also receive attention. There exists a very wide variability among service providers of what is offered to a patient seeking to modify their voice. There is no consensus on how a service decides upon the format and delivery of the voice therapy they will offer, meaning great variability across different providers. For example, for some providers, the number of sessions offered to patients is predefined and consequently the same for every patient. Similarly, providers might offer only one therapy format, or a mixed format approach.

This initial review of service provision via questionnaire starts to explore the range of voice therapy delivery that is offered, through asking a selection of service users themselves about their experiences. It explores respondents' thoughts regarding service delivery, as well as their self-rated outcomes on their voice, their satisfaction with the service, and reasons for why their therapy course finished. This questionnaire places service users' input at the centre of the study as cooperation between providers and service users is vital if the needs of the patients are to be fully met.

**Methods**

An online qualitative and quantitative questionnaire was used, which 82 self-selecting and post-voice therapy trans women completed. The study includes former patients from NHS and independent providers from across England.

**Results and Conclusions**

The 82 respondents represented a wide range of ages and locations: ages ranged from 18 to 80+ years and every region of England was represented. The study's key variables: format, no. of sessions and length & frequency of therapy were subject to initial analysis including correlation with voice satisfaction, among other outcomes.

Initial results show that as predicted there was great variability in the number of voice therapy sessions that service users had undertaken (range 1-22+), however, this variability was not mirrored in the format typically offered by providers.

Further analyses will explore the issues of satisfaction with service and any correlation with outcomes. It is hoped that this review of provision will be replicated on an even bigger and more encompassing scale. The authors also intend that the information gained from this study and any future study will be used to further inform and shape policies for the future delivery of voice modification therapy.

# Inside competence: growing a speech and language therapy workforce which guarantees trans affirmative, quality voice and communication therapy services throughout the UK.

Friday, 12th April - 12:00: Voice Session II (Bramante 12)

***Matthew Mills*** [1], ***Nazlin Kurji-Smith*** [2], ***Carys Bracken*** [1], ***Helen Greener*** [2], ***James Barrett*** [1]

***1.*** *Gender Identity Clinic. Charing Cross. London,* ***2.*** *Northern Region Gender Dysphoria Service Newcastle*

**Background**

The challenge for gender dysphoria NHS services with its soaring referrals, including speech and language therapy both in tertiary gender specialist centres and in secondary local services, is to provide more equitable delivery of high quality care to trans and gender diverse people throughout the UK. NHS England Clinical Reference Group Gender Identity Services and the Royal College of Speech and Language Therapists (RCSLT) commissioned the *Trans and Gender Diverse Voice and Communication Therapy Competency Framework*to support training and growth in the speech and language therapy workforce.

**Methods**

The RCSLT and its Trans and Gender-Diverse Voice and Communication Clinical Excellence Network developed a draft framework, in liaison with other disciplines and royal colleges. Public consultation took place in 2017 and the RCSLT appointed a feedback review panel drawn from a cross section of the speech and language therapy profession. The panel met between March and June 2017 to review a total of 264 separate responses to the draft. Their remit was to ensure that the framework not only adequately reflected the broad range of views in the profession, but that it is also a useful and practical guide for developing knowledge and skills and a comprehensive, logical tool for supervising SLTs and managers.

**Results and Conclusions**

Respondents to the consultation came from all regions of the UK: SLTs (93.1%), managers (13.8%), researchers (10.3%), newly qualified practitioner (3.4%) and worked in NHS (82.8%), independent practice (20.7%), and university/higher education institution (10.3%). Respondents reported an annual trans caseload of up to: 5 (25%), 10 (10.7%), 20 (25%) and more than 20 (32.1%). *The Trans & Gender Diverse Voice & Communication Therapy Competency Framework*was published in January 2018 and describes prerequisite skills, and 3 levels of competence related to caseload size and complexity. The Framework has identified training needs for SLTs, and clinical education providers, such as the Tavistock and Portman NHS Foundation Trust, have now developed courses which map directly on to each described competency. Furthermore, NHS England, University of London and the Royal College of Physicians are currently also collaborating with the RCSLT and other colleges to develop post-graduate credentialing qualifications in gender dysphoria treatment, which will include training modules for SLTs. The Framework will be reviewed later in 2019 regarding how it continues to be used nationally to sign off on competence and contribute to professional appraisal.

# Taiwanese Speech-Language Therapists' Awareness and Experiences of Service Provision to Transgender Clients

Friday, 12th April - 12:15: Voice Session II (Bramante 12)

***Lia Litosseliti*** [1], ***Ioanna Georgiadou*** [2]

***1.*** *City, University of London,* ***2.*** *Nottingham Centre for Transgender Health*

**Background**

Voice and communication style are two important identifying dimensions of gender and transgender individuals often seek voice and communication therapy as part of their transition. However, evidence suggests that few transgender individuals can access this therapy, possibly because of concerns about confidentiality, discrimination, stigmatization, or negative past experiences. It is essential, therefore, for this client group to have access to culturally competent healthcare services. Some studies of SLTs' experience and confidence working with transgender individuals have recently been undertaken in the US. However, little research has been carried out in Asia.

The aim of the research presented in this paper was to investigate Taiwanese SLTs' knowledge, attitudes and experiences of providing transgender individuals with relevant therapy.

**Methods**

A cross-sectional self-administered web-based survey hosted on the Qualtrics platform was delivered to 140 Taiwanese SLTs. The data was collected by way of a questionnaire containing questions about their demographics and their awareness and experiences of providing services to transgender clients.

**Results and Conclusions**

Taiwanese SLTs were, (i) more familiar with the terminology used to address 'lesbian, gay, and bisexual groups' than with 'transgender' terminology, (ii) generally positive in their attitudes towards transgender individuals, and (iii) comfortable about providing them with services. However, the majority of participants did not feel that they were sufficiently skilled in working with transgender individuals, even though most believed that providing them with voice and communication services fell within the SLT scope of practice.

It is important for clinicians to both be skilled in transgender voice and communication therapy and to be culturally competent when providing services to transgender individuals. This study recommends that multicultural issues relating to gender and sexual minority groups should be addressed in SLTs' university education as well as in their continuing educational programs.

# Decision aid for gender affirming surgery in trans men

Friday, 12th April - 11:30: Surgery Session I: Surgical mental health (Bramante 15)

***Müjde Ozer*** [1], ***Garry Pigot*** [1], ***Mark-Bram Bouman*** [1], ***Tim van de Grift*** [1], ***Lian Elfering*** [1], ***Norah Van Mello*** [1], ***Hoda Al-itejawi*** [1], ***Marlon Buncamper*** [1], ***Margriet Mullender*** [1]

***1.*** *VU Medical Center*

**Background**

In transgender men, multiple options are available for genital gender affirming surgery. The trans men should be able to weigh these options based on outcomes, risks and consequences that are most important to him. Hence, the aim of this study was to develop and evaluate a Decision Aid for Genital Surgery in Trans men (DA-GST). The DA-GST aims to support the trans men in making thoughtful choices among treatment options and facilitate shared decision-making between the health care professionals and the trans men.

**Methods**

A qualitative focus group study was performed. In total, five focus groups with both trans men and health care professionals (HCPs) involved in the treatment of individuals diagnosed with gender dysphoria (plastic surgeons, gynecologists, urologists, physician assistants, psychologists) were organized. Study participants were trans men who had already undergone genital gender affirming surgery, trans men who were considering to undergo genital gender affirming surgery, or trans men who decided not (yet) to undergo genital gender affirming surgery. All focus groups were led by an independent professional moderator who instructed participants to first write down their “answers or issues” on a specific topic before letting everyone, in turn, share within the group. This approach prevented the overshadowing of some participants and it stimulated active participation of all group members.

**Results and Conclusions**

The exact scope of the decision aid was determined during the first focus group. The DA addresses various choice combinations regarding the removal of native reproductive organs and/or parts of the native genitals, including various options for the creation of a masculine genital with or without urethral lengthening. HCPs and transgender men agreed that the desired outcome and realistic expectations should form the core of the content of the DA, but not the medical information per se. Its aim should be to assist the trans men in the decision-making process by giving arguments for and against specific options, however, it does not render a particular “best option”.Items collected from the focus groups were grouped into five themes: outcome, quality of life, environment, sexuality, and beliefs. For each item within these themes arguments for and against a specific type of surgery were collected. Careful consideration was taken in the phrasing of the DA because of the delicate situation and feelings involved in gender issues and genital affirmation surgery. The results of usability will be presented at the WPATH.

CONCLUSION

This Decision Aid for Genital Surgery in Trans men concerns all surgical options for genital gender affirming surgery in trans men. This tool is useful in assisting trans men in their decision-making process by providing arguments for or against specific options and to assist health care professionals in the exploration of which domains are most relevant for each specific individual.

# Personalized care for individuals seeking gender affirming treatments: The Development of a Patient Reported Outcome Measure (PROM)

Friday, 12th April - 11:45: Surgery Session I: Surgical mental health (Bramante 15)

***Maeghan Ross [1], Müjde Ozer [1], Timotheüs Van De Grift [1], Baudewijntje Kreukels [1], Mark-Bram Bouman [1], Marlon Buncamper [1], Danny Young Afat [2], Andrea Pusic [3], Anne Klassen [4], Manraj Kaur [4], Margriet Mullender [1]***

***1.*** *VU Medical Center,* ***2.*** *UMC,* ***3.*** *Harvard Medical School,* ***4.*** *McMaster University*

**Background**

Gender-affirming treatment is thought to be the most appropriate approach for individuals who experience incongruence between their experienced gender and their assigned gender. The gender-affirming procedure itself is multifaceted and requires a lot from the health care provider and the transgender persons themselves. The transgender individual's goals and possible outcomes may or may not include all or any medical interventions.

Currently there are no appropriate tools available to properly evaluate experiences within the gender-affirming health care system and the outcomes of various treatment options. Therefore, in order to accurately be able to evaluate and organize health care for transgender individuals, it is essential for providers to know which patient-reported outcomes (PROMs) are critical to the transgender individuals themselves.

The aim of this project is to develop a validated instrument for outcome measurement within transgender healthcare. This PROM will be used to measure domains that the transgender individuals themselves find important before, during, and after treatment by directly asking them.

**Methods**

Working in close cooperation with the target group and gender-affirming health care providers, the goal of our study is to develop a transgender PROM. The study consortium consists of an international group of expert clinics from North America and Europe,.

The study will include three phases that occur iteratively and interactively: Phase I—item generation, Phase II—item reduction, and Phase III—psychometric evaluation. In Phase I the concepts of interest for the transgender individuals regarding their outcome will be identified. This will be determined using a systematic review of the literature and semi-structured qualitative interviews with transgender individuals. In alignment with the concepts of interest identified in Phase I, Phase II will focus on the development of items for the preliminary scales. This will be achieved through a pilot field study and followed by a much larger international field study of the finalized scale set. An expected number of 60-80 transgender persons will participate in the interviews and 500-750 transgender persons in the field test study. In addition, Rasch Measurment Theory will be used to define measurement characteristics and aid in the process of item reduction. Phase III will focus on further tests of reliability, validity, and responsiveness of the finalized instrument.

**Results and Conclusions**

This PROM will be the product of a multiphase mixed methods approach. The developed PROM will be measuring Quality of Life of the transgender persons and assess transition-related experiences. Concepts within the domains of physical, sexual, psychological, and social health will be identified. We plan to present the protocol article of the

development this instrument as well as any preliminary findings.
Our collaboration with the transgender community will guarantee a PROM containing outcome measures important for the transgender individuals themselves, while ensuring scientific validity.

# The BODY-Q Chest Module: Presentation of a novel patient-centered self-reported outcome measure and first findings using the instrument.

Friday, 12th April - 12:00: Surgery Session I: Surgical mental health (Bramante 15)

*Tim van de Grift* [1], *Lian Elfering* [1], *Marijke Greijdanus* [1], *Jan Maerten Smit* [1], *Mark-Bram Bouman* [1], *Anne Klassen* [2], *Andrea Pusic* [3], *Manraj Kaur* [2], *Margriet Mullender* [1]

*1. VU Medical Center, 2. McMaster University, 3. Harvard Medical School*

**Background**

**Introduction:** Gender affirming surgical interventions are best evaluated on self-reported outcome measures that include subjects that are most relevant to the group themselves. At present, only few of such transgender-specific measures are available.

**Objectives:** To present a self-reported measure specific to transgender chest wall masculinization surgery and to distribute this measure in a cohort of pre- and postoperative trans men.

**Methods**

**Methods:** Combined literature search and multiple rounds of qualitative interviewing determined a preliminary version of the Chest Module. Subsequently, the measure was field tested in Canada, Denmark, the Netherlands and the USA between June 2016 and June 2017. The Chest Module was developed for and tested on individuals with surgery for gynecomastia, weight loss and transmen chest surgery. Rasch Measurement Theory was applied to qualitatively determine the final items of the measure. At the VU University Medical Center data collection included preoperative examination, screening questions on anxiety and depression and seven BODY-Q scales including the Chest Module.

**Results and Conclusions**

**Results:** The total sample of the Chest Module validation study included 689 participant (including 291 trans men). Rasch Measurement Theory analysis revealed a 10-item chest and a 5-item nipple scale. Both scales showed good internal consistency and reliability. Also, high correlations with other self-reported outcome measures were observed. At the VU University Medical Center, 101 trans men participated (50 preoperative, 51 postoperative). Postoperative participants reported significantly higher (better) scores on the chest (M=67), nipple (M=58), body (M=58; all p<.001) and psychological (M=60; p=.05) scales compared with preoperative patients. Postoperative chest and nipple scores did not differ significantly from a gynecomastia comparison groups, whilst scores were less favorable on the psychosocial domains. Pre-operatively, chest scores were not associated with objective breast size. Lower post-operative chest scores were associated with planned revision surgery (β=-.52) and depressive symptoms (β=-.59).

**Conclusions:** The BODY-Q Chest Module is a valid and applicable measure to assess experienced outcomes after chest wall masculinization surgery in trans men. First analysis of cross-sectional data indicates that surgery improves these outcomes, and indicates that topics such as revision surgery and depressive symptoms are associated.

# Ethical Considerations Regarding Penile Transplantation Surgery in Transgender Men: An Empirical Ethical Study.

Friday, 12th April - 12:15: Surgery Session I: Surgical mental health (Bramante 15)

***Anne Gehrels*** [1], ***Kristin de Haseth*** [1], ***Margriet Mullender*** [1], ***Floyd Timmermans*** [1], ***Guy Widdershoven*** [1], ***Mark-Bram Bouman*** [1], ***Tim van de Grift*** [1]

***1.*** *VU Medical Center*

**Background**

**Background:** Up until March 2018, five penis transplantation were performed to a cisgender man after traumatic genital injury. Transgender men desiring to have male genitalia might have the wish to receive a donor penis as well. However, alongside other ethical and societal considerations regarding transgender surgery, new topics might arise with the possible introduction of this technique.
**Aim:** The purpose of this study was to investigate the ethical considerations amongst different stakeholders regarding penile transplantation surgery in transgender men.

**Methods**

**Methods:** Separate focus groups were conducted; one focus group consisting of six experts in transplantation surgery or gender affirming treatments and one consisting of six transgender men. Participants were invited based on professional background (professionals) and the phase of gender transitioning (transgender men). Themes discussed during focus groups were formulated based on a prior literature study on ethical considerations in transplantation surgery and in gender affirming treatments. Two additional one-on-one interviews were conducted with a gynecologist working on uterus transplantation and a researcher previously working on penile transplantation. The focus groups were audio recorded and transcribed. Data was coded by two researchers and thematic analysis was performed. Extracted themes were combined with themes described in the literature.

**Results and Conclusions**

**Results:**Three major ethical themes emerged from analyses from both stakeholder groups; (1) The first issue was balancing the presumed gains and likely involved risks. Life-long immunosuppressive medication was especially seen as a major risk by both experts and transgender men. Whereas aesthetics and (sexual) function were seen as the main benefits by the transgender men. Risks-benefit weighing differed individually, with health care providers generally putting more emphasis on the risks. (2) Secondly, personal identity and uncertainty about the transplantation's impact on the patient perceived wholeness of the body were addressed. These topics were mentioned less frequently by the health care professionals. (3) Lastly, the (unknown) impact of introducing penile transplantation for transgender men on the national donor system and the societal attitude towards gender affirming health care in the Netherlands was mentioned by health care providers specifically.
**Conclusion**: The present data suggest that both transgender men and health care professionals are aware of ethical pro's and con's regarding penile transplantation surgery for transgender men. Considerations pertain to both anticipated risks and gains, identity development and the wider societal impact. Weighing these factors differed both between and within the stakeholder groups.

# Transgender Minors and the Surgical Taboo: Is Age Restriction Justified?

Friday, 12th April - 12:30: Surgery Session I: Surgical mental health (Bramante 15)

***Ed Horowicz*** [1]

***1.*** *Edge Hill University*

**Background**

The need for clinical guidelines for controversial interventions to be founded on 'expert opinion' and an evidence base is to minimise individual clinicians making subjective decisions influenced by bias or cultural norms. This paper considers clinical guidelines that through recomendation effectively prohibit the provision of Genital-Alignment Surgery (GAS) for competent adolescents diagnosed with gender dysphoria. I argue that although the rationale for this particular guideline is based on serious concerns, these need to be better understood to allow reconsideration of this unilateral prohibitive recommendation on GAS in adolescence. I do not propose that GAS should be prima facia provided for all adolescents diagnosed with gender dysphoria. Instead I argue that by developing ourunderstanding of the current concerns we can allow current guidelines to incorporate a margin of clinical discretion in order to allow clinicians to provide GAS to some adolescents, where clinically appropriate. In faciltiating this we can move towards establishing a solid evidence base. The basis of this position is that clinical guidelines and medical practice should treat these young people with the same standards of evidence-based care as others who have less controversial conditions.

**Methods**

To answer the question the paper considers the impact of guidelines on the provision of clinical care through the perspectives of professional, legal and surgical arguments. The paper draws on empirical, doctrinal, ethical and sociolegal literature throughout.

**Results and Conclusions**

In focusing on the provision of genital-alignment surgery for minors, I argue that the deference to clinical guidelines in this area of adolescent healthcare may directly impede on the ability of doctors to act in their patient's best interests. The paper highlights that the deference of this surgery until the age of majority lacks a solid evidence-base on which to justify this guideline. In fact, if applied strictly, these guidelines could force a doctor to act in a way that does not represent the best interests of the patient. Ultimately concluding that the concerns around genital-alignment surgery in adolescence should be better undestood and thus regarded as being an ethically justifiable medical treatment for competent minors, where appropriate and based on clinical judgment, which means that current clinical guidelines should be reconsidered.

# Educational and clinical practices of speech and language therapists/pathologists in Europe, in the field of transgender voice and communication - A symposium proposal

Friday, 12th April - 14:00: WS 1: Speech and language therapists/pathologists in Europe (Bramante 7)

***Ioanna Georgiadou*** [1], ***Marjan Cosyns*** [2], ***Elif Meryem Unsal*** [3], ***Matthew Mills*** [4], ***Maria Södersten*** [5]

***1.*** *University of Nottingham - Nottingham Centre for Transgender Health,* ***2.*** *Ghent University,* ***3.*** *Anadolu University, Faculty of Health Sciences, Department of Speech and Language Therapy,* ***4.*** *Gender Identity Clinic. Charing Cross. London,* ***5.*** *Karolinska Institutet, Department of Clinical Science, Intervention and Technology, Division of Speech and Language Pathology and Karolinska University Hospital, Functional Area Speech & Language Pathology*

**Background**

European university programs in speech and language therapy (SLT) or speech and language pathology (SLP) differ depending on the country, in terms of length of the study program, content, and academic level of the degrees. It is possible that these differences relate to how prepared SLTs/SLPs are to clinically work with transgender clients and also to participate in research activities related to transgender voice and communication. Some studies of SLTs/SLPs' experience and confidence working with transgender individuals have recently been undertaken in the US and in Asia. However, little research has been carried out in Europe. The aim of this symposium is to begin mapping European SLTs/SLPs' educational experiences, as well as the clinical underpinnings of transgender voice and communication therapy. Moreover, the aim of this symposium is to facilitate and encourage a European SLT/SLP network. The four authors proposing this symposium will discuss both educational and clinical experiences in Great Britain, the Nordic countries, Belgium and Holland. The authors will aim to collaborate with colleagues from other European countries, especially those participating at EPATH.

**Methods**

…

**Results and Conclusions**

….

# Ethical dilemmas in gender surgery

Friday, 12th April - 14:00: WS 2: Ethical dilemmas in gender surgery (Bramante 8)

***Müjde Ozer*** [1]***, Luk Gijs*** [2]***, Tim van de Grift*** [1]***, Els Elaut*** [3]***, Joz Motmans*** [4]***, Mark-bram Bouman*** [5]***, Margriet Mullender*** [1]

***1.*** *VU Medical Center,* ***2.*** *Amsterdam UMC, location VUmc,* ***3.*** *Department of Sexology and Gender in Ghent, University Hospital Ghent, Belgium,* ***4.*** *Ghent University,* ***5.*** *Vumc*

**Background**

Over the past decade, the conceptualization of the concept of "gender" has shifted rather strongly from a dichotomous view of man/woman as a binary to a more continuous concept of each person possessing both masculine and feminine characteristics in varying degrees. As a result of these more continuous views, health care providers acknowledge more often individual differences in (gender-)identity development and treatment requests. Subsequently they are willing to support the unique paths individuals may take to one's hoped for goals and outcomes may or may not have included different medical interventions, and to offer accessible and flexible affirmative non-stigmatizing health care. This flexible approach to treatment requests, following changes in diagnostic criteria (ICD-11), societal changes, changes of law in European countries,can be challenging for health care professionals.
In principal health care professionals follow the fundaments of medicine and the Hippocrates oath: "Practice two things in your dealings with disease: either help or do not harm the patient".
When it comes to surgery, the surgeon must trust, more than before, on the patient itself and the health care professionals concerned with the gender incongruent individual prior to the surgical consultation, when it comes to possible risks and gains of surgery. In order to "help", the surgeon must fully understand what treatment is desired. In order to "do no harm", the expectations and underlying motives of the individual in relation to the wished for treatment should be explored thoroughly.

**Methods**

Aim of this workshop:
In a period when there are many innovations in surgical policies regarding the treatment of gender incongruence and a shift toward more shared decision making between patients and surgeons, we are aiming at (1) facilitating a dialogue between health professionals on the impact of these trends on how they handle (a)typical surgical request and (2) clarifying the criteria that are used by surgeons and other health professionals to accept or reject (a)typical requests. Finally, we e are hoping that health care professionals participating in the workshop afterwards feel more empowered when encountering diverse treatment requests of gender incongruent individuals.

Questions addressed during the workshop:
What diverse treatment requests did you come across?
Do these requests form an ethical dilemma?
What is your approach when it comes to atypical requests?
How do you handle treatment requests that transgress your professional boundaries?
Is there a need to draw a line for accepting or rejecting surgical requests? Per clinic? Per country? European? Worldwide?
If there is a need to draw a line, where should we draw it?

Method:
In an era of more acceptance of gender diversity and gender incongruence, we want to discuss these (ethical) questions in an interactive interdisciplinary workshop. Led by experts in the field of trans gender health care. The workshop will use clinical cases as a starting point
Depending on people count this can be done in smaller groups or engroup.

**Results and Conclusions**
Will follow from this workshop.

# The ENIGI initiative: Lessons learned from multi-center follow-up studies in Europe

Friday, 12th April - 14:00: WS 3: The ENIGI initiative: Lessons learned from multi-center follow-up studies in Europe (Bramante 9)

***Timo Nieder*** [1]***, Baudewijntje Kreukels*** [2]***, Els Elaut*** [3]***, Inga Becker*** [4]***, Gunter Heylens*** [5]***, Tim van de Grift*** [2]***, Guy T'Sjoen*** [6]

***1.*** *University Medical Center Hamburg-Eppendorf,* ***2.*** *VU Medical Center,* ***3.*** *Ghent University Hospital,* ***4.*** *University Medical Center Hamburg,* ***5.*** *Ghent University,* ***6.*** *Uz Gent*

**Background**

Follow-up studies in healthcare are promising in their ability to report on the outcome of interventions. However, there are challenges for both researchers conducting the study as well as participants reporting on their life situation years after their first referral to a specialized clinic. Especially when it comes to rare phenomena, like individuals who follow uncommon treatment trajectories, follow-up studies often lack power due to small sample sizes.

The European Network for the Investigation of Gender Incongruence (ENIGI) was founded in 2007 with the goal to provide a standardized long-term assessment of healthcare in different countries. Four European gender clinics (Amsterdam, Ghent, Hamburg and Oslo) established a standardized protocol for the assessment of all individuals who entered specialized care. All individuals aged 17 years or above were asked to fill-in a standardized battery of self-administered questionnaires on gender, sexuality and mental health-related aspects of their lives. The aim of the study is to examine how pre-treatment factors relate to post-treatment outcome in terms of quality of life, social, psychological and sexual functioning. In addition, we will evaluate which factors will predict drop-out or regret

The endocrine part of the study was started in 2010, and aimed to describe in full detail the effects and side-effects of hormone treatment.

**Methods**

The ENIGI psychosocial research project so far collected baseline data of around 2000 individuals from four different countries as well as follow-up data from two cohorts around five years after first referral in three countries (FU1 and FU2; total N = 560). The workshop aims at presenting and discussing advantages and challenges of a European multi-center research project by reflecting on the methods used and samples that eventually participated in the follow-up study. We will provide recommendations for follow-up studies based on our own experience.

The ENIGI endocrine research project also has baseline data of 2000 participants, and recruitment is ongoing.

**Results and Conclusions**

Being without financial research funding since 2007, there were several major challenges for ENIGI. First of all, it continuously needs research assistants resp. fellows who are looking for both the data entry and the data base. When research staff is changing, in order to take care of data entry and data management, it needs a transparent and detailed description to ensure quality.

Secondly, the contact to the participants is highly important and needs to be cared for throughout the study. If participants who have provided baseline data are still coming to the gender clinic, facilitation of future contact and follow-up studies appeared easier than with those who dropped out of care. Therefore, a major challenge exists with regard to analysis of drop-out cases or with regard to those who discontinued care.

Therefore, clinical research almost always entails biases when it comes to the assessed samples. Ideas for possible future research approaches will be discussed.

The details of the endocrine protocol, short-term health data, data on body shape, bone health, breast development, changes in hematocrit and prolactin, and the results of some translational research and data on voice changes will be discussed.

# Gender dysphoria; beyond the diagnosis

Friday, 12th April - 14:00: WS 4: Gender dysphoria: beyond the diagnosis (Bramante 10)

***Johanna Olson-Kennedy*** [1]***, Aydin Olson-Kennedy*** [2]

***1.*** *Children's Hospital Los Angeles/University of Southern California,* ***2.*** *Los Angeles Gender Center*

**Background**

Gender dysphoria is widely understood as the persistent emotional, psychological or physical distress experienced by individual's whose gender does not align with their sex at birth. The Diagnostic and Statistical Manual of Mental Illness outlines criteria that are positioned from a cisgender perspective, are limited in scope, and set up an unrealistic expectation that medical and/or surgical intervention will result in the eradication of gender dysphoria. This workshop proposes to present gender dysphoria as an experience beyond a criteria checklist, demonstrate how dysphoria shows up across different developmental stages, and how it impacts the lives of transgender children, adolescents and young adults. Understanding how gender dysphoria disrupts the lives of transgender individuals is critical to shaping our professional models of care. Dr. Olson-Kennedy is the medical director of the Center for Transyouth Health and Development, and has been providing medical intervention, advocacy and education for transgender children, adolescents and young adults for 12 years. She also spearheads a multi-site NIH grant that is aiming to understand the impact of early intervention among transgender youth on physiologic and mental health parameters. Aydin Olson-Kennedy is a Licensed Clinical Social Worker who has worked with underserved and marginalized populations over the course of his professional career. Aydin brings a unique perspective to his career as mental health professional, and as a transgender man who at one time needed similar mental health and medical services for himself. In 2015, Aydin joined the Los Angeles Gender Center and in 2016, he was hired as the Executive Director, where he continues to focus his work on creating accessible mental care for the gender non-conforming and transgender community, and their families. In addition to his role at the Los Angeles Gender Center and his full time private practice, Aydin speaks internationally to medical and mental health providers, educators, social workers and families on the importance of accessible, informed-consent model of care.

**Methods**

Using case examples, and interactive activities, this workshop will help attendees have an improved understanding of how gender dysphoria is impacting the developmental trajectories of transgender youth. We will explore the overlap of symptoms of gender dysphoria that often lead to diagnoses of ADHD, bipolar disorder, high functioning autism, and others. Co-presenter Aydin Olson-Kennedy, LCSW will explore mechanisms to identify and address gender dysphoria in transgender, gender non-conforming and non-binary individuals.

**Results and Conclusions**

Medical and mental health providers can improve care for transgender youth and young adults if their understanding of gender dysphoria can expand beyond the distress associated with the presence or absence of primary or secondary sex characteristics. Participation in this workshop will improve cultural competency and clinical skills of professionals working with transgender patients and clients.

# Religion and mental health: influence of Hijra culture on the spirituality of transgender people

Friday, 12th April - 14:00: WS 5: Religion and mental health: influence of Hijra culture on the spirituality of transgender people (Bramante 11)

***Aisha Mughal*** [1]***, Bubbli Malik*** [1]***, Raja Nadeem*** [1]

***1.*** *Wajood Society*

**Background**

In South Asia gender is governed to confirm a stereotypical form of patriarchy that clearly demarcates the spheres for women and men. In predominantly Muslim society, which manifests distinctly dichotomous male and female roles, permits no place for any other gender in the religious sphere.

Transgender in Pakistani society, also termed as Hijra or Khawaja sara, isolate themselves in self-sustaining, close-knitted groups where a leader, or guru [word used in hijra or Khawaja sara culture for the leader/mentor], adopts transgender children after they have been rejected or disowned by their parents at a young age because of social stigma and personal shame associated with them (Wijngaarden, et al., 2013). The hijra community is composed of a strict hierarchy with outsized groups of hijras from various areas forming different dynasties or houses called 'gharanas'. Each of these gharanas is headed by a Naayak, who is the principal decision maker for that house (Kalra, 2012). Each Naayak may have a number of gurus under him. Hijras are marginalized and stigmatized gender minority in Pakistan (Jami & Kamal 2015). They are not allowed to perform Hajj (A religious obligation) like the rest of the Muslims and also other religious obligations.

Islamic teachings emphasize on maintaining the masculine identities by males and not to act in feminine way in terms of putting make-up, cross-dressing, taking hormones, or undergoing sex change operation (Yip, 2004). So, transgender people in Pakistan are considered to be violating the tenets of Islam, and consequently are delinquents in Pakistani society.

Nevertheless, a large number of Muslims in Asian countries practice a gentler, more tolerant faith, which is strongly influenced by Sufism where religious tolerance toward transgender people is still evident (Kugle, 2013). Some Hijra people found more comfort in keeping in touch with people of this school of thought.

**Methods**

The primary objective of this panel is to facilitate the 'representation' of marginalized voices, especially of trans and Hijra culture from the South Asian region, not by their mere participation, but by ensuring their agency and spearheading capacity by providing them centre-stage. 3 human rights and gender justice activists from Pakistan and Hijra Culture, which has a rich spiritual history, will head this panel, zooming in on their lived experience as Transgender rights activists. They will highlight, most importantly, how their Faith, Religion, Hijra culture and modern date trans activism benefits their community and societies as a whole.

**Results and Conclusions**

Religious and spiritual satisfaction leads toward mental peace and good health. Studying Hijra culture, which has a rich history of faith and Sufism, is an interesting case study from which Europe can learn. Spiritual status of Hijra members in South Asia brings attention to the fact how mental health is related to faith and religion.

# Embodied Experiences: Gender Related Distress and Eating Disorders in Adolescence

Friday, 12th April - 16:00: WS 9: Gender Identity Development and Eating Difficulties in Adolescence (Bramante 7)

***Anastassis Spiliadis*** [1], ***Anna Churcher Clarke*** [1]

***1.*** *Tavistock and Portman NHS Foundation Trust*

**Background**

The number of young people presenting to gender identity services who also suffer from an eating disorder is increasing, as is the number of gender diverse and gender questioning young people presenting to specialist eating disorders services. This workshop integrates theory and practice around working with young people experiencing distress in relation to their developing bodies; specifically, those who present with both gender related distress and an eating disorder. The workshop will consist of a brief introduction to the work of the Tavistock & Portman's Gender Identity Development Service and The Maudsley Hospital's Child & Adolescent Eating Disorders Service; consider areas of overlap and potential conflict in the care of these young people, and offer the opportunity to engage with clinical examples and interactive exercises.

**Methods**

We will draw upon psychosexual developmental frameworks and wider systemic ideas to formulate the possible meanings of these complex intersecting experiences and consider what optimal care pathways might look like.

**Results and Conclusions**

We aim to explore opportunities to improve clinical practice both within and across UK NHS and European specialist services in this rapidly developing area.

# Medical follow-up after the initiation of gender affirming hormonal therapy

Friday, 12th April - 16:00: WS10: Medical follow-up after the initiation of gender affirming hormonal therapy (Bramante 8)

***Justine Defreyne*** [1], ***Laurens Van De Bruaene*** [1], ***Chantal Wiepjes*** [2], ***Nienke M Nota*** [2], ***Maartje Klaver*** [2], ***Christel De Blok*** [2], ***Dennis van Dijk*** [2], ***Marieke Tebbens*** [2], ***Alessandra Daphne Fisher*** [3], ***Yona Greenman*** [4], ***Sean Iwamoto*** [5], ***Giovanni Castellini*** [6], ***Thomas Schreiner*** [7], ***Koen Dreijerink*** [2], ***Martin Den Heijer*** [2], ***Guy T'Sjoen*** [8]

***1.*** *Ghent University Hospital,* ***2.*** *VU Medical Center,* ***3.*** *Department of Experimental, Clinical and Biomedical Sciences, Careggi University Hospital, Florence, Italy,* ***4.*** *Tel Aviv Sourasky Medical Center,* ***5.*** *University of Colorado School of Medicine, Rocky Mountain Regional Veterans Affairs Medical Center & UCHealth Integrated Transgender Program,* ***6.*** *Department of Health Science, Careggi University Hospital,* ***7.*** *Oslo University Hospital,* ***8.*** *Uz Gent*

**Background**

Gender affirming hormonal therapy should be widely available to all transgender people. In the past few years, guidelines on medical care for transgender people have been updated, including the WPATH SOC 7 and the Endocrine Society Clinical Practice Guideline on Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons. Informing hormone prescribing physicians about transgender care may increase access to gender affirming hormones. However, some recommendations are based on scarce evidence or research that was not conducted in transgender people.

**Methods**

Guidelines for hormone therapy and follow-up will be discussed during the workshop. We will discuss the prevalence and time of occurrence of physical and biochemical changes, possible pitfalls when interpreting lab results, (prevalence of) possible side effects and how to treat undesirable effects. The workshop will also include hormone therapy in gender non binary people.

**Results and Conclusions**

Topics that will be included:

- physical changes (C. De Blok, A.D. Fisher): A overview of the literature on physical changes: which changes can be expected? What is the expected time frame?
- bone health (C. Wiepjes): Gender affirming hormone therapy has proven not to decrease areal bone mineral density over 1-3 years of follow-up. Dr. Wiepjes will present 10-year follow-up data and include fracture risk.
- cardiovascular health (L. Van de Bruaene): Studies describing a higher risk for cardiometabolic and thromboembolic morbidity and/or mortality in transgender women (but not transgender men) mainly covered data on transgender women using the nowadays obsolete ethinyl estradiol (EE) and are therefore no longer valid. Currently, the majority of the available literature on transgender people adhering to standard treatment regimens consists of retrospective cohort studies of insufficient follow-up duration.
- hepatologic safety (L. Van de Bruaene): According to the Endocrine Society guideline, hepatotoxicity is not anticipated in TM taking parenteral or transdermal testosterone, although they still mention severe liver dysfunction as a medical risk associated with testosterone therapy. We will discuss the risk for (severe) liver dysfunction in transgender people on gender affirming hormones and when to be vigilant.
- metabolic health (J. Defreyne): The current literature in transgender people provides no uniform evidence of in-

creased insulin resistance in transgender people on HT, although changes in other markers of insulin sensitivity have been reported.
- biochemical changes (D. Van Dijk): Changes in serum prolactin, hematocrit, hemoglobin occur within the first months of gender affirming hormonal therapy. To date, these changes in biochemical markers have not been associated with morbidity in transgender people.
- oncology (J. Defreyne): Both healthcare practitioners and TM themselves have expressed concern about the oncological risk of long term testosterone therapy, however, prospective studies with sufficient sample size and follow up duration are lacking.
- hormones and the brain (N.M. Nota): Dr. Nota will discuss brain sexual differentiation and effects of HT, brain functional connectivity patterns and the occurrence of brain tumours.
- mental health (G. Castellini): The change in psychological/psychiatric wellbeing and co-occurring morbidities after initiation of HT will be discussed.

# What does the future hold for learning and development in the field of gender affirming surgery ?

Friday, 12th April - 16:00: WS11: What does the future hold for learning and development in the field of genital gender affirming surgery ? (Bramante 9)

***Muhammed Al-tamimi*** [1], ***Marlon Buncamper*** [2], ***Marijke Houx*** [1], ***Wouter Van Der Sluis*** [1], ***Kristin de Haseth*** [3], ***Mark-Bram Bouman*** [2]

***1.*** *Amsterdam UMC, location VU University Medical Center,* ***2.*** *VU Medical Center,* ***3.*** *VU*

**Background**

Worldwide the need for skilled gender surgeons has increased dramatically as a result of a growing transgender population that seeks genital gender affirming surgery. Also, the treatment of transgender people has evolved from a standardized approach to a patient-centered approach with multiple surgical options. Most surgeons are familiar with the traditional way of teaching and learning: looking over the shoulder of the master and observing the surgery. It looks easy, until we have to do it ourselves. Sooner or later, you realize you missed some important knowledge which forces you to take risks. Risks that may affect the surgical outcomes. However, delivering the best surgical care requires more than just a skilled gender surgeon. Delivering the best surgical care is a team sport, that involves all levels of staff including psychologists, endocrinologists, urologists, gynecologists, nurses, physicians assistants, physical therapists and anesthesiologists. Working in multidisciplinary teams limits adverse events and improves surgical outcomes. A great challenge lies ahead of us to train future surgical teams. Therefore, we urgently need a new and innovative way to train dedicated surgeons and their surgical teams to achieve the highest standards of care.

**Methods**

Attendees are members that are involved in the (surgical) care of transgender people. This workshop is an attempt to engage in thinking outside the box. Therefore, the workshop will have a 'group sketching' concept to encourage participants to think outside the box. Visual thinking can help to trigger and develop ideas that discussion and writing might otherwise leave unturned. Group sketching involves participants to build on each other's ideas. Each member of the team will sketch an image related in a central way to the topic 'The future of gender genital surgery'. Each sketch is then passed to someone else, who sketches another related image on the same piece of paper. This process is repeated multiple times around the group and the final images are then reviewed and discussed. The aim is to discover connections that individuals had not spotted on their own. The key words for the future of genital gender affirming surgery will be identified and captured in a short sentence of no more than 15-20 words

**Results and Conclusions**

The workshop is intended to produce a pencil-sketch from which ideas can be identified and actions defined.

# Affirmative support outside the binary – an interdisciplinary view

Friday, 12th April - 16:00: WS12: Affirmative support outside the binary (Bramante 10)

***Wiebke Rebetez*** [1], ***Alecs Recher*** [2]

***1.*** *Dr.med., Child and youth psychiatrist, works in Zurich in their shared office specialized in support for trans people.,* ***2.*** *Master of Law and Diploma in remedial education and social pedagogy, is a specialist in trans human rights and holds the position of head of Transgender Network Switzerlands legal support service*

**Background**

A still small but growing number of studies shows that non-binary people have an even poorer mental health and quality of live than trans people who identify as female or male (e.g. JELLESTAD, LENA et al.: Quality of Life in Transitioned Trans Persons: A Retrospective Cross-Sectional Cohort Study, BioMed Research International, Vol. 2018, Article ID 8684625). As a minority, non-binary people are under an additional stress in strongly binary societies as they are inexistent in many languages, legal systems, medical care schemes, and the like.

But non-binary people, and by this also their living conditions and specific needs, are becoming more and more visible in social, medical and legal care givers practices. As professionals supporting the trans community we must ask ourselves how we can best support non-binary people individuals but also the non-binary community on a structural and by this political level. In this work, we cannot fall back on the common binary understanding of gender identity, gender expression and sex characteristics as it hinders an adequate and supportive care for non-binary people. Therefore, we need to reflect about our own working approaches, especially our communication, and radically think outside the binary gender boxes.

**Methods**

In this workshop, we share our expertise and experience as psychiatrist and lawyer in giving affirmative support to non-binary clients, including non-binary people affected by multiple discrimination, such as racism, age or disability.

**Results and Conclusions**

We want to make space for mutual learning, for an exchange of experiences and ideas on how to best support non-binary people without pathologizing or categorizing them.

# Running a family therapy clinic within a gender identity service for young people and their families

Friday, 12th April - 16:00: WS13: Running a family therapy clinic within a gender identity service for young people and their families (Bramante 11)

***Sarah Favier*** [1], ***Nicholas Stenning*** [1], ***Sarah Faithorn*** [1], ***Hayley Davies*** [1]

***1.*** *GIDS Tavistock and Portman NHS Foundation Trust*

**Background**

Families have adjustments to make when young people are questioning their gender identity and making transitions. Previous family histories of relationships and communication are likely to influence these transitions. Family and significant others can be a powerful source of support for young people as they explore gender identity.
We will describe the forming of a family therapy clinic, how we work, clinical dilemmas and preliminary participation data from families.

**Methods**

We run a family therapy clinic in the Leeds base of the Gender Identity Development Service (GIDS), UK. We see families who sometimes find it difficult to communicate about the issues around their young person's gender identity. Our clinic provides a therapeutic and systemic context to think with families about how they can navigate the challenges specific to them. We use a reflecting team to offer families a variety of perspectives.
We have gathered some initial feedback from families participating in this clinic through use of questionnaires (SCORE) capturing quantitative and qualitative data.

**Results and Conclusions**

Preliminary results indicate a high level of satisfaction with the clinic. Our clinical view is that families make good use of this space to talk about and reflect on their experiences in relation to how gender affects their relationships. Initial feedback indicates that young people were able to discuss their gender identity more with their families.
We will invite workshop participants to consider the experiences of families they have worked with alongside anonymised case studies. We will share systemic approaches, methods and techniques which we have found useful. We aim to do this in an interactive manner.

# Sexuality after gender affirmative surgery: an update

Friday, 12th April - 16:00: WS 14: Sexuality after gender affirmative surgery (Bramante 12)

***Luk Gijs*** [1]***, Cecilia Dhejne*** [2]***, Timo Nieder*** [3]***, Müjde Ozer*** [4]***, Gennaro Selvaggi*** [5]***, Guy T'Sjoen*** [6]

***1.*** *Amsterdam UMC,* ***2.*** *Karolinska University Hospital, 171 76 Stockholm,* ***3.*** *University Medical Center Hamburg-Eppendorf,* ***4.*** *VU Medical Center,* ***5.*** *Plastic Surgery Department, Sahlgrenska University Hospital, Gothenburg,* ***6.*** *Uz Gent*

**Background**

During the last five years, there has been a lot of new research on sexuality after gender affirming surgery. Furthermore, there has also been a rather strong move away the traditional binary (female – male), towards an acceptance of gender diversity and gender incongruence. However, there has not been done much research on the sexuality of gender diverse or gender incongruent individuals. This symposium will give

- An overview of the effects of gender affirming surgery on sexuality
- Evaluate the methodological quality of the designs used in research on sexuality
- A discussion and conclusion

**Methods**

This symposium will have the following presentations

.Introduction: Ozer & Gijs (Amsterdam): a short overview of the symposium: 5 minutes

.Hormonal treatment effects on sexuality: an overview: T'Sjoen (Gent):10 minutes

.Effects of gender affirmative surgery on sexuality in trans women: Selvaggi Gennaro (Gotheburg): 15 minutes

.Effects of gender affirmative surgery on sexuality in trans men: Ozer (Amsterdam): 15 minutes

.Sexual problems after gender affirmative surgery: what do we know? Timo Nieder (Hamburg): 15 minutes

.Interventions for sexual problems after gender affirmative surgery: what can we do? Cecilia Dhejne (Stockholm ): 15 minutes

.Sexuality after gender affirmative surgery: quo vadis? Gijs & Ozer (Amsterdam): 5 minutes

.Discussion: 10 minutes

**Results and Conclusions**

The authors will present a global overview of what we know on sexuality of transgender persons after gender affirmative surgery. The lead questions will be: (1) what do we know? (2) what are clinical implications? and (3) which research is needed?

# ICD-11: What it means to me - a dialogue among providers and community members about trans depathologisation

Friday, 12th April - 16:00: WS 15: A dialogue among providers and community members about trans depathologisation (Bramante 14)

***Richard Köhler*** [1], ***Leo Mulio*** [1]

***1.*** *Transgender Europe*

**Background**

In June 2018, the World Health Organization (WHO) released the long-awaited update to its medical classification system, the International Classification of Diseases v. 11 (ICD-11). This system lays out how medical procedures and interactions are diagnosed and coded so that patients and providers can receive care with continuity and clarity regardless of where they are in their country or the world. ICD-11 also is used for research and statistics collection through a consistent system. In the ICD-11 update, there are three significant changes related to the classification of trans-related diagnoses. (1) All previous diagnoses, which were coded as Mental and behavioural disorders, have been removed. (2) A new chapter on Conditions related to sexual health was created. (3) Within the new chapter, diagnostic codes of Gender incongruence in adolescence and adulthood and Gender incongruence in childhood were created.

**Methods**

This workshop seeks to host a frank discussion among healthcare providers and trans community members about the impacts of ICD-11, its forthcoming implementation processes, and strategies on how to engage collectively to ensure continued and/or improved access to trans-specific healthcare through these processes.
Note: Moderation will not tolerate psychopathologizing arguments or discussions; those wishing to have these conversations will be asked to do so elsewhere.

**Results and Conclusions**

This workshop seeks to foster stronger alliances among providers and community members and to encourage strategic thinking and planning when it comes to trans depathologization and ICD-11 at the national level.

# Transgender Health Care in Europe: Italy

Saturday, 13th April - 09:30: Plenary Session IV: Transgender Healthcare in Europe (Michelangelo Ballroom)

***Alessandra Daphne Fisher*** [1]

***1.*** *Department of Experimental, Clinical and Biomedical Sciences, Careggi University Hospital, Florence, Italy*

**Background**

As in other European countries, transgender people in Italy have to face many barriers and difficulties in accessing healthcare. During the last years, an increasing interest has been shown in Italy by many scientific societies as well as by national institutions to implement access to health care for transgender people, overcoming cultural and healthcare barriers.

**Methods**

The aim of this talk is to describe the current Italian transgender clinical health care offer, providing also an historical overview.

**Results and Conclusions**

Many gender clinics exist in Italy, however, only some offer a multidisciplinary service. Moreover, gender affirming hormone treatment is covered by NHS only in some regions, creating inequalities across the country. Thus, transgender persons in Italy receive often non-homogeneous support and treatment. A court Authorization is requested to proceed toward surgery according to an Italian law defined on 1982. After the Constitutional Court decision in July 2015, legal name change can be authorized without gonadectomy. Centers offering specialized support to gender incongruent youths on the basis of international guidelines are relatively few and only recently set up. In order to define and develop a commonly accepted Italian approach to transgender adolescents, Italian guidelines in line with WPATH recommendations have recently been published.

**Conclusions**. The Italian context shows still many lacks in offering proper healthcare access to transgender people. However, some changes have been noticed.

# Transgender Health Care in Europe: Ireland

Saturday, 13th April - 09:45: Plenary Session IV: Transgender Healthcare in Europe (Michelangelo Ballroom)

***Vanessa Lacey*** [1]

***1.*** *TENI*

**Background**

Ireland's healthcare service (HSE) has been providing transgender related services mainly through non-trans endocrine clinics, over the last 2 decades. However, in 2011 the HSE began collaborating with professional bodies and an Irish Trans NGO (TENI), with the objective of developing Trans related services for both adult and young-persons.

**Methods**

This presentation aims to set-out the challenges experienced, positives encountered and the key players involved in this process. The current state of services will be explained and our hopes for the future highlighted.

**Results and Conclusions**

The current state of services will be explained and our hopes for the future highlighted.

# Transgender Health Care in Europe: Poland

Saturday, 13th April - 10:00: Plenary Session IV: Transgender Healthcare in Europe (Michelangelo Ballroom)

***Bartosz Grabski*** [1], ***Marta Dora*** [2]

***1.*** *Polish Sexological Society, Jagiellonian University Medical College, University Hospital Kraków,* ***2.*** *University Hospital Kraków*

**Background**

The lecture will present intricacies of transgender care in Poland.

**Methods**

First, social, political, and legal contexts will be presented, which influence both the health and well-being of transgender individuals as well as practitioners involved in assessment and health care. Next, the current situation in clinical services, which are rather scattered, based mostly on individual practitioners or networking rather than integrated multidisciplinary teams/centres will be displayed.

**Results and Conclusions**

In the end we will present our own experiences both form the public as well as private settings and we will try to elucidate areas of urgent change and action.

# Sexual orientation during transition, fixed or fluid? A study in the ENIGI cohort.

Saturday, 13th April - 11:00: Mental Health Session III: Sexuality and sexual health (Bramante 8)

***Brand Coumou*** [1], ***Justine Defreyne*** [2], ***Martin Den Heijer*** [1], ***Guy T'Sjoen*** [3], ***Els Elaut*** [4], ***Baudewijntje Kreukels*** [1]

***1.*** *VU Medical Center,* ***2.*** *Ghent University Hospital,* ***3.*** *Uz Gent,* ***4.*** *Department of Sexology and Gender in Ghent, University Hospital Ghent, Belgium*

**Background**

L. Diamond (2012) suggested that CIS women show more fluidity in sexual orientation than CIS men, linking sexual orientation in CIS women to contextual influences. Does fluidity in sexual orientation in transgender persons follow the pattern of their gender assigned at birth, or the pattern of their gender identity? I.e. would sexual orientation show more fluidity in persons who were assigned female at birth (AFAB) than persons who were assigned male at birth (AMAB), or would sexual orientation show more fluidity in AMAB than in AFAB? The aim of the current study is to describe changes and shifts in sexual orientation prospectively during a gender affirming treatment.

**Methods**

In the ENIGI study, questions regarding SO (Kinsey scale, behavior, fantasy and attraction) are asked at baseline at the start of hormonal treatment, and after 3, 6, 9, 12, 24 and 36 months of hormonal treatment in assigned male at birth (AMAB) and assigned female at birth (AFAB) transgender persons. In this preliminary study we have narrowed our analysis to baseline and 12 months of hormonal therapy. For logistical reasons, data from Ghent and Amsterdam only (n=766) were selected. We aimed to prospectively assess changes in sexual fantasies, attraction and partnership status after the initiation of HT.

**Results and Conclusions**

At baseline, AMAB people fantasized about men (33%), women (28,8%) or both (31,1%). The majority of the AFAB people fantasized about women (61.4%) and less frequently about men (10.4%) or both (16.7%).

Sexual attraction as measured on a Kinsey scale did not change after 12 months of HT in AMAB (P=1.000) and AFAB (P=1.000) people compared to baseline.

Partnership status differed significantly among birth-assigned gender groups over the course of HT (P<0.001) and changed over the course of HT for both AFAB and AMAB people (P<0.001). At the initiation of HT, the majority of the AMAB (61.1%) and AFAB (50.1%) reported having no partner. After 12 months, 59.0% of the AMAB and 56.4% of the AFAB reported having a partner.

In conclusion, the transgender population is a very diverse population, which is also reflected in their sexual attraction preferences. Although partnership status may change over the course of HT in both AMAB and AFAB transgender people, with more people having a partner relationship, sexual attraction appears to remain stable over the first year of HT.

# The interrelations between sexual dysfunction, sexual (dis)satisfaction and sexual pleasure in transgender individuals: results of the ENIGI follow-up study.

Saturday, 13th April - 11:15: Mental Health Session III: Sexuality and sexual health (Bramante 8)

***Mauro Kerckhof*** [1], ***Baudewijntje Kreukels*** [2], ***Timo Nieder*** [3], ***Inga Becker*** [3], ***Tim van de Grift*** [4], ***Gunter Heylens*** [1], ***Els Elaut*** [1]

***1.*** *Ghent University Hospital,* ***2.*** *Amsterdam UMC, location VU University Medical Center,* ***3.*** *University Medical Center Hamburg,* ***4.*** *Amsterdam UMC, loc*

**Background**

Recently, research attention for the sexual life of individuals diagnosed with Gender Dysphoria (GD, more commonly known as transgender individuals) is increasing. Research has shown that the prevalence rates of sexual dysfunction (including the experience of distress) in transgender persons who received Gender Confirming Interventions (GCI) were higher compared to the general population. However, less is known on the impact of having a sexual dysfunction on satisfaction with sexual behaviour, and its interrelation with sexual pleasure. Possibly, the relationship between sexual dysfunction and sexual pleasure differs between individuals in different treatment trajectories and also between individuals with or without a current relationship.

**Methods**

ENIGI, or the European Network for the Investigation of Gender Incongruence, is a multi-center study, aimed at describing large cohorts from several gender clinics (Kreukels et al, 2012). A follow-up study was designed to assess psychological symptoms, satisfaction with treatment, sexual health, social support, amongst other themes. The clinics of Amsterdam, Ghent and Hamburg ran two rounds of this follow-up study: a first round was conducted in 2013, aimed at the cohort that had first contact with the clinic during the years 2007, 2008 and 2009 (van de Grift et al, 2017). The same questionnaire was presented at the cohort that made first clinical contact during 2011, 2012 and 2013, in a second round during 2017. Both rounds resulted in a four to six year follow-up. In total, 560 individuals participated in the study. Participants filled in the Amsterdam Sexual Pleasure Index (ASPI) (Werner, Gaasterland, van Lunsen & Laan, in press), a recently developed questionnaire to measure sexual pleasure, and answered a broad range of questions about sexual dysfunctions (including the distress criteria).

**Results and Conclusions**

The present study will investigate the relation between different sexual dysfunctions and sexual pleasure. Further, we will assess whether participants with no further treatment plans experience more sexual pleasure compared to participants with further treatment plans. Finally, we expect to find a correlation between the experience of a sexual dysfunction, and negative sexual satisfaction/pleasure outcomes.

# The prevalence of sexual dysfunction after Gender Confirming Interventions: results of the ENIGI follow-up study.

Saturday, 13th April - 11:30: Mental Health Session III: Sexuality and sexual health (Bramante 8)

***Els Elaut*** [1]***, Mauro Kerckhof*** [2]***, Timo Nieder*** [3]***, Baudewijntje Kreukels*** [4]***, Inga Becker*** [5]***, Tim van de Grift*** [4]***, Gunter Heylens*** [6]

***1.*** *Department of Sexology and Gender in Ghent, University Hospital Ghent, Belgium,* ***2.*** *Department of Endocrinology in Ghent, University Hospital Ghent, Belgium,* ***3.*** *University Medical Center Hamburg-Eppendorf,* ***4.*** *VU Medical Center,* ***5.*** *University Medical Center Hamburg,* ***6.*** *Ghent University*

**Background**

Just as cisgender persons, most transgender individuals strive towards a fulfilling and enjoyable sexual life; both before, during and after their social and medical transition. Little is known on which sexual dysfunctions (with distress) and sexual function disturbances (without distress) cause the biggest obstacles after Gender Confirming Interventions (GCI), initiated for the treatment of gender dysphoria.

**Methods**

ENIGI, or the European Network for the Investigation of Gender Incongruence, is a multi-center study, aimed at describing large cohorts from several gender clinics (Kreukels et al, 2012). A follow-up study was designed to assess psychological symptoms, satisfaction with treatment, sexual health, social support, amongst other themes. The clinics of Amsterdam, Ghent and Hamburg ran two rounds of this follow-up study: a first round was conducted in 2013, aimed at the cohort that had first contact with the clinic during the years 2007, 2008 and 2009 (van de Grift et al, 2017). The same questionnaire was presented at the cohort that made first clinical contact during 2011, 2012 and 2013, in a second round during 2017. Both rounds resulted in a four to six year follow-up. In total, 560 individuals participated in the study. This study will present the data-analyses for the 526 individuals that filled out the questions on sexual functioning.

**Results and Conclusions**

Sexual dysfunctions (including the distress criterion) were more prevalent in transgender individuals, compared to prevalence rates available from population-based surveys. In the group of sexually active trans women, distress on orgasm dysfunction was reported most often, followed by initiating and seeking sexual contact, and by dyspareunia. The most prevalent complaints of trans men were distress due to difficulties initiating and seeking sexual contact, fear of sexual contact, and distress on fear of injury during sexual contacts. Just as in the general population, co-morbidity of sexual dysfunction is highly prevalent. While GCI's can offer transgender individuals a better quality of life and self-esteem, health care providers should inform themselves on the specificity of transgender sexuality. A potential picture of sexual life after GCI should always be thoroughly addressed in counseling.

# Gender Diversity and Psychological Functioning in Adolescents

Saturday, 13th April - 11:00: Mental Health Session IIIb: Symposium: Gender Diverse Identities: Development, Psychological functioning and Treatment Biographies (Bramante 9)

***Nastasja M. de Graaf*** [1], ***Jos Twist*** [2], ***Polly Carmichael*** [2], ***Peggy Cohen*** [1], ***Thomas Steensma*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center,* ***2.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust*

**Background**

It is apparent that young people seeking help through specialist gender services are a heterogeneous group who show that gender can be experienced and expressed in various ways. Over the last few years there is some evidence to suggest that both heterogeneity and complexity are increasing. There has been a rise in the number of people who are publicly identifying with, and outwardly expressing, a gender identity other than male or female. Further, it is suggested that there is a difference in psychological functioning between people identifying as trans compared to people holding a non-binary identity (Thorne et al., 2018). Our aim was to see if there is a difference in psychological functioning in gender diverse adolescents referred to specialist gender services.

**Methods**

473 adolescents referred to the Gender Identity Development Service UK (GIDS) were included in this study. 25.58% (N=121) were assigned male at birth and 74.41% (N=352) were assigned female at birth. The mean age of this sample was 15.31 years (SD = 1.35) with an age range between 12 and 18 years. The newly developed Gender Diversity Questionnaire (GDQ) was used to gather how adolescents self-define their gender identity when entering the specialist gender service. On basis of their self-defined identity, adolescents were grouped into three categories: Trans, Binary, Non-binary & Agender. Psychological functioning in this study was assessed at baseline with use of the Youth Self Report (YSR).

**Results and Conclusions**

Preliminary outcomes of this study showed that the majority of the adolescents presenting to GIDS in 2017 identified as Trans* (52.7%), 35.4% presented with a binary identity (identifying as “male” or “female”) and 10.5% identified with a non-binary identity (such as “genderfluid”, “genderqueer” or “Agender”). Furthermore, differences in psychological functioning and treatment wishes between the three identity-categories will be presented and discussed. This information will increase our understanding on the currently observed heterogeneity and complexity in adolescents referred to specialist gender services.

# Non-binary gender identity development: A qualitative biographical interview study

Saturday, 13th April - 11:15: Mental Health Session IIIb: Symposium: Gender Diverse Identities: Development, Psychological functioning and Treatment Biographies (Bramante 9)

***Annelijn Wensing-Kruger*** [1], ***Baudewijntje Kreukels*** [2], ***Henny Bos*** [3], ***Mathilde Brewaeys*** [1], ***Thomas Steensma*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center,* ***2.*** *VU Medical Center,* ***3.*** *University of Amsterdam*

**Background**

With the increasing awareness in society, the (social) media and scientific literature that gender identities cannot be captured within the binary of male and female, knowledge on the development of individuals who identify as *neither*male nor female or as *both*male and female is lacking.

The current study aims to investigate non-binary gender identity development and the processes and factors involved in the desire to socially, legally and/or physically transition.

**Methods**

In this semi-structured biographical interview study, a total of 34 adolescents and young adults (Mean age 22.3 years) were interviewed. Fourteen of these individuals had a desire for medical treatment (7 birth assigned males, 7 birth assigned females) and were recruited at the Center of Expertise on Gender Dysphoria in Amsterdam, the Netherlands. Twenty-one individuals did not desire any medical treatment (9 birth assigned males, 12 birth assigned females) and were recruited from the general population. All individuals identified as non-binary.

The interviews focused on the processes and contextual and cultural factorsinvolved in the discovery and formation of the young people's non-binary gender identities.

All interviews were transcribed in verbatim, reviewed and analyzed using the qualitative analysis software package ATLAS.ti. Using the method of open coding, coding categories were generated, discussed in the research group, and applied to all transcripts.

**Results and Conclusions**

The results from this study aim at the following 3 outcomes:

1. Description of the reported developmental routes and factors involved in gender identity exploration and identification sequence for all interviewed non-binary identifying adolescents and young adults.
2. Comparison of the developmental trajectories between adolescents and young adults, who were referred to a specialized gender clinic (with treatment wish) and those who were recruited from the general population (without treatment wish)
3. Possible differences in developmental trajectories and the factors / processes involved between birth assigned males and females.

# Psychological well-being in clinically referred gender diverse adults

Saturday, 13th April - 11:30: Mental Health Session IIIb: Symposium: Gender Diverse Identities: Development, Psychological functioning and Treatment Biographies (Bramante 9)

***Thomas Steensma*** [1], ***Nastasja M. de Graaf*** [1], ***Annelijn Wensing-Kruger*** [1], ***Nina De Wet*** [1], ***Mathilde Brewaeys*** [1], ***Baudewijntje Kreukels*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

Simultaneously to the increase in referrals to specialized gender identity clinics over the years, the composition of the referred population has become more diverse in several ways. Beside the observed changes in sex ratio's and treatment desires, the diversity of expressed and experienced gender identities has clearly increased. A growing proportion of the clinically referred population identifies outside the binary of male or female (i.e. non-binary, genderqueer).

The result of the recent growth of this group of non-binary identifying individuals is that clinicians and mental health professionals are increasingly confronted with a group that they know relatively little about when it comes to development, treatment desires and their psychological well-being.

The aim of the current study was to explore associations between diverse gender identities and psychological well-being in adults referred to a specialist gender identity clinic.

**Methods**

In a sample of 252 assigned females at birth (*M*age 25.2, *SD* 11.9), and 317 assigned males at birth (*M*age 31.6, *SD* 12.9), referred to the Center of Expertise on Gender Dysphoria in Amsterdam, the Netherlands, diversity in gender identity was measured with use of the *Gender Queer Identity Scale*(GQI; McGuire et. al., 2018). We explored how diverse gender identities (degree of gender diversity on the GQI) were associated with psychological well-being (scores on the Symptom Checklist-90-R (SCL-90; Derogatis, 2000) and two Quality of Life measures; Life as a whole (Bradburn, 1969) and Social Readjustment Scale (Holmes & Rahe, 1967).

**Results and Conclusions**

Preliminary analyses show that a larger degree of gender diversity (less binary identification) was associated with lower quality of life scores and increased psychological symptom scores in both birth assigned males and females. We will present these findings in more detail, provide possible explanations and discuss them in terms of clinical relevance.

# Gender Identities and treatment biographies in transgender individuals: Comparing the ENIGI follow-up sample with a community sample

Saturday, 13th April - 11:45: Mental Health Session IIIb: Symposium: Gender Diverse Identities: Development, Psychological functioning and Treatment Biographies (Bramante 9)

***Timo Nieder*** [1], ***Andreas Koehler*** [1], ***Baudewijntje Kreukels*** [2], ***Els Elaut*** [3], ***Gunter Heylens*** [4], ***Thomas Steensma*** [2], ***Inga Becker*** [5]

***1.*** *University Medical Center Hamburg-Eppendorf,* ***2.*** *VU Medical Center,* ***3.*** *Ghent University Hospital,* ***4.*** *Ghent University,* ***5.*** *University Medical Center Hamburg*

**Background**

Following a binary understanding of gender as female or male, transgender individuals were expected to experience themselves as a sex/gender opposite to their sex assigned at birth (Nieder & Richter-Appelt, 2011). In line with this, transgender healthcare (THC) and related research were conducted according to the gender binary. As the transition from male to female and vice versa was and still is paramount for a large group within the transgender spectrum, there are individuals not fitting into the gender binary (e. g., genderqueer, non-binary) but seeking transition-related healthcare as well (Richards et al., 2016). Although there are data from large surveys from the US and the EU capturing around 1/3 transgender individuals identifying as diverse, genderqueer and/or non-binary (EU-FRA, 2014; Grant et al., 2011), data from clinical studies largely lack information about this group so far. Hence, the numbers seem to differ between clinical and non-clinical samples, and little is known about implications of various genders on treatment biographies.

The overall aim of the analysis is to compare the distribution of gender identities and treatment biographies in trans individuals between a European clinical and a German non-clinical sample. The research questions in detail are (1) whether trans individuals from a community sample differ from those of a clinical sample at follow-up regarding the distribution of gender, (2) whether they differ with regard to their (undergone and further intended) gender-related medical interventions, both between the sample groups (clinical vs. non-clinical) as well as between the groups based on the binarity of gender (binary vs. non-binary), (3) if genital surgery plays a crucial role differencing between binary and non-binary identified trans individuals in the clinical sample (as it was the case in the non-clinical sample (Koehler et al., 2018)), and (4) if demographical and/or clinical aspects are associated with the decision to undergo certain gender-related medical interventions (and possible differences between binary and non-binary identified individuals).

**Methods**

Therefore, the present study aims to compare a large clinical sample from the ENIGI follow-up study with a non-clinical community sample, which was assessed via an online-survey for transgender individuals in Germany. The clinical sample was collected as a part of the ENIGI initiative with an online questionnaire filled-in by n=526 trans individuals. All participants had their clinical entry in specialized care in Ghent (BE), Amsterdam (NL) or Hamburg (GER). The non-clinical sample was collected within a research project on the needs and concerns of transgender individuals regarding interdisciplinary transition-related healthcare in Germany. N=415 participants completed an online questionnaire (Eyssel, Koehler, Dekker, Sehner, & Nieder, 2017).

**Results and Conclusions**

Based on preliminary analyses, we expect a higher number of transgender individuals identifying as diverse, genderqueer and/or non-binary in the community sample compared to the clinical sample (even at follow-up). We expect non-binary transgender individuals to report lower numbers of undergone and further intended treatments, especially regarding treatments focusing on primary sex characteristics. Moreover, we expect differences regarding demographical data (e. g., age, education) between binary and non-binary individuals. Both clinical and non-clinical implications of the findings will be discussed.

# Body dissatisfaction and internalising problems predict health related quality of life outcomes in transgender adolescents

Saturday, 13th April - 11:00: Children & Adolescents III: Transgender clinics around Europe (Bramante 7)

***Inga Becker*** [1], ***Mieke Röder*** [1], ***Claus Barkmann*** [1], ***Ulrike Ravens-Sieberer*** [1], ***Michael Schulte-Markwort*** [1], ***Hertha Richter-Appelt*** [1]

***1.*** *University Medical Center Hamburg*

**Background**

Transgender adolescents who apply for gender dysphoria (GD) related treatment often experience a marked increase in body related distress when entering puberty, in many cases accompanied by internalizing problems and poor peer relations. Although adolescence is a time of considerable psychosocial and physical change, generally associated with a decline in Health Related Quality of Life (HRQoL), research on HRQoL in transgender youth and possible predictors is sparse. This study thus aims to explore the predictive value of different body image factors (body satisfaction and weight concerns) and emotional and behavioral problems (internalising and peer related problems) for HRQoL.

**Methods**

This cross-sectional one-group observational study on adolescents was carried out at the Child and Adolescent psychiatric department (Gender Identity Service) in Hamburg, Germany. A sample of n = 126 (103 trans male and 23 trans female) adolescents, who were referred for GD related counselling and/or treatment completed different standardized instruments before undergoing any sort of treatment (referral between 2013 and 2016). Firstly, five dimensions of HRQoL were explored in transgender youth in relation to the German norm population, and secondly, a linear regression model was applied to assess the impact of body image (measured via the HBDS) and emotional and behavioral problems (measured via the YSR) on overall HRQoL.

**Results and Conclusions**

HRQoL was generally impaired in transgender adolescents compared to norm scores, especially with regard to aspects of psychological and physical well-being. Linear regression analysis revealed that lower HRQoL outcomes were significantly predicted by greater internalizing problems and less body satisfaction, but not by peer relation problems or weight concerns.

Thus, impaired HRQoL may be explained by high degrees of internalizing problems and low body satisfaction. Therefore, one important aim of mental health professionals working with transgender youth should be to provide appropriate treatment and counseling options that may contribute to diminishing internalizing and body image related problems, and thus to overall well-being in the long-term.

# Suicidality in Adolescents Diagnosed with Gender Dysphoria: A Cross-National, Cross-Clinic Comparative Analysis

Saturday, 13th April - 11:15: Children & Adolescents III: Transgender clinics around Europe (Bramante 7)

***Nastasja M. de Graaf*** [1]***, Thomas Steensma*** [2]***, Polly Carmichael*** [3]***, Peggy Cohen*** [1]***, Annelou de Vries*** [2]***, Baudewijntje Kreukels*** [2]***, Doug P. Vanderlaan*** [4]***, Kenneth Zucker*** [4]

***1.*** *Amsterdam UMC, location VU University Medical Center,* ***2.*** *VU Medical Center,* ***3.*** *The Gender Identity Development Service, Tavistock and Portman NHS Trust,* ***4.*** *University of Toronto*

**Background**

Youth with a minority sexual orientation and/or gender identity have been reported to be at an elevated risk for suicidality. Concern about suicidality among youth diagnosed with gender dysphoria has become an urgent clinical issue in many narrative reviews pertaining to best-practice. For youth diagnosed with gender dysphoria, however, there have been only a few empirical studies, with variation in source of ascertainment and in how suicidality was measured. Of the studies that used samples of clinic-referred youth diagnosed with gender dysphoria, none utilized any type of clinical comparison or control group.

**Methods**

The present study examined suicidality in adolescents diagnosed with gender dysphoria (M age, 15.98 years) seen at specialty clinics in Amsterdam, the Netherlands, London, England, and Toronto, Canada (total N = 2737). Suicidality was measured using two items from the Child Behavior Checklist (CBCL) and the Youth Self-Report (YSR): Item 91 ("Talks about killing self") and Item 18 ("Deliberately harms self or attempts suicide"). The CBCL/YSR referred and non-referred standardization samples from both the U.S. and the Netherlands were used for comparative purposes. Both items were rated on a 0-2 point scale for frequency of occurrence. Two types of analyses were conducted. First, we used multiple regression to predict suicidality. The predictor variables were Clinic, birth-assigned sex, age at assessment, year of assessment, a 3-item CBCL/YSR metric of poor peer relations, and the sum of all other items rated as a 1 or a 2 on the CBCL and YSR. Second, we compared the percentage of youth diagnosed with gender dysphoria who endorsed these two items compared to youth in the CBCL/YSR standardization samples.

**Results and Conclusions**

With the exception of birth-assigned females from the London clinic, "Talks about killing self" was more common than "Deliberately harms self or attempts suicide." For both the CBCL and the YSR, two variables predicted suicidality: Clinic and the sum of all other behavioral/emotional problems rated as a 1 or a 2. Both the London and Toronto youth diagnosed with gender dysphoria had a higher rate of suicidality compared to the Amsterdam youth. Although poor peer relations was associated with suicidality, it did not remain in the regression equations once all of the other CBCL/YSR items were taken into account. Compared to the CBCL/YSR standardization data, the rate of suicidality of the youth diagnosed with gender dysphoria from all three clinics was significantly higher than non-referred youth in the standardization sample, but more similar than different from the referred youth in the standardization sample. We discuss these results in relation to both gender identity specific and more general risk models of suicidality, the need for more detailed assessment methods of suicidality, particularly with regard to the distinction between bona fide suicide attempts and self-harm (e.g., cutting without the intent to commit suicide),

and possible reasons for the cross-clinic variation in degree of suicidality.

# An overview of numbers and of the well-being of the Flemish youth in the pediatric gender clinic

Saturday, 13th April - 11:30: Children & Adolescents III: Transgender clinics around Europe (Bramante 7)

***Gaia Van Cauwenberg*** [1], ***Karlien Dhondt*** [2], ***Joz Motmans*** [2]

***1.*** *Ghent University Hospital,* ***2.*** *Ghent University*

**Background**

This presentation presents an evaluation of the first decade (January 2007 - December 2016) in working with adolescents between 12 and 18 years old. We will present the number of intakes, the mean age and how many dropped out, alongside the emotional and behavioral well-being of the gender-referred adolescents at the time of intake, by analyzing the CBCL and YSR outcomes.

**Methods**

Information about the adolescents (such as date of birth, gender assigned at birth, year of referral, date of intake, how many had stopped the counseling) was collected from the patient's files by the practitioners. These data were anonymized and passed on to the researchers.

The adolescents and their parents had been asked to fill out the YSR and CBCL questionnaires during the diagnostic stage. In 2018 these adolescents and their parents were contacted again and asked for their permission to use the collected data for this study. Of the 177 adolescents who had an intake during the selected time period, only 59 gave their written consent to use their CBCL and YSR questionaires. The dependent variables are the mean total problem score, the mean score for the internalizing problems and the mean score for the externalizing problems. We also developed a peer relations scale.

The second part of this study consisted of contacting the drop-outs to ask why they stopped the counseling at the Pediatric Gender Clinic. Thirty-nine adolescents were contacted in writing to ask if one of the researchers could phone them to ask them some questions. Only four drop-outs responded with a positive answer.

**Results and Conclusions**

Of the 235 referrals 35 adolescents are excluded based on the inclusion criteria (33 had an intake in 2017 and two in 2018), 12 were directed to the adult team at the time of the referral and 11 never made an appointment or never showed up at their appointment. This gives us a total of 177 participants. The mean age at intake was 15.01 years old (*SD*=1.42), and there were 113 (63.8%) AFAB's and 64 (36.2%) AMAB's. During their counseling, 12 young adults were referred to the adult team.

Because of the low response rate, we only have 42 CBCL scores and 52 YSR scores. For both the YSR and the CBCL, adolescents score significantly higher on the internalizing problem score than on the externalizing problem score. When comparing the externalizing problem scores, we see significantly higher scores on the CBCL than on the YSR. The multiple linear regression only shows an effect of the peer relations scale on the CBCL total problem score.

29 of the 177 (16.4%) stopped their counseling at the pediatric gender clinic. Significantly more AMAB's (*N*=19) than AFAB's (*N*=10) stopped the counseling.

Seven (20%) re-referred to the adult clinic of the same hospital later in life. It is unknown how many of them went through a transition.

# Gender Dysphoria related to Psychopathology and Quality of Life in Swiss Transgender Youth

Saturday, 13th April - 11:45: Children & Adolescents III: Transgender clinics around Europe (Bramante 7)

***Dagmar Pauli*** [1], ***Nicole Fluetsch*** [1], ***Juliane Ball*** [1], ***Manuela Guenthard*** [1]

***1.*** *Zurich University*

**Background**

Transgender adolescents suffer from gender dysphoria but frequently also from co-occurring psychopathology, such as depression, suicidality and anxiety. In a previous study we compared Swiss adolescents diagnosed with young transgender adolescents of gender clinics across Europe (Belgium, England and the Netherlands). Swiss and English transgender youth seemed to suffer more from internalized psychopathological symptoms at time of referral such as depression and anxiety and show less quality of peer relation than those from Belgium and the Netherlands. In our study we aim to follow transgender adolescents in Switzerland over the course of treatment to examine about their quality of life and rate of psychopathology over time and after receiving treatment.

**Methods**

N=85 Adolescents (64% assigned girls, 36% assigned boys) in a consecutive sample of the transgender clinic of the Child and Adolescent Psychiatric University Hospital in Zurich have been examined with questionnaires related to psychopathology (Child Behavior Checklist CBCL and Youth Self Report YSR), gender dysphoria (Utrecht Gender Dysphoria Scale UGDS, Gender Identity/ Gender Dysphoria Questionnaire for Adults and Adolescents GIDYQ-AA ), family life (Family Assessment Device M-FAD), body satisfaction (Body Image Scale BIS) and quality of life (Kidscreen-27). In a follow up study we contacted all 62 patients with a referral more than 12 month ago and used the same questionnaires as well as a treatment satisfaction scale.

**Results and Conclusions**

The study confirms high rates of psychopathology measured by CBCL and YSR and very high gender dysphoria rate measured by UGDS in transgender youth in Switzerland at time of referral. During the course of treatment after one year gender dysphoria remains high, but rates of psychopathology and quality of life improve as well as peer relations. Most of the adolescents (90%) received hormone treatment. Treatment satisfaction is high or very high in 81% of the examined youths.

Appropriate treatment seems to lower the burden of psychopathology and improve quality of life in transgender youth.

# Access to health care among trans population in Europe

Saturday, 13th April - 11:00: Social Sciences Session III: Access to health care among trans populations in Europe (Bramante 10)

***Alain Giami*** [1], ***Henri Panjo*** [1], ***Cristiano Scandurra*** [2], ***Paolo Valerio*** [2], ***Elsa Almås*** [3], ***Esben Esther Benestad*** [4], ***Tor-Ivar Karlsen*** [4], ***Silje-Håvard Bolstad*** [4], ***Carla Moleiro*** [5], ***Violeta Alarcao*** [6]

***1.*** *INSERM / Université Paris-Saclay,* ***2.*** *University of Naples Federico II,* ***3.*** *University of A,* ***4.*** *University of Agder,* ***5.*** *Lisbon University Institute ISCTE-IUL, CIS,* ***6.*** *ISCTE-IUL*

**Background**

The symposium is part of an international project titled: "Trans Health and Citizenship: International comparisons". The project is currently developing in France (INSERM – CESP), Denmark (Aalborg University), Italy (Sinapsi, University Federico II of Napoli), Norway (Dept of Health Sciences, Agder University), Portugal (ISCTE-IUL, University of Lisboa), and Brazil (Instituto de Medicina Social, State University of Rio de Janeiro).

The objective of the whole project is to develop national knowledge about trans situations (including transgender, trans identity, travestis, gender incongruence, etc…) which will allow international comparisons in order to understand the specificity of each countries, the characteristics of the trans populations and their internal diversity, and also the strengths and limitations of policies towards trans people performed in each of these countries.

**Methods**

A questionnaire was previously developed in France (Giami & Beaubatie, 2014) and was translated and culturally adapted to Italian, Portuguese, Norwegian, using a forward-backward translation procedure. The final version of the questionnaire were tested on a reference group of trans people before being used in the survey. The survey consisted of 129 items, aimed to collecting data on socioeconomic status, gender affirmation process, health, sexuality, sexual health and discrimination. In each country, partnership with local trans organizations and health professionals were developed and when possible a steering committee including representants of trans organizations and health professionals accompanied the project across performance.Question about gender identification were included as open ended question which allow to collect self-definitions of trans people which were analysed and built into specific categories. Local Ethical committees approved the project in each country.

**Results and Conclusions**

The study of trans situations in the participating countries raises important issues regarding access to health care and citizenship but also questions related to self determination, autonomy, the right at disposal of one's body, equality, discrimination based on gender, sexual orientation and appearance. The symposium will explore more specifically access to health care institutions, including gender affirming process, access to hormone, surgeries, mental health issues, etc. and will raise questions about these difficulties. Important differences between countries were observed including mode of self identification, access to health care or wish/access to genital surgeries and hormonal treatment. Gender self definition appeared as predictor of the pathways carried by trans people. Results from Italy, Norway, and Portugal will be presented in order to open comparative discussions about the situation and difficulties of access to health care in Western and Northern Europe .

# Health and Citizenship of Trans People in Portugal: research-informed training actions to prevent discrimination based on gender expressions and identities

Saturday, 13th April - 11:15: Social Sciences Session III: Access to health care among trans populations in Europe (Bramante 10)

***Carla Moleiro*** [1]***, Violeta Alarcão*** [2]***, Lia Neves*** [2]***, Alain Giami*** [3]

***1.*** *Lisbon University Institute ISCTE-IUL, CIS,* ***2.*** *Instituto de Saúde Ambiental, Faculdade de Medicina, Universidade de Lisboa,* ***3.*** *INSERM / Université Paris-Saclay*

**Background**

National and international evidence indicates high levels of discrimination and social exclusion among trans people, as well as inequities in access to fundamental spheres of citizenship such as health, education, employment, or safety. Research has also revealed the need for information, awareness and training targeting diverse audiences in matters of gender and gender identity.

The Health and Citizenship of Trans People in Portugal study aims to validate the research protocol and the questionnaire developed by the INSERM team and applied in France, as part of a research project titled 'Trans and sexual health', that will be used in a survey to be carried in a partnership between academia and trans associations and health professionals in Portugal. This partnership intents to establish long-term research and health promotion activities contributing to health in general, and sexual health in particular, as a vital resource available to all individuals, regardless of their personal, social and cultural context. Also, these activities will give visibility to trans minorities and promote their citizenship.

**Methods**

The overall project aims are to: (i) implement a national survey in order to study the sociodemographic characteristics, access to medical, and psychological care, and state of health among trans individuals in Portugal; (ii) develop information and awareness actions among college students (future actors in the social network of trans people), health professionals and other social stakeholders, and society as a whole in the area of trans health in order to combat discrimination based on gender, gender expressions and gender identities, in particular in the access to physical and psychological health, and the full experience of citizenship of Trans people; and (iii) draw training actions for professionals of social, community and health intervention for the development of affirming skills to support and intervene with Trans people in Portugal.

**Results and Conclusions**

Preliminary results (qualitative and quantitative) will be presented.

The expected results of the project are to increase the awareness, knowledge and technical skills related to health care for a variety of trans people in Portugal, reducing inequities in access to health and full experience of citizenship, and seeking to meet international commitments to respect human rights of trans people (i.e. based on the gender, gender expressions and identities).

# Gender Self Definition for Measuring Transition Pathways in Norway

Saturday, 13th April - 11:30: Social Sciences Session III: Access to health care among trans populations in Europe (Bramante 10)

***Silje-Håvard Bolstad*** [1], ***Tor-Ivar Karlsen*** [1], ***Esben Esther Benestad*** [1], ***Elsa Almås*** [1], ***Alain Giami*** [2]

***1.*** *University of Agder,* ***2.*** *INSERM / Université Paris-Saclay*

**Background**

Sex – the binary man/woman distinction – is the first variable used in most demographic, sociological or epidemiological surveys. The inclusion of people who do not fit into the sex/gender binary model is both a scientific and a political problem. The presentation is part of the project "Trans Health and Citizenship: International comparisons". In this project, gender identification is an open question, i.e. verbatim that participants use to define themselves, and the responses were constructed as subgroups categories and used as independent variables for analyzing responses. It is important to elaborate categories that trans people use to define themselves. These categories can be used both by clinicians, researchers and others to understand and explain the basic differences inside this diverse population. Doing so, discussions on gender issues will be more ethical and valid.

**Methods**

The original framework from the French survey was developed and adapted to the Norwegian context. In the Norwegian survey, a total of 336 respondents provided a qualitative description of their gender identity. These ranged from one-worded descriptions like "man", "trans" or "agender" to more complex descriptions like "non-binary trans girl" or "man, partially genderqueer, and trans".

**Results and Conclusions**

The following six gender identity categories were elaborated: *man; woman; trans man; trans woman; non-binary; agender*. We report our initial analysis aimed at describing similarities and differences between these subgroups on key variables related to the gender transition process.

When thinking about their transition process as completed or not, those who identify as *trans men* and *trans women* do not differ from *men* and *women*. In contrast, those who identify as *non-binary* or *agender* more often report *not knowing* if their process is completed. Those who identity as *men*, *women* or *trans men* are more likely to apply for a legal gender change than *trans women* and *non-binaries*, while none of the *agenders* have applied. The *non-binaries* and *agenders* are less likely to seek assessment for gender incongruence. *Men* and *trans men* are more likely to have obtained the F64.0 diagnosis, while *women*, *trans women* and *non-binaries* are more likely to have had their assessment cancelled. *Trans men* are as likely as *men* to be using hormones, while *trans women* are less likely than *women*. Fewer *non-binaries* are using hormones, but more than one third do. *Trans men* want breast removal as much as *men*, and *trans women* want breast augmentation as much as *women*. The *non-binaries* are less likely to want breast surgery, but 32-65% of them do. A minority of the total sample (8%) has had experience with genital surgery, and there is no significant difference between subgroups. However, *men* are more likely than *trans men* to express a wish for genital surgery, while *women* are not more likely than *trans women*. The *non-binaries* and *agenders* are less likely to want genital surgery, but one third of them do.

We propose the following gender identity categories:*man; woman; trans man; trans woman; non-binary; agender*.Our initial analyses indicate that these categories are relevant to understand empirical distinctions.

# Transition Path and Gender Identification in a Sample of Italian Transgender and Gender Nonconforming People

Saturday, 13th April - 11:45: Social Sciences Session III: Access to health care among trans populations in Europe (Bramante 10)

***Roberto Vitelli*** [1], ***Cristiano Scandurra*** [1], ***Anna Lisa Amodeo*** [1], ***Rosa Pacifico*** [2], ***Maria Serena Selvino*** [2], ***Paolo Valerio*** [1], ***Alain Giami*** [3]

***1.*** *University of Naples Federico II,* ***2.*** *Department of Neurosciences and Reproductive and Odontostomatological Sciences, University of Naples Federico II, Naples, Italy,* ***3.*** *INSERM / Université Paris-Saclay*

**Background**

Italian studies assessing the multifaceted transgender and gender nonconforming (TGNC) subjective experiences are still very limited. Within the international project "Health and citizenship among trans individuals" developed in France, Italy, Brazil and Norway, this Italian study aims at exploring the socio-demographic characteristics and the role that hormonal treatments and Gender Affirming Surgery (GAS) play in gender identifications and transition pathways.

**Methods**

One hundred sixty-seven Italian TGNC individuals (71 trans women and 96 trans men) participated in a survey assessing socio-demographic information, feelings about one's own identity and transition paths by means of medical/psychological treatments. Two main indicators (sex assigned at birth and gender self-identification) were used to analyze medical and legal pathways.

**Results and Conclusions**

A strong heterogeneous diversity of this population, whose definition cannot be restricted to binary categorization and which differently make recourse to hormonal treatment or GAS, emerged. An increasing trend in self-identifying in non-binary gender identifications was detected, although the majority of the sample still expressed the need of undergoing GAS.

# Paths leading to suicide attempts among Norwegian trans people

Saturday, 13th April - 12:00: Social Sciences Session III: Access to health care among trans populations in Europe (Bramante 10)

***Tor-Ivar Karlsen*** [1], ***Alain Giami*** [2], ***Esben Esther Benestad*** [1], ***Silje-Håvard Bolstad*** [1], ***Elsa Almås*** [1]

***1.*** *University of Agder,* ***2.*** *INSERM / Université Paris-Saclay*

**Background**

The literature suggests that the suicide risk is higher in the trans population compared to both the LGB-population and the general population. Attempted suicide is shown to be the strongest predictor for later suicide attempts. Some studies report that more than one third of trans people have attempted suicide in their lifetime. However, surveys of trans people are often limited to subgroups (eg. only trans men/women, sex workers, SRS etc.) and few studies have explored the relationship between self-harming, suicidal ideation and suicide attempts in open surveys. Our aim was to assess the prevalence of these factors in the Norwegian trans population and to suggest associations between these.

**Methods**

A French questionnaire (Giami & Beaubatie, 2014) was translated and culturally adapted to Norwegian, using a forward-backward translation procedure. The final version was tested on a reference group of trans people. The survey consisted of 129 items, aimed to register data on socioeconomic status, gender transition, health, sexuality and discrimination. A website was designed where the study was explained and a link to the survey was given. After approval from the Norwegian Regional Committee for Medical and Health Research Ethics the anonymous survey was performed digitally between April 5$^{th}$ and August 1$^{st}$ 2018. A total of 538 respondents answered the web-questionnaire. Through structural equation modelling (SEM) a path-model was designed to test associations between relevant independent variables (age, education, employment status, assigned gender at birth, shame of being trans, depressive episodes, self-harming, and suicidal ideation) and suicide attempts. Only statistical significant associations with p-values <.05 and corresponding standardized regression coefficients (beta) are reported.

**Results and Conclusions**

One third of the respondents got the web-site URL from health care providers (17%) or organizations (16%). The rest (67%) found it through social media. Respondents assigned female gender at birth (64%) were younger than those assigned male gender. More than half of the sample (56%, n=226) reported depressive episodes of more than 2 weeks duration during the last 12 months, 48% (n=189) reported self-harming, 84% (n=247) reported suicidal ideations, and 29% (n=118) reported suicide attempts. Among those who attempted suicide, 91% (n=108) did it before start of bodily adjustments. The SEM path-model had an acceptable fit (CFI=.934 and RMSEA=.056) and showed that suicide attempts were associated with self-harm (beta=.28) and suicidal ideation (beta=.33). Self-harming was in turn associated with depressive episodes (beta=.22), education (beta=.12), and age (beta=.28). Suicidal ideation was associated with depressive episodes (beta=.25) and employment status (beta=-.17). Assigned gender at birth was associated only with age (beta=.31), and shame of being trans was associated only with depressive episodes (beta=.39).

Our data suggest that depressive episodes, self-harming and suicidal ideation are associated with suicide attempts, and that these symptoms should be of special interest for clinicians serving this population. Protective factors seem

to comprise employment status (being in paid work) and having higher education.
Since our data suggest that most suicide attempts happen during the first phases of the transition process, clinicians should be especially focused on depressive episodes, self-harming and suicidal ideation during the initial consultations.

# Effectiveness of an online decision aid for fertility preservation in trans men

Saturday, 13th April - 11:00: Social Sciences Session IIIb: Fertility (Bramante 11)

***Norah Van Mello*** [1], ***Victor van Hofwegen*** [2], ***M. Verhoeven*** [3], ***Müjde Ozer*** [1], ***Garry Pigot*** [1], ***Freek Groenman*** [3], ***Judith Huirne*** [1]

***1.*** *VU Medical Center,* ***2.*** *Amsterdam UMC, location VUmc,* ***3.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

Treatment options to live in accordance with the gender experienced can be hormone therapy and/or genital surgical interventions. These options both have a negative effect on fertility. In the Netherlands legislation has only changed in 2014, before that time sterilization was obligatory for transgender people. It is possible for transgender people to become a biological parent, but very little transgender specific information about fertility and fertility preservation (FP) is available. An online patient decision aid (PDA) has been developed with the perspective and experience of trans men about the FP options for trans men.

**Methods**

A semi-structured qualitative pilot-study has been conducted to investigate the attitude towards the PDA for FP in trans men. The participants were all scheduled for fertility counseling by a gynaecologist, or currently in diagnostics at the outpatient clinic. Three groups were made: Group A (PDA prior to consultation), Group B (consultation and the PDA afterwards (standard care)) and Group C (Only PDA). Primary outcome was the decisional conflict measured with the decisional conflict scale (DCS). Other outcomes were preparation for decision making (Prep-DM), attitude towards the PDA and attitude towards the fertility counseling.

**Results and Conclusions**

Group A (n=8) had a significant decline in decisional conflict after PDA + consultation (DCS1 total mean 47.9 to DCS2 total mean 28.7 (p=.012)). Group B (n=13) felt better informed after seeing the PDA. Group C was divided into the two groups subject to whether they were interested in FP options prior to using the PDA or not. The interested group (n=22) showed significant decline in DCS scores after PDA (DCS1 mean (sd) 42.1 (3.3) to DCS2 mean (sd) 28.7 (2.8)(p<.001)). Those who were not interested were consistent with their choice (n=19) 28.9 (3.2) vs 25.2 (1.7) (p=0.45). Conclusion: For trans men with interest in FP options the online PDA for FP options decreased the decisional conflict and helped to feel better informed about the divers options.

# Reaching for parenthood: A phenomenological study of how men who are diagnosed with transsexualism and undergo fertility preservation wish to build a family

Saturday, 13th April - 11:15: Social Sciences Session IIIb: Fertility (Bramante 11)

***Felicitas Falck*** [1], ***Gabriela Armuand*** [2], ***Cecilia Dhejne*** [3], ***Kenny Rodriguez-wallberg*** [3]

***1.*** *Karolinska University Hospital,* ***2.*** *Linköping University,* ***3.*** *Karolinska Institutet*

**Background**

Contemporary assisted reproduction techniques have extended possibilities beyond the normative heterosexual family, as the reproductive rights of LGBT individuals are increasingly being recognized. However research is still sparse. In Sweden transgender men, who were assigned female at birth, can undergo cryopreservation of oocytes after being diagnosed with transsexualism. No studies have investigated how men diagnosed with transsexualism experience wanting children and a family, nor the motivations behind the decision to undergo FP. To guide legal reform and clinical practice it is important to understand how these men experience the options of building a family when undergoing fertility preservation (FP).

**Methods**

Based on the research question: "How do transgender men experience the options of building a family when undergoing fertility preservation (FP)?" transgender men diagnosed with transsexualism undergoing cryopreservation of oocytes in Karolinska University Hospital in Stockholm, Sweden, were invited to participate in a prospective interview study. The interviews lasted 68-95 minutes, were digitally recorded and transcribed verbatim. Study inclusion started in May 2014 and continued until December 2015 when sixteen men (age 19-33) had participated, shortly after having undergone FP. The interviews focused on the plan of having children and motives behind undergoing FP. Data was analysed by using thematic content analysis.

**Results and Conclusions**

**Results**

The preliminary analysis resulted in one main-theme and three sub-themes. The main-theme: *Striving for self-determination:* describes how the desire to build a family was dependent and limited by biological and societal boundaries. This caused feelings of powerlessness, distress and bitterness, as laws and regulations prevented participants to reach life goals but also inspired activism.

The sub-theme: *Wanting a child on my terms*: concerns how the route to having children had to be adjusted to available possibilities as well as the importance placed on having a genetically related child. It describes how different methods to achieve parenthood were considered, such as carrying a pregnancy as a man, embryo donation to a partner, surrogacy or adoption as well as hopes for new fertility techniques.

The sub-theme *Masculinity* describes how participants navigate gender identity and masculinity as they imagine their future role as a parent and the role that FP plays in leaving femininity behind.

The sub-theme *Having gametes in the freezer* shows how the performance of FP had provided them with resources and opened options concerning future possibilities to have Children.

**Conclusion**

Men diagnosed with transsexualism who undergo FP find it important to have children but experience limited possibilities to achieve parenthood without the availability of embryo donation, surrogacy or adoption, which should

be considered in law reform. FP only gave them respite while waiting for such legal amendments. Participants commonly lacked information about the treatment options that were available to them including what fertility options that can be accessed abroad. They were reluctant to reveal their reproductive wishes and ask health care providers for information to avoid limiting their options further. There is a need to offer targeted reproductive counselling to transgender men to increase the relevance of services.

# Trans masculine reproduction and the implications for health, law and ethics.

Saturday, 13th April - 11:30: Social Sciences Session IIIb: Fertility (Bramante 11)

***Sally Hines*** [1]***, Ruth Pearce*** [1]***, Francis Ray White*** [2]***, Carla Pfeffer*** [3]***, Damien Riggs*** [4]***, Elisabetta Ruspini*** [5]

***1.*** *University of Leeds,* ***2.*** *Westminster,* ***3.*** *South Carolina,* ***4.*** *Flinders,* ***5.*** *University of Milano-Bicocca*

**Background**

Coupled with technical advances around reproduction, changing attitudes and practices concerning gender diversity across legal, social and cultural realms, have allowed more equal access to fostering, adoption and assisted reproductive technology for some trans people in many countries in the West. Trans masculine pregnancy shows how shifts in gendered and intimate practices occur within changing social institutions and cultural understandings. Vice versa, such social and cultural transformations impact on how individuals live their gendered and intimate lives.

Drawing on initial data from an on-going qualitative research project funded by the UK Economic and Social Research Council (ESRC): 'Trans Masculine Pregnancy: An International Exploration of Trans Masculine Practices of Reproduction', this paper considers the questions trans male practices of pregnancy and birth raise for health, ethics and law. Using case studies from in-depth interviews with trans men who have become pregnant and given birth after gender transition in Europe, the US and Australia, the paper first explores the limitations of existing health and reproductive care for this population. The paper then moves on to examine gaps in legal provision for the recognition of trans masculine birth parents. In conclusion, the paper outlines the project's preliminary recommendations for future best ethical practice on trans reproduction.

**Methods**

One-to-one interviews with trans masculine people who have given birth or who are pregnant, and with health professionals, focus groups with young trans masculine people, film.

**Results and Conclusions**

The paper explores the limitations of existing health and reproductive care for trans masculine people who become pregnant and/or give birth. The paper examines gaps in legal provision for the recognition of trans masculine birth parents. In conclusion, the paper outlines the project's preliminary recommendations for future best ethical practice on trans reproduction.

# Learning the needs of a new patient group: Health care professionals experiences of caring for transgender men undergoing fertility preservation by cryopreservation of oocytes

Saturday, 13th April - 11:45: Social Sciences Session IIIb: Fertility (Bramante 11)

***Gabriela Armuand*** [1]***, Felicitas Falck*** [2]***, Cecilia Dhejne*** [3]***, Kenny Rodriguez-wallberg*** [2]

***1.*** *Linköping University,* ***2.*** *Karolinska University Hospital,* ***3.*** *Karolinska Institutet*

**Background**

In connection with a legislative change in Sweden 2013, where individuals diagnosed with gender dysphoria no longer had to undergo sterilization in connection with change of legal sex, transgender individuals were given the possibility to undergo fertility preservation (FP). Earlier research among transgender men show that FP may negatively impact gender dysphoria as the procedures are closely linked to female identified body parts. In addition, transgender individuals have repeatedly reported negative experiences of healthcare encounters, both within general health care as well as in reproductive care, where they have experienced discrimination and even been refused care. However, no studies were found investigating healthcare professionals' (HCP) experiences of caring for transgender men who undergo FP. The aim of this study was therefore to investigate HCPs experiences of meeting transgender men undergoing FP by cryopreservation of oocytes.

**Methods**

All HCPs working at an academic reproductive medicine clinic at a large university hospital in Sweden were invited to participate in the study; gynecologists, embryologists, midwifes and administrative staff alike. Inclusion criteria were having cared for at least one transgender man after the new patient group had been introduced at the clinic. The study were conducted between January and April 2016. In the end, 13 women and one man participated in a semi-structured interview lasting between 17 to 53 minutes (mean 34 min). The interviews covered two areas: The preparation, education and planning for the new patient group, and personal experiences of caring for transgender men undergoing cryopreservation of oocytes. The interviews were digitally recorded and thereafter transcribed verbatim and analyzed by thematic content analysis.

**Results and Conclusions**

The analysis resulted in identification of one main theme consisting of three sub-themes. The main theme, *How to maintain professionalism*, is about how the HCPs, through the three sub-themes —*The learning experience*, *Encounters with the patients* and *Modification of procedures*— learned the needs of the new patient group. Their professionalism was challenged as they were obliged to confront their preconceived opinions and cis-normative assumptions. Through a combination of new knowledge, experiences of meeting the transgender men and the adjustments of the FP procedures, the HCPs found ways of providing care for the transgender in a professional manner. The results demonstrate the difficulties that may arise when introducing a new patient group in an already established clinical routine workflow and how continued professional development is required to assess learning needs of HCPs. Importantly, addressing issues related to negative experiences in patient encounters as well as having open dialogue about the impact of personal values should be encouraged. The findings of the study provide an insight into what facilitators and barriers that may be present when introducing the new patient-group at a reproduction clinic; transgender men undergoing FP. This in turn may help other clinics to prepare for the patient group in order to

optimize the care.

# Prostate cancer in trans women receiving hormone treatment

Saturday, 13th April - 11:00: Endocrinology Session III: New and original discoveries (Bramante 14)

***Iris de Nie*** [1], ***Noëlle Valkenburg*** [1], ***Dennis van Dijk*** [1], ***Chantal Wiepjes*** [1], ***Christel De Blok*** [1], ***Garry Pigot*** [1], ***Koen Dreijerink*** [1], ***Norah Van Mello*** [1], ***Judith Huirne*** [1], ***Martin Den Heijer*** [1]

***1.*** *VU Medical Center*

**Background**

Gender-affirming hormone treatment in trans women consists of estrogens and anti-androgens. In addition, trans women may undergo bilateral orchiectomy combined with vaginoplasty. This procedure does not involve prostatectomy. Activation of the androgen receptor plays an important role in prostate carcinogenesis. Due to the androgen deprivation, the relative risk of prostate cancer in trans women is likely to be reduced compared to the general male population.

This retrospective study aims to gain more insight into prostate cancer risk in trans women using gender-affirming hormone treatment.

**Methods**

We assessed clinical data of trans women from the Amsterdam Cohort of Gender dysphoria (ACOG). We included trans women who were treated at our clinic for at least one year between 1972 and 2018 with documented hormone treatment. Data were linked to the national Dutch pathology database.Age–adjusted standardized incidence ratios (SIRs) were calculated using the number of observed prostate cancer cases in the cohort and the expected cases based on reference incidence numbers from the Dutch Cancer Registry.

**Results and Conclusions**

The study population consisted of 2,433 trans women with a median person time of 15 years (IQR 7-25, range 0-64), the total person time was 41,815 years. Six prostate cancer case were identified resulting in a SIR of 0.1967 (95%CI 0.0797-0.4092). Prostate cancer risk appears to be significantly reduced in trans women. Our observations provide no basis for prostate cancer screening in trans women. However, physicians should be aware that prostate cancer does occur in this group. We plan to further validate our follow up time by using data on mortality obtained from Statistics Netherlands (CBS).

# Digit Ratio 2D:4D Suggests a Role of Prenatal Testosterone in Gender Dysphoria

Saturday, 13th April - 11:15: Endocrinology Session III: New and original discoveries (Bramante 14)

***Mostafa Sadr*** [1], ***Behzad Sorouri Khorashad*** [1], ***Ali Talaei*** [1], ***Johannes Honekopp*** [2]

***1.*** *Mashhad University of Medical Sciences,* ***2.*** *Northumbria University*

**Background**

The pattern of gender dysphoria (GD) rates across different Disorders/Differences of Sex Development suggests that high prenatal testosterone (T) levels in females and low prenatal T levels in males might contribute to GD. Here, we investigated if digit ratio 2D:4D, a marker of prenatal T effects is related to GD. In a large Iranian sample, we compared 2D:4D in trans women and trans men against controls with the same sex assigned at birth. We then conducted random-effects meta-analyses of relevant studies ($k$=6, $N$=925 for trans women and $k$=6, $N$=767 for trans men). In line with the hypothesized prenatal T effects, trans women showed significantly feminized 2D:4D ($d$≈0.24). Conversely, trans men showed similarly masculinized 2D:4D ($d$≈-0.28); however, large unaccounted heterogeneity across studies emerged, which makes this effect less meaningful. We discuss implications of our results for the status of 2D:4D as a means to study prenatal T effects and for our understanding of GD.

**Methods**

**2D:4D in a Sample of Iranian Transgender people**

**Participants.** Between January 2015 and December 2016, 203 individuals diagnosed with GD were consecutively referred to the Transgender Studies Centre, at Mashhad University of Medical Sciences, in Mashhad, Iran. The diagnostic process of GD was largely based on the Standards of Care, version 7 of the World Professional Association of Transgender Health (WPATH) (Coleman et al. 2011).

**2D:4D measurement.** The palmar surface of the right and left hand of all participants was photocopied. Participants stretched their fingers and applied minimal pressure to the glass plate. All 2d and 4d lengths were then measured with digital vernier callipers from the digit tip to the middle of its most proximal crease.

**Meta-analysis of 2D:4D in Transgender people**

We used $d$ as our effect size measure. As in our Iranian study, positive effect sizes indicate higher average 2D:4D in trans people than in controls of the same sex assigned at birth (expected in trans women), whereas negative effect sizes indicate lower average 2D:4D in trans people (expected in trans men).

**Results and Conclusions**

Iranian Study

For all sex assigned at birth × hand combinations, results were in the predicted direction, i.e. compared to controls, trans men had on average masculinized (lower) 2D:4D (which we express as a negative Cohen's $d$) and trans women had feminized (higher) 2D:4D (positive $d$). However, a statistically significant difference emerged only for trans women's right hand, $t(143)=2.4$, $p$=.016, which was small-to-medium in size ($d$=0.43).

Meta-analysis

For trans women, a clear pattern emerged. In line with our hypothesis, trans women showed feminized (higher) 2D:4D. The effect was small, but consistent across studies and across both hands. For trans men, the evidence was more tentative: In both hands, trans men showed masculinized (lower) 2D:4D, and the average effects were slightly stronger than for trans women.

Our results suggest that weak prenatal T effects in males assigned at birth contribute to GD risk. The meta-analyses tentatively suggest that strong prenatal T effects in females assigned at birth increase GD risk under circumstances yet to be identified.

# Testosterone and X chromosome number associate with the type 1 interferon response in transgender young people.

Saturday, 13th April - 11:30: Endocrinology Session III: New and original discoveries (Bramante 14)

***Kate Webb [1], Gary Butler [2], Hannah Peckham [1], Anna Radziszewska [1], Sophie Lee [1], Claire Deakin [1], Coziana Ciurtin [1], Lucy R Wedderburn [1], Yiannis Ioannou [1]***

***1.*** *University College London,* ***2.*** *Gender Identity Development Service adolescent endocrine clinic and Reproductive Medicine Unit, University College London Hospital*

**Background**

Cisgender females have a stronger immune response than males, but are more prone to autoimmune disease, such as juvenile systemic lupus erythematosus (jSLE). It is unclear whether this is due to hormonal or chromosomal differences between the sexes. It has been impossible to separate the effects of hormone or chromosome in humans previously. Interferon alpha (IFNα) is a potent anti-viral cytokine, produced by plasmacytoid dendritic cells (pDC) that is also important in SLE and viral infections. We sought to investigate whether females had different IFNα response than males, and whether this was influenced by cross sex hormone therapy in transgender volunteers.

**Methods**

Blood was collected, with informed consent, from healthy, cisgender volunteers (n=110, age=6-18); volunteers with Turner's syndrome (n=9, age=13.8-19.6) and transgender volunteers (n=27, age=17.3-19.5) undergoing pubertal blockade and cross-sex hormone treatment. Clinical data and puberty self- assessment were recorded. Peripheral blood mononuclear cells were separated by Ficoll gradient centrifugation. Cells were stimulated with TLR7 agonist, R848, or TLR9 agonist, CpGODN2216, before assessing for the production of IFNα by pDC by flow cytometry. Serum testosterone and oestradiol were measured by high performance liquid chromatography/mass spectrometry. Statistical analysis was performed using SPSS.

**Results and Conclusions**

In healthy, cisgender volunteers only, females had, on average, 8.3% more pDC producing IFNα after TLR7 (R848) stimulation than males after correcting for pubertal phase (p=0.008). In addition, post pubertal volunteers had on average 6.5% more pDC producing IFNα after R848 stimulation after correcting for sex (p=0.039). There were no significant sex (p=0.535) or pubertal (p=0.162) differences in the percentage of pDC producing IFNα in cisgender volunteers after cells were stimulated with TLR9 agonist (CpG). When transgender young people were compared to cisgender young people, (ANOVA with Bonferroni post- hoc test), there was a lower percentage of TLR7 induced IFNα-producing pDC in transgender males (birth female-two X chromosomes; high testosterone) compared to cisgender females (mean difference=15.23; p=0.018; 95% CI=1.75-28.72) and transgender females (birth males-one X chromosome, low testosterone) when compared to cisgender males (mean difference=17.41; p=0.047; 95% CI=0.16-34.66). When Turner's and transgender volunteers were included in a regression model, if two X chromosomes were present, there was on average 12.41% more pDC producing IFNα after R848 stimulation (p=0.003) compared to if one X was present. The model included a significant association between the percentage of pDC producing IFNα after TLR7 stimulation and serum testosterone (p=0.008) and a significant interaction term between X chromosome number and serum testosterone (p=0.002).

Conclusion

We have shown that females produced more IFNα after TLR7 stimulation than males, and that this associated with

pubertal development. Regardless of sex hormones, possessing two X chromosomes associated with a higher TLR7 induced pDC IFNα production. Serum testosterone concentration associated with the TLR7 mediated IFN response differently in transgender young people, depending on the number of X chromosomes present. These novel insights are important in the understanding of sex based differences in the anti-viral immune system, for transgender young people and young people with sex based immune disease like jSLE .

# Sexual desire in transgender persons: linked to gender affirming hormone therapy? Results from ENIGI

Saturday, 13th April - 11:45: Endocrinology Session III: New and original discoveries (Bramante 14)

***Justine Defreyne*** [1], ***Baudewijntje Kreukels*** [2], ***Guy T'Sjoen*** [3], ***Annemieke Staphorsius*** [2], ***Martin Den Heijer*** [2], ***Gunter Heylens*** [1], ***Els Elaut*** [1]

***1.*** *Ghent University,* ***2.*** *VU Medical Center,* ***3.*** *Uz Gent*

**Background**

Sexual health is an important element of general health, although often underexposed, also by healthcare professionals providing gender affirming care for transgender people. Several steps in the transitioning process may affect sexual desire, including gender affirming hormones and chest and/or genital gender affirming surgery. Testosterone therapy in TM generally leads to increasing frequency of desire, masturbation, sexual fantasies and arousal. Studies in TW are inconclusive: some report an increase in the prevalence of hypoactive sexual desire after initiation of hormone therapy, whereas others have shown a positive impact of hormonal therapy on sexual quality of life in both TM and TW.

**Methods**

This prospective cohort study was part of the European Network for the Investigation of Gender Incongruence (ENIGI). Sexual desire was prospectively assessed in 766 participants (401 transgender women (TW), 364 transgender men (TM)) by Sexual Desire Inventory (SDI) during a three-year follow-up period, starting at the initiation of hormone treatment (HT). At baseline, psychological questionnaires were administered. Sex steroids were measured at each follow-up visit. Data were analyzed cross-sectionally andprospectively.

**Results and Conclusions**

Baseline total SDI scores were comparable in TW and TM (39.0 [23.0 – 54.5] versus 40.0 [17.0 – 52.0], P=0.342. In TW, total SDI scores decreased from 39.0 [23.0 – 54.5] (baseline) to 33.0 [16.3 – 49.8] after 12 months (-4.77, P<0.001), returning to scores comparable to baseline after 18 (P=0.152) months (P=0.114). After 36 months, total SDI scores were higher than baseline scores (51.5 [39.5 – 61.0], P=0.003). In TM, total SDI scores increased from 40.0 [17.0 – 52.0] at baseline to 55.0 [40.5 – 67.0] (+14.61, P<0.001) after 12 months, 48.0 [37.3 – 60.0], remaining stable over the following year and returning to scores comparable to baseline scores (58.0 [23.0 – 62.0], P=0.250) after 36 months.

People with a partner reported higher total SDI scores at baseline (P<0.001), month 3 (TW: P=0.004, TM: P=0.038) and month 12 (TM only: P=0.005). Scores for negative affect (PANAS) were positively correlated to total SDI scores in TW at baseline (ρ=0.202, P<0.001) and after 3 months (ρ=0.240, P<0.001). Scores for positive affect were positively correlated to total SDI scores in TM at baseline (ρ=0.194, P<0.001) and after 3 months (ρ=0.240, P<0.001) and in TW after 12 months (ρ=0.228, P<0.001). TW with lower levels of self-reported gender dysphoria (Utrecht Gender Dysphoria Scale) had higher total SDI scores at baseline (ρ=0.336, P=0.002).

Prospective changes in scores for the different SDI factors were not influenced by prospective changes in serum levels of testosterone and/or oestradiol in both TM and TW. Lower baseline levels of gender dysphoria (Utrecht Gender Dysphoria Scale) were correlated to a higher prospective increase in total SDI scores in TM after 12 months of HT (ρ=-0.355, P<0.001).

Sexual desire scores vary largely, with so far unexplained differences over the third year of hormone therapy. We observed no correlation between sexual desire and absolute serum testosterone levels. However, other factors,

including relationship status, gender dysphoria and positive and negative affect may influence sexual desire in transgender people.

# At the Cutting Edge: Non-Binary Voice – towards a new terminology and understanding of voice and communication therapy for non-binary people

Saturday, 13th April - 11:00: Voice Session III: Transgender men and non-binary people (Bramante 12)

***Matthew Mills*** [1], ***Gillie Stoneham*** [1], ***Carys Bracken*** [2], ***Nicola Gorb*** [1], ***Skye Davies*** [3]

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**Background**

Referral rates for non-binary people seeking treatment for gender dysphoria have significantly increased in the UK since 2016; so too have referrals of non-binary people requiring voice and communication therapy. A clinical audit of non-binary people referred to 'Charing Cross' Gender Identity Clinic speech and language therapy service between April 2017 and August 2018 was conducted in order to better understand service user voice and communication needs. There is a drastic paucity in the literature regarding non-binary voice and communication, and current clinical-research language is often enmeshed with unconscious bias assumptions based on binary concepts of gender, vocal and communicative expression. This audit contributes to documenting more accurate descriptors of this population, their voice and communication therapy objectives and the associated interventions used with this group.

**Methods**

Patient NHS electronic records of core psychological and psychiatric assessment and follow up appointments, speech and language therapy assessment and therapy appointments, correspondence and clinical notes were searched using a discrete inventory of terms (non-binary, genderqueer, trans masculine, trans feminine, bi-gender, a-gender, gender diverse) to locate patients who identify as non-binary or experience themselves in non-binary ways and who have commenced voice and communication exploration. Data was anonymised, coded and analysed using descriptive statistics and thematic analysis.

**Results and Conclusions**

37 patients met the inclusion criteria, of which 20 (54.1%) self-identified unequivocally as non-binary, and 17 (45.9%) as gender fluid, or experiencing self in non-binary ways. Mean age of patients was 29.6 years (SD 7.09) ranging from 18-45 years; a mean of 3 (SD 1.27) speech and land language therapy sessions were received by individuals (with a range of 1- 4 sessions); 45% attended voice group programmes in addition. Themes of therapy goals ranged from exploring voice, finding confidence, discovering maverique voice, queering voice, reducing/increasing/approaching masculine-perceived or feminine-perceived vocal features. Therapeutic interventions used ranged from vocal parameter mechanics (pitch, resonance, intonation, loudness, voice quality, breath support), electroglottographic vocal measurement, monitoring and voice care, to vocal situation and social communication focus, presence and personal impact, and assertiveness development. Psychological approaches were used, such as Solution Focussed Brief Therapy, Mindfulness, ACT, and Narrative Therapy, to support goal setting and self-efficacy, change process in terms of vocal identity, and develop self-esteem, relationships and social skills. A proposed system of classifying therapy focus according to laryngeal dimension emerged from a need to overhaul current clinical practice and move to greater non-binary affirmation by avoiding birth assigned descriptors. $VFT^{*t}$ (vocal folds and tract grown significantly with androgens in adolescent puberty affecting pitch and resonance);

*VFT*(vocal folds and tract not grown significantly with androgens in adolescent puberty affecting pitch and tone) *VFT+t* (vocal folds and tract not grown significantly with androgens in adolescent puberty affecting pitch and tone, now commenced on testosterone). The audit identifies therapy needs of and interventions used with this group, and makes recommendations for reflexive trans affirmative practice and terminology which challenges heterocis-normative assumption in vocal and communicative descriptors. It also locates need for more research into patient personal vocal authenticity, and correlation of vocal parameters to satisfaction.

# A Voice and Communication Program for Transgender and Gender Expansive Pediatric Clients

Saturday, 13th April - 11:15: Voice Session III: Transgender men and non-binary people (Bramante 12)

***Nathan Waller*** [1], ***Sarah Penzell*** [1]

***1.*** *Northwestern University*

**Background**

Clinical services across multiple disciplines including psychology, social services, surgery, endocrinology as well as speech-language pathology have been available for the transgender population for several decades. Significant advances have been made to help individuals transition in a healthy and affirming way. Advances in medication, psychology and surgery continue to be developed, improved and made more accessible. In the field of speech-language pathology, we are also developing our role as service providers using evidence-based practice in our work in the management of voice and communication.

However, when completing a systematic literature review of current clinical practice, there is a paucity of research pertaining to the treatment of adolescent transgender individuals. Given that culturally we are seeing a rise in adolescents coming out as transgender or gender diverse, there is a need for additional research and resources for speech-language pathologists to provide the most efficient and thoughtful care for this population.

In addition to lack of published research, we are also challenged with this population's laryngeal development. Pubertal changes include increases in testosterone and estrogen which confound the difficulty and the special considerations when working with these voices. An understanding of pubertal changes that coincide with hormone therapy (estrogen, progesterone, anti-androgens, androgens and anti-estrogens) is essential for the speech-language pathologist when aiding an individual in voice modification.

Challenges increase when providing services for transgender voice and communication in a group setting. Groups may include a wide spectrum of ages, personal goals, co-ed environments, and a variety of vocal ranges and attributes. In addition, the challenges of working with adolescents should be considered.

It is essential that clinicians take into consideration cultural competency before pursuing work, whether individually or in a group, with this population. Cultural competency includes: gender attribution/discrimination, coming out, bullying, racial and cultural diversity and cultural considerations of masculine communication versus feminine communication.

In addition to biological and cultural understanding, this course will include the organization and execution of assembling an adolescent group program. The model discussed is for a 7-week program, but the format is certainly adaptable. Screening participants, class structure, goal tracking and long term planning is discussed in addition to evidence-based therapy practices that have been modified to the treatment of this population. These include vocal hygiene practices, respiratory retraining, rate and volume, resonance, pitch modification and language (semantics/syntax, pragmatics and non-verbal communication).

**Methods**

This is not a presentation on an existing research study.

**Results and Conclusions**

This is not a presentation on research.

# Thyroplasty type III to lower the vocal pitch in trans men

Saturday, 13th April - 11:30: Voice Session III: Transgender men and non-binary people (Bramante 12)

***Charlotte Bultynck*** [1], ***Marjan Cosyns*** [1], ***John Van Borsel*** [1], ***Katrien Bonte*** [1]

***1.*** *Ghent University*

**Background**

Most trans men develop an acceptable male voice after long-term testosterone therapy. However, difficulties in lowering the fundamental frequency (F0) can be expected in about 10% of trans men after cross-sex hormone therapy (CSHT). Research on possibilities and results of phonosurgery in trans men who are not satisfied with their voice is virtually non-existent.

The aim of this study was to examine the effect of the Isshiki thyroplasty type III (TP III) in trans men.

**Methods**

From October 2002 to September 2015 ten trans men, unsatisfied with their voice, underwent phonosurgery at the department of head, neck and maxillofacial surgery in UZ Ghent. An Isshiki TP III was performed to lower the F0. Pre- and postoperatively an evaluation of the voice took place.

**Results and Conclusions**

The F0 dropped significantly from the preoperative mean of (154.60 +/- 12.294) Hz to the postoperative mean of (105.37 +/- 10.522) Hz. The difference was statistically significant ($t=9.821$, $P<0.001$).

We conclude that TP III is effective for lowering the F0 in trans men who are not satisfied with their voice after CSHT.

# National Swedish quality register for transgender health. Data from people assigned female at birth registered by speech and language pathologists

Saturday, 13th April - 11:45: Voice Session III: Transgender men and non-binary people (Bramante 12)

***Ulrika Nygren*** [1], ***Maria Södersten*** [1]

***1.*** *Karolinska Institutet, Department of Clinical Science, Intervention and Technology, Division of Speech and Language Pathology and Karolinska University Hospital, Functional Area Speech & Language Pathology*

**Background**

In Sweden there is a tradition of using National Quality Registers in healthcare. In 2013 the planning of a National Quality Register for the transgender population started. An interdisciplinary steering group, including a user patient representative, has been working to develop infrastructure for data collection and questionnaires together with the Register Center South. Data includes information from assessments, different gender-confirming treatments and lifelong follow-up regarding quality of life. The speech language pathologists (SLP) were the first professional group to start registering data in 2017. During the first year, information was collected from 190 registrations from six SLP-units related to gender teams at University hospitals. The patient participation is voluntary. The purpose of the presentation is to give overall information about data recorded so far for the people assigned female at birth (AFAB).

**Methods**

It is possible to collect data at the first visit to the SLP, after voice therapy and at follow-up and for AFAB during hormonal treatment up to 12 months. Information regarding waiting time from referral by the psychiatrist in the gender team to the first the visit to the SLP, patient's assigned sex at birth, diagnosis for gender incongruence, hormonal treatment, background factors relevant for voice use such as employment, vocal load, hearing and previous voice training were registered. Furthermore information about recording routines in the voice clinic and computer programs used for acoustic analyses were collected as well as results from questionnaires and acoustic analysis.

**Results and Conclusions**

Preliminary results show that 90 patients AFAB of a total of 98 were registered at a first SLP visit. In this abstract we will present data from the first visit. There was a large variation regarding waiting time after referral from the psychiatrist to the first visit to the SLP: 1 to 10 months. Eighty five of the patients were diagnosed with Transsexualism (F64.0) according to ICD-10, for three patients a gender incongruence diagnose was not yet confirmed and for 12 patients either "Other gender identity disorder" (F64.8) or "Gender identity disorders, unspecified" (F64.9) were confirmed. Eighty one of the 90 patients were recorded in a sound treated booth according to clinical routine. Mean fundamental frequency ($f_o$), of habitual speaking voice, for the group was 176 Hz (range: 95 to 231 Hz) and for $f_o$ mode the mean value was 167 Hz (range: 88 to 326 Hz). Thirty five of 90 had started hormonal treatment with testosterone at the first visit. In conclusion there is a large variation regarding waiting time from referral to first visit and it will be of interest to see if there are regional differences. There will be of great interest to compare data from first SLP visit to data at follow up and end of voice therapy and/or during hormonal treatment, when more data are available.

# Gender affirmation surgery for gender dysphoria: Systematic review on benefits and risks

Saturday, 13th April - 11:00: Surgery Session II: Surgical session (Bramante 15)

***Konstantinos Georgas*** [1], ***Ulrika Beckman*** [2], ***Inger Bryman*** [3], ***Anna Elander*** [1], ***Lennart Jivegård*** [4], ***Ellenor Mattelin*** [3], ***Teresa Olsen Ekerhult*** [5], ***Josefine Persson*** [4], ***Lars Sandman*** [6], ***Ida Stadig*** [4], ***Ulla Vikberg Adania*** [7], ***Annika Strandell*** [4], ***Gennaro Selvaggi*** [1]

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**Background**

Gender dysphoria (or transsexualism) denotes individuals with a persistent cross-gender identification and discomfort with their anatomical sex, manifesting the necessity of removing one's sex characteristics, or the perception of being born in the wrong sex. Gender affirmation surgery (GAS) aims in affirming the patient's self-perceived gender, and includes genital, facial and body procedures. Currently there is no systematic review assessing the quality of the studies previously performed on this topic.

The objective was to study the effect of GAS on: 1. patients' quality of life (QoL); 2. patients' satisfaction with the surgery; 3. frequency of regret; 4. frequency and extent of complications.

**Methods**

The PRISMA protocol was followed. During January 2018 two of the co-authors performed systematic searches in PubMed, Embase, the Cochrane Library, PsychInfo and Human Technology Assessment databases: the obtained abstracts have been independently assessed by all the co-authors, and selected for inclusion as full-text articles. Final inclusion was decided by consensus according to well defined PICO criteria. The quality of comparative studies was assessed. Data were extracted by at least two authors.

**Results and Conclusions**

The literature search resulted in 70 observational studies. Outcomes were grouped by type of gender affirmation. There were few comparative studies and most of those were hampered by selection bias. The certainty of evidence for the benefits of genital, facial and body gender affirmation surgery is generally very low (GRADE□OOO). It is uncertain if GAS improves the patient quality of life (QoL) (GRADE□OOO). Patients are generally very satisfied after surgery, although the certainty of evidence of patient satisfaction is low (GRADE □□OO). None of the included studies reported regret after GAS. The complications extent and frequency vary depending on the GAS procedure. Major surgical complications are frequent after *genital* gender affirmation surgery (GRADE□□□O).

**Conclusions:** The included literature contains only observational studies of mostly poor quality; data from long-term follow-ups are lacking. Patients usually value the effects of the interventions highly, in spite of the lack of long-term follow-ups. Gender affirmation surgery needs to be performed within systematically research projects in order to improve the knowledge about benefits and risks.

# Testosterone and breast cancer in trans men: case reports, review of literature and clinical observation

Saturday, 13th April - 11:15: Surgery Session II: Surgical session (Bramante 15)

***Sara Tanini*** [1], ***Alessandra Daphne Fisher*** [2], ***Jiska Ristori*** [2], ***Mario Maggi*** [3], ***Giulia Lo Russo*** [1]

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**Background**

Trans men describes individuals assigned female at birth but who later in life identify and live as men. Many, but not all transgender people, seek a social or a somatic transition in order to alleviate the significant distress (called gender dysphoria) resulting from the incongruence between the body and the gender identity. Somatic interventions - aimed at aligning the body with the perceived gender - may include a treatment with testosterone as well as the creation of an aesthetically pleasing male chest. These two steps play a crucial role for many trans men in alleviating the experienced sufferance. Limited information exists regarding breast health in the transgender population. The incidence of breast cancer in trans men is very rare and only a few cases were described in the literature. Nonetheless, a correlation between high dosage of testosterone and risk of breast cancer has been postulated. This is a very important issue within the health care of transgender people.

**Methods**

Our experience is on 100 transmen that underwent top surgery to create an aesthetically pleasing male chest. Only in two of them we identified breast cancer. The first diagnosis was before top surgery, the second one as an occasional histological finding. In both cases a double incision mastectomy with nipple areola complex have been performed. Our cases have some common characteristics with those described in the literature: young age, BC hormone receptor positive status and BC family history. Both cases here described are in a quite uncommon age range (between thirty and forty).All individuals have family histories of BC but did not have prophylactic mastectomy while receiving hormonal manipulation.

**Results and Conclusions**

No complications occurred with complete healing of the grafts and excellent aesthetic result.

It is important to bear in mind all the complex relationships between testosterone therapy and breast cancer. It is necessary to inform transgender persons who have not yet undergone to top surgery about the potential risk of developing a breast cancer, about the importance to select the most appropriate surgical technique according to the patient's risk and preferences and to perform an accurate post- operative surveillance. A multidisciplinary approach to these patients is strongly recommended, and large database creation and networking is warranted.

# Gender affirming surgery in transgender men in the Netherlands from 1989 to 2018: a sign of the times

Saturday, 13th April - 11:30: Surgery Session II: Surgical session (Bramante 15)

***Muhammed Al-tamimi*** [1], ***Wouter Van Der Sluis*** [1], ***Marlon Buncamper*** [1], ***Garry Pigot*** [1], ***Mark-Bram Bouman*** [1]

***1.*** *Amsterdam UMC, location VU University Medical Center*

**Background**

Some transgender men express their wish to undergo Genital gender Affirming Surgery(GAS). Transgender men generally report an improved quality of life and satisfactory sexual function after GAS, e.g., phalloplasty and metoidioplasty. During the last decades the surgical options given to transgender men has been a reflection of the trends in reconstructive flap advances as well as the trend towards patient centered decision making. Starting from the metoidioplasty to the free radial fore arm flap and now numerous combinations of flaps including the superficial circumflex iliac artery perforator (SCIP) flap. Treatment of the trans man has evolved from a standardized approach to a patient centered approach with multiple surgical options. Genital GAS in the Netherlands is done in a single-center; the VU University Medical Center, ideally placing it as a marker for trends.

**Methods**

Retrospective analysis of medical records of all transgender men who underwent genital GAS from January 1989 to January 2018 at the VU University Medical Center, Amsterdam, The Netherlands.

**Results and Conclusions**

**Results:** Four hundred transgender men underwent GAS. Metoidioplasty (MET) was performed in 219 (55%) patients, 186(85%) of whom underwent urethral lenghtening. Phalloplasty was performed in 179 (45%) patients, 144(80%) underwent urethral lenghtening. As shown in Figure 1 the following flaps were used for phalloplasty reconstruction: 76 (42%) free radial forearm flap (FRFF), 55 (31%) anterolateral thigh (ALT) flap, 21(12%) SCIP flap , 17 (9%) abdominal flap (AF), 7(4%) lateral upper arm flap (LUAF), 2(2%) fibula flap (FF). From the 179 patients that underwent phalloplasty, total flap failure occurred in 10( 5.5%) patients. The choices offered to the patients has grown from one simple option, the metoidioplasty, to a choice out of a combination of nine flaps. **Conclusion:** Genital gender affirming surgery in transgender men at the VU University Medical Center has developed over time in accordance with the reconstructive surgical innovations, this is especially seen in the surgical options of transgender men. As the options abound so has the guidance of the transman in their decision making process changed to a more patient centered process in order to achieve the best standards of care .

# Scrotal reconstruction technique in transgender men undergoing gender affirming surgery without urethral lengthening.

Saturday, 13th April - 11:45: Surgery Session II: Surgical session (Bramante 15)

***Garry Pigot [1], Muhammed Al-tamimi [1], Wouter Van Der Sluis [2], Müjde Ozer [1], Brechje Ronkes [3], Mark-Bram Bouman [1]***

***1.*** *VU Medical Center,* ***2.*** *Amsterdam UMC, location VU University Medical Center,* ***3.*** *Amsterdam UMC, location VUmc*

**Background**

One of the primary goals of genital gender affirming surgery (GAS) in transgender men is to create an external genital resembling the biological male external genital with corresponding sexual and voiding function. Transgender men who underwent genital GAS report an improved quality of life and satisfactory sexual function. Albeit, in case of genital GAS with urethral lengthening, with the aim to void while standing, significant complications have been reported (e.g. urethral strictures and urethral fistulae). These complications frequently lead to multiple surgical corrections , not infrequently leading to additional distress. Therefore, in the VU University Medical center, we offer the option to undergo genital GAS without urethral lengthening resulting in a much lower complication rate. Historically, different techniques have been described to reconstruct the scrotum in transgender men. Although the reconstruction of the scrotum is traditionally combined with the creation of the fixed part of the neo urethra and additional lengthening of the urethra. In transgender men who opt for genital GAS without urethral lengthening we modified the scrotal reconstruction technique as originally described by Selvaggi et al.

**Objective:**To describe our scrotal reconstruction technique in transgender men undergoing genital GAS without urethral lengthening.

**Methods**

The technique consists of a caudally based bi-pedicled horseshoe flap (consisting of pubic, clitoral and cranial part of the labia majora skin) and cranially based bilateral labia majora transposition flaps. The latter are rotated 90 degrees medially to bring the neo-scrotum in front of the legs. Bilateral pedicled labia majora fat pads (LMFP) are released cranially and positioned in the neo-scrotum to achieve more bulkiness. An inconspicuous urogenital orifice is created underneath the scrotum placed in the lengthened perineum.

**Results and Conclusions**

Our technique results in a neo-scrotum with increased bulkiness, minimal visible scars, a proper neo-perineum length.

**Conclusion:** Scrotal reconstruction in transgender men without urethral lengthening using a 'horseshoe' bi-pedicled pubic flap, LMFP and cranially based bilateral labia majora transposition flaps results in a neo-scrotum that resembles the biological scrotum closely in terms of bulkiness, size, shape and anatomical position.

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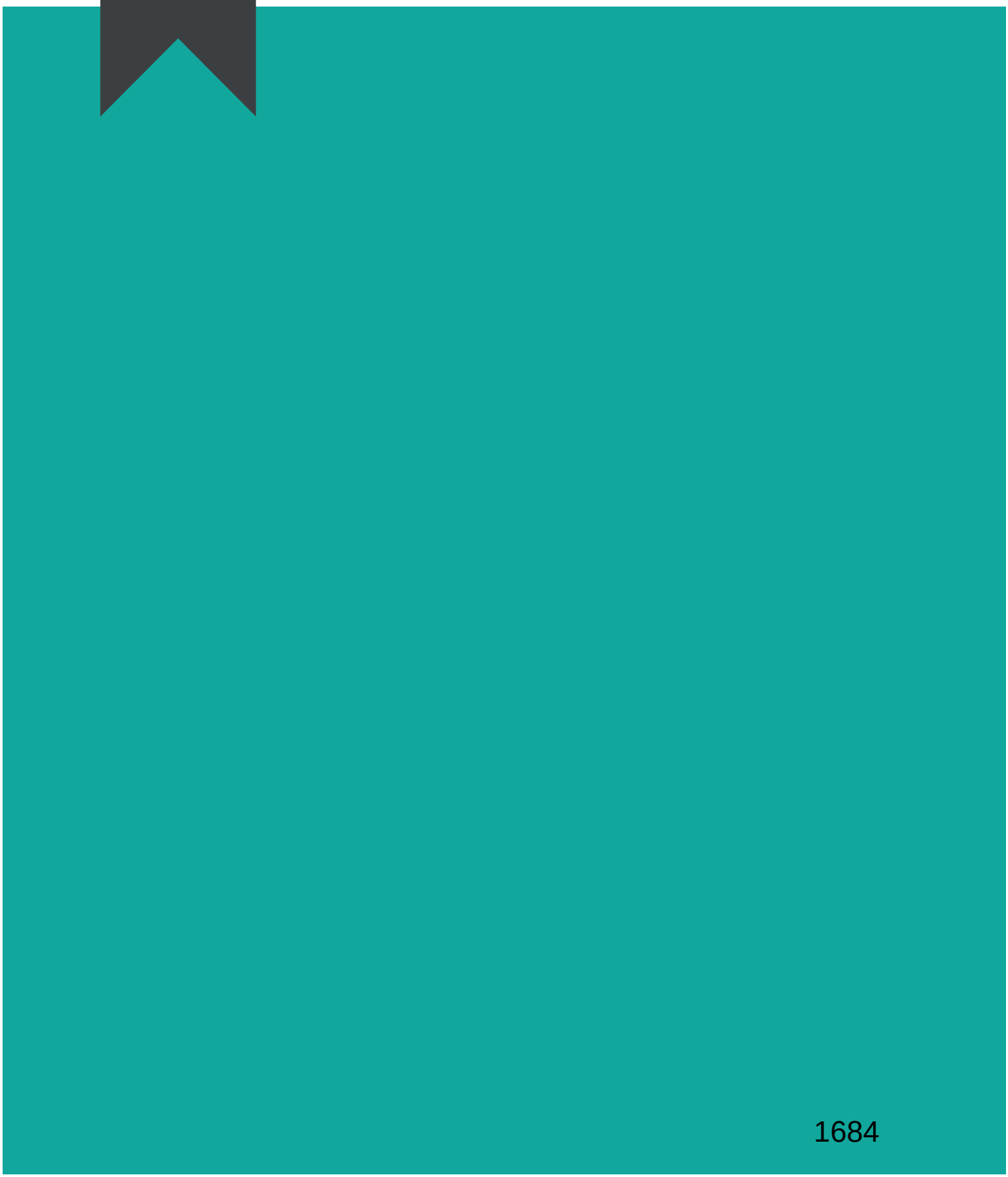
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# Detransition rates in a national UK Gender Identity Clinic

Thursday, 11th April - 16:30: Attended Poster Session (FOYER)

***Skye Davies*** [1]***, Stephen McIntyre*** [1]***, Craig Rypma*** [1]

***1.*** *Charing Cross Gender Identity Clinic, Tavistock and Portman NHS Foundation Trust*

**Background**

Detransitioning refers to the process whereby people who have undergone gender transition later identify or present as the gender that was assigned to them at birth. Transgender people may also go on to retransition, that is, to identify or present with a different transgender identity. Detransition and retransition may involve a change in identity, social presentation, legal documentation, or physical interventions. Most previous studies indicate very low rates of detransition. Some people who do not detransition, may still feel regret related to their transition. The aim of this study was to investigate treatment outcomes in a UK National Health Service (NHS) adult gender identity clinic by examining the rates of and reasons for detransition and regret.

**Methods**

Patient assessment reports created between August 1st 2016 to August 1st 2017 were scanned electronically for words related to detransition or regret. The reports that were retrieved in the search were reviewed by study authors to identify evidence that patients had detransitioned or expressed regret related to their transition. Data extraction included patients' age, gender identity, gender assigned at birth, and descriptions of their detransition or regret.

**Results and Conclusions**

Of the 3398 patients who had appointments during this period, 16 (0.47%) expressed transition-related regret or detransitioned. Of these 16, one patient expressed regret but was not considering detransitioning, two had expressed regret and were considering detransitioning, three had detransitioned, and ten had detransitioned temporarily. The reasons stated by patients for their regret or detransition included: social factors, reporting physical complications, and changing their mind about their gender identity and identifying as their gender assigned at birth. The 16 patients consisted of 11 trans women, two trans men, two cis men, and one person assigned male at birth who said their gender identity was "trans".

Study findings are consistent with previous research showing low rates of detransition. Detransition was most often prompted by social difficulties rather than changes in gender identity or physical complications and was most often temporary. Only three patients made a long-term detransition. Strengths of this study include our use of an electronic search to efficiently scan a large number of patient records and our investigation of reasons for regret and detransition. Limitations of this study include that it only provides a snapshot of current rates of detransition and regret and relied on self-reported experiences of patients who may not have disclosed information relevant to this study in their appointments. These results suggest that current practices at the clinic are related to very low rates of detransition and regret. Future studies in gender identity clinics may investigate factors that predict detransition in a larger sample of patients.

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Arch Sex Behav. 2014 Nov;43(8):1535-45. doi: 10.1007/s10508-014-0300-8. Epub 2014 May 29.

# An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: prevalence, incidence, and regrets

HHS Vulnerability Disclosure

Cecilia Dhejne [1], Katarina Öberg, Stefan Arver, Mikael Landén

Affiliations

PMID: 24872188 DOI: 10.1007/s10508-014-0300-8

## Abstract

Incidence and prevalence of applications in Sweden for legal and surgical sex reassignment were examined over a 50-year period (1960-2010), including the legal and surgical reversal applications. A total of 767 people (289 natal females and 478 natal males) applied for legal and surgical sex reassignment. Out of these, 89% (252 female-to-males [FM] and 429 male-to-females [MF]) received a new legal gender and underwent sex reassignment surgery (SRS). A total of 25 individuals (7 natal females and 18 natal males), equaling 3.3%, were denied a new legal gender and SRS. The remaining withdrew their application, were on a waiting list for surgery, or were granted partial treatment. The incidence of applications was calculated and stratified over four periods between 1972 and 2010. The incidence increased significantly from 0.16 to 0.42/100,000/year (FM) and from 0.23 to 0.73/100,000/year (MF). The most pronounced increase occurred after 2000. The proportion of FM individuals 30 years or older at the time of application remained stable around 30%. In contrast, the proportion of MF individuals 30 years or older increased from 37% in the first decade to 60% in the latter three decades. The point prevalence at December 2010 for individuals who applied for a new legal gender was for FM 1:13,120 and for MF 1:7,750. The FM:MF sex ratio fluctuated but was 1:1.66 for the whole study period. There were 15 (5 MF and 10 MF) regret applications corresponding to a 2.2% regret rate for both sexes. There was a significant decline of regrets over the time period.

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# Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence

Valeria P. Bustos, MD,[*] Samyd S. Bustos, MD,[†] Andres Mascaro, MD,[‡] Gabriel Del Corral, MD, FACS,[§] Antonio J. Forte, MD, PhD, MS,[¶] Pedro Ciudad, MD, PhD,[‖] Esther A. Kim, MD,[**] Howard N. Langstein, MD,[††] and Oscar J. Manrique, MD, FACS[✉††]

## Abstract

### Background:

There is an unknown percentage of transgender and gender non-confirming individuals who undergo gender-affirmation surgeries (GAS) that experiences regret. Regret could lead to physical and mental morbidity and questions the appropriateness of these procedures in selected patients. The aim of this study was to evaluate the prevalence of regret in transgender individuals who underwent GAS and evaluate associated factors.

### Methods:

A systematic review of several databases was conducted. Random-effects meta-analysis, meta-regression, and subgroup and sensitivity analyses were performed.

### Results:

A total of 27 studies, pooling 7928 transgender patients who underwent any type of GAS, were included. The pooled prevalence of regret after GAS was 1% (95% CI <1%–2%). Overall, 33% underwent transmasculine procedures and 67% transfemenine procedures. The prevalence of regret among patients undergoing transmasculine and transfemenine surgeries was <1% (IC <1%–<1%) and 1% (CI <1%–2%), respectively. A total of 77 patients regretted having had GAS. Twenty-eight had minor and 34 had major regret based on Pfäfflin's regret classification. The majority had *clear regret* based on Kuiper and Cohen-Kettenis classification.

### Conclusions:

Based on this review, there is an extremely low prevalence of regret in transgender patients after GAS. We believe this study corroborates the improvements made in regard to selection criteria for GAS. However, there is high subjectivity in the assessment of regret and lack of standardized questionnaires, which highlight the importance of developing validated questionnaires in this population.

## Introduction

Discordance or misalignment between gender identity and sex assigned at birth can translate into disproportionate discomfort, configuring the definition of gender dysphoria.[1–3] This population has increased risk of psychiatric conditions, including depression, substance abuse disorders, self-injury, and suicide, compared with cis-gender individuals.[4,5] Approximately 0.6% of adults in the United States identify themselves as transgenders.[6] Despite advocacy to promote and increase awareness of the human rights of transgender and gender non-binary (TGNB) individuals, discrimination continue to afflict the daily life of these individuals.[4,7]

Gender-affirmation care plays an important role in tackling gender dysphoria.[5,8–10] Gender-affirmation surgeries (GAS) aim to align the patients' appearance with their gender identity and help achieve personal comfort with one-self, which will help decrease psychological distress.[5,10] These interventions should be addressed by a multidisciplinary team, including psychiatrists, psychologists, endocrinologists, physical therapists, and surgeons.[1,9] The number of GAS has consistently increased during the last years. In the United States, from 2017 to 2018, the number of GAS increased to 15.3%.[8,11,12]

Significant improvement in the quality of life, body image/satisfaction, and overall psychiatric functioning in patients who underwent GAS has been well documented.[5,13–19] However, despite this, there is a minor population that experiences regret, occasionally leading to de-transition surgeries.[20] Both regret and de-transition may add an important burden of physical, social, and mental distress, which raises concerns about the appropriateness and effectiveness of these procedures in selected patients. Special attention should be paid in identifying and recognizing the prevalence and factors associated with regret. In the present study, we hypothesized that the prevalence of regret is less than the last estimation by Pfafflin in 1993, due to improvements in standard of care, patient selection, surgical techniques, and gender confirmation care. Therefore, the aim of this study was to evaluate the prevalence of regret and assess associated factors in TGNB patients 13-years-old or older who underwent GAS.[20]

## Methods

### Search Methodology

Following the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) guidelines, a comprehensive research of several databases from each database's inception to May 11, 2020, for studies in both English and Spanish languages, was conducted.[21] The databases included Ovid MEDLINE(R) and Epub Ahead of Print, In-Process & Other Non-Indexed Citations, and Daily, Ovid EMBASE, Ovid Cochrane Central Register of Controlled Trials, Ovid Cochrane Database of Systematic Reviews, and Scopus. The search strategy was designed and conducted by an experienced librarian, with input from the study's principal investigator. Controlled vocabulary supplemented with keywords was used to search for studies of de-transition and regret in adult patients who underwent gender confirmation surgery. The actual strategy listing all search terms used and how they are combined is available in Supplemental Digital Content 1. (**See Supplemental Digital Content 1,** which displays the search strategy. http://links.lww.com/PRSGO/B598.)

### Study Selection

Search results were exported from the database into XML format and then uploaded to Covidence.[22] The study selection was performed in a 2-stage screening process. The first step was conducted by 2 screeners (V.P.B. and S.S.B.), who reviewed titles and abstracts and selected those of relevance to the research question. Then, the same 2 screeners reviewed full text of the remaining articles and selected those eligible according to the inclusion and exclusion criteria (Fig. 1). If disagreements were

encountered, a third reviewer (O.J.M.) moderated a discussion, and a joint decision between the 3 reviewers was made for a final determination. Inclusion criteria were all the articles that included patients aged 13 years or more who underwent GAS and report regret or de-transition rates, and observational or interventional studies in English or Spanish language. Exclusion criteria were letter to the editors, case series with <10 patients, case reports correspondences, and animal studies.

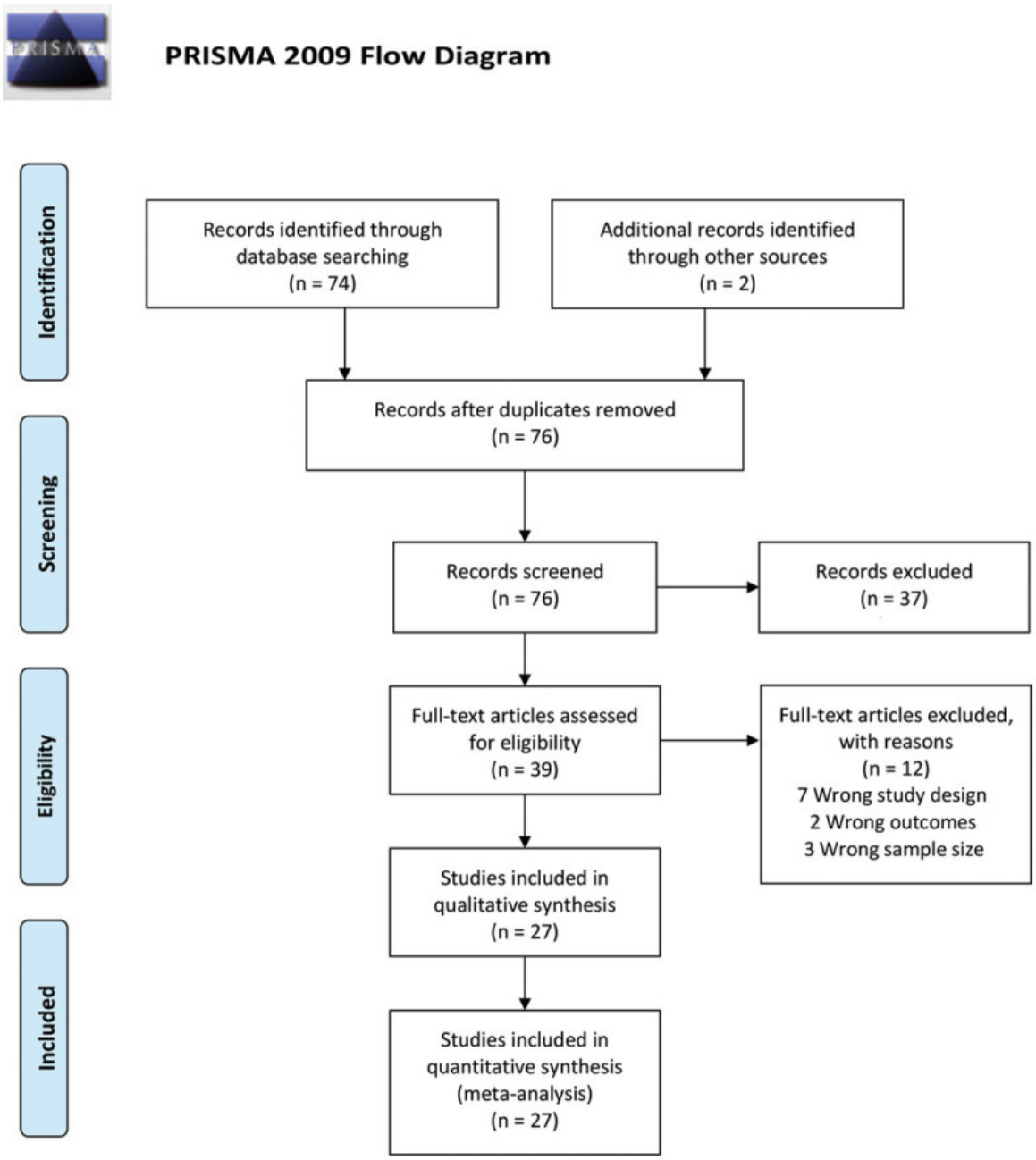



Fig. 1.

PRISMA flow diagram for systematic reviews.

## Data Extraction/Synthesis

After selecting the articles, we assessed study characteristics. We identified year of publication, country in which the study was conducted, population size, and number of transmasculine and transfemenine patients with their respective mean age (expressed with SD, range, or interquartile range if included in the study). In addition, we extracted information of the method of data collection (interviews versus

questionnaires), number of regrets following GAS, as well as the type of surgery, time of follow-up, and de-transition procedures. We classified the type of regret based on the patient's reasons for regret if they were mentioned in the studies. We used the Pfäfflin and Kuiper and Cohen-Kettenis classifications of regret (Table 1).[20,23]

Table 1.

Pfäfflin and Kuiper and Cohen-Kettenis Categories of Regret

| | | |
|---|---|---|
| Pfäfflin, 1993 | Minor | Feeling of regret secondary to surgical complications or social problems. |
| | Major | "True" regret. Feeling of dysphoria secondary to the new appearance, or desires of pursuing a de-transition surgery. |
| Kuiper and Cohen-Kettenis, 1998 | Clear regret | Patients openly express their regret and have role reversal either by undergoing de-transition surgery or returning to their former gender role. |
| | Regret uncertain | Patients don't have role reversal, but freely express their regret by never considering doing GAS or pass through the same preoperative scenario again. They are truly disappointed with the results of GAS. Also, they don't consider the new gender role so difficult and might consider a second GAS. |
| | Regret | Patients have role reversal but don't express their feelings of regret. Some might state that they are happy about their decision and consider themselves as transgender. However, they live as their former gender role for practical and social reasons. |
| | Regret assumed by others | Don't have role reversal and don't express feelings of regret but have unfavorable social circumstances or psychological disturbances that raise concerns to relatives, clinicians, and others that patient might be regretful (eg, feeling loneliness, suicide attempts). |

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## Quality Assessment

To assess the risk of bias within each study, the National Institute of Health (NIH) quality assessment tool was used.[24] This tool ranks each article as "good," "fair," or "poor," and with this, we categorized each article into "low risk," "moderate risk," or "high risk" of bias, respectively.

## Outcomes

Our primary outcome of interest was the prevalence of regret of transgender patients who underwent any type of GAS. Secondary outcomes of interest were discriminating the prevalence of regrets by type gender transition (transfemenine and transmasculine), and type of surgery.

## Data Analysis and Synthesis

The binominal data were analyzed, and the pooled prevalence of regret was estimated using proportion meta-analysis with Stata Software/IC (version 16.1).[25] Given the heterogeneity between studies, we conducted a logistic-normal-random-effect model. The study-specific proportions with 95% exact CIs and overall pooled estimates with 95% Wald CIs with Freeman-Turkey double arcsine transformation were used. The effect size and percentage of weight were presented for each individual study.[25,26]

To evaluate heterogeneity, $I^2$ statistics was used. If $P < 0.05$ or $I^2 > 50\%$, significant heterogeneity was considered. A univariate meta-regression analysis was performed to assess the significance in country of origin, tools of measurement, and quality of the studies.

To assess publication bias, we used funnel plot graphic and the Egger test. If this test showed us no statistical significance ($P > 0.05$), we assumed that the publication bias had a low impact on the results of our metanalysis. To assess the impact of the publication bias on our missing studies, we used the trim-and-fill method.

A sensitivity analysis was conducted to assess the influence of certain characteristics in the magnitude and precision of the overall prevalence of regret. The following characteristics were excluded: <10 participants included, and the presence of a high risk of bias.

## Results

### Study Selection

A total of 74 articles were identified in the search, and 2 additional records were identified through other sources. After the first-step screening process, 39 articles were relevant based on the information provided in their titles and abstracts. After the second-step process, a total of 27 articles were included in the systematic review and metanalysis (Fig. 1).

### Quality Assessment

Based on the NIH quality assessment tool, the majority of article ranged between “poor” and “fair” categories.[24] (**See Supplemental Digital Content 2,** which displays the score of each reviewed study. http://links.lww.com/PRSGO/B599.)

### Study Characteristics

In total, the included studies pooled 7928 cases of transgender individuals who underwent any type of GAS. A total of 2578 (33%) underwent transmasculine procedures, 5136 (67%) underwent transfemenine surgeries, and 1 non-binary patient underwent surgery. In Table 2 characteristics of studies are listed. Without discriminating type of surgical technique, from all transfemenine surgeries included, 772 (39.3%) were vaginoplasty, 260 (13.3%) were clitoroplasty, 107 (5.5%) were breast augmentation, 72 (3.7%) were labioplasty and vulvoplasty, and a small minority were facial feminization surgery, vocal cord surgery, thyroid cartilage reduction, and oophorectomy surgery. The rest did not specify type of surgery. In regard to transmasculine surgeries, 297 (12.4%) were mastectomies, 61 (2.6%) were phalloplasties, and 51 (2.1%) hysterectomies (Table 3 and 4). Overall, follow-up time from surgery to the time of regret assessment ranged from 0.8 to 9 years (Table 2).

Table 2.

Study Characteristics

| Authors and Year of Publication | Country | Sample Size | Transmasculine | Mean Age (y) | Transfemenine | Mean Age (y) | M |
|---|---|---|---|---|---|---|---|
| Blanchard et al, 1989 | Canada | 111 | 61 | 28.5 | 50 | 41.4 (He), 29.0 (Ho) | |
| Bouman, 1988 | Netherlands | 55 | NA | NA | 55 | NS | |
| Cohen-Kettenis et al, 1997 | Netherlands | 19 | 14 | 22* | 5 | 22* | |
| De Cuypere et al, 2006 | Belgium | 62 | 27 | 33.3 | 35 | 41.4 | Tr<br>Tr |
| Garcia et al, 2014 | London | 25 | 25 | 34 –RAP without<br>39.2 – RAP<br>35.1 – SP | NA | NA | RA |
| Imbimbo et al, 2009 | Italia | 139 | NA | NA | 139 | 31.4 | |
| Jiang et al, 2018 | USA | 80 | NA | NA | 79 (+ 1 NB) | 57.9 – Vulvoplasty<br>39.2 – Vaginoplasty† | |
| Johansson et al, 2010 | Sweden | 32 | 14 | 38.9 | 18 | 46 | |
| Krege et al, 2001 | Germany | 31 | NA | NA | 31 | Me 36.9 | |
| Kuiper et al, 1998 | Netherlands | 1100 | 300 | 46.4* | 800 | 46.4* | |
| Lawrence, 2003 | USA | 232 | NA | NA | 232 | 44 | |
| Lobato et al, 2006 | Brazil | 19 | 1 | 31.2* | 18 | 31.2* | |
| Nelson et al, 2009 | UK | 17 | 17 | 31 | NA | NA | |
| Olson- | USA | 68 | 68 | 18.9 | NA | NA | |

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*Reflects the mean of both transmasculine and transfemenine.

†Includes both scheduled and completed surgery.

‡Includes both surgery and no surgery patients.

H, High; He, Heterosexual; Ho, Homosexual; I, Interview; IQR, Interquartile Range; L, Low; M, Moderate; Me, Median; NA, Not applicable; NS: Not specified, Q: Questionnaire; RAP: Radial Arterial Forearm-Flap Phalloplasty without or with cutaneous nerve to clitoral nerve anastomosis; SP: Suprapubic Pedicle-Flap Phalloplasty.

Table 3.

Studies Differentiating Type of Surgery among Transfemenine Patients

| Type of Surgery | No. Procedures |
|---|---|
| **Breast Augmentation** | |
| Smith et al, 2001 | 7 |
| Van de Grift et al, 2018 | 33 |
| Judge et al, 2014 | 19 |
| Weyers et al, 2009 | 48 |
| Total | 107 |
| Vaginoplasty | |
| Blanchard et al, 1989 | 50 |
| Bouman, 1988 | 7 |
| Cohen-Kettenis et al, 1997 | 5 |
| Imbimbo et al, 2009 | 139 |
| Jiang et al, 2018 | 64 |
| Krege et al, 2001 | 31 |
| Kuiper et al, 1998 | 8 |
| Lawrence, 2003 | 232 |
| Papadopulos et al, 2017 | 47 |
| Rehman et al, 1999 | 28 |
| Van de Grift et al, 2018 | 71 |
| Zavlin et al, 2018 | 40 |
| Weyers et al, 2009 | 50 |
| Total | 772 |
| Vulvoplasty | |
| Rehman et al, 1999 | 28 |
| Jiang et al, 2018 | 16 |
| Total | 44 |
| Others | |
| Lawrence, 2003 | Clitoroplasty 232 |
| Rehman et al, 1999 | Clitoroplasty + labioplasty 28 + Orchiectomy 5 |
| Van de Grift et al, 2018 | Thyroid cartilage reduction 9, facial surgeries 7, and vocal cord 3 |
| Wiepjes et al, 2018 | Gonadectomy 2868 (adults), 262 (adolescents) |
| Judge et al, 2014 | Facial surgeries 6, laryngeal surgeries 2, GAS not specified 15 |
| Weyers et al, 2009 | Vocal cord surgeries 20, cricoid reduction 15 |

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Table 4.

Studies Differentiating the Type of Surgery among Transmasculine Patients

| Type of Surgery | No. Procedures |
|---|---|
| Mastectomy | |
| Blanchard et al, 1989 | 61 |
| Cohen-Kettenis et al, 1997 | 14 |
| Kuiper et al, 1998 | 1 |
| Nelson et al, 2009 | 17 |
| Olson-Kennedy et al, 2018 | 68 |
| Smith et al, 2001 | 13 |
| Van de Grift et al, 2018 | 49 |
| Judge et al, 2014 | 16 |
| Poudrier et al, 2019 | 58 |
| Total | 297 |
| Phalloplasty | |
| Cohen-Kettenis et al, 1997 | 1 |
| Garcia et al, 2014 | 25 |
| Smith et al, 2001 | 1 |
| Song et al, 2011 | 19 |
| Van de Grift et al, 2018 | 15 |
| Total | 61 |
| Hysterectomy | |
| Kuiper et al, 1998 | 1 |
| Smith et al, 2001 | 2 |
| Van de Grift et al, 2018 | 48 |
| Total | 51 |
| Others | |
| Cohen-Kettenis et al, 1997 | Neoscrotum 2 |
| Kuiper et al, 1998 | Oophorectomy 1 |
| Van de Grift et al, 2018 | Metoidioplasty 3 |
| Wiepjes et al, 2018 | Gonadectomy 1361 (adults), 372 (adolescents) |
| Judge et al, 2014 | GAS not specified 9 |

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## Regrets and De-transition

Almost all studies conducted non-validated questionnaires to assess regret due to the lack of standardized questionnaires available in this topic.[15, 19–33] Most of the questions evaluating regret used options such as, "*yes,*" "*sometimes,*" "*no*" or "*all the time,*" "*sometimes,*" "*never,*" or "*most certainly,*" "*very likely,*" "*maybe,*" "*rather not,*" or "*definitely not.*"[14, 18, 19, 23, 27–38] Other studies

used semi-structured interviews.[34,37,39–43] However, in both circumstances, some studies provided further specific information on reasons for regret.[14,20,23,29,32,36,41,44–46] Of the 7928 patients, 77 expressed regret (12 transmen, 57 transwomen, 8 not specified), understood by those who had "sometimes" or "always" felt it.

### Reasons for Regret

The most prevalent reason for regret was the difficulty/dissatisfaction/acceptance in life with the new gender role.[23,29,32,36,44] Other less prevalent reasons were "failure" of surgery to achieve their surgical goals in an aesthetic level and psychological level.[29,32,36,47] Based on the reasons presented, we classified the types of regrets according to Pfäfflin's types of regret and Kuiper and Cohen-Kettenis classification. According to Pfäfflin's types, 28 patients had minor regret, and 34 patients had major regret.[14,20,23,29,32,36,41,44,45] Based on the Kuiper and Cohen-Kettenis regret classification, 35 patients had clear regret, 26 uncertain regret, 1 regret, and none presented with regret assumed by others.[23] In Table 5 and 6, the reasons and classifications are shown.

Table 5.

Type of Regret

| Studies | No. Regrets | Transmasculine | Transfeminine | Type of Regrets based on Pfafflin, 1993 | | Type of Regrets based on Kuiper and Cohen-Kettenis, 1998 | | | | Surgery |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Minor | Major | 1 | 2 | 3 | 4 | |
| Blanchard et al, 1989 | 4 | — | 4 | 4 | — | 2 | 2 | — | — | Vaginoplas |
| Bouman, 1988 | 1 | — | 1 | — | 1 | 1 | — | — | — | Vaginoplas |
| De Cuypere et al, 2006 | 2 | 1 | 1 | 2 | — | — | 2 | — | — | NS |
| Imbimbo et al, 2009 | 8 | — | 8 | NS | NS | NS | NS | NS | NS | Vaginoplas |
| Jiang et al, 2018 | 1 | — | 1 | 1 | — | — | 1 | — | — | Vulvoplas |
| Kuiper et al, 1998 | 10 | 1 | 9 | 4 | 6 | 6 | 3 | 1 | — | NS |
| Lawrence, 2003 | 15 | — | 15 | 13 | 2 | 2 | 13 | — | — | Vaginoplas |
| Olson-Kennedy et al, 2018 | 1 | 1 | — | NS | NS | NS | NS | NS | NS | Mastecton |
| Pfafflin, 1993 | 3 | 3 | — | — | 3 | 3 | — | — | — | NS (complicati urethral-vaginal fistu |
| Van de Grift et al, 2018 | 2 | 1 | 1 | 2 | — | — | 2 | — | — | Transfemen = Vaginopla Transmascu = mastecto and uteru extirpatio (hematom |

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*8 mastectomies, 2 vaginectomies, 2 phalloplasties, 2 testicular implants removal, and 1 breast augmentation.

N, no; NS, not specified; Y, Yes.

Table 6.

Causes of Regret

| Studies | Reasons of Regrets |
|---|---|
| Blanchard et al, 1989 | • 1 patient was dissatisfied with life as a woman and considered returning to the masculine role<br>• 1 patient reported that surgery failed to produce the coherence of mind and the body he wanted<br>• 1 patient would not opt for a new surgery as it had not accomplished what she wanted<br>• 1 patient dressed as a man but didn't felt as feminine nor masculine |
| Bouman, 1988 | Work and social acceptance |
| De Cuypere et al, 2006 | • Transmasculine = Physiologic period before GAS (delusional disorder-erotomaniac type), scored very low in credibility<br>• Transfemenine = Emotionally troubled by a break-up with his girlfriend |
| Imbimbo et al, 2009 | NS |
| Jiang et al, 2018 | Didn't want to wait genital electrolysis prior vaginoplasty |
| Kuiper et al, 1998 | • 4 patients mentioned they were not transsexual<br>• 1 patient after surgery she realized she did not want to live as a woman. 1 never wished for the surgery (forced by the partner)<br>• 2 patients lost the partner and had social problems<br>• 1 patient had no doubts (double role requested by the partner) |
| Lawrence, 2003 | • 8 patients felt disappointed with physical or functional outcomes of surgery (lost clitoris sensation)<br>• 2 participants reported reversion to living as a man after GAS. There were family and social problems |
| Olson-Kennedy et al, 2018 | NS |
| Pfafflin, 1993 | NS |
| Van de Grift et al, 2018 | • Transmasculine = Body does not meet the feminine ideal<br>• Transfemenine = Recurrent abdominal pains, dependence on exogenous hormones |
| Wiepjes et al, 2018 | • 5 patients had social regret (still as their former role/"ignored by surroundings" or "the loss of relatives is a large sacrifice")<br>• 7 patients had true regret (though that the surgery was the solution)<br>• 2 patients felt non-binary |
| Zavlin et al, 2018 | NS |
| Judge et al, 2014 | NS |
| Weyers et al, | NS |

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NS, not specified.

## Prevalence of Regret

The pooled prevalence of regret among the TGNB population after GAS was 1% (95% Confidence interval [CI] <1%–2%; $I^2$ = 75.1%) (Fig. 2). The prevalence for transmasculine surgeries was <1% (CI <1%–<1%, $I^2$ = 28.8%), and for transfemenine surgeries, it was 1% (CI <1%–2%, $I^2$ = 75.5%) (Fig. 3). The prevalence of regret after vaginoplasty was of 2% (CI <1%–4%, $I^2$ = 41.5%) and that after mastectomy was <1% (CI <1–<1%, $I^2$ = 21.8%) (Fig. 4).

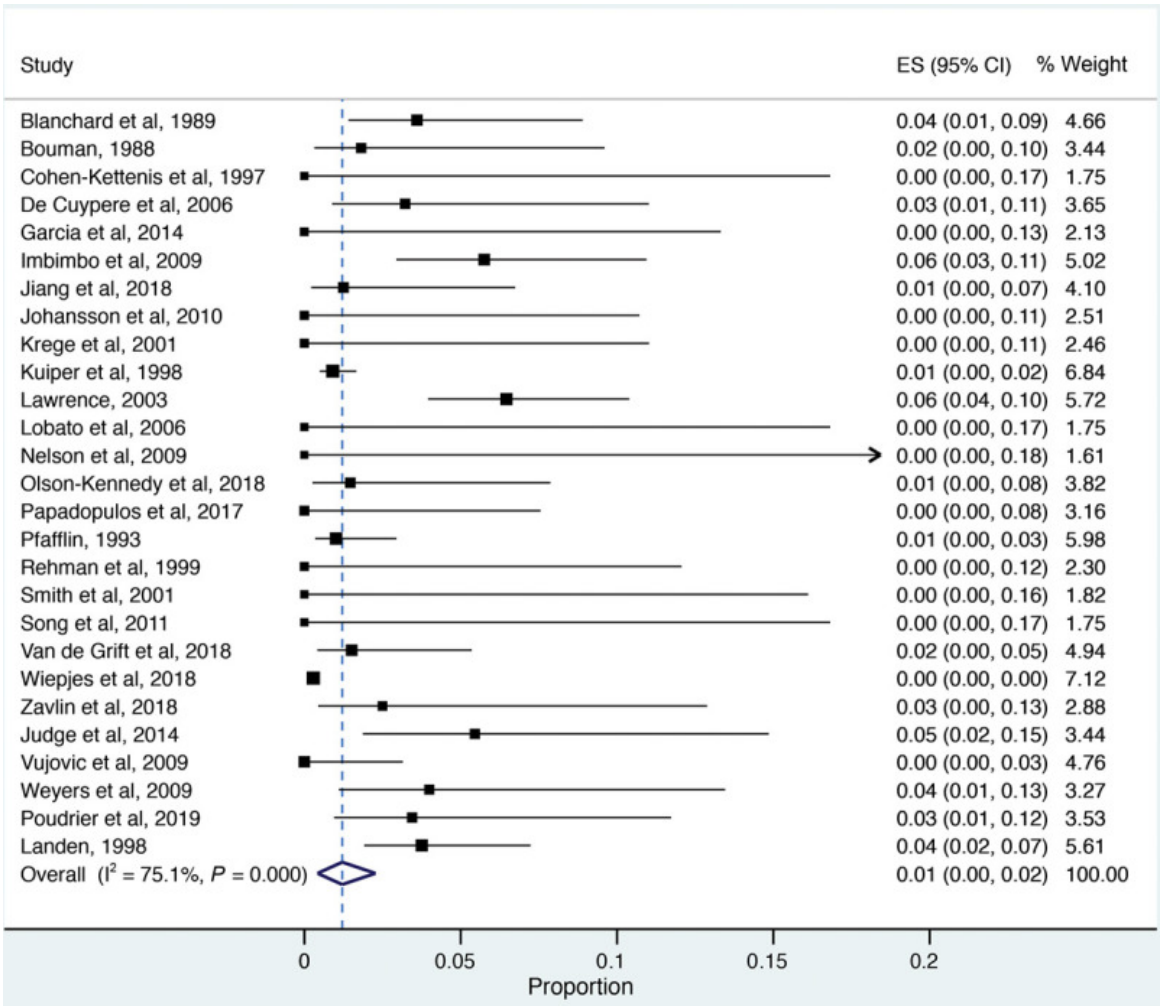



Fig. 2.

Pooled prevalence of regret among TGNB individuals after gender confirmation surgery. Heterogeneity $\chi 2$ = 104.31 (d.f. = 26), $P$ = 0.00, $I^2$ [variation in effect size (ES) attributable to heterogeneity] = 75.08%, Estimate of between-study variance $\tau^2$ = 0.02, Test of ES = 0, z = 4.22, $P$ = 0.00.

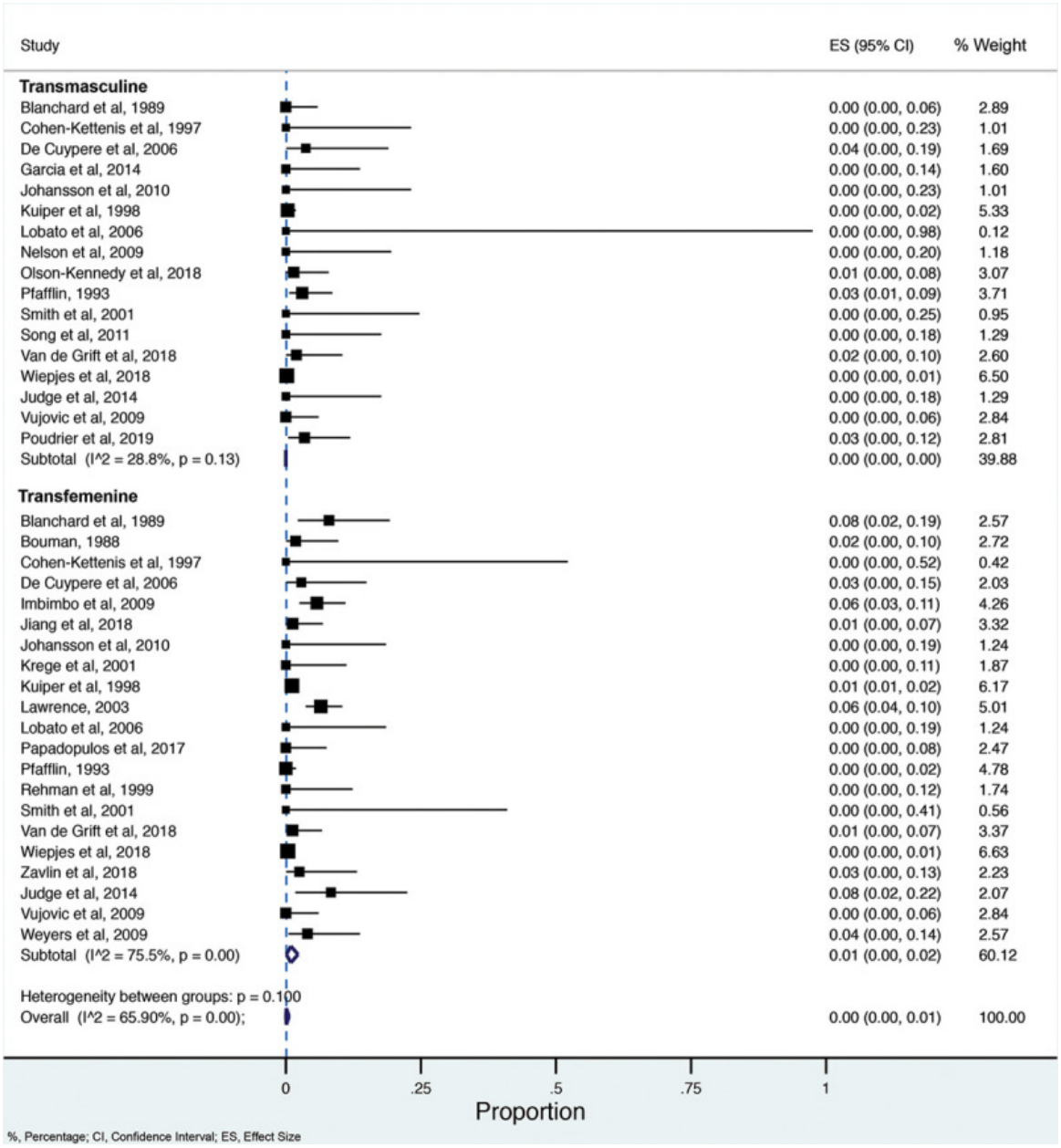



Fig. 3.

Subgroup analysis of the prevalence of regret among TGNB individuals after gender confirmation surgery based on gender. ES, effect size.

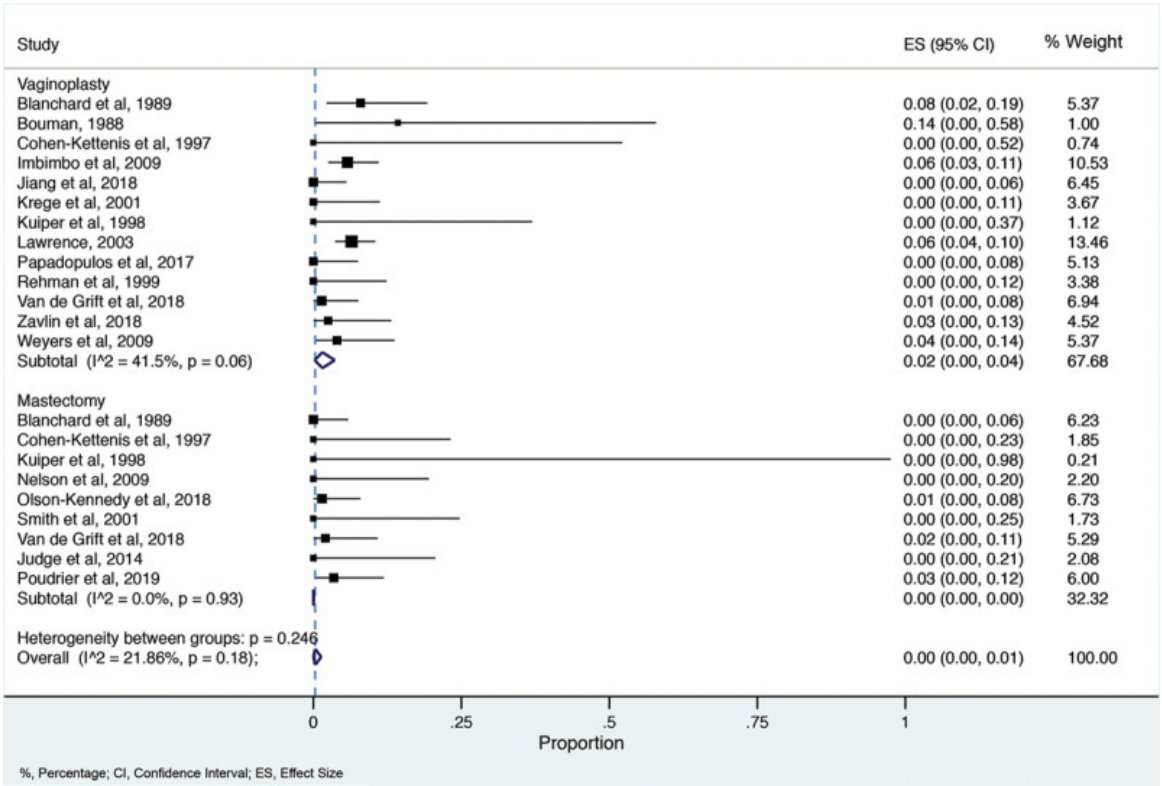



Fig. 4.

Subgroup analysis of the prevalence of regret among TGNB individuals after gender confirmation surgery based on the type of surgery. ES, effect size.

## Meta-regression and Publication Bias

No covariates analyzed affected the pooled endpoint in this metanalysis. The Funnel Plot shows asymmetry between studies (Fig. 5). The Egger test resulted in a *P* value of 0.0271, which suggests statistical significance for publication bias. The Trim & Fill method imputed 14 approximated studies, with limited impact of the adjusted results. The change in effect size was from 0.010 to 0.005 with no statistical significance (Fig. 6).

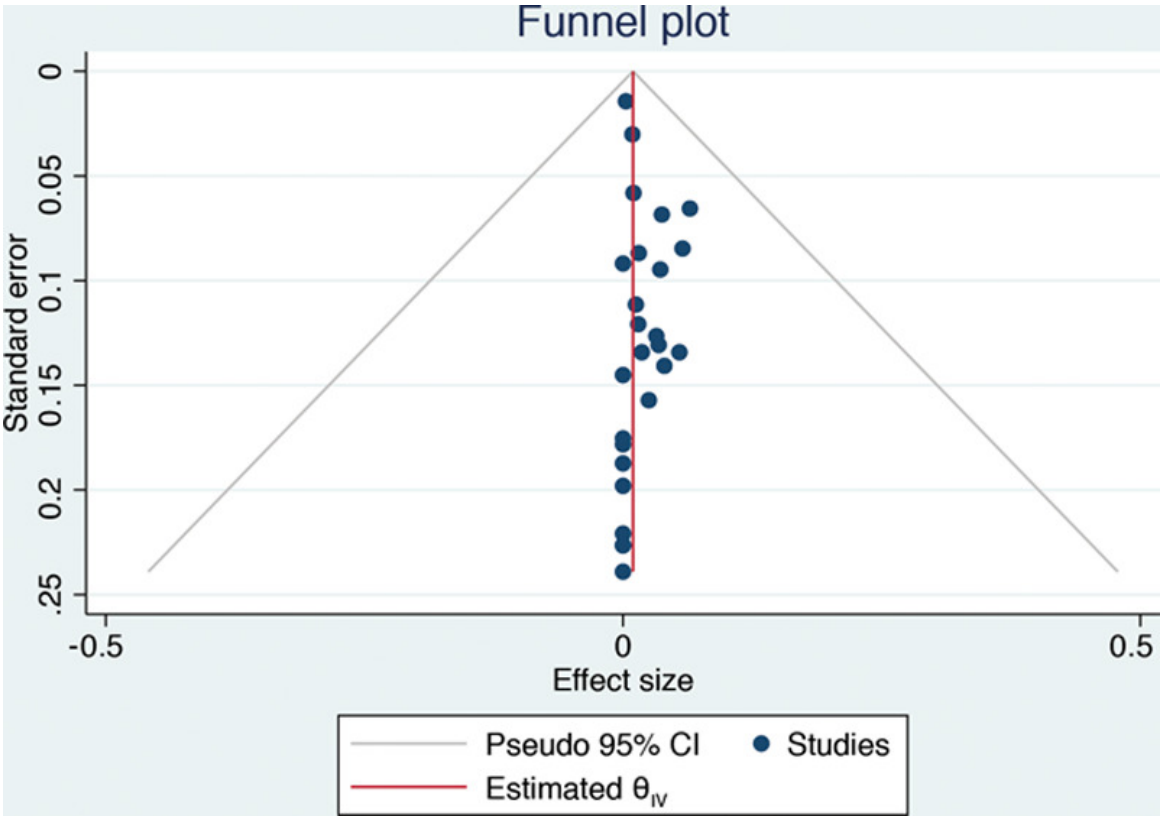



Fig. 5.

Funnel plot.

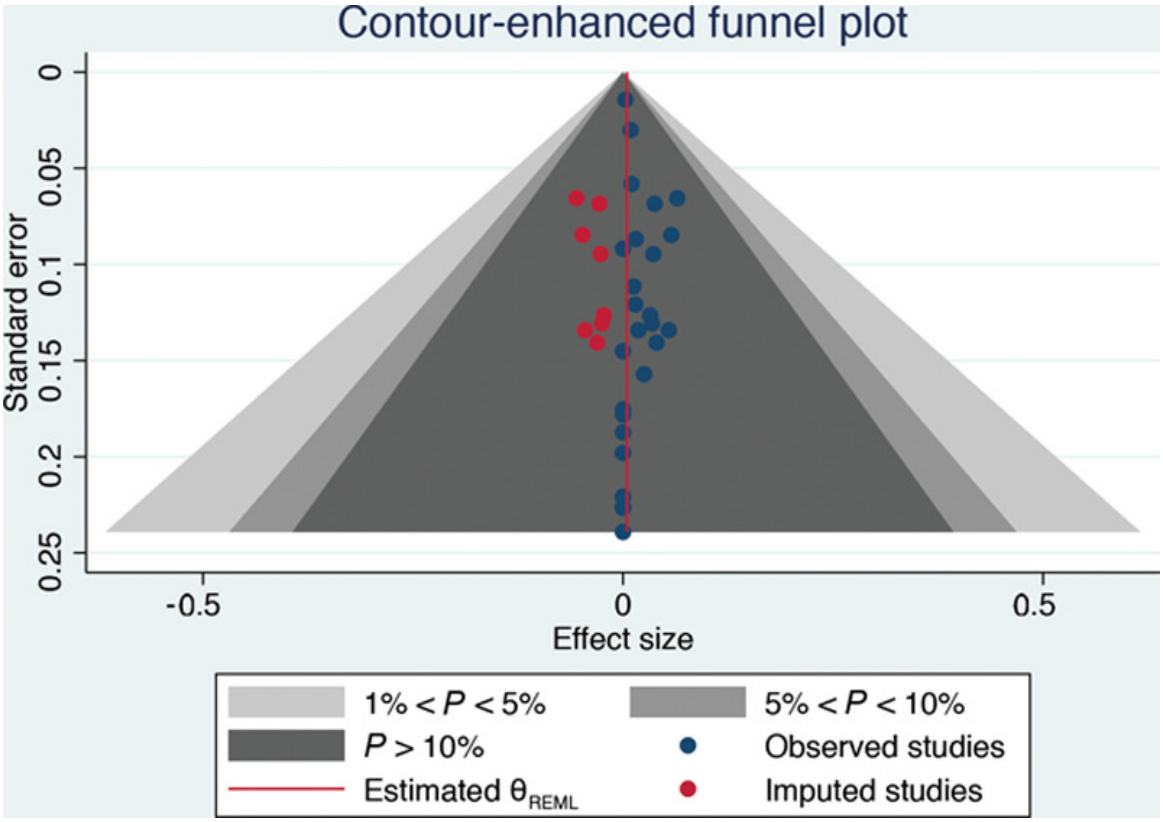



Fig. 6.

Funnel plot of the Trim & Fill method.

### Sensitivity Analysis

When excluding studies with sample sizes less than 10 and high-risk biased studies, the pooled prevalence was similar 1% (CI <1%–3%) compared with the pooled prevalence when those studies were included 1% (CI <1%–2%).

## Discussion

The prevalence of regret in the TGNB population after GAS was of 1% (CI <1%–2%). The prevalence of regret for transfemenine surgeries was 1% (CI <1%–2%), and the prevalence for transmasculine surgeries was <1% (CI <1%–<1%). Traditionally, the landmark reference of regret prevalence after GAS has been based on the study by Pfäfflin in 1993, who reported a regret rate of 1%–1.5%. In this study, the author estimated the regret prevalence by analyzing two sources: studies from the previous 30 years in the medical literature and the author's own clinical practice.[20] In the former, the author compiled a total of approximately 1000–1600 transfemenine, and 400–550 transmasculine. In the latter, the author included a total of 196 transfemenine, and 99 transmasculine patients.[20] In 1998, Kuiper et al followed 1100 transgender subjects that underwent GAS using social media and snowball sampling.[23] Ten experienced regret (9 transmasculine and 1 transfemenine). The overall prevalence of regret after GAS in this study was of 0.9%, and 3% for transmasculine and <0.12% for transfemenine.[23] Because these studies were conducted several years ago and were limited to specific countries, these estimations may not be generalizable to the entire TGNB population. However, a clear trend towards low prevalences of regret can be appreciated.

The causes and types of regrets reported in the studies are specified and shown in Table 5 and 6. Overall, the most common reason for regret was psychosocial circumstances, particularly due to difficulties generated by return to society with the new gender in both social and family enviroments.[23,29,32,33,36,44] In fact, some patients opted to reverse their gender role to achieve social acceptance, receive better salaries, and preserve relatives and friends relationships. These findings are in line with other studies. Laden et al performed a logistic regression analysis to assess potential risk factors for regret in this population.[46] They found that the two most important risk factors predicting regret were "poor support from the family" and "belonging to the non-core group of transsexuals."[46] In addition, a study in Italy hypothesized that the high percentage of regret was attributed to social experience when they return after the surgery.[33]

Another factor associated with regret (although less prevalent) was poor surgical outcomes.[20,23,36] Loss of clitoral sensation and postoperative chronic abdominal pain were the most common reported factors associated with surgical outcomes.[14,36] In addition, aesthetic outcomes played an important role in regret. Two studies mentioned concerns with aesthetic outcomes.[14,47] Only one of them quoted a patient inconformity: "body doesn't meet the feminine ideal."[14] Interestingly, Lawrence et al demonstrated in their study that physical results of surgery are by far the most influential in determining satisfaction or regret after GAS than any preoperative factor.[36] Concordantly, previous studies have shown absence of regret if sensation in clitoris and vaginal is achieved and if satisfaction with vaginal width is present.[36]

Other factors associated to regret were identified. Blanchard et al in 1989 noted a strong positive correlation between heterosexual preference and postoperative regret.[32] All patients in this study who experienced regret were heterosexual transmen.[32] On the contrary, Lawrence et al in 2003 did not find such correlation and attributed their findings to the increase in social tolerance in North American and Western European societies.[36] Bodlund et al found that clinically evident personality disorder was a negative prognostic factor for regret in patients undergoing GAS.[48] On the other hand, Blanchard et al did not find a correlation among patient's education, age at surgery, and gender assigned at birth.[32]

In the present review, nearly half of the patients experienced *major regret* (based on Pfäfflin classification), meaning that they underwent or desire de-transition surgery, that will never pass through the same process again, and/or experience increase of gender dysphoria from the new gender. One study found that 10 of 14 patients with regret underwent de-transition surgeries (8 mastectomies, 2 vaginectomies, 2 phalloplasties, 2 testicular implants removal, and 1 breast augmentation) for reasons of social regret, true regret or feeling non-binary.[23] On the other hand, based on the Kuiper and Cohen Kettenis' classification, half of the patients in this review had *clear regret* and *uncertain regret*. This means that they freely expressed their regret toward the procedure, but some had role reversal to the former gender and others did not. Interestingly, Pfäfflin concluded that from a clinical standpoint, trangender patients suffered from many forms of *minor regrets* after GAS, all of which have a temporary course.[20] This is an important consideration meaning that the actual true regret rate will always remain uncertain, as temporarity and types of regret can bring a huge challenge for assessment.

Regret after GAS may result from the ongoing discrimination that afflicts the TGNB population, affecting their freely expression of gender identity and, consequently feeling regretful from having had surgery.[15] Poor social and group support, late-onset gender transition, poor sexual functioning, and mental health problems are factors associated with regret.[15] Hence, assessing all these potential factors preoperatively and controlling them if possible could reduce regret rates even more and increase postoperative patient satisfaction.

Regarding transfemenine surgery, vaginoplasty was the most prevalent.[14, 19, 23, 30–33, 35, 36, 44, 45]Interesintgly, regret rates were higher in vaginoplasties.[14,36,44] In this study, we estimated that the overall prevalence of regret after vaginoplasty was 2% (from 11 studies reviewed). This result is

slightly higher than a metanalysis of 9 studies from 2017 that reported a prevalence of 1%.[13] Moreover, vaginoplasty has shown to increase the quality of life in these patients.[13] Mastectomy was the most prevalent transmasculine surgery. Also, it showed a very low prevalence of regret after mastectomy (<1%). Olson-Kennedy et al demonstrated that chest surgery decreases chest dysphoria in both minors and young adults, which might be the major reason behind our findings.[38]

In the current study, we identified a total of 7928 cases from 14 different countries. To the best of our knowledge, this is the largest attempt to compile the information on regret rates in this population. However, limitations such as significant heterogeneity among studies and among instruments used to assess regret rates, and moderate-to-high risk of bias in some studies represent a big barrier for generalization of the results of this study. The lack of validated questionnaires to evaluate regret in this population is a significant limiting factor. In addition, bias can occur because patients might restrain from expressing regrets due to fear of being judged by the interviewer. Moreover, the temporarity of the feeling of regret in some patients and the variable definition of regret may underestimate the real prevalence of "true" regret.

Based on this meta-analysis, the prevalence of regret is 1%. We believe this reflects and corroborates the increased in accuracy of patient selection criteria for GAS. Efforts should be directed toward the individualization of the patient based on their goals and identification of risk factors for regrets. Surgeons should continue to rigorously follow the current Standard of Care guidelines of the World Professional Association for Transgender Health (WATH).[49]

## CONCLUSIONS

Our study has shown a very low percentage of regret in TGNB population after GAS. We consider that this is a reflection on the improvements in the selection criteria for surgery. However, further studies should be conducted to assess types of regret as well as association with different types of surgical procedure.


## Acknowledgments

All the authors have completed the ICMJE uniform disclosure form. The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.


## Supplementary Material

| | |
|---|---|
| Click here to view. | (52K, pdf) |
| Click here to view. | (41K, pdf) |

## Footnotes


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**Disclosure:** The authors have no financial interest to declare in relation to the content of this article.


Related Digital Media are available in the full-text version of the article on www.PRSGlobalOpen.com.

## References


1. Safer JD, Tangpricha V. Care of transgender persons. *N Engl J Med*. 2019; 381:2451–2460 [PubMed] [Google Scholar]

2. Schechter LS. Gender confirmation surgery: an update for the primary care provider. *Transgend Health*. 2016; 1:32–40 [PMC free article] [PubMed] [Google Scholar]

3. Schechter LS. Schechter LS. Background. *Surgical Management of the Transgender Patient*. 2016, Philadelphia, Pa: Elsevier; 3–7 [Google Scholar]

4. Carmel TC, Erickson-Schroth L. Mental health and the transgender population. *Psychiatr Ann*. 2016; 46:346–349 [Google Scholar]

5. Wernick JA, Busa S, Matouk K, et al. . A systematic review of the psychological benefits of gender-affirming surgery. *Urol Clin North Am*. 2019; 46:475–486 [PubMed] [Google Scholar]

6. Flores A R, Brown, et al. . How many adults identify as transgender in the United States. *The Williams Institute*. 2016. (June):15. Available at https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/ Accessed June 15, 2020.

7. Downing JM, Przedworski JM. Health of transgender adults in the U.S., 2014–2016. *Am J Prev Med*. 2018; 55:336–344 [PubMed] [Google Scholar]

8. Lane M, Ives GC, Sluiter EC, et al. . Trends in gender-affirming surgery in insured patients in the United States. *Plast Reconstr Surg Glob Open*. 2018; 6:e1738. [PMC free article] [PubMed] [Google Scholar]

9. Nolan IT, Dy GW, Levitt N. Considerations in gender-affirming surgery: demographic trends. *Urol Clin North Am*. 2019; 46:459–465 [PubMed] [Google Scholar]

10. Rider GN, Mcmorris BJ, Gower AL, et al. . Health and care utilization of transgender and gender nonconforming youth: a population-based study. www.aappublications.org/news. Accessed May 12, 2020 [PMC free article] [PubMed]

11. American Society of Plastic Surgeons 2018. *Plastic Surgery Statistics Report 2018*

12. American Society of Plastic Surgeons *Plastic Surgery Statistics Report 2017*. www.plasticsurgery.org. Accessed May 28, 2020

13. Manrique OJ, Adabi K, Martinez-Jorge J, et al. . Complications and patient-reported outcomes in male-to-female vaginoplasty-where we are today: a systematic review and meta-analysis. *Ann Plast Surg*. 2018; 80:684–691 [PubMed] [Google Scholar]

14. van de Grift TC, Elaut E, Cerwenka SC, et al. . Surgical satisfaction, quality of life, and their association after gender-affirming surgery: a follow-up study. *J Sex Marital Ther*. 2018; 44:138–148 [PubMed] [Google Scholar]

15. Hadj-Moussa M, Ohl DA, Kuzon WM. Feminizing genital gender-confirmation surgery. *Sex Med Rev*. 2018; 6:457–468.e2 [PubMed] [Google Scholar]

16. Barone M, Cogliandro A, Di Stefano N, et al. . A systematic review of patient-reported outcome measures following transsexual surgery. *Aesthetic Plast Surg*. 2017; 41:700–713 [PubMed] [Google Scholar]

17. Agarwal CA, Scheefer MF, Wright LN, et al. . Quality of life improvement after chest wall masculinization in female-to-male transgender patients: a prospective study using the BREAST-Q and body uneasiness test. *J Plast Reconstr Aesthet Surg*. 2018; 71:651–657 [PubMed] [Google Scholar]

18. Nelson L, Whallett EJ, McGregor JC. Transgender patient satisfaction following reduction mammaplasty. *J Plast Reconstr Aesthet Surg*. 2009; 62:331–334 [PubMed] [Google Scholar]

19. Papadopulos NA, Lellé JD, Zavlin D, et al. . Quality of life and patient satisfaction following male-to-female sex reassignment surgery. *J Sex Med*. 2017; 14:721–730 [PubMed] [Google Scholar]

20. Pfäfflin F. Regrets after sex reassignment surgery. *J Psychol Hum Sex*. 1993; 5:69–85 [Google Scholar]

21. Liberati A, Altman DG, Tetzlaff J, et al. . The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. *PLoS Med*. 2009; 6 [PMC free article] [PubMed] [Google Scholar]

22. Covidence. Better systematic review management. https://www.covidence.org/home. Accessed May 28, 2020.

23. Kuiper AJ, Cohen-Kettenis PT. Gender role reversal among postoperative transsexuals. *Int J Transgenderism*. 1998; 2 [Google Scholar]

24. NIH *Study Quality Assessment Tools*. Bethesda, Md: National Heart, Lung, and Blood Institute (NHLBI). https://www.nhlbi.nih.gov/health-topics/study-quality-assessment-tools. Accessed May 25, 2020 [Google Scholar]

25. Nyaga VN, Arbyn M, Aerts M. Metaprop: a Stata command to perform meta-analysis of binomial data. *Arch Public Health*. 2014; 72:39. [PMC free article] [PubMed] [Google Scholar]

26. Freeman MF, Tukey JW. Transformations related to the angular and the square root. *Ann Math Stat*. 1950; 21:607–611 [Google Scholar]

27. Rehman J, Lazer S, Benet AE, et al. . The reported sex and surgery satisfactions of 28 postoperative male-to-female transsexual patients. *Arch Sex Behav*. 1999; 28:71–89 [PubMed] [Google Scholar]

28. Song C, Wong M, Wong CH, et al. . Modifications of the radial forearm flap phalloplasty for female-to-male gender reassignment. *J Reconstr Microsurg*. 2011; 27:115–120 [PubMed] [Google Scholar]

29. Wiepjes CM, Nota NM, de Blok CJM, et al. . The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *J Sex Med*. 2018; 15:582–590 [PubMed] [Google Scholar]

30. Zavlin D, Schaff J, Lellé JD, et al. . Male-to-female sex reassignment surgery using the combined vaginoplasty technique: satisfaction of transgender patients with aesthetic, functional, and sexual outcomes. *Aesthetic Plast Surg*. 2018; 42:178–187 [PubMed] [Google Scholar]

31. Weyers S, Elaut E, De Sutter P, et al. . Long-term assessment of the physical, mental, and sexual health among transsexual women. *J Sex Med*. 2009; 6:752–760 [PubMed] [Google Scholar]

32. Blanchard R, Steiner BW, Clemmensen LH, et al. . Prediction of regrets in postoperative transsexuals. *Can J Psychiatry*. 1989; 34:43–45 [PubMed] [Google Scholar]

33. Imbimbo C, Verze P, Palmieri A, et al. . ORIGINAL RESEARCH-INTERSEX AND GENDER IDENTITY DISORDERS. A report from a single institute's 14-year experience in treatment of male-to-female transsexuals. *J Sex Med*. 2009; 6:2736–2745 [PubMed] [Google Scholar]

34. Johansson A, Sundbom E, Höjerback T, et al. . A five-year follow-up study of Swedish adults with gender identity disorder. *Arch Sex Behav*. 2010; 39:1429–1437 [PubMed] [Google Scholar]

35. Krege S, Bex A, Lümmen G, et al. . Male-to-female transsexualism: a technique, results and long-term follow-up in 66 patients. *BJU Int*. 2001; 88:396–402 [PubMed] [Google Scholar]

36. Lawrence AA. Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Arch Sex Behav*. 2003; 32:299–315 [PubMed] [Google Scholar]

37. Lobato MI, Koff WJ, Manenti C, et al. . Follow-up of sex reassignment surgery in transsexuals: a Brazilian cohort. *Arch Sex Behav*. 2006; 35:711–715 [PubMed] [Google Scholar]

38. Olson-Kennedy J, Warus J, Okonta V, et al. . Chest reconstruction and chest dysphoria in transmasculine minors and young adults: comparisons of nonsurgical and postsurgical cohorts. *JAMA Pediatr*. 2018; 172:431–436 [PMC free article] [PubMed] [Google Scholar]

39. Cohen-Kettenis PT, van Goozen SH. Sex reassignment of adolescent transsexuals: a follow-up study. *J Am Acad Child Adolesc Psychiatry*. 1997; 36:263–271 [PubMed] [Google Scholar]

40. De Cuypere G, Elaut E, Heylens G, et al. . Long-term follow-up: psychosocial outcome of Belgian transsexuals after sex reassignment surgery. *Sexologies*. 2006; 15:126–133 [Google Scholar]

41. Garcia MM, Christopher NA, De Luca F, et al. . Overall satisfaction, sexual function, and the durability of neophallus dimensions following staged female to male genital gender confirming surgery: the Institute of Urology, London U.K. experience. *Transl Androl Urol*. 2014; 3:156–162 [PMC free article] [PubMed] [Google Scholar]

42. Smith YLS, Van Goozen SHM, Cohen-Kettenis PT. Adolescents with gender identity disorder who were accepted or rejected for sex reassignment surgery: a prospective follow-up study. *J Am Acad Child Adolesc Psychiatry*. 2001; 40:472–481 [PubMed] [Google Scholar]

43. Judge C, O'Donovan C, Callaghan G, et al. . Gender dysphoria – prevalence and co-morbidities in an Irish adult population. *Front Endocrinol (Lausanne)*. 2014; 5:87. [PMC free article] [PubMed] [Google Scholar]

44. Bouman FG. Sex reassignment surgery in male to female transsexuals. *Ann Plast Surg*. 1988; 21:526–531 [PubMed] [Google Scholar]

45. Jiang D, Witten J, Berli J, et al. . Does depth matter? Factors affecting choice of vulvoplasty over vaginoplasty as gender-affirming genital surgery for transgender women. *J Sex Med*. 2018; 15:902–906 [PubMed] [Google Scholar]

46. Landén M, Wålinder J, Hambert G, et al. . Factors predictive of regret in sex reassignment. *Acta Psychiatr Scand*. 1998; 97:284–289 [PubMed] [Google Scholar]

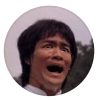
47. Poudrier G, Nolan IT, Cook TE, et al. . Assessing quality of life and patient-reported satisfaction with masculinizing top surgery: a mixed-methods descriptive survey study. *Plast Reconstr Surg*. 2019; 143:272–279 [PubMed] [Google Scholar]

48. Bodlund O, Kullgren G. Transsexualism–general outcome and prognostic factors: a five-year follow-up study of nineteen transsexuals in the process of changing sex. *Arch Sex Behav*. 1996; 25:303–316 [PubMed] [Google Scholar]

49. Coleman E, Bockting W, Botzer M, et al. . Standards of care for the health of transsexual, transgender, and gender-nonconforming people. www.wpath.org. Accessed May 13, 2020

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# At what point does incompetence become fraud?

In March of 2021 a paper was published by the journal *Plastic and Reconstructive Surgery Global Open*, the open access only (meaning pay-to-publish) version of *Plastic and Reconstructive Surgery*. This is the journal of the *American Society of Plastic Surgeons*, a fairly reputable medical organization — as far as plastic surgeons go, at least.

The article published, *Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence*, was part of a larger set of four papers on the topic of gender medicine: three of which purported to be systematic reviews of regrets, complications and satisfaction with surgery respectively and one called *Building a Multidisciplinary Academic Surgical Gender-affirmation Program: Lessons Learned* about how they set up their own gender clinic. However, as it is the topic I am most familiar with, I'll mainly be talking about the regret paper.

As the evidence for the efficacy of these interventions is tenuous at best — something even WPATH studies note — other ways to prove they are at least not detrimental or mistaken are explored. Looking at reported regret and detransition is one such option. It's worth adding that historical data for this is not actually that meaningful as both the population and the criteria to undergo medical transition in the past are worlds apart from what we find today, but it is all we have to go on.

The time and effort required to put together four academic papers, including three systematic reviews, is considerable. The cost to publish an article of this format in the journal is listed as (USD) $2195, which adds up to $8780 to publish these articles. The academic publishing process involves lengthy peer review and high standards. The authors report using PRISMA and NIH quality assessment tools to aid them in their process. Their credentials are impeccable, with the nine listed authors having MDs across the board, as well as two PhDs and two FACS. Everything appears set up to go right.

## So what actually happened?

I've been following this issue for a few years now and I'm quite familiar with the source material, so when a systematic review was published it quickly rose to the top of my to-read list. As soon as I read the paper it became clear something was very wrong here.

*United States identify themselves as transgenders*" with a reference to 2014 data. This completely ignores the explosive growth of the phenomenon since then, as well as the uneven distribution of that growth — for some areas and age groups the number appears closer to 10% more recently. This kind of misinformation is expected in these papers — it's not technically lying or even erroneous but it's still simply wrong.

What I got with this paper was on another level. Sure, the usual warning flags appeared right away — conclusions in the introduction, rampant equivocations and completely unsupported statements — but something more fundamental was at play here. Nine authors, peer review and a six month publication process, thousands of dollars, yet they didn't even run spell check on it? And what are these numbers? These are all wrong, all over the place. And these weren't even simple one-off errors, instead different tables disagreed with each other. The metaphor that comes to mind is drunk driving.

The most glaring example is Wiepjes et al., 2018, where Bustos et al. claim 4863 people had gonadectomies, at mean ages of 23 and 33 for adult females and males respectively, and 26 and 16 for adolescents. They were then supposedly investigated for regret via questionnaire. If we read the actual paper, we find that 2627 people had gonadectomies, no one was under 18 at the time of surgery and it was a medical records search rather than a questionnaire.

Table 2 has 10 columns, and somehow Bustos et al. managed to put erroneous data in eight of them for Wiepjes et al. — only "*Authors and Year of Publication*" and "*Country*" were correct. Normally those would go without saying, but surprisingly they managed to get them wrong elsewhere: they get the names of the authors wrong for two of the papers and the country wrong for three.

I spent some time going over the whole table in detail, finding dozens of errors. If we include inconsistencies and erroneous footnotes, the number approaches 50 — for a single table! There are errors in every single column, and for 19 of the 27 papers. The most frequent error is that Bustos et al. claims that data was "*not specified*" in a paper where it actually was. For example in Landén et al. (who they here call Laden) the sex ratio is clearly provided but is listed as not specified in the review, one of dozens of this type of error. There appears to have been no effective proof reading stage of any kind.

The erroneous sample sizes are eye catching, but more fundamental is perhaps their misreporting of the "*assessment tool*", how regret was measured in these papers. It reveals that the authors did not actually understand what they were reading, and that they did not care that they did not understand. The same goes for the reviewers — for something like this to be

The errors span every possible aspect of a review, or academic paper in general for that matter. The numbers are incorrect, the procedures are incorrect, the fundamental thing they aim to extract — the rates of regret — is incorrect. They don't seem to have understood what they were reading. Although perhaps that is asking too much as they don't even spell correctly in an article they paid $2195 to publish.

### What then?

I fairly quickly heard of others with these concerns, with plans to reach out to the journal, and in a published letter to the editor Expósito-Campos and D'Angelo point out that the search was insufficient (my own list of papers matching the search criteria has at least another ten on it, and it is not exhaustive) and even plain wrong in including a paper which clearly should not have been included as it measured "*regret*" in choosing neo-vulva construction over full neo-vagina construction. The letter notes some of the data errors, as well as the absurdity of suggesting any of the findings could be generalized to "*non-binary*" as the sample size for that group was a single individual.

In a reply to this letter the authors make only non-responses:

- When confronted with the fact that their systematic review missed a number of key studies they simply state that they developed a "*comprehensive search strategy*" following PRISMA guidelines. Skipping past that they only partially followed PRISMA, "*we performed a comprehensive search*" is not an answer to "*you missed a lot of papers, here are examples*" as their answer is already shown to be false in the lead-up to the question. Why would anyone respond this way?
- For the paper that they erroneously included they simply state that it "*complied with the selection criteria […] clearly stated in our methods section*", which is simply inaccurate. The paper measured regret in choosing one procedure over another, which is a completely different question from regret with undergoing gender-affirming surgery in the first place. It is clear that the authors did not understand what this paper investigated, as is evident from the fact that they use the **wrong rate** as well.
- Regarding their Wiepjes et al. miscalculation they appear to double down, stating that they "*identified only those patients who underwent gonadectomy*" before detailing their exact calculation. Despite being **explicitly informed** of the step they skipped they repeated their error and once again arrived at the incorrect number.

To hammer that home further, this should never have happened in the first place, as Table 1 in

and 885 females. Even a brief moment of consideration reveals an odd situation if their calculations were accurate: it would mean that many more people had gonadectomies than were started on cross-sex hormones.

- Regarding generalizing a non-binary sample size of 1 to an entire population — now the most common form of trans — they simply don't respond. They do not admit fault, nor do they offer a justification. And how could they? There is no defense for this. Their response is simply to pretend it didn't happen.

The authors end their reply by stating that in conclusion, they "*strongly believe that this study is of very high-quality and adds important and relevant information to the literature despite the observations stated in the letter.*"

A baffling situation, to say the least. The level of incompetence required to make these mistakes is only comparable to the level of brazenness it would be if this was fraud. Perhaps the question should be "*incompetence, fraud, or delusion*". Or perhaps I am just reinventing the wheel and it should be described with the phrase "*this is not just 'not right', it's not even wrong*".

### Where does this leave us?

Even a casual look at the paper reveals trivial flaws. A deeper look reveals a fundamental lack of understanding for what science is. The process did not work. This would have been given a failing grade if it was written by a high schooler. I've seen much higher quality papers be fully retracted. This one has not even been corrected despite ample opportunity. So where exactly is the line between incompetence and fraud?

I don't know. Perhaps the original paper was a result of incompetence, and the handling of it after this became apparent is fraud. Perhaps it's incompetence throughout, with a healthy dose of delusion on the part of the authors. But where is the editor in all of this? Why has this mess not been cleaned up? Why has the editor allowed the situation to reach a state where the credibility of the complete staff and process is falling apart? I certainly don't have answers, and I doubt they do either. They certainly haven't responded to my attempts to get answers from them.

Perhaps it is the wrong question to ask in the first place — it doesn't actually matter if it's a result of incompetence or fraud. The reality of the matter is that this is normal in this field. You'll find it in every journal, from every discipline. Something about this field makes people lose their heads. It's very rare to read a paper and not have to ask yourself if it's out of ignorance or malice.

Welcome to trans research. Abandon all hope, ye who enter here.

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LETTER TO THE EDITOR

# Letter to the Editor: Regret after Gender-affirmation Surgery: A Systematic Review and Meta-analysis of Prevalence

**Pablo Expósito-Campos, MA*; Roberto D'Angelo, PsyD†‡**

Sir,

Bustos et al[1] aimed to measure the prevalence of regret following gender-affirmation surgery. Given the significant rise in young people seeking medical intervention for gender dysphoria, which can include surgery, outcome studies that accurately assess regret are of increasing importance. In this letter, we argue that the conclusions of their systematic review and meta-analysis are questionable due to limitations in their methods and shortcomings of the studies selected.

Starting with methods, the authors overlooked numerous relevant studies, including one of the best-known,[2] raising questions about the adequacy of their search strategy. One study[3] was inappropriately included as it only investigated regret regarding choice of surgical procedure, not of surgery itself. In addition, there are significant data extraction errors, leading to erroneous conclusions. For instance, the sample for surgical regret in their largest included study[4] was inflated from 2627 to 4863, likely due to a miscalculation from a table reporting the treatment patterns of that paper's total study population.

Besides these methodological inaccuracies, data in this field are often of low quality because of "lack of controlled studies, incomplete follow-up, and lack of valid assessment measures,"[5] as well as the long amount of time regret can take to manifest (the average and median are estimated at 8–8.5 years[2,4]). Many of the included studies had participants with follow-up periods of only 1 or 2 years post-surgical transition. None appear to have a long enough follow-up period to reliably identify regret. The study contributing almost half of the participants[4] explicitly noted their inclusion of participants with short follow-up time, relative to time to regret, and their large 36% loss to follow-up as limitations. These shorter studies only provide an estimated lower limit, as the large numbers of patients lost to follow-up add correspondingly large uncertainties to any quoted number.

Bustos et al[1] acknowledge "moderate-to-high risk of bias in some studies." Actually, this affects 23 of the 27 studies. The majority of included studies ranged between "poor" and "fair" quality: only five studies—representing just 3% (174) of total participants—received higher quality ratings. However, even these had loss to follow-up rates ranging from 28% to more than 40%, including loss through death from complications or suicide, negative outcomes potentially associated with regret.

A last and major concern involves sample selection. The cohort presenting with gender dysphoria today is substantially different from the cohort presenting during the research periods of the included studies. Further, there has been a significant liberalization over time of the criteria assessing readiness for surgery. Thus, the outcomes reported may be of limited relevance for estimating current surgery outcomes. Additionally, the generalization to "TGNB" populations seems unreliable, as it is based on an explicit sample size of only one "non-binary" patient. The authors do not address these issues.

In light of these numerous issues affecting study quality and data analysis, their conclusion that "our study has shown a very low percentage of regret in TGNB population after GAS" is, in our opinion, unsupported and potentially inaccurate.

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## DISCLOSURE

*The authors have no financial interest to declare in relation to the content of this article.*

## REFERENCES

1. Bustos VP, Bustos SS, Mascaro A, et al. Regret after gender-affirmation surgery: a systematic review and meta-analysis of prevalence. *Plast Reconstr Surg Glob Open.* 2021;9:e3477.
2. Dhejne C, Öberg K, Arver S, et al. An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: prevalence, incidence, and regrets. *Arch Sex Behav.* 2014;43:1535–1545.
3. Jiang D, Witten J, Berli J, et al. Does depth matter? Factors affecting choice of vulvoplasty over vaginoplasty as gender-affirming genital surgery for transgender women. *J Sex Med.* 2018;15:902–906.
4. Wiepjes CM, Nota NM, de Blok CJM, et al. The Amsterdam cohort of gender dysphoria study (1972–2015): Trends in prevalence, treatment, and regrets. *J Sex Med.* 2018;15:582–590.
5. Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an endocrine society clinical practice guideline. *J Clin Endocrinol Metab.* 2017;102:3869–3903.

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# Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners

Lisa Littman [1]

Affiliations

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## Abstract

The study's purpose was to describe a population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both. Recruitment information with a link to an anonymous survey was shared on social media, professional listservs, and via snowball sampling. Sixty-nine percent of the 100 participants were natal female and 31.0% were natal male. Reasons for detransitioning were varied and included: experiencing discrimination (23.0%); becoming more comfortable identifying as their natal sex (60.0%); having concerns about potential medical complications from transitioning (49.0%); and coming to the view that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition (38.0%). Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed by 23.0% as a reason for transition and subsequent detransition. The majority (55.0%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition and only 24.0% of respondents informed their clinicians that they had detransitioned. There are many different reasons and experiences leading to detransition. More research is needed to understand this population, determine the prevalence of detransition as an outcome of transition, meet the medical and psychological needs of this population, and better inform the process of evaluation and counseling prior to transition.

**Keywords:** Detransition; Gender dysphoria; Transgender.

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## Figures




**Fig. 1** Distribution of participants' current gender...

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November 2, 2021

# Gender-Dysphoric Adolescents and Gender Transition Regret: What We Don't Know

*The Lancet debate on gender-dysphoric youth: getting the facts right*

Recently, The Lancet published an editorial defending the broad availability of medical gender transition interventions for gender-dysphoric youth. The editorial was written in response to several US bills that aim to limit the use of hormones and surgery in minors. The editorial asserted that hormonal and surgical interventions for gender-dysphoric youth are proven treatments; that puberty blockers are fully reversible and prevent suicidality; and that, because regret for gender transition is below 1%, concerns about future regret in gender-transitioned youth are not justified.

The scientific debate that ensued (with six Letters to the Editor published, three of which were critical of the Editorial's position) revealed that these assertions are not supported by the evidence. While the debate covered several topics, the final round centered on transition regret. This is not surprising. Both the supporters and critics of transitioning minors agree that transition carries numerous medical risks, and the evidence of benefit is graded as "low/very low" quality. Thus, the argument of “low future regret” is essential to the advocates of medicalizing gender-dysphoric minors.

Below we summarize the findings that emerged from the debate on regret, as well as other key arguments that have been highlighted by the Letters to the Editor critical of The Lancet's Editorial.

## Future Regret

One of the proponents of pediatric medical transition submitted a Letter to the Editor in defense of The Lancet's position, asserting that regret in those who gender-transitioned as adolescents is nearly nonexistent. The Letter cited a recent regret study that is frequently cited to support medical gender transition of minors. However, this study suffers from significant limitations that lessen the certainty of the claim of "low regret" in youth:

> The currently-treated populations of adolescents are very different from the population studied. All study subjects had severe gender dysphoria that began in early childhood and had no significant mental health comorbidities, which is not true of today's adolescent patients. Further, the study only evaluated those who underwent gonadectomy (surgical removal of testes/ovaries), which is not as commonly performed today, especially among gender-dysphoric natal females.
>
> The study excluded 22% of those who started on the hormonal treatment pathway but did not proceed further with surgical removal of ovaries or testes. These individuals may have higher levels of regret than the group that proceeded to complete their medical transition as outlined in the Dutch protocol.
>
> The follow-up time was less than 10 years, which is when regret typically emerges in adult studies.

20% of study subjects dropped out of care / were lost to follow-up, which can mask regret.

Importantly, the definition of "regret" was exceedingly narrow. For example, neither Keira Bell, nor many of the regretful detransitioners from the recent research on detransition would be considered to be "regretters" by the study.

To qualify as a "regretter," one had to revert to living in their natal sex role by starting natal-sex hormone supplementation, and do so under medical supervision of the same clinic that facilitated the original transition. However, as a recent study demonstrated, most detransitioners do not return to their medical providers to tell them about their detransition or regret. In addition, many post-gonadectomy patients who regret their gender transition find it is not feasible to revert to living in their natal sex, in part due to the irreversible nature of genital surgeries. Just as not all detransitioners regret their prior attempt at transition, not all those who continue to live in their gender-transitioned role are free from regret over their original decision to transition.

The interpretation of “regret” is further limited because patients who died from medical complications related to transition, and those who committed suicide following transition, were excluded from the study. We know very little about the medical outcomes of the adolescents treated by the Dutch, because only the psychological outcomes have been reported. However, we do know that at least one adolescent died from surgical complications. Another paper from the same Dutch clinic published in 2020 reported that four individuals referred as adolescents subsequently died by suicide.

The debate led to a subsequent correction of the Letter that had defended the Editorial's claim. While SEGM welcomes the correction, it did not adequately explain how these corrections and other limitations of the study reduce the certainty of the "low regret" claim. Specifically, the evidence of low regret of gender transition in youth comes from a study based on a protocol that has very little applicability to today’s clinical practice. It is incorrect to assert that we know future regret rates of adolescents transitioning under vastly different circumstances today.

It is also concerning that the statement, "*the only relevant case of regret of which we are aware is Keira Bell*" was not corrected, given the depth and complexity of the literature, spanning decades and dozens of papers. Evidence of the rising numbers of detranstioners and their accounts have been noted by many clinicians and researchers, including Expósito-Campos (2020), Vandebussche (2021); Pazos-Guerra, et al. (2020); Entwistle (2020); and Littman (2021).

(We expand on the correction and its implications in the section "The Rebuttal—and the Correction of the Rebuttal" below).

## Critical Responses to The Lancet’s Editorial

In addition to the issue of regret, the scientific debate that followed The Lancet Editorial highlighted several other key areas of disagreement regarding the evidence. This debate was made possible by The Lancet publishing 3 critical Letters to the Editor (LTE).

The LTE “Puberty Blockers for Gender Dysphoria: the Science is Far From Settled,” submitted by SEGM, noted that the evidence for the use of puberty blockers and cross-sex hormones in teenagers comes from the Dutch studies that considered a population distinctly different from the one presenting today: specifically, youth whose gender dysphoria began in early childhood, and who had no significant co-occurring mental health problems. The critique questioned whether earlier findings could be generalized to the novel population of young people whose gender distress and transgender identification emerged for the first time after puberty. Many of these young people have no history of childhood gender dysphoria and frequently suffer from significant mental health problems.

SEGM also noted that the magnitude of the post-treatment improvements in mental health in the original Dutch study on puberty blockers was of marginal clinical significance. The depression (Beck Depression Inventory) scores improved by around 3 out of 63 points, and the global function (Children's Global Assessment Scale) scores improved

by around 4 out of 100 points, and other measures of psychological health had similar improvements of marginal clinical significance—or no improvement at all. SEGM raised the question whether such small gains justify the risks to bone health, fertility, and other as yet unknown long-term effects of interrupting puberty.

An LTE from Richard Armitage highlighted the fact that the low purported prevalence of regret among adults cannot be extrapolated to youth whose capacity to make a truly informed decision is considerably different from that of adults. Armitage also took issue with the claim that puberty blockers reduced suicidality, pointing out that the review cited to support this claim only contained a single study on suicidality, and that study considered adults not children. (More comprehensive critiques of the suicidality study and the sample the study used were published in Archives of Sexual Behavior).

Another LTE, from a group of psychotherapists submitted by Stella O'Malley (a SEGM advisor), also took issue with the 1% regret rate, noting that this number comes from an era when more stringent guidelines determined who received medical interventions. O'Malley et al. recounted the changing practices in Sweden, Finland, and the UK, where the need for much more caution when considering pediatric medical transitions has been recently recognized.

## The Rebuttal—and the Correction of the Rebuttal

In response to these letters, Ken Pang, a leading pediatrician from Melbourne's Royal Children's Hospital gender clinic, defended the editorial's claim of low rates of transition regret, asserting that the regret rate is extremely low not just among those who transitioned as adults, but also among adolescents. To support their claim, they cited another Dutch study (Wiepjes et al. 2018): "*Wiepjes and colleagues observed that of 812 adolescents who presented to their gender clinic since the late 1980s, 635 (78·2%) received gender-affirming hormones and surgery, and none regretted their treatment in follow-up to 2015.*"

However, this summary of the Wiepjes study indicating a 0% regret rate for adolescents receiving hormonal and surgical treatments contained several factual errors and misrepresentations, which were subsequently corrected. The relevant section of the Letter to the Editor now reads, "*Wiepjes and colleagues observed that of 812 adolescents who presented to their gender clinic since the late 1980s, 309 received gender-affirming hormones and gonadectomy and, of the 80% who continued to attend the clinic up to 2015, none regretted their treatment.*"

This seemingly minor correction reveals a major misstatement. Specifically:

> While the correction does not make it explicit, the additional data it contains make it clear that only 247 adolescents were evaluated for regret (80% of 309). This is less than 40% of the sample size originally claimed by Pang et al.
>
> The correction also reveals that 20% of the treated adolescents were lost to follow-up as of 2015. It is unclear under what conditions the youth who depend on hormonal supplementation for life would be lost to follow-up in a country with centralized gender services. It is possible that those who dropped out of gender services care may have higher rates of regret.
>
> Finally, the correction specifies that gonadectomy (surgical removal of testes/ovaries) was a key study eligibility requirement. This excluded 22% of the eligible participants who could have received gonadectomy but did not. The population that opted to undergo gonadectomy may have different levels of regret from the population that opted out of, or was disqualified from, completing their surgical transition, as called for by the Dutch protocol.

## Concluding Thoughts

Frontline clinicians caring for the growing numbers of gender-dysphoric youths rely on scientific journals to present unbiased, objective and reliable information. By platforming both sides of scientific debates, peer-reviewed journals play a critical role in helping clinicians navigate areas of medicine where evidence is uncertain and the science is

not settled. While The Lancet corrections were much more limited in scope than we had hoped, we thank the journal for platforming this important debate, and we hope that other top-ranked journals will soon follow suit, bringing nuance and balance to the gender medicine debate.

**Note:** The original Editorial, the 3 critical responses, the rebuttal by Pang et al., and the subsequent correction of the rebuttal are available on The Lancet site free of charge following a simple registration process.



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# r/detrans | Detransition Subreddit

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122 PINNED BY MODERATORS

Posted by u/DetransIS Detrans Female with a CCSD 20 days ago

**The r/detrans demographic survey - Screened and broken down** DATA

6 Comments Share Save ···

146 Posted by u/DetransIS Detrans Female with a CCSD 15 days ago

**Questioners, please be careful of people DMing you** P.S.A.

7 Comments Share Save ···

208 Posted by u/normaldevon detrans female 22 hours ago 3

**I used to be afraid of this subreddit** RANDOM THOUGHTS

I came out publicly as ftm transgender when I was 15 years old. I started taking Lupron soon after, and at 16 I started testosterone. I was on T for almost three years. I thought transitioning was the only path I could take. I could not bear to grow up to be a woman; I knew absolutely no women who were gender nonconforming or lesbians. I felt like the only way to be happy was to be male. I did pass as male and at first I was happy. I was free from the misogyny, homophobia, and female gender roles I hated so much growing up. But as time went on I felt less and less like myself. I wanted to be a lesbian again, I wanted to be seen as a woman, I just didn't want to be oppressed for my sex. Being so far into transition, detransition felt almost impossible. I thought I was transphobic for not wanting to be trans anymore and for even questioning it at all.

I am now about 9 months off of testosterone. I am a gay woman, and I am proud of who

10 Comments Share Save ···

2 u/BJSSUK · Promoted

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0 Comments Share Save

28 Posted by u/AnyConcern7275 questioning own gender transition 15 hours ago

**If your thinking about stopping hrt due to feeling sick do it** INSPIRING POSITIVITY

Hello! I've had been on T for around 7 months I started getting bad reactions to it around 2 months in. I had bad headaches, nose bleeds, constant cramps, low energy, vomiting after eating, weight gain, joint pain, and bad chest pain. I've only been off for

## About Community

Welcome all detransitioners/desisters and self-questioners. Please self-identify your detrans status with user flair, or your content will be removed (medical or legal professionals, please message mods for an exception). Post anything about gender detransition. Ask questions, share memes, inspire, vent, wonder, etc. Abide by our rules (listed in the right rail below on If you are in urgent need of an area of detrans support please visit and join our discord server: https://discord.gg/VE5SNCjKnx

26.7k Members 70 Online

Created Nov 14, 2017

## Discord Server

Come join our discord server to chat!

Discord

## r/detrans Rules

1. **Be civil (don't label or antagonize individual users here).**

   We'll each see words we like and dislike. Moderators can't limit word choice practically nor without bias. Terminology applied to self and theory are permitted. Language applied to other users must be considerate of any views they hold and respectful of Reddit policies. Character attacks aren't permitted, nor are labels for other users. Even if you think an expression is neutrally descriptive, don't call another user here by any epithet. Address action more than actors. Say "I" more than "you".

2. **Be tolerant (no bigotry/tribalism against individual users here).**

   This subreddit was created for all detrans folk. Users may express differing philosophical and political theories and beliefs, lightly or passionately, without disparaging other users for merely belonging to a group (especially groups into which we are born, eg sex, race, nationality, generation). Moderation is to be unbiased. Please respect freedom of thought, speech, and association while you are here.

3. **Be on topic.**

   Posts should be of interest in some way to detransitioners and self-questioners

around a week yes I feel a little sick from stopping it but I feel way better then I did before. My bottom growth is shrinking and my voice feels like it's changing a little bit. All my head aches and all the other negative effects I had are all most gone all the way. Don't be scared to stop or pause medical transition if it's physically harming you. After all that I figured out I could be happy and live as an androgynous female don't be scared to explore your identity due to others judgement. Also if you want to hear more of my story just ask questions and I'm free to talk in dm's I just want to help people out there that are going through what I went though!

2 Comments Share Save ...

42

Posted by u/somethngsomewhere detrans female 21 hours ago

### One thing they don't tell you about top surgery

One thing they don't tell you about a mastectomy, when it's done as a top surgery for trans men it is very common for them to leave mammary gland tissue in order to help shape the chest in a more masculine appearing way. They ask if you ever plan on having children, because if you do get pregnant later on there can be restimulation and growth of the breast tissue due to the hormones. Besides pregnancy, if you stop taking T long term and return to having menstrual cycles, you have the rise and falls of progesterone and estrogen, which means you now have mammary glands/breast tissue that is being effected by these hormones. So you do not have breasts, you are flat chested but you can then have cyclical breast pain, or 3ven fibrocystic breast changes that feel lumpy. So you go to the Dr, confused about this pain in your chest, and the Dr's really don't know, but 4hwy tell you for the 1pth time your heart is fine, you are healthy.

I now have cyclical breast pain with every cycle, mainly right before ovulation. like right

8 Comments Share Save ...

65

Posted by u/ofthefutureart Socially Trans - Regrets Medical Transition 1 day ago

### Socially Trans Regrets Medical Transition. Trans Man ADVICE REQUEST

26 was a big year for me. A big year for growth and learning. I started transitioning when I was 19 in Florida, I started Testosterone there after about a year and a half of therapy and endocrinologist bs. My parents told me they wouldn't accept that I'm transgender until they saw I had facial hair, all my friends said I should get top surgery, and I was getting a lot of crap from coworkers. I was pressured to start the medical path as soon as I came out as trans. EVERYTHING was under the table and not official because my insurance was through my mom's job in the military" Tricare" which didn't cover transitioning in the insurance. Because it was under the table ALL my money was going to the endocrinologist and he could charge WHATEVER he wanted. Because the insurance didn't cover the pharmaceuticals like needles, Testosterone, and syringes, each pharmaceutical was being charged CASH at and way higher cost than under insurance. I was being EXTORTED. I moved to California for the transition process and

3 Comments Share Save ...

3

Posted by u/Banaanisade detrans 16 hours ago

### Made a voice recording comparing "female" and "male" voices. What do you think? Voice Training

I'm a detrans FtM person, off T for some three years now. I got a new microphone for Christmas and figured, since I finally have a good quality one to record what my voice *actually* sounds like, I'd drop a clip here. (It... might be really loud. Don't blow out your ears!)

I assume this is a problem for everyone, but I *cannot* hear my own voice objectively, so I can't ever tell if I sound male or female when I talk in either voice. Even when I listen back to it, I can't properly pinpoint how "normal" my voice sounds (for gender x or y) when it just sounds like *my* voice.

What do you guys think?

6 Comments Share Save ...

15

Posted by u/troubledthrow123 detrans female 1 day ago

### How to stop getting "sir'ed"? ADVICE REQUEST - FEMALE REPLIES ONLY

I'm early in detransitioning but I know for a fact I pass as female...but this problem proceeds my transition entirely. I have been getting called sir since I was a little girl (even when I would dress feminine!). Testosterone deepened my voice but I've gotten it back to a passable female range, but I still get called sir after strangers hear my voice. It could be because I'm very tall, angular, and butch, but I'm definitely visibly (and audibly) female. Do any other butch/gnc women know how to rectify this issue? It's annoying! I just want to tell them, I'm a woman! What gives! Advice appreciated

6 Comments Share Save ...

Detrans folk may discuss controversial issues, but this isn't a debate space for persons without personal experience in detransition. Outsiders will be banned if seen giving advice or suggestions.

4. **Never promote cross-sex hormones or surgery.**

   Cross-sex hormones and surgery affect the body in ways that are not fully understood nor easily reversed. Many detransitioners report having felt pressure to pursue HRT and/or surgery in the past. Therefore, because this is a detransition-focused sub, advising others to start, continue or pursue further transitional care is discouraged here. Those with severe distress are advised to seek a professional opinion. (Reporting strictly positive experiences with treatments does not violate this rule)

5. **Respect users' privacy (no doxxing).**

   Content is posted here voluntarily and in good faith. However, all users should exercise appropriate care when sharing personal information to this or any subreddit. This forum is visible to the public, and bots regularly copy all Reddit content to third-party sites beyond moderators' control. Users who share personally identifying information about others users of this subreddit to this subreddit or to any other location without express permission of the other users are subject to ban.

6. **Posters must be detrans or questioning their gender transition with flair**

   Our subreddit is reserved for detransitioners/desisters and those questioning their own transition; your user flair must clearly indicate that you fall into this group. Healthcare or legal professionals can apply for exception by messaging the moderators. User flair helps mods keep this forum on Reddit for all detransitioners. Violating content will be removed. Violators will be banned. If you need help setting user flair, do not hesitate to ask a moderator.

7. **Give space to detransitioners (no outsider soap-boxing).**

   Detrans folk and self-questioners may express controversial views here; those who haven't detransitioned or who aren't considering detransition may not. This is not a debate forum for the general public to prop their egos, promote their views, or evangelize. Please take it to another subreddit or be banned.

8. **Advice giving should not have an ulterior motive**

   Members are encouraged to give advice to their fellow member here but there are unfortunately individuals who set a user flair and then strictly give advice only with no clarity on their own situation or status of their questioning/detransition status. These members with questionable post history will be investigated and subject

Posted by u/RulerTheLion Socially Trans - Regrets Medical Transition 23 hours ago

14

**I tried a bra for the first time in years** RANDOM THOUGHTS

Just needed to say, it was uncomfortable af.

7 Comments Share Save ...

Posted by u/peeinggiraffe 22 hours ago

7

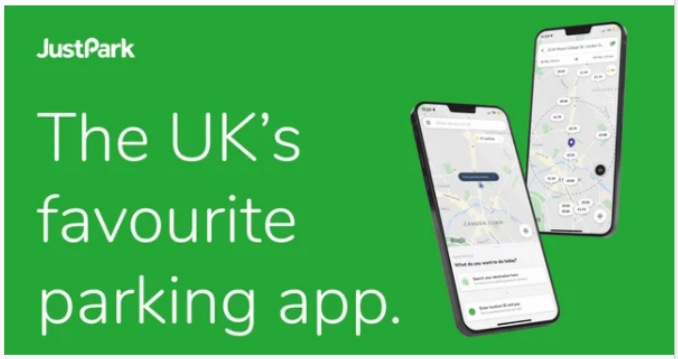
**How to deal with bottom dysphoria?** ADVICE REQUEST

Hi everyone! So I'm not sure transitioning is the right path for me. I don't hate most of my body (at least not for reasons that have anything to do with me being male). I don't mind having body hair, I don't mind having no boobs. I don't mind my voice. It feels silly thinking about transitioning when I can fully picture myself living my life as a guy, and I think if I were to go through it I should be absolutely sure, which I'm obviously not. However for some reason I have bottom dysphoria which is kicking my ass, and I don't know what to do.

I always wished that one day I won't have a penis. I can't remember a time when I wasn't tucking it between my legs&covering it when taking a bath. I used to not even hold it when peeing because I was so grossed out by it. I didn't masturbate at all until I was about 16 but even then it consisted of me being fully clothed and sort of rubbing

6 Comments Share Save ...

u/JustParkHQ · Promoted




0 Comments Share Save

Posted by u/bendy1000 questioning own gender transition 22 hours ago

7

**Questions for/from someone just starting** ADVICE REQUEST

OK maybe this isn't the place for this idk I've seen a few similar past before but I'm currently questioning weather or not I should transition mtf(20) and want to hear both sides as best as possible and the Internet is literally designed to keep you seeing the one side of things that keep you coming back so I don't want that trapping my thinking on this kinda fucking big decision and u wanted to know what you would have asked yourselves in my shoes.

I'm already out to some of my friends asking them to use they/them for a few months now which I'm fairly confident I can say feels better than been thaught of or treated as a man all of the time and I've been trying a few different clothes or style options here and ther like my nails which I honestly like, tho I've never really crossed the boundary of outwardly even attempting to present as a woman more of a feminine man and I

7 Comments Share Save ...

7

**hey hi hello. help?** ADVICE REQUEST

so my pronouns are currently he/they (ftm) and recently i've been feeling dysphoric in a different way than normally. i've thought about the label genderfluid but i'm considering detransitioning. i need help, if anyone has any information :) thank you so much

4 Comments Share Save ...

Posted by u/AdThat2134 desisted female 2 days ago

49

**The Authenticity Myth** RANDOM THOUGHTS

"Being authentic means coming from a real place within. It is when our actions and words are congruent with our beliefs and values. It is being ourselves, not an *imitation*

to punishment if found to be exploiting the rules.

**9. Anti-detrans activism and tropes are unwelcome.**

This subreddit puts detransitioners' rights, needs, and interests first. Detransitioners have for years experienced a culture of detransphobia, victim-blaming, and censorship. Users who belittle or blame us for our existence or experiences as detransitioners, users with a history of doing so anywhere online, and moderators of anti-detrans subreddits may be banned swiftly, long-term, or permanently.

**10. Spam is unwelcome.**

Users who post the exact same content in three or more subreddits are usually bots and/or are being off-topic; they are therefore subject to immediate and permanent ban. Users who promote their own products and services must be related to the topic of detransition, must not break any other subreddit rule, and should not be posted more than once a week (and if they're repeatedly downvoted, they should take it elsewhere entirely).

**11. Clutter-making bots are unwelcome.**

This sub is for humans. Bots that add automated content of little or no value may be banned permanently.

**12. Be forgiving and fair.**

Censorship isn't our goal. Please vote, empathize, agree to disagree, or ignore and move onward. Please report content only if a rule is broken. Mods may delete content and ban users for short or long periods based on a person's history or association if it is deemed inherently harmful to any minority group.

**13. Polls must be moderator approved**

Due to previous abuse and various acts of soapboxing and flair abuse polls that are posted will be automatically deleted and then later looked through by a moderator and possibly approved if given the okay. Moderators are not obligated to provide reason for not restoring polls.

**Origin Story**

In late 2017, the founder of this subreddit noticed that "r / detransition" was quietly deleting posts (https://archive.vn/2kWMf). It was then discovered that the creator of that sub was deceased (https://archive.is/rr7sb), the other three moderators had become mods hours after this death's announcement (https://archive.is/oA51m), and their profiles, histories, and activity showed a bias against detransition. The mods were contacted, as were Reddit admins for violation of the sitewide "no camping" rule, to no reply.

This newer subreddit seeks to put detransitioners' rights, needs, and interests first, while respecting all viewpoints in a civil environment.

**Sibling Subreddits**

r/detransnotes
156 members

Join

of what we think we should be or have been told we should be. There is no “should” in authentic.” ~ Diane Mottl on psychcentral.com

Which in turn quotes Jung; “The privilege of a lifetime is to become who you truly are.” ~ Carl Jung

I've recently been thinking a lot about how my interest in authenticity lead me to latch onto gender ideology. Many times in my life I felt out of place or as though I was playing pretend. Including as an adult - in many areas not just in regards to my sex at birth. I tried to find deeper reasons why I didn't fit in. The idea of living authentically was really appealing to me because I thought it would lead me to happiness and acceptance of

9 Comments Share Save ...

25

Posted by u/somethngsomewhere detrans female 2 days ago

## Boobs

I had typed up a long emotional thing about my breasts /lack of breasts, but nevermind. I'm going to try to summarize and condense my question/thoughts..

Do any detrans women pass as female in public without wearing breast forms? I have breast forms but I would like to feel confident without them... like they get hot and uncomfortable in the hot climate I live, pinching, etc, I don't think any woman finds bras particularly comfortable. And I sure don't with heavy silicone breast prosthetics strapped onto me. They make me feel and look much more balanced and attractive... but Ideally it'd be nice to embrace my small boobs. (I had some growth so I have like..an

have, to be fixed up and shaped) I developed early, like I had DD cups at 16 when I had surgery. So A cups don't really look natural on my body I think. But....Anyway.

12 Comments Share Save ...

132

Posted by u/redholga desisted female 2 days ago

## Desisted almost 20 years ago INSPIRING POSITIVITY

I'm a cis female who went through a tough patch in my adolescence, depression and gender dysphoria. I wasn't (still aren't) pretty, had no boobs, felt I was 'failing' as a female, felt like a freak. I thought that if I can't be a 'real woman', then I'd rather find another niche, another identity. I didn't identify as female (still don't), thought I'd be better off as a male. I lost weight due to depression and it made me even more androgynous. I wanted to tell my parents that I wasn't a girl, but was scared because of their strict Christian views. I waited, dressed in genderless clothes, gave up on makeup etc. and kept thinking about transition. One day, I watched a movie about Christiane F., the famous drug addict from West Berlin. There was a lot of David Bowie's music in the movie and I loved it. I researched Bowie, became a fan and I loved how he played with gender while remaining a cis male. It dawned on me that regardless of my biology, I can present how I like. That there's no good or bad way to be a female. I discovered butch

15 Comments Share Save ...

3

Posted by u/Ripple_Ex detrans 1 day ago

## Pelvic question QUESTION

When you take estrogen at 18 and ur pelvis widens, and then you stop, how long does it take for your pelvis to narrow back up? It makes me look skinny af and I can legit feel my skin being stretched by it

2 Comments Share Save ...

11

Posted by u/NervousThrowAwayAc detrans 2 days ago

## cheating `ftm` blood test urgent ADVICE REQUEST

i was ftm for so many years but have not taken testosterone in over a year approx maybe more

the people overseeing my transition sent a letter today giving me an appointment and

i have been detransitioning for a while but because of covid they have not seen this and i have been questioning stuff like if i wanted the hysterectomy and stuff

i know i do not want the hysterectomy now because now i know all the bad long term health problems that will happen

but i am really scared to communicate with them about all this right now

11 Comments Share Save ...

2

u/Elonious · Promoted

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0 Comments Share Save

Posted by u/cinnamongrahmcracker detrans female 2 days ago

22 **Telling my parents** ADVICE REQUEST

anybody else here live with their parents? or even better, are a minor who lives at home?

I have to find a way to tell my mother that I want to detransition but I don't know how...

for those who told their parents, how did you do it? how did they take it? any recommendations to make the conversation go smoothly as possible?

19 Comments Share Save ...

Posted by u/ElleALibre desisted 2 days ago

70 **First full day off hormones in over four years** DETRANS TIMELINE

Just thought I'd re-introduce myself because I've changed my Reddit name. I'm the guy in Nepal, who cut his long hair off with nail scissors.

A few days ago I gave 6 months worth of Oestrogel to a local trans woman and just kept a few weeks worth for myself to taper off with, but quite honestly, I was just so sick of [illegible] hours 'clean' and I'm feel pretty good. My itchy skin has stopped itching too which is one of the things I was hoping for.

1 Comment Share Save ...

Posted by u/Sonderosity [Detrans] 2 days ago

18 **Please Share your Thoughts, Experiences, or Insight about Autoimmune Disease in Trans people (particularly Trans Women)**

Article about increased risk of MS for GID patients

My trans ex developed multiple sclerosis, seemingly out of the blue, roughly two years into HRT (Estradiol and anti-androgens). It was devastating. Relapse/remittance type, so she seemed perfectly able-bodied one day, but the next day could hardly walk, leading to some people accusing her of faking it (she was not faking). Her brain scan showed severe demyelination.

I think it's fair to say the disease ruined her life because the chronic pain turned her bitter and she was constantly stoned from all the drugs she was taking. She eventually [illegible] recovered? Why didn't the doctor suggest it; seeing as MS is mostly suffered by women, it follows that feminizing hormones in males may be a risk factor.

6 Comments Share Save ...

Posted by u/lacroiscz5 retired mod 3 days ago

83 **A Detrans Awareness Day opportunity** OPPORTUNITY

Detransition Awareness Day is March 12, 2022. A group of parents and detransitioners put together a website, http://detransawareness.org. It has testimonials from some detransitioners as well as therapist on its Youtube Channel. It also has a guide on how to hold an event to spotlight our existence. In an effort to highlight detransitioners, they want to get photograph or video testimonials from 50 representative towns or cities. This could be as simple as holding a sign and snapping a picture, writing out Detrans Awareness Day on a Starbuck's cup, chalking it on a sidewalk or blacktop, or even put together a larger event, like they will be doing in San Francisco and LA. Laura Becker, a detransitioner designed some awesome T-Shirts too. https://inktothepeople.com/detrans-day-of-awareness-shirts.

If you want to submit a testimonial, contact Charliejacobs@protonmail.com

5 Comments Share Save ...

48

Posted by u/InevitableJambalaya questioning own gender transition 3 days ago

**Dysphoria keeps getting worse. Anything other than therapy or transition that helped y'all get over it?**

I concider myself an Androgyne/nonbinary. I'm not out yet, but I voice train, try to pass as male/androgynous and I do my damnest to avoid being viewed as feminine.

The thing is, since I'm not out (don't want the attention that comes from it), people see me as butch, not masculine in a male/androgynous way. I still get she/her'd a lot, and I feel crushed. I occasionally get weird looks or the occasional "sir", but most people just avoid gendering me.

I have a theory that me wanting to pass as male is just a coping mechanism for being lonely with no friends in college due to autism. If I had more of a social life, I probably would stop hating myself so much. I view everything feminine as ugly and weak and I turn that on myself a lot. I have had genuine dysphoria from a young age, but it got horrible in my teen years and is excruciating now. Any tips or anything that's helped for

13 Comments Share Save ...

21

Posted by u/AnyConcern7275 questioning own gender transition 3 days ago

**How long did it take for people to see you as your sex?** DISCUSSION

Hey I'm ftmtf and it's just so hard for everyone to just see me as a female again they are so uncomfortable calling me my name and pronouns. I pass as a female in public it's nothing about how I look it's just how they see me.

12 Comments Share Save ...

20

Posted by u/FuckCapitalism1 questioning own gender transition 3 days ago

**Is There Any Way To Overcome Genuine Gender Dysphoria Without Transitioning?** QUESTION

I suffer severe gender dysphoria, I look at my face and body and it doesn't feel like mine, I have a picture of myself having a female body and face in my mind. That feels like me. Doing things to reduce testosterone levels like gaining weight seems to make me calmer and more functional. I don't identify with masculine ideals or hobbies at all

Yet at the same time, I am not satisfied with the effects of transitioning because it's unlikely I will pass as a woman nor does it give meaning for the years I was socialized as male . I am unhappy with the idea of coming out to people, mostly because I won't be taken seriously. Even though my family knows, but they don't use preferred pronouns. I wish there was some way I could come to terms with my body without changing it. I wish I could develop a male gender identity and attraction to women because it would make my life so much easier and I could have a nice ordinary family with a wife and kids

5 Comments Share Save ...

16

Posted by u/drink-fast [Detrans] 3 days ago

**Periods kicking my ass** ADVICE REQUEST - FEMALE REPLIES ONLY

I started T on November 2nd 2018 and quit December 13th 2021. I got my period again somehow on February 2nd, and got this next one today. I've had the most horrible mood swings and cramps. My body aches pretty bad (idk why i haven't done any physical work lately) and my brain feels like scrambled eggs. Will this get easier over time?

9 Comments Share Save ...

16

Posted by u/Intrepid_Doctor_9113 detrans male 3 days ago

**Detransitioning from f to m after 3 months Set on getting TRT, anyone done this before? Could use advice**

I want to detransition after 3 months. I was confused, I think I had low T and I was struggling with the difficulty today that comes with being a man. However, my sense on manhood came out stronger than ever, and I would like to enhance it further with TRT, because I want to start getting into lifting and I want to get swole.

I want to leave all the hrt stuff behind, and I'd rather not tell the Dr I was taking HRT, or anyone for that matter going forward.

I'm assuming my T, having been a few days without estrogen or spirolactone is higher, but still extremely low. Don't really care about fertility much already have a kid, etc just want to get on T right away, and if I can't get it through legit means I'm going to get it online somehow.

3 Comments Share Save ...

u/Gathertown_Official · Promoted

246

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0 Comments Share Save

Posted by u/phonopithecus detrans female 5 days ago

172

**Losing friends over detransitioning?** QUESTION

I (FtMtF) identified as a man for around 6 years from ages 14-20. I'm currently 21. Has anyone else had the experience of losing all of your transmasc friends because they suddenly feel threatened by your personal choice? I had so many people say to me that they couldn't be friends with me because my detransitioning made them feel insecure about their own transition. At that point all of my friends were trans men and I lost all of them. Still fail to see how that's my fault cuz I am and have always just been doing my own thing. Anyways, I'm still an insanely traditionally masculine chick and as much as I try to be genuine and welcoming women just don't seem to want to interact with me or be friendly with me (exception being my singular chick friends that's in a punk band, luv her) and men take me broing around with them as me flirting which is not at all the case and has lead to some awkward rejections. Just wanna know if I'm alone in this madness

13 Comments Share Save ...

Posted by u/wildflowerden questioning own gender transition 4 days ago

26

**Does hair thinning improve when stopping T after being on it for 6 years?** QUESTION

Hello. I'm not totally detransitioning but I just stopped T. I've heard a lot of people have their head hair grow back thicker after stopping T, but I've mostly heard this from people who were on it for a shorter amount of time than myself - usually 3 years or fewer. I've been on it for 6 years. Does that make a difference in that regard?

I don't have any bald spots, but my hair is a somewhat thinner throughout my entire head. My hairline is a bit receded at the temples as well. Neither is extremely significant, but the thinning is a little noticeable on the top of my head when my hair gets longer than 1.5 inches or so.

Is there a chance, especially since I don't have fully smooth areas on my scalp, that the hair will thicken back up even after being on T for 6 years?

Murray
Blackburn
Mackenzie

# The room where it happens

FEBRUARY 11, 2022



1730

Drawing on a recent Freedom of Information (FOI) response, this blog looks at the pattern and substance of Scottish Government meetings on gender recognition reform between May and December 2021. We describe what meetings took place, at whose initiative, what was discussed and what these records tell us about the Scottish Government's relationship with external bodies, and its understanding of reform.

The analysis highlights a marked bias in engagement towards those who agree with the Government position. Despite a manifesto commitment to a consultative approach, the Scottish Government did not set up any meetings with groups that submitted critical comments to its last consultation.

The account adds further weight to our previous analysis, which considered whether the Scottish Government had 'conscientiously taken into account' submissions to its last consultation, as required under the *Gunning* principles. The record of engagement discussed herein provides further evidence that the Scottish Government has not done so. It also provides further evidence that the Scottish Government simply does not recognise that the proposal to remove the need for a medical diagnosis will make a change of sex in law available to a much larger ***and different*** population than at present.

We conclude that if legislation is introduced soon, the parliament will be faced with compensating for an unfair and unreasonable process that is demonstrably biased, in which the government has insulated itself from having to engage with critics or the substance of their concerns. It will be asked to do so in the crucible of a highly charged atmosphere, where government and its allies have sat in private earnestly discussing the need for respectful debate while agreeing that all disagreement with them is "misinformation".

# Background: 2021 SNP manifesto

**1st Freedom of Information request**

On 30 November 2021 we asked the Scottish Government for information about its 2021 manifesto commitment to work with a range of stakeholders to reform the Gender Recognition Act 2004.

> Please provide any information held by the Scottish Government on what work it has done "*with trans people, women, equality groups, legal and human rights experts to identify the best and most effective way to improve and simplify the process by which a trans person can obtain legal recognition, so that the trauma associated with that process is reduced*" since May 2021.
>
> MBM FOI request, 30 November 2021

The answer (here) which came back on 31 December (the date shown on the Scottish Government website is wrong) referred to the two pre-election consultations and the report commissioned to summarise the responses. The response added:

> The Scottish Government is taking account of consultation responses and other evidence ahead of introducing the Bill.
>
> Since May 2021, the Cabinet Secretary has also met with organisations that requested a meeting including:
>
> – Equality Network
> – Scottish Trans
> – Stonewall Scotland
> – LGBT Youth Scotland
> – LGBT Health and Wellbeing
>
> In addition, Scottish Government Officials have also met with:
>
> – Equality and Human Rights Commission
> – National Records of Scotland
>
> There have been no further requests for meetings from other organisations since May 2021.
>
> Scottish Government, 31 December 2021

**2nd Freedom of Information request**

As this was low on detail, we then asked:

> Further to the information provided in FOI response reference 202100258782 dated 16 December (sent 31 December), for the organisations named in that response, and for any others not included in the list with which relevant meetings have been held, please provide:
>
> – the dates of the meetings held,
> – any notes or other records of what was discussed at each meeting, and
> – any information held relating to setting up the meetings.
>
> MBM FOI request, 3 January 2022

On 2 February 2022 the Scottish Government replied. The full response is here.

Below we describe what meetings took place (Ministerial and officials), at whose initiative, the relationship between the government and groups advocating for self-declaration, and what was discussed. We also supplement the information provided in the FOI response with information from the Lobbying Register, which we checked for any Ministerial meeting which listed GRA reform as a topic, and more generally, for meetings with the main groups advocating for the approach to reform adopted by the government.

## Ministerial meetings

The Lobbying Register shows that the Equality Network met Christina McKelvie MSP, Minister for Equalities and Older People, in June 2021, at their request; however no discussion of GRA reform is recorded.

The first relevant ministerial meeting after the election appears to have been with Ms McKelvie on 5 August 2021. The meeting was not listed as a relevant event in the response to our FOI. Both Stonewall and LGBT Youth Scotland recorded in the Lobbying Register that GRA reform was among the issues discussed. Stonewall also describes the Equality Network, Scottish Trans Alliance (STA) and LGBT Health and Wellbeing being present at this meeting. The Equality Network (which for this purpose includes the STA) and LGBT Health and Wellbeing have not included this meeting in submissions to the register; however, where the government initiates a meeting, it is optional to report it.

The FOI response then records that the relevant Cabinet Secretary, Shona Robison MSP, had three meetings relating to GRA reform:

- 18 November 2021: 'LGBTI Equality Groups' (Stonewall Scotland, the Equality Network including Scottish Trans Alliance, LGBT Youth Scotland, LGBT Health and Wellbeing)
- 1 December 2021: Scottish Trans Alliance only
- 13 December 2021: LGBT Youth Scotland

## Meetings with civil servants

Between August and December 2021 Scottish Government officials met the following groups to discuss GRA reform:

- 27 August 2021: The Equality Network (including STA) and Stonewall
- 11 November 2021: 'LGBT Stakeholders' (the same organisations as on 27 August)
- 7 December 2021: 'LGBT Stakeholders' (the same organisations as on 11 November plus LGBT Youth Scotland)

Officials also met three bodies with public functions: the Equality and Human Rights Commission (EHRC); the Children and Young People's Commissioner (not listed in the original FOI response); the Scottish Civil Justice Council (also not listed in the original FOI response); and the National Records of Scotland (on three occasions, although note that the NRS works direct to Scottish Ministers, so these meetings were not external engagement in the same way as others).

The FOI response states that some meetings are excluded as 'outside scope' (we are asking for this to be reviewed). This may for example, include meetings of the Scottish Government's Non-binary Working Group and its sub-groups, on which Stonewall Scotland, the Equality Network including Scottish Trans Alliance (STA), LGBT Youth Scotland, LGBT Health and Wellbeing (the same groups as met the Cabinet Secretary on 18 November) are represented, attending alongside civil servants. Several meetings under this banner took place between May and December. On 16 September, the minutes record that the group was told 'The Bill will be introduced in February 2022 and it is unlikely that there will be big changes to the Bill.'

## Who arranged the meetings

In January 2022, in responding to critical media coverage about the narrow scope of its engagement to date, the Scottish Government indicated that it had met with everyone who requested a meeting. However, this left unclear whether meetings had happened *only* with those who had requested one. The second FoI response makes it clear this was not the case and that the Scottish Government was active in seeking engagement with the various organisations it met, particularly at an official level.

The FoI response includes an email showing that on 6 July 2021, shortly after the June meeting with the Equality Network noted above, Ministers issued an invitation to an introductory roundtable with LGBT groups. Although further details of this are not included in the FOI response, this looks likely to be the 5 August meeting recorded in the lobbying register, at which GRA reform was discussed.

The Cabinet Secretary's meetings can be traced more clearly to approaches from the Equality Network and the STA. However the meeting on 13 December 2021 with LGBT Youth Scotland was proposed by LGBTYS during the discussion on 18 November. Being in the room provided more chances to be in the room again.

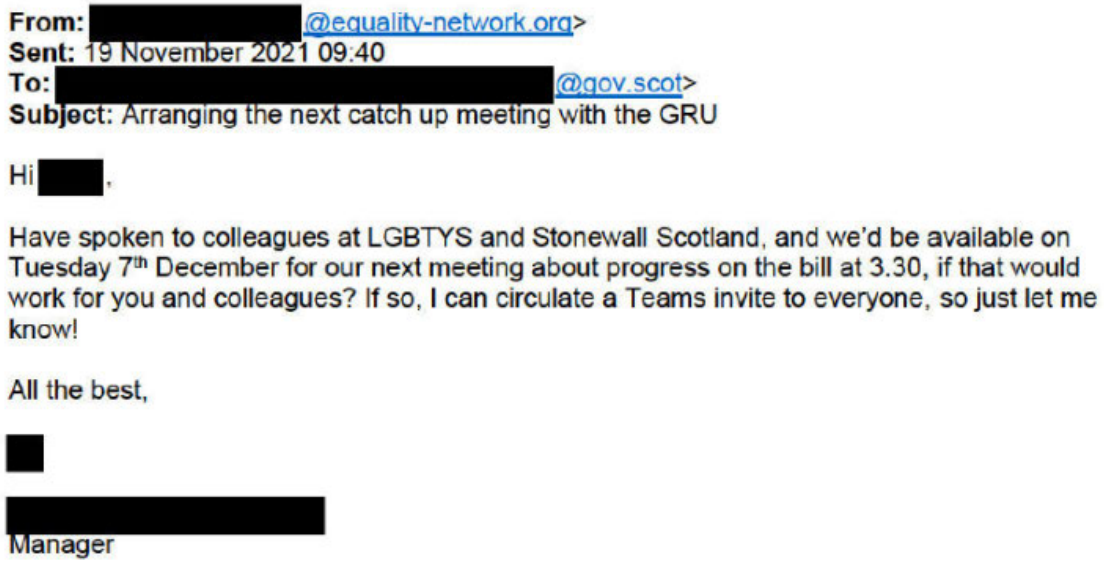
The official-level meeting on 11 November 2021 with LGBTI stakeholders on GRA reform was initiated by civil servants. The day before the Equality Network suggested adding 'arranging regular meetings' to the Agenda. The 7 December meeting with several groups appears to have followed on from this. Again, being in the room opened the door to further meetings. The 17 November meeting with LGBT Youth Scotland came out of an invitation offered by civil servants of 'a follow up chat if anyone was interested' at a separate meeting (of the National Gender Identity Clinical Network for Scotland) attended by the various groups. The 27 August meeting with the STA appears to be the only meeting with officials that took place purely due to an approach from cold by an external body.

Based on the information provided, the official-level meetings with the EHRC, NRS, CYPCS and the Scottish Civil Justice Council were all initiated by civil servants.

## A close working relationship

The exchanges show a well-developed working relationship between government and groups advocating for self-declaration, strengthened by the same people meeting in other contexts as well.

Emails go backwards and forwards quickly. More than one meeting is hosted online by one of the external groups.



**From:** [redacted]@equality-network.org>
**Sent:** 19 November 2021 09:40
**To:** [redacted]@gov.scot>
**Subject:** Arranging the next catch up meeting with the GRU

Hi [redacted],

Have spoken to colleagues at LGBTYS and Stonewall Scotland, and we'd be available on Tuesday 7th December for our next meeting about progress on the bill at 3.30, if that would work for you and colleagues? If so, I can circulate a Teams invite to everyone, so just let me know!

All the best,

[redacted]

[redacted]
Manager

Approaching the Minister for a meeting the day after the launch of the Programme for Government, the STA offers 'to answer any questions you may have about the proposed changes'. Ministerial meetings with external bodies are usually expected to work the other way round.

It should be emphasised that the pro self-declaration advocacy groups did nothing unusual in approaching government and taking all chances they could to put their case. The STA email indeed acknowledges that other views exist, saying they 'hope that we can help [reduced polarisation in the debate] by being part of a constructive and respectful conversation about the range of views on these issues'.

What is more exceptional is where the Cabinet Secretary and the STA (which as part of the Equality Network derives its income from the Scottish Government) discuss how the STA will 'help raise the understanding' of MSPs and by implication encourage their support of government proposals. Concerns about undeclared co-ordination between government and external bodies during the legislative process has come up before (for example in relation to the legislation on named persons).

The question here is not, as it has sometimes been in other contexts, whether the STA has been pressured into its position. Clearly it has not. The issue is how far its apparent separate status and the resources attached to that are used to amplify the government's

voice and influence in the parliamentary process, to help delegitimise those critical of government proposals and so make it harder for those criticisms to be properly heard in the parliamentary process.

Parliamentary planning aside, the problem here is not the government talking to these organisations; but that it has not talked to anyone else. Critics, even those (ForWomenScotland, ourselves) who had met ministers or officials in the previous parliament, were ignored. As recorded in our previous blog, while all these discussions were going on, even just a letter we had sent in March 2020 was too much to answer. Although the offer of a meeting came on the same day as we finally chased a response, 21 months on, that should be set against having had no acknowledgment of a paper we submitted to the government earlier in the month. It should not take acute embarrassment to get a government to engage directly with more critical responses to a consultation. Similarly, the government only issued a wider 'invitation' to meet a wider range of stakeholders after critical press coverage. Even then, this offer was only made through the media. Our letter remains unanswered.

## Notes of the meetings

We previously argued that there is no evidence to indicate that the Scottish Government has engaged properly with the substance of criticisms. This is further supported by the various meeting notes.

The 18 November ministerial meeting discussed GRA reform and conversion therapy. Much of the discussion of GRA reform was about the tone of the debate. An unidentified person, who may be an official or an external attendee, noted:

> it was important to highlight that the Bill allowed people to access rights they already had.
>
> Cabinet Secretary and LGBTI stakeholders meeting, 18 November 2021: para. 2

This statement was not questioned or challenged, but supported by Ms Robison:

> Ms Robison said the purpose of the reform was about a making existing processes easier and fairer for a small number of people for whom the current process was difficult and unfair.
>
> Cabinet Secretary and LGBTI stakeholders meeting, 18 November 2021: para. 3

LGBT Youth Scotland argued that lowering the age was important as:

> Trans young people struggled to access services as they were not able to apply for a Gender Recognition Certificate.
>
> Cabinet Secretary and LGBTI stakeholders meeting, 18 November 2021: para. 6

This statement does not appear to have been explored further. Instead, a separate meeting with LGBT Youth Scotland was agreed (see below). The only other follow up action on GRA reform agreed was that:

> Ms Robison agreed to reflect on how to challenge misinformation surrounding the Gender Recognition Reform (Scotland) Bill.
>
> Cabinet Secretary and LGBTI stakeholders meeting, 18 November 2021: Follow Up Actions 1

On 1 December the STA set out its view that the process was 'complicated and pedantic'. They stressed:

> the requirement for medical evidence can feel disconnected, stigmatising and retraumatising.
>
> Cabinet Secretary and STA meeting, 1 December 2021: Discussion

The STA welcomed the Bill but, in contrast to its earlier commitment to be part of a process recognising different views existed, said:

> There are some aspects that are not ideal and seem like they are already concessions to critics of reform, for example the two 3-month periods.
>
> Cabinet Secretary and STA meeting, 1 December 2021: Discussion

The discussion as recorded shows no sign of the Scottish Government recognising the distinction between evidence requirements and the principle of a diagnostic criterion, despite having had this point put to it repeatedly. As we have argued since 2019, concerns about the administrative burden can be addressed by changing what evidence is required, whilst retaining the requirement of a diagnosis.

On 13 December members of the LGBT Youth Scotland Youth Commission 'discussed their difficult experiences' related to the current lower age limit for a GRC being set at 18, rather than 16. They argued:

> reducing this age limit would send a message to society that trans people understood their identity and could make this decision.
>
> Cabinet Secretary and LGBT Youth Scotland meeting, 13 December 2021: para. 2

They were concerned that people deterred by the "unnecessarily bureaucratic and intimidating" GRC process would have their deaths recorded with the wrong details. They asserted that

> Trans young people faced particularly high rates of homelessness and mismatched documents made them more vulnerable.
>
> Cabinet Secretary and LGBT Youth Scotland meeting, 13 December 2021: para. 2

There is no suggestion in that record that any of these statements being explored or questioned further. Ms Robison responded that she:

> understood the difficulties trans people faced when accessing gender services and that the process medicalised trans people.
>
> Cabinet Secretary and LGBT Youth Scotland meeting, 13 December 2021: para. 3

The minutes show no sign of meetings being used to explore the content of criticism, or to test the arguments of pro self-declaration groups. Instead, the meeting notes reinforce how far the Scottish Government has accepted all points put to it in favour of self-declaration at face value and show Ministers starting from the position that any objections to self-declaration are based on 'misinformation'.

No records have been provided of the official meetings; we have asked if any exist.

The only indication of what issues were discussed are in the emails setting up arrangements. For the 27 August meeting, the STA asked to discuss 'GRA reform and rUK issues', which the STA described on 6 August as:

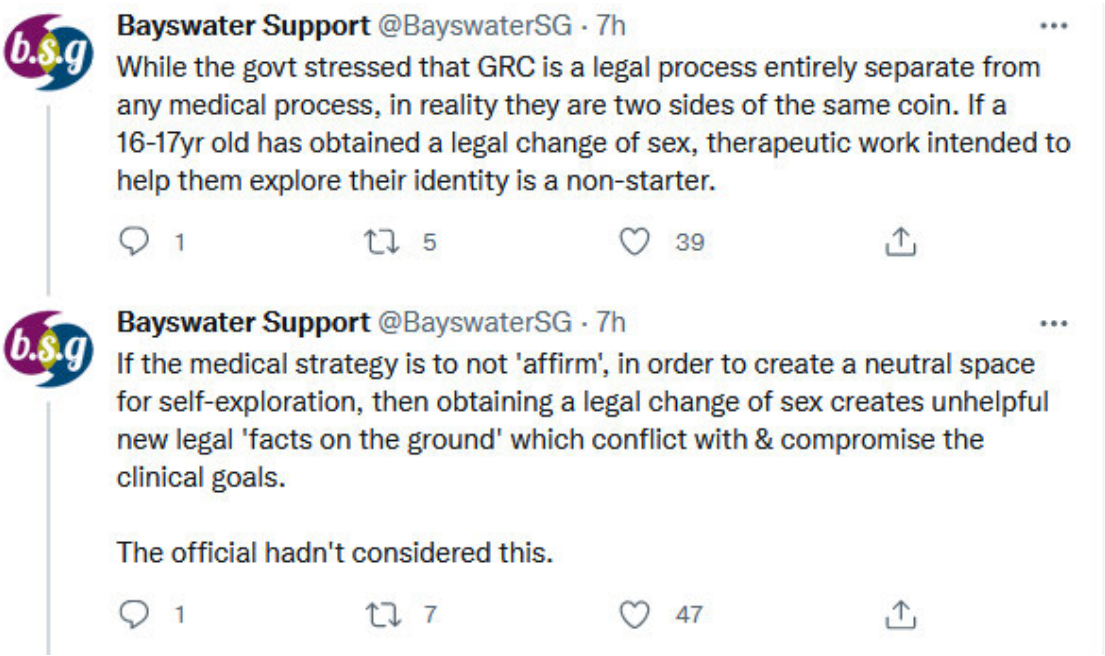
> something we've been discussing a little in sector policy meetings in recent weeks!
>
> Scottish Trans Alliance, email correspondence 6 August 2021 (FOI page 14 )

Officials also suggested 'cross-border issues' as a topic for the 11 November meeting (FOI page 3 ).

Yet more recent meetings between the Minister and those critical of self-declaration have shown the government to be no clearer on cross-border effects than it was at the time of the last consultation. In one case, the government's defensive line against a critical point rested on a misunderstanding of the current law. Discussing cross-border issues only with those with whom it agrees may have introduced new misunderstandings, rather than resolved issues.

The other issues on the agenda for 11 November included 'Bill policy (including minimum age, statutory declarations and associated offence, fees)', timelines, and the meetings arranged with the Minister.

Again, recent meetings have provided no reassurance that the government can defend its reliance on statutory declaration as a safeguard, or the interaction of this with detransition, any better than it could two years ago. The account of a meeting with a support group for parents of children who identify as trans suggests that whatever discussion there has been with groups arguing to lower the age for a GRC, it has left fundamental questions unconsidered.




Twitter thread, 9 February 2022

# Reforming an imaginary law

At the root of the disagreement over GRA reform is the proposal to decouple the entitlement to obtain a change of sex in law with the basis on which specialist treatment is made available on the NHS, which is a diagnostic test.

**These new meeting accounts are further evidence that the Scottish Government really does not recognise that the proposal to remove the need for a medical diagnosis will make a change of sex in law available to a much larger *and different* population than at present.**

This is a point that has been made to government repeatedly. It was a key issue we raised in our discussion with officials in March 2020 and which we pressed further in our (long-time unanswered) letter to them afterwards.

The EHRC appears to have a similar concern, having emphasised to the Scottish Government that:

> These concerns centre on the potential consequences for individuals and society of extending the ability to change legal sex from a small defined group, who have demonstrated their commitment and ability to live in their acquired gender, to a wider group who identify as the opposite gender at a given point.

It becomes clear, in fact, that one reason why the Scottish Government has been unable to "conscientiously take into account" any criticism of its proposals is that it fundamentally misunderstands the law it is proposing to reform.

The Scottish Government has reimagined the *existing* legislation as something it is *not,* either on its face or in its original conception. It has been persuaded that the GRA 2004 is *already* a piece of law which is mainly about providing access to a new birth certificates for anyone who feels a mismatch between their inner sense of self and their sex, as matter of record at birth, and just does not do this well enough.

But the Act was designed to be, and is written and functions as, something very different: a piece of law enabling a change of sex for multiple (but not quite all) legal purposes, for those who have made specific, major practical changes to how they live, and can show they have done that, in response to an objectively assessed need. In a judgement last year from the High Court of Northern Ireland, a GRC was described as:

> a major change in the status of the individual in the eyes of the law …
>
> I accept the respondent's (the UK government's) submission that the legal change in a person's gender is a significant and formal change in their status with potentially far-reaching consequences for them and for others, including the State.
>
> High Court of Northern Ireland Judicial Review [2021] NIQB 48 (paras. 31 and 135)

The inclusion of some medical gate-keeping for a GRC process at present is a feature, not a bug. As the 2021 judgement also said:

> I cannot accept the applicant's submission that the 2004 Act was specifically designed to fracture any such link [between legal recognition and entitlement to medical treatment]. Although it was designed to facilitate gender recognition without an applicant having had to undergo any gender reassignment surgery or treatment, the requirement for a diagnosis and more especially the requirement that a medical member form part of the GRP demonstrates that Parliament considered it proper to have some read-across between the two processes by way of professional clinical involvement in each.
>
> High Court of Northern Ireland Judicial Review [2021] NIQB 48 (para. 139)

It might well be possible to streamline the evidence requirements (and the 2021 judgment also suggests amendment to the detailed definition of the diagnosis). But the brief comments from the Minister in these notes confirm what was also apparent from the most recent meetings. The Scottish Government does not understand that moving GRCs from something linked to a diagnostic test to validation of self-perception changes *why* the law exists and *who* it is for, and how easily it might be misused. From that change flows all the criticism and concern. But no one in government can hear it.

Not understanding the law they are proposing to reform has caused the Scottish Government to minimise *to themselves* the effect of the change proposed, making it easier to dismiss even the possibility of unintended consequences. Maintaining this mindset has been aided by officials and Ministers avoiding engagement with those who disagree with them. They have instead kept their detailed engagement to people who share, indeed who presumably supported in the first place, their (mis)perception of the law as it stands.

None of this prevents anyone from arguing that the GRA should no longer include a diagnostic test. It does mean however that in proposing to remove this, the government has been unable so far to engage in a conscientious way with the consequences of doing so.

## A law unto itself?

Administrative practice in government is not a free for all, but subject to basic principles set in law, whether case law for the basics of administrative process, concepts such as maladministration, concerned with matters including bias and delays, or the Equality Act, which sets rules about the treatment of groups with different protected characteristics. Advice from the Solicitor to the Scottish Government to civil servants on how to stay within the law while doing their job notes that in administrative law the test of “reasonableness” includes:

> seeing whether [public bodies] have taken into account matters which they ought not to take into account, or conversely, have refused to take into account or neglected to take into account matters which they ought to take into account.
>
> Right First Time: a practical guide for public authorities to decision-making and the law. 2nd edition

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Under the Equality Act public bodies must act and make decisions in a way that avoids discrimination, harassment and victimisation. Under the Public Sector Equality Duty they must:

> foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

It is hard to see how the process described above, taken with the evidence here meets those tests.

## Conclusion: fair or reasonable?

The Scottish Government appears to be planning to introduce a Bill in a context where:

- there is strong case to argue that the *Gunning* principles governing lawful consultation, especially the duty to "conscientiously take into account", have not been met
- *Gunning* aside, it has systematically pursued a partial approach to engagement, in which any critical voices have been ignored.
- there is clear evidence that it does not understand how its proposals will change the current position in law.
- the EHRC has asked it to consider matters further before introducing a bill.

Discussing 'failures of consultation (and indeed other lapses in due process)' the Solicitor to the Scottish Government has said:

> the decision-maker may be tempted to say "but it was an open and shut case. Consultation would have made no difference. The decision would inevitably have been the same". That may well be true, but the courts are unlikely to be sympathetic to such a response. And for good reason: the principle is that **only a fair procedure will enable the merits to be determined with confidence, and must therefore come first.**
>
> Right First Time: a practical guide for public authorities to decision-making and the law. 2nd edition

We think the Scottish Government would have a difficult time defending its processes here in court. However, as explained in the UK Government's guide to lawful decision-making, the courts cannot be asked to rule on whether 'decisions by ministers as to what to propose to Parliament by way of legislation' are lawful under the general principles of administrative law. On this, the courts defer to the judgement of our elected representatives.

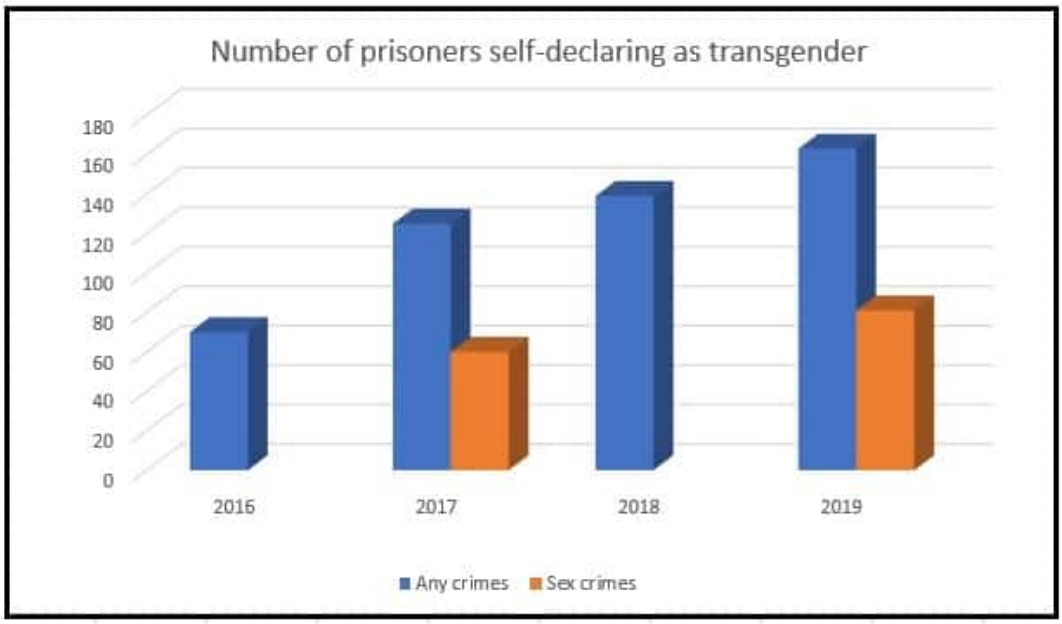
This means that if legislation is introduced soon, the parliament will be faced with compensating for an unfair and unreasonable process, demonstrably biased, in which the government has insulated itself from having to engage with critics or the substance of their concerns. It will be asked to do so in the crucible of a highly charged atmosphere, where government and its allies have sat in private earnestly discussing the need for respectful debate while agreeing that all disagreement with them is misinformation.

Good law is not made this way.

(https://fairplayforwomen.com/)

# Transgender women exhibit a male-type pattern of criminality: Implications for legislators and policy makers.

12th December 2020 by FPFW (https://fairplayforwomen.com/author/nlw/)




In 2018 the MOJ released statistics showing half of the people in prison who declare themselves transgender have been sentenced with one or more sexual offences. We have now obtained new data which is the clearest and most recent evidence confirming the vast majority of these trans sex offenders were born male. These MOJ statistics show that transgender women exhibit a male-type pattern of criminality. We conclude that transwomen in prison exhibit a propensity to sexual crime that matches their birth sex and not their gender identity. This is relevant and necessary information when making legislation and policies designed to keep women safe.

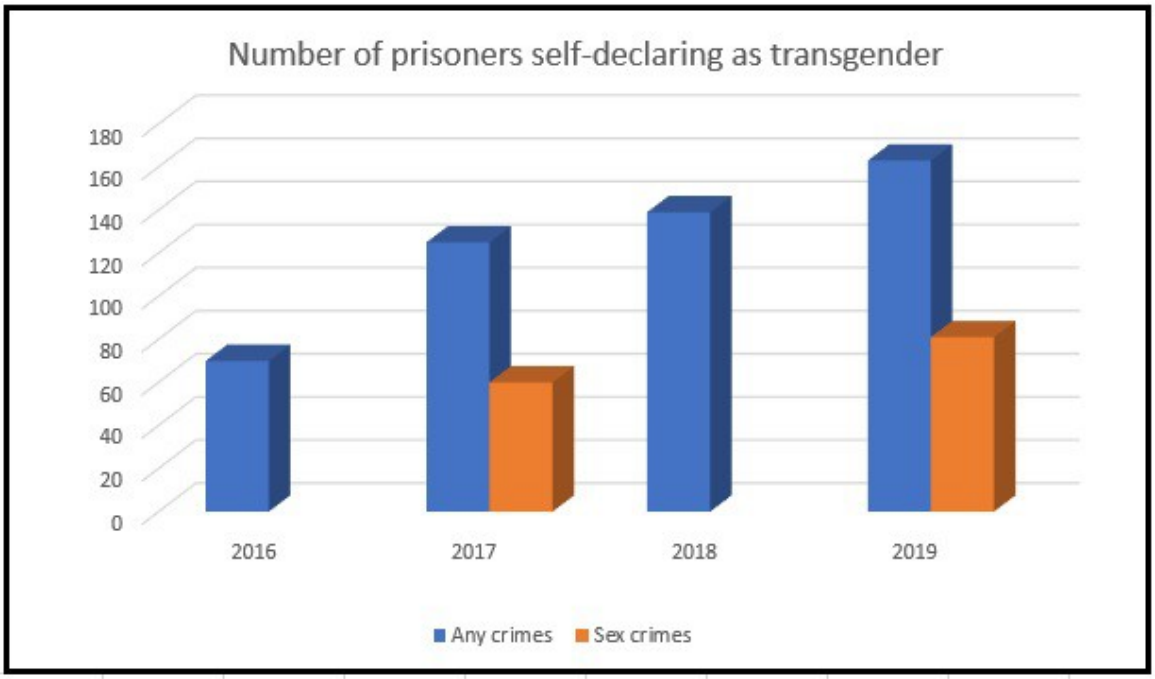
## High numbers of transgender prisoners have been convicted of sex offending.

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We first revealed this in 2017 based on our own analysis of prison inspection reports (https://fairplayforwomen.com/transgender-prisoners/) that allowed us to estimate how many transgender prisoners were being housed in prisons reserved for sex offenders. Our findings were then confirmed by prison statistics obtained from the MOJ through Freedom of Information requests revealing 60 out of the 125 transgender prisoners (https://www.bbc.co.uk/news/uk-42221629) in England and Wales in 2017 had at least one conviction for a sexual offence.

A new Freedom of Information request (https://fairplayforwomen.com/wp-content/uploads/2020/12/FOI-transgender-sex-offenders.jpg) submitted by Fair Play For Women now reveals the same pattern is observed in data from 2019. This time 81 out of the 163 transgender prisoners (https://fairplayforwomen.com/foi-200615022-data-final/) in England and Wales had at least one conviction for a sexual offence.

(Note: No data is available for 2020 because the annual count of transgender prisoners was postponed to due operational difficulties caused by Covid restrictions).




## What's new?

Previously sex crime statistics were given for transgender prisoners as a whole. The information for (male-born) transwomen and (female-born) transmen was combined so there was some doubt expressed over which group was actually responsible for committing the sex crimes.

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For the first time we have now obtained sex crime data from the MOJ according to the trans person's legal sex, their gender identity, or whether they are in a men's prison or a women's prison. This means we can draw conclusions regarding the cohort of **male-born** transgender prisoners specifically. See Appendix for the analysis performed for each data variable. Taken together we conclude:

> *Half of the **male prisoners** who declared themselves transgender in 2019 have been sentenced with one or more sexual offences.*

## Why does this matter?

In recent years an active and important public debate has begun about who should have access to women's safe spaces. Should access be based on someone's gender identity or their biological sex? Should women's spaces be open to anyone who identifies as a woman or should they be reserved for the female sex? Could reforming the Gender Recognition Act 2004 change who gets access to women's safe spaces to the detriment of women?

It is important for legislators and policy makers to make evidenced-based decisions to ensure the impact on all affected groups is considered, understood and fairly balanced. This means they need information on the demographics of different groups in society, including for transgender women.

The evidence we present here is relevant to two areas of legislation: the Equality Act 2010 (https://fairplayforwomen.com/equality-act-2010_womens-rights/) and the Gender Recognition Act 2004 (https://fairplayforwomen.com/grascrapped/). It is relevant to service providers when evaluating whether providing a single-sex service is a "proportionate means of achieving a legitimate aim". It also informs legislators on the potential impact of GRA reform on women in prison.

## 1) Can the exclusion of transwomen from female-only spaces and services be objectively justified?

The Equality Act 2010 (https://www.legislation.gov.uk/ukpga/2010/15/contents) sets out conditions when discrimination based on sex and gender reassignment can be lawful. Provisions in the Act mean people born male, irrespective of gender identity, can be lawfully

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excluded from female-only spaces or services for reasons of privacy, safety and fairness for women and girls.

> *Some people argue that 'transwomen are women' and like all other women should not be excluded from women-only spaces. Access to women's spaces should be based on gender identity.*
>
> *Others argue that 'transwomen are male' and like all other males should be excluded from women-only spaces. Access to women's spaces should be based on birth sex. They should be female-only.*

To make the right decision policy makers need to understand why their specific women-only space is needed and whether this can be achieved with a policy based on gender identity or birth sex.

If a space is considered necessary in whole or in part to protect women from the physical or psychological impact of sexual crime (sexual assaults, voyeurism, triggering a survivor of sexual abuse) this means policy makers need to understand sex crime patterns.

It is well known that most sexual and violent crime is overwhelmingly committed by men and that's why women and girls sometimes need their own safe space away from men. Not because all men pose a danger but because saying no to all men is a simple and effective way to keep women and girls safe.

MOJ Offender Management Statistics (https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-april-to-june-2019) show that men and women have very different patterns of criminality; men have a higher propensity to commit sexual crimes. The difference between the two sexes is stark.


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*Data from March 31st 2019 show that 99% of the 13359 sex offenders in prison in England and Wales were male (13234 prisoners). Only 1% of sex offenders were female (125 prisoners).*

*Data from March and April 2019 show that 17% of men in prison in England and Wales have been sentenced for a sexual offence (13234 out of a total of 78781 men in prison). However, only 3% of women in prison in England and Wales have been sentenced for a sexual offence (125 out of 3812 women in prison).*

We can now answer a simple question about transgender women criminality:

### Does the crime pattern observed in the transwomen prison cohort match what we see for men or for women?

The fact that half of male prisoners who identify as transgender have been sentenced for sexual crime is strong evidence that transwomen exhibit a high propensity to commit sexual crime similar to that observed for men. They do not exhibit a low propensity to commit sexual crime like that observed for women.

It appears that identifying as a woman does not reduce the risk that male people can pose to others. If identifying as a women did reduce the propensity to commit sex crime to female levels we would have expected to see just 3 or 4 of transwomen in prison with sex crime convictions. Instead we see up to 76.

See Appendix 2 for more discussion about whether the conclusion we have reached is valid

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***!!This doesn't mean that all transwomen are sex offenders!!***

*For the avoidance of doubt, and because this is a very sensitive topic, this data does not show that all or most transwomen in society are predatory males. Likewise, acknowledging that men as a class commit most sex crimes does not mean most men are sex offenders. The vast majority of males do not pose a sexual threat to women. However, women won provision in the Equality Act to exclude all males from some spaces because we can't tell who is a threat and who is not. Excluding all males is a simple and effective way to keep women and girls safe.*

*Transgender pressure groups argue that males who identify as women should be exempted from this safeguarding convention and treated differently from other male people. Some people consider it transphobic to even question this. However, they offer no evidence to reassure women that opening access to this group of males would have no impact on women's safety. There is a paucity of research on transgender women so this analysis is an attempt to address this issue to enable evidence-based discussion.*

## 2) What effect would GRA reform have on women in prison?

Transgender pressure groups want the law to be changed to allow anyone to swap their legal sex status on demand (self-ID) rather than needing medical approval. This would mean any male could self-declare as a woman and get a new birth certificate to say they'd been born female.

The Government recently rejected this idea after a length consultation process concluding that "It is the Government's view that the balance struck in this legislation is correct, in that there are proper checks and balances in the system and also support for people who want to change their legal sex" (https://www.gov.uk/government/speeches/response-to-gender-recognition-act-2004-consultation)

However, it remains Labour and LibDem party policy that they would introduce self-ID through GRA reform. Many conservative MPs also favour this position. The Women and Equalities Select Committee is conducting another inquiry into GRA reform (https://committees.parliament.uk/call-for-evidence/291/reform-of-the-gender-recognition-


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act/) and made a ‘call for evidence’ in October 2020. One of the questions is “Are there challenges in the way the Gender Recognition Act 2004 and the Equality Act 2010 interact?”.

**These MOJ sex crime statistics highlight one of the ways GRA reform would directly impact women.**

Some policies are already being created based on the assumption that GRC holders should be treated more favourably than non-GRC holders. One example is the HMPPS 2019 prison policies; namely the “HMP Downview E Wing policy (https://fairplayforwomen.com/wp-content/uploads/2020/03/E-Wing-Policy-Version-16.0-For-Publication.pdf) ” and “Care and management of individuals who are transgender (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863610/transgender-pf.pdf)”.

Current prison policy requires that “*all individuals who are transgender must be initially allocated to part of the estate which matches their legally-recognised gender [sex recorded on their birth certificate]*”(Section 4.6) (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863610/transgender-pf.pdf). This is to give time for a transgender case review to be conducted that includes an assessment of the physical risks to other prisoners if a transwoman wishes to transfer into a women’s prison. The most recent MOJ statistics from 2019 show there were 11 transwomen legally recognised as male housed in women’s prisons (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/848759/hmpps-offender-equalities-2018-19.pdf). Prisoners with a GRC are excluded from the annual transgender count so there are no accurate figures of the total number of transwomen (with and without a GRC) in women’s prisons.

If a transgender prisoner without a GRC is considered to present a high risk of harm to female prisoners that person will be located in a men’s prison (while being fully supported to express the gender with which they identify). The MOJ sex crime statistics for 2019 have revealed that 81 of the prisoners who have had a transgender case review have at least one conviction for sexual offending. Only 5 were allowed to be housed on the women’s estate. **The decision was made for 76 trans sex offenders to remain in men’s prisons.**


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If the process to obtain a GRC became a self-declaration process it would be possible for all 129 transwomen currently held on the men's estate (including the 76 transwomen sex offenders) to obtain a GRC on demand. The prison system would then have to treat them differently. Some would be moved into mixed population with women and others would be housed in special accommodation unit.

If a transwoman with a GRC is considered to present a high risk of harm to female prisoners that person will be located on E-Wing at Downview women's prison. This is because they are *"required to be located in the women's estate because they hold Gender Recognition Certificates and are legally female (https://fairplayforwomen.com/wp-content/uploads/2020/03/E-Wing-Policy-Version-16.0-For-Publication.pdf)"* (as stated in paragraph 3.1 of E-Wing policy). During the day some of these high-risk transgender prisoners will *"have access to the …. activities within the main site alongside other women (https://fairplayforwomen.com/wp-content/uploads/2020/03/E-Wing-Policy-Version-16.0-For-Publication.pdf)"* (paragraph 10.3 of E-wing policy). No official figures are available for the number of GRC holders in prison but it has been reported there have been up to 3 GRC holders (https://www.bbc.co.uk/news/uk-47434730) requiring supervision in E-wing.

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*GRA reform could lead to a dramatic increase in the number of transwomen housed on the women's estate. Increasing from at least 14 (11 without a GRC and 3 in E wing) to as many as 143. This could mean that around 1 in every 30 prisoners in the women's estate would have been born male and not female.*

*Up to 76 of these transwomen obtaining a GRC by self-ID could be the ones with convictions for sexual offending, including rape and sexual assault (the data set for this group includes convictions 36 convictions for rape, 10 for attempted rape and 21 sexual assaults).*

*The fact that GRC holders are treated more favourably than non-GRC holders in prison presents an incentive to all 80,000 males in prison, including 13,000 male sex offenders. The current medical gatekeeping process prevents exploitation of this incentive but a self-declaration system will be unregulated and open to abuse. Expert written evidence (http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Women%20and%20Equalities/Transgender%20Equality/written/19532.html) was provided to 2015 Trans Inquiry conducted WESC to say exploitation by non-transgender prisoners should be expected.*

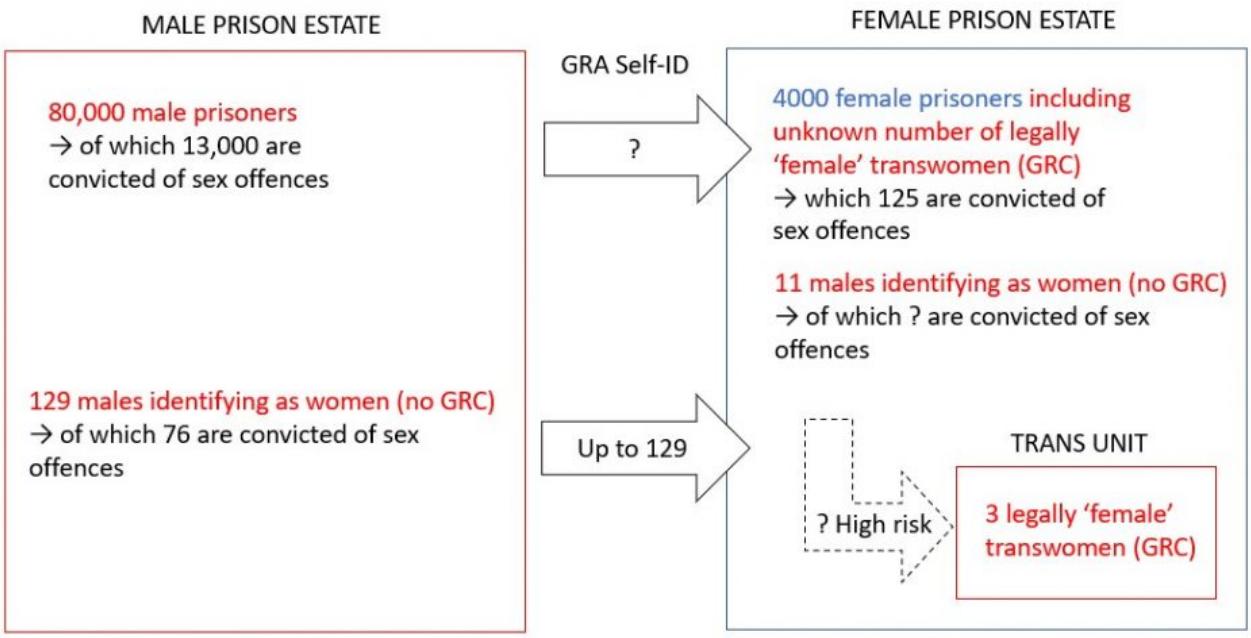
Some sex offenders will be considered too dangerous for unsupervised association with women and so would be housed in E-wing (current capacity 16 beds). Nevertheless the expectation is that where ever possible they will be allowed supervised access to communal activities on the main site such as the chapel, canteen, laundry, showers, telephones, gym and exercise classes. Fair Play For Women has seen the unpublished Equality Impact Assessment for E-wing where it states this is to allow them to experience as much of the women's regime as possible and to 'foster good relations' with other women.

While the physical safety of the female inmates has been considered as part of E-wing policy it is apparent that the psychological impact of forcing women to share space with high-risk prisoners they perceive as male has not. It is well known that a high proportion of women in prison have experienced male violence and sexual abuse. The impact on their mental well-being, rehabilitation success and self-harm rates has never been assessed. This is currently the subject of a Judicial Review of transgender prison policy (https://fairplayforwomen.com/why-female-inmate-suing-government-transgender-


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prisoners/) expected to be heard in the High Court in early 2021. It will be argued that current prison policy indirectly discriminates against women in prison and should be scrapped and redrawn.

**However, as policy stands now it means GRA reform could lead to an extra 76 male sex offenders moving to women's prisons. This is a practical example of what GRA reform would mean for women. Women in prison are stakeholders in GRA reform. The idea that GRA reform only impacts transwomen is demonstrably wrong.**




# Appendix 1:

The full dataset can be downloaded here (https://fairplayforwomen.com/foi-200615022-data-final/).

### 1) Data on legally male transgender prisoners

This data refers specifically to male-born transgender prisons. 129 transgender prisoners said their legal gender was male [i.e. the sex written on their birth certificate is male]. The HMPPS Offender Equalities report (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/848759/hmpps-offender-equalities-2018-19.pdf) states that *"Prisoners who have already transitioned and have a full Gender Recognition Certificate are excluded from this*


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*dataset"*. This means no female-born transgender prisoners who have become legal male on their birth certificate by virtue of a GRC will be included in this count. All 129 transgender prisoners must therefore be legally male **by virtue of birth.**

**Table 2: Sexual offences recorded for legally male transgender prisoners identified in the March/April 2019 data collection and sentenced with one or more sexual offences**

| Offence | Number of sexual offences to which legally male transgender prisoners were sentenced |
|---|---|
| Rape | 36 |
| Attempted rape | 11 |
| Possessing/distributing/making indecent photograph or pseudo-photograph of child | 22 |
| Sexual assault or attempted sexual assault | 18 |
| Causing or inciting a child under 16 to engage in sexual activity | 11 |
| Sexual activity with a child under 16 | 12 |
| Indecent assault or gross indecency | 9 |
| Other sexual offences[1] | 15 |
| **Total number of legally male transgender prisoners sentenced for one or more sexual offence[2]** | **74** |
| **Total number of legally male transgender prisoners in March/April 2019[2]** | **129** |

(1) Other includes exposure, buggery, breach of a sexual risk order or sexual offences prevention order or sexual harm order, meeting a child following sexual grooming, arranging/facilitating the commission of a child sex offence, arranging/facilitating travel of another person with a view to exploitation, falsely imprisoning a person with intent to commit a sexual offence, causing a child to look at images of sexual activity, causing/inciting a child into prostitution/pornography, controlling prostitution for gain, attempting to cause/incite a girl aged 13 to 15 into penetrative sexual activity.

(2) Note that the bolded counts at the bottom of this table are person counts and will not sum to the offence counts provided above it. This is because it is possible for a prisoner to be sentenced to more than one offence.

## 2) Data on transgender prisoners housed in male prisons:

We can say with high certainty that the 129 trans prisoners in men's prisons are all male-born transgender prisoners. We know this from conversations with MOJ and HMPPS staff members who were involved in creating transgender prison policy that it would simply be too dangerous to house female-born transgender prisoners in men's prisons. This is also backed up by Freedom of Information request obtained in December 2017 that stated *"currently there are no prisoners who were assigned female at birth, held in male prisons". (https://fairplayforwomen.com/prison-no-women-in-mens/)* The Equality Impact Assessment (currently unpublished) conducted in March 2019 for E-wing policy similarly states *"There are no transgender men in the male estate"*

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**Table 3: Sexual offences recorded for transgender prisoners identified in the March/April 2019 data collection and sentenced with one or more sexual offences, in male establishments across England and Wales**

| Offence | Number of sexual offences to which transgender prisoners were sentenced in male |
|---|---|
| Rape | 36 |
| Attempted rape | 10 |
| Possessing/distributing/making indecent photograph or pseudo-photograph of child | 18 |
| Sexual assault or attempted sexual assault | 21 |
| Causing or inciting a child under 16 to engage in sexual activity | 11 |
| Sexual activity with a child under 16 | 9 |
| Indecent assault or gross indecency | 11 |
| Other sexual offences[1] | 20 |
| **Total number of transgender prisoners in male establishments sentenced for one or more sexual offence[2]** | **76** |
| **Total number of transgender prisoners in male establishments in March/April 2019[2]** | **129** |

(1) Other includes exposure, buggery, breach of a sexual risk order or sexual offences prevention order or sexual harm order, meeting a child following sexual grooming, arranging/facilitating the commission of a child sex offence, arranging/facilitating travel of another person with a view to exploitation, falsely imprisoning a person with intent to commit a sexual offence, causing a child to look at images of sexual activity, causing/inciting a child into prostitution/pornography, controlling prostitution for gain, attempting to cause/incite a girl aged 13 to 15 into penetrative sexual activity.

(2) Note that the bolded counts at the bottom of this table are person counts and will not sum to the offence counts provided above it. This is because it is possible for a prisoner to be sentenced to more than one offence.

## 3) Data on transgender prisoners house in the male prisons who 'identify as female'

Some of the data published within the HMPPS Offender Equalities report (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/848759/hmpps-offender-equalities-2018-19.pdf) is obtained by asking transgender prisoners what their 'legal gender' is. This self-reported 'legal gender' may not always be accurate and is not confirmed by checking any official records. While most transgender prisoners in men's prisons accurately reported their 'legal gender' as male, two reported their 'legal gender' as female. The most likely explanation is that these prisoners have provided false information because the report states that *"Prisoners who have already transitioned and have a full Gender Recognition Certificate are excluded from this dataset"* .

Any doubt regarding the sex of the transgender prisoners can be avoided by instead using the data on gender identity. When asked about the gender with which the prisoner identified 119 said they identify as 'female' (10 did not give a response). This means we can say with absolute confidence that at least 119 of the 129 prisoners in men's prisons were transwomen.

Even if all 10 transgender prisoners in men's prisons who did not confirm their gender identity were sex offenders this still means AT LEAST 66 of the 119 confirmed transwomen must have been sentenced for one or more sexual offences (55%)

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According to the data collection exercise conducted in April and May 2019:

- 62 of the 121 public and private prisons (51%) in England and Wales said that they had 1 or more transgender prisoner[11].
- There were 163 prisoners currently living in, or presenting in, a gender different to their sex assigned at birth and who have had a local transgender case board.
- Of these, 129 reported their legal gender[12] as male, 32 reported their legal gender as female and 2 did not state their gender. When asked about the gender with which the prisoner identified, 130 identified as female, 20 as male and 13 did not provide a response.
- Prisoners were asked to specify another identity[13] and 88 gave a response. 15 identified as gender-fluid, 8 as Transvestite, 7 as intersex, 6 as non-binary and the remaining 51 gave preferred not to say.
- 10 of the 163 prisoners reported their ethnic group as Black, Asian and Minority Ethnic Group and 152 as White, with 1 unknown.
- There were 34 transgender prisoners in women's prisons: 30 reported their legal gender as female and 4 as male. When asked about the gender with which the prisoner identified, 11 identified as female, 20 as male and 3 did not provide a response.
- There were 129 transgender prisoners in men's prisons: 2 reported their legal gender as female and 125 as male, with 2 not providing a response. When asked about the gender with which the prisoner identified, 119 identified as female, 0 as male and 10 did not provide a response.
- Based on this exercise, there were 2 transgender prisoners reported per 1,000 prisoners in custody.

Taken together, no matter which data variable is used, the result is that over half of the transwomen cohort identified as at least one conviction for sexual offending.

| Variable analysed: | Sex offenders/total | % sex offenders |
|---|---|---|
| Legal 'gender' is male | 74/129 | 57% |
| In a man's prisons | 76/129 | 59% |
| Female' gender identity | 66/119 | 55% |

# Appendix 2:

### Are our conclusions based on this data valid?

We have used the MOJ sex crime and transgender statistics to conclude that transwomen in prison exhibit a male-type pattern of criminality. However, it could also be argued that 76 transwomen with a sexual conviction is indicative of low female levels. This would be the case if lots of transwomen hide their transgender status in prison and so don't get included in the annual transgender count. It could be that transwomen on short sentences are more


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likely to hide their status in prison and do not request a transgender case review. This would skew the annual transgender count by selecting for prisoners on longer sentences and more serious crimes, meaning sex offending convictions are disproportionately represented.

There are about 80,000 men in prison in England and Wales. This represents about 0.34% of the adult male population. If transwomen exhibit a male-type criminality pattern we would expect to see the same 0.34% of the adult transwomen population in prison. Unfortunately no reliable data exists for the size of the transgender population in the UK but estimates have ranged up to as many as 500,000. If we assume the transgender population is distributed according to location, sex and age similarly to the UK population as a whole this estimate would mean there would be up to 180,000 adult males who identify as transgender in England and Wales. Based on that scenario we'd expect to see 612 in prison (0.34%) meaning that as many as 4 in 5 male-born transgender prisoners are not revealing their trans status. This is likely to be a significant over-estimate, but if this were the case then 76 trans sex offenders would still represent 12% of transwomen prisoners in men's prison and a much higher rate of offending than the low level observed for women in prison of just 3%.

In fact, there would need to be at least 2317 transwomen in prison for the figure of 76 transwomen sex offenders to reflect the lower female levels of sex offending of 3%. For this to be true as many as 95% of all transwomen sent to prison would need to be hiding their trans status when sent to prison. There is no evidence to suggest such a large level of under-counting exists.

*UPDATE 13/01/21: In a recent report by Bent Bars (page 12) (https://uploads-ssl.webflow.com/5f008e177bc6f82d3047d132/5fccb7f83e0fae043ce1b2b8_BB_TIS_2.pdf) it is claimed there could be up to 1600 trans prisoners in prison, meaning sex offending levels in 2017/18 represent just 4% of the trans population. This is based on on a Prison Inspection report that estimates 2% of the male prison estate is transgender (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/814689/hmip-annual-report-2018-19.pdf). (Appendix 6, page 116, Survey question 19.7). It should be noted that the Prison Inspection report marks the 2% figure as "not significant and may have occurred by chance".*

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**Taken together we conclude that this analysis of official MOJ statistics provides good evidence that transwomen in prison exhibit a male pattern of criminality and do not exhibit a female pattern of criminality. Crime patterns correlate with birth sex and not gender identity. This supports the idea that, when a women-only space is needed to protect against the physical and psychological impact of sex crimes, access should be based on birth sex and not gender identity. All males should be excluded, including males who identity as women.**

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## Prisons, crime and protecting women

The facts about transgender prisoners (https://fairplayforwomen.com/transgender-prisoners/)

Karen White & prison review (https://fairplayforwomen.com/prison-review/)

Sex attacks in female prisons (https://fairplayforwomen.com/sex-attacks-mps-must-investigate-risks-of-transgender-prisoners/)

Female inmate suing the government (https://fairplayforwomen.com/why-female-inmate-suing-government-transgender-prisoners/)

Refuge shelters deeply worried (https://fairplayforwomen.com/rebirth/)

How do women in prison feel about sharing with transgender prisoners? (https://fairplayforwomen.com/insidetime/)

Can you believe what you read about sexual and violent crimes? (https://fairplayforwomen.com/ipso/)

Factsheets (https://fairplayforwomen.com/factsheets/)

## Sport and the human body

Biological sex differences (https://fairplayforwomen.com/biological-sex-differences/)

Chromosomes, sex and gender (https://fairplayforwomen.com/chromosomes-biological-sex-gender/)

Guidelines for single-sex sport policy (https://fairplayforwomen.com/sport_policy/)

A scientist reviews the IOC's transgender inclusion policy (https://fairplayforwomen.com/emma_hilton/)

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The science and statistics behind the transgender debate (https://fairplayforwomen.com/science-statistics-behind-transgender-debate/)

Safeguarding in sport still matters (https://fairplayforwomen.com/safeguarding_sport/)

Testosterone reduction policies (https://fairplayforwomen.com/compliance/)

Rachel McKinnon transwoman cyclist (https://fairplayforwomen.com/mckinnon/)

You can help (https://fairplayforwomen.com/donate/)

## Making policy and the law

The Equality Act 2010 and women's rights (https://fairplayforwomen.com/equality-act-2010_womens-rights/)

GRA reform (https://fairplayforwomen.com/campaigns/gra-reform/)

Advice and guidance for policy makers (https://fairplayforwomen.com/policy-guidance/)

Equality impact analysis advice (https://fairplayforwomen.com/mbm/)

Public Sector Equality Duty (https://fairplayforwomen.com/equality-act-2010_womens-rights/#jump2)

Changing room policy advice (https://fairplayforwomen.com/changing_rooms/)

Scottish Government omits women's evidence (https://fairplayforwomen.com/eqia/)

The Scottish bill that stole the word woman (https://fairplayforwomen.com/scottish_stole_woman/)

What can I do now? (https://fairplayforwomen.com/equality-act-2010_womens-rights/#jump10)

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# Unreliable Narrators

Dave Hewitt
Mar 26, 2021

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On March 24th, 2021, SNP MP John Nicolson recounted the story of being abused by an organisation he has repeatedly described as “sinister”, “far-right” and a “hate group” with “dodgy funders”. The transcript of the video is below:

**JOHN NICOLSON M.P.**
@MrJohnNicolson

When I praised a young, trans constituent of mine who bravely spoke of her life last year, the sinister LGB Alliance offered rewards of retweets to anyone who donated money to it in my name. I was, as a result, deluged by abuse. @Twitter has failed to act against the hate group.



March 24th 2021

**369** Retweets **1,237** Likes

> I've had a wee taste of it myself recently. I praised, online, a young trans constituent of mine last year who had bravely spoken of her life in a BBC documentary.
>
> Almost instantly, a sinister organisation called the LGB Alliance began trolling me. They offered the reward of a retweet to anyone who donated money to it in my name.

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> I was as a result deluged by abuse from anonymous accounts. I was called a rape enabler, a misogynist, and - although I am an openly gay man - a homophobe.
>
> As an openly gay man I was also called a "greasy bender". The organisation concerned, the LGB Alliance, was thrown off the country's two largest crowdfunders as a hate group.
>
> But Twitter wouldn't take their account down, despite clearly and egregiously violating Twitter's own rules.
>
> I'm a man in my 50s, the experience wasn't pleasant, but I was acutely conscious of all the young trans people reading the venom and despairing.

That sounds appalling, I would never condone abuse, and I have sympathy for anyone on the receiving end. However, this is not my recollection of these events, which I watched unfold at the time.

While I am sure that Nicolson firmly believes his account of events, my intention here is to reconstruct the timeline a little and present an alternative view of what happened.

## April 15th & 16th 2020

The Tweet that Nicolson refers to as the precipitating factor is here:



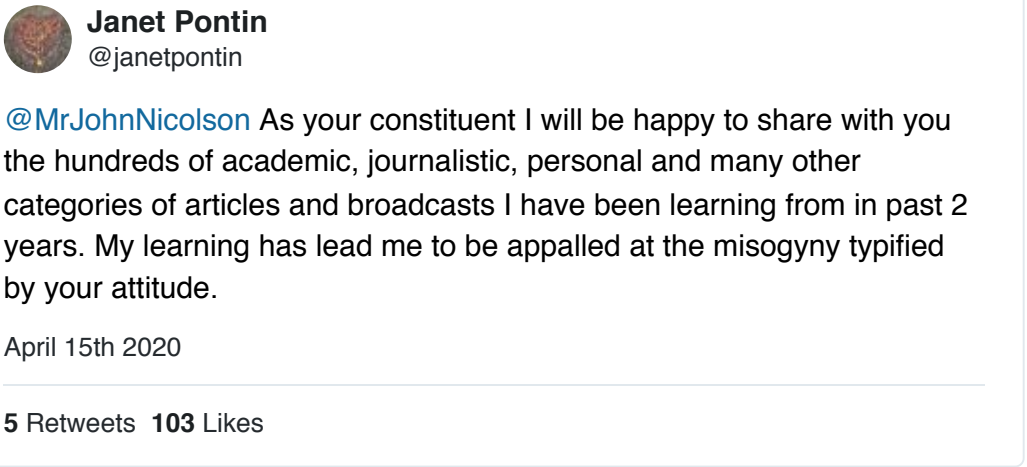

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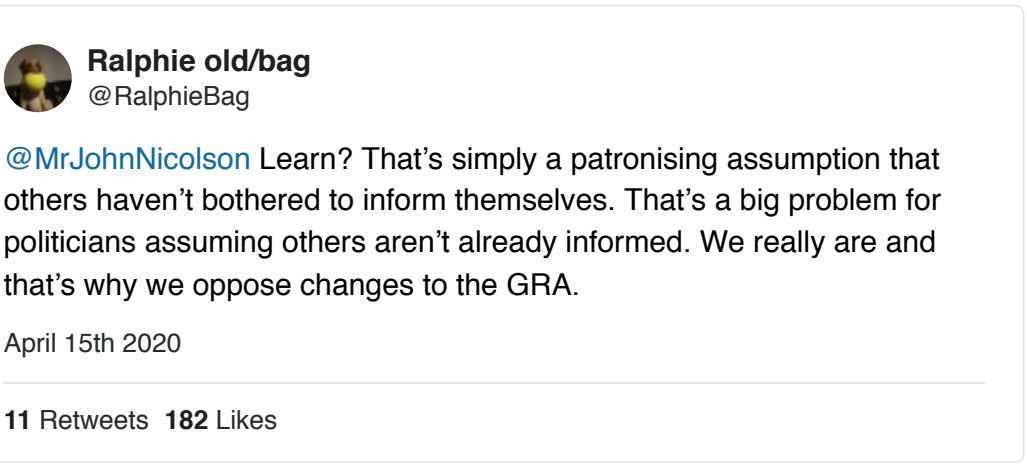
April 14th 2020

**24** Retweets **66** Likes

Note that John has used multiple hashtags. This will obviously increase the visibility of a tweet for any trending topics - that is what they are for after all, to promote your tweet beyond merely your own followers.

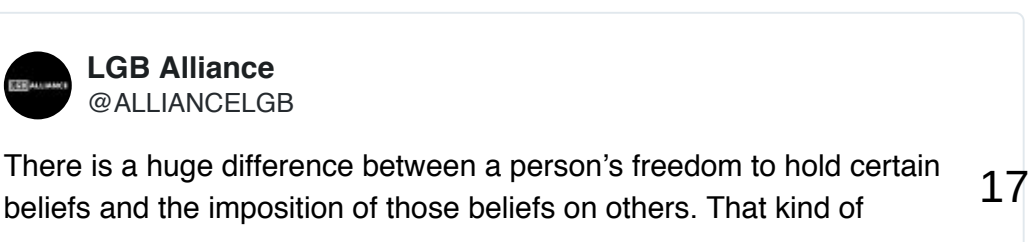
As a result, he got hundreds of replies to his original tweet, most of which looked like this:




In the account in the video at the head of this piece he claims he was trolled, but none of that really leaps out at me when I read the thread. The responses mostly read like people sick of not being listened to, or of having their positions and motives impugned trying to get a politician to engage. John didn't reply to any of them as far as I can tell.

None of these responses are from the LGB Alliance either. On the 16th, a full day after the original tweet, they did quote one of the replies:



coercion is no more acceptable than mandating a belief in, or teaching of, a particular religious doctrine. #SexNotGender

> **Chocolatey** 🍒💚 💜 **#WomenWontWheesht** @BlomshellII
> @MrJohnNicolson Trans people's views about their own identity are perfectly valid. What ISN'T valid is demanding I share those views & punishing me when I refuse. What ISN'T valid is telling children that if they don't adhere to stereotypes they should take harmful drugs. What ISN'T valid is...

April 16th 2020

**63** Retweets **289** Likes

That is the extent of their interaction, and this is **a day later**. This is hardly precipitating a pile-on and it is certainly not instantaneous.

So what was the LGB Alliance doing on April 15th? Well mostly tweeting about LGB movies, which they did dozens of times. Aside from the tweet above they had nothing further to do with Nicolson.

Next, Nicolson tweeted this challenge to a now-suspended account:



**JOHN NICOLSON M.P.**
@MrJohnNicolson

Hi Stuart. Keen to have you on my radio show to advance your “all trans women are really men” position. Would you be free to debate the distinguished author Jan Morris on air and tell her she’s really a man? On @talkRADIO ? Open invitation. https://t.co/kLHLKnNY10

April 15th 2020

**20** Retweets **82** Likes

And the replies were full of this sort of response:



**serialsockthief**
@serialsockthief

@MrJohnNicolson @talkRADIO Have you asked any females who disagree with you to join your show and discuss this? Call me awkward if you must but two men arguing about what a woman is probably isn’t the best idea.

April 15th 2020

**29** Retweets **481** Likes



**Julie Smith Haunted Womb**👻
@lazyjoolz

@MrJohnNicolson @talkRADIO There are women who have engaged with this issue for years. Instead of a shout out for men to come and have a ding dong in a radio studio, why not plan a properly researched programme and invite speakers with expertise and knowledge to discuss the issue.

April 16th 2020

**3** Retweets **39** Likes



**CarrieD**
@Carriedenne1

@MrJohnNicolson @talkRADIO I love it. You want 3 men discussing what a woman is. It beggars belief. @joannaccherry @JoanMcAlpine @HotchkissRhona

April 16th 2020

**14** Retweets **207** Likes

These responses being a clear continuation of those to the April 15th tweet, and again nothing orchestrated - just many of the same connected accounts replying and retweeting each other.

## April 18th 2020

It is not until April 18th that the LGB Alliance directly @ John Nicolson, and even then, only in response to someone else:

**LGB Alliance**
@ALLIANCELGB

@MichaelSturrock @helenstaniland @MrJohnNicolson @JUProctor @EHRC @amnesty @clanchildlaw @rapecrisisscot @EqualityinHE How about you listen to LGB Alliance? Probably the first lobby group ever to campaign for the existing law to be implemented correctly. Don't be fooled by tax funded propaganda machines pushing theories which are unscientific and damaging. Unless you prefer fantasy over fact?

April 18th 2020

**18** Likes

We are now 3 days since John's original tweet about a "young trans constituent", and LGB Alliance still have not orchestrated a pile-on.

## April 20th 2020

On April 20th, John tweeted the following:

**JOHN NICOLSON M.P.**
@MrJohnNicolson

Having been on the receiving end of a Twitter pile on by the sinister transphobic @ALLIANCELGB a joy to catch up with this superb @BBCsarahsmith interview on #bbcnewsnight




**Father Ted creator Graham Linehan on trans rights - BBC Newsnight**
Father Ted writer Graham Linehan says his online campaign against what he calls 'trans rights activists' has made him the 'most hated man on the internet'. S...
youtu.be

April 20th 2020

**25** Retweets **140** Likes

He then **reposted** the documentary about the trans teen, six minutes after calling the LGB Alliance sinister and transphobic and blaming them for a pile-on.

**JOHN NICOLSON M.P.**
@MrJohnNicolson

On again just now on TogetherTV as it was last week when I posted this. Lovely documentary - lots of kind men and women in my constituency filled with common sense. #transrightsarehumanrights

> **JOHN NICOLSON M.P.** @MrJohnNicolson
> Immensely moving documentary. Opponents of the #GRA will, I hope, watch and learn. #trans #lgbt https://t.co/rSxHCzWbWP

April 20th 2020

**2** Likes

And went on to have a lengthy back and forth with Jonathan Ross:



**JOHN NICOLSON M.P.**
@MrJohnNicolson

@wossy @StewartMcDonald Shall we hold a public debate on this Jonathan?

April 20th 2020

**14** Likes

Meanwhile his tweet calling the LGB Alliance transphobic and sinister again generated hundreds of responses, many of which looked like this:



**Gavin Barrie** 🏳️‍🌈🦌🏴‍☠️👫🎮
@jammach

@MrJohnNicolson @ALLIANCELGB @BBCsarahsmith John,
@ALLIANCELGB are neither sinister, nor transphobic.
I'm an old hand #LGBT rights activist who has attended their meetings.

They are very nice, decent, open minded people.

If you want to discuss this, DMs are open too.

April 21st 2020

**21** Retweets **205** Likes




It is hard to assess a mass interaction like this objectively. Twitter does not present the same neutral view of information to everybody. I am sure there is some abuse in there, and some that has been taken down since, and I'm positive that it is deeply unpleasant to receive more notifications than you can keep track of.

But this still isn't an orchestrated pile-on by the LGB Alliance. While all this was going on, they were tweeting threads like this:

> **LGB Alliance**
> @ALLIANCELGB
>
> We have been trying to have a fact-based and respectful conversation for a long time. In this week of solidarity we say — if not now, when? #lesbianstrength #lesbianvisibility #lesbiannotqueer #lesbianvisibilityweek /4of4
>
> April 20th 2020

1769

**7** Retweets **103** Likes

John Nicolson simply experienced being the focus of attention of people via their social connections - which is exactly what Twitter is designed to do. Once he had added hashtags that brought his April 15th tweet to wider notice than just his followers, Twitter's network effects did the rest, attracting similarly-minded responders via replies and retweets. That's all. Most people will have seen their own interactions, and those that seemed reasonable to them, making John's responses (or lack thereof) seem completely unreasonable. John meanwhile will have been deluged with confrontational responses, and doubtless felt under siege. Whatever abuse was there will understandably have been what attracted his attention. Perhaps even reasonably intended requests were perceived as abusive, just because of the sheer volume of them.

In all this there was barely any contact with the LGB Alliance, until John called them sinister and transphobic, without any evidence, and blamed them for his pile on of the previous six days - thus generating even more incredulous responses from people who:

1. Don't believe the LGB Alliance are sinister or transphobic
2. Don't believe they were responsible for a pile-on, and
3. Can't quite believe an MP is making such baseless statements

John Nicolson continued into the night and early hours of the next morning, mostly arguing with Jonathan Ross, and suggesting that the LGB Alliance were sinister again, holding them responsible for multiple pile-ons, implying that they would have supported section 28, and calling the people responding to him a "transphobic army".



**JOHN NICOLSON M.P.**
@MrJohnNicolson

@rowan9sam @StewartMcDonald No they should not. Given the polls at the time there would have been huge support for keeping Clause 28. But who'd support it now. Well apart from the LBG Alliance I imagine....

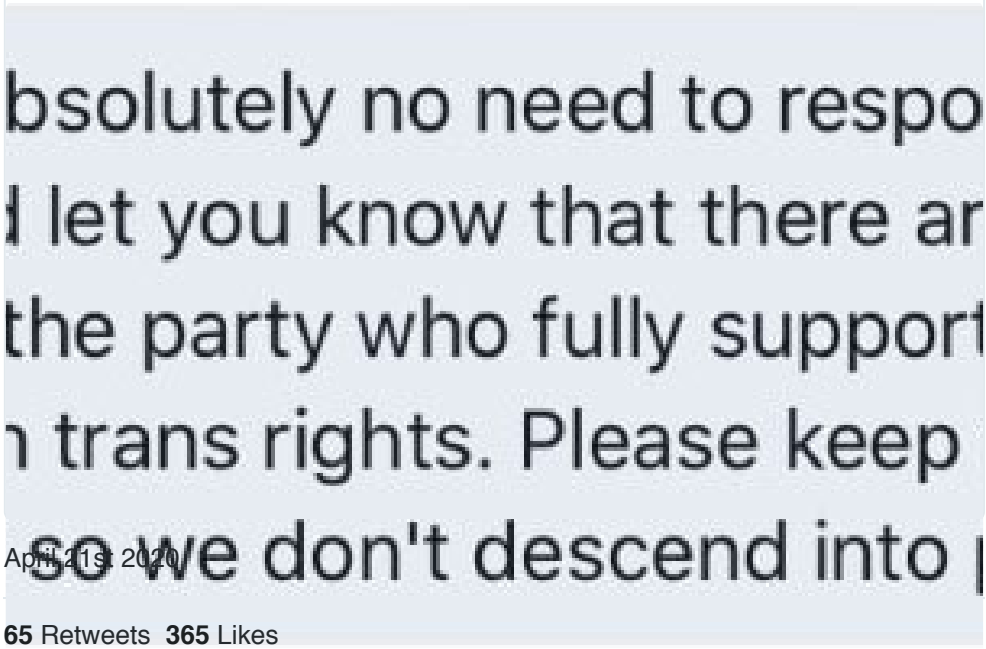
April 20th 2020

**2** Retweets **28** Likes



**JOHN NICOLSON M.P.**
@MrJohnNicolson

Women who support #LGBTQ rights can often feel bullied by all the transphobic pile ons from the sinister @ALLIANCELGB (whoever they are). Here's one of many messages I've had. tonight. Name withheld out of fear of intimidation.




**JOHN NICOLSON M.P.**
@MrJohnNicolson

@balibarney @PirateMute @wossy (Though I do tend to prioritise real people - not pseudonym like you with 13 followers.) That said I know you guys are the backbone of the transphobic army.

April 21st 2020

**1** Retweet **5** Likes

## April 21st 2020

At 10am on April 21st, 6 days after John Nicolson's tweet about a trans constituent we finally arrive at the point where the LGB Alliance start to solicit donations. During all this time he had been receiving large numbers of organic traffic angered by his behaviour, his dismissal of concerns, his insults and now his unsubstantiated attack on the LGB Alliance. Up to now the responses had comprised a mix of reasoned engagement and increasing amounts of outright hostility and exasperation. Responders spontaneously began donating to the LGB Alliance crowdfunder in John Nicolson's name - and once it started, the LGB Alliance simply amplified it. The following link is a thread containing dozens such messages:

**LGB Alliance**
@ALLIANCELGB

To everyone who is annoyed by the defamatory remarks made about us by the MP (really!) @MrJohnNicolson, who clearly doesn't have a clue

who we are or what we do: please make a donation to us IN HIS NAME and we will tweet out your message.” #FactsNotLies

April 21st 2020

**294** Retweets **1,034** Likes

## April 24th - 30th 2020

On April 24th, John Nicolson tweeted Janey Godley, and again blamed the LGB Alliance for a pile-on.



**JOHN NICOLSON M.P.**
@MrJohnNicolson

Janey is such a loyal ally against the transphobes. Consistently on the side of gay rights & human rights. Sorry to hear that, as a feminist, she’s being bullied by the sinister @lgballiance #TransRightsAreHumanRights

> **Janey Godley** @JaneyGodley
> Big love to all the transpeople getting trolled again - I support transpeople -
>
> please don’t send me your tweets to try and convince me otherwise and please DO NOT send
> “I too support transpeople but...” I will block you https://t.co/kYGdKtsLGS

April 24th 2020

**8** Retweets **28** Likes

This then descended into spreading conspiracy theories about US far-right involvement without any basis (their timeline contained no evidence of whatever it was that John Nicolson thought would be substantiated there), claiming they wrote “angry” tweets, and copying in Police Scotland:



**JOHN NICOLSON M.P.**
@MrJohnNicolson

@ClareWi11665062 @JaneyGodley @ALLIANCELGB Yes, check out their Twitter time line. Multiple donations from far right American homophobes. And a deeply creepy pile on citing me. Weird.

April 24th 2020

**3** Retweets **41** Likes



**JOHN NICOLSON M.P.**
@MrJohnNicolson

@ClareWi11665062 @JaneyGodley @ALLIANCELGB And tens of thousands of pounds raised for as yet unclear purposes. Well worth any independent journalist checking. Who writes their angry tweets? And where is their money going? Sinister and suspicious.

April 24th 2020

**3** Retweets **38** Likes



**JOHN NICOLSON M.P.**
@MrJohnNicolson

The transphobic @ALLIANCELGB is raising tens of thousands of pounds. Much of it comes from far right sources abroad. And there are multiple pseudonyms donating. Who is getting the cash? How is it being being spent? Are accounts available? @policescotland

> **JOHN NICOLSON M.P.** @MrJohnNicolson
> @JaneyGodley @ClareWi11665062 @ALLIANCELGB I don't think so. So deeply dodgy. Will @ALLIANCELGB publish accounts. Who is getting all the cash?

April 24th 2020

**84** Retweets **280** Likes

The LGB Alliance reached out to try to open dialogue, without success.

**LGB Alliance**
@ALLIANCELGB

Hello @MrJohnNicolson. Kate Harris from LGB Alliance here. We're always pleased when MPs are interested in our work. We're happy to share as much information as you'd like. DM or email me & let's set up a Zoom meeting. Pls invite @JaneyGodley - we are huge fans #FactNotFiction

> **JOHN NICOLSON M.P.** @MrJohnNicolson
> The transphobic @ALLIANCELGB is raising tens of thousands of pounds. Much of it comes from far right sources abroad. And there are multiple pseudonyms donating. Who is getting the cash? How is it being being spent? Are accounts available? @policescotland https://t.co/fhPG4wug17

April 25th 2020

**117** Retweets **580** Likes

Meanwhile donations continued to come in, further mocking John's behaviour:

**LGB Alliance**
@ALLIANCELGB

Thanks to our donor Rob, who writes: “I wanted to chip in after seeing all the other donations made by decent LGB men and women and their allies in response to John Nicolson’s attacks.”

April 26th 2020

**3** Retweets **30** Likes

**LGB Alliance**
@ALLIANCELGB

Thanks to the anonymous donor who writes: “In honour of John Nicolson. Lesbians have the right to organise on the basis of same sex attraction.”

April 25th 2020

**5** Retweets **36** Likes

**LGB Alliance**
@ALLIANCELGB

Should we send @MrJohnNicolson an #LGBAlliance t-shirt for his sterling fundraising effort on our behalf?

April 26th 2020

**2** Retweets **29** Likes

Which is all quite understandable on an individual level because if you think an MP is making an idiot of himself then this sort of mockery can seem like harmless needling. To each person donating it seems minimal enough, but to the target it no doubt feels like a torrent of criticism. As such, by April 29th, the fundraiser had been taken down for targeted harassment.



**JOHN NICOLSON M.P.**
@MrJohnNicolson

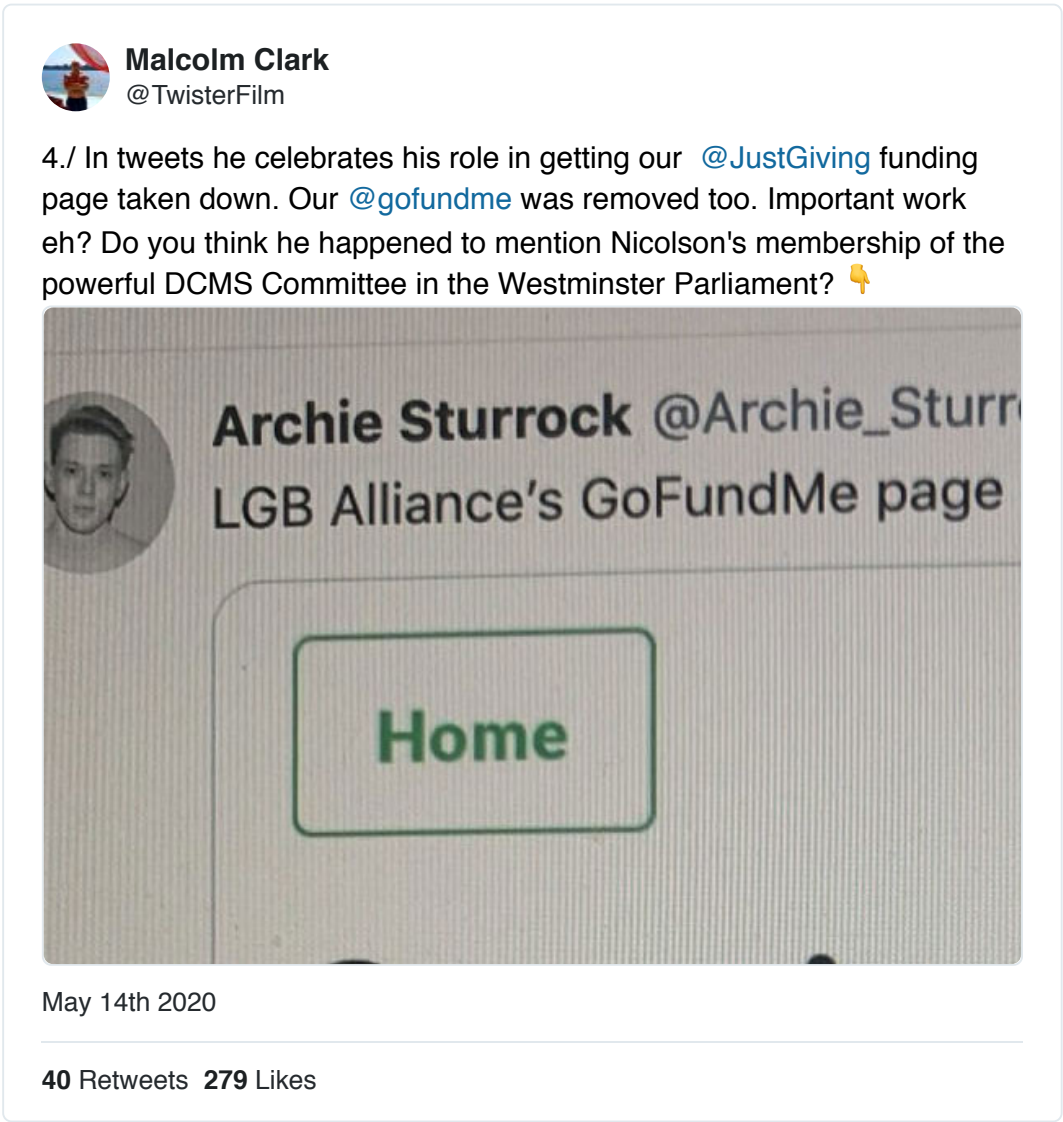
Thanks David. The bullies don’t win when we stand together. #LGBT

> **David Paisley** @DavidPaisley
> Amazing news #2 📰
>
> The @GoFundMe set up by LGB Alliance after their @JustGiving page closed has now ALSO been shut down!
>
> Well done all who reported 👏
>
> And special thanks to @MrJohnNicolson & his team for all their work supporting trans rights & helping shut down these pages 💜
> https://t.co/ng2DW0PyeG

April 30th 2020

**27** Retweets **182** Likes

Over this period there were several replies about the crowdfunder from Archie Sturrock, one of John Nicolson's staff, but those tweets have all been deleted so little remains apart from screenshots, such as this one:

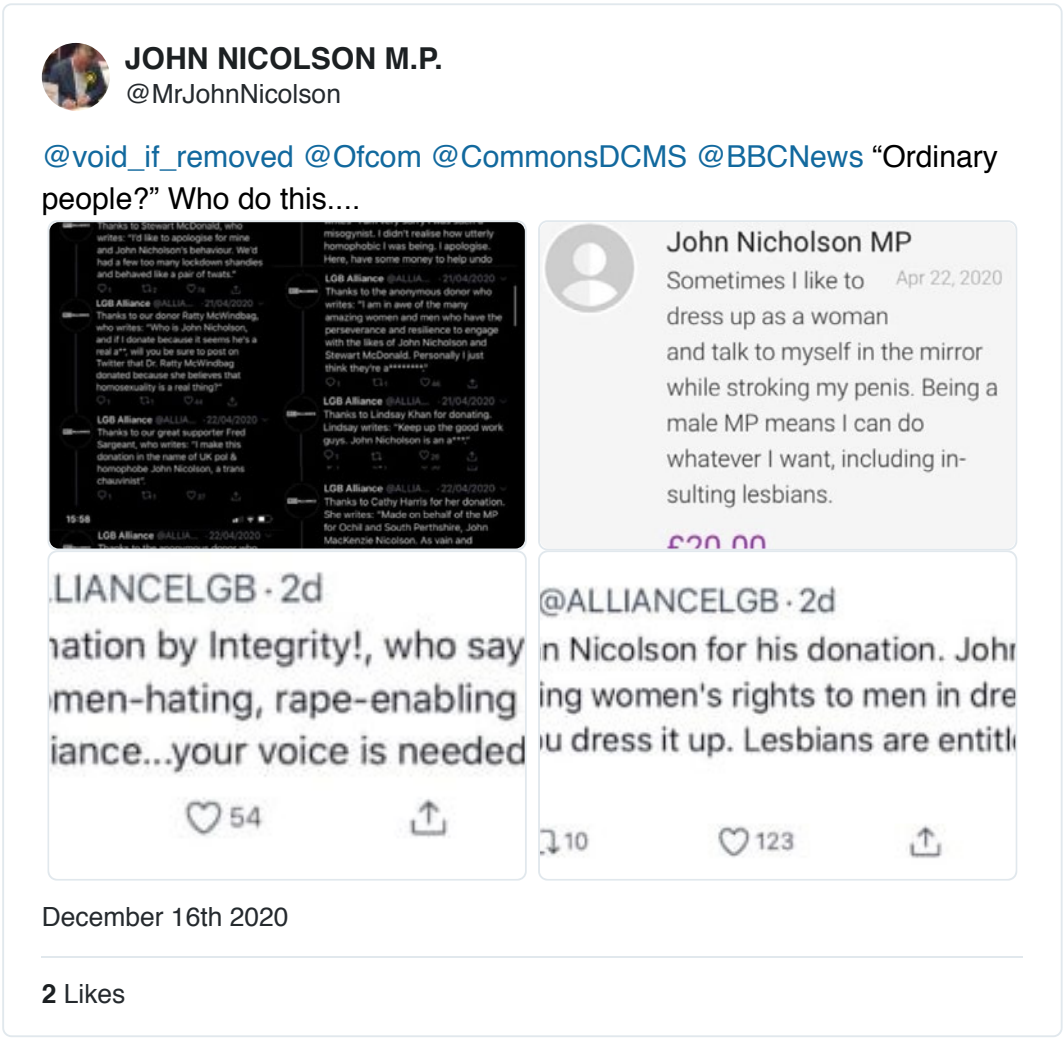



## Aftermath

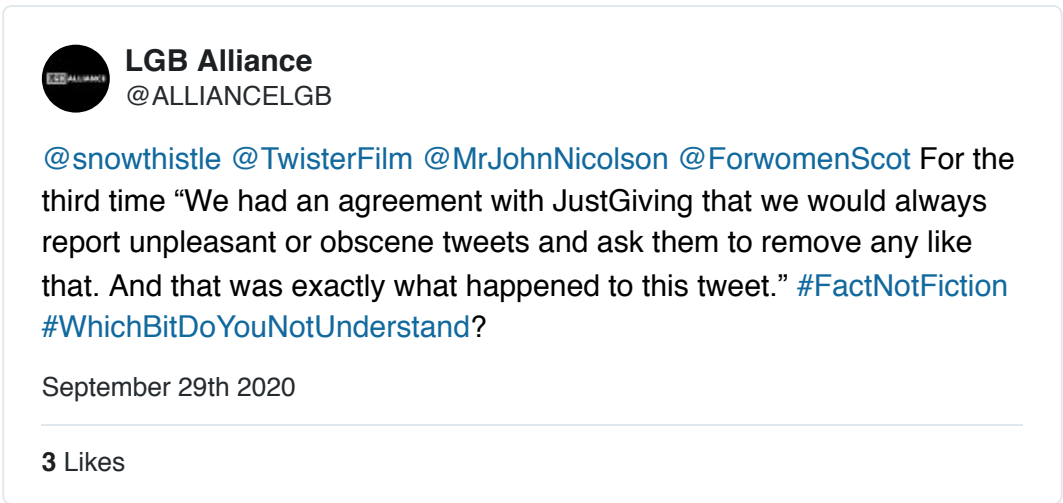
Since then, John Nicolson has on a few occasions produced images of the abuse from the crowdfunder to illustrate what he was subjected to, to justify his initial unsubstantiated assertions about the LGB Alliance and label them a "hate group".

However, I think it is worth actually reading the comments, which are mostly mockery or frustration. The ones screenshotted here are the absolute worst that could be found - the vast majority, of dozens upon dozens, were completely benign. Even in these images that so offend

John, there is nothing abusive about saying that lesbians can assert same-sex attraction, and the third image is a repeat from the first. The second image is by far the worst, but merits closer inspection:




You'll note the format of the second image is different. This is because it was **not** retweeted by the LGB Alliance - rather, it is an abusive message left on the crowdfunder, that the LGB Alliance asked JustGiving to remove once it appeared.



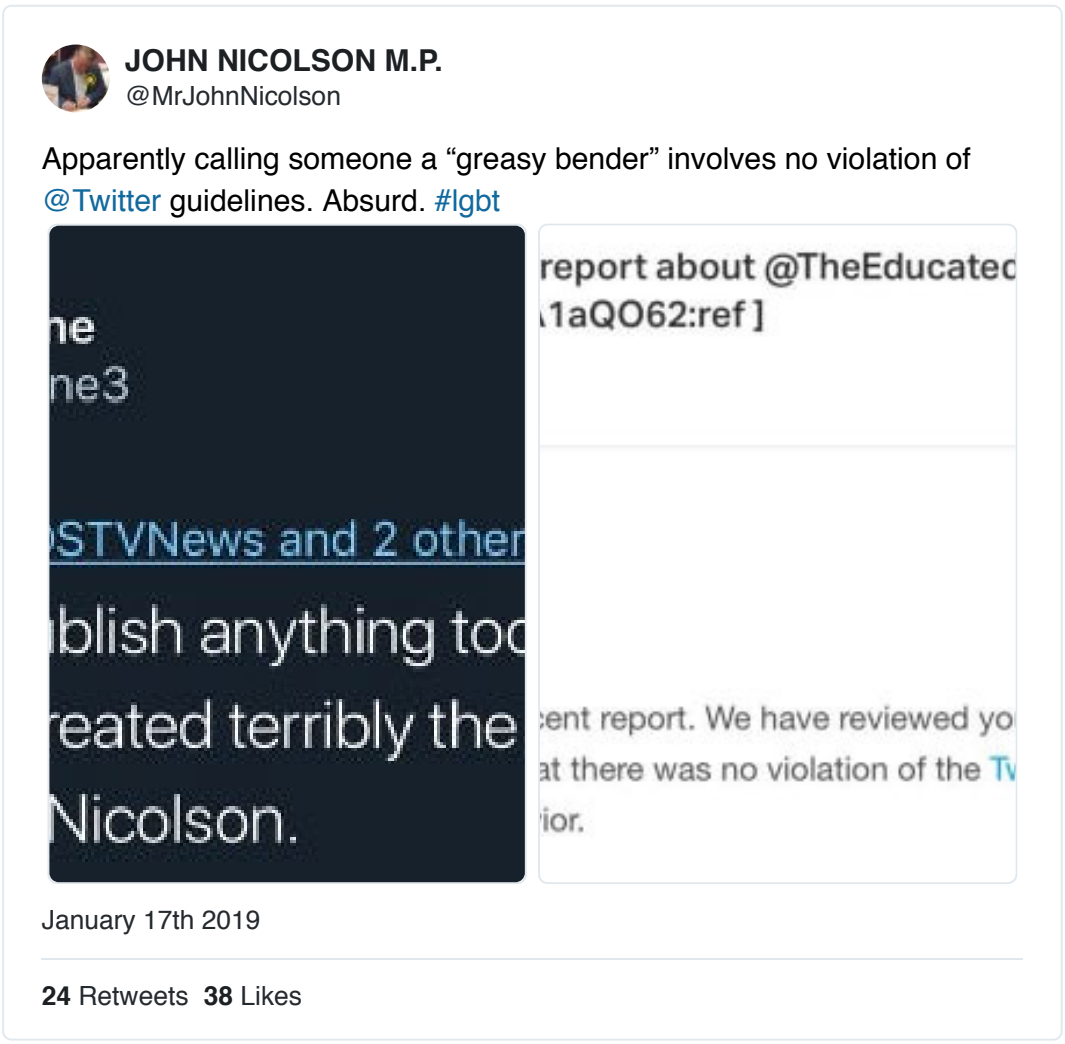

The tone of this removed comment is markedly different to even the most swear-filled ones that were retweeted. While there is no proof whatsoever that this was left maliciously, it can't really

be ruled out.

It could be a genuine supporter with hateful views. Or someone who thought it was worth £20 to see if they could actually get the LGB Alliance to retweet something that creepy. Or it could be disinformation, and £20 is a small price to discredit the LGB Alliance and get their fundraising shut down. There is no way to know, but the actions of the organisation in not retweeting it and trying to get it taken down of their own volition would certainly dispute John's framing.

At no point could I find any response calling John a "greasy bender", as alleged. It is possible this happened, and such appallingly hateful language was rightly removed from twitter in the last year.

Or it is possible John is referring to this incident in 2019, 10 months before the formation of the LGB Alliance:



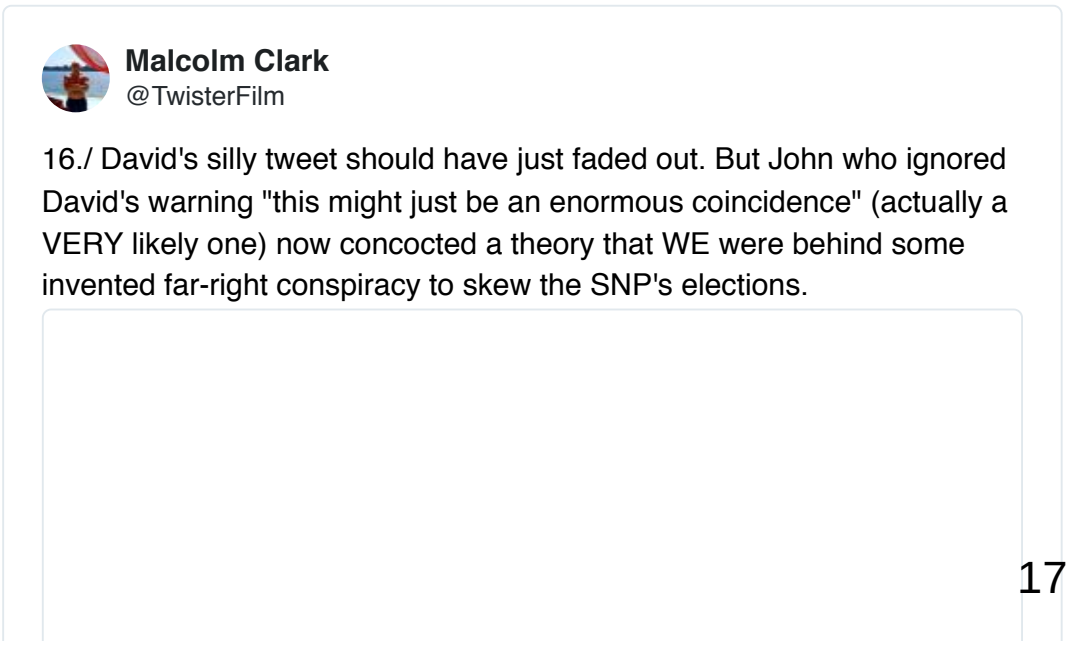

## Summary

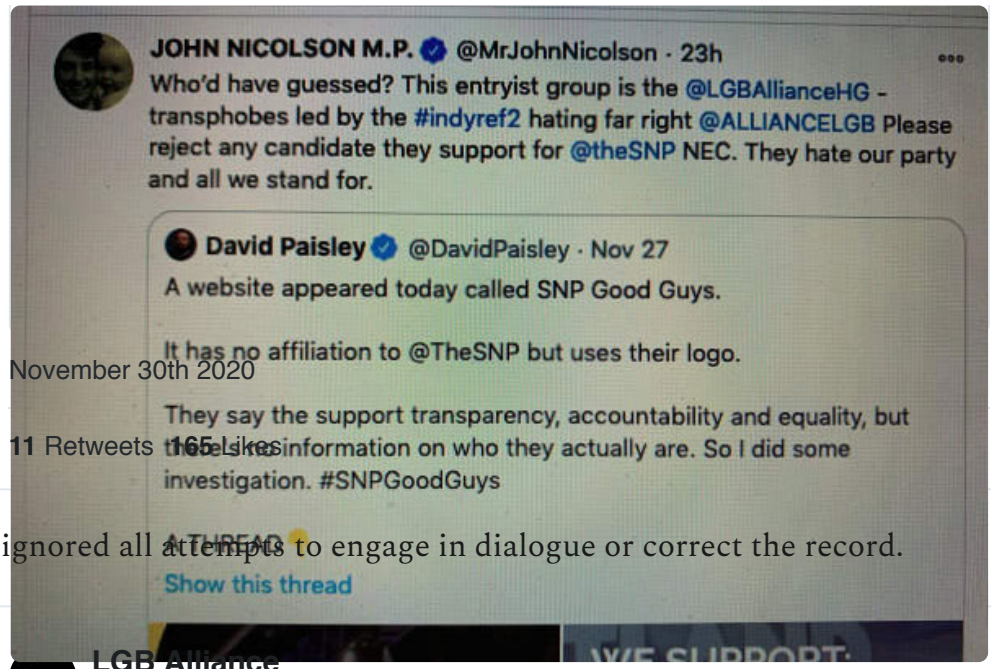
Which brings us to the end of the sequence of events John referred to in the video. So, in summary:

- It was 6 days between tweeting about the documentary and the LGB Alliance encouraging donations in John's name.
- The traffic John received from that tweet was organic, initially from the hashtags he used to encourage engagement.
- Whatever pile-on he experienced was a result of Twitter's engagement model, not anything orchestrated.
- The replies he got were largely reasonable individually, with some impatience and hostility over the subsequent days due to perceived lack of response (eg. ignoring hundreds of women who felt they were asking fair questions, but having time to exchange a couple of dozen tweets with a male celebrity)
- The precipitating event for the LGB Alliance involvement was John calling them sinister, transphobic and far right, as well as blaming them for the replies he was getting.
- This led to mockery in the replies, and donations in his name on the crowdfunder, which the LGB Alliance then started to retweet.
- The majority of comments on the crowdfunder were uncontroversial. The worst comment was removed at the request of the LGB Alliance, and its provenance is unknown.
- John's implication that he was called a "greasy bender" as a result of the LGB Alliance cannot be substantiated, and it seems possible that it is a reference to an earlier, unrelated incident.

Hopefully this sheds some light on events. It is certain that the timeline I have pulled out is not truly authoritative or free of bias, but even taking that into account, I don't believe John Nicolson's description of this incident in the video is fair or accurate.

Additionally, in the year since these events, John Nicolson has continued to repeat unsubstantiated smears, such as accusations of engineering far-right entryist interference in an SNP election:






November 30th 2020

**11** Retweets **165** Likes

So far he has ignored all attempts to engage in dialogue or correct the record.

**LGB Alliance**
@ALLIANCELGB

@MrJohnNicolson As you can easily check we have nothing whatsoever to do with the far right or the religious right and are not a hate group. This is offensive not just to us but also to our supporters. It is very unedifying for an MP to spread defamatory gossip in this way.

November 21st 2020

**2** Retweets **36** Likes

**LGB Alliance**
@ALLIANCELGB

@MrJohnNicolson Hello John - sinister LGB Alliance here. As we've pointed out before, a quick look at our website will reveal that the Directors are Malcolm Clark, Kate Harris, Bev Jackson and Ann Sinnott. And as stated previously we are happy to Zoom or come on your show anytime. #FactsMatter

December 18th 2020

**12** Retweets **166** Likes

## Coda

Twitter is a truly awful platform for informing us about the present or the past, but a great one for making us fervently believe whatever we are shown. Twitter shows none of us anything close to an objective and balanced view of what is happening. Instead we see a personalised one tailored to flatter our sense of ourselves and our place in a group, or to drive us into polarised bunkers.

Hence it is entirely possible for people to be presented with the same sequence of events and experience it in totally opposing ways. Our prior beliefs shape the information we subsequently receive. If we have bias, Twitter amplifies it - and we all have bias.

Not only that but because the past is mutable, with tweets and accounts being deleted and expunged from the record, it becomes impossible to see fully what the past was. Thus the present is ephemeral and personalised.

200 million different views of now, all tailored to us, presented in a way designed to make us accept it without thinking, lost once we have seen it, and none of it operating in our interest.

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← **Tweet**



**JOHN NICOLSON M.P.**
@MrJohnNicolson

Replying to @LGBAlliance_USA

They do. Why not explain how, as a far right hate group, you've been expelled from the UK's biggest crowdfunder sites? They out you as a #transphobic hate group. And you can remind correspondents how and why you're not allowed charitable status. Again ... as a hate group...

1:10 AM · Nov 21, 2020 · Twitter for iPhone

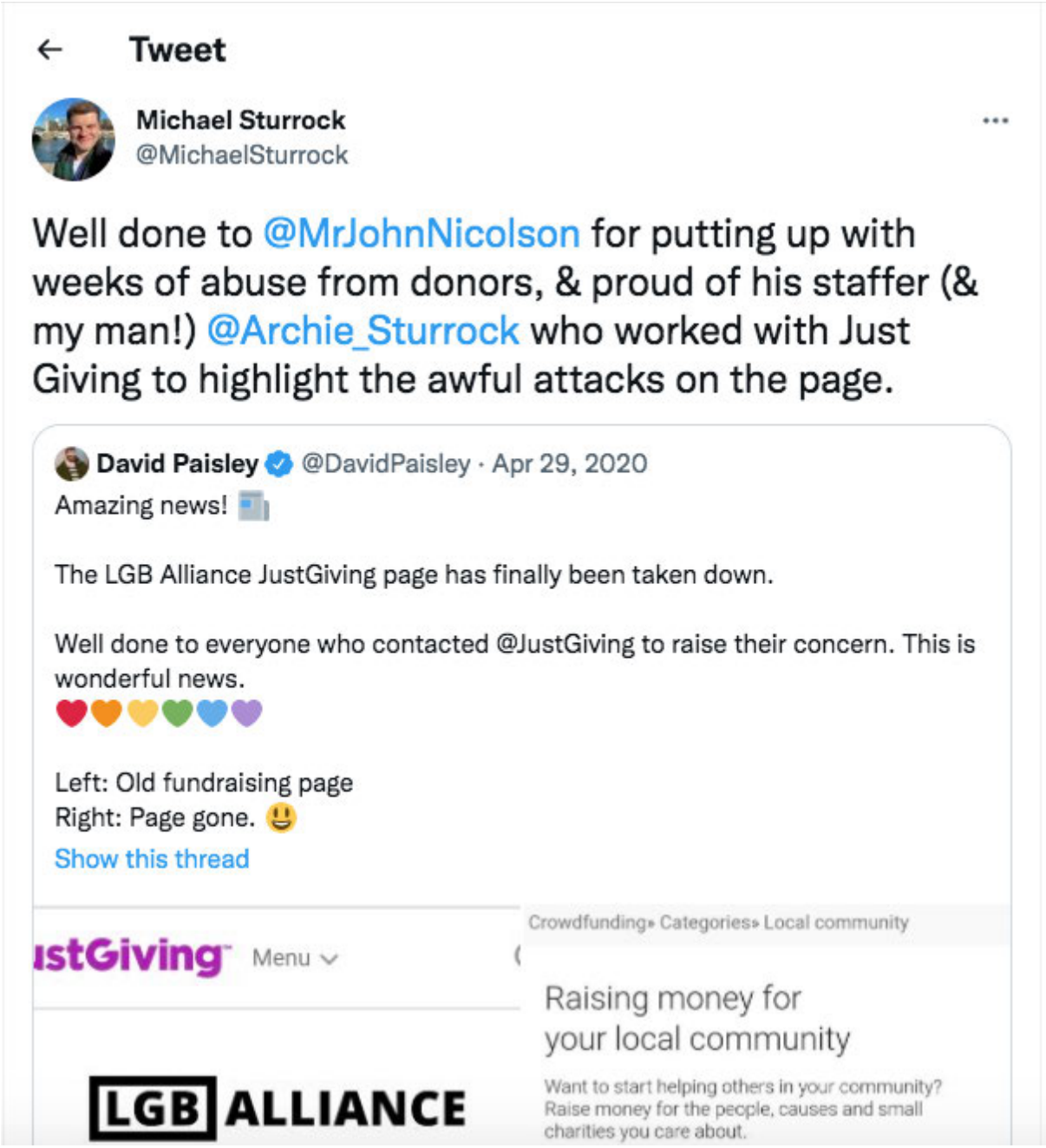


**JOHN NICOLSON M.P.**
@MrJohnNicolson

Replying to @Nicholson_420

Bigots are seldom bright. It had a positive impact though. The sinister LGB Alliance, which was directing the pile on, had its crowdfunder taken down as a hate group directing targeted abuse.

2:52 PM · May 17, 2020 · Twitter Web App


Tweet
Michael Sturrock
@MichaelSturrock
Well done to @MrJohnNicolson for putting up with weeks of abuse from donors, & proud of his staffer (& my man!) @Archie_Sturrock who worked with Just Giving to highlight the awful attacks on the page.
David Paisley @DavidPaisley · Apr 29, 2020
Amazing news!
The LGB Alliance JustGiving page has finally been taken down.
Well done to everyone who contacted @JustGiving to raise their concern. This is wonderful news.
Left: Old fundraising page
Right: Page gone.
Show this thread
istGiving Menu
LGB ALLIANCE
Crowdfunding› Categories› Local community
Raising money for your local community
Want to start helping others in your community? Raise money for the people, causes and small charities you care about.

# Fact Checking Oz Katerji

Dave Hewitt
Feb 11, 2021

86

On February 9th 2021, freelance investigative journalist Oz Katerji started a lengthy thread on twitter about his support for trans rights.

As part of this he made repeated false assertions in a manner that should raise alarm bells with anyone who cares about honest conversation.

In this piece I want to look at just one single claim in detail, explain why he is incorrect, and show how when we come to believe ourselves “good” and opposition “bad” it is all too easy to bend reality in service of defending our self image.

The initial thread took a combative tone from the outset, and generated exactly the sort of argumentative replies you would expect:

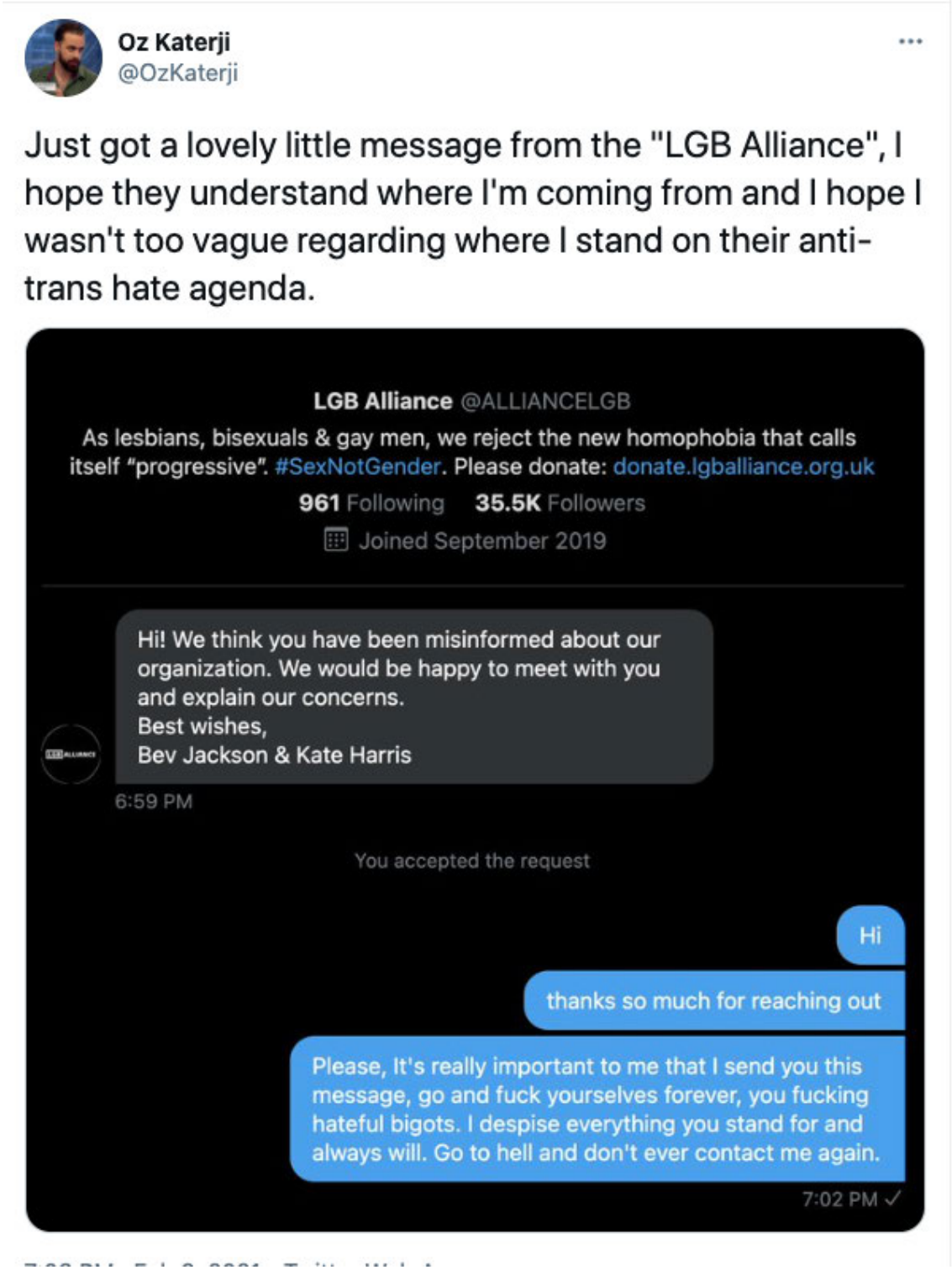



In more than one response, he made the following claim with reference to the LGB Alliance:




As a result, Bev Jackson and Kate Harris of the LGB Alliance reached out via DM and offered to meet.

How do we know this, you ask? Well, Oz helpfully shared this DM publicly on twitter, along with his response:




This predictably blew up in the replies, and as justification, Oz made some variation of the following claim at least a dozen times:




His claim, based on this article, is that the LGB Alliance is allied with "far right" organisations, and it is specifically this assertion that I want to focus on.

If you put yourself through the onerous task of reading the article, you find that the central claim turns on a single tweet made by Bev Jackson in April 2019.

Thankfully, you can spare yourself a click, because Oz helpfully shared the tweet itself. He also expanded on his claims of "links to the far right" by asserting that the group "were happy to share a platform" with the Heritage Foundation.




Given that Oz is an investigative journalist, one might reasonably expect him to be able to investigate the 32 words of this tweet to find clues as to its meaning.

The first sentence states that the "leftwing silence on gender in the US is even worse than in the UK". This provides a hint to the observant reader - furnished with the background knowledge that Bev Jackson is in the UK - that an article about matters in another country might not directly involve the tweet's author at all.

The second, and final sentence refers to "this story", and follows up with an external link. At this point, the authorship and content of the piece itself still remain a nail-biting mystery. Could it actually be a lengthy confessional by Bev Jackson, revealing a shared platform with Heritage?

If only there were some way of reading the article itself to gain further context.

## The Medical Scandal that the Mainstream Media Ignores

APRIL 8, 2019 | BY KATHERINE CAVE

So, absolutely nothing to do with Bev Jackson or the LGB Alliance after all.

A quick skim through reveals that it is a story written by a desperate and concerned parent struggling to find anyone in mainstream US media who would take them seriously or publish their views, and ultimately attending an event arranged by the Heritage Foundation.

Can we glean anything else from the tweet? Well the truly diligent reader might notice that the date it was sent (April 2019) was actually several months before the founding of the LGB Alliance in October 2019.

Thus, by reading 32 words, one date, and clicking a link we can establish that the tweet refers to someone else, in another country, doing things Bev Jackson had not herself done, six months before the LGB Alliance existed.

I can understand this exhaustive process being too taxing for all but the most dogged investigator.

So it turns out that Oz claimed that the LGB Alliance “were happy to share a platform with” Heritage, and that they “have an alliance with far-right organisations”, but cited a tweet and an article based around that tweet that backs up absolutely none of this.




In fact, what is abundantly clear is that this article is really about expressing sympathy with **other** people who feel they have been left with no recourse because of the polarised state of discourse on this subject, and perhaps cautioning “the left” from freezing out dissent.

In all, Oz recycled screenshots of this tweet or the Pink News headline that was based on it a dozen times.




So what has happened here? Oz has become so convinced that the LGB Alliance are a hate group that he is not only happy to tell a pair of veteran LGB rights campaigners to go fuck themselves, but to also share his own abuse of them publicly for approval from his followers.

Yet a key piece of factual information he repeatedly relies on as the basis of continued abuse and dismissal of Kate Harris and Bev Jackson is obviously false, in a way that takes less than a minute to verify. He seems to have become unable to see the reality before him, simply repeating the headline, over and over, and attacking anyone who disputes his claim.



There was a particularly revealing response at one point when he was asked to pause for a moment and consider if it was realistic to believe that veteran leftwing rights campaigners had suddenly transformed into hateful bigots:




There can be no question. The past must be rewritten to service the present.

Oz is **kind** and **inclusive**, therefore the people he disagrees with must be **hateful** and **bigoted** - indeed, must always have been bigots. It is the only possible permitted explanation.

My prediction, were Oz to be challenged with evidence that he has been spreading a false smear would be some combination of the following:

- Denial, and a doubling down that it does actually mean what he said it means, when it plainly does not.
- A switch to some alternative evidence for the claims he made, that might also prove to be equally disingenuous under scrutiny.
- A switch to some evidence that Bev and Kate were in some **other** way hateful, and therefore deserving of whatever invective they had been subjected to.

What would be thoroughly unlikely would be an admission of being wrong - because if that were true, he would have publicly insulted a pair of blameless lesbians, without provocation.

That would be the sort of thing a bad person would do, and since Oz is a **good** person, doing **good** things for **virtuous** reasons, that can't possibly be true.

It can't be allowed to be true, and in service of that, anyone who tries to persuade him otherwise has been blocked or branded a bigot.

We have always had the capacity to dig a hole for our own psyche, becoming impervious to inconvenient truths, and social media has supercharged this process. Any amount of vitriol we might direct at our opponents is justifiable in the service of the good.

This whole sorry piece is about one single fact. A simple, easily understood one, that takes seconds to verify, yet one that is contentious and has been used as the basis of widespread smears for well over a year now, with no end in sight. Fact checking and consensus on truth feel increasingly impossible in the age of social media, and it is destroying our ability to have meaningful conversations. How do we ever come back from divisiveness like this?

The sad truth is though that someone who already believes LGB Alliance to have "ties to the far right" is unlikely to have read this, and even if they did this will not change their mind. If your worldview relies on something being true, then an outsider challenging one piece of evidence makes no difference, because surely other evidence exists. You and your circle are **good** people, and nobody would believe this sort of thing for no reason would they? So, it is just a matter of finding the evidence to support what you already **know** to be true.

Leaving aside the futility of all this, what Oz has tweeted here is clearly not substantiated by the evidence he's provided. Whatever other assertions he makes, whatever else his position is, whatever other facts he relies on, anybody reading should be able to see that, shouldn't they?

And anybody - especially an investigative journalist - could have verified this for themselves before sharing it so widely, so many times, and with such venom as was displayed in this thread.

I think it should raise the question for anybody reading his other interventions on this subject: if Oz is wrong about this, what else is he wrong about?

Update 13/02/2021:

Many thanks to Jeremy Duns and Jesse Singal for pressing the issue, Oz Katerji has now issued a correction to the claims he initially made.



**Oz Katerji**
@OzKaterji

Replying to @jessesingal

Here: I am unaware of any evidence that the LGBA currently works with far right groups, I am only aware that one of their founders described working with the HF as "sometimes the only possible course of action." shortly before the LGBA was formed.

11:24 PM · Feb 11, 2021 · Twitter Web App

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# Gary Powell: "Let's nail the gender activists' lies about me, the Heritage Foundation, and LGB Alliance."



by Lesbian and Gay News — October 27, 2021 in Opinion 13 min read



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The lies that have been concocted and that are blindly peddled about LGB Alliance – including the utter idiocy that they are somehow in league with the Heritage Foundation and receiving funding from the American

Religious Right – are a simple continuation of the baseless anti-gay smears that characterised the early days of

Some of those who "spread lies" do so while knowing what they say is untrue: indeed, they may have invented the fictions themselves. Others will "spread lies" because they have heard the fictions repeated so many times that they end up believing them to be true, and they don't make the effort to fact-check first – perhaps sometimes because the malevolent impact of what they say is more important to them than whether the assertion is really true, or even likely to be true.

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On 21 October, the day of the LGB Alliance conference, the high-profile LGBTQ+ campaigner Peter Tatchell seized the opportunity to tweet, *"Boris Johnson thanks anti-trans LGB Alliance for its 'incredible hard work'. He's siding with the oppressors of trans people. The LGB Alliance collaborates with groups like Heritage Foundation that are anti-gay, anti-abortion & oppose same-sex marriage."*

We must assume that Mr Tatchell sincerely believes the nonsense he tweeted to be true, and that he has been successfully duped by the dishonest propaganda attacking LGB Alliance. However, a proper fact-check before issuing an *ex cathedra* accusation of this kind to his 95,000 followers would have revealed his intended accusation to be baseless and unjust.

My reverence for free speech and association is something that, completely inadvertently, has provided ammunition to the gender activists who started these malicious rumours, and I am pleased to have the opportunity to set the record straight as to how the false accusations about LGB Alliance and the Heritage Foundation first arose.

In May 2019, I spoke as a guest on a panel at the Heritage Foundation in Washington DC, flanked by two colleagues who also campaign for women's and children's rights. The title of our panel discussion was, *"Casualties of surrogacy: Women for rent, infants for sale, LGBT rights for hijacking."* Although I then described myself as an *"LGBT activist"*, I was at that point not quite yet aware of the harm being caused by gender ideology. Today, I call myself a *"gay rights activist"* once more.

One colleague and I spoke about the exploitation of and dangers to women in the commercial surrogacy process, and another colleague spoke about the exploitation of women in prostitution. My focus was on opposing all forms of surrogacy as a gay man, as the LGBT+ lobby was starting to be instrumentalised by Big Fertility as a vehicle to promote commercial surrogacy.

The Heritage Foundation is a long-established American conservative think-tank that has always been strongly [redacted] I am myself a small-c mainstream conservative. However, whereas the Heritage Foundation takes a hard line with a blanket opposition to abortion, I support the legal right to abortion, according to the German model. Whereas the Heritage Foundation opposed gay marriage, I supported it and campaigned for it. Accepting an invitation to speak at the Heritage Foundation as a guest, where I spoke in defence of women's and children's rights, does not, of course, make me a "member" of the Heritage Foundation, or "linked" to the Heritage Foundation in any non-trivial way, or automatically "aligned" to the Heritage Foundation's particular views on abortion or gay rights or anything else.

My visit to the Heritage Foundation was one where I was treated with respect and courtesy by everyone I met: a far cry from the vicious hatred I have experienced from gender ideology activists and their toxic propaganda vehicles. Freedom of speech is crucially important to me as a conservative. Many left-wing organisations deny anti-surrogacy campaigners (and gender-critical campaigners) a platform; and the offer from a conservative organisation of a platform, with a video reach to tens of thousands of viewers, is something I value in the service of promoting important causes.

Just as it is only the Conservative Party in the UK that is (albeit hesitantly) preventing the worst aspects of gender ideology becoming law, the conservatives are the only significant force in the USA battling against gender extremism in defence of women's and children's rights.

When I spoke at the Heritage Foundation, it was emphatically as a gay man. It is important to me as a gay man to try to model a positive image of gay people, to challenge stereotypes, and to show my support for socially responsible attitudes and behaviour. Social and religious conservatives have lesbian and gay children too. My hope is to demonstrate to conservatives who may think that being gay means being a slavish adherent to LGBTQ+ lobby ideology, that their children can be lesbian or gay without taking on the LGBTQ+ identity with its associated catechism and values.

> Accepting an invitation to speak at the Heritage Foundation as a guest, where I spoke in defence of women's and children's rights, does not, of course, make me a "member" of the Heritage Foundation, or "linked" to the Heritage Foundation in any non-trivial way, or automatically "aligned" to the Heritage Foundation's particular views on abortion or gay rights or anything else.

There are people on the political Left who assert that no one should ever accept a platform from, or have any dealings with, the Heritage Foundation, because of their position on abortion. It strikes me that gender ideologists might similarly warn against any non-adversarial contact or engagement with LGB Alliance because it exclusively centres sexual orientation. There would even be a similar case for gender-critical people boycotting such contact with Stonewall UK because of the very serious harm its gender ideology promotion does to women, children and gay people. If the no-platforming principle is applied consistently, then the possibility of respectful dialogue with political opponents becomes severely curtailed.

If we vilify and no-platform social conservatives and regard them as untouchables – as beneath contempt – when so many are perfectly willing to interact with lesbian and gay people courteously and thoughtfully, then we are missing an opportunity for respectful engagement, when we could change some minds and soften some

views. We are also, I fear, abandoning their struggling lesbian and gay children and denying them the [redacted] presenting ourselves to their parents as positive alternative role models.

My conservative values centre freedom of speech, association, and belief, which means I need to be able to make my own decisions as to where I speak, and with whom. We are living in a no-platforming culture where it can be very difficult to find a platform for gender-critical views, or for opposition to surrogacy: exactly as was once the case when I entered gay activism in 1980, and we struggled to find any platform for expressing views and sharing accurate information about lesbian and gay rights. There is, perhaps, a lot to be said for respectful dialogue with people who may hold different views from oneself.

Of course, much gender activism is characterised by hostility, silencing, cancellation, deliberate obtuseness, threats, sexual verbal abuse, and mudslinging; and when that happens, respectful dialogue becomes impossible. However, at the Heritage Foundation, you can be sure that no one will call you four-letter words and tell you to do something unmentionable with one of their private body parts.

Little did I realise, though, the significance that my appearance on that Heritage Foundation panel in May 2019 was destined to take on only a few months later.

On Sunday 22 September 2019, I saw the Sunday Times article by Nicholas Hellen that also referenced a letter in the same edition from 22 signatories, including Simon Fanshawe, who had been an original founder of Stonewall UK. The letter criticised Stonewall for undermining women's and girls' sex-based rights and protections and for promoting gender ideology to children, and Mr Fanshawe was quoted as saying, *"If Stonewall remains intransigent, there must surely now be an opening for a new organisation committed both to freedom of speech and to fact instead of fantasy […] It has the working title LGB Alliance"*.

By this point, I was just beginning to realise how harmful gender ideology was and how much we, as lesbian and gay people, needed our movement back.

The Sunday Times article was very heartening, but I was immediately concerned that gender activists, seeing the public announcement of the new organisation's name, would buy up the domain names for LGB Alliance and point them at hostile and pro-gender ideology sites: a common tactic. I contacted Simon Fanshawe with my concerns and, after gaining consent from the founders, immediately secured the relevant domain names, which I later transferred to LGB Alliance. Unfortunately, someone had already been quick and had grabbed the Twitter handle *"@LGBAlliance"* – an account that would later be used to attack LGB Alliance – which is why the Twitter handle for LGBA is "*@AllianceLGB"*.

A Facebook group calling itself *LGB Alliance* had also been set up in the USA and was attracting quite a number of members. It had no connection to LGB Alliance UK but – entirely coincidentally, I am sure – the group was set up on 22 September 2019, the very same day that the Sunday Times article was published announcing the formation of LGB Alliance in the UK.

Although this Facebook group was not an anti-gender critical entity, I was concerned that people might be joining it in the belief it was run by LGBA UK. It is a private group, and I was allowed to join, though I soon got thrown out and blocked for posting links to posts on the new LGB Alliance UK Facebook page. It is no longer possible for me to access the group from my disgraced exile in blockdom, but I have been informed that, when

applying to join, one of the questions you now have to answer is, *“Are you aware that the creator of this group [redacted] d logo?”*.

The group has in the meantime accumulated around 1,400 members. It is a concern to me that people might still be joining that group in the mistaken belief that it is associated with LGB Alliance UK: particularly as, before I was booted out, I did not appreciate some of the posts or comments I was reading from a small number of members. Confusion around this US-based Facebook group may, I believe, have helped to fuel the early false accusations that LGB Alliance UK was an American proxy outfit of some kind.

LGB Alliance kindly sent me an unexpected invitation to their pre-launch meeting on 22 October 2019: presumably as a thank-you for securing the domain names. I was not one of the speakers at this meeting, and I was simply there as a guest. Having spoken to the founders at the meeting and offered to help with the campaign, I was invited to join their comms team, and for a short while, I helped to update the new LGB Alliance UK Facebook account. Nothing I did was ever done without either receiving an instruction from the founders or consulting them for permission and approval. I had no management or leadership responsibilities at all in LGB Alliance, at any point, and neither did I seek any. Furthermore, neither Simon Fanshawe nor the LGBA founders knew me. I was just this random guy, a longstanding gay rights activist, who had secured their domain names and had agreed to help on their comms team.

> The whole suggestion that the conservative Religious Right – the Heritage Foundation, or any other similar body – might be channelling funds to LGB Alliance is, of course absurd. It is a lie, and it belongs to the same category as that old family of lies and smears to which lesbian and gay people were frequently subjected decades ago.

When LGBA was founded, the inevitable backlash came swiftly from LGBTQ+ lobby activists, who were outraged at this challenge to their ideological empire. Readers will be well acquainted with the vicious attacks on Allison Bailey after she tweeted about LGB Alliance following the pre-launch meeting. Hit pieces also began to appear, referring to LGB Alliance as a “hate group”.

My personal Facebook account was public, and a gender activist noticed I was on the LGBA comms team and began a snooping expedition as to what mud they might be able to throw at me. They alighted on the YouTube video of my presentation at the Heritage Foundation opposing surrogacy, clearly seeing this as an opportunity to tar me as someone “collaborating with” or “linked to” a socially conservative think-tank with its traditional religious values – with the purpose then of smearing LGB Alliance by association with me. It was to be nothing but a lazy smear-by-association stretched beyond the limits of credibility.

Some time later, Pink News published a hit-piece that focused on attacking me to denigrate LGBA by association. I had been tipped off that the hit-piece was coming, but I knew something that I correctly suspected Pink News didn’t know, and I could see that their malice was likely to rebound on them spectacularly. It was written by a reporter called Vic Parsons and carried the heading, *“Activist instrumental in the launch of the LGB Alliance linked to anti-abortion and anti-LGBT+ hate groups.”* Predictably, the person portrayed in it bore no resemblance to me, to my work, to my values, to my relationships and alliances, or to my personal beliefs.

The Pink News hit piece was clearly going to try to get as much mileage as possible from my visit to speak at [redacted] a quality and significance of connection between me and LGB Alliance that didn't exist. By smearing me, they were intending for the mud to stick to LGB Alliance. Those regular attacks on LGB Alliance that assert they are connected to the Heritage Foundation are an idiocy that derives solely from my presentation in Washington DC opposing surrogacy.

The whole suggestion that the conservative Religious Right – the Heritage Foundation, or any other similar body – might be channelling funds to LGB Alliance is, of course absurd. It is a lie, and it belongs to the same category as that old family of lies and smears to which lesbian and gay people were frequently subjected decades ago. LGB Alliance is an organisation that, while remaining impartial with regard to support for political parties, has an overwhelmingly left-wing support base, having grown out of the radical lesbian feminist movement. Its two founders are lesbians and left-wing radical feminists. In the LGB Alliance values statement, they also explicitly declare: "(*W)e do not, and will not, forge links with, or accept funding from, any organisation… that seeks to undermine women's reproductive rights*."

Why, under any circumstances whatsoever, would an American socially conservative institution that promotes traditional religious values, that opposes abortion, and that opposes gay marriage, donate money to an organisation not even in the USA that supports abortion rights so ardently that its values statement prohibits connections with any organisation that opposes abortion? Why would it donate to an organisation that campaigns for lesbian, gay and bisexual rights, that has an overwhelmingly left-wing membership, and that was founded by two left-wing lesbian feminists? It is ridiculous in the extreme to suggest that any such thing would happen. Insane. It is as likely to happen as being hit by a meteorite, struck by lightning, swallowed up by a sinkhole, and winning the lottery, all on the same day.

What the Pink News writer and editor had clearly not realised was that I myself had previously been a writer for Pink News – their own publication. I was still listed as a Pink News writer when they published this hit-piece. They had failed to do basic journalistic research, which would have revealed that the articles I had written for them in 2013 were still available on their website. I had done far more work for Pink News than I had for LGB Alliance, and if organisations were to be denigrated by association with me, then it was Pink News that came off worst. I had even written pieces for them where I attacked fundamentalist, anti-gay religion and supported gay marriage: a very far cry from the picture of me that their execrable article tried to paint.

The publication of a Pink News article where they foolishly attacked one of their own writers in an attempt at damage-by-association gave rise to much Schadenfreude and mocking on social media. My hunch that they were too unprofessional and chaotic to even discover in their "research" that I was one of their own writers had been correct. Of course, I had stopped writing for them in 2013, around the time when they had started to became a gender ideology website, and it seems my status as a fellow Pink News writer had been too difficult for them to discover.

That Pink News hit-piece is still regularly shared on social media by LGBTQ+ lobby activists who continue to falsely claim that LGB Alliance is aligned with the Heritage Foundation or other similar US organisations. To this day, I still get falsely accused of being a member of the Christian Right, of campaigning against abortion, of opposing gay marriage and the rights of gay people, and of supporting anti-gay conversion therapy. Flattering promotions have also been bestowed upon me by some of these rabid fantasists, where I have been described

as a "leading member of the Heritage Foundation", as a "founder of LGB Alliance", and as a "speaker at the [redacted] of which are in the slightest true, of course.

> Why, under any circumstances whatsoever, would an American socially conservative institution that promotes traditional religious values, that opposes abortion, and that opposes gay marriage, donate money to an organisation not even in the USA that supports abortion rights so ardently that its values statement prohibits connections with any organisation that opposes abortion?

A director of LGB Alliance, Malcolm Clark, responded to the hit-piece with a characteristically incisive Twitter thread, in which he exposed Pink News for having attacked one of their own writers, and even one who had written for them specifically in defence of gay marriage and in opposition to fundamentalist religion. Mr Clark drew attention to the fact that the previous CEO of Stonewall UK, Baroness Hunt, was a practising Catholic and therefore a member – an actual member, not a guest – of an institution that opposed abortion and categorised homosexuality as sinful and disordered: yet no similar hit-piece had been written about her on this basis, implicating Stonewall UK by association.

As Mr Clark pointed out, Ruth Hunt's status as a practising member of the Catholic Church does not automatically imply that she believes every one of the Church's orthodox teachings: so why should my appearance as a mere guest on a panel at the Heritage Foundation be taken to automatically imply I support every position of the Heritage Foundation, including their blanket opposition to abortion? Or indeed, be taken to automatically imply that I necessarily support *any* of their positions? The double-standards were glaring.

For some time before the hit-piece was published, I had already ceased to work with LGB Alliance. The steering committee had decided that, for someone to be allowed to work with LGB Alliance, they must commit never to speak on a platform if the host organisation *"opposed women's reproductive rights"* or to write for any publication whose policies included opposition to abortion. As platforming my voice in opposition to surrogacy and gender ideology is extremely important to me, and as my conservative beliefs centre the importance of freedom of speech and association, it was impossible for me to give that undertaking to the steering committee and, sadly, we had to part ways.

It would be a very bizarre thing indeed if a gay man and gay rights campaigner over four decades who supports the German model for legal abortion, who has written to attack fundamentalist religion for causing harm to lesbian and gay people, and who is, by the way, a Buddhist, is to be credibly painted as representing the US Christian Right, so that anyone or any organisation that is in any even very tenuous way "linked" to him is also "linked" to the US Christian Right in any remotely meaningful sense. It really does smack of desperation when this kind of fabricated drivel is the main counter of gender activists to the arguments and evidence against gender ideology. The positive take from this is the exposure of how weak and fragile their position really is. All they have is lies and smears. It is a signal to us that, if we keep pushing hard, we will prevail.

LGB Alliance is a crucially important organisation that has made sterling achievements since it was set up two years ago. It is not particularly easy for me to continue my political efforts as a satellite orbiting in the Outer Darkness, untethered from an LGB Alliance Mothership that feels it cannot recognise my contributions, promote

any of my work, or afford me a supportive political community. However, I will still speak out to challenge the [redacted] ed by people who lack arguments and evidence. Although I cannot say I am a "supporter" of LGB Alliance, I do still support many of its objectives, and I want LGB Alliance to be superlatively successful.

Whenever you see claims that LGB Alliance is a hate group and that it works in collusion with the Heritage Foundation or is funded by the American Religious Right, perhaps you will feel inclined to respond by sharing this article or some information from it.

The experience I share above with regard to the Heritage Foundation, LGB Alliance, and the LGBTQ+ media, lays bare the malevolent and dishonest strategies deployed to undermine us, divide us, and peel off our committed activists. We cannot allow our antagonists' baseless attacks to stand without challenge, and we cannot allow their cancel-culture machinations to set the parameters for how, and with whom, we are allowed to campaign. Our strength is in truth and unity.

**Gary Powell is a gay man and has been active in gay politics since 1980. He is the Research Fellow for Sexual Orientation and Gender Identity at the Bow Group and the European Special Consultant to the Center for Bioethics and Culture.**

**Tags:** Gary Powell Heritage Foundation LGB Alliance Peter Tatchell


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**Brian Robinson** 5 months ago

My goodness what a web of lies and slanders the opposition fabricated. By the way I'm increasingly disappointed in Peter Tatchell. Over the years now and then I've contributed to his Foundation but I shan't be doing so again. It's concerning that LGB Alliance is so purist about even apparently transient connections that must be abjured by anyone who would work with it, but I still support it and hope to continue doing so. I loved that sting in the tail concerning Pink News -- hoist with its own petard. Thanks for a really well-written, informative and highly cautionary piece. If I come across those lies and smears elsewhere, I shall certainly cite the piece with its link.

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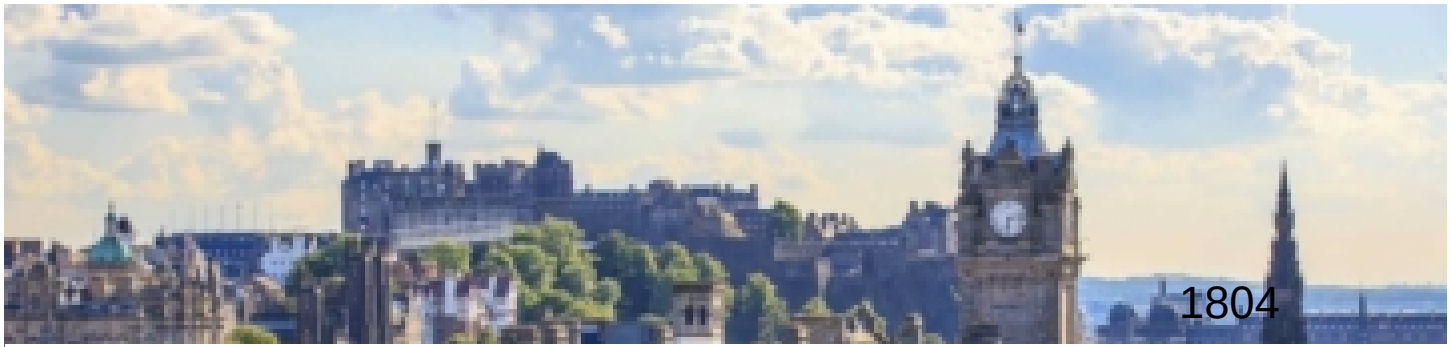
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# Stonewall is split by row about same-sex marriages

Cahal Milmo, Chief Reporter • Saturday 02 October 2010 00:00 • Comments

Stonewall, Britain's largest gay-rights campaigning group, is in the grip of a deepening row – involving such prominent activists as Sir Ian McKellen – over accusations that the group is failing to back a campaign for same-sex marriages.

The Oscar-nominated gay-rights campaigner, who is a co-founder of Stonewall, has joined other high-profile figures to call for the organisation to campaign for the legal union between a same-sex couple to be enshrined as "marriage" in British law. Marriage is still barred for homosexuals, and many feel lifting the bar would mark the final step in the process of gaining full recognition for same-sex relationships.

The current law categorises any same-sex legal union as a civil partnership and while they accord homosexual couples the same rights as married heterosexual couples, campaigners say the law remains iniquitous by failing to allow a same-sex union to be legally called a marriage.

Stonewall, which has 20,000 supporters and has been at the forefront of Britain's gay-rights movement for more than 20 years, has publicly stated it has no formal position on gay-marriage equality because it is consulting lesbian, gay, bisexual or transgender (LGBT) people on how to approach the issue.

The charity's chief executive, Ben Summerskill, raised eyebrows when he told a fringe meeting at the Liberal Democrat conference that a policy allowing all couples the right to a civil partnership or a marriage regardless of gender could cost the public purse up to £5bn over ten years because of the tax implications of opening up civil partnerships to heterosexual couples.

Critics including Michael Cashman, a Labour MEP who is also a co-founder of Stonewall, said the organisation's silence on the issue was in danger of being interpreted as opposition to marriage equality, and the cost implications for the taxpayer of such a move should not be the concern of the charity.

In a statement on the issue, Mr Cashman said: "Surely no pounds sterling figure can be any serious argument against civil rights. Will Stonewall go to Pride marches next spring with placards reading: 'We're still consulting on equality'? Stonewall is not in government and their role is to represent the interests of LGBT communities. Stonewall has been 'consulting' for so long that its deafening silence may end up being interpreted as being against universal marriage."

Sir Ian joined the row this week when he said that while issues such as homophobic bullying should remain a higher priority for Stonewall, it was right that the group should also lobby for gay marriage. He told the Pink News website: "If people want to get married, whoever they are, they should be allowed to. That's self-evident to me and all I've ever campaigned for is equality for gay people, and at the moment there is inequality in that civil partnerships are all that's available."



Mr Summerskill – who led Stonewall's successful campaigns for the repeal of the Section 28 law banning "promoting homosexuality" and the establishment of civil partnerships – told The Independent it was wrong to say that the charity was against gay-marriage equality, and that Stonewall was obliged to take into account a diversity of views among its supporters.

The charity will finish its consultation exercise later this month. He said: "There is a range of views on this subject, from those who very much want gay marriages and for them to be mandatory in churches, to those who reject civil partnerships as 'hetero-normative'. We are determined to achieve as broad a consensus on this as possible and to that end we are consulting our supporters on what issues they want us to prioritise.

"It would be entirely inappropriate to announce the outcome of that process before it is complete," he added. "It is also categorically wrong to say that we are opposed to gay-marriage equality generally." Campaigners want to build on willingness among political parties, including Labour, the Liberal Democrats and the Greens, to push for legislation removing the legal definition of marriage, first laid down in 1973, as being a union only between a man and a woman. But that would likely be opposed in the House of Lords.

marriage and that is homophobic. Any gay rights organisation should be fighting to overturn it. Separate isn't equal."

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# Up against the Stonewall on equal marriage

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**Latecomer to campaign, Ben Summerskill smears Lib Dems**

**By Peter Tatchell**

Huffington Post – London, UK – 18 March 2014
http://huff.to/1lK3lHN (https://huff.to/1lK3lHN)

Former Stonewall chief Ben Summerskill has made astonishing allegations against the Liberal Democrats, claiming they never sincerely supported same-sex marriage. He suggested they acted with "cynical and opportunistic" motives.
http://bit.ly/1fAhKq0 (https://bit.ly/1fAhKq0)

This is outrageous. I don't support the Lib Dems, but they backed equal marriage at a time when Summerskill and the gay lobby group, Stonewall, refused to do so. The Lib Dems deserve credit for their early embrace of marriage for all. Ben's petty, sectarian smears are unbecoming – and unjustified.

As evidence of his claim, Summerskill alleged that former MP, Dr Evan Harris, responded to the 2010 Lib Dem conference vote to adopt gay marriage by saying: "This is great because we put clear blue water between us and the Tories."

Summerskill went on to insinuate that Evans and the Lib Dems only supported marriage equality as a means to gain political advantage over the Conservatives.

Speaking to Pink News, Dr Harris denies saying what Summerskill alleged: "It is very poor of Ben to invent a quote and claim it is all that was said. Ben was always annoyed by my criticism of Labour 1997-2010 for its slowness on all the issues (including) age of consent, armed forces,

civil partnerships, and sexual offences….As you know, Clegg backed gay marriage in Feb 2010 an[illegible] Scottish Lib Dem Conference in March 2010 – long before the coalition," he said. http://bi[illegible]e8eXIp

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On the eve of the Lib Dem's 2010 autumn conference vote for marriage equality, Summerskill spoke at the party's lesbian, gay, bisexual and transgender (LGBT) fringe meeting. Attendees were expecting rousing support from Stonewall for the equal marriage motion. Instead, to gasps of disbelief, they were lectured about the cost and pitfalls of same-sex marriage.

Why? Ben Summerskill is a long-time Labour supporter and ex-Labour councillor. There is speculation that he is bidding for a safe Labour seat. He was reportedly one of the guests on Ed Miliband's table at a fundraiser for the Labour Party last Wednesday. Perhaps his outburst was party point-scoring? Surely not?

Summerskill and Stonewall have done much important, valuable work. I salute their efforts on many fronts. I want to work with them in the future. However, since Summerskill decided to make baseless allegations against key supporters of marriage equality, it needs to be said that Stonewall got it badly wrong on this issue. They refused to support marriage equality for four years – from 2006, when many other LGBT groups were urging an end to the ban on same-sex marriage.

As late as October 2010, Stonewall was claiming there was little support for marriage within the LGBT community (untrue; it was 90+%); adding that many gay people opposed it (in reality only a tiny minority; less than 10%). They also insisted that civil partnerships were sufficient (most LGBT people disagreed, as did many heterosexual allies).

Even worse, while opinion polls from 2009 onwards showed that two-thirds of the general public agreed that same-sex couples should be able to marry in civil ceremonies, Stonewall did not agree with marriage for LGBTs.

Although many members of the LGBT human rights group OutRage! shared the feminist critique of marriage, the activist group had been lobbying for marriage equality since 1992, on the grounds that the ban was a form of homophobic discrimination. In 2010, it joined forces with other organisations to form the Equal Love campaign, which sought to end the twin legal bans on same-sex civil marriages and opposite-sex civil partnerships.

Stonewall repeatedly briefed against OutRage! and Equal Love; making bogus claims about the cost of equal marriage. Has anyone ever heard another LGBT organisation reduce equality to a financial calculation? Equal rights is a human rights principle – not something that can be embraced or rejected, depending on the cost.

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Stonewall's unwillingness to support the equal marriage campaign was quoted by homophobes to justify their opposition to same-sex marriage. The anti-gay crowd: "Even Stonewall doesn't support [it's] getting married."

This was hugely damaging to the push for marriage equality.

I remember a meeting of LGBT organisations at the House of Commons in the summer of 2010, hosted by Equalities Minister, Lynne Featherstone MP. Every LGBT representative supported same-sex marriage – except Ben Summerskill of Stonewall. He refused to endorse equality and advanced arguments against equal marriage. The rest of us were shocked and appalled. In addition, he mounted what I interpreted as a veiled personal attack on Featherstone over her willingness to consider equal marriage legislation.

Stonewall only switched to support same-sex marriage in late October 2010, after a coalition of other organisations had done the groundwork and after it faced a huge LGBT backlash – including harsh criticism from two of its founders, Ian McKellen and Michael Cashman.

But even this switch was not straightforward. Instead of coming out in favour of equality, Stonewall opted to consult its members on whether it should support equal marriage. How bizarre. An organisation set up to fight for LGBT equality was unwilling to support equal marriage rights until it consulted its members. On no other issue has Stonewall insisted on consulting its membership before backing equality.

After being a latecomer to the campaign, Stonewall now brags that it won same-sex marriage; never acknowledging the contribution of OutRage!, Equal Love, Out4Marriage, the Coalition for Equal Marriage, Pink News – and many others.

Having long urged straight people to support marriage for gay couples, Stonewall is still refusing to support the right of straight couples to have a civil partnership. This comes across as one-sided and selfish. What happened to Stonewall's professed mantra of equality?

• For more information about Peter Tatchell's human rights campaigns and to make a donation: www.PeterTatchellFoundation.org

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← **Thread**



**Malcolm Clark**
@TwisterFilm

A thread about sex, lies and paedophiles. Yesterday @PinkNews published an article on comments I made on a Facebook thread about teachers. I have to say whenever I hear Pink News is publishing something resembling a story I think  of Cecilia Martinez.

10:53 PM · Jan 24, 2020 · Twitter Web App



**Malcolm Clark**
@TwisterFilm

16./ Sometimes single misquotes can lead to bonkers accusations. I once said to someone on Facebook I was concerned about poor child safeguarding in LGBT groups in schools. Cue: claims in Pink News I thought gay teachers were predators. Here's the truth 👇

> **Malcolm Clark** @TwisterFilm · Jan 24, 2020
> A thread about sex, lies and paedophiles. Yesterday @PinkNews published an article on comments I made on a Facebook thread about teachers. I have to say whenever I hear Pink News is publishing something resembling a story I think  of Cecilia Martinez.
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3:15 AM · Nov 30, 2020 · Twitter Web App



**Malcolm Clark**
@TwisterFilm

11./ Aimee went into schools as a mentor. But in Scotland our carelessness went further. The leading gay organisation of the 2000s, Lesbian and Gay Youth Scotland, was led for years by a disgusting paedophile, James Rennie. 👇

scotsman.com
Horror upon horror that unfolded in 'worst ever' abuse trial
THINK of a description such as vile, disgusting or revolting. Multiply it ten times, a hundred, a thousand. You are ...

12:44 PM · Apr 11, 2021 · Twitter Web App

← **Thread**

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@TwisterFilm

15./ Remember when Mhairi Black (now bleating loudly about how referring to paedophilia and ILGA is homophobic) wandered into school with a drag queen who promptly broke all child safeguarding rules by putting pics of schoolkids on his instagram?



thescottishsun.co.uk
Drag queen Flow Job removes Paisley schoolkid pics from 'highly sexualised' In...
SCOTS drag queen Flow Job has removed pictures from a primary school visit after fuming parents said they didn't want their kids appearing on the "highly ...

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Practitioners face up to 18 months in prison *(Getty Images/iStockphoto)*

# 'LGB ALLIANCE' GROUP FACES CRITICISM FOR BEING TRANSPHOBIC

'I am utterly disgusted at your attacks on our trans siblings'

**Olivia Petter** • Thursday 24 October 2019 17:15 • Comments

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group met in London on Tuesday evening, with lawyer Allison Bailey of Garden Court "historic moment for the Lesbian, Gay and Bisexual movement".

"Spread the word, gender extremism is about to meet its match," Bailey tweeted.

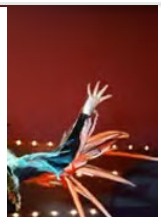
The new alliance is formed of previous members of LGBT+ charity Stonewall who have decided to protest against the organisation's transgender stance.

At the meeting, the group formed of "influential lesbians, gay men and bisexuals" revealed its mission to "counteract the confusion between sex and gender which is now widespread in the public sector and elsewhere".

Top 25 LGBT moments in pop culture since Stonewall Show all 25



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l be formally launched in January 2020, but hundreds of people have already criticised edia for its perceived anti-trans stance.

› describes its aim as: "Asserting the right of lesbians, bisexuals and gay men to define ex attracted. Gender is a social construct."

one person tweeted: "As a bisexual woman, I am utterly disgusted at your attacks on your alliance with the religious right. You do not speak for me (or for any of the other ; all equally repulsed by your ideas)."

Another person tweeted that members of the group "should be ashamed" of themselves.

Others sought to deny the existence of an "LGB" movement altogether, with one person tweeting: "There is no LGB movement. Not one that doesn't stand side by side with trans people. Speaking as a bisexual guy, no less is acceptable, and you definitely don't speak for me."

**Allison Bailey** · Oct 22, 2019
@BluskyeAllison
This is an historic moment for the Lesbian, Gay and Bisexual movement. *LGB Alliance* launched in London tonight, and we mean business. Spread the word, gender extremism is about to meet its match.

**Zoë Paskett**
@ZoePaskett

Sincerely, no thank you. At all.

2:07 PM · Oct 23, 2019

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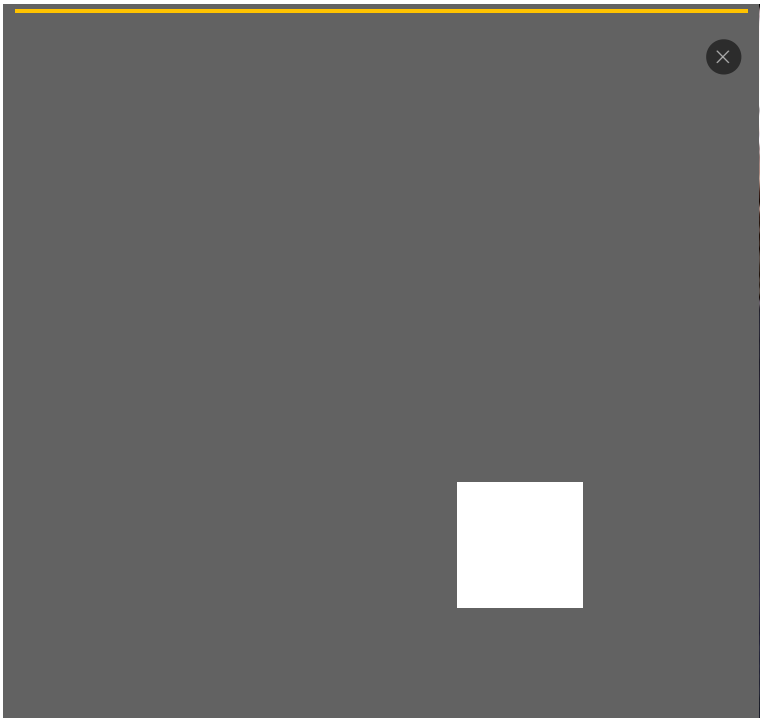
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nder of the Gay Liberation Front and spokesperson for LGB Alliance, told *The*

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n sexual orientation. This has become necessary, because lesbians in particular, and are suffering from the confusion between sex and gender. Lesbians and gay men are ted to others of the same sex. I fought for their rights to be respected fifty years ago and defend those rights again today."



Stonewall has been keen to distance itself from the group after reports claimed the charity was "splitting".

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Paul Twocock, Stonewall's interim CEO said: "There is no truth to reports of Stonewall 'splitting', so please ignore the alarmist headlines.

"These stories don't refer to any current Stonewall staff or trustees. There is no equality for lesbian, gay and bi people without equality for trans people. We're all united in our mission to achieve acceptance without exception for all LGBT+ people."

**More about:** Anti-LGBT Discrimination Stonewall

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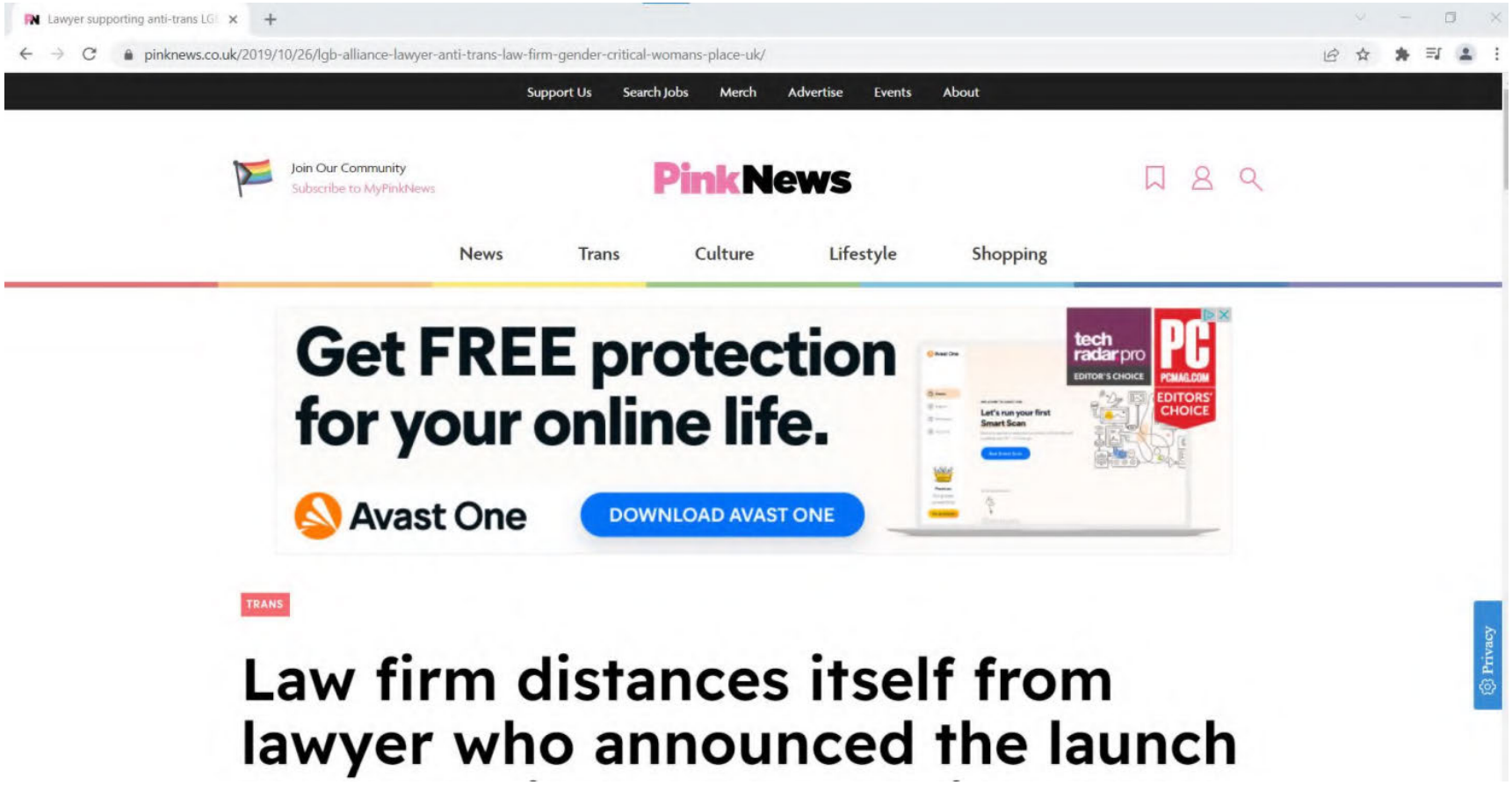
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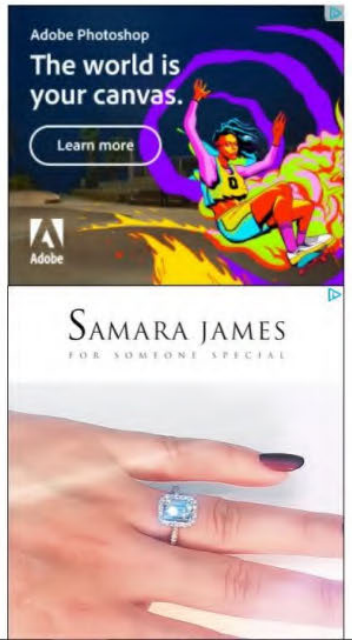
# of the anti-trans LGB Alliance

LILY WAKEFIELD | OCTOBER 26, 2019 | SAVE FOR LATER



Allison Bailey, the lawyer who announced the launch of the "LGB Alliance". (Allison Bailey/ Twitter)

**The lawyer who announced the launch of the "LGB Alliance", which has been branded anti-trans, has been thrown under the bus by her own law firm.**

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Lawyer Allison Bailey of Garden Court Chambers, who describes herself as "gender critical", wrote a tweet on Tuesday (October 22) announcing the launch of the group.

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She wrote: "This is an historic moment for the Lesbian, Gay and Bisexual movement.

"LGB Alliance launched in London tonight, and we mean business. Spread the word, gender extremism is about to meet its match."

However, lesbian, gay and bisexual people were quick to call out the new group – blasting it for being "transphobic", "disgusting" and "vile", and many telling members: "You do not speak for me."

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Many in the LGBT+ community also pointed out that many members of the new group are straight, as are a lot of the people backing it online.

But now, Garden Court Chambers has posted on its website to say that it does not agree with Bailey's views.

The post read: "We wish to make it clear that LGB Alliance is not part of Garden Court Chambers nor representative of the views of Chambers."

The next day the chambers announced on Twitter that it would be investigating complaints it had received about Bailey's comments.

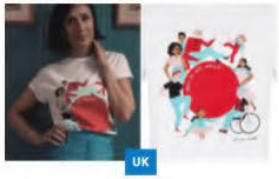
The tweet read: "We are investigating concerns raised about Allison Bailey's comments in line with our complaints/Bar policies.

"We take these concerns v seriously and will take all appropriate action.

"Her views are expressed in a personal capacity and do not represent a position adopted by Garden Court."

It added: "Garden Court Chambers is fiercely proud of its long-standing commitment to promoting equality, fighting discrimination and defending human rights."

On Friday, Bailey chaired a meeting of the anti-trans group A Woman's Place UK (WPUK), in Oxford.




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WPUK campaigns for spaces and services reserved for cis women only, excluding trans women.

On the Eventbrite page for the meeting, Bailey's bio reads: "Allison has always supported the rights of gender-reassigned persons to live full lives, free from discrimination, however, she believes that in matters of public policy and law, including safeguarding and statistical gathering and analysis, biological reality must always come before gender identity."

More: anti-trans, gender critical, lawyer, lgb alliance, WPUK

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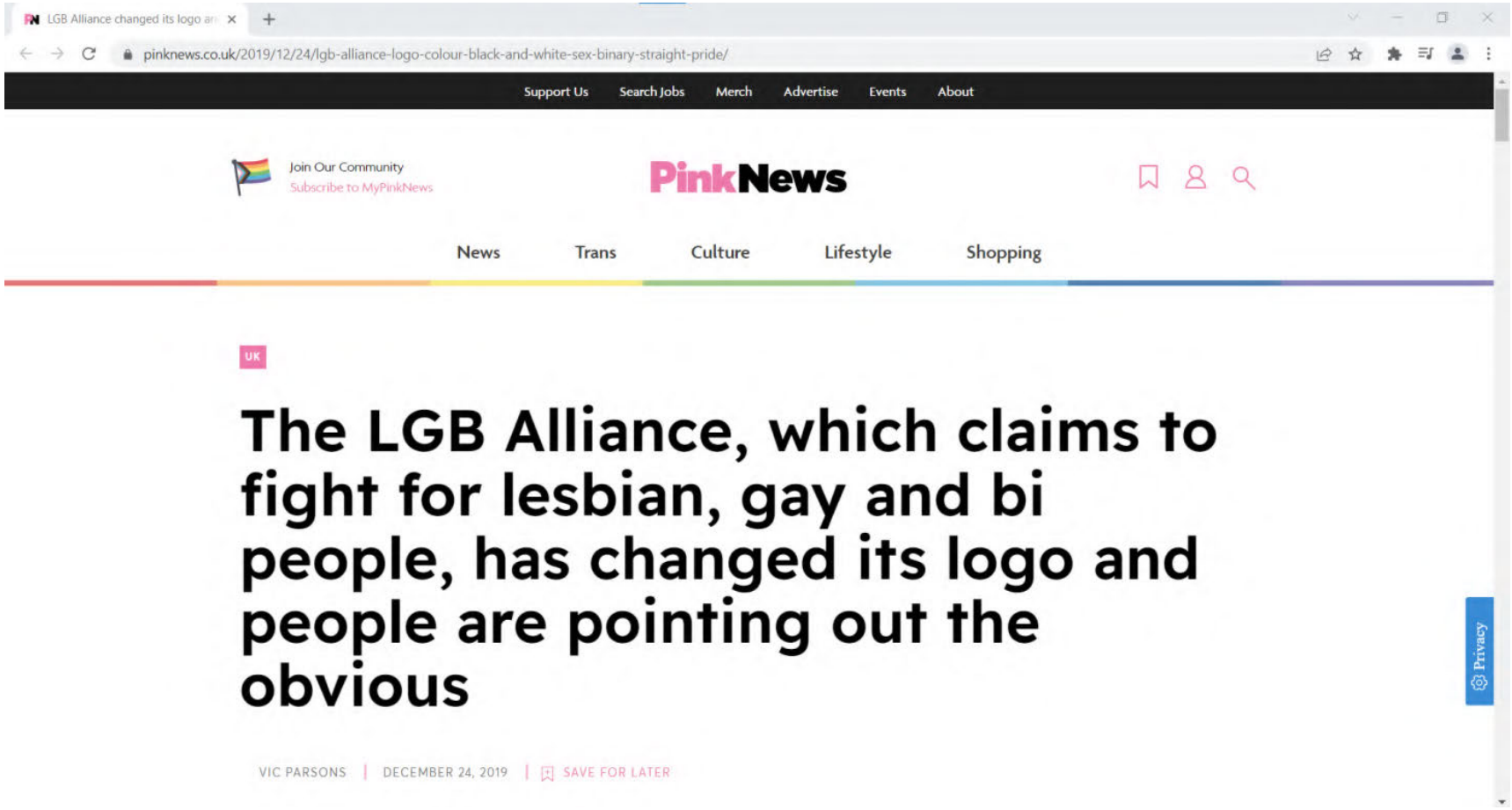
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pinknews.co.uk/2019/12/24/lgb-alliance-logo-colour-black-and-white-sex-binary-straight-pride/
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The LGB Alliance, which claims to fight for lesbian, gay and bi people, has changed its logo and people are pointing out the obvious
VIC PARSONS | DECEMBER 24, 2019 | SAVE FOR LATER
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A group of lesbian campaigners show solidarity with the trans community at 2019's Pride in London march. (Wiktor Szymanowicz/NurPhoto via Getty)

## A controversial group calling itself the 'LGB Alliance' has undergone a rebranding exercise, and the results are somewhat unexpected.

The group, which purportedly represents lesbians, gay men and bisexual people – though this has been disputed by many lesbians, gay men and bisexuals, and by the existence of groups like LWithTheT (pictured above) – recently unveiled a new colour scheme and logo.

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The colour scheme, which is black and white, sees the group's slogan – "Homosexuality is same-sex attraction. Biological sex is real. Sex is binary, not a spectrum" – written in bold white text on a striped black background.

**Homosexuality is same-sex attraction.**
**Biological sex is real.**
**Sex is binary, not a spectrum.**

LGB Alliance slogan, from Twitter.

## Is sex binary?

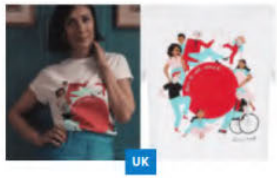
First, and let's just get this out of the way: sex is not actually binary, according to scientists.

We used to think it was, but our understanding of it has evolved. Remember how people used to think the Earth was flat, but then people explored* (*violently colonised) other countries via the oceans and found out it was, in fact, round? That paradigm shift must've been tough for people to get their heads around, but the Earth being round is not something most rational people still question.

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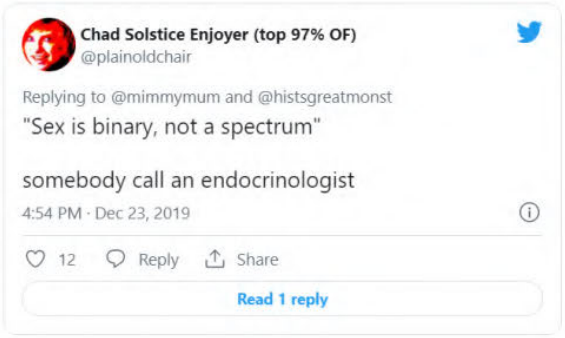
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While the idea that there are only two sexes is one that we've stuck to for ages, where we're at now is learning that sex isn't actually as binary as we thought. This is according to actual science, as outlined in this *Scientific American* piece, by this biologist writing for the *New York Times* and this scientist working as a bone researcher writing for *Slate*, among many others.

Oh, and also, let's remember that intersex people literally exist.

Second, and let's get straight to the point here: the colour scheme. As people on Twitter haven't been able to stop noticing, it's not an original colour scheme – it's eerily similar to that of another group: it's…… the Straight Pride flag!



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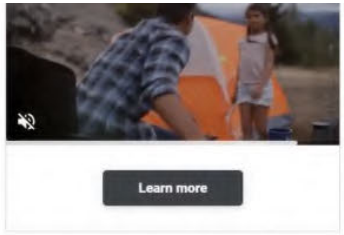
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**'LGB Alliance' co-founder: Logo was designed 'on back of fag packet'.**

Privacy

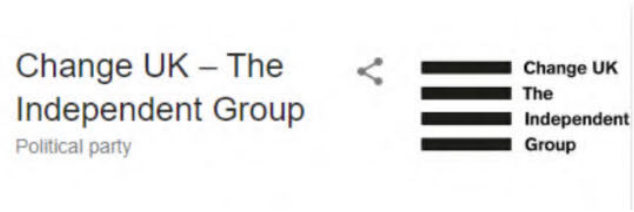
1841

3206

Now, aside from the fact that this is truly the most boring colour scheme ever, one that is literally devoid of colour, there are a few things to consider here.

Obviously, the 'LGB Alliance' is unsure if people are getting its message – that's "sex is binary", keep up – so they've chosen a black and white colour scheme. Black and white, no grey areas. We get it. A black and white colour scheme for black and white thinkers.

Another question is whether the group's "non-party political" affiliations, as per its website, are actually that. Recently disbanded political group Change UK (the final version of its name, much like how 'LGB Alliance' is the latest named iteration of several small but loud groups of people who are against trans rights) also had a stripy, black and white colour scheme.




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*PinkNews* took these questions to Kate Harris, co-founder of the 'LGB Alliance', who told us that the new logo had been come up with "on the back of a fag packet" and that the image of Stormé DeLarverie (the butch biracial lesbian who some say threw the first punch at the Stonewall uprising), which the group previously used on its social media accounts, would be used again.

"I didn't know there was such a thing as Straight Pride and I didn't know that it had a flag," Harris said, adding that there had also been "no conscious reference" to Change UK when designing the new logo.

"That's a sheer coincidence and slightly unfortunate given their demise," Harris said. Of the colour scheme, she added: "We think there are black and white issues to be discussed. We think there's a huge hunger for clarity in the area of sex and gender, we think things have been really muddled up."

When asked if she accepted that science was "evolving" on the issue of sex being binary, Harris said she did not.

When asked about intersex people, she said: "Every intersex person is male or female, but within that they have certain conditions that necessitate medical treatment."

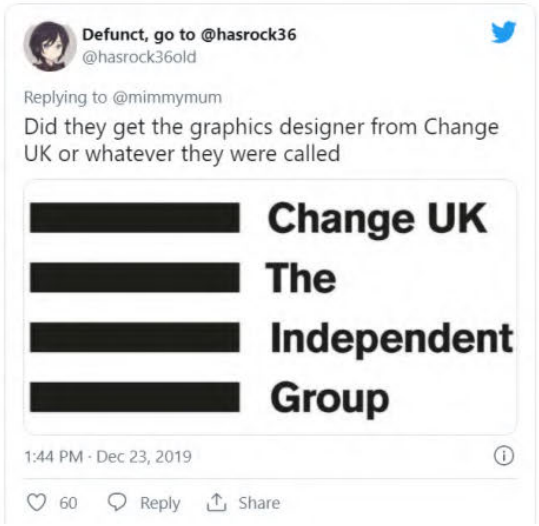
Harris then pointed *PinkNews* to the 'LGB Alliance' website on this question, which states: "We reject the co-opting of rare medical conditions that affect reproductive development or function (known as DSDs/intersex) in order to cast doubt on the biological reality of sexual dimorphism, i.e. two sexes."

Privacy

# Twitter reacts to new 'LGB Alliance' logo.

The similarity of the new 'LGB Alliance' colour scheme to both the Straight Pride flag and to Change UK's logo is coincidental.

But the similarities are so obvious that people can't stop pointing them out.




Privacy

"Their design sense has always been hideous, almost as though they're a conservative AstroTurf group :)" wrote one person.

Another pointed out that the flag seems to suggest that the 'LGB' alliance has its fair share of straight members: "Given that they are mostly cishets its kinda accurate that they show their true colours."







Privacy

While it's unsurprising coming from a group who sent 12 questions to prospective MP's that had nothing to do with lesbian, gay or bisexual rights (they were all anti-trans, instead), it's still somewhat disappointing.

After all, the LGBT+ community has some amazing flags with wonderful colour schemes. It's such a shame that the 'LGB Alliance' isn't one of them.

More: are the straights ok, change uk, lgb alliance, Pride flags, straight pride

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LGB Alliance: LGBT clubs in scho
pinknews.co.uk/2020/01/23/lgb-alliance-co-founder-malcolm-clark-predatory-gay-teachers-anti-gay/
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LGB Alliance founder says there shouldn't be LGBT clubs in schools because of 'predatory gay teachers'
VIC PARSONS | JANUARY 23, 2020 | SAVE FOR LATER
Adobe Photoshop
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1847



LGB Alliance co-founder Malcolm Clark said schools shouldnt have LGBT+ clubs because of "predatory gay teachers". (Twitter)

# Malcolm Clark, co-founder of controversial anti-trans group the LGB Alliance, has denounced LGBT+ clubs in schools.

Clark said LGBT+ clubs – a safe space for many LGBT+ schoolchildren to accept their sexuality – shouldn't exist because of "predatory gay teachers".

ADVERTISING






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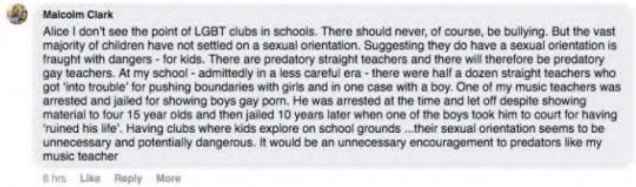
Privacy

Clark's inflammatory anti-gay comments were made in an online discussion about an LGB Alliance supporter being kicked out of an LGBT+ nightclub in Glasgow for refusing to reverse her t-shirt bearing the group's slogan.

The LGB Alliance claims to represent LGB people, but this latest incident appears to confirm, yet again, that this is not the case.

Clark later doubled down on his comments, tweeting that "99% of the Scottish public" would agree with him that LGBT+ clubs in schools shouldn't exist because of "the risks of predatory adults exploiting this situation".

"I don't see the point of LGBT clubs in schools," said Clark, whose bio on the LGB Alliance website says he makes science documentaries for the BBC "and many other international broadcasters", on January 23.




Malcolm Clark's Facebook comment on January 23. (Facebook/Screenshot)

"There should never, of course, be bullying. But the vast majority of children

2022 t-shirt

EMILY CHUDY - MARCH 9, 2022



WORLD

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NEWS

**Fears Scottish plan to criminalise gender 'fraud'**

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have not settled on a sexual orientation. Suggesting they do have a sexual orientation is fraught with dangers – for kids.

"There are predatory straight teachers and there will therefore be predatory gay teachers.

"At my schools – admittedly in a less careful era – there were half a dozen straight teachers who got 'into trouble' for pushing boundaries with girls and in one case with a boy. One of my music teachers was arrested and jailed for showing boys gay porn.

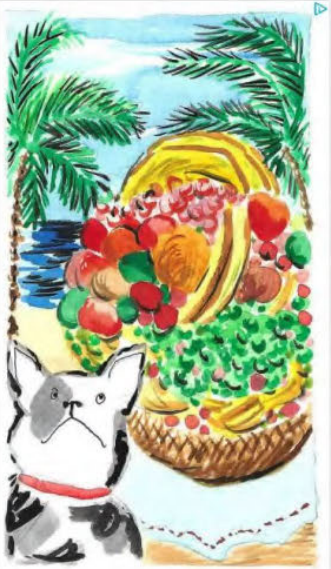
"He was arrested at the time and let off despite showing material to four 15 year olds and then jailed 10 years later when one of the boys took him to court for having 'ruined his life'.

"Having clubs where kids explore on school grounds …their sexual orientation seems to be unnecessary and potentially dangerous. It would be an unnecessary encouragement to predators like my music teacher."

Clark later doubled down on his comments on Twitter, saying: "I think you'll find 99 per cent of the Scottish public would agree. You'd win them round if you could at least express concern about the risks of predatory adults exploiting this situation."

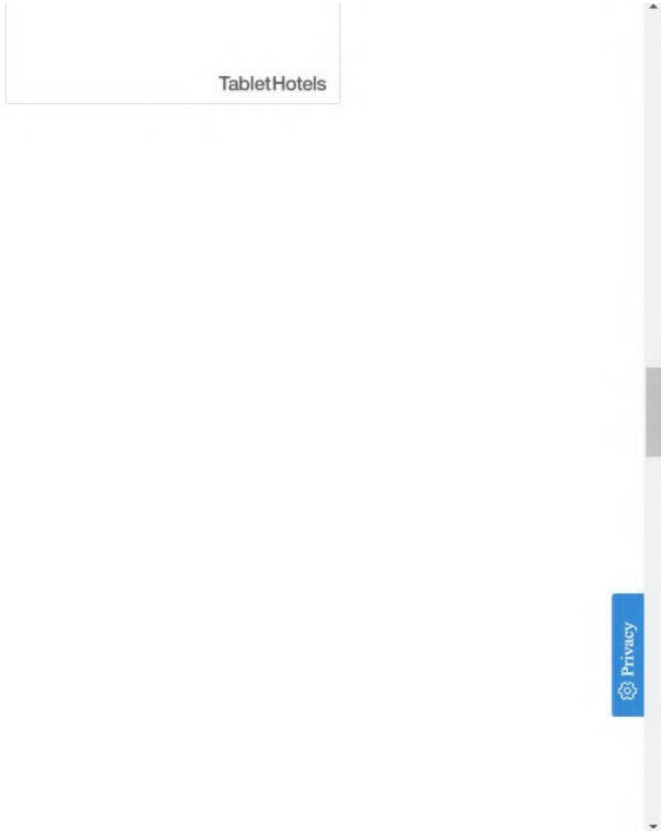
**will become 'licence to harass trans people'**

VIC PARSONS - MARCH 9, 2022



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Dr Whoise J Whoody? @notCursedE · 7h
"Gay kids can't support each other because paedophiles exist" - @TwisterFilm
Alice Something Or Other @MechaniVal · 7h
This man is part of LGB Alliance. He just said this to me in a comment on a Facebook post about the events last weekend.
Look at this absolute bollocks! Because of his idea that teachers are somehow going to predate on gay kids, there shouldn't be LGBT clubs?
Show this thread
dozen straight teachers who got 'into trouble' for pushing boundaries with girls and in one case with a boy. One of my music teachers was arrested and jailed for showing boys gay porn. Having clubs where kids explore on school grounds ...their sexual orientation seems to be unnecessary and potentially
5
11
47
Malcolm Clark
@TwisterFilm
Replying to @notCursedE
So please circulate Alice, I think you'll find 99% of the Scottish public would agree. You'd win them round if you could at least express concern about the risks of


TabletHotels
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Malcolm Clark of the LGB Alliance tweeted that "99% of the Scottish public" would agree with him that LGBT clubs in schools shouldn't exist. (Twitter/Screenshot)

The furore is the latest in a long line of embarrassments for the LGB Alliance.

Last week, the group released its first-ever pop song, "Stand Up", to unanimously negative reviews and general bafflement.

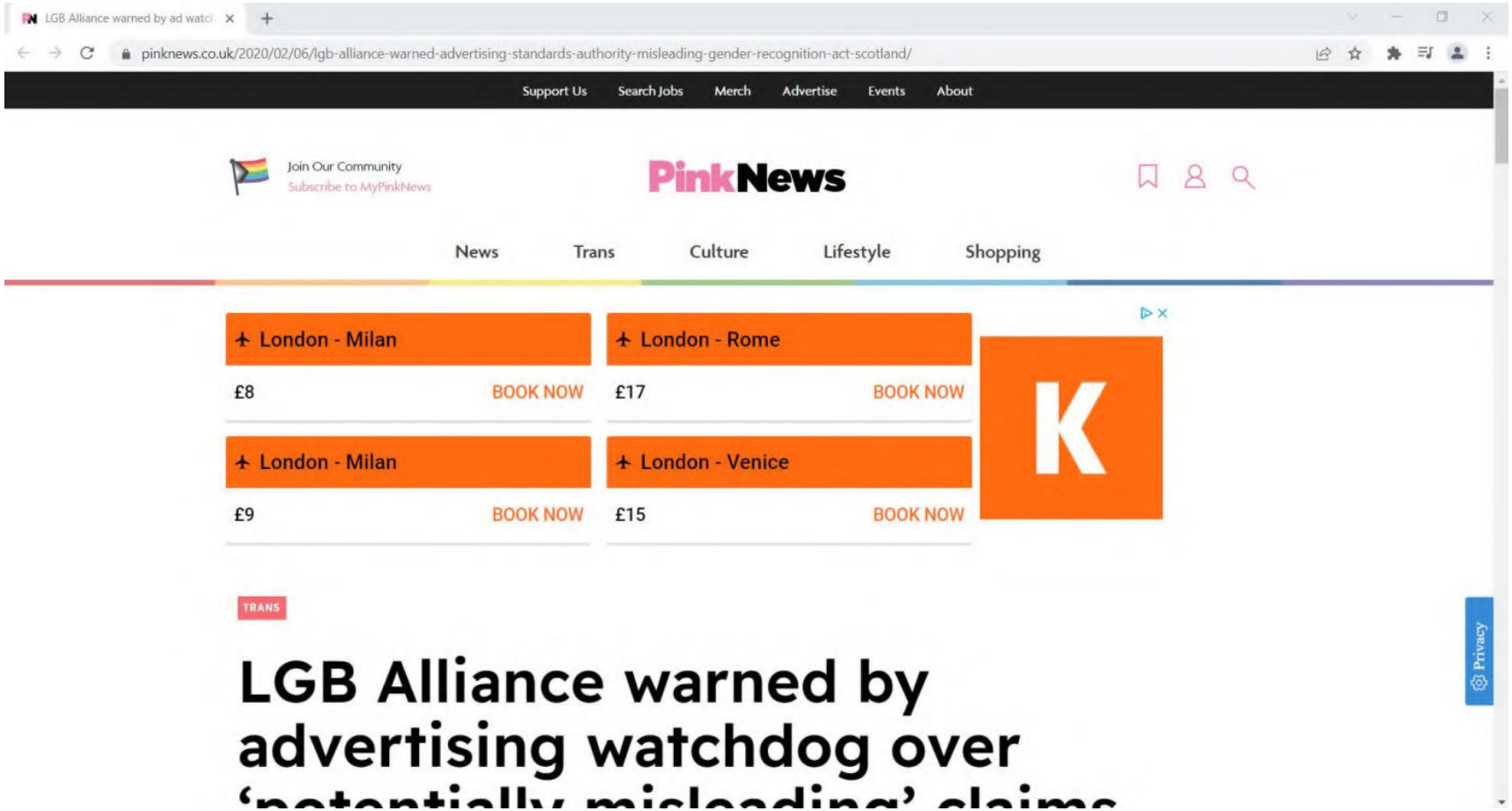
Just before Christmas, it unveiled a new logo and branding, which many pointed out bore a strong resemblance to the Straight Pride flag.

When asked to comment on the remarks made by Clark, Kate Harris and Bev Jackson, two other LGB Alliance co-founders, declined. They did however insist that *PinkNews* print an email in full – for some reason including a thank you to *PinkNews*' editor for reaching out for comment a second time after they declined the first time.

Harris and Jackson also said they wanted to have a "grown up, fact-based conversation" with *PinkNews* while declining to respond to the facts presented to them in the form of Clark's comments.

More: Anti-gay, BBC, Homophobia, lgb alliance, lgbt clubs, malcolm clark

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LGB Alliance warned by ad watch
pinknews.co.uk/2020/02/06/lgb-alliance-warned-advertising-standards-authority-misleading-gender-recognition-act-scotland/
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TRANS
LGB Alliance warned by advertising watchdog over
Privacy

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3218

# ‘potentially misleading’ claims about gender recognition laws

VIC PARSONS | FEBRUARY 6, 2020 | SAVE FOR LATER




Protesters demonstrate outside the Scottish Parliament for reform of the Gender Recognition Act. (Ken Jack/Getty Images)

**The LGB Alliance has been warned by the UK’s advertising watchdog over “potentially misleading” claims in two paid-for newspaper adverts in Scotland.**

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## paid-for newspaper adverts in Scotland.

The Advertising Standards Authority (ASA) said it received a number of complaints about the newspaper advert, called 'Press Pause on the Gender Recognition Bill'.

ADVERTISING




The ASA said the anti-trans group's advert was "potentially misleading" because "the legislation it refers to is still under consultation".

The advert appeared in *The Herald* (18 January) and *Scotland on Sunday* (19 January) as part of the group's campaign against the Scottish government's plan to reform the Gender Recognition Act, which is currently under public consultation.

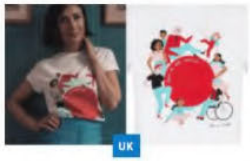
The GRA reforms will simplify the way that trans people update the gender on their birth certificate, demedicalising the process and lowering the age at which trans people can access the service from 18 to 16.

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EMILY CHUDY - MARCH 9, 2022



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"We contacted the advertiser to make them aware of the potential misleadingness in their advertising with reference to the claims of what the implications of the legislation will be, because the legislation it refers to is still under consultation," the ASA told *PinkNews*.

"We dealt with this case through an 'Advice Notice'. We issue Advice Notices where we consider there are potential problems under our advertising rules but do not consider the issues raised are so significant as to warrant a full formal investigation."

Because the issue was not judged serious enough for a full formal investigation, details of the case won't be published online.







**Brave Polish activists helping LGBT+ Ukrainians flee Putin's cruel, unjust and barbaric war**

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**Fears Scottish plan to criminalise gender 'fraud' will become 'licence to harass trans people'**

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Because the issue was not judged serious enough for a full formal investigation, details of the case won't be published online.






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**Fears Scottish plan to criminalise gender 'fraud' will become 'licence to harass trans people'**

VIC PARSONS - MARCH 9, 2022






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## LGB Alliance claim GRA reform 'pushed through' despite first consultation being held almost three years ago.

The LGB Alliance advert said that GRA reform would create a "gender free-for-all" and is "a law that could be exploited by predatory men who wish to hurt women and girls".

In documents published alongside the draft bill, the Scottish government flatly rejected claims that gender recognition reform would impact women's rights or present a risk to single-sex spaces.

The advert also claimed that GRA reform was being "pushed through in haste", despite the first public consultation on the changes being held in 2017.

More than 15,000 people responded to that consultation, with 65 per cent of Scottish respondents supporting the government's plans to introduce a self-declaratory system for legal gender recognition.

## Group's advert 'peddled same old nonsense about GRA reforms'.

One person who had complained to the ASA about the adverts told *PinkNews* that it was a "shame" the case won't be taken further.

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that it was a "shame" the case won't be taken further.

"I'm glad that the ASA has spoken to the LGB Alliance but it seems a shame that this has not been taken further – especially in a climate when so many people are spreading misinformation and downright lies about the GRA reforms and trans people," said the person, whose identity is being withheld by *PinkNews* due to fears of retaliation.

The person added: "The advert peddled the same old nonsense about the GRA reforms that transphobes have been spreading for years.

"Therefore the advert was little more than straw man scaremongering – if there was a problem it would exist now. The fact that any organisation would spread this type of stuff does make you wonder about their agenda.

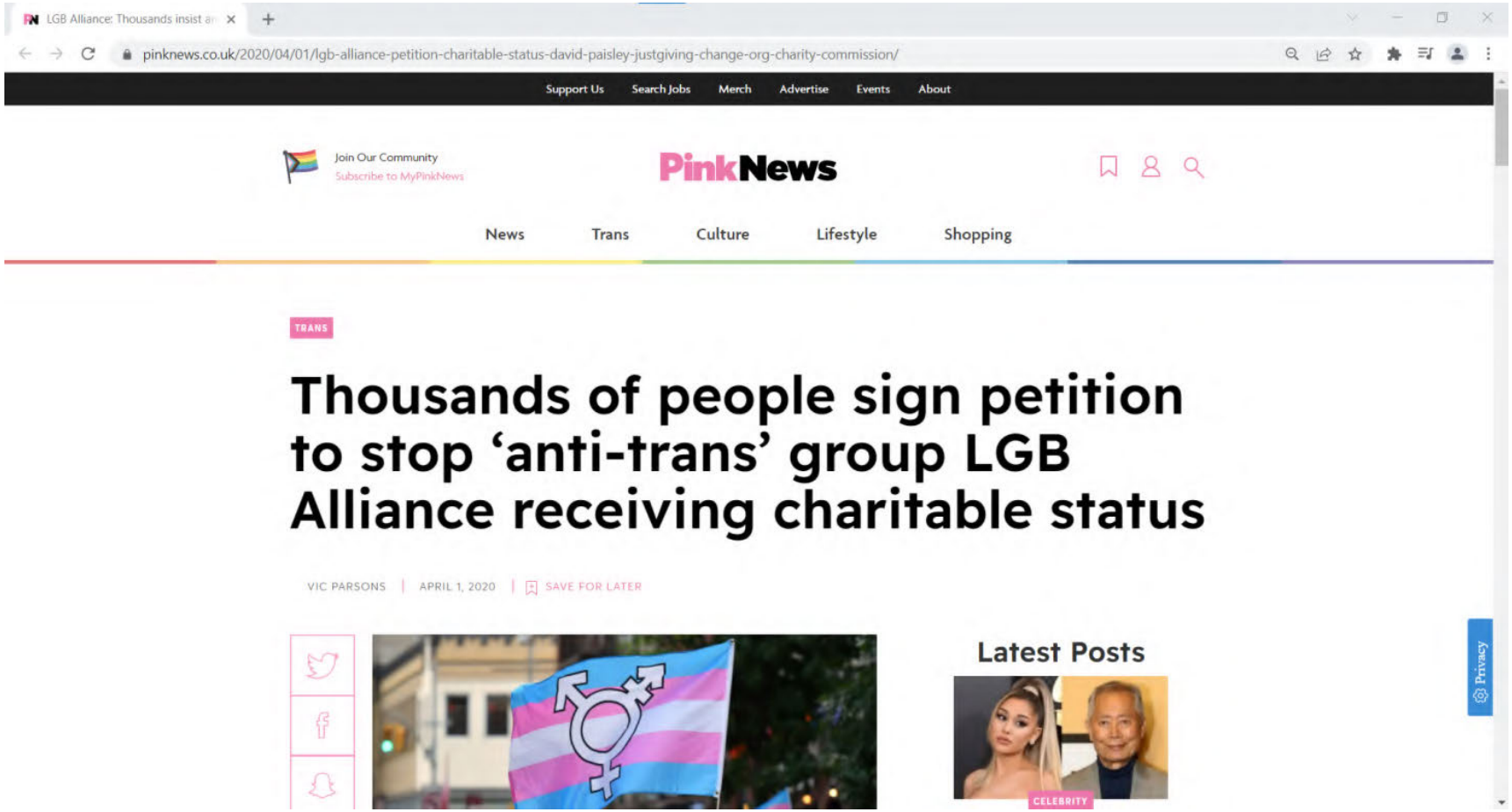
"No wonder only around 20 or so were present at the Alliance's much-heralded Scotland launch recently.

"They have no support from any LGBT+ people I know and the saddest thing of all is that you suspect many of those hoping it succeeds are those with an agenda against all LGBT+ people who merely see it as a useful wedge to try and split the community."

The ASA said it will keep the complaints it received about the LGB Alliance advert on file so that it can "respond as appropriate" in case there are similar complaints in future, should the group choose to pay for advertising again.

*PinkNews has contacted the LGB Alliance for comment.*

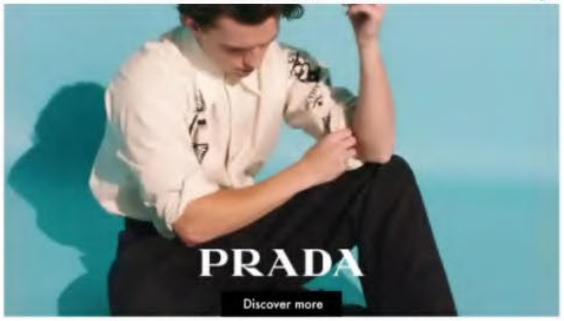
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LGB Alliance: Thousands insist ar
pinknews.co.uk/2020/04/01/lgb-alliance-petition-charitable-status-david-paisley-justgiving-change-org-charity-commission/
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Thousands of people sign petition to stop 'anti-trans' group LGB Alliance receiving charitable status
VIC PARSONS | APRIL 1, 2020 | SAVE FOR LATER
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# Thousands of people are calling on the Charity Commission not to give charitable status to the LGB Alliance for being a "transphobic hate group".

In just three days, more than 13,000 people have signed the petition to stop the LGB Alliance gaining charity status.

ADVERTISING



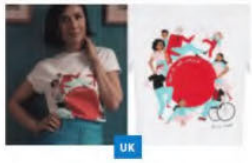

The group, which launched in 2019 and promptly faced a blistering backlash from the wider LGBT+ community for its position on trans rights, strongly denies it is transphobic.

But the Change.org petition, signed by 13,400 people at time of writing, says that "many in the LGBT+ community agree they are a transphobic hate group".




## George Takei and Ariana Grande lead stars condemning Florida's 'disgusting' Don't Say Gay bill

NOLA OJOMU - MARCH 9, 2022




## Meet the queer illustrator behind this joyfully inclusive Red Nose Day 2022 t-shirt

EMILY CHUDY - MARCH 9, 2022



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group".

"LGB Alliance is a political campaign organisation, set up primarily to oppose trans rights and equality… LGB Alliance are not fit to be given charitable status," the petition says.

The petition points to the fact that the LGB Alliance paid for Scottish newspaper adverts opposing reform of Scotland's Gender Recognition Act (GRA).

The adverts appeared in *The Herald* (18 January) and *Scotland on Sunday* (19 January).

The LGB Alliance was later warned by the UK's advertising watchdog, the Advertising Standards Authority, over the "potentially misleading" claims it had made about Scotland's proposals to update gender-recognition laws.

The petition comes as cis gay actor David Paisley, a Scottish trans ally who recently promised to send nudes to all those who filled out Scotland's consultation on GRA reform, wrote a complaint to the JustGiving website for hosting the LGB Alliance's fundraising page.

Paisley pointed out that JustGiving's community guidelines say all fundraising campaigns must be "for good, for all and for the community".

Scotland's Gender Recognition Bill could – until coronavirus caused it to be put on hold – have modernised the process by which trans people update the legal gender on their birth certificates, a small step forward for trans rights.

But the LGB Alliance opposes any changes to gender-recognition laws because, it claims, reforms would "hurt women and girls" and "undermine"



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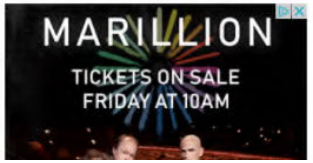
PATRICK KELLEHER - MARCH 9, 2022



NEWS

**Fears Scottish plan to criminalise gender 'fraud' will become 'licence to harass trans people'**

VIC PARSONS - MARCH 9, 2022




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But the LGB Alliance opposes any changes to gender-recognition laws because, it claims, reforms would "hurt women and girls" and "undermine" LGB rights – despite LGBT+ groups and women's organisations in Scotland strongly supporting the proposed changes.

LGB Alliance co-founder Malcolm Clark suggested that the money raised on JustGiving was used to pay for newspaper adverts attempting to prevent GRA reform and would be again in future, telling supporters in a now-deleted March 7 tweet that if they "liked those ads and want more we'll need a LOT more money. Please donate", and sharing a link to the organisation's JustGiving page.






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statement precludes us doing that.
justgiving.com/crowdfunding/l...

**LGB ALLIANCE**

**Homosexuality is same-sex attraction.**
**Biological sex is real.**
**Sex is binary, not a spectrum.**

JustGiving

**Donate to help us assert the right of lesbians, bisexuals and gay men to defin...**
justgiving.com

12:03pm · 7 Mar 2020 · Twitter for iPhone

**7** Replies **87** Retweets **221** Likes

LGB Alliance co-founder Malcolm Clark encourages supporters to donate to the JustGiving fundraiser for more ads like the ones paid for in Scottish newspapers. (Twitter/Screenshot)

Paisley told *PinkNews* that he's been "a strong critic of the LGB Alliance since their inception, they particularly drew my attention when one of their directors, Malcolm Clark, spoke out against LGBT+ youth groups in schools".



LGB Alliance co-founder Malcolm Clark encourages supporters to donate to the JustGiving fundraiser for more ads like the ones paid for in Scottish newspapers. (Twitter/Screenshot)

Paisley told *PinkNews* that he's been "a strong critic of the LGB Alliance since their inception, they particularly drew my attention when one of their directors, Malcolm Clark, spoke out against LGBT+ youth groups in schools".

"The LGB Alliance falls far short of conducting any operations for the common good, they actively campaign against trans equality," Paisley said.

"As an ally I can't allow myself to be silent when I see a group of people being attacked and marginalised by a wealthy and well-organised campaign of disinformation."







1865

3230



# PRESS PAUSE on the Gender Recognition Bill

The new Gender Recognition Reform Bill is described by the Scottish Government as an easier way for people to legally change their sex.

Sounds reasonable enough. Until you think through the implications, especially for women and girls.

The proposed reform removes the need for psychiatric assessment and medical diagnosis. Nor will there be a need for any physical change such as surgery. There would be nothing to stop any man gaining legal recognition as a woman with a birth certificate to match and thereby accessing women's hospital wards, refuges, prisons, toilets or changing rooms. It will create a gender free-for-all.

**This is a bad law being pushed through in haste. It is a law that could be exploited by predatory men who wish to hurt women and girls.**

We believe that the majority of genuinely trans people will recognise the harm that malign individuals could cause if this Bill is rushed through Parliament. We think they will welcome the chance to determine the best way forward.

Equality matters! The right of a person to self-identify as a woman must not outweigh the right for a woman to be safe, supported and valued.

Some lobby groups claim that lesbians and gay men support these changes. We don't. These changes will undermine our rights.

The Government must withdraw this Bill and think again. Join the campaign for a reasoned debate and urge your MSP to Press Pause so that more voices can be heard.

WHAT DO WE WANT?

Just an opportunity for a proper debate on the implications of the Bill. That's all.

WHEN DO WE WANT IT?

Let's give it as long as it needs. Why rush when there's so much at stake?

LGB ALLIANCE SCOTLAND

forwomen.scot



The actor has sent the letter to JustGiving and is waiting for a response.

He also warned that giving the group charitable status would "afford them credibility" and give them "access to funding sources" not currently available.

"Since formation the LGB Alliance have focused primarily on campaigning against reform to the Gender Recognition Act. I've found no evidence that they have helped the LGBT+ community or conducted operations for public benefit," the *River City* and former *Holby* star said.

Paisley, who is a passionate advocate for women's rights, said that he agrees with feminist organisations like Sisters Scotland that feminism should be intersectional and that trans rights do not come at the expense of women or LGB people, as the LGB Alliance claims.

"LGBT+ people are well practiced at spotting intolerance and calling out hatred when they see it, we've heard many of the offensive anti-trans tropes before: they are sexual predators, they are perverts, they can't be trusted in changing rooms, they are a danger to children," Paisley said.

"LGBT+ people recognise these as the same hateful arguments used against us in the past, we see it for the bigotry it is – homophobia recycled as transphobia."

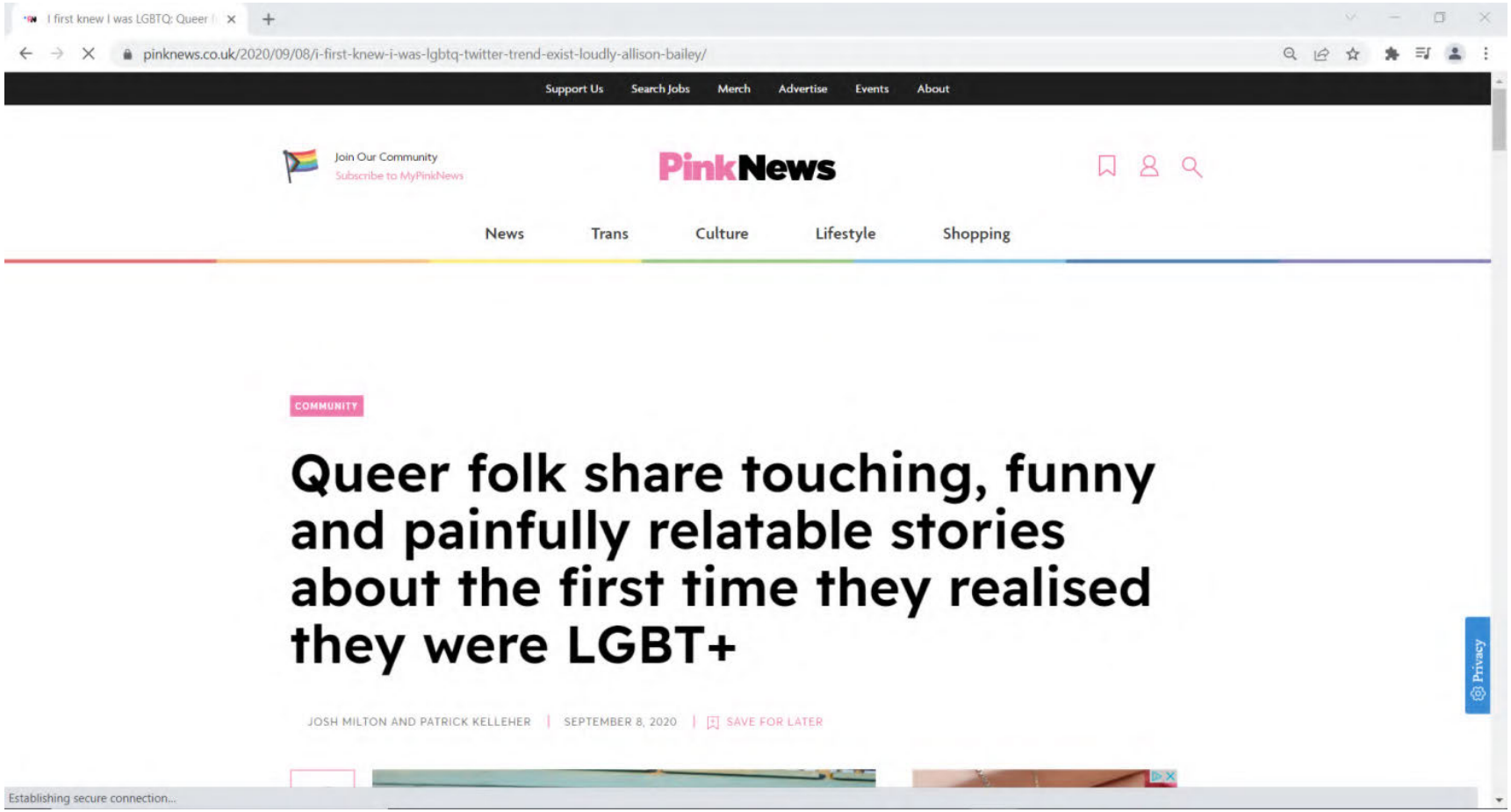
*LGB Alliance has been contacted for comment.*

More: Advertising Standards Authority, David Paisley, lgb alliance, scotland gender recognition bill

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I first knew I was LGBTQ: Queer
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Queer folk share touching, funny and painfully relatable stories about the first time they realised they were LGBT+
JOSH MILTON AND PATRICK KELLEHER | SEPTEMBER 8, 2020 | SAVE FOR LATER
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Establishing secure connection...

1868

3233




After an anti-trans figurehead said young people shouldn't be 'labelled' LGBT+, Stonewall asked users to share when they realised they were queer. (Stock photograph via Elements Envato)

# Countless LGBT+ people took to Twitter Tuesday (September 8) to give endearing accounts of how they realised they were queer, after a lawyer with links to the LGB Alliance claimed young people shouldn't be "labelled".

"I first knew I was LGBTQ" was the UK's number one trending topic after Allison Bailey, a lawyer who describes herself as a "gender critical" lesbian, said a 12-year-old cannot know they are queer.

ADVERTISING





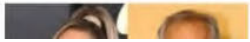




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Bailey is best-known for announcing the launch of the LGB Alliance, an association which has sought to strike a wedge between the LGB and T communities.

She spoke out after queer Black youth advocacy group Exist Loudly asked for followers aged between 12 and 23 to answer a questionnaire.

"A 12-year-old is a child," she wrote. "Stop putting children in with adults and labelling them LGBTQ+."

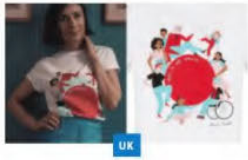
As the backlash against Bailey's tweet grew, Stonewall urged people to share their stories in an effort to show that being queer is not reserved for adults.




## From Section 28 to crushes on Batman, queer people reveal when

## Grande lead stars condemning Florida's 'disgusting' Don't Say Gay bill

NOLA OJOMU - MARCH 9, 2022




## Meet the queer illustrator behind this joyfully inclusive Red Nose Day 2022 t-shirt

EMILY CHUDY - MARCH 9, 2022




## Brave Polish activists helping LGBT+ Ukrainians flee Putin's cruel, unjust

Privacy

1870

3235

LGBT+ people rushed forward to share their stories, with many talking about childhood crushes, stolen glances and first kisses — as well as the shame that society puts on young queer people.

**Hafsa Qureshi**
@MsHafsaQureshi

#ifirstknewIwasLGBTQ when I was 11. I just didn't feel what my friends did for boys. But there was this girl at school, she had the most charming smile. My heart melted. I realised that's how I was 'supposed' to feel for boys. And now I'm super bi 😍

> **Stonewall** @stonewalluk
> It sounds like some people still think you can only know you're LGBTQ+ once you become an adult. Whoever knew they were LGBTQ+ at 12, put your hand up! 🖐
>
> When did you realise? Share your story on the hashtag #ifirstknewIwasLGBTQ – we will retweet our favourites ❤️

2:55 PM · Sep 8, 2020

Read the full conversation on Twitter

176 Reply Share

Read 4 replies

**Vaneet Mehta**
@nintendomad888



NEWS

## Fears Scottish plan to criminalise gender 'fraud' will become 'licence to harass trans people'

VIC PARSONS - MARCH 9, 2022




Privacy

Read 4 replies

**Vaneet Mehta**
@nintendomad888

#ifirstknewIwasLGBTQ when I started to become curious about the boys in my year at around 10/11, whilst also having crushes on the girls. I started looking at guys and feeling something...but buried it because I still liked girls. Not knowing bisexuality held me back so much

> **Stonewall** @stonewalluk
> It sounds like some people still think you can only know you're LGBTQ+ once you become an adult. Whoever knew they were LGBTQ+ at 12, put your hand up! 🖐
>
> When did you realise? Share your story on the hashtag #ifirstknewIwasLGBTQ – we will retweet our favourites ❤️

1:59 PM · Sep 8, 2020

38 Reply Share

Explore what's happening on Twitter

**Alice Morose (They/Them)**
@AliceintheVoid

#ifirstknewIwasLGBTQ

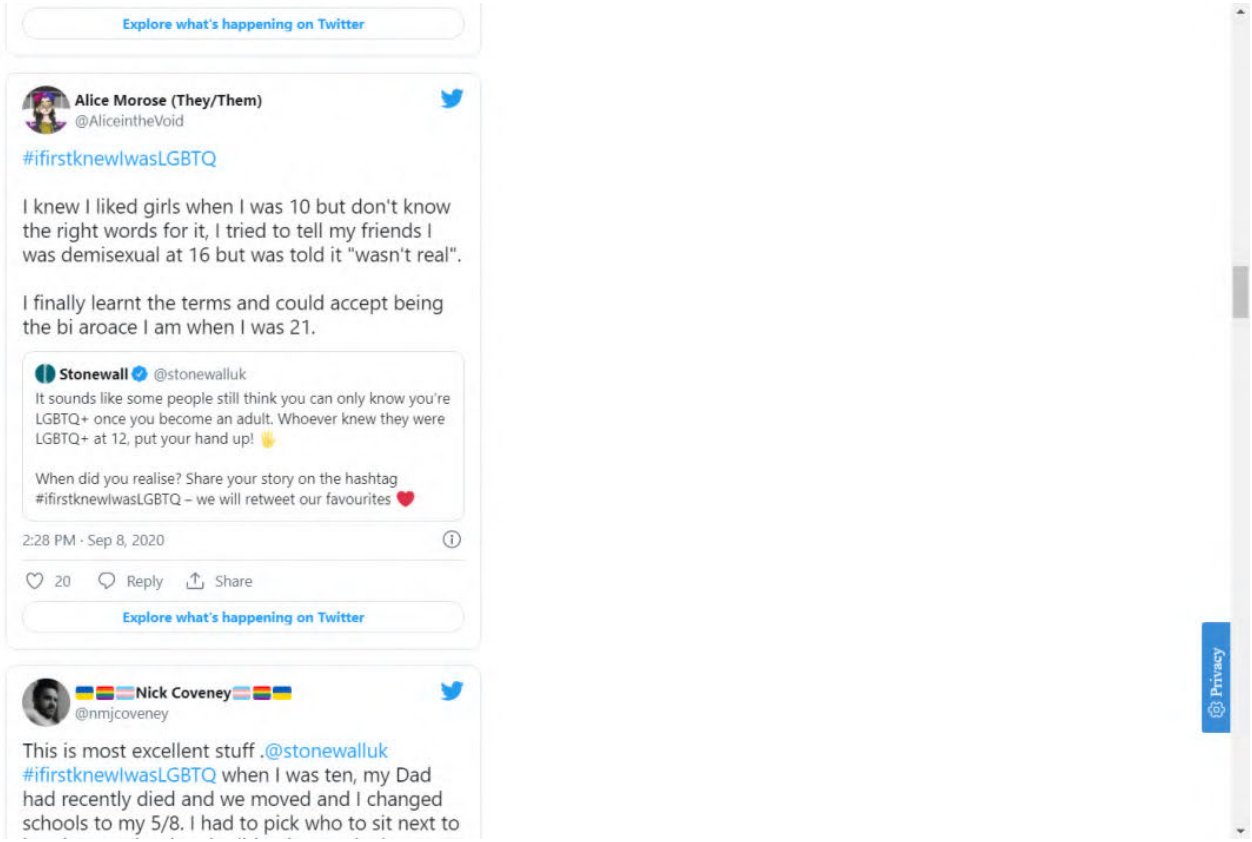
I knew I liked girls when I was 10 but don't know the right words for it, I tried to tell my friends I was demisexual at 16 but was told it "wasn't real".




Privacy

1872

3237


Explore what's happening on Twitter
Alice Morose (They/Them)
@AliceintheVoid
#ifirstknewIwasLGBTQ
I knew I liked girls when I was 10 but don't know the right words for it, I tried to tell my friends I was demisexual at 16 but was told it "wasn't real".
I finally learnt the terms and could accept being the bi aroace I am when I was 21.
Stonewall @stonewalluk
It sounds like some people still think you can only know you're LGBTQ+ once you become an adult. Whoever knew they were LGBTQ+ at 12, put your hand up!
When did you realise? Share your story on the hashtag #ifirstknewIwasLGBTQ – we will retweet our favourites
2:28 PM · Sep 8, 2020
20
Reply
Share
Explore what's happening on Twitter
Nick Coveney
@nmjcoveney
This is most excellent stuff .@stonewalluk #ifirstknewIwasLGBTQ when I was ten, my Dad had recently died and we moved and I changed schools to my 5/8. I had to pick who to sit next to
Privacy

1873

3238




Privacy

1874

it's been a journey over the last eight years, but I'm so much more comfortable with my identity now that I have the words to describe how I feel ^^

1:46 PM · Sep 8, 2020

2 Reply Share

Explore what's happening on Twitter

**Many trans people waded into the conversation to point out that children often understand their gender identity far more than most adults give them credit for.**

Au79-gold
@jesse_piette

#ifirstknewIwasLGBTQ at 8-10 years old. At first i claimed i didn't know if i was a 'boy or a girl'. At 9 years old i came out as agender, still questioning. 10 years old i came out as trans in the most embarrassing way. I sent my parents a picture of a trans jumper/hoodie



#ifirstknewIwasLGBTQ at 8-10 years old. At first i claimed i didn't know if i was a 'boy or a girl'. At 9 years old i came out as agender, still questioning. 10 years old i came out as trans in the most embarrassing way. I sent my parents a picture of a trans jumper/hoodie




**Stonewall** @stonewalluk

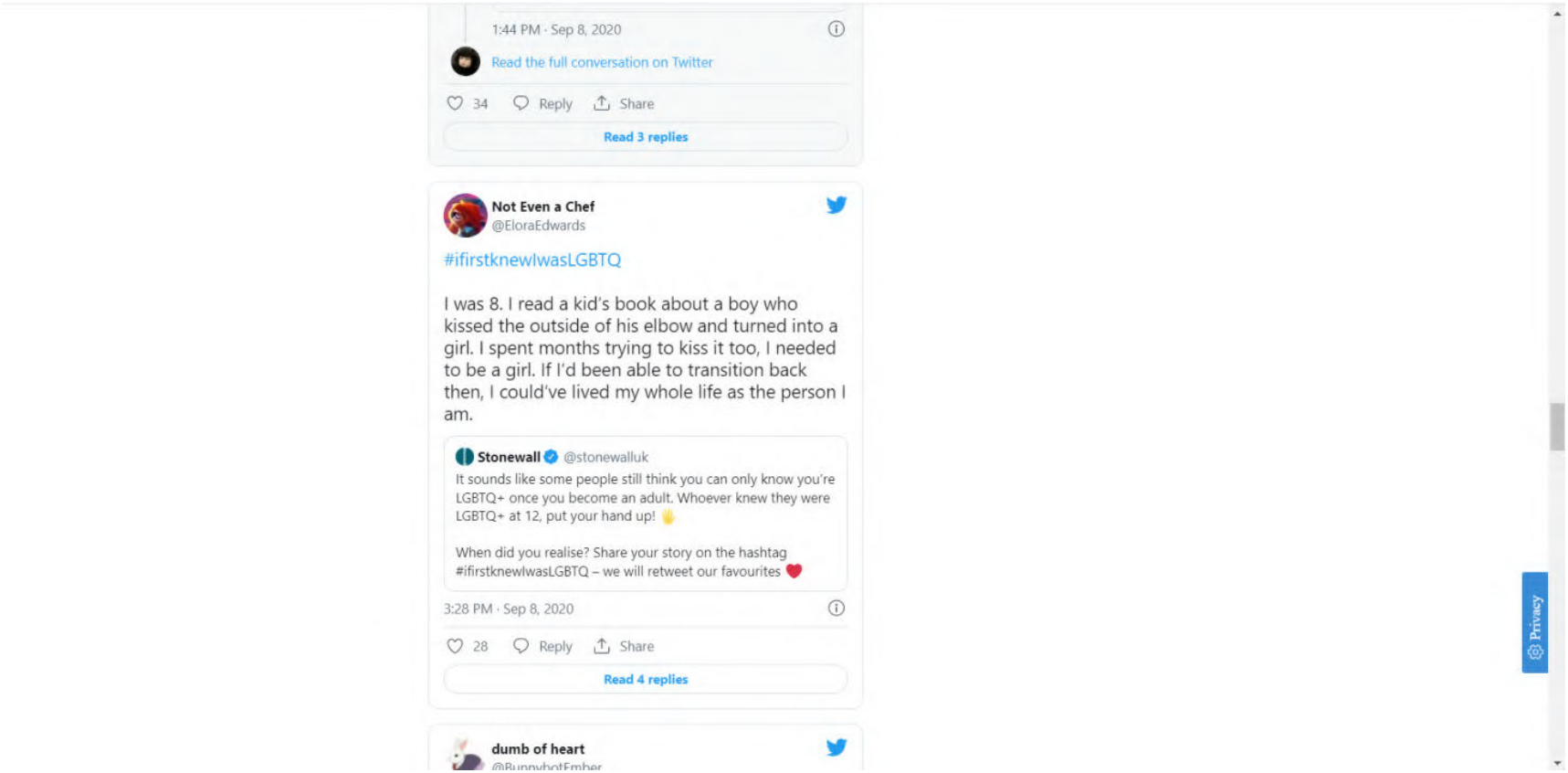
It sounds like some people still think you can only know you're LGBTQ+ once you become an adult. Whoever knew they were LGBTQ+ at 12, put your hand up! 🖐

When did you realise? Share your story on the hashtag #ifirstknewIwasLGBTQ – we will retweet our favourites ❤️

1:44 PM · Sep 8, 2020

Privacy

1876


1:44 PM · Sep 8, 2020
Read the full conversation on Twitter
34
Reply
Share
Read 3 replies
Not Even a Chef
@EloraEdwards
#ifirstknewIwasLGBTQ
I was 8. I read a kid's book about a boy who kissed the outside of his elbow and turned into a girl. I spent months trying to kiss it too, I needed to be a girl. If I'd been able to transition back then, I could've lived my whole life as the person I am.
Stonewall @stonewalluk
It sounds like some people still think you can only know you're LGBTQ+ once you become an adult. Whoever knew they were LGBTQ+ at 12, put your hand up!
When did you realise? Share your story on the hashtag #ifirstknewIwasLGBTQ – we will retweet our favourites
3:28 PM · Sep 8, 2020
28
Reply
Share
Read 4 replies
dumb of heart
Privacy



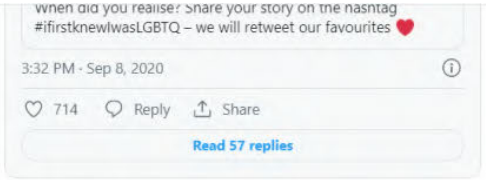

**Many people, of course, came to realise they were LGBT+ by their first TV crushes.**




Privacy

1878

3243







**Meanwhile, others spoke of that general feeling of not fitting in that so**

**Meanwhile, others spoke of that general feeling of not fitting in that so many LGBT+ children experience.**




Privacy

1880

3245




**Exist Loudly, the group which sparked the discourse, sent an apt tweet restating its mission to protect all queer and trans Black youth, regardless of any attempts to erase their reality.**

Privacy

their reality.

"Lastly, to any TERF, transphobe or homophobe who may have found our page. I hope you have some time to find a straw today to suck your mums. pic.twitter.com/mbNu1LN9tk — ExistLoudly (@ExistLoudlyUK) September 8, 2020"

More: coming out, lgb alliance, LGBT

**PinkNews** @PinkNews · Nov 7, 2021

Gay footballer Josh Cavallo says 'trans rights' with epic shutdown of **LGB Alliance**



pinknews.co.uk

Gay footballer Josh Cavallo says ‘trans rights’ with epic shutdown of L...

Newly out gay footballer Josh Cavallo epically shut down anti-trans pressure group LGB Alliance, and the internet has crowned him "king".

84 556

1883

3248

**PinkNews** @PinkNews · Oct 24, 2021

Tunnock's faces boycott after 'donating' to anti-trans group **LGB Alliance**




pinknews.co.uk

Tunnock's faces boycott after 'donating' to anti-trans group LGB Allia...

LGBT+ people have threatened to boycott Scottish chocolatier Tunnock's after it "donated" sweet treats to the LGB Alliance. The ...

7 14 48

**PinkNews** @PinkNews · Oct 21, 2021

Boris Johnson thanks anti-trans **LGB Alliance** for its 'incredible hard work'



pinknews.co.uk

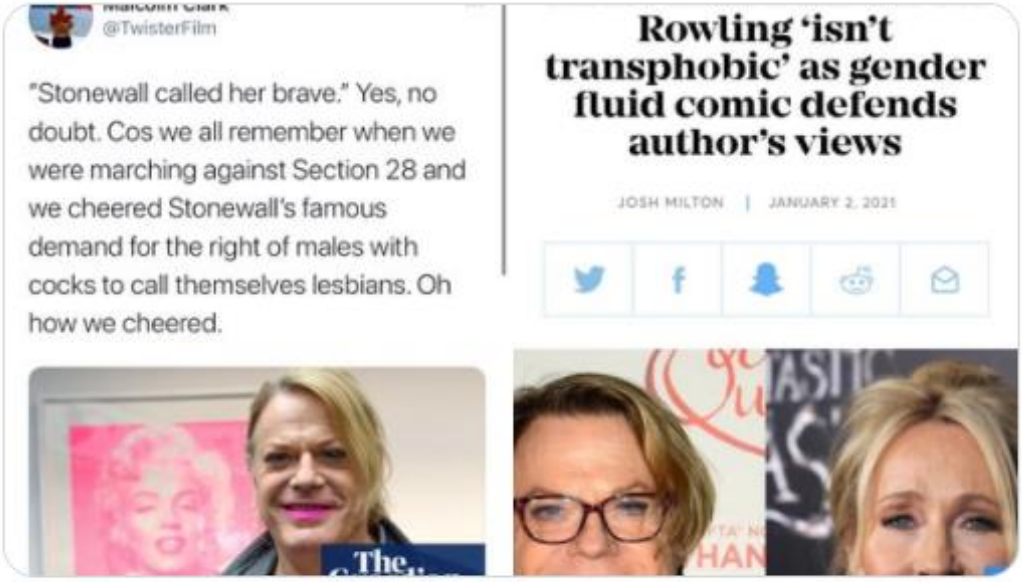
Boris Johnson thanks anti-trans LGB Alliance for its 'incredible hard w...

British prime minister Boris Johnson has thanked the anti-trans LGB Alliance for its 'incredible hard work'.

15 24 36

**Benjamin Cohen** @benjamincohen · Jan 2, 2021

Counting down until the **LGB Alliance** and its vile founders change their views about Eddie Izzard...




24 5 66



**Benjamin Cohen** @benjamincohen · Jan 1, 2021

More here from the hateful **LGB Alliance**

> **Benjamin Cohen** @benjamincohen · Jan 1, 2021
>
> Replying to @ALLIANCELGB @stonewalluk and @PinkNews
>
> I guess you mean reports like these? It is frankly sickening that you are spreading lies and weaponising the murder of three men to further your disgusting cause pinknews.co.uk/2020/11/11/rea...

2 2 36

Show this thread

**Peter Tatchell** @PeterTatchell · Oct 3, 2021

Row looms over Tory conference invitation to anti-trans lobbying group. **LGB Alliance** is misnamed. I have never seen it attend or support any campaign for **LGB** rights in the UK or internationally. It is focussed on opposing #trans rights. SHAME!




theguardian.com

Row looms over Tory conference invitation to gay lobbying group accu...

Invitation to LGB Alliance risks repeat of disputes at Labour meeting, say senior figures

**Peter Tatchell** @PeterTatchell · Oct 21, 2021

Boris Johnson thanks anti-trans **LGB Alliance** for its 'incredible hard work'. He's siding with the oppressors of trans people. The **LGB Alliance** collaborates with groups like Heritage Foundation that are anti-gay, anti-abortion & oppose same-sex marriage



pinknews.co.uk

Boris Johnson thanks anti-trans LGB Alliance for its 'incredible hard w...

British prime minister Boris Johnson has thanked the anti-trans LGB Alliance for its 'incredible hard work'.

**Peter Tatchell** @PeterTatchell · Jan 24, 2020

A founder of the anti-trans rights **LGB Alliance** says there shouldn't be LGBT clubs in schools because of 'predatory gay teachers'. This sickening homophobia has not been condemned by other **LGB Alliance** leaders. Shameful! ow.ly/MrRM50y3l9g

11 23 63


Peter Tatchell @PeterTatchell · Feb 13, 2020
Labour leadership contenders split over trans group pledge card. Candidates differ on pledge that describes Woman's Place UK & LGB Alliance as 'trans-exclusionist hate groups'. Time to stop the demonisation of trans women as a threat to non-trans women
theguardian.com
Labour leadership contenders split over trans grou...
Candidates differ on pledge that describes Woman's Place UK and LGB Alliance as 'trans-exclusionist ...
8
1
13

**Christine Burns MBE** @christineburns · Oct 1, 2021

Just in from my inbox. This is an appeal against **LGB Alliance**'s charity status. The hearing will be between Mar-May next year but LGBA, as a respondent, have until next Friday to set out a full legal case for themselves. This is what we should do with these folk: run them ragged.




**Christine Burns MBE** @christineburns · Oct 23, 2019

#LGBAlliance is a hate group, pass it on

> **Theresa Davis** @helresa · Oct 23, 2019
> #LGBAlliance is a hate group, pass it on twitter.com/SennaLoveAlway...

1 83 181

**Christine Burns MBE** @christineburns · Oct 2, 2021

High-profile appeal against anti-trans **LGB Alliance**'s charity status inches closer to courtroom




pinknews.co.uk

High-profile appeal against anti-trans LGB Alliance's charity status inc...

A high-profile appeal against the Charity Commission's decision to register the LGB Alliance as a charity is expected to go to trial in 2022.

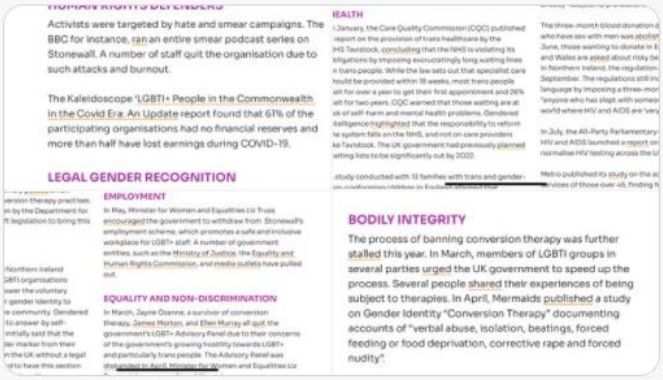
**Christine Burns MBE** @christineburns · Oct 24, 2019

Does anyone know what those heading up the #LGBAlliance did to secure Equal Marriage or to educate schools about **LGB** lives, or to end the military ban or basically anything that has mattered to **LGB** people in this generation? "We don't support trans" is not much of a policy list.

24 69 300

**India Willoughby** @IndiaWilloughby · Feb 15

Another damning report from Brussels on Britain's relentless attack on trans people.
*Negative story ran EVERY DAY in the UK media
*Laws passed protecting the right to 'question' trans identity.
*Trans hate group **LGBAlliance** given charity status
*Hate crime rocketing



Activists were targeted by hate and smear campaigns. The BBC for instance, ran an entire smear podcast series on Stonewall. A number of staff quit the organisation due to such attacks and burnout.

The Kaleidoscope 'LGBTI+ People in the Commonwealth in the Covid Era: An Update report found that 61% of the participating organisations had no financial reserves and more than half have lost earnings during COVID-19.

HEALTH

LEGAL GENDER RECOGNITION

EMPLOYMENT

EQUALITY AND NON-DISCRIMINATION

BODILY INTEGRITY

The process of banning conversion therapy was further stalled this year. In March, members of LGBTI groups in several parties urged the UK government to speed up the process. Several people shared their experiences of being subject to therapies. In April, Mermaids published a study on Gender Identity "Conversion Therapy" documenting accounts of "verbal abuse, isolation, beatings, forced feeding or food deprivation, corrective rape and forced nudity".

6 27 89

**India Willoughby** @IndiaWilloughby · Feb 17

England's corrupt @EHRC (working with hate-group **LGB Alliance**) did everything in its power to STOP trans people being given the dignity of filling out National Census forms as who we really are.

Basically, the body set-up to protect us
tried to have us register as men.



Equality and Human Rights Commission

Paul Lowe
Chief Executive
National Records Scotland
By email only

Marcial Boo, CEO
Our ref: 802Lowe
Wednesday 24 November 2021

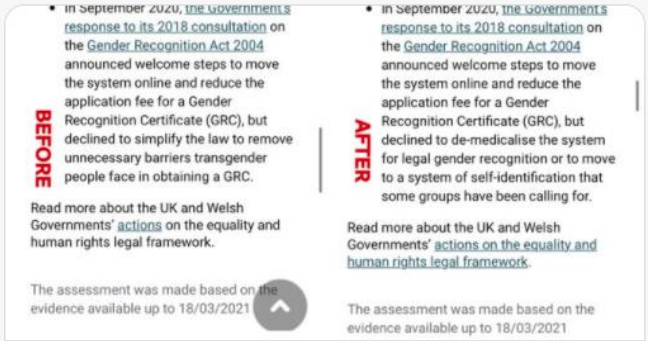
Dear Mr Lowe,

**Collecting data on sex and gender**

I am writing in relation to the guidance you produced earlier this year on the upcoming census in Scotland. As you know, the Equality and Human Rights Commission was involved in the Scottish Government's sex and data working

**India Willoughby** @IndiaWilloughby · Feb 17

Busted! @EHRC caught tampering with records relating to trans people, at the behest of hate group **LGB Alliance**. MASSIVE SCANDAL. But it will be totally ignored by Brit media, because trans folk don't matter 🤦‍♀️ #EHRC




transsafety.network
EHRC caught tampering with Human Rights tracker at request of anti-...
LGB Alliance command and EHRC follows

2 17 41

**India Willoughby** @IndiaWilloughby · Jan 29

Garbage PT1. So you had no problem with poofter, faggot, shirt-lifter etc? There was no campaign to legalise homosexuality, gay marriage etc? You're a hate group @AllianceLGB that will tell any lie. And your days are numbered alongside this Gov. #VichyGays

**LGB Alliance** @ALLIANCELGB · 45m

This a really important point. In our historical gay and lesbian rights movement, we never demanded that society change its laws, its activities and its language to accommodate us. We never cursed people who disagreed with us or tried to get them fired. We always built bridges.

2 1 23

**India Willoughby** @IndiaWilloughby · Feb 21

Replying to @KishwerFalkner and @dobleplusungood

You got this gig from Liz Truss purely BECAUSE you were anti-trans. You view trans people as a disease, and are actively pursuing us. There is no balance. Cosy back-door chats with hate group **LGB Alliance**? Joke.

2



**Owen Jones** 🌹 @OwenJones84 · Aug 29, 2021

A man wearing a t-shirt with the anti-trans rights **LGB Alliance** is made to leave Manchester Pride to chants of "Trans lives matter".

Media outlets note: the '**LGB Alliance**' does not represent lesbian, gay or bisexual people in any shape or form.




From **Paddy**

793 1,650 8,676

← **Tweet**

**Owen Jones** 🌹
@OwenJones84

The anti-trans 'LGB Alliance' is now defending opponents of equal marriage from accusations of homophobia. Amazing.

**LGB Alliance**
@ALLIANCELGB

To those people saying it is "homophobic" not to be in favour of gay marriage have a look at the statistics. It seems it's rather a small minority who have made their wedding vows. #LGBIssues #CanWeDropItNowPlease #NotABigDeal #PluralityOfViewsIsAllowed




Thread
Owen Jones
@OwenJones84
The 'LGB Alliance' is a hate group. It was set up purely to agitate against the rights and dignity of trans people and to drive them from the LGBTQ movement. If people promote bigotry against L, G, B, T or Q people in LGBTQ spaces, they should expect to be asked to leave.
3:13 PM · Jan 19, 2020 · Twitter Web App
Owen Jones @OwenJones84 · Jan 19, 2020
Replying to @OwenJones84
As it happens the 'LGB Alliance' is completely marginal to the LGBTQ movement, it is anathema to the vast majority of LGBTQ people, and is being cheered and promoted by bigoted people who aren't even LGBTQ. Their bigotry and their aims will be defeated, and they know it.
16
67
860
Owen Jones @OwenJones84 · Jan 19, 2020
Also: like most bigots, the anti-trans cult are the most awful crybullies. They have the support of most of the press and constantly try to get their opponents fired, but claim they're being silenced, and loudly promote their bigotry and cry victim when it's challenged.
64
104
888


Owen Jones @OwenJones84 · May 24, 2020
On the anniversary of the introduction of Section 28, the anti-trans 'LGB Alliance' claims that the LGBTQ rights movement "never demanded that society change its laws, its activities and its language to accommodate us."
Where do you even start!
LGB Alliance @ALLIANCELGB · 45m
This a really important point. In our historical gay and lesbian rights movement, we never demanded that society change its laws, its activities and its language to accommodate us. We never cursed people who disagreed with us or tried to get them fired. We always built bridges.
57
284
1,610

**Owen Jones** @OwenJones84 · Nov 7, 2021

Anti-trans rights organisation the '**LGB Alliance**' burned to a crisp by newly out Australian footballer @JoshuaCavallo

#LGBWithTheT

> **LGB Alliance** @ALLIANCELGB · Oct 27
> "I'm beginning to wonder why I hid this for so long". We applaud the courage of @JoshuaCavallo and hope he inspires others. Here's to a time when society as a whole can look back and wonder why anyone felt the need to hide who they love.
>
> 
> 
>
> bbc.co.uk
> Josh Cavallo: 'I'm a footballer and I'm gay,' says Australian player
> The Adelaide United footballer has become the only current top-flight male professional to do so.
>
> 38 69 596

**Owen Jones**
@OwenJones84

This article doesn't even mention the anti-trans rights LGB Alliance, for which Kathleen Stock is a Trustee, and which is the *main focus of the Sussex students' objections*, which shows how utterly bereft of basic journalistic standards this is.

> **Harry Lambert** @harrytlambert · Oct 20, 2021
> Protests, police, a fight over free speech - what is happening at Sussex? I spent the past week there talking to @docstockk and others. Here's the story in 1000 words, in this week's @newstatesman. newstatesman.com/politics/educa...

2:10 PM · Oct 21, 2021 · Twitter Web App



**Owen Jones** 🌹 @OwenJones84 · Oct 13, 2021

Brilliant letter from Labour's Shadow Minister for Women and Equalities, @TaiwoOwatemi, rightly condemning the **LGB Alliance**, which exists solely to agitate against trans rights, not to represent **LGB** people.

Reassuring stuff from Labour - so please give it some love 🏳️‍🌈



**Taiwo Owatemi MP**
Member of Parliament for Coventry North West
House of Commons, London, SW1A 0AA

Ms Anne Shirley
The Women Group
Coventry

Our Ref: TO9376 — 13 October 2021

Dear Ms Shirley,

Thank you for writing to me about Professor Kathleen Stock and her position at the University of Sussex.

I have read the statement from the University's Vice-Chancellor, Adam Tickell, published on 7th October. As the matter is still being investigated, he limited his comment to reaffirming his institution's policy regarding the protection of its staff, following the peaceful protests of a number of LGBT+ students.

I have also studied the statement made by UCU Sussex, which was shared by the union's national channels. On behalf of their members, they have made a strong and principled request that the University live up to its own Trans Equality Statement – a commitment that was sadly absent from the Vice-Chancellor's statement.

While I am not familiar with Professor Stock's philosophical writings, I am greatly concerned by her work as a Trustee for the LGB Alliance group. My predecessor as Shadow Minister for Women and Equalities, Charlotte Nichols MP, was highly critical of their activities and I share her position.

LGB Alliance – whose application for charitable status was opposed by over 50 LGBT+ groups, as well as politicians from al parties – should be rejected by all those who believe in equality. They oppose reform of the Gender Recognition Act, which has long been the position of my party and to which we remain committed.

Furthermore, the group opposes LGBT+ inclusive education; believe that adolescents should not be able to access puberty blockers (in flagrant disregard of the entire concept of 'Gillick' competency); criticises measures to make conversion 'therapy' illegal; rejects the very existence of non-binary people; and refuse to condemn as homophobic those who would deny same-sex couples the right to marry.

**Owen Jones** @OwenJones84 · Oct 30, 2021

If you're embarrassing enough to have any illusions in the horribly misnamed '**LGB Alliance**', listen to this and please pull yourself together.

> **LGB Alliance Watch** @LGBAWatch · Oct 30, 2021
>
> LGB Alliance trustee Bev Jackson confirming that they do not support a ban on conversion therapy for sexual orientation.
> #BanConversionTherapy
> #LGBAllianceWatch




**Owen Jones** @OwenJones84 · Oct 1, 2021

The **LGB Alliance** exists solely to fight against the rights of trans people, and this underlines the historic role of the Tories as enemies of LGBTQ people

> **Paul Brand** @PaulBrandITV · Sep 29, 2021
>
> EXCLUSIVE: The Conservatives will host the LGB Alliance at this year's party conference.
>
> The charity has paid for a stall at the event, igniting a row within the party.
>
> itv.com/news/2021-09-2...
> Show this thread

52 359 1,880



**Owen Jones** @OwenJones84 · Oct 21, 2021

I'm sure the **LGB Alliance** will be delighted by the approval of Boris Johnson, who famously called gay men "tank topped bum boys".

(They will be absolutely unironically delighted).

> **PinkNews** @PinkNews · Oct 21, 2021
> Boris Johnson thanks anti-trans LGB Alliance for its 'incredible hard work' pinknews.co.uk/2021/10/21/bor...

18 110 874



**Owen Jones** @OwenJones84 · Jun 13, 2020

Even by the standards of this grotesque anti-trans outfit, what an unhinged lie.

In late October 2019, I approached them for an interview for a column on transphobia. My editors told me understandably to abandon it because of the trivial matter of a general election being called

> **LGB Alliance** @ALLIANCELGB · Jun 12, 2020
> This suggests @OwenJones84 that you care about women. Particularly if they have been abused. Are you still only willing to speak to male reps of LGB Alliance? Is that because you don't care about women at all? Is this tweet what is called virtue signalling? #IStandWithJKRowling twitter.com/OwenJones84/st...

25 45 675


Owen Jones @OwenJones84 · Jun 13, 2020
For those who don't know them, the LGB Alliance are spending a deadly pandemic working with Tory MPs who proudly voted against equal marriage to whip up bigotry against trans people.
And as you can see, they rely on lies to advance their abhorrent political cause.
MP pledges
ort for anti-tr
Alliance while
ling down on
sition to equa
iage
PRIL 22, 2020
ness Nicholson
roness_Nichol
I foresaw (with some justification) tha
d to degrading the status of women a
as we now see has happened and is
g,so my sex are as a binary class in di
tsKateActually · Jun 10
@Baroness_Nichol
u vote against Gay Marriage?
n 10, 2020 · Twitter for iPhone
112 Likes
19
107
497



**Owen Jones** 🌹 @OwenJones84 · Jan 19, 2020

The 'LGB Alliance' is a hate group. It was set up purely to agitate against the rights and dignity of trans people and to drive them from the LGBTQ movement. If people promote bigotry against L, G, B, T or Q people in LGBTQ spaces, they should expect to be asked to leave.

131 1,016 5,949



**Owen Jones** 🌹
@OwenJones84

As it happens the 'LGB Alliance' is completely marginal to the LGBTQ movement, it is anathema to the vast majority of LGBTQ people, and is being cheered and promoted by bigoted people who aren't even LGBTQ. Their bigotry and their aims will be defeated, and they know it.

3:13 PM · Jan 19, 2020 · Twitter Web App



**Owen Jones** 🌹
@OwenJones84

Also: like most bigots, the anti-trans cult are the most awful crybullies. They have the support of most of the press and constantly try to get their opponents fired, but claim they're being silenced, and loudly promote their bigotry and cry victim when it's challenged.

3:13 PM · Jan 19, 2020 · Twitter Web App



**Owen Jones** 🌹 @OwenJones84 · Oct 24, 2021

Following the **LGB Alliance**'s first conference, we're joined by the brilliant @KatyMontgomerie to discuss the latest episode of Britain's anti-trans media.

Their disco will be one of the topics.

JOIN US LIVE AT 12PM 👇

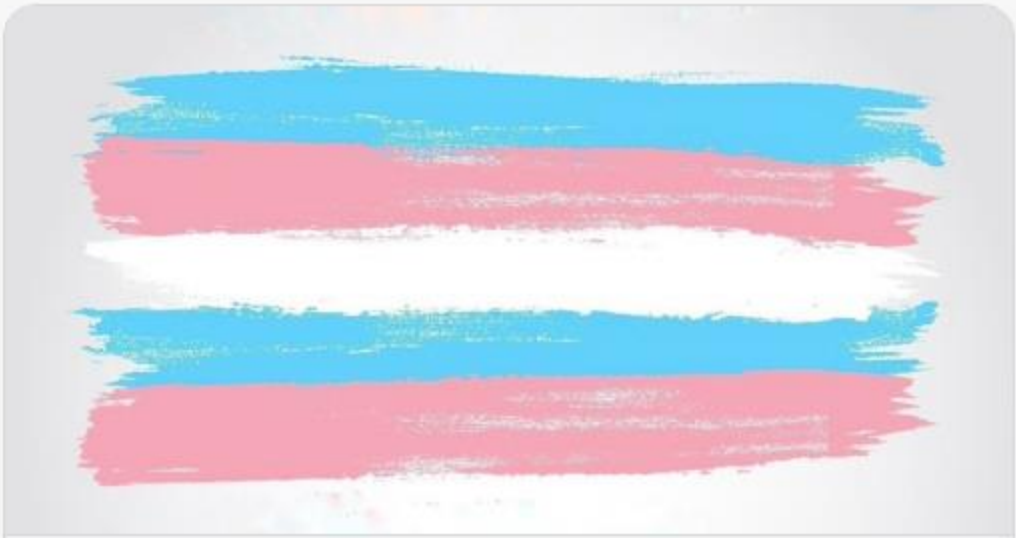
youtube.com/watch?v=f_EeOO...



**Owen Jones** 🌹 @OwenJones84 · Mar 31, 2020

If you want to do just one thing to help trans people on #TransDayOfVisibility, do this.

The so-called '**LGB Alliance**' was set up to campaign against trans rights and divide LGBTQ people. Please sign and share this to stop them getting charitable status >



change.org

Sign the Petition

Stop LGB Alliance Gaining Charity Status



**Owen Jones** 🌹 ✓
@OwenJones84

Replying to @CJ_liberte and @CorruptionSick

Sorry, CJ, it doesn't work like that. You don't help spread lies to accuse someone of misogyny and then refuse to retract and apologise. The LGB Alliance and its followers are liars and enemies of LGBTQ people everywhere, and you going to be defeated.

10:33 AM · Jun 13, 2020 · Twitter Web App



**Owen Jones** 🌹 ✓ @OwenJones84 · Jun 14, 2020
Replying to @ALLIANCELGB
You're not only a reactionary bigoted organisation allied to Tory politicians who voted against equal marriage, you've still not retracted and apologised for your lie. twitter.com/OwenJones84/st...

I should have blocked you before: please do moan about it forever more. Byeeeeeee!

> **Owen Jones** 🌹 ✓ @OwenJones84 · Jun 13, 2020
> Even by the standards of this grotesque anti-trans outfit, what an unhinged lie.
>
> In late October 2019, I approached them for an interview for a column on transphobia. My editors told me understandably to abandon it because of the trivial matter of a general election being called twitter.com/ALLIANCELGB/st...
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# The shocking rise in anti-LGBTQ hate crime shows bigotry is still ruining lives

*Owen Jones*



Sadly, blending in for a quiet life remains a necessary survival strategy for far too many people in Britain today

Fri 3 Sep 2021 16.35 BST




It is impossible to know how much of the surge in reported hate crimes against LGBTQ people is due to escalating harassment and violence, and how much is down to the increased willingness of victims to inform the authorities. What we do know that is that

increased willingness of victims to inform the authorities. What we do know that is that recorded homophobic and transphobic hate crimes have jumped every year since 2015, and yet with an estimated four in five still going unreported, the already grisly figures only hint at a far bleaker reality.

The incidents vary in nature and severity: from abuse hurled at someone identified as LGBTQ because of their appearance, or mannerisms, or a fleeting or profound show of affection towards a partner; to gay men being beaten and robbed, as happened in a suspected homophobic attack on the streets of Edinburgh last month, or a trans man savagely attacked in Bournemouth earlier this year. "According to our research, many experienced verbal harassment, physical abuse, threatening messages, and damage to property," says Eloise Stonborough of the LGBTQ civil rights organisation Stonewall.

In all cases, there is often a visceral sense of humiliation linked to a sudden invasive reminder that your innate characteristics still drive a section of society to violent disgust. After all the undoubted progress, anti-LGBTQ bigotry remains a kind of secret authoritarian regime in this country. It compels many LGBTQ people to alter their behaviour in order to quietly blend in, or to pretend they are something they are not to relatives, friends and colleagues in order to avoid experiences ranging from the uncomfortable to the outright menacing.

> "Reported hate crimes surge. There are no openly trans national politicians and the media is almost entirely hostile

These statistics should not leave a false impression. The experiences of LGBTQ people are not the same. A white, middle-class, gay, cis man - that is, someone generally at one with their gender assigned at birth - in an urban area is likely to suffer far less meaningful oppression than other groups. Beyond the fear of holding hands with their partner in public, their main grievances tend to centre on the psychological scars left by the often suffocatingly homophobic environment of their school years.

This can lead to lasting trauma, which largely explains the higher rates of mental distress and abusive relationships with alcohol and drugs among LGBTQ people. The most damaged are frequently those whose fathers and mothers violated the most sacred principle of parenthood - unconditional love - in deference to their own bigotry, often implanting a ticking time bomb in their children that may detonate in later life, be it in the form of emotional breakdown or drug addiction.

For a young gay black man, homophobia may collide with increased risk of police harassment and racist behaviour from other LGBTQ people: victims can be perpetrators, too, sometimes believing their own mistreatment makes it impossible to oppress others.

Yet as Shon Faye's brilliant new book The Transgender Issue underlines, it is trans people - the T in the LGBTQ - now suffering the most severe onslaught. It's said that history doesn't repeat itself but it often rhymes. Today's relentless campaign against trans people seems a near-carbon copy of the previously widespread monstering of gay and bisexual people, with

all the same tropes repeated: that they are would-be sexual predators, that they seek to brainwash and recruit children, that biology is destiny, that this is a whimsical lifestyle choice, that they are defined by mental illness or a creepy fetish that imposes an intolerable burden on the "normal" majority.

In the 1980s and 1990s, many supposed liberals participated in the anti-gay offensive, lamenting that the case for gay rights was being undermined by "militant homosexuals" making unreasonable demands on the rest of society, such as asking newspapers not to call them "poofters". Again, history repeats itself. The panic over trans rights has airbrushed the cruel reality facing trans people: the quadrupling of reported transphobic hate crimes; the one in four that have been homeless; the 41% who suffered a hate crime in a 12-month period; the nearly half who feel uncomfortable using public toilets; the quarter discriminated against when looking to rent or buy a home.

This panic has also obscured the threats facing all LGBTQ people. Only last week, police confirmed the identity of Ranjith Kankanamalage, a 50-year-old murdered in a suspected homophobic attack in east London on August 16. This horrific story has been rightly covered by all the papers, but it has been overshadowed in public discourse by the preposterous row over a man who appeared at a LGBTQ rights protest in Manchester wearing a T-shirt and hat with the logo of the LGB Alliance, an organisation whose main purpose appears to be campaigning against trans rights.

This was akin to someone turning up to an anti-Trump protest in a Maga cap, with the same predictable result. After he was met by chants of "Trans lives matter", police escorted him away from the march. Supporters of the LGB Alliance - many of whom are straight - promptly took to Twitter to denounce this incident as homophobia and even gay-bashing by the queer protesters - some of whom will inevitably have suffered actual hate crimes. The man became something of a cause célèbre, in an incident that has been marshalled to support the increasingly common claim that the trans rights movement is homophobic; a "woke homophobia" as a GB News presenter put it, rendering LGBTQ people the real homophobic bigots.

Yet as reported hate crimes surge, Stonewall - by far the largest LGBTQ civil rights organisation - finds itself targeted by a McCarthyite campaign against its defence of trans rights. Organisations such as Ofcom have been successfully pressured into cutting ties with Stonewall's diversity scheme. There are no openly trans national politicians, and the British media has been rendered an almost entirely hostile environment for trans people and their LGBTQ allies. Meanwhile, anti-trans activists claim to be "silenced" while enjoying support from the country's newspapers. While those cruelly hounding trans people may be driven by an undoubted realisation that they will, in time, lose - the polling shows younger people, and women in particular, are most supportive of trans people - that is of little comfort to an extremely besieged minority today.

But as Faye's book eloquently puts it, the liberation of trans people - and indeed LGBTQ people as a whole - will free everyone. For example, a strengthened welfare state and solved housing crisis would provide a trans person rejected by their family with desperately needed

housing crisis would provide a trans person rejected by their family with desperately needed independence; but those benefits would help anyone in need of security. The biggest killer of men under 45 is suicide: freeing them from rigid gender norms, which teach them to believe that opening up about their problems is unmanly or "gay", will make them more likely to seek support. More than half a century since the partial decriminalisation of homosexuality, LGBTQ people still fear the repercussions of simply being themselves. Oppression rots a society from the inside out.

When true liberation happens, "coming out" as LGBTQ won't be the stressful ritual known to many with experiences ranging from the good to the tragic. It won't actually be a thing at all - and everybody else will be much freer, too.

Owen Jones is a Guardian columnist

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## 4.23pm

John Nicolson
(Ochil and South Perthshire) (SNP) [V]

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Online abuse is a curse. Once upon a time when kids got bullied at school, that bullying stopped at the school gates. Even if they did not talk about their ordeals—and sadly, we know that many children feel that they cannot—back at home, in a loving household, they were safe. All that has changed with social media. Today, the bullies and trolls pursue their victims home and online. We know that this can be traumatic for children. We know that some have, tragically, taken their own lives as a result.

The sadism comes in many forms. Recently we have learned of the phenomenon of flashing GIFs posted and targeted at children with epilepsy, with the intention of causing seizures. Let that sink in for a moment— trolls targeting epileptic kids with potentially dangerous consequences, again, under the guise of anonymity. Paedophiles have exploited the internet since its inception. With false identities and ever more sophisticated software, young people can be entrapped by those pretending to be someone they are not.

As a member of the Digital, Culture, Media and Sport Committee, I have listened to evidence from the social media companies—TikTok, Facebook, Twitter and Instagram. They all promise to target the problem, but they are all woefully unresponsive. I asked a TikTok boss recently why he was not more tenacious in tackling anti-vaccination disinformation targeted at young people. He said that his company had thousands of moderators hot on the heels of the anti-vaxxers. It only took me a few moments to find a TikTok account with hundreds of thousands of followers posting lies with impunity.

Politicians are not meant to moan, or we get called self-indulgent, but we all know the shocking abuse sent to women politicians in particular. When the First Minister Nicola Sturgeon revealed personal details of tragic miscarriages she had suffered, she was deluged by trolls mocking her or saying that she was lying about her family grief. A *Holyrood* magazine survey found that a third of MSPs had received a death threat, with a third of female MSPs receiving a threat of a sexual nature in addition. Before the 2019 election, a survey showed that many female MPs who were not standing again cited the abuse they received online as a major factor in their decision.

Misogyny, homophobia and racism have sadly always been a part of politics, but they are now magnified by the perfect poisonous storm: a huge worldwide audience and anonymity. I have had a wee taste of it myself recently. I praised online a young trans constituent of mine last year who had bravely spoken of her life in a BBC documentary. Almost instantly, a sinister organisation called the LGB Alliance began trolling me. It offered the reward of a retweet to anyone who donated money to it in my name. I was,

as a result, deluged by abuse from anonymous accounts. I was called a rape enabler, a misogynist and, although I am an openly gay man, a homophobe. As an openly gay man, I was also called a “greasy bender”.

The LGB Alliance was thrown off the country’s two largest crowdfunders as a hate group, but Twitter would not take its account down, despite it clearly and egregiously violating Twitter’s own rules. I am a man in my 50s. The experience was not pleasant, but I was acutely conscious of all the young trans people reading the venom and despairing. They have, after all, been subjected to a vile online onslaught in recent weeks and months.

There can be no accountability in anonymity. Social media is now so ingrained in our lives that it cannot be allowed to continue without some form of verification. The cowards who send death threats or seizure-inducing messages or who attempt to groom children would not dare be so bold if we knew who they were, or at least if the social media companies knew who they were. Of course, the trolling does not exclusively come from the UK. Abuse, misinformation and disinformation flood in from Russian bots, attempting to undermine our values and democracy, and over the course of the pandemic, they threaten our health with covid disinformation.

Like the hon. Member for Stroud (Siobhan Baillie), I believe that verification is the best way to protect people online. That does not mean that people—especially those who are vulnerable—should not be able to use a nom de plume, but social media users should have the option to prove their identity. That could come with an equivalent to the blue tick for verified profiles on Twitter. Such verification would allow us to know who we are interacting with online and know that those we talk to are who they say they are. Users would also then be able to decide whether to block all non-verified users. This would offer protection to parents worried about their children’s safety online, to those who wish to avoid Russian and other bots, and to all of us who would choose to talk only to real people.

Who among us does not seek to stem the avalanche of poison, abuse and disinformation? Will the social media companies embrace such proposals and self-enforce? The evidence suggests not. The Government need to get tough. Soft-touch regulation is not working.

John Nicolson
(Ochil and South Perthshire) (SNP) [V]

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I thank the Secretary of State for the advance copy of his speech, much of which we SNP Members agree with.

At a time when anti-vax disinformation floods social media, when hate is spouted at minority groups under the cowardly veil of anonymity, often without consequence for the perpetrators, and when more children than ever before are using the internet and need to be shielded from harmful content, the proposed online harms Bill is welcome.

We welcome, too, the requirement that companies must accept a duty of care, and the fact that Ofcom will be the independent regulator—but it must be a regulator with teeth. As Dame Melanie Dawes, Ofcom's boss, told the Digital, Culture, Media and Sport Committee a short while ago, Ofcom needs much-enhanced powers to be effective; what additional powers will she have?

To enjoy maximum support in the House, the Bill must, while balancing the right to free expression, tackle illegal content as well as content that is potentially harmful but not illegal. In particular, companies must protect all children from harm, and the Government are right to recognise that.

The covid epidemic and lockdown have seen a surge in homophobia and transphobia online. The TIE—Time for Inclusive Education—campaign reports a 72% rise in attacks on and cyber-bullying of lesbian, gay, bisexual and transgender young people, with organisations such as the so-called LGB Alliance leading the onslaught. In that context, surely there is a case for looking again at social media anonymity. Noms de plume are fine, but we believe that users' identities should be known to the social media publishers—they should not be completely anonymous in all circumstances. Does the Secretary of State agree with that?

Social media disinformation has been especially pernicious during the covid pandemic. Experts tell us that the disinformation during this crisis is unparalleled in the internet era, and the consequences of online harm can be catastrophic, undermining public trust, faith in health officials and acceptance of the value of the vaccine now being rolled out.

In principle, we welcome much in the proposals. Of course, the proof of the pudding will be in the eating—exactly how tough the Government are prepared to be in reality, how hard they will be on the social media companies, and whether they will enforce some of the proposals—but we welcome it.

2.53pm

John Nicolson
(Ochil and South Perthshire) (SNP) [V]

Share

Let us consider these words:

“People can’t, unhappily, invent their mooring posts, their lovers and their friends, anymore than they can invent their parents. Life gives these and also takes them away and the great difficulty is to say Yes to life.”

So wrote the late, great James Baldwin in his much lauded 1956 novel “Giovanni's Room”, in which the author writes profoundly of the rife gay shame of his time. I am so pleased to have secured this debate with my friend the hon. Member for Wallasey (Dame Angela Eagle). We have heard some wonderful, deeply moving contributions.

For the past month, we have been celebrating Pride. What a contrast Pride is to the shame taught to gay kids for so much of the century in which every one of us here today was born. This shame was much of the source of much of the suffering our LGBT+ communities endured. That enduring stigma forced many lesbian, gay, bisexual and trans people into the closet. For many, living a lie, however painful, was safer than living openly with the truth. Decriminalisation in England and Wales in 1967, and in Scotland in 1980, laid the groundwork for change. Even after decriminalisation, many homophobic laws remained on the statute book and homophobic attitudes were commonplace in society, which entrenched the inequality faced by LGBT people.

Since the turn of the millennium, we have seen further progress towards our overall pursuit of equality. My Turing Bill—the Sexual Offences (Pardons Etc) Bill—which sought to pardon all those convicted of sexual offences no longer on the statute book was, sadly, filibustered by a Conservative Minister, despite the Government’s promise to support it. The SNP Scottish Government, however, picked up my Bill and passed it with all-party support at Holyrood. It is a source of great pride to me and, I think, to the First Minister. This year, too, we have seen a long-awaited law reform. Only two weeks ago, the blood donor ban, which prevented so many men from donating, was finally lifted.

Huge advances have been made at home, but LGBT people live in great peril abroad. Hungary’s recent introduction of its version of clause 28 drags civil rights backwards in the very heart of the European Union. Russia under Putin is a hellish place for gay people to live, and 69 countries round the world still criminalise homosexuality. Half of them are in Africa. On the roll call of shame, Iran and Saudi Arabia still have state-sanctioned murder for consensual gay love.

We must not be complacent at home, however. Older LGBT people are more likely to be socially isolated so, during the pandemic, many have felt that they have nowhere to turn and no one to turn to. We know, too, that young LGBT people bullied at home are more

likely to become homeless.

Also, while our legal rights have seemed increasingly enshrined, as other speakers have noted, an onslaught against our trans siblings has been unleashed over the past year by social conservatives, importing the cultural wars from the United States, amplified by social media and whipped up by the right-wing press. The transphobic bullies in the sinister LGB Alliance and elsewhere claim that they represent ordinary voters, but, as we saw in the Scottish elections, when they emerge from behind their keyboards they get trounced at the ballot box: 0.5% percent for the Scottish Family party and, for the Alba party, 1.666%—a significant number, surely.

The future is full of promise. Young people hate intolerance and they hate bigotry. They have gay friends, gay teachers and gay role models. The TIE—or Time for Inclusive Education—campaign does wonderful work in schools. It is a world away from the society in which I grew up in the 1970s. While we on the SNP Benches find much to criticise this Parliament about, I will end on a proud note: my party has more openly elected LGBT members than any other parliamentary party in the world, and our very gayness has made Westminster the second gayest Parliament in the world.

6.31pm

Crispin Blunt
(Reigate) (Con) [V]

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I congratulate my hon. Friend the Member for Carshalton and Wallington (Elliot Colburn) on leading the debate so well, and I congratulate his Committee on securing it. I have two key points for the Government. The first is that we must legislate. Deliver the promise to protect in law. Use the work done in the Government Equalities Office before 2019. Use the examples elsewhere, particularly in Spain and the Australian state of Victoria, which have already legislated. Our common law system enables the drafting challenge of defining conversion therapy to be met. There is no need to overcomplicate this issue. The police, prosecutors and jurors will know conversion therapy when they see it. Most critically, the victims will know it too, and they will have been equipped with a defence mechanism.

Such a law is an important step as a declaratory statement, as it is as a legal tool. If someone is LGBT, the law says that the state supports them. It supports how they want to live their life. When victims find themselves under pressure that is improperly applied to convert them to something they are not, they will know that it is against the law and that they can call it out. They can say to the person or people who are the source of this —*[Interruption.]*

James Gray
(in the Chair)

Share

We have lost the sound, Mr Blunt. You are mute.

Crispin Blunt

Share

My apologies.

The law gives the victims the opportunity to go to the police and, therefore, to have a weapon in their hand against the source of a conversion therapy. The state is on the side of victims' freedom—the freedom that that individual is trying to take away from them.

The second point I want to make is that such protection must include trans people. They are by far and away the most vulnerable group among the LGBT community. Identity around gender dysphoria is surely a much more challenging thing to meet than a minority sexuality, but all must be protected. The law must include trans people, and not only because they are the group who need it the most. In 2018, it appeared that trans people were on a trajectory to achieve their rights and protections to live their lives as they wished, supported by the Government's comprehensive LGBT action plan, but all that now seems to have changed. Trans people are a community under siege. Organisations whose principle raison d'être is to attack and challenge the very legitimacy of trans people have come into being, and they appear to trans people to be firmly in the ascendant.

The lived experience of trans people reflects the awful paucity of services for them in the United Kingdom, as graphically illustrated by VICE News in January and November. They also see 250 articles a year attacking them in our newspaper of record, *The Times.* They see that groups such as the Conservative Women's Pledge and LGB Alliance, whose purpose seems to be to protect cisgender women from trans women, have the ear of Ministers. They see reform of the Gender Recognition Act 2004 abandoned, and the principle of gender-neutral legislation was reversed only last week.

Gender is much more complicated than sexuality, and the drafting of the ban on conversion therapy will need to protect those giving informed, regulated and properly peer-reviewed advice to assist those on the path to reconciling their gender dysphoria. If the legislation does not include the protection of trans people, however, it will send to them the unmistakeable message that their Government do not want to protect them, do not value them and, at some level, do not really accept that trans is really a thing. That awful message would inadvertently make the Government themselves party to the practice of conversion therapy.

Crispin Blunt
(Reigate) (Con) [V]

Share

Let me briefly try to set the context in which these amendments are being considered. This is an issue that goes to trans and women's rights. It is a year since I was elected as chair of the all-party parliamentary group on global LGBT+ rights, which is the only LGBT rights APPG. While the title of the group is not meant to exclude the domestic LGBT rights agenda, it is a statement about where the focus should be, given our astonishing legal and societal progress for LGB people in the UK over the last two or so decades—progress of which I am a personal and fortunate beneficiary.

When I put it in the language of my first profession, the war on these issues had been won, and we were really in the business of rounding up the prisoners—tidying up. Much of that tidying related to the complexities generated by enabling trans people also to be able to enjoy the freedom to live their lives as they wished. The trans agenda understandably became the dominating issue for the British LGBT rights lobby in our civil society. By 2018, with the publication of the LGBT action plan and the consultation on reform of the Gender Recognition Act 2004, the direction of travel looked set fair for trans people to be able to enjoy those rights and live their lives as they wished.

However, to say that there has been a change of climate for trans people since my right hon. Friend the Paymaster General, who is guiding this Bill through the House, lost her responsibilities for equalities is something of an understatement. There is going to be no change to the Gender Recognition Act; self-identification, which is the global gold standard for rights in this area, is going to have to wait; and gender identity services, now acknowledged to be grossly underfunded, with enormous demand on them, are now under well-funded legal assault as well.

We currently face a situation where trans people feel under a full-on attack, yet if one listened to their lordships who were making the case for this amendment, one would have thought it was the other way round. The proponent of these amendments said in the other place:

"We are currently faced with a full-on attack on women's sex- based rights—a misogynistic and bullying campaign which seeks to diminish women's rights in the name of the rights of trans people."—[*Official Report, House of Lords,* 25 February 2021; Vol. 810, c. 962.]

I want to gently suggest that my noble Friend Lord Lucas turn the board around and see what the perspective is from the other side. The context is wild and exaggerated threats about the position of women's rights from trans people. For example, his colleague in the other place, the noble Baroness Fox of Buckley, said:

"What is a threat to women is a particular brand of trans identity ideology. That does threaten women, but that is not the same as trans people."—[*Official Report, House of Lords,* 25 February 2021; Vol. 810, c. 945.]

I look forward to hearing the explanation of that, because what trans people are seeing is *The Times* newspaper —the newspaper of record in the United Kingdom—carrying 250 stories of this kind, generally without satisfactory supporting evidence.

We have this amendment in a Bill that deals with the maternity leave arrangements of one woman who happens to be the Attorney General. A debate in this House and the other place suddenly came out of nowhere, generating the most extraordinary amount of interest and passion for an entirely technical correction of an anomaly in ministerial maternity leave arrangements. Sitting behind the passion engaged on this are agendas, which are in public for those who are taking an interest—principally the trans community —of the Heritage Foundation and the LGB Alliance, which, if one examines its followers on Twitter, does not seem to have a huge wider interest in the subject of LGBT rights. They are hearing an agenda being used, which we heard only yesterday from Donald Trump in his address to the Conservative Political Action Conference, exploiting the issue of a potential threat to women's sports, which need to be rescued from this threat. We know that, under the Equality Act 2010 in the United Kingdom, it is for sports administrators to make reasonable decisions to protect the integrity of their sports. These threats, in reality, do not exist.

What I want to say to trans people and their supporters is that today is not the ground on which we should stand. An innocuous sounding amendment in a tiny, technical Bill aimed at resolving the Attorney General's maternity leave is not the place to have the fight around the principle. But there is a principle engaged here about gender-neutral language, and we have work to do to make it clear that trans rights do not come at the expense of women's rights. We can perfectly well have both. Women's rights must be protected, and reasonable provision must be made to protect women from threats that are real and evident. In reality, trans women pose no threat to women, but we do have those issues to address.

I therefore support the Government in accommodating this amendment, which has, to a degree, been forced upon them. But this necessary compromise must not undermine the position of the Government and what I believe to be the decent, caring majority in both Houses of Parliament who want to see trans rights properly established.

Gmail **Bev at LGB Alliance <lgballiancebev@gmail.com>**

# Your email of 11th November of and twitter statements in October

**BARKER, Baroness** <BarkerE@parliament.uk> 8 December 2020 at 19:37
To: "kate.harris@lgballiance.org.uk" <kate.harris@lgballiance.org.uk>
Cc: "WILSON, Munira" <munira.wilson.mp@parliament.uk>, Anna Robinson [redacted]>, [redacted]>

Kate

I am sorry for the delay in replying to you, but constructive work which benefits our community had to take precedence.

I welcome the opportunity to put on record the facts which disprove the wrongful assumptions and misrepresentations you have made in recent weeks.

You asked me to explain what, or rather who, I mean when I talk about enemies of LGBT people who are organised and well resourced. It is simple. There are groups which campaign against LGBT+ equality or for the reversal and removal of LGBT+ rights in places where they do exist. These groups exist in many forms and have a variety of basic beliefs and motivations. What unites them is that they share similar if not the same core objective – to perpetuate discrimination against and advocate the exclusion of LGBT people. Most, but not all, argue that affording a minority inclusion, equality and dignity can only be achieved at some unacceptable cost and with significant threat to another group of people in society.

Such groups work hard to present themselves as polite and just expressing “legitimate concerns”, but that is a thin veneer designed to disguise the inescapable nastiness of their underpinning aims. These groups often look to sow division and dissension within existing communities, and use a variety of tactics to come across as plausibly as they can.

There is a growing body of evidence, despite efforts to conceal and deny it, that extreme right-wing, evangelical organisations such as the Heritage Foundation, the Alliance Defending Freedom, and the Family Research Council, are providing significant resources, in terms of finance, people and strategy, across the world to individuals and organisations which attack or otherwise seek to divide LGBT+ people.

From the content of your carefully crafted mission statement, aims and objectives, it is evident beyond dispute that you do little other than present trans and non-binary people as a danger to straight, bi, lesbian and gay men and women. Furthermore, in order to protect wider society from this unfounded threat, trans people’s existing legal rights, freedoms and equalities must be curtailed. In that regard, you share the objectives of organisations who are unapologetic enemies of our LGBT community.

I have never said that your group receives funding from religious extremists. There are two reasons for this. I try not to name groups such as yours because you already receive undue publicity from media, such as the Daily Mail and the Murdoch press, which share your agenda. More to the point it is impossible to know the details of your funding. You don’t produce audited accounts and you are not an incorporated body. You have taken no steps to ensure transparency about the sources of your funding.

You describe the suggestion that you would receive funding or support from an organisation with which you have shared aims and objectives as “defamatory”. Your colleague (and LGB Alliance co-founder) Bev Jackson has no such qualms, as she says on Twitter ‘The left wing silence on gender in the US is even worse than in the UK. This story explains why working with the Heritage Foundation is sometimes the only possible course of action.’ So, if the shoe fits, wear it.

You assert that we are not ‘enemies’. Yet you and your group do little else than perpetuate discrimination against trans people using identical tactics, and many of the same arguments, that have been used for years to discriminate against, and in some countries criminalise, LGB people. Your colleague (and LGB Alliance co-founder) Malcolm Clark

is on record opposing LGBT education within schools, and LGB Alliance has also openly opposed the campaign to ban conversion therapy – both arguments based on demonising trans people.

You give enthusiastic support on Twitter to, amongst others, Baroness Nicholson who has opposed every legal advance for LGBT people since 1994.

You had as a speaker at your launch Gary Powell, currently employed by the Alliance Defending Freedom, who has allied himself with the Heritage Foundation and has written for The Witherspoon Institute which staunchly opposes gay marriage.

In view of all of this it is good to see that in your email of 18th November you say that “We have no wish to convince others that it (the LGB Alliance) should be considered as part of the community”. I agree that in view of your increasing alignment with people who openly advocate discrimination against LGBT people you should not be considered part of the community. I will be happy to point that out to people who may have been taken in by your name.

I will also be pointing out to people that many of the LGB Alliance presences which have sprung up in countries abroad are almost entirely comprised of the same small set of individuals and that the appearance of a growing movement is little more than an old and well-understood campaign tactic.

Running through your correspondence is the refrain that I do not know what your campaign is or what it is trying to achieve. On the contrary, I and my colleagues do understand your aims only too well.

This correspondence, including as it does evidence of the conflict between the claims you make about your aims and the reality of your activities, has been most helpful.

Liz

[Quoted text hidden]
[Quoted text hidden]

Gmail **Bev at LGB Alliance <lgballiancebev@gmail.com>**

# Your email of 11th November of and twitter statements in October

**BARKER, Baroness** <BarkerE@parliament.uk> 15 March 2021 at 18:57
To: "kate.harris@lgballiance.org.uk" <kate.harris@lgballiance.org.uk>
Cc: "WILSON, Munira" <munira.wilson.mp@parliament.uk>, Anna Robinson [redacted],
'[redacted]>

Kate, Again apologies for the delay in replying but as ever work which makes a positive contribution to our community takes precedence.

Once again you have produced a carefully crafted response which gives a wholly misleading impression of your group.

I made several evidence based responses to your questions and assertions. If you could have disproved my analysis of your group's objectives and tactics you would have done so. You did not.

Instead you came up with two arguments which are so weak that they can be dismissed instantly.

You claim that reports of your activities are should be discounted because they are produced by Pink News. What you don't say is that what is reported is untrue. Indeed you would find it difficult to do so when the most telling statements are those made by your founders. When you are a hate group, as you are, the greatest condemnation comes out of your own mouth.

Second, the old chestnut, we cannot be anti-trans because we have a few trans members. It is not unknown for organisations set up to discriminate against minority communities to have people from those communities seek to join. You will remember Derek Laud, a black Briton who joined the notoriously racist Monday Club. The National Front, dedicated to "sending immigrants back home" had one member who was a British citizen who had migrated here from the Indian sub-continent. Why a person would join a group which actively campaigns against equality and justice for them is a question only they can answer. If you have a few trans members that does not alter the fact that the clear objective of your organisation is the perpetuation of discrimination against trans people.

I will continue to point out the growing body of evidence, most of which you produce yourself, that your intent is continued discrimination against trans people. I now have on record your blatant attempt to silence legitimate, evidence based criticism of your group's aims and tactics.

You ask why I do not "stand in Keira Bell's shoes". I do not for the simple fact that if I were to do so I would look at the people who are supporting her campaign. I would see that they are individuals and organisations which have opposed LGBT equality and women's rights for years. I would know beyond any doubt that to be in collusion with them is the wrong place for anyone who values LGBT equality and women's rights. I understand that you are ashamed of the company you now keep. But it is your choice.

I look forward to many more opportunities to expose the poisonous hate that permeates everything your organisation does.

[Quoted text hidden]
[Quoted text hidden]

From: **BevatLGB Alliance** <bev.jackson@lgballiance.org.uk>
Date: Sat, 20 Mar 2021 at 18:42
Subject: Complaint attn. Commissioner Lucy Scott-Moncrieff CBE
To: <lordsstandards@parliament.co.uk>
Cc: Kate Harris <kate.harris@lgballiance.org.uk>

20 March 2021

Dear Commissioner,

I am writing to bring to your attention a series of offensive communications from a member of the House of Lords to my associate Kate Harris, co-founder of LGB Alliance.

Kate and I founded LGB Alliance in 2019 primarily because of our concerns about young gays and lesbians. We both have a history in gay and lesbian rights activism. Our concerns and our message are persistently misrepresented by a number of MPs and peers, who believe they can lie about us with impunity. Although the lies told about us in the Houses of Parliament are protected by parliamentary privilege, emails are a different matter. I refer to an exchange of emails between Kate and Baroness Barker, copying in Munira Wilson MP (Kate's constituency MP) and Anna Robinson (coordinator of the APPG LGBT+ Secretariat).

Kate Harris has written several civil emails to Baroness Barker over the past few months. She suggested meeting up for an exchange of views, noting that they had both been involved in a few LGBT initiatives several years ago. Baroness Barker did not recall these meetings and responded in the rudest possible way. Perhaps she is entitled to do so. What she is not entitled to do, I would assume, is to repeat (and to communicate to Kate's MP) outright lies and damaging insinuations about us. Which she does in each of her emails.

She states that we are not an incorporated body (we are in fact a company limited by guarantee, and have been since November 2019); that we are allied to the 'unapologetic enemies of our LGBT community' (we are lesbians and gays, campaigning for LGB rights), she names a person as a speaker at our launch who has never in fact spoken at any of our events, whether in real life or online, and so on. She compares us to the National Front, and insinuates indirectly, without citing a shred of evidence, that our organisation is funded by 'extreme right-wing, evangelical organisations', a lie that is frequently circulated by our detractors in their efforts to discredit us. In her email of 8 December, she cites false information disseminated by Pink News. This is a hostile website that has published defamatory articles about us ever since our launch and has no credibility whatsoever as a source of information. I will gladly supply pages of examples of the defamatory articles it has published about us, as well as an article describing the campaign of defamation targeting our organisation, should you deem such to be useful.

When Kate pointed out that Pink News is not a reliable source of information, Baroness Barker responded on 15 March 2021 with an email that crosses every conceivable boundary of decorum. She described our organisation as a 'hate group', stated that our 'intent is continued discrimination against trans people' and concluded her vitriolic letter with the following sentence: 'I look forward to many more opportunities to expose the poisonous hate that permeates everything your organisation does.'

I would like to invoke several principles in the Code of Conduct for Members of the House of Lords that I believe to have been breached here. Besides Principles 9 (c) on objectivity, 9 (f) on honesty and 9 (g) on leadership, I would suggest that these communications breach Principle 10, on 'professionalism, understanding others' perspectives, courtesy, and acceptance of responsibility.'

Given especially that all Baroness Barker's disrespectful communications were sent in response to polite requests, I very much hope you will see fit to investigate these apparent breaches and take the necessary action. I enclose as attachments the correspondence to which I refer.

I look forward to hearing from you.

Kind regards,

Bev Jackson
co-founder, LGB Alliance

Gmail **Bev at LGB Alliance <lgballiancebev@gmail.com>**

# Your email of 11th November of and twitter statements in October

**BARKER, Baroness** <BarkerE@parliament.uk> 18 November 2020 at 16:47
To: "kate.harris@lgballiance.org.uk" <kate.harris@lgballiance.org.uk>
Cc: "WILSON, Munira" <munira.wilson.mp@parliament.uk>, Anna Robinson [redacted]>,
'[redacted]>

Thank you for the reply.

As this correspondence is not confidential it is important that there be no misrepresentation.

As I suspected your statement that we have “worked together in the past” is misleading. As the obsessive level of detail makes plain, far from having worked together, we have happened , by chance, to attend a few events.

I also note that you omitted from your list the series of sour tweets you sent in March 2019 deigned to undermine LBT Women’s Health Week. I quite understand why you would not want attention drawn them when your organisation is desperate to convince others that it should be considered as part of the community. That you have to clutch at straws and rely on a selective history speaks volumes.

I will respond to your other points in due course when I have time.

Liz Barker

---

**From:** kate.harris@lgballiance.org.uk <kate.harris@lgballiance.org.uk>
**Sent:** 13 November 2020 13:32
**To:** BARKER, Baroness <BarkerE@parliament.uk>
**Cc:** WILSON, Munira <munira.wilson.mp@parliament.uk>; Anna Robinson [redacted]
**Subject:** RE: Your email of 11th November of and twitter statements in October

Dear Baroness Barker

Sincere apologies. If I have made false assertions or assumptions do let me know and I will withdraw them. Of course, it is quite understandable that as a Peer you meet hundreds or thousands of people each year so I should have realised that you may well not remember me.

You ask for details, so I have checked back into my email for 2014 and 2015!

What I was thinking about was my memory of discussing housing options for elderly gays and lesbians and attending the same meetings as we shared an interest in this issue. I was working on an informal project called "Growing Old Disgracefully" where a group of lesbians were working with Jo Blundell while she was studying at the Royal College of Art. With her help we got as far as designing a housing project incorporating many of the features the group wanted. You were working in the area of LGBT Housing and speaking at conferences and as far as I remember we met at several and discussed the very real need for action.

These are some of the meetings I was thinking of in 2014 & 2015:

*National Older LGBT Housing Network Conference, on Wednesday 18th June hosted by Stonewall Housing, Opening Doors London, Age UK and Rainbow Hamlets. This was held at Oxford House in East London.*

*ESRC seminar series on Older Lesbian, Gay, Bisexual and Trans People –*

*Minding the Knowledge Gaps Final Conference held on*

*January 28, 2015 (Wed) 10:30-17:00 The Abbey Centre, London*

*Older LGBT Conference 28th Jan 2015 University of Surrey*

Finally - we also had a mutual interest in a group called Freeformers - led by Gi Fernando and Alexis Dormondy. You kindly hosted a lunch on 8th July 2014 in the House of Lords and gave several of us a fascinating tour of Parliament before the lunch – despite you having a rotten cold. Here is a copy of the email I sent to thank you.

*Kate Harris*

*Wed 09/07/2014 07:39*

*Liz - thanks so much for yesterday! The tour was brilliant - I could have gone on all day with you - amazing building and history. And the lunch was fascinating too. What a great idea Gi has - look forward to the half day training! Do hope u feel a lot better soon - somehow a summer cold is so much more annoying than a winter one!*

*Very best wishes Kate*

*PS Launch of our growing old disgracefully project went well last night!*

I have no wish to misrepresent you and hope this clears up any confusion.

Kind regards Kate

Kate Harris

LGB Alliance

@ALLIANCELGB

www.lgballiance.org.uk

> On 12/11/2020 13:33 BARKER, Baroness <barkere@parliament.uk> wrote:
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> Again , already false assertions and assumptions. So for that reason our discussions will be only in writing that there is a record and all misrepresentations can be challenged.
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> I have no recollection of ever having worked with you. Please give me details.
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> **From:** kate.harris@lgballiance.org.uk <kate.harris@lgballiance.org.uk>
> **Sent:** 12 November 2020 13:05
> **To:** BARKER, Baroness <BarkerE@parliament.uk>
> **Cc:** WILSON, Munira <munira.wilson.mp@parliament.uk>; Anna Robinson [redacted]
> **Subject:** Re: Your email of 11th November of and twitter statements in October

Great - so good to hear from you. We welcome dialogue - it is the only way forward. And inclusivity for all is central to our beliefs so maybe we could start our discussions by how we each understand that.

But again let me say how pleased I am to hear from you. Perhaps we could have a Zoom and see where we agree - which is probably on the majority of issues - and where we can listen and learn from each other? And if I have made assertions which are incorrect then of course it would be right for me to apologise.

I hope you are keeping well and thanks again for your reply. No rush as you say, but I am sincere in my wish to talk. I certainly do not see you or others who may disagree with us as enemies. We have worked together in the past and let's hope we may be able to do so again in the future. Let's keep in touch.

Best wishes Kate

Kate Harris

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On 12/11/2020 12:38 BARKER, Baroness <barkere@parliament.uk> wrote:

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Gmail **Bev at LGB Alliance <lgballiancebev@gmail.com>**

# For the attention of Baroness Liz Barker

**Kate Harris** <kate.harris@lgballiance.org.uk> 11 November 2020 at 19:37
To: "contactholmember@parliament.uk" <contactholmember@parliament.uk>, [redacted]
[redacted]g>, "munira.wilson.mp@parliament.uk" <munira.wilson.mp@parliament.uk>
Cc: Bev Jackson <lg[redacted]>

Re: The Economic Case for LGBT Equality w/ APPG on Global LGBT+ Rights

Dear Liz

First of all many thanks for an interesting webinar and I look forward to others in the series. I do have two questions for you though - and I very much hope you may reply.

At the end of a very constructive and informative meeting you made a statement about your "enemies" who are against LGBT+ rights and that they are being heavily funded by right wing US evangelicals. You have previously made this allegation in the House of Lords.

Could you tell me who you think your enemies are? If you think it could be LGB Alliance you are misinformed. Throughout the past three years we have sought respectful dialogue on issues of sex and gender and only formed LGB Alliance in Oct 2019 as Stonewall refused to engage - even with previous Stonewall trustees. We continue to seek to build bridges across party and across a variety of state and private organizations. We would very much welcome the opportunity to speak to you!

Second, if you are referring to us when you mention funding from religious extremists again you are misinformed. This defamatory statement has been made to us directly but - **a bit like Trump's suggestion that the elections were rigged** - there is no evidence for this whatsoever and it is completely untrue.

May I invite you and my MP Munira Wilson to have a Zoom meeting to see how we might start a more constructive discussion?

We are not enemies. We hold different views and are happy to share them with you and answer any questions or concerns you may have. In the meantime I attach a link to our 1 year anniversary webinar. I encourage you to listen and really think again about the benefit of talking and reaching a better understanding.
https://www.youtube.com/watch?v=gHtNmUnbG3U

I look forward to hearing from you.

Kind regards Kate

Kate Harris
LGB Alliance
@ALLIANCELGB
www.lgballiance.org.uk

Gmail **Bev at LGB Alliance <lgballiancebev@gmail.com>**

# Your email of 11th November of and twitter statements in October

**kate.harris@lgballiance.org.uk** <kate.harris@lgballiance.org.uk> 3 January 2021 at 17:21
To: "BARKER, Baroness" <BarkerE@parliament.uk>
Cc: "WILSON, Munira" <munira.wilson.mp@parliament.uk>, Anna Robinson [redacted]rg>, [redacted]

Hello Baroness Barker and Happy New Year! I wish you and yours good health and a much better year than 2020.

I am glad you have found our correspondence useful. I have found it sad. Sad that most of what you say seems to be based on popular myths about LGB Alliance propagated by Pink News. I am pleased you left out their accusation that we are neo-Nazis - one needs to be thankful for small mercies! There are so many inaccuracies but I will just comment on one - that we believe "trans people's existing legal rights, freedoms and equalities must be curtailed". You will find that the opposite is true if you take the quickest of glances at our web site. Why would trans supporters have attended our meetings if that were true in any shape or form?

I would respectfully request that you don't repeat any of these myths again in the House of Lords or elsewhere. As we are the only group standing up against the damage caused to all of us, but particularly children & young people, by gender identity theory, it is quite clear who you mean whenever you speak on the subject.

The same is true of Lord Cashman - who encourages us all to "imagine standing in another's shoes". Perhaps you could both do that next time you meet. Imagine being in Keira Bell's shoes. Or being in the shoes of the young lesbians who write to us saying they are not welcome in LGBT youth groups unless they accept that "TWAW". Or in the shoes of a sensitive young boy who comes home from school in floods of tears because he thinks he will wake up a girl one morning after RSE lessons give him the idea that he's been "born in the wrong body". Or the terrified mother of a teenage girl, who is convinced she is a boy, and wants to start puberty blockers or cross sex hormones despite the fact she has never shown the slightest interest in being anything other than a girl. We need to talk about all of these shocking examples of what is happening as a result of the promotion of gender identity theory at the expense of facts, biology and good sense.

It would be lovely to meet over a cup of tea and discuss these issues properly when normality returns.

Kind regards Kate
[Quoted text hidden]


Michael Cashman @mcashmanCBE · Mar 17, 2021
Stop Uncritically Platforming Anti-LGBT Hate Group LGB Alliance - Sign the Petition! chng.it/GsBv8VZd via @UKChange
change.org
Sign the Petition
UK Media: Stop Uncritically Platforming LGB Alliance
79
101
263


Michael Cashman @mcashmanCBE · Dec 12, 2020
UK Media: UK Media: Stop Uncritically Platforming LGB Alliance "Hate Group" - Sign the Petition! chng.it/ydHZrZkh via @UKChange
change.org
Sign the Petition
UK Media: Stop Uncritically Platforming LGB Alliance
16
50

## Good Law Project / Jolyon Maugham

The Good Law Project is a UK political non-profit company. Founded by Jolyon Maugham, the Good Law Project states that its mission is to achieve change through the law.

The Good Law Project, and Jolyon Maugham, are leading a campaign to remove charitable status from LGB Alliance. The Good Law Project started crowdfunding in June 2021 for an appeal against the Charity Commission decision to award charitable status to LGB Alliance. At the time, Jolyon Maugham said: "Charitable status is for those who serve the public good. Denigrating trans people, attacking those who speak for them, and campaigning to remove legal protections from them is the very opposite of a public good. We do not believe they meet the threshold tests to be registered as a charity." ([https://www.consortium.lgbt/2021/06/02/consortium-supports-challenge-to-lgb-alliance-charity-status/](https://www.consortium.lgbt/2021/06/02/consortium-supports-challenge-to-lgb-alliance-charity-status/)) The Good Law Project issued a media release stating:

*"Ever since it was established in 2019, LGB Alliance has repeatedly targeted registered LGBT rights charities including Mermaids, Stonewall, LGBT Foundation, GIRES and others. LGB Alliance has accused these organisations of extremism and homophobia, of spreading disinformation, of endangering children, and of campaigning against women's and gay rights."* ([https://lesbianandgaynews.com/2021/06/lgb-alliance-have-confidence-in-the-charity-commission-as-trans-childrens-charity-mermaids-leads-legal-attempt-to-overturn-decision-on-charity-status/](https://lesbianandgaynews.com/2021/06/lgb-alliance-have-confidence-in-the-charity-commission-as-trans-childrens-charity-mermaids-leads-legal-attempt-to-overturn-decision-on-charity-status/))

Jolyon Maugham has said (interviewed by Pink News 27/04/2021: [https://www.pinknews.co.uk/2021/04/27/good-law-project-jolyon-maugham-trans-rights-uk-keira-bell-puberty-blockers-lgb-alliance/](https://www.pinknews.co.uk/2021/04/27/good-law-project-jolyon-maugham-trans-rights-uk-keira-bell-puberty-blockers-lgb-alliance/)) *:"I strongly encourage you to quote me calling the LGB Alliance a transphobic hate group."*

### Good Law Project tweets:

This one is rather ironic, considering they are trying to get LGB Alliance's charitable registration cancelled:



**Good Law Project** @GoodLawProject · Aug 20

"Charitable status is for those who serve the public good. Denigrating trans people, attacking those who speak for them, and campaigning to remove legal protections from them is the very opposite of a public good." @JolyonMaugham

pinknews.co.uk

Charity watchdog in talks with anti-trans LGB Alliance after 'hateful' b...

The government's charity commission is engaging with the LGB Alliance after it breached Twitter rules by comparing LGBT+ people to bestiality

**Good Law Project** @GoodLawProject · Jun 2

"Charitable status is for those who serve the public good. Denigrating trans people, attacking those who speak for them, and campaigning to remove legal protections from them is the very opposite of a public good." @JolyonMaugham

pinknews.co.uk

LGBT+ groups appeal decision to register anti-trans LGB Alliance as c...

Trans kids charity Mermaids said that the decision to register the LGB Alliance as a charity was wrong and should be overturned.

**Good Law Project** @GoodLawProject · Jun 2

"No organisation whose raison d'etre is the persecution of a minority should have charitable status in a modern, progressive, pluralistic society. The rights of all groups need to be protected." - @JolyonMaugham




vice.com

'Anti-Trans' LGB Alliance Should Not Be a Charity, Say UK LGBTQ Gro...

Mermaids, LGBT+ Foundation and other organisations will legally appeal the charitable status granted to the controversial LGB Alliance.

Outside Twitter, Dave Hewitt has written a very good article on Substack (8 October 2021): https://voidifremoved.substack.com/p/crowdjustice-and-the-good-law-project on how the Good Law Project's crowdfunding page (https://www.crowdjustice.com/case/lgba-charity-status/) is being used to host many abusive and defamatory comments about LGB Alliance.

Jolyon Maugham tweets prolifically (more than 125,000 tweets) and here are some I could find on LGB Alliance:

This first tweet is not about the LGB Alliance, but an example of his inconsistent attitude towards free speech:




Jolyon Maugham's language against LGB Alliance is intemperate and libellous:



**Jo Maugham** @JolyonMaugham · Oct 22

Rare to find unanimity in this space - but pleasing to see that even LGBA now publicly accepts it's an anti-trans group.

@ALLIANCELGB

It's not often we feel able to share a headline from Pink News.

**PinkNews** @PinkNews

Boris Johnson thanks anti-trans LGB Alliance for its 'incredible hard work'

---

**Jo Maugham** @JolyonMaugham · Oct 17

Replying to @joss_prior

No shortage of evidence of deep pools of dark money for anti-trans campaigns. There's this globalphilanthropyproject.org/wp-content/upl... and this ohchr.org/Documents/Issu... and this epfweb.org/node/837 just for starters.

---

Jo Maugham Retweeted

**Attitude Magazine** @AttitudeMag · Oct 13

"To cut out the T is to kill."

Russell T Davies blasts the LGB Alliance as he collects the Attitude Inspiration Award on behalf of It's A Sin at the 2021 @VirginAtlantic #AttitudeAwards, powered by @JaguarUK.

---

**Jo Maugham** @JolyonMaugham · Aug 20

Shocking that the @ChtyCommission ever gave its seal of approval to this hate group.

LGB ALLIANCE

pinknews.co.uk

Charity watchdog in talks with anti-trans LGB Alliance after 'hateful' b...

The government's charity commission is engaging with the LGB Alliance after it breached Twitter rules by comparing LGBT+ people to bestiality

---

**Jo Maugham** @JolyonMaugham · Aug 12

'Defending trans people means you are greenlighting bestiality': but so-called LGB Alliance is not a hate group, apparently.

e @ALLIANCELGB · 1h

to LGB gives the green light to paraphilias
be part of one big happy "rainbow family".
people refuse to be used in your artificial
at we must all be lumped together. #NoToH
BluskyeAllison...

**Jo Maugham** @JolyonMaugham · Jun 23

I'd be thrilled if the hate group that styles itself "**LGB Alliance**" wanted to sue me instead of James for calling it a hate group. Do feel free to place my invitation in front of it.

> **James Billingham** @oolon · Jun 23
>
> I thought about not tweeting as I know their followers will harass, try to get me sacked. But it is clear from their lawsuit they really wanted to sue for libel over lgballiance-is-a-hate-group.co.uk, so getting the word out there to friendly lawyers who can help me if so is important.
>
> Show this thread

**Jo Maugham** @JolyonMaugham · Jun 16

We have posted an update to our challenge to the Charity Commission's decision to grant charitable status to a group which exists to denigrate trans people, attack those who speak for them, and which campaigns to remove their legal protections.




crowdjustice.com

Appeal “LGB Alliance’s” charity status

**Jo Maugham** @JolyonMaugham · Jun 2

Charitable status is earned by those who serve the public good. Denigrating trans people, attacking those who speak for them, and campaigning to remove legal protections from them is the very opposite of a public good.



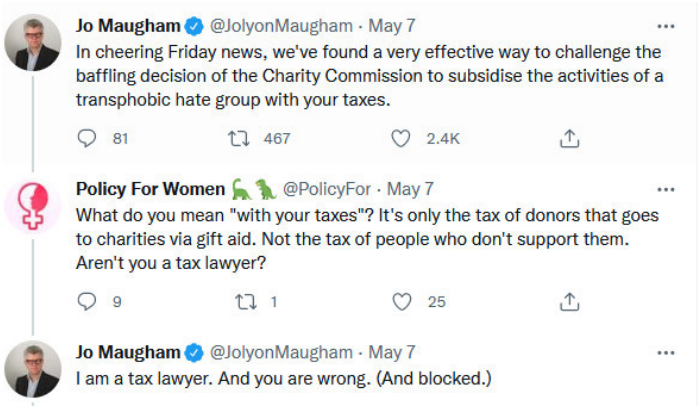

crowdjustice.com

Appeal “LGB Alliance’s” charity status

Jolyon Maugham

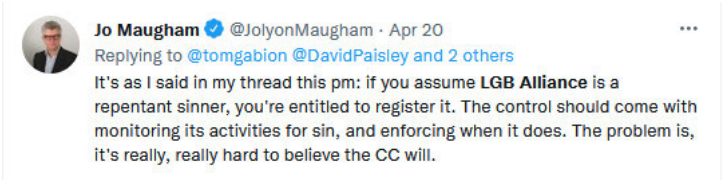



In June 2021, Jolyon Maugham, through the Good Law Project and with the support of several charities, started a crowd funder to challenge the granting of charity status:












2020 tweets by Jolyon Maugham:






This is an LGB Alliance tweet pointing out a tweet Maugham has 'liked':



**Jo Maugham** @JolyonMaugham · Aug 12, 2021

'Defending trans people means you are greenlighting bestiality': but so-called **LGB Alliance** is not a hate group, apparently.

> e @ALLIANCELGB · 1h
> + to LGB gives the green light to paraphilias
> be part of one big happy "rainbow family".
> 3 people refuse to be used in your artificial
> at we must all be lumped together. #NoToH
> /BluskyeAllison...

80 467 2,104

**Jo Maugham** @JolyonMaugham · Nov 23, 2020

Although purporting to care about LGB issues, the lobbying of the LGB Alliance reveals it to be what it is: an anti-trans group.




pinknews.co.uk

The 'LGB Alliance' has 12 questions for potential MPs and none of the...

The brave new 'LGB Alliance' has 12 questions for prospective MP's, but – spoiler alert – they're actually all about transgender rights.

15 57 260

**Jo Maugham** @JolyonMaugham · Nov 23, 2020

The third point is they have quoted the so-called **LGB Alliance** - a dark money funded astro-turfed hate group - on the healthcare of trans teenagers. What next? Will the BBC be quoting white supremacists on whether sickle cell anaemia should be treated on the NHS?

76 481 2,834

Show this thread

**Jo Maugham** @JolyonMaugham · Jun 23, 2021

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> Show this thread

4 72 414


Jo Maugham @JolyonMaugham · Mar 13, 2021
Hey @StephenNolan, what's all this about? The (woefully misnamed) LGB Alliance is a hate group - and don't you think you should have had someone on who is trans, even if only for show? Would you have a bunch of white guys on discussing racism?
BBC
pinknews.co.uk
BBC invites two straight cis men and LGB Alliance to debate conversi...
The BBC is facing criticism after it invited two straight men and an LGB Alliance representative to debate conversion therapy.


Jo Maugham @JolyonMaugham · Nov 24, 2020
Even that headline "Boy launches..." is a powerful rebuke to the dark money funded hate groups like the LGB Alliance that the BBC chooses to legitimate.
8
12
183