

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE
MEDICAL LICENSING BOARD OF
INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Plaintiffs' Responses to Defendants' Motions to Maintain Filings Under Seal

Presently pending are two motions by the State to maintain certain filings under seal. (Dkts. 50, 55). This Court has ordered an expedited briefing schedule as to those motions, in light of the preliminary injunction hearing in this matter scheduled for June 14, 2023. (Dkt. 57). Plaintiffs, by their counsel, hereby submit their responses.

I. Evidentiary submissions at docket entry 48

At docket entries 48-1 through 48-17, the State has filed evidentiary materials in support of its response opposing plaintiffs' motion for a preliminary injunction. As to docket entries 48-1, 48-2, and 48-4 through 48-17, the plaintiffs authorize the unsealing of those documents, as no good cause exists to maintain those documents under seal. *See* Local Rule 5-11(d)(3).

A. Docket entry 48-3 should be maintained under seal, but a public version may be filed with the proposed redactions

Docket entry 48-3, a report proffered by Dr. Dianna Kenny, PhD, provides opinions as to the diagnosis and treatment of gender dysphoria generally and as to the minor plaintiffs specifically. Appended to the end of Dr. Kenny's report is a selection of the minor plaintiffs' medical records. (*See* Dkt. 48-3 at 160-319). The plaintiffs request that this document be

maintained under seal, but also request that a redacted version of this report, attached to this Response, be publicly filed.

1. The plaintiffs' medical records should be maintained under seal

The public's right to view documents filed with the court is not unlimited, and Federal Rule of Civil Procedure 26(c) "allows a court to shield certain documents from the public when there is good cause to do so." *Bond v. Utreras*, 585 F.3d 1061, 1074 (7th Cir. 2009) (citation omitted). Good cause exists where, among other things, "the privacy interests of the litigants . . . predominate in the particular case." *Id.* (citing *Jessup v. Luther*, 227 F.3d 993, 997-98 (7th Cir. 2000)). Medical records are among the documents that are frequently subject to protective orders and may be maintained by a court under seal. *See, e.g., Doe v. Oberweis Dairy*, 456 F.3d 704, 718 (7th Cir. 2006) (indicating that court may seal medical records and limit their use at trial to the extent that the plaintiff's privacy interest outweighs the probative value of the information contained in the records); *Chapman v. Raemisch*, 2009 WL 425813 (E.D. Wis. Feb. 20, 2009) (granting plaintiff's request to maintain medical records under seal). Here, the plaintiffs' privacy interests are particularly pronounced, and good cause exists to maintain their medical records under seal. The plaintiffs address below each of the factors identified in Local Rule 5-11(e)(2).

The selection of medical records appended to Dr. Kenny's report have been designated as "confidential" pursuant to the protective order entered by this Court. (Dkt. 39). These medical records contain confidential information regarding the minor plaintiffs' health, welfare, and medical care, including details regarding the minor plaintiffs' physical characteristics, the names of the schools they attend, their grades, intimate specifics about the physical progress of their pubertal development, and private details of conversations had with mental health practitioners,

among a host of other sensitive information. They also include information relating to conditions and diagnoses unrelated to gender dysphoria. Certainly many adults would seek to avoid this sort of disclosure, and the Federal Rules of Civil Procedure are particularly solicitous of the privacy interests of minors in federal court proceedings. *See, e.g.*, Fed. R. Civ. P. 5.2(a)(3) (requiring that a filing may include, as to a minor party, only initials). This information is sensitive and personal, and it was provided for the purpose of seeking medical care that is itself unusually sensitive in nature. Strong privacy interests favor maintaining its confidentiality.

To the extent that information contained within these medical records is pertinent to the legal issue before the Court, and much of it is not, the parties have entered into stipulations that address many, if not all, of the relevant facts contained within the medical records. (Dkt. 51). Therefore, to the extent that the Court finds the contents of the report relevant or material to resolution of the pending matter, it is unlikely that the Court would find citation to specific statements within the medical records to be necessary. The public's interest in reviewing those records is accordingly relatively minimal, compared to the privacy interests of the youth. For all of these reasons, the report filed at docket entry 48-3 should be maintained under seal.

2. *A redacted report protects the privacy interests of the plaintiffs while accommodating the public interest in an open court docket*

The plaintiffs do not object to the body of Dr. Kenny's report being unsealed, provided that the medical records, and two other small categories of information, are redacted. The plaintiffs have therefore submitted a proposed redacted report contemporaneously with this filing. This approach appropriately balances the plaintiffs' privacy interests with the public's interest in

viewing the documents before the Court. This version redacts the medical records in their entirety, and includes two additional minor redactions.¹

First, Federal Rule of Civil Procedure 5.2(a)(2) requires that a filing that contains an individual's birth date be redacted to remove the month and date of the individual's birth. The redacted report attached by plaintiffs, therefore, redacts birth month and date, leaving visible only the plaintiffs' years of birth.

Second, plaintiffs have redacted two sentences contained in Paragraph 213 of Dr. Kenny's report. (Dkt. 48-3 at 110). Those sentences contain extremely sensitive information that is taken largely verbatim from the medical records. (*Id.*). In addition, the third sentence references confidential, sensitive information regarding an individual who is not a party to this litigation. (*Id.*). The substantive import of these sentences is captured by Paragraph 58 of the parties' Joint Stipulation of Facts. (Dkt. 51 at 9). Paragraph 213 of Dr. Kenny's report is not cited by the State in its brief, and this information is not material to resolution of this matter. This redaction provides the narrowest and most targeted means to protect this confidential information.

II. The State's brief may be unsealed

The plaintiffs authorize the unsealing of the State's brief, contained at Docket Entry 54.

III. The State's position as to the motions to maintain under seal

Stevie Pactor, one of plaintiffs' counsel, conferred with Solicitor General Tom Fisher regarding the State's position as to the motions to maintain under seal and the plaintiffs' response, including the above-described proposed redactions. Mr. Fisher responded that the plaintiffs "can

¹ An attempt to individually redact each piece of confidential information from the medical records would result in a document, 160 pages long, that more resembles Swiss cheese than a medical record.

represent that [the State] take[s] no position and that [the State] will not be filing an objection or any other response.”

IV. Conclusion

For the reasons articulated above, the plaintiffs request that the Court maintain docket entry 48-3, the report of Dianna Kenny, PhD, under seal. The plaintiffs request that the Court accept for public filing the attached redacted report.

The plaintiffs authorize the unsealing of all other entries at docket 48 as well as the State’s brief at docket entry 54.

The plaintiffs request all further appropriate relief.

Kenneth J. Falk
Gavin M. Rose
Stevie J. Pactor
ACLU of Indiana
1031 E. Washington St.
Indianapolis, IN 4602
317/635-4059
fax: 317/635-4105
kfalk@aclu-in.org
grose@aclu-in.org
spactor@aclu-in.org

Chase Strangio
Pro Hac Vice
Harper Seldin
Pro Hac Vice
American Civil Liberties Union
125 Broad Street
New York, NY 10004
212/549-2500
cstrangio@aclu.org
hseldin@aclu.org

*Attorneys for Plaintiffs and the
Putative Classes and Subclasses*

EXHIBIT 3

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., <i>et al.</i> ,)	
)	
Plaintiffs,)	
)	
v.)	No. 1:23-cv-00595-JPH-KMB
)	
THE INDIVIDUAL MEMBERS)	
OF THE MEDICAL LICENSING)	
BOARD OF INDIANA, in their)	
official capacities, <i>et al.</i> ,)	
)	
Defendants.)	

EXPERT DECLARATION OF DIANNA T. KENNY, PhD, FAPsS

Pursuant to 28 U.S.C. 1746, I declare:

Background

1. I have been retained by counsel for Defendants as an expert witness in connection with the above-captioned litigation. I have actual knowledge of the matters stated in this report. My professional background, experience, and publications are detailed in my curriculum vitae. A true and accurate copy of my CV is attached as Exhibit A to this report.

2. I received a Doctor of Philosophy (Developmental and Educational Psychology) from Macquarie University, Sydney, Australia in 1988, a Master’s degree in School Counselling from Macquarie University, Sydney, Australia in 1980, a Bachelor (Honours) degree in psychology from The University of Sydney in 1974,

a graduate diploma in education from Sydney Teachers' College in 1975, an associate diploma in piano teaching, Trinity College of Music, London, (1977), a graduate certificate in marriage and family therapy from the Marriage Guidance Council of NSW, Australia in 1986, and a graduate diploma in family dispute resolution from the New South College of Law in 2016.

3. From 2006 to 2019, I was Professor of Psychology, The University of Sydney. I had conjoint personal professorial chairs in both psychology and music during this time. I have teaching (and research) expertise in developmental psychology and developmental psychopathology, with a focus on the effects of trauma on the developmental trajectories of children and adolescents. I have extensive experience in educational psychology, including cognitive and language development, and infant and child memory. I have graduated 47 Masters by research and PhD students studying a diverse range of topics in the fields of developmental, educational, forensic, clinical, and health psychology. I was awarded the "Excellence in Higher Degree Research Supervision" (2003) and the "Excellence in University Teaching (1991)" by The University of Sydney. From 1988 to 2005, I held positions as lecturer, senior lecturer, and associate professor of psychology at The University of Sydney. During my entire tenure at The University of Sydney, I had rights to private practice which I exercised for about 10–12 hours per week.

4. Before I joined The University of Sydney, I was a primary school teacher, a district school counsellor, and a specialist counsellor for emotionally disturbed children with the New South Wales Department of Education, Australia.

Since retiring from the university in mid-2019, I have been in full time private practice as Principal, DK Consulting. I work as a psychodynamic psychotherapist, child, marriage, and family therapist, family dispute resolution practitioner, mediator, medico-legal consultant, and expert report writer. For the past five years, I have been engaged in exploratory psychotherapy with children, adolescents, and their families who are struggling with gender dysphoria. I have a case load that includes patients from all states of Australia and New Zealand. I have advised on and written medico-legal reports for families, including one in Canada. Based on this clinical experience, I have made substantial contributions to two clinical guides on the therapeutic management of children and young people who are expressing gender confusion and gender dysphoria. I have assisted the State of Alabama with legal challenges to new legislation that attempts to safeguard young people under the age of 18 from medicalized gender transition, similar to that which is occurring currently in Indiana.

5. Throughout my employment as a tenured academic, I held various adjunct, visiting, and distinguished professorships in music, psychology, and education, including the Musik Hochschule, University of Freiburg, Germany (March, 2009), Dept. of Psychology, Würzburg University, Germany (Summer School, October, 2008), University of Alaska Anchorage, College of Education and Special Education, Alaska, USA (2006), National Institute of Creative Arts and Industries, University of Auckland, New Zealand (2006, 2007-2009), Communication, Culture & Information Technology (CCIT) Centre and Department of Psychology, Univer-

sity of Toronto at Mississauga, Ontario, Canada (August–November, 2004), and Department of Psychology, James Cook University, Townsville and Cairns, North Queensland, Australia (Nov. 2004). I had an adjunct professorship at Boston University in 2016.

6. I am a registered psychologist in Australia with the Australian Health Practitioner Regulation Agency, with special accreditation in developmental, educational, and counselling psychology from the Australian Psychological Society. I am also a registered family dispute resolution practitioner with the Australia Attorney General’s Department, and a nationally accredited mediator. My professional memberships/eligibility for membership include the Australian Psychological Society, American Psychological Association, American Psychological Society, International Association of Applied Psychologists, International Society for Psychotherapy Research, and International Association of Relational Psychotherapists. In addition, I am a council member of The University of Sydney Association of Professors (USAP) and a council member of the Australian Association of University Professors (AAUP).

7. I have published over 300 works over my academic and clinical career, including books with international publishers (10); edited books (3); book chapters (36); scholarly peer-reviewed articles (190); invited submissions to government (5); non-peer reviewed articles (150+) including in newspapers, websites, blogs (see www.diannakenny.com.au); and podcasts (6). I have made substantial contributions to two published clinical guides on the treatment of gender dysphoric young people

and their families. I have been ranked in the 99th percentile for my publications in developmental psychology/developmental psychopathology on ResearchGate. I have an h-Index of 53 (Google Scholar), which places my output and impact in the range “outstanding.”

8. I have served on editorial boards, acted as associate editor, consulting editor and guest editor as well as reviewer for a number of leading journals in relevant fields including *Frontiers in Psychology*, the *New England Journal of Medicine*, *Psychology*, *Public Policy and the Law*, *Clinical Psychology Review*, *Frontiers in Performance Science*, *Psychological Medicine*, *Medical Journal of Australia*, *Journal of Sexual Abuse and Treatment*, *Sexual Abuse*, *International Journal of Offender Therapy and Comparative Criminology*, *Journal of Anxiety Disorders*, *Anxiety, Stress and Coping*, *Psychology and Health*, and *Personality and Individual Differences*, inter alia. I have received over \$5 million in government and non-government funding for scientific research including grants from the National Health and Medical Research Council, Australian Research Council, Australia Council for the Arts, NSW Department of Juvenile Justice, Justice Health, WorkCover Authority of NSW, National Breast Cancer Council, and Sydney University Research Grant Scheme. I was awarded the SEMPRE Lifetime Achievement Award in September 2022.

9. During the more than forty years that I have worked as a teacher, school counsellor, specialist school counsellor for emotionally disturbed children, aca-

demic, author, clinician, medico-legal consultant, public intellectual, and expert witness, I have participated in the assessment and care of hundreds of children, adolescents, and families for a wide range of developmental, educational, psychosocial, and familial issues. In the past five years, I have become a tertiary referral source for young people with gender dysphoria and their families and am one of only a few clinicians practising exploratory psychotherapy with this population given that the so-called “conversion therapy ban” legislation is gradually being introduced in most states across Australia prohibiting all forms of therapy except gender affirmation.

10. My CV (Exhibit A) contains a list of my publications, memberships, and consultancies. I am unable to list cases in which I have testified as an expert witness or expert report writer because there are strict non-disclosure laws in place in Australia protecting the identity of minors. Failure to adhere to Section 105 of the Act carries penalties up to and including incarceration and loss of licence to practice. There have been approximately 100 such cases, including one in the United States, *Boe v. Marshall* (United States District Court for the Middle District of Alabama Northern Division, Civil Action No. 2:22-cv-184-LCB).

11. I am being compensated at an hourly rate for actual time devoted, at the rate of U.S. \$400 per hour including report drafting, travel, deposition, testimony, and consultation. My compensation does not depend on the outcome of this litigation, the opinions I express, or the oral or written testimony I provide.

12. I have extensively studied the existing scientific research literature and contributed to it via publications and other fora related to the incidence, potential

etiology, and treatment of gender dysphoria. I have participated in local, national, and international meetings where the care of children and young people with gender dysphoria has been discussed. I am a frequent keynote speaker at such events.

13. In addition to gender dysphoria, I have several other specializations in developmental psychology and developmental psychopathology, including child sexual abuse, juvenile offending and juvenile sex offending, the common psychopathologies of childhood and adolescence, educational assessment and achievement, marriage and family therapy and family dispute resolution. I have expertise in a broader array of subspecialties of my discipline that is unusual but highly advantageous to case analysis and medico-legal work, particularly in the field of gender dysphoria, in which young people present with complex clinical pictures that almost always involve one or more comorbid conditions. Also advantageous is the fact that I have been, in equal parts, an academic, author, and researcher, and a clinician for almost the entirety of my professional life.

14. My opinions as detailed in this report are based upon my:
- a. knowledge, training, and clinical experience in caring for patients over many years;
 - b. detailed methodological reviews of hundreds of relevant peer-reviewed publications;
 - c. consults, discussions, and team analyses with colleagues and other experts in the field, including attendance and participation in various professional conferences;

- d. publications in peer reviewed scientific journals;
- e. editorial work for peer reviewed scientific journals; and,
- f. peer reviewed research grant receipt and review work.

The materials that I have relied upon are the same types of materials that other experts in my field of clinical practice rely upon when forming opinions on the subject, including hundreds of published, peer reviewed scientific research (and professional) articles. I also draw upon my extensive clinical experience and discussions and conferencing with peers, particularly in clinical matters.

15. My opinions and hypotheses in this matter are—as all expert reports—subject to the limitations of documentary and related evidence, the impossibility of absolute predictions, and the limitations of social/psychological, biological, and medical science. I have not met with, or personally interviewed, anyone in this case. I have no expert opinions regarding the veracity of witnesses in this case. I may not have reviewed all the evidence in this case and my opinions are subject to change at any time as new information becomes available to me. I have been provided with the following documents:

- a. Complaint
- b. Deposition Notice from Plaintiffs
- c. Senate Enrolled Act 480
- d. Expert Declaration of Dr. Dan H. Karasic
- e. Expert Declaration of Dr. Daniel Shumer
- f. Expert Declaration of Dr. Jack Turban

- g. Declaration of Nathaniel Clawson and Beth Clawson
- h. Declaration of Lisa Welch and Ryan Welch
- i. Declaration of Emily Morris
- j. Declaration of Maria Rivera
- k. Deposition of Dr. Jack Turban (Final Transcript)
- l. Deposition of Dr. Dan H. Karasic (Final Transcript)
- m. Deposition of Beth Clawson (Final Transcript)
- n. Deposition of Nathaniel Clawson (Final Transcript)
- o. Deposition of Lisa Welch (Rough Transcript)
- p. Deposition of Ryan Welch (Rough Transcript)
- q. 2023 U.S. Surgeon General Social Media Advisory
- r. Medical Records for all minor plaintiffs

16. Only the trier of fact can determine the credibility of witnesses and how scientific research may or may not be related to the specific facts of any particular case. In my opinion, a key role of an expert witness is to assist the court, lawyers, parties, and the public to understand and apply reliable scientific, technical, and investigative principles, hypotheses, methods, and information.

Summary of Opinions

17. There are two chapters in this submission. In the first chapter, I present theoretical argument and empirical evidence to support the view that social contagion is at least partially responsible for the upsurge in gender dysphoria in the past decade, a phenomenon that urges extreme caution by treating health practitioners

when advising on the best course of action with respect to management of young people presenting with gender dysphoria. The second chapter presents a review of the medical records of the four plaintiffs in this action with respect to the decision to medically transition¹ them.

18. In chapter 1, I reflect on the role of social contagion in several pathological adolescent behaviours and review the evidence that similar mechanisms may explain the increased frequency of gender dysphoria during adolescence. I begin with a review of the historical phenomenon of social contagion, demonstrating that it predated the digital age.

19. I then examine the nature of social contagion and the mechanisms by which certain phenomena are propagated through social networks. Social network analysis studies contagions of all kinds but was first developed and used in public health to determine the spread of diseases. For the spread of social phenomena among adolescents, three mechanisms—peer contagion, deviancy training, and co-rumination in peer groups—have been identified. Three possible causes of peer effects (i.e., endogenous, exogenous, and correlated) and social media all amplify the spread of information in a social network.

20. Six areas of empirically established social contagion in adolescents—marijuana use, eating disorders, suicide, non-suicidal self-injury, and emotion—are presented as a prelude to the discussion of how the same processes may be at work

¹ I object to the use of the term “transition” because it is scientifically fallacious. The correct terminology is “masculinization” and “feminization” but for the sake of brevity and clarity, I will use the term “transition” to depict these concepts.

in the social contagion of gender dysphoria in children and adolescents. Specific mechanisms of transmission such as low gender typicality, peer victimization, in-groups, the transactivist “lobby,” and the role of social media in rapid onset gender dysphoria (ROGD) in adolescents are proposed. Preliminary statistical support for social contagion in gender dysphoria is presented. Alternative explanations for the increase in young people presenting with gender dysphoria are offered.

21. I conclude that social contagion may have a major role in the propagation and perpetuation of gender dysphoria in young people and that social contagion also affects medical, legal, legislative, educational, sporting institutions, and parents which amplifies that effect. I complete this section with a brief review of the recent re-thinking that is underway internationally.

22. In the second chapter, I discuss each of the four plaintiffs with respect to their family and social histories, the red flags that caution against automatic gender transition, and the problems I perceive in their medical management. I then link co-occurring factors to each case where relevant. I conclude that all four children have been precipitated prematurely into a medicalized gender treatment before due consideration and treatment of significant mental health issues and time for natural maturation to clarify their sexual orientation and gender identity.

CHAPTER 1

Introduction

23. The influence of social contagion on the upsurge in the number of children and young people who are presenting to gender clinics around the world for

advice regarding social transition, puberty blockade (PB), cross sex hormones (CSH), and ultimately surgery in the belief that they can change their gender in the past decade has not been canvassed by the academic or research communities. Nonetheless, this upsurge demands close attention because of the invasive and irreversible nature of most of the unproven medical and surgical interventions used to treat young people who believe they have been “born in the wrong body.” Explanations for this 21st century phenomenon must be scrutinized apart from the popular view that today’s permissive cultural milieu has permitted disinhibition of expression of their transgendered identity in the same way that left-handedness and homosexuality in young people were permitted freer expression in previous decades. There are complex statistical arguments that question the validity of these comparisons that I discuss briefly later in this submission.

24. First, I examine the concept of social contagion and the mechanisms by which it influences behaviour and attitudes. Then I review key adolescent behaviours that have been shown to be subject to social contagion. Next, I argue that the same principles of social contagion that have been demonstrated in other adolescent psychopathologies apply to the increase in young people who believe that they are transgender and are consequently seeking medical remedies to assuage their gender dysphoria. Finally, I explore the social contagion in our social institutions – medicine (medicalization, gender affirmation), the law (legislation), education (curricula, policy and practices within schools), sport (inclusion of transmales in female sport),

and among groups of parents (presentation of their children for gender reassignment), with respect to their beliefs and actions regarding gender dysphoria, despite our collective failure to date to fully understand the phenomenon of gender dysphoria and its rapid, epidemic-like spread around the world.

25. The most compelling yet least discussed causative factor among proponents of so-called “gender-affirming” treatment is that social contagion is at play in the expression of gender dysphoria. The influence of this potent human behavioural phenomenon was understood by Carl Jung (1904) who stated:

It is not famine, not earthquakes, not microbes, not cancer but man himself who is man's greatest danger to man, for the simple reason that there is no adequate protection against psychic epidemics, which are infinitely more devastating than the worst of natural catastrophes (CW15, para 339).

26. The term “psychic epidemic”, now called social contagion, describes the “spread of phenomena (i.e., behaviours, beliefs, and attitudes) across network ties” (Christakis & Fowler, 2013, p. 556). It has been documented through the ages. In 1841, a Scottish journalist, Charles Mackay (2012) wrote a book entitled *Extraordinary Popular Delusions and the Madness of Crowds*. In the preface to the first edition of the book, he outlines his aim for writing it as:

...to collect the most remarkable instances of those *moral epidemics*... to show how easily the masses have been led astray, and how imitative and gregarious men are, even in their infatuations and crime (p. 1) ...Popular delusions began so early, spread so widely, and have lasted so long, that instead of two or three volumes, fifty would scarcely suffice to detail their history... The present may be considered...a miscellany of delusions, a chapter only in the great and awful book of human folly (p. 3).

The preface to the second edition in 1852 continued this theme: Nations... like individuals, ...have their whims and their peculiarities; their seasons of excitement and recklessness... whole communities suddenly fix their minds upon one object and go mad in its pursuit; ...millions of people become simultaneously impressed with one delusion, and run after it, till their attention is caught by some new folly more captivating than the first. At an early age in the annals of Europe its population lost their wits about the sepulchre of Jesus and crowded in frenzied multitudes to the Holy Land; another age went mad for fear of the devil and offered up hundreds of thousands of victims to the delusion of witchcraft... the belief in omens and divination of the future...[and] defy the progress of knowledge to eradicate them entirely from the popular mind... *Men... think in herds; ...they go mad in herds, while they only recover their senses slowly, and one by one* (emphasis added) (p. 7).

27. With the arrival of COVID-19, the World Health Organization (WHO) warned that there would be an “infodemic” of misinformation spawned by social contagion (Richtel, 2020). This did in fact occur, but those false beliefs did not take centre stage and sweep all science before it in the manner of gender ideology.

28. More recently, using very large datasets (e.g., Framingham Heart Study) that have collected longitudinal data on original participants (original cohort), as well as their children (offspring cohort) and their children’s children (third generation cohort) and including their spouses, siblings, friends, and neighbours, Christakis and Fowler have shown that social network effects, known as clustering, remain strong and can extend to those up to three degrees of separation from the original cohort. Such effects have been demonstrated across a large range of factors by different researchers using differing datasets. Examples include overweight/obesity, sleep patterns, smoking, alcohol abuse, alcohol abstention, marijuana use, loneliness, happiness, depression, cooperation, and divorce among others.

29. Social network analysis, the method applied to study contagions of all kinds, was first developed and used in public health as a way of determining the spread of diseases (e.g., influenza, HIV/AIDS) that resulted in pandemics. It was subsequently applied to the challenges of introducing changes and innovations in the health system (Blanchet, 2013). Its applications have since expanded with the advent of computers, the internet, mobile and smart phones, and social media. Members of a network play different roles in the dissemination of innovations. A small number will adopt early (i.e., early adopters). Some of these will become opinion leaders who are central to the network, who contaminate their “peers” who in turn will influence those others at different levels of the network.

30. There are three types of social networks; (i) egocentric (networks assessing a single individual); (ii) sociocentric (social networks in a well-defined social space, such as a hospital or a school); and (iii) open system networks (e.g., globalised markets, social media). Each network consists of nodes (members), ties (between nodes), and measures of centrality, density and periphery or distance between the nodes. Networks with high centrality are the most effective in disseminating information or innovation. Other characteristics of networks include cohesion (number of connections within a network) and shape (distribution of ties within the network) (Otte & Rousseau, 2002). A key example with respect to this submission is the trans-activist lobby that has achieved spectacular success in a short time in changing health care, educational practices, and legislation related to transgender individuals.

Mechanisms of social transmission

31. I begin with a discussion of three mechanisms that may be involved in the social contagion of gender dysphoria.

Peer contagion

32. Peer contagion is a form of social contagion, defined as a process of reciprocal influence to engage in behaviours occurring in a peer dyad that may be life-enhancing (e.g., taking up a sport, studying for exams, health screening, resisting engaging in negative behaviours, altruism) or life-compromising (e.g., illegal substance use, truanting from school, aggression, bullying, obesity). Three possible causes of peer effects have been enumerated by Ali, Amialchuk & Dwyer (2011), as follows:

- a. *Endogenous effect*. This effect would occur in a situation in which “...an individual is more likely to use marijuana if there is a high rate of marijuana usage among the reference group because friends’ engagement in such activities could develop a social norm which might compel an individual to use drugs in order to fit in with one’s peer” (p. 2), a process described as induction (Christakis & Fowler, 2013), colloquially described as “birds of a feather flock together.”
- b. *Exogenous or shared contextual effect*. This effect occurs when other social factors influence adolescent behaviour; for example, high substance abuse in a community population of adults, in which the adoles-

cent's parents are also substance abusers. In such a scenario, adolescents whose parents abuse substances will be more likely to abuse, and contagion may occur in adolescents as a result of peer influence even in those whose parents do not abuse substances.

- c. *Correlated effect*: These effects, known as environmental confounders, occur when adolescents in the same group behave in a similar way due to a third, perhaps unobserved factor, such as socioeconomic or demographic variables that cause their attributes to covary.

33. Peer contagion has a powerful socializing effect on children beginning in the pre-school years. By early childhood, the time spent interacting with same-age playmates frequently exceeds time spent with parents (Ellis, Rogoff, & Cromer, 1981). Further, characteristics of peer interactions in schools (e.g., aggression, coercive behaviours, mocking peers) are carried over into the home environment (Patterson, Littman, & Bricker, 1967). By middle childhood, gender is the most important factor in the formation of peer associations, highlighting the significance of gender as the organizing principle of the norms and values associated with gender identity (Fagot & Rodgers, 1998). Indeed,

...peer contagion effects can undermine the goals of public education from elementary school through college and impair the goals of juvenile corrections systems. ...Programs that "select" adolescents at risk for aggregated preventive interventions are particularly vulnerable to peer contagion effects. It appears that a history of peer rejection is a vulnerability factor for influence by peers... (Dishion & Tipsord, 2011).

Deviancy training as a mechanism of social contagion

34. Different mechanisms of transmission of peer influence have been identified. Deviancy training, in which deviant attitudes and behaviours are rewarded by the peer group have a significant effect on the development of antisocial attitudes and behaviours such as bullying, physical violence, weapon carrying, delinquency, juvenile offending, and substance abuse (Dishion, Nelson, Winter, & Bullock, 2004). Aggression in adolescence becomes more covert and deliberate and takes the form of exclusion, spreading rumours, and suborning relational damage among an adolescent's friendship network (Sijtsema, Veenstra, Lindenberg, & Salmivalli, 2009). Interestingly, adolescents associated with peers who engage in instrumental aggression became more instrumentally aggressive, while those associated with peers who engaged in relational aggression became more relationally aggressive, demonstrating the specificity of the effects of peer contagion via the deviancy training.

Co-rumination as a form of social contagion

35. Another form of peer contagion in adolescence is co-rumination, a process of repetitive discussion, rehearsal and speculation about a problematic issue within the peer dyad or peer group that underlies peer influence on internalizing problems such as depression, anxiety, self-harm, suicidal ideation and suicide (Schwartz-Mette & Rose, 2012). Co-rumination is more common among adolescent girls (Hankin, Stone, & Wright, 2010) although a similar phenomenon has been observed among boys. Being in a friendship that engages in perseverative discussions

on deviant topics has been associated with increased problem behaviour over the course of adolescence. The longer these discussions, the greater the association with deviant behaviour in later adolescence (Dishion & Tipsord, 2011).

36. Peer contagion may undermine the effects of positive socializing forces such as schools, rehabilitation programs for young offenders, and treatment facilities for eating disorders among others. Collecting same-minded adolescents into group programs may be counter-productive because the peer influence impacts of a homogeneous peer group to maintain disordered behaviours may be greater than the program effects of the treatment facility (Dishion & Tipsord, 2011).

37. Young people are particularly vulnerable to peer contagion if they have experienced peer rejection, hostility, and/or social isolation from the peer group (Light & Dishion, 2007). On the contrary, protective factors against peer contagion effects include secure attachment to parents, adequate adult supervision and oversight of the young person's activities, school attendance, and the capacity for self-regulation (Gardner, Dishion, & Connell, 2008).

The special case of social contagion via social media

38. In the world of social media, social contagion takes on a new, less complex, and narrower meaning:

Unlike the broadcasts of traditional media, which are passively consumed, social media depends on users to deliberately propagate the information they receive to their social contacts. This process, called social contagion, can amplify the spread of information in a social network (Nathan & Kristina, 2014, p. 1).

39. An important issue in assessing the influence of the internet (social media) in behavioural and attitudinal uptake is to understand causal relationships that drive the spread of ideas and behaviour and identify who is most susceptible. In online social networks, user characteristics and behaviour cluster in space and time (Aral & Walker, 2011). Two primary underlying mechanisms affect this observed clustering - peer influence and homophily. Targeted marketing campaigns to friends on and offline generate additional influence.

40. In peer interactions, one individual influences another to take a particular action. In homophily, an individual befriends peers like oneself. In both situations, we observe correlations between the behaviour of the target individual and the behaviour of his/her friends. However, in homophily, "...the peers may not influence each other at all, ...the observed correlation of their actions comes from their intrinsic similarity" (Bapna & Umyarov, 2015, p. 1903). This intrinsic similarity may lead to independent similar choices among the group. Nonetheless, in real-life networks more than 50 percent of the perceived behavioural contagion has been explained by homophily (Aral, Muchnik, & Sundararajan, 2009), suggesting that homophily is a major factor influencing the behaviour of those embedded in social networks.

41. Despite resulting in similar observations, the implications of achieving influence via each of these mechanisms are different. Peer influence operates via social contagion while homophily may not. However, peer influence and homophily

may occur together, but peer influence is more likely to trigger positive, self-reinforcing feedback loops, where the imitation of the target individual's behaviour by peers enhances that behaviour in the target individual so that s/he does more of the behaviour, in the manner that is observed with non-suicidal self-injury (NSSI) and eating disorders among adolescents that becomes more extreme over time, creating a social multiplier effect. This effect also occurs in online communities which is enhanced by introducing certain features into the market design of products, such as, in this case, PB, CSH, and sex reassignment surgery, and identifying the influential and susceptible users (Aral & Walker, 2012).

42. An ingenious study (Kramer, Guillory, & Hancock, 2014) using Facebook (a large real-world social network) and a large dataset (N = 689,003) collected over 20 years has demonstrated how emotional states are transferred to others via the mechanism of social-emotional contagion without direct interaction between “spreaders” and recipients. The authors manipulated the amount of positively-and negatively-valenced emotional content in the News Feed. When positive and negative content was either increased or reduced, Facebook users posted more or less positive and negative posts in response to content.

43. The social network “Instagram” is one of the most popular platforms for adolescents and young people, with 44 percent reporting Instagram to be an important part of their daily lives (Feierabend, Plankenhorn, & Rathgeb, 2015). Analysis of content shows that it is a major vehicle for the sharing of mental health issues, including depression, eating disorders, and non-suicidal self-injury (NSSI) (Fischer,

2015). The authors argued that emotions expressed by others on Facebook influence the reader's emotions, concluding that these results "constitute[e] experimental evidence for *massive-scale contagion via social networks*" [author's italics] (p. 8788). The study also demonstrated that direct interaction between individuals is not a necessary condition for the transmission of positive or negative emotions.

44. Systematic reviews have identified both potential risks and benefits of online activity. On the one hand, it reduces social isolation and offers encouragement, camaraderie, and reduction of self-harm impulses. On the other, it enables, enhances, or triggers potential risks of "copycat" behaviours such as NSSI, suicide, and eating disorders through the normalization of pathological behaviours, or vicarious and social reinforcement of these behaviours (Brown, Fischer, Goldwich, & Plener, 2020). It appears to have a similar effect on the uptake of gender transition.

45. A paper by Pang, de Graf, Chew, et al. (2020) found a robust relationship between the number of positively framed media reports of transgender issues and increases in referrals of self-declaring transgender and gender diverse (TGD) children and adolescents to specialist gender services. The study used a serial cross-sectional design and covered eight years of media content during which time more than 5,242 TGD young people were referred to two paediatric gender clinics, one in the UK and one in Australia. Results showed a robust association between weekly referral rates and the number of positively-valenced TGD-related items appearing within the local media one and two weeks prior to referral. Increased media coverage

of TGD-related topics was associated with increased referrals in the number of TGD young people presenting to the two gender clinics.

Evidence for social contagion among adolescents

46. We now turn to whether social contagion has a causal effect on behaviour uptake. Establishing a causal role for the effect of peer behaviour on adolescents is difficult because adolescents choose their peer networks; that is, they choose to associate with like-minded adolescents and those exhibiting similar attributes i.e., they search for homophily. This raises the question: Do adolescents choose their peers because they sanction and engage in similar behaviours or can peer social networks explain the uptake of (new) behaviours in individuals in the network? Sophisticated statistical models have been used to tease out the relative contributions of peer selection and peer influence. Correctly attributing the effects of these two factors has important policy implications since most interventions for reducing risky behaviour among adolescents are implemented at a school level (Ali & Dwyer, 2010).

47. In this section, I review the evidence for social contagion for several frequently occurring psychopathologies that arise in adolescence (i.e., anorexia nervosa, marijuana use, suicide, non-suicidal self-injury, and emotion) and compare the mechanisms of social contagion in these well documented areas with evidence for social contagion of gender dysphoria.

Anorexia nervosa

48. Social contagion plays a central role in the development and propagation of anorexia nervosa in adolescent girls (Allison, Warin, & Bastiampillai, 2014). Adolescence is a time in which the focus on oneself becomes intense, and for some, critical and unrelenting. The developing female body constitutes one of the main objects of scrutiny. When this scrutiny is compounded by the collective inspection of all of one's body's flaws, the peer group becomes a powerful crucible for both the development and maintenance of disordered eating.

49. Intensification of peer influence in closed communities of like individuals, such as schools, inpatient wards, residential units (Huefner & Ringle, 2012), or therapy groups often results in the advocacy of the practices (e.g., self-starvation, compulsive exercise, deceitful practices around eating) associated with anorexia nervosa (Dishion & Tipsord, 2011).

50. If we add social media and online networks as further sources of influence, affected adolescents can effectively surround themselves exclusively with like minds, thereby normalising cognitive distortions around eating and body image and making recovery very difficult. These effects are further compounded by the high status of thinness in western culture, and an ubiquitous focus on nutrition and exercise. Originally thought to be caused by genetics and pathological family dynamics, this view was revised with the finding, using longitudinal study designs and social

network analyses, that same-gender, mutual friends were most influential in the development of obesity in adulthood, with siblings and opposite-sex friends having no effect (Christakis & Fowler, 2008).

Marijuana use

51. Substance use in adolescents is a major public health issue (Fletcher, Bonell, & Hargreaves, 2008). A population study conducted by the Center for Disease Control and Prevention showed that 10 percent of youths reported using illegal substances before the age of 13, with marijuana the most frequently used substance (Chen, Storr, & Anthony, 2009). Peer influence has long been suspected as a stimulus that amplifies risky behaviours in the social network (Clark & Loheac, 2007; Lundborg, 2006).

52. The *National Longitudinal Study of Adolescent Health* (Add Health) (n=20,745) representing a sample of adolescents from grades 7–12 in 132 middle and high schools in 80 communities across the USA examined the influence of peer networks in the uptake and continued use of marijuana. The peer group, identified by the nomination of close friends and classmates within a grade, were used to identify the broader social network from which friends were chosen (Ali, Amialchuk, & Dwyer, 2011). Results showed that for every 10 percent increase in marijuana use in adolescents in a close friend network increased the likelihood of marijuana use by two percent. An increase of 10 percent in usage in grade peers was associated with a 4.4 percent increase in individual use. Reporting a good relationship with one's parents, living in a two-parent household and being religious were protective against

marijuana uptake. When peer selection and environmental confounders were held constant, increases in close friend and classmate usage by 10 percent both resulted in a five percent increase in uptake in individuals within those networks.

Non suicidal self-injury (NSSI)

53. NSSI is defined as a deliberate self-inflicted attack on one's own body without suicidal intent. It excludes cultural practices such as ear piercing, tattooing, or circumcision, most of which are performed by others. NSSI is defined as socially contagious when at least two people in the same group inflict NSSI within 24-hours. The social contagion of NSSI has been reported in a variety of 'closed' social networks such as in inpatient units, prisons, group homes, and special education schools, as well as in community samples of adolescents, young adults, and college students (Jarvi, Jackson, Swenson, & Crawford, 2013).

54. Adolescence (onset between 12 and 14 years) and early adulthood are high-risk developmental periods for NSSI (Lloyd-Richardson, Perrine, Dierker, & Kelley, 2007). Between 14 percent and 21 percent of high-school aged adolescents report engaging in NSSI, with higher estimates (30–40 percent) for adolescent psychiatric populations (Muehlenkamp, Hoff, Licht, Azure, & Hasenzahl, 2008).

55. More recently, social media has been identified as an important conduit for social contagion of NSSI among young people. Platforms such as Instagram have high-frequency occurrences of pictures from adolescents who have self-harmed. When associations between characteristics of pictures (e.g., seriousness and type of the self-injury) and comments (e.g., supportive, empathic, negative, offers of help)

and weekly and daily trends of posting were analysed, patterns emerged suggesting social contagion. For example, the more serious injuries attracted more views and comments. Social reinforcement, imitation, and modelling of NSSI through social media are the possible mechanisms whereby young people increase their risk of engaging in NSSI through digital means (Brown et al., 2017; Fulcher, Dunbar, Orlando, Woodruff, & Santarossa, 2020).

Suicide

56. Three theories account for the social transmission of suicidality. Firstly, it can be considered as one aspect of behavioural contagion theory, in which an individual overcomes aversion and constraint to perform a particular behaviour if s/he observes another engaging in the behaviour. Thus, the reportage of suicides in the media may serve to overcome internal restraints against performing the behaviour. Secondly, social learning theory offers additional insights, demonstrating that imitation and modelling are powerful mechanisms of social transmission of behaviour, attitudes, and beliefs. Learning is strengthened by attractive or powerful models and the incentives accruing to learning and performing a particular behaviour. Thirdly, a public health or infectious diseases model of contagion that assesses the roles of agents (i.e., models/influencers/media/social media), hosts (i.e., vulnerable individuals), and environments (i.e., network characteristics) in disease transmission, is applicable to the spread of behaviours in the same way that bacteria and viruses spread throughout a population (Gould, 2001).

57. Although media has been shown to be a critical agent in the social contagion of suicide, the phenomenon existed long before the advent of the digital age and social media. For example, in 1774, Johann von Goethe published a novel, *The sorrows of young Werther*, in which an idealistic young man finds his actual life too difficult to reconcile with his poetic fantasies, including his unrequited love for his friend's fiancée. He eventually becomes so depressed and hopeless by the perceived emptiness of his life, he commits suicide. Goethe was able to capture the nameless dread and endless longing of the human condition so well that his novel spawned a number of suicides, committed in the same way that Werther had killed himself, by shooting (Phillips, 1974). Such was the alarm created by this phenomenon, the book was banned in several European cities.

58. More than two hundred years later, in 1984, the suicide of a young Austrian businessman, who threw himself in front of a train, initiated a spate of similar suicides that averaged five per week for nearly a year. Sociologists argued that this alarming occurrence was amplified by media coverage that glamorised suicide by providing graphic images of the suicidal act and details of the young man's life. When media exposure of the event was curtailed and then stopped completely, the suicide rate dropped by 80 percent almost immediately.

59. Although the influence of suggestion and imitation on suicide rates was dismissed by Durkheim (1897/1951), Phillips's (1974) work indicated that these factors do indeed play a significant role in the increase in suicides following a publicised suicide. Baller and Richardson (2002) provided a more nuanced analysis

showing that although geographical clustering of suicide is, in part, determined by the degree of social integration, imitation also plays a role.

60. Positive social ties are generally protective against loneliness, depression and suicide, but social ties can be toxic and can amplify the risk of psychopathology in members of a social network (Christakis & Fowler, 2008). Exposure to the suicidal ideation or suicide attempts of significant others increases the risk of suicidality in other network members (Abrutyn & Mueller, 2014). Experiencing self-harm or suicide at close quarters may erode the emotionally regulating effects of normative moral precepts against such behaviour (Mueller, Abrutyn, & Stockton, 2015). When vulnerable individuals share “ecologically bounded spaces” (p. 205) like schools or the family home, this may increase suicide contagion if social relationships within those spaces are psychopathological. Our emotional connection to members of our social networks is the mechanism through which social learning and the development of normative behaviours and attitudes are built. However, negative emotions are more “contagious” and thus exert a greater impact on members (Turner, 2007).

61. The media has been demonstrated repeatedly to act as a conduit for the indirect transmission of suicide contagion. For example, highly publicized celebrity suicides trigger spikes in suicide rates, with the greater visibility of the celebrity and more prolonged coverage of the suicide triggering higher spikes and longer duration of elevation of rates of suicide amongst fans (Fu & Chan, 2013; Stack, 2005).

62. Perhaps one of the most compelling studies on the social contagion of suicide is the study of celebrity suicides by Ha and Yang (2021). This study tracked the suicides 10 days before a well-publicised celebrity suicide and then the suicides 10 days after the suicide was reported in the media. Figure 1 presents these data graphically.

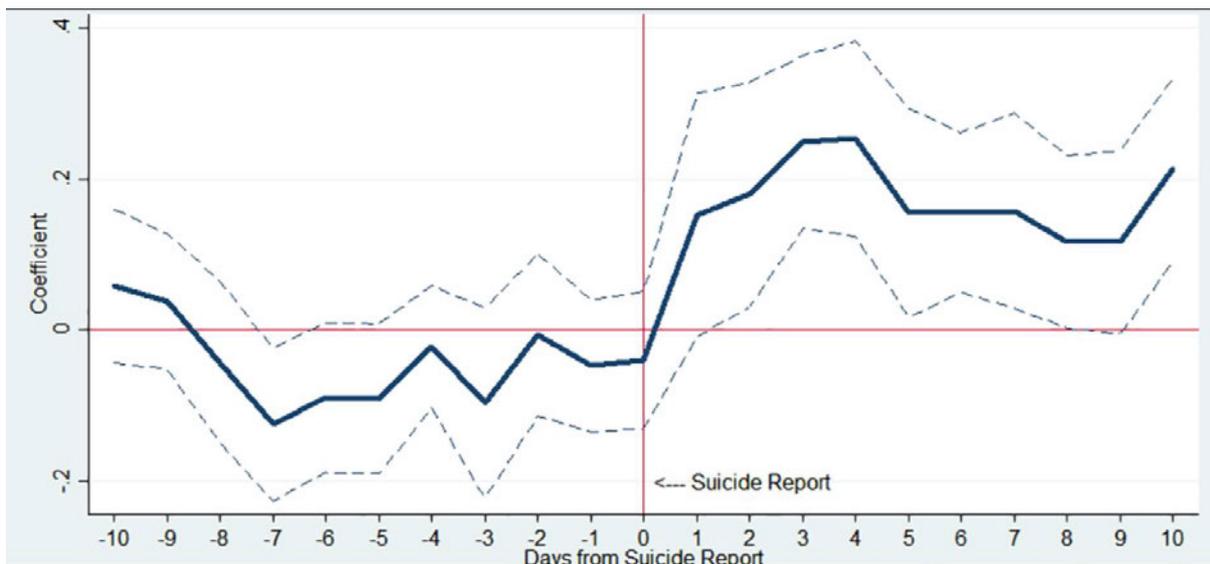


Figure 1² Suicide trends before and after the reporting of a celebrity suicide (Source: Ha & Yang, 2021).

63. Similarly, Durkheim (1951) highlighted the phenomenon of suicide outbreaks or “point clusters” defined as “temporally and geographically bounded clusters” such as gaols, regiments, monasteries, psychiatric wards, and First Nations reservations (Mueller et al., 2015, p. 206). Individuals in such networks share a collective identity that appears to heighten subsequent suicides following the suicide of the first decedent (Niedzwiedz, Haw, Hawton, & Platt, 2014).

²The y-axis indicates an approximate percent change in public suicide by corresponding day

64. The sharp increase in suicides following celebrity suicide was mostly accounted for by suicides in the 10–29-year age group. When the data were segmented by sex, the figures showed that females were more susceptible to social contagion than males. This is the same pattern of social contagion we are witnessing in gender dysphoria – young females aged between 10 and 29 years. Is this a coincidence? Suicide is one of the major causes of death in young people and is more likely to occur in clusters than for other age groups (Hawton et al., 2020). This is a robust finding for suicide; the rapidly increased incidence of gender dysphoria in females in this age group may also be driven by social contagion in a similar way.

65. Using the same data set as the study examining marijuana use but following up in four waves with these participants into adulthood, wave IV assessed suicidality in young adults aged 24–32 years. This study showed that holding all other psychological risks constant, those young people having a role model who attempted suicide were more than twice as likely to report suicidal ideation in the following 12 months. Participants who had a friend or family member commit suicide were 3.5 times more likely to attempt suicide themselves compared with those who had no close associate attempt or commit suicide in the same 12-month timeframe. These effects were enduring. Young adults who reported an attempted suicide of a role model were more than twice as likely to report a suicide attempt six years after the role model’s attempt compared with their otherwise similar peers. Attempting suicide in adolescence increased suicidal ideation and suicide attempts in young

adulthood. Significant risk factors for this association included experiencing emotional abuse in childhood, a diagnosis of depression, and a significant other attempting suicide.

66. A well-documented example of a suicide “echo” cluster (an identical suicide cluster occurring within 10 years of a first cluster) occurred in two high schools in Palo Alto that, between them, had suicide rates four to five times higher than the national average. In 2009, three students committed suicide in a nine-month period by stepping in front of a commuter train. A fourth student committed suicide by hanging. In 2013 a mental health survey showed that 12 percent of students from these schools had seriously considered suicide in the previous 12 months. Thereafter, there was another spate of suicides, with three students taking their lives within three weeks of each other. A fourth committed suicide four months later by jumping off a tall building and a fifth followed shortly afterwards by walking in front of a train. Extreme perfectionism and pressure to excel at school, get into Stanford, make a lot of money, and be ostentatiously successful materially and intellectually were assessed to be far too great a burden for the more vulnerable students to withstand.

67. Thus, suicide contagion appears to be a significant risk factor for suicide in young adulthood but contagion in this study did not require bounded social contexts. Gould (2001) concluded that

... the existence of suicide contagion no longer needs to be questioned. We should refocus our research efforts on identifying which particular story components promote contagion under which circumstances and which components are useful for preventive programming.

Emotion and mood

68. Several studies have demonstrated the impact that social media can have on emotional contagion. For example, one study (e.g., Block & Burnett-Heyes, 2020) demonstrated that interactions with others can alter our mood in the direction of the mood of the person with whom we are interacting. Various mechanisms, for example, social influence, social selection, and shared external causation, can affect changes in mood. The phenomenon is prevalent in bounded social networks such as touring orchestras where adolescent musicians have been observed to become more reciprocally similar in mood to their close associates on tour. The observed emotional contagion effects are greater for negative than positive moods. In a study on Twitter posts (Golder & Macy, 2011) the distribution of positive and negative comments varied according to weekends and holidays, with more positive comments on weekends and holidays.

69. Pain behaviour has also been shown to be affected by the social mechanisms of observation, modelling, vicarious learning, social interaction, and media reports. Both placebo and nocebo hyperalgesia have been recorded in patients who observed confederates modelling pain behaviour in response to social stimuli (Benedetti, 2013).

70. While many studies show how emotions spread between individuals in direct contact, a novel study demonstrated that online social networks produce emotional contagion in the same way (Coviello et al., 2014). Using data from millions

of Facebook users, the researchers showed that rainfall directly influences the emotional content of young people's status messages, including messages of friends in other cities who were not experiencing rainfall. Results showed that "...for every person affected directly, rainfall altered the emotional expression of one to two other people, suggesting that online social networks may magnify the intensity of global emotional synchrony" (p. 1165).

Is gender dysphoria socially contagious?

71. The UK has reported a 4,000 percent increase in the number of children presenting to gender clinics over the past 10 years. Similarly, Sweden has reported a 1,500 percent increase. In view of the evidence for social contagion in general and peer contagion particularly in suicide, NSSI, substance abuse, eating disorders, and emotion/mood, the hypothesis that social contagion in general and peer contagion specifically may underlie the burgeoning incidence of young people claiming that they are transgender is not only warranted but imperative. Notwithstanding, this hypothesis has not yet received sufficient high quality epidemiological investigation nor been considered critically as a possible explanation for the increase in gender dysphoria, or as an explanation for the reversal of the male/female ratio in recent presentations.

72. If we examine the gender dysphoria epidemic in social network terms, we see several features operating. It is an open-system network with nodes and ties expanding across the oceans to the US, UK, Asia, Europe, Scandinavia, Australia, and New Zealand. Most countries are reporting sharp increases in the number of

young people seeking services and treatment for gender dysphoria. Many are ramping up services and setting up new gender clinics to cope with demand, despite the recent closure of the Tavistock Gender Identity Disorder Service (GIDS) in the UK following the Cass review (Cass, 2022). This network is highly centralised with only one voice—the transactivist lobby. Its opinion leaders operating at the centre of these networks are very influential. The level of density in a network has two effects—firstly, it enhances the circulation of information between members and secondly, it blocks the introduction of dissenting ideas and evidence (Iyengar, Van den Bulte, & Valente, 2011).

73. Several sources of peer contagion may account for the sharp increases in young people presenting with gender dysphoria.

Low gender typicality, peer victimization, ingroups and the trans lobby

74. Low gender typicality (i.e., perceived lack of fit within one’s binary gender) has a significant impact on social acceptance within one’s peer group (Sentse, Scholte, Salmivalli, & Voeten, 2007). It is strongly associated with adjustment difficulties, behavioural problems, lower self-esteem, and increased internalizing disorders (e.g., anxiety, depression) (Smith & Juvonen, 2017). As children progress to adolescence, peer as opposed to parental acceptance becomes paramount. Peers therefore take over the role of gender socializing agents from parents (Blakemore & Mills, 2014). Adolescent peers tend to be critical of behaviours, dress, mannerisms and attitudes that are not gender typical as a way of policing and rein-

forcing gender norms and respond with criticism, ridicule, exclusion and even intimidation of non-conformers (Zosuls, Andrews, Martin, England, & Field, 2016). Problems accruing to low gender typicality are mediated by peer victimization and that reducing peer victimization may ameliorate these difficulties (Smith & Juvonen, 2017).

75. Gender non-conformity and gender atypicality have also been associated with higher physical and emotional abuse by caregivers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). Mental health is difficult to sustain in the face of caregiver abuse and peer bullying and victimization (Aspenlieder, Buchanan, McDougall, & Sippola, 2009). Indeed, gender non-conformity and gender atypicality have been associated with higher physical and emotional abuse by caregivers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012). These youth are also at higher risk of depression, anxiety and suicidality in adulthood (Alanko et al., 2009). Conversely, peer acceptance mediates the self-worth of gender non-conforming 12-to 17-year-olds (Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

76. It is possible that these groups of young people, searching for homophily (i.e., like peers) started to exaggerate their points of difference from their gender-conforming peers rather than to hide and minimize them to avoid being bullied and excluded. In so doing, they left the “outgroup” of nonconformers and formed an ingroup of extreme gender-nonconformers, transcending the gender barrier altogether and declaring themselves transgender. Suddenly, the discomfort and fear of not being gender typical becomes a virtue and rather than fearing the disapprobation

of their peers, their open revolt in declaring themselves transgender is valorised by a politically powerful transactivist lobby. One would expect that gender atypical children who feel both internal and external pressure to be gender conforming would experience greater discomfort (Carver, Yunger, & Perry, 2003) and therefore be more susceptible to the message of trans activism.

77. Ingroups behave in stereotypical ways with respect to outgroups – they favour ingroup characteristics, assigning more positive attributes to its members and derogating outgroups in order to enhance the status of their ingroup (Leyens et al., 2000). It is not surprising, then, that members of the transgender ingroup exaggerate the characteristics of the “trans” gender they take on – becoming more “feminine” or “masculine” than heteronormative groups of cismen and ciswomen. Transactivist groups have proliferated and consolidated in a short time frame by exploiting the characteristics of ingroups and outgroups. For example, social projection (i.e., the belief that other members of the group are like oneself) has been a powerful integrating process that simultaneously creates protection for its own members and distance from outgroup members. Those disagreeing with the ideology of the trans lobby are denounced, publicly shamed, and labelled “transphobic” (Bindel, 2022; Bodenner, 2016; Moynihan, 2021; Siddique, 2021).

Rapid onset gender dysphoria (ROGD) and the role of social media

78. The upsurge in rapid onset gender dysphoria (ROGD) tends to occur mostly in girls at around the age of 14 years, which is an age identified by developmental psychologists to be particularly susceptible to peer influence (Steinberg & Monahan, 2007).

79. Tables 1 and 2 present figures for young people referred to the Tavistock gender service in Britain 2019–2020. They show a peak in presentations at 14–15 years, comprising mainly girls.

Table 1 Age at referral to GIDS, 2018-2019

Age	Referrals
3 and 4	10
5	21
6	21
7	42
8	34
9	43
10	59
11	78
12	135
13	331
14	511
15	529
16	474
17	88
18	30

Source: NHS (2019)

Table 2 Age and gender at referral to GIDS, England only, 2019-2020

Age	FtM	MtF
3 and 4	<5	<5
5	5	12
6	7	9
7	13	16
8	17	24
9	24	21
10	22	32
11	52	23
12	127	37
13	270	45
14	404	90
15	470	152
16	350	162
17	101	67
18+	30	28

Source: NHS (2020)

80. These figures indicate a reversal of the sex distribution of transgender identifying individuals from previous decades. For example, the DSM IV (APA, 1994) reported that five times as many boys were referred to child clinics for gender confusion compared with girls (p. 535).

81. Littman (2019) canvassed the perceptions of parents who had children who displayed ROGD during or just after puberty. There were 256 respondents, of whom 83 percent had daughters, with a mean age of 15.2 years when they declared themselves transgender, 41 percent of whom had previously expressed a non-heterosexual sexual orientation, and 62.5 percent of whom had received a diagnosis for a mental health disorder (e.g., anxiety, depression) or a neurodevelopmental disability [e.g., autism spectrum disorder (ASD), ADHD]. Thirty-seven percent of these young people belonged to peer groups with other members identifying as transgender. Parents also reported a decline in their child's mental health (47%) and relationship with parents (57%) after declaring themselves transgender. Thereafter, they preferred transgender friends, websites, and information coming from the transgender affirming sources.

82. These findings are consistent with findings from other studies of peer contagion for risky behaviours that found that exposure to risk-taking peers doubled the amount of risky behaviour in middle adolescents, increased it by 50 percent in older adolescents and young adults, and had no impact on adults (Gardner & Steinberg, 2005). This group of young people were likely to belong to peer groups in which one or more of their friends had become gender dysphoric or transgender identified. Their coming-out announcement to parents also tended to be preceded by recent increases in their child's social media and internet usage.

83. An indicative case study was written up in an article for *The Atlantic* by Jesse Singal (2018) in which a 14-year-old girl decided she must be trans because

she was uncomfortable with her body even after she restricted her food intake, was finding puberty uncomfortable, had difficulty making friends, was feeling depressed, and was lacking in self-confidence. Against this backdrop of woes, she came across *MilesChronicles*, a transman with 1.14 million subscribers. Watching this video resulted in Claire pouring all her sadness and unease about herself into the “realisation” that she was really a “guy.” This is a very common scenario reported by parents of teenage girls with ROGD. Such websites, all easily accessible to vulnerable adolescents, can have a very persuasive effect on viewers. Recent studies show that contagion is enhanced when the influencer is perceived to have high credibility and reduced when the influencer is perceived to have low credibility. A similar effect is observed if the influencer belongs to an out-group or an in-group (Andrews & Rapp, 2014). One post dedicated to coming out in middle school (2018) attracted 723,000 views and more than 5,000 comments of the type:

Hi, I’m a trans guy in 8th grade! You’re both awesome and I love you guys cause you’ve helped me so much with dealing with dysphoria and all this crap we have to deal with Especially bullying (I’m called an “it” on a regular basis).

There are so many gay beans at my school, my school is super gay.

Another viewer came out as “trans pan” and received 34 confirmations from other trans pan young people with comments of the kind, “Trans pans, UNITE!”

84. A recent Swedish study (Indremo et al., 2022) tracked referrals and attendances at gender clinics of young people following major media events related to transgender health care in 2019. One event was positive, and two media events [i.e., the airing of “The Trans Train and the Teenage Girls” (Swedish Public Service

Television Co. April 3, 2019), a 2-part documentary series broadcast on April 3, 2019 (event 2), and October 9, 2019 (event 3)] determined as negative portrayed gender transition as dangerous and damaging. In the three months following one of the negative media events, referrals decreased by 25 percent overall—there was a 32 percent reduction in female referrals—and by 25 percent for young people aged 13–18 years. On the contrary, increased positive media coverage of trans issues resulted in an increase in referrals to gender clinics (Pang et al., 2020).

85. Nonetheless, a statement released in August 2021 by the Coalition for the Advancement & Application of Psychological Science (CAAPS)³ called for the elimination of the use of Rapid-Onset Gender Dysphoria (ROGD), “given the lack of rigorous empirical support for its existence,” although this evidence abounds (see next section). Deplorably, CAAPS did not question the exponential increase in the adolescent trans phenomenon, both in declarations and referrals to gender clinics across the globe (Frisen et al., 2017; de Graaf et al., 2018; Kaltiala-Heino, 2015) nor how these new referrals differed substantially in profile from previously recorded demographics of transgender young people along dimensions of age of onset, sex ratio, comorbid mental health issues (Aitken, 2015; Ashley, 2019; Becker et al., 2014; Littman, 2018)⁴ and clustering.

³ <https://www.caaps.co/rogd-statement>

⁴ Aitken, M., Steensma, T. D., Blanchard, R., VanderLaan, D. P., Wood, H., Fuentes, A. ... Zucker, K. J. (2015). Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. *Journal of Sexual Medicine*, *12*, 756–763.

Ashley, F. (2019). Shifts in assigned sex ratios at gender identity clinics likely reflect changes in referral patterns [Letter to the Editor]. *Journal of Sexual Medicine*, *16*, 948–949.

Becker, I., Gjergji-Lama, V., Romer G., & Möller, B. (2014). Characteristics of children and adolescents with gender dysphoria referred to the Hamburg Gender Identity Clinic [German]. *Prax Kinderpsychol Kinderpsychiatr*, *63*, 486–509.

Empirical evidence

86. Population estimates of transgender individuals have been difficult to quantify due to varying definitions and methods used to collect the data. Estimates that conflate transgender with gender non-conforming (GNC) individuals result in inflated estimates as GNC individuals may be neither gender dysphoric nor transgender, nor have any desire to socially, medically, or surgically transition to the opposite binary. A similar issue may arise with those identifying as non-binary because some individuals from this group may not seek treatment while others pursue medical or surgical interventions. What is not in doubt is the rapid rise over the past 30 years in the populations of children, adolescents, and adults seeking gender affirming care.

87. A retrospective analysis (Wood et al., 2013) (Figure 2) of the pattern of referrals to a gender identity service from 1976 to 2011 is instructive in demonstrating the shifting patterns of presentations of young people to gender clinics. The sample comprised 577 children aged 3–12 years and 253 adolescents aged 13–20 years. Prior to around 2000, the child referrals greatly exceeded referrals of adolescents. After that time, there was a steep and significant increase in adolescents. Also of interest is that the overall sex ratio of male to female children was 4.5:1 (boys: girls). For three-year-olds the ratio was 33:1 (boys: girls). The ratio dropped to 3.4:1 in the last cohort of children (2008–2011). The adolescent sex ratios were at parity but by 2008–2011 girls exceeded boys.

Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS ONE*, 13(8), e0202330.

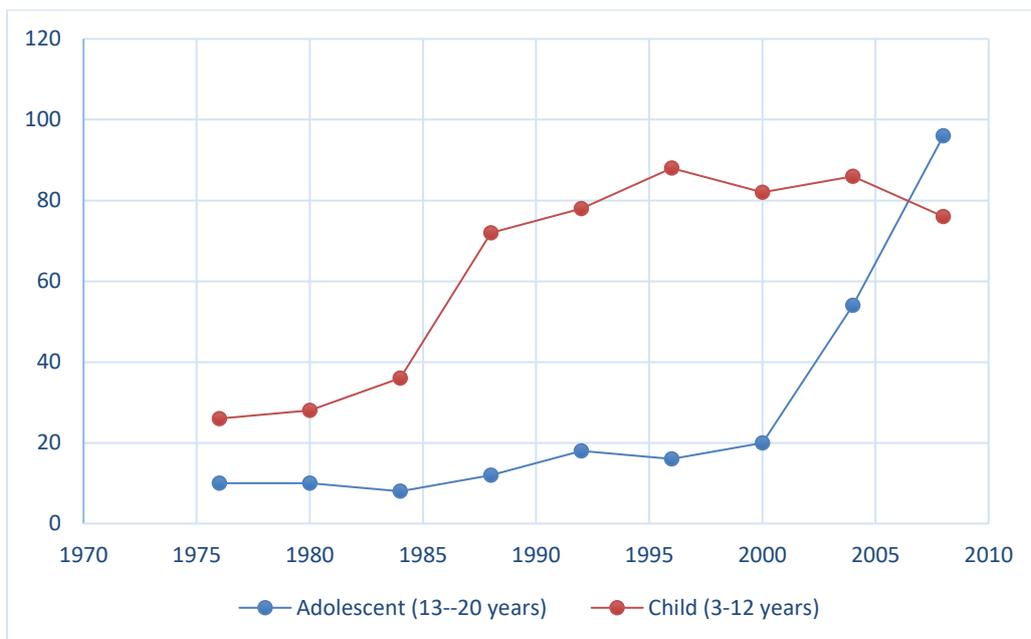


Figure 2 Number of children and adolescents referred to a gender clinic (1976-2011)
 Source: Wood et al., (2013).

88. For the adolescents in this study, data on sexual orientation were available for 248 participants. Using standardized measures (Zucker et al., 2012) to assess heteroerotic and homoerotic sexual orientation in fantasy, 76 percent of the girls were classified as homosexual compared with 57 percent of boys. These figures vastly exceed population estimates of homosexuality and beg the question as to whether many young people presenting to gender clinics are confused about their sexual orientation, experience socialized and/or internalized homophobia or do not understand the difference between gender identity and sexual orientation.

89. Other studies are also showing a significant change in the demographic of those identifying as transgender, most notably the increased ratio of adolescent girls compared with preschool boys from earlier decades (Arnoldussen et al., 2020). Early Dutch data collected from 1976 to 1986, reported that 5.6 per 100,000 males and 1.9 per 100,000 females (>15 years) sought treatment for gender dysphoria.

When data up to the end of 1990 were added, prevalence estimates rose to 8.4/100,000 males and 3.3/100,000 females (Bakker, van Kesteren, Gooren, & Bezemer, 1993). Another Dutch population study covering the years 1972–2015 (Wiepjes et al., 2018) reported a ratio of 1.1:1 for children <12 years and 0.7:1 (M:F) in the 12–18 year age range, compared with a ratio of 1:1 for children <12 years and 3:1 (M:F) for adolescents in the 12–18 year age range for the British NHS (2020) sample. According to The Diagnostic and Statistical Manual (DSM 5) of the American Psychiatric Association (APA, 2013), in children, sex ratios of natal boys to girls ranged from 2:1 to 4.5:1 (p. 454). In adolescents, the sex ratio was close to parity.

90. In adults, DSM 5 reports a sex ratio favouring natal males, ranging from 1:1 to 6.1:1 (p. 454). A study of population estimates for natal adult males ranged from 0.005 to 0.014 percent, and from 0.002 to 0.003 percent for natal females. However, about 0.7 percent of 13- to 17-year-olds living in the United States identify as transgender according to the Williams Institute at the University of California, Los Angeles, School of Law (Blad, 2017). This estimate is between 140 (males) and 350 (females) times higher than that for adult males and females estimated by the DSM 5. The *Growing Up Today* prospective cohort study of 7,831 US young adults (Reisner et al., 2014), using a precise definition of transgender-response options were “female,” “male,” “transgender,” and “do not identify as female, male or transgender” produced figures more concordant with the DSM 5. It reported that 26 (0.33%) identified as having a gender identity that differed from their natal sex.

Seven (0.09%) were cross-sex (sex not concordant with baseline sex) identified; five (0.06%) self-described as transgender; and 14 (0.18%) did not identify as female, male, or transgender. These estimates are now over 10 years old and both absolute estimates and sex ratios have changed in the intervening period. For young people in particular, subsequent research has pointed to both increases in the population and a change in sex distribution.

91. A survey of 80,929 9th and 11th grade students in Minnesota, USA, 2.7 percent reported that they identified as either transgender or gender non-conforming in the ratio of 2:1 (boys/girls) (Eisenberg et al., 2017). Note that these absolute figures are not directly comparable because of the inclusion of GNC with transgender in this study.

92. However, other studies show the continued increase in numbers. One study (Meerwijk & Sevelius, 2017) which presented the findings of a meta-regression of population-based probability samples, provides compelling evidence of an upward trend in transgender identifying individuals. Estimates more than doubled or tripled within the eight years from 2007 to 2015. Two extraordinary population studies have also identified the upswing in transgender declaring individuals, this time in veterans of the US Army. The first (Blosnich et al., 2013) covered the years 2002 to 2011. Proportions almost doubled in that time from 12.52/100,000 (0.013%) in 2002 to 22.88/100,000 (0.022%) in 2011. For the period 2006 to 2013, the proportion had increased to 32.9/100,000 (0.033%) (Kauth, Blosnich, Marra, Keig, & Shipherd, 2017). One could reasonably speculate that the latter data present evidence

of a sociocentric social network, in which a high-profile influencer, Chelsea Manning, a former United States Army soldier, who leaked classified army documents to WikiLeaks in 2010, declared herself transgender and transitioned under the public gaze.

93. Studies using populations identified in health records report estimates ranging from 17 (0.017%) to 33/100,000 (0.033%). Self-report estimates are much higher, ranging from 0.3 percent to 0.5 percent among adults, and from 1.2 percent to 2.7 percent among children and adolescents. For studies using broader definitions that encompass “gender diversity” and GNC, the estimates increase again, from to 0.5–4.5 percent among adults and 2.5–8.4 percent among children and adolescents (Zhang et al., 2020).

94. Upward trajectories of enrolments in gender clinics for young people under the age of 18 years have been observed in the UK and Australia as well as Europe and Scandinavia. The British data represent a 3,264 percent rise in referrals to the national gender identity service in London over the 10 years from 2009–2019) (Tavistock and Portman NHS Foundation Trust, 2019), increasing to 5,000 percent since 2019. Figure 3 shows the trends in the UK and Australia between 2003 and 2022.

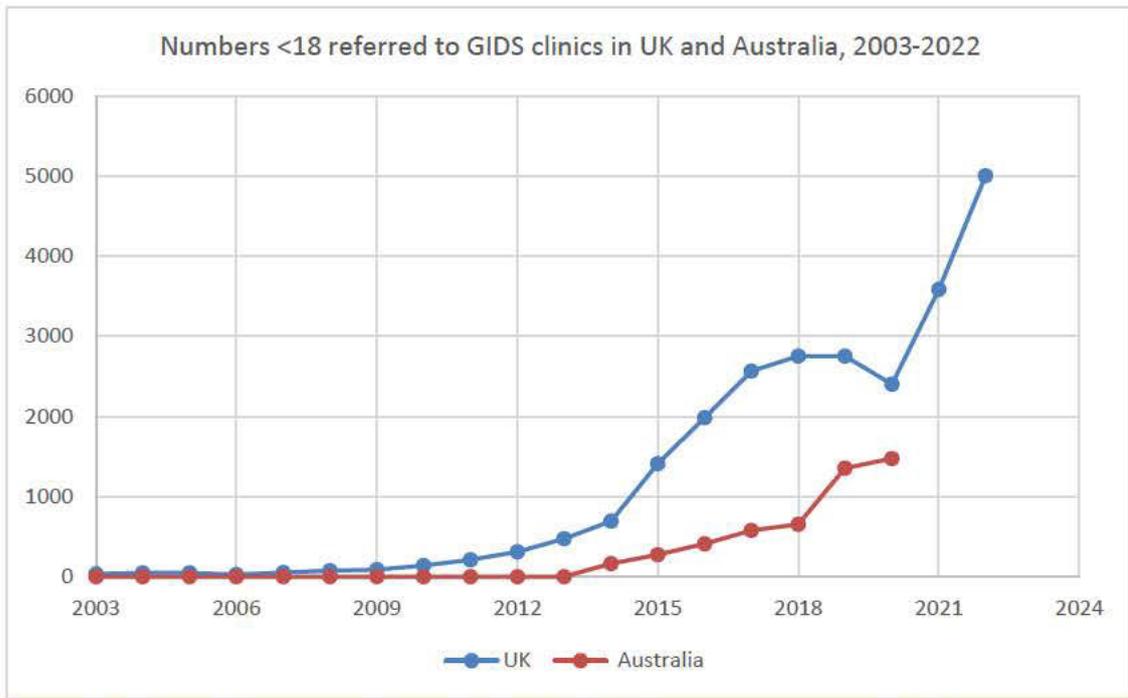


Figure 3⁵ Figure 3 [Source: Kenny, D.T. (2021). Australian data provided by the gender clinics under freedom of information applications] [Note: Population of UK = 67.509 million; Australia=26.125 million]

95. In 2022 there were nearly 5,000 referrals into GIDS, UK, an increase from 136 referrals in 2010 and between zero and 36 in the years preceding. Further, casemix changed from predominantly prepubertal males to peri- or pubertal females. Neurodiverse children (ASD, ADHD etc) were also over-represented in the new presentations. These developments cannot be accounted for solely through the disinhibition of expression through greater social acceptance. There are indisputably other forces operating, like social contagion of more suggestible and vulnerable young people who are succumbing to the misinformation taught in schools, the relentless persuasions from social media, and the ready acceptance and treatment from affirming medical practitioners without the safeguards of due diligence and patience,

⁵ Australian data: Kenny, D.T. (2022). Number of children enrolled in five gender clinics in Australia, 2014-2021 www.diannakenny.com.au; UK data: <https://gids.nhs.uk/about-us/number-of-referrals/>; <https://www.gires.org.uk/tavistock-gender-identity-development-service-data/> Note: numbers vary across data sources.

thorough assessment, and the search for alternatives. Additional support for this hypothesis is that in the USA, in 2022, 13–17-year-olds constituted 8 percent of the USA population but accounted for 18 percent of those identifying as transgender.⁶

96. Between 2008–2018, Sweden also reported unprecedented increases of 1,500 percent in girls aged 13–17 seeking gender reassignment.

97. Data below from Australia (Figure 4) show an upward trajectory in the number of children enrolled in gender clinics in the five states of Australia that offer a gender service to young people under 18 over the period 2014–2021. These are not population figures; they represent data from the specified gender clinics in each state, so under-represent the total but are presented here to show consistently upward trends and clustering in different states.

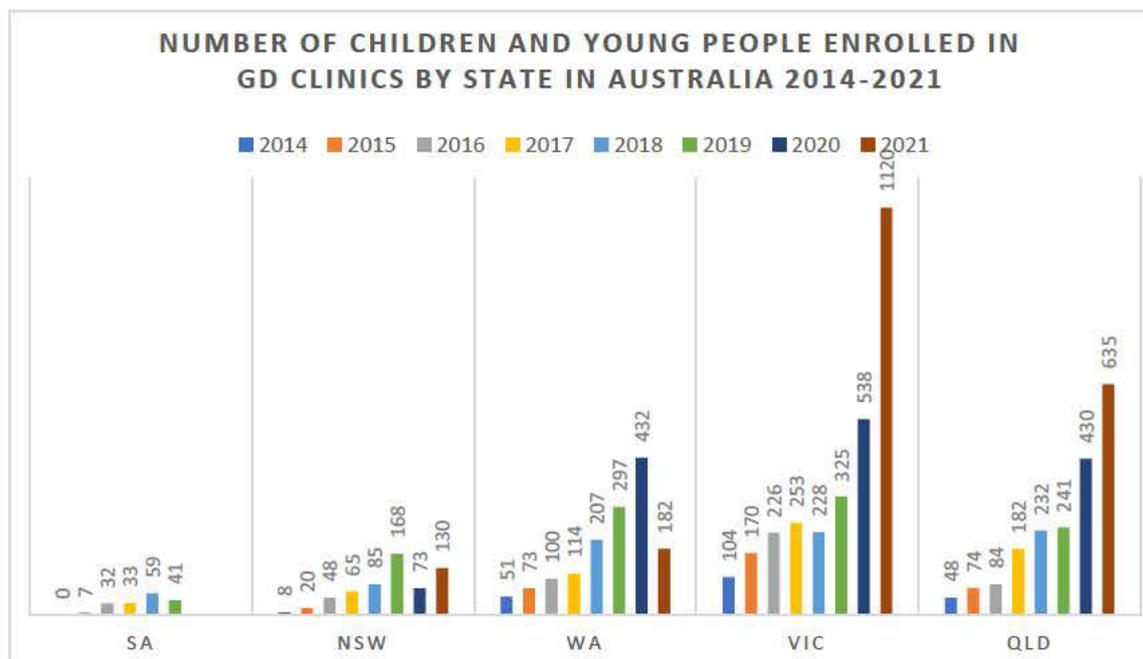


Figure 4 (Source: Kenny, 2022⁷). [Data provided by the gender clinics under freedom of information applications]

⁶<https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>

⁷ Population in millions: of New South Wales= 8130.1; Victoria=6593.3; Queensland=5296.1; South Australia= 1815.5; Western Australia=2773.4.

98. The noteworthy feature of this graph is that three states [Western Australia (WA), Queensland, and Victoria] show similar increases over the five-year study period (2014–2020), although WA showed a downturn in 2021. Although figures in NSW, the most populous state in Australia increased, the magnitude of absolute numbers was significantly lower than for the other states (excluding South Australia, which was a late comer to gender services provision). Overall, Victoria had the largest numbers. It is also a state where the trans lobby has been particularly vocal, where the concept of the “safe schools” policy was conceived and implemented, and where the gender clinic at the Royal Children’s Hospital, Melbourne has assumed the mantle of trailblazer and international player in global transgender politics, creating the AusPATH guidelines (2022) modelled after the international WPATH guidelines (WPATH, 2022), and hence acting as a sociocentric social network with high centrality. In addition, the Victorian government (2020) passed legislation banning “conversion therapy” which prohibits all practising health professionals from engaging in any form of therapy other than gender-affirming therapy.

99. It is hard to explain this pattern of prevalence without considering social forces other than greater social acceptance of transgender people. If no social contagion were operating, one would expect a more proportionate and even distribution across states based on population. These data are strongly suggestive of clustering, a phenomenon that points to the possible effects of social contagion in states with unexpectedly high numbers of young people requesting assessment at gender clinics.

100. Figures from the Nordic countries (Kaltiala et al, 2020) show very similar patterns as those described above. See for example, Figure 5 below.

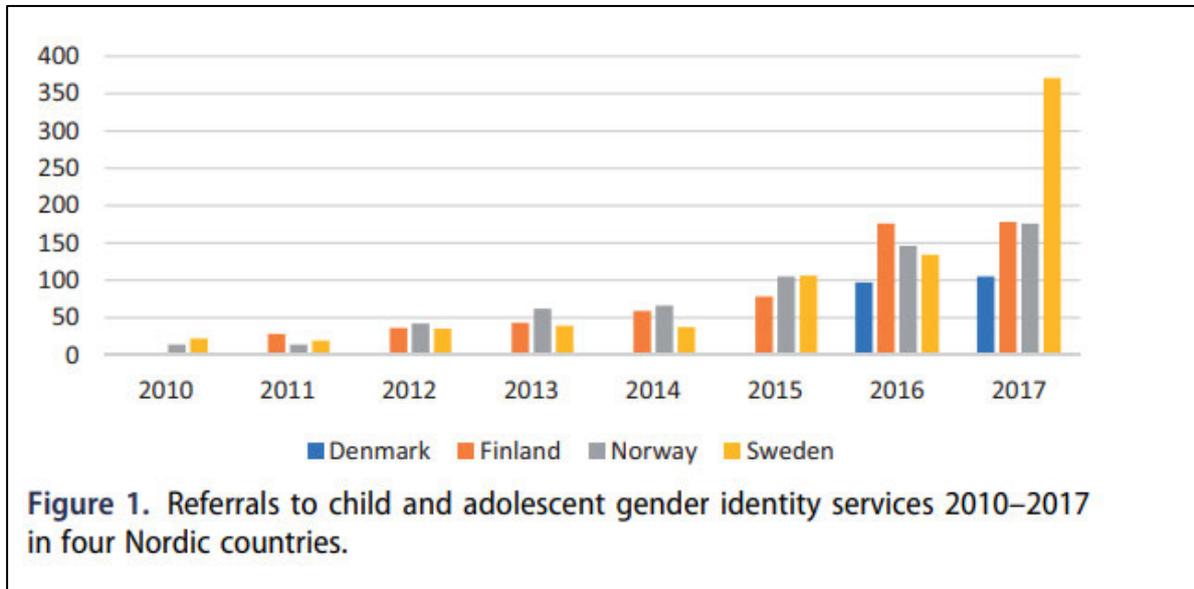


Figure 5⁸

101. Table 4 shows the increases within a six-year time frame between 2011 and 2017 in the four Nordic countries and the UK (for comparison).

Table 1. Population adjusted numbers of referrals to gender identity services for minors in four Nordic countries and the UK in 2011 and 2017.

	2011	2017
Denmark ^a	–	9.0/100,000 (1/11,000) ^c
Finland	2.63/100,000 (1/38,071) ^b	16.7/100,000 (1/10,155)
Norway	1.24/100,000 (1/80,643)	15.6/100,000 (1/6414)
Sweden	0.90/100,000 (1/111,663)	17.4/100,000 (1/5719)
UK	1.25/100,000 (1/79,588)	17.5/100,000 (1/5078)

⁸ Referenced as Figure 1 in original publication

102. These population adjusted rates are orders of magnitude higher than those observed in transgender adult populations (Zucker, 2017). Rapid changes in any relevant biological factors that could possibly account for these trends across global populations appears both unlikely and implausible.

103. Figure 6 shows the increase in the number of gender clinics across the USA in the past 15 years, from 2007 to 2022. One must wonder whether the increase in clinics is to meet demand or whether the demand has been fuelled by the increased availability of gender clinics.

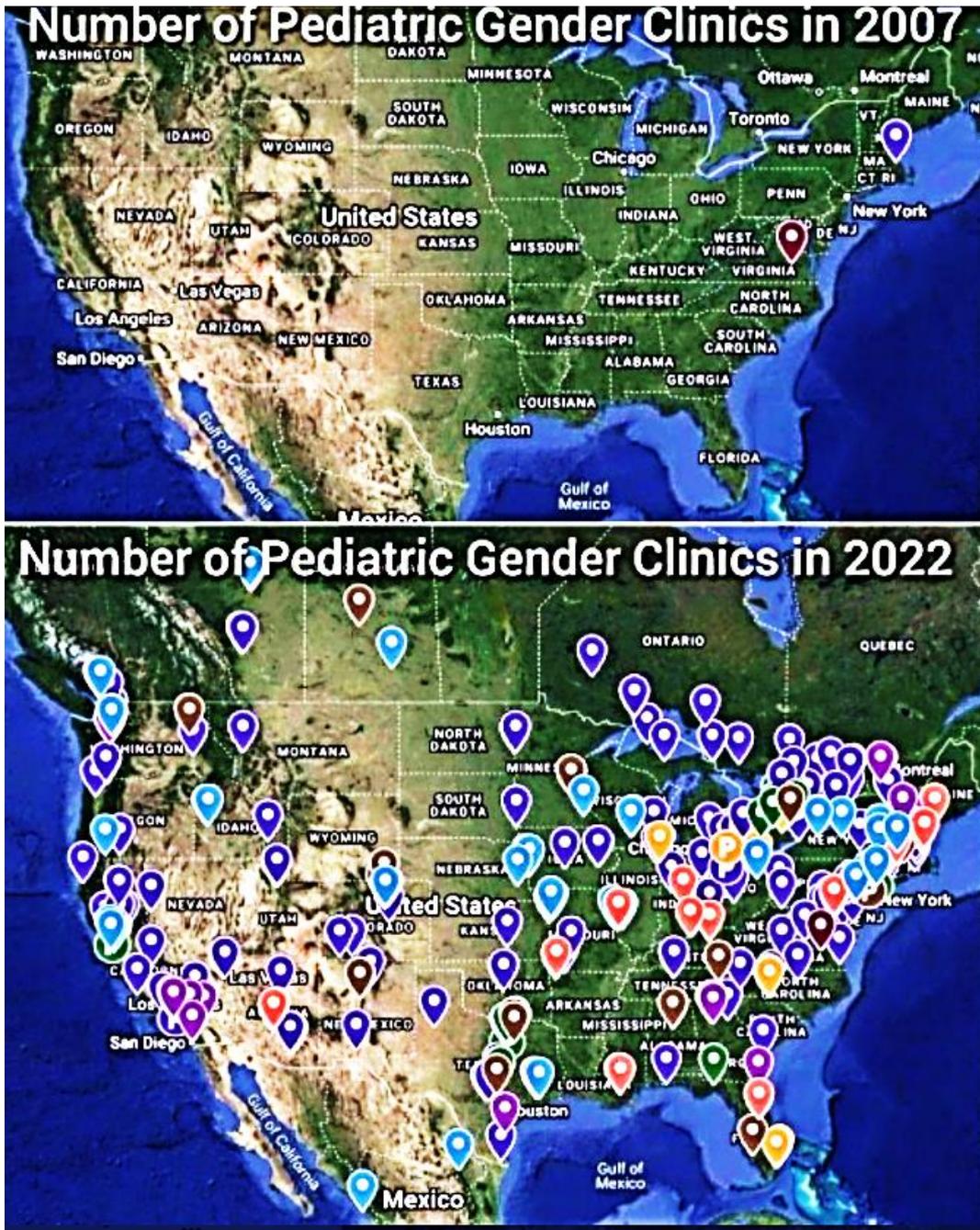


Figure 6 Number of gender clinics in USA and Canada in 2007 and 2022.

104. Figure 7⁹ shows the total number of young people attending gender clinics taking puberty blockers and cross-sex hormones over the seven-year study

⁹NSW supplied “0” in each data cell for each of the seven years. A follow-up inquiry to Sydney Children’s Hospital Network (Ref No: SCHN18/7854, 6/8/19) indicated “Sydney Children’s Hospitals Network (SCHN) does not provide cross sex hormones at The Children’s Hospital at Westmead. [O]ccasionally SCHN sees a patient in a cross-over transition phase who has had stage two treatment initiated by an adult physician, as The Children’s Hospital at Westmead pharmacy is still providing the patient’s treatment in that cross-over phase. However, their primary care at this stage is under the adult physician who prescribes the stage two therapy. The zero-response provided in the GIPA

period across Australia. Note that these data are not population figures because they do not include young people receiving treatment from private paediatricians, endocrinologists, or other medical practitioners or those sourcing medications outside Australia). They are included to show the upward trends in prescription rates within the gender clinics.

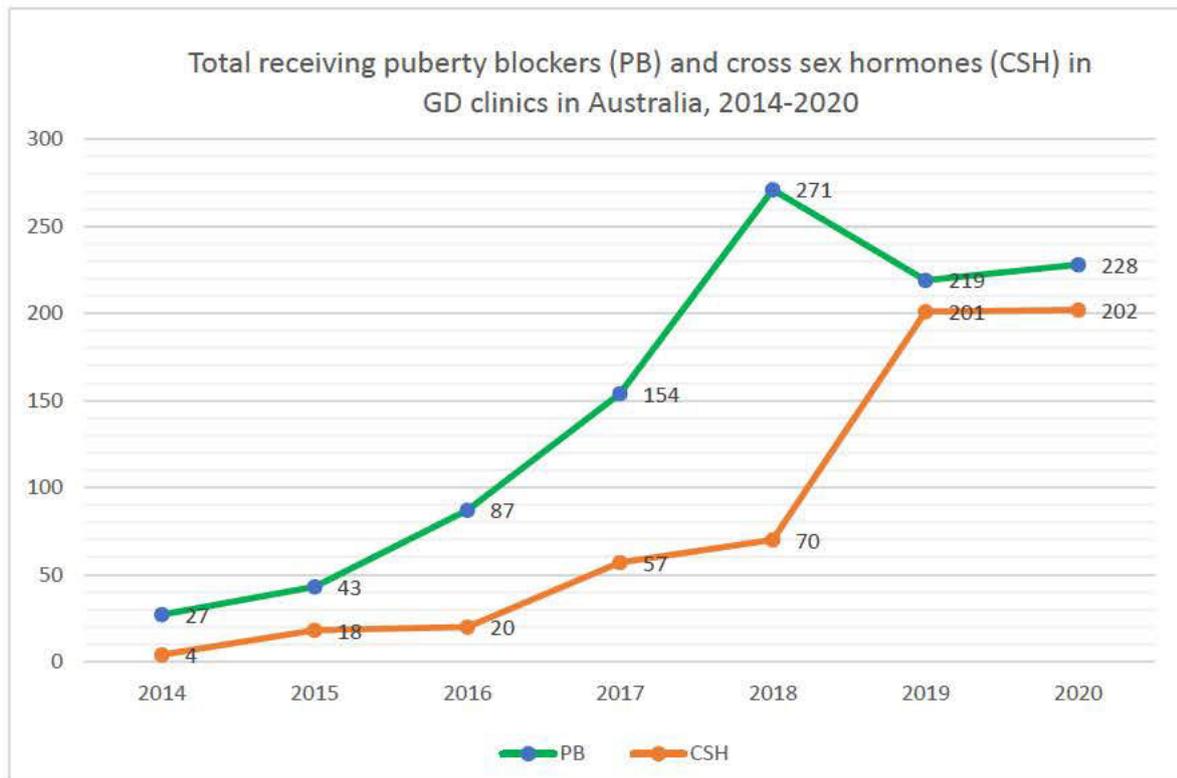


Figure 7 [Source: Kenny (2022). [Data provided by the gender clinics under freedom of information applications]

105. Data on PB prescription is also available from New Zealand (NZ) (Tegg, 2022, personal communication) (Figure 8). The New Zealand data are more complete than Australian data because they have been derived from prescription data

Notice of Decision is correct but that there may be instances in which children are receiving active stage 2 treatment elsewhere while still attending The Children's Hospital at Westmead clinic”.

from NZ's Pharmacy and Ministry of Health and adjusted for precocious puberty, so represent close to the total population of gender dysphoric young people currently receiving GnRHa medications. New Zealand does not have gender clinics. Gender medicine is delivered through primary health youth/sexual health clinics and GPs in NZ, and prescriptions for GnRHa are centralized by the prescribing agency.

GnRHa treatment rate per 100k adolescent population 9-17

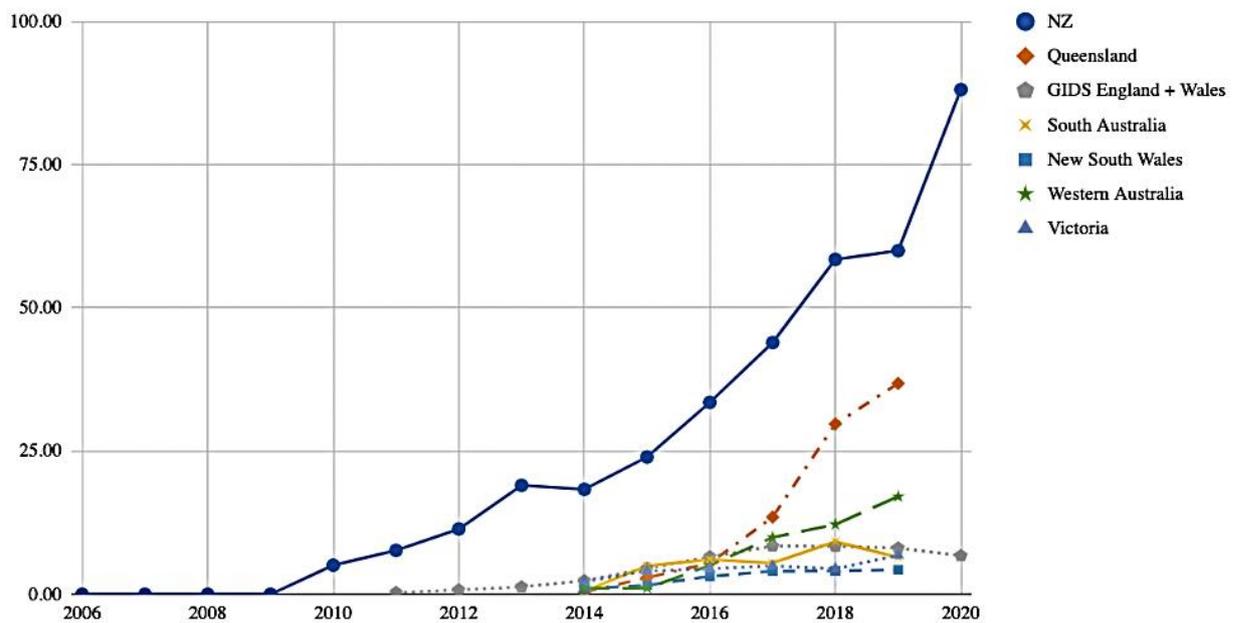


Figure 8 Source: NZ data (Tegg, 2022), Australian data (Kenny, 2022), British data (NHS, 2020) [Population of NZ=5.142 million].

106. One can only speculate as to why New Zealand, that has one fifth of the population of Australia, would have vastly more transgender young people than either Australia or the UK, which has 13 times the population of NZ taking PB. A prominent candidate would surely be social contagion. Similarly, it is a puzzle as to why one of the states of Australia would have significantly more young people taking PB compared with four other states with gender clinics. Certainly, there is room to speculate about measurement error in some or all these data, yet that alone cannot

account for the unmistakable upward trends in prescription of PB in NZ, Australia, and the UK.

107. Similar trends are also evident in the USA. For example, the health technology company Komodo Health Inc, drawing on health insurance claims for 330 million Americans, calculated that in 2017, 15,172 young people aged 6–17 years received a diagnosis of gender dysphoria. By 2021, the number had nearly tripled to 42,167. In total, across this five-year period, 121,882 6–17-year-olds in the USA received a diagnosis of gender dysphoria. There was considerable variation by state. Increases were largest in California (3,000 in 2021) and lowest in Massachusetts (1,100 in 2021). A total of 17,683 young people aged 6–17 years, with a prior gender dysphoria diagnosis initiated either puberty blockers or hormones or both during the five-year period. Of these, 4,780 patients had initiated puberty blockers and 14,726 patients had initiated hormone treatment (Respaut & Terhune, 2022).

108. To explain these increases, one could speculate that the numbers comprise two groups of young people, a core group of “actual” cases and the additional cases created by social contagion. Within the actual cases, there would be the group who declared themselves and a group of latently gender dysphoric young people who have not felt able to declare themselves until recently because of greater community acceptance and support from the transgender community and social media. This latter group of “actual” cases and the ROGD group could both be hypothesized to have been affected by social contagion. Further analysis is required to determine the nature of the clustering of these increased numbers. In school-aged children, one

would expect to see multiple cases in particular high schools. If gender dysphoria referrals occurred independently of each other, one would expect to see referrals per high school follow a Poisson distribution, in which the variance is equal to the mean. A clustering effect would be hypothesised if the variance were greater than the mean. The strongest indicator of social contagion would occur if the ROGD young people showed strong clustering effects. Supporting evidence is provided by the distribution of new referrals by age in the GIDS sample, where new referrals in the 12–16-year age group far exceeds those in younger and older age groups. These data would also be influenced by the social contagion occurring in institutions responsible for the health and education of children, a subject to which I will return later.

109. Transgender advocates proclaim that increases in the transgender population may be compared with increases in left-handedness and homosexuality in recent decades and is explained by increasing social acceptance of each of these phenomena. This is a glib comparison at best. These two issues are so complex, they warrant their own submissions. However, the brief exposé below will show that, simply because disparate phenomena increase over time, one cannot draw conclusions about the equivalence in causation of those increases.

Left-handedness

110. Five meta-analyses have concluded that left-handedness prevalence lies between 9 percent (using the most stringent criterion of left-handedness) and 18 percent (using the most lenient criterion of non-right-handedness, including ambidexterity and weak right handedness), with the best overall estimate being 10.6 percent.

Mixed lateral dominance as a separate category shows rates of around nine percent (Papadatou-Pastou et al., 2020). Handedness is generally established within the first two years of life and has been noted in utero with fetuses sucking right and left thumbs and has a strong genetic component (Michel et al., 2013).

111. A variety of moderators including methodological problems in studies, differences in prevalence overall and in different geographic regions, brain hemispheric asymmetries, seasonal anisotropy, possibly due to higher secretion of sex hormones during seasons with a long photoperiod, (i.e., extended day length), have all affected the estimates of left handedness. For example, cultural factors such as prohibition of using the left hand in schools in the Victorian era (c. 1840–1920) produced the lowest estimates of 2-4 percent. Direct social pressure (i.e., being made to write using the right hand during schooling) and indirect social pressure, (i.e., being stigmatized for being left-handed)¹⁰ accounted for this drop in what is believed to have been a stable rate of left-handedness (9–11 percent) before and after this period. It is likely that the aversion to left-handedness arose during the second Industrial Revolution (c. 1870–1914) as production was rapidly mechanised and mass produced, most machines were designed for right-handed people and left-handed workers were more likely to appear clumsier and have more industrial accidents. At school, children were taught to write with steel-tipped pens dipped in ink, which left-

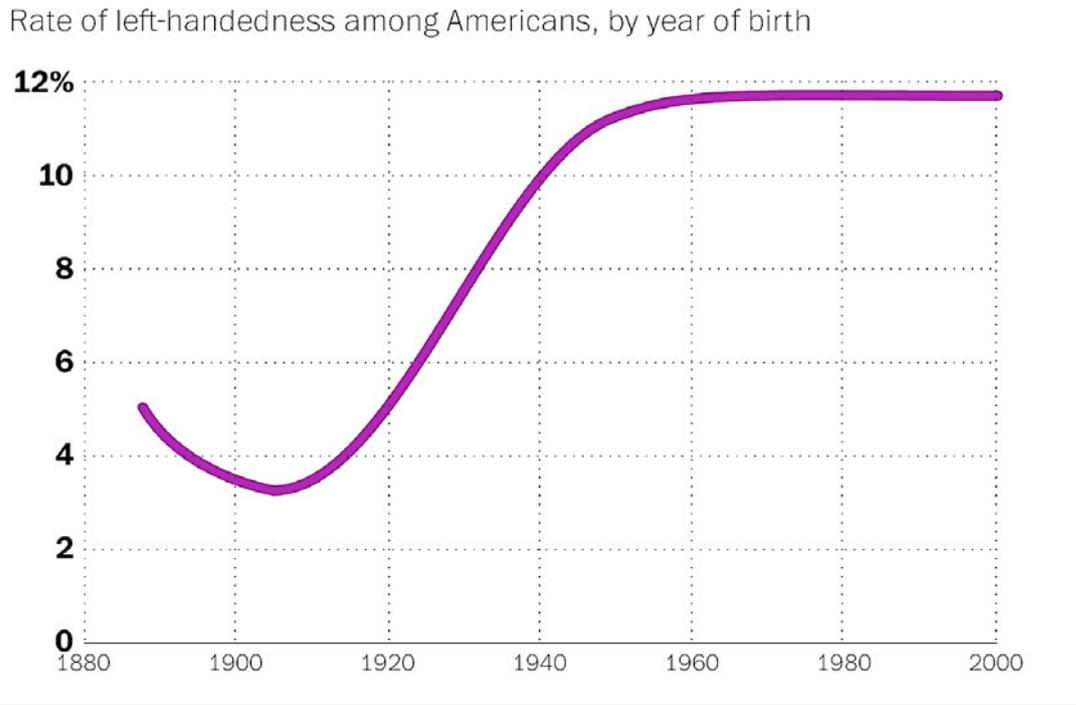
¹⁰ Stigmatization of left-handedness in the 19th century apparently caused a drop in left-hander birth rate and there were thus fewer left-handers in the mating population and thus fewer left-handers born. This is perhaps a flawed argument as people who were forced to revert to right handedness would still be genetically left-handed. Alternatively, left-handed people were less likely to marry because they were seen as less desirable partners (having been stigmatised for being left handed) thereby reducing procreation of children with left-handed genes.

handed children could not navigate successfully without smudging and blotting the page as their left hand slid over wet ink (McManus, 2004).

112. Notwithstanding, the rate of left-handedness steadily increased after 1920 reaching an asymptote at around 10 percent and this has remained stable over the ensuing decades (Porac, 2015).

113. Prevalence rates of left-handedness differ by subgroups, for example, higher in men (13%, includes ambidextrous), possibly due to higher intrauterine testosterone levels that delay left brain hemisphere maturation and thus promote left-handedness, higher in neurosurgeons (17%) (perhaps because the majority are men?), people with schizophrenia and other cognitive and psychiatric disorders (de Kovel et al., 2019), thought to be related to impaired brain lateralization, and lower in professional basketball players (5%), reason unknown.

114. Thus, only a small component of incidence of left-handedness is due to the lifting of social prohibitions and stigmatization, so any direct comparisons between changes in left-handedness and frequencies of transgender-declaring young people in the past decade are not helpful or appropriate. For example, there is no evidence of social contagion of left-handedness after stigma was removed. The rates returned to historically pre-stigmatisation rates but did not exceed them. That is, its frequency rose to its 'natural' biological asymptote (i.e., ceiling) and remained stable once achieved, as illustrated in the graph (Figure 9) below.



WAPQ.ST/WONKBLOG

Source: Survey data reported in "The History and Geography of Human Handedness" (2009)

Figure 9¹¹

115. Not so for transgender curves, which have shown increasingly upward slopes at least since 2000, coinciding with the increased activity and visibility of the transgender marketing machine and interactive social media, and the ever-expanding transgender medical industry providing hormones and surgery.

Homosexuality

116. Homosexuality is currently considered a normal variant of human sexuality. Male homosexuality is both familial and heritable and possibly caused by an X-linked gene. Percentage of siblings who were also homosexual (or bisexual), ranged from 7 to 10 percent for brothers and 3 to 4 percent for sisters showing the importance of familial factors in male homosexuality (Bailey et al., 1999). It appears

¹¹ This is a "smoothed" curve

to be a stable polygenic (i.e., multiple genes contributing to a characteristic) trait that occurs on a continuum from bisexual, to mostly gay to exclusively gay (Savin-Williams et al., 2017). Available evidence from genetic and epidemiological studies indicate that biological and congenital factors regulate male and female sexuality. Many sexuality-related behaviours previously thought to be of sociocultural origin such as mating practices, sexual attraction, propensity to fidelity or infidelity, sexual orientation, and sexual dysfunctions such as premature ejaculation or female sexual dysfunction all seem to have a genetic component (Jannini et al., 2015).

117. In addition to the genetic contribution which accounts for 33 percent of the variance, hormonal, and environmental factors also affect sexual orientation. The most significant environmental influences occur intrauterine but there is continuing debate about what, if any, part is played by the postnatal familial and social environment (Cook, 2021). Many of these factors overlap with those that are also influential in gender development. Because of these commonalities, there is a strong relationship between gendered behaviour in children and sexual orientation in adulthood (Bailey & Zucker, 1995). For example, a meta-analysis of 28 studies (n~5,300) demonstrated a very close association between gendered behaviour in childhood (e.g., rough-and-tumble play, toy and activity preferences, role playing, cross-gender dressing, sex of peer group, appellations of “sissy” or “tomboy,” and stated gender identity) and sexual orientation in adulthood (Bailey & Zucker, 1995). In boys, lack of interest in rough-and-tumble play in childhood correlated with homosexual interest in adulthood (McConaughy et al., 1994; Zucker, 2008).

118. Li, et al. (2017) have confirmed earlier findings of the link between childhood gender nonconforming (GNC) behaviour and later sexual orientation. The study, comprising 2,428 girls and 2,169 boys from a population-based longitudinal study, the *Avon Longitudinal Study of Parents and Children*, (Golding, et al., 2021) that followed children born in the 1990s for 15 years, found that the levels of GNC behaviour at ages 3.5 and 4.75 years accurately predicted adolescents' perceived/stated sexual orientation at age 15 years. The authors argued that the factors contributing to the association between childhood GNC behaviour and sexual orientation may not be primarily socially determined, because children who develop into non-heterosexual adults appear to diverge from gender norms regardless of social encouragement to conform to gender roles.

119. The graphs below show that the rate of self-identification as homosexual men in Australia increased from a low baseline of 1.5 percent in 2001 to 3.5 percent 2020. The declared rates for men and women reached parity in 2020.

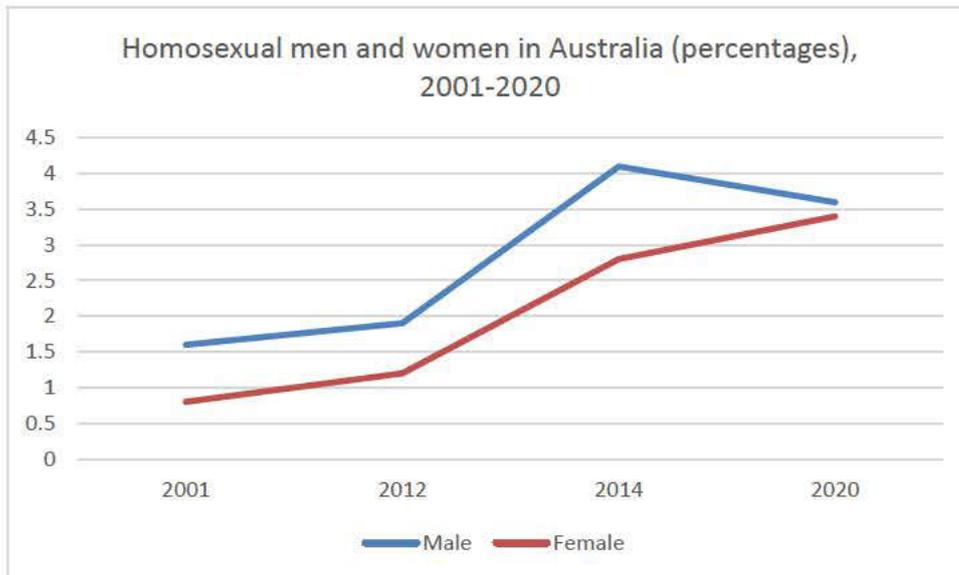


Figure 10¹²

120. The same overall downward trend in Australian men is also evident in the American data for both sexes. However, estimates do vary across studies. For example, according to the Williams Institute, the current estimate of LGB in the USA population is 3.5 percent.¹³ The graph below estimated the percentage in 2016 at 5.4 percent. In the Gallup poll in 2021, the estimate of LGB was 6.5 percent. One factor that is very likely to affect disclosures is the manner in which data are collected – by phone or electronically (i.e., anonymously). Rates reported from phone interviews tend to be lower than electronic surveys.

¹² https://en.wikipedia.org/wiki/Demographics_of_sexual_orientation

¹³ <https://williamsinstitute.law.ucla.edu/publications/how-many-people-lgbt/>

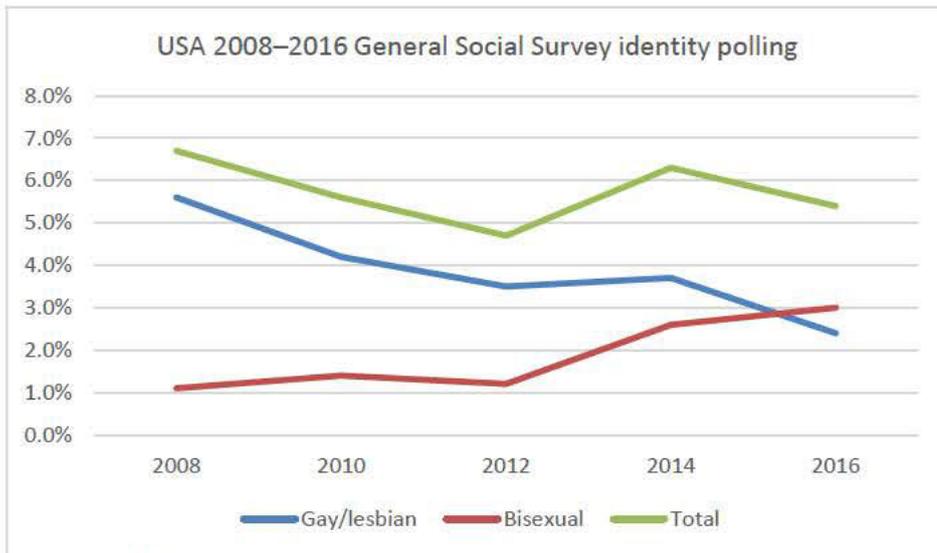


Figure 11¹⁴

121. Surveys from UK and Canada for self-identification as LGB show a small increasing slope over the specified years. The Williams Institute compared rates for adults who identified as lesbian, gay, or bisexual in various surveys between 2005 and 2010 across the USA and compared them with international surveys from Canada, Australia, UK, and Norway. The rates for eight of the nine surveys obtained values between 1.2 and 3.7 percent of the populations studied. One survey (*National Survey of Sexual Health and Behavior*, 2009) obtained a value of 5.6 percent that was due to higher reporting of bisexuality (3.1 percent).



Figure 12¹⁵ 2009–2016: Integrated Household Survey Figure 13¹⁶ Canadian Community Health Survey

¹⁴ https://en.wikipedia.org/wiki/LGBT_demographics_of_the_United_States

¹⁵ https://en.wikipedia.org/wiki/Demographics_of_sexual_orientation

¹⁶ https://en.wikipedia.org/wiki/Demographics_of_sexual_orientation

122. Not so for the data on young people declaring themselves transgender, which demonstrate very steep increases over similar time frames in both UK and Australia, details of which were described in the section on empirical evidence above (see Figure 3).

123. Additional evidence against disinhibition of stigma as the sole reason for the increases in frequency of transgender-declaring young people are the different shapes of curves emanating from different countries. For example, the rates in Sweden started to decrease while other countries were still rising (Figure 14).

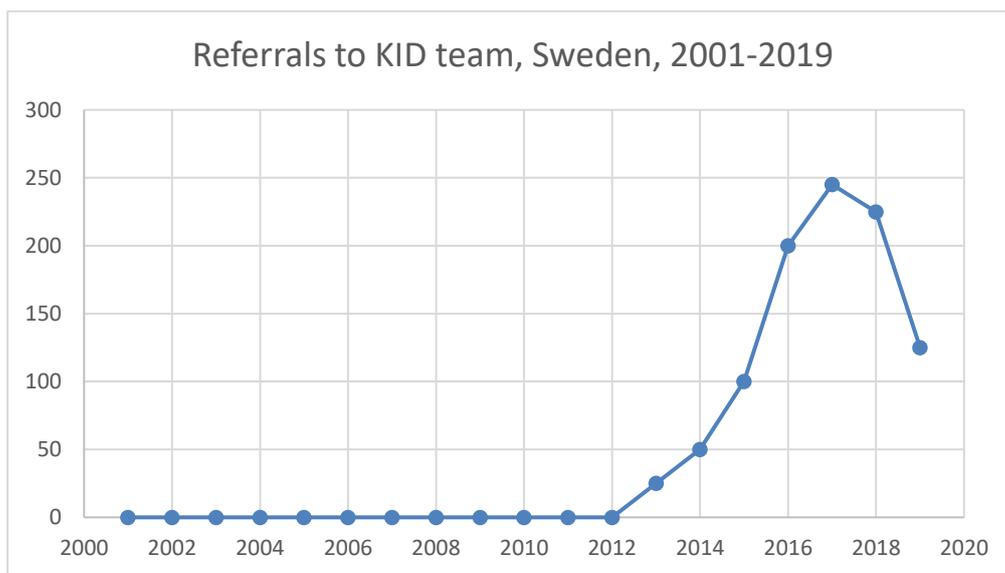


Figure 14¹⁷

124. In 2019, there was a 65 percent decline in the number of referrals to gender clinics in Sweden. This corresponded with a concerted appeal to government

¹⁷ Presentation, Louise Frisé, Chief Physician, Associate Professor of Child and Adolescent Psychiatry at the KID (Stockholm) clinic for gender incongruence and gender dysphoria – delivered at a Swedish Medical Ethics Council Seminar February 6, 2020. <https://genderreport.ca/the-swedish-u-turn-on-gender-transitioning/>

to review clinical protocols, insist on more balanced media coverage of the phenomenon of regret and detransition, and the airing of a documentary entitled “Trans Train.”¹⁸”

What can be learnt about social contagion from detransition?

125. In 2021, *The Lancet* published an editorial defending medical gender transition interventions for gender-dysphoric youth against numerous US bills introduced to prevent the prescription of hormones and surgery to youth aged <18 years, claiming that the treatments are safe, and regret is low (i.e., <1 percent). The letters to the editor following its publication are most instructive of the manner in which disinformation and misreporting of study outcomes, in this case, regret [the evidence for which was graded as low/very low in several systematic reviews (NICE, 2021)] occur and often go unchallenged, allowing them to enter the ether uncorrected and to be reproduced and reinforced through social networks.

126. Among the many problems with the “evidence” used to support these positions are the short follow-up periods and the high rates of those lost to follow-up, which create positive bias in those responding to satisfaction questionnaires. For example, Vandebussche (2022) observed that the average time lag from transition to detransition was five years and that any study reporting on shorter time periods would likely be underreporting the true rates of detransition (WordPress, 2020).

127. Studies reporting low regret mostly predate the post-2010 reversal in patient profile from mostly early-onset pre-pubertal males with gender dysphoria to

¹⁸ https://www.youtube.com/watch?v=sJGAoNbHYzk&ab_channel=PeachyoghurtGenderfree

mostly adolescent-onset females with gender dysphoria (ROGD). Other studies often quoted to demonstrate low regret and detransition rates (e.g., Wiepjes et al., 2018) report on mainly adult transitioners. In the Wiepjes study, only 10 percent of transwomen and 30 percent of transmen were adolescents (12–18 years), with adolescents constituting only 15 percent of the total sample. The definition of detransition is often so narrow as to exclude significant numbers of regretters, as in this study. For example, only those who underwent surgical removal of testes/ovaries were counted. It excluded the 22 percent who commenced CSH but did not proceed to surgery, and the 20 percent who dropped out of care or who were lost to follow-up. To qualify as a regretter, the individual had to revert to natal sex and be taking natal-sex hormones under medical supervision at the clinic at which they were treated. However, most detransitioners do not return to the same clinic following regret or decisions to detransition because of feared rejection and mistreatment (Littman, 2021). Many abstain from detransition after irreversible gonadectomy because they find it impossible to do so.

128. Of course, it is not possible to include among counts of regretters or detransitioners those who have died of surgical complications or by suicide sometime after surgery. In one study of 869 patients undergoing vaginoplasty (mean age 38.9 years), 220 (25.3%) suffered at least one complication, 97 of whom required further surgery. Complications included bleeding (5.8%), surgery for a stricture (3.2%), fistula (0.7%) and surgery for surgical site bleeding, breakdown, or infection

(5.7%). One patient died after surgery (Dallas et al., 2021) and four adolescents died by suicide (Wiepjes et al., 2020).

129. Pang et al. (2020) disingenuously attributed the association between positively framed media reports of transgender issues and increases in referrals of self-declaring transgender and gender diverse (TGD) children and adolescents to specialist gender services to the disinhibiting effect of the media articles, arguing that fearful young people may have been empowered to expose and express their true transgender selves that they had hitherto kept hidden after receiving encouragement to do so by the media. The authors, however, did concede that

... increased media content (specifically via social media) might act as a ... means of social contagion, whereby some individuals erroneously come to believe through exposure to such media that their nonspecific emotional or bodily distress is due to gender dysphoria and being transgender/gender diverse (p. 7).

130. Pang et al dismiss this concern by arguing that one would expect to see high rates of desistance or regret in young people who made their way to gender clinics and gender transition via social contagion and that this had not been observed. On the contrary, Sweden's NBHW concluded that the risks of puberty blockers and cross-sex hormones for young people outweigh the benefits, and that there was a strong likelihood of possible under-reporting of treatment regret.

131. Turban et al. (2021), using data from the U.S. Transgender Survey, a cross-sectional nonprobability survey of 27,715 TGD adults in the United States (that conflated transgender with gender diverse individuals), reported a 13 percent overall detransition rate. The rate for transwomen was 44 percent, a rate high enough

to give pause to the notion that gender identity is innate and immutable. The detransition rates were highest among the age group 18–24 years. Interestingly, Turban et al. (2018) also published a case report in which a young person desisted from their transgender identity and ceased GnRHa and oestrogen after several fluctuations in gender identity and a course of psychotherapy. Turban conceded “the dynamic nature of gender identity among youths. In this case, the patient met all published standards for treatment of gender dysphoria and their gender identity evolved to a point at which they no longer felt that hormones were appropriate for them.” This has been a common experience of this author, who works psychotherapeutically with gender questioning young people.

132. There is growing informal and formal evidence that the rates of detransition are much higher than claimed. A poignant documentary (BBC, 2004) *One life: Make me a man again*, was televised as early as 2004. In 2017, a number of gender reassignment surgeons reported an increase in requests for reversal surgeries (Borrelli, 2017; Djordjevic, Bizic, Duisin, Bouman, & Buncamper, 2016). There is also an increasing number of websites¹⁹ for regretters and detransitioners, for example, *Sex change regret*²⁰ run by Walt Heyer, a man who transitioned and detransitioned several times; *The Detransition Advocacy Network*²¹, founded by Charlie Evans, a 28-year-old biological female who lived as a transgender male for almost 10

¹⁹ Detransition - Transgender Trend; Resources for Detransitioners - Rethink Identity Medicine Ethics; Detransition resources – Genspect; Post Trans - Detransition Stories; www.sexchangeregret.com; Home | #DetransAwarenessDay; Detransitioners - Person and Identity Project; From trans to detransitioners - what can we learn from this ... 4thWaveNow; ThirdWayTrans; Retransition.org.

²⁰ <http://sexchangeregret.com/>

²¹ <https://detransinfo.tumblr.com/tags>

years before de-transitioning. According to The Federalist²², in 2018 Heyer’s website was already receiving about 25,000 visits a month. Heyer stated “I detransitioned more than 25 years ago. I learned the truth: Hormones and surgery may alter appearances, but nothing changes the immutable fact of your sex.”

133. The Trans Youth Project followed up 317 children in the US and Canada who had socially transitioned between the ages of three and 12 (average age of transition was 6.5 years). Five years later, 94 percent of these young people had retained their transgender identities (Open Access Government, 2022) but whether any of these young people were offered exploratory psychotherapy was not reported. These figures cannot be generalized to other groups of transitioners, particularly the group of interest in this paper – ROGD adolescents. In a review of detransition studies up to 2016, Cantor (2016) concluded that between 10 and 40 percent of young transitioners remained transgender by adulthood. A British study reporting on gender affirming health care of 182 transitioning young people, median age 25 years, reported that only 56 percent completed the course of care that they originally sought from the gender service. A further 22 percent disengaged from the service after accessing all the care that they originally sought (Hall, Mitchell, & Sachdeva, 2021). It is unclear whether such young people are counted among detransition statistics reported elsewhere.

134. A profiling study of 100 detransitioners (Littman, 2021) reported that 70 percent were white female college graduates, 56 percent of whom experienced

²² <https://thefederalist.com/2018/01/09/walt-heyer-proves-sex-change-regret-real-thats-trans-lobby-hates/>

pre-pubertal gender dysphoria. If gender dysphoria and gender transition are socially contagious, particularly among adolescent females, it would be expected that there would be a greater proportion of female detransitioners as they mature and become more able to reason logically and independently and less susceptible to suggestion and the influence of social media. There was an average of four years between transition and detransition for these female participants.

135. A recent study on 237 detransitioners recruited from online detransition communities reported on their psychological needs in relation to gender dysphoria, comorbid conditions, feelings of regret, and internalized homophobic/sexist prejudices. Many were not receiving medical assistance with their medical detransition (e.g., how to safely stop cross-sex hormones) or with the complications arising from “gender-affirming” surgery. The majority reported lack of support and other negative experiences from their former treating medical and mental health professionals and from the LGBT+ community generally (Vandenbussche, 2022).

136. Because of the recency of the onset of ROGD and the lack of long-term data, it is not possible at this stage to estimate what the true rates of detransition will be for this specific population of transgender individuals. However, awareness of detransition and exposure of the harms of medicalised gender treatments have increased significantly since 2021 (Mieli, 2023). Figure 15 shows the frequency with which gender dysphoria and detransition were discussed online, showing peaks in response to media exposure.

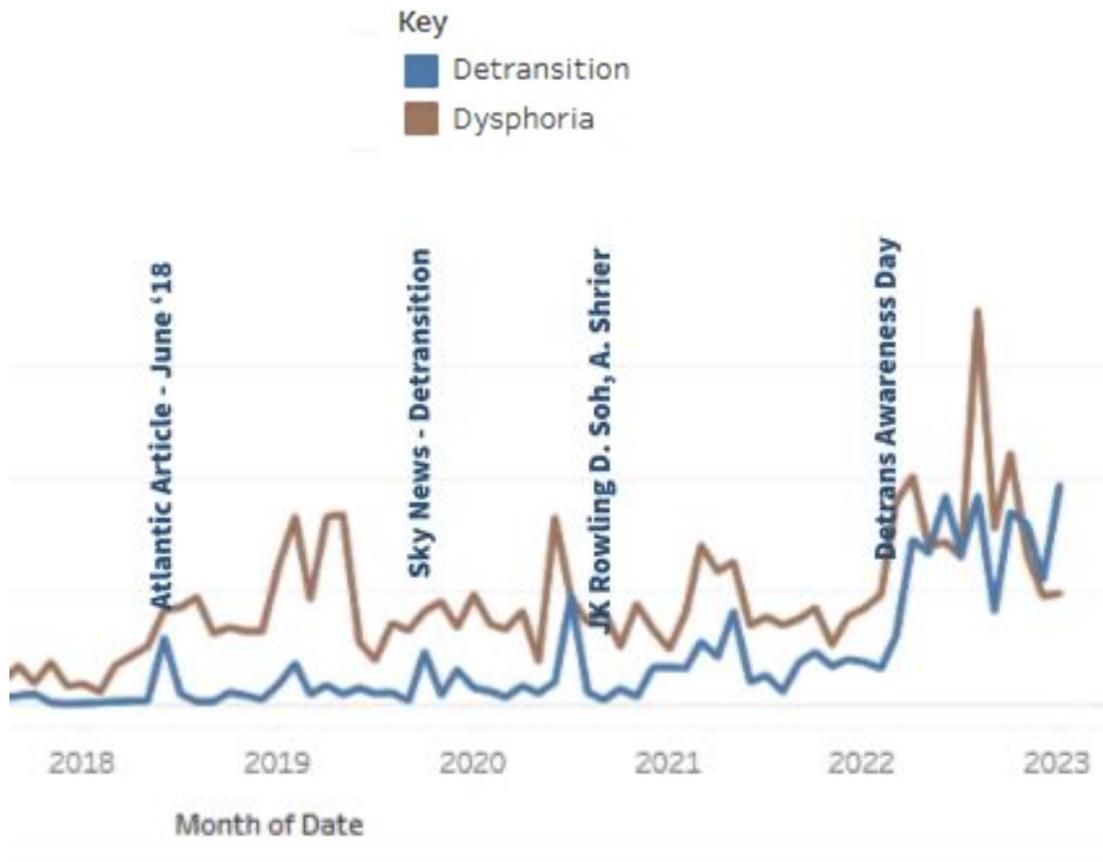


Figure 15 Increasing exposure for detransition on the internet

137. The longer-term outlook for transgender adults appears bleak. A 30-year follow-up study of 324 transsexual individuals [male-to-female (n=191) and female-to-male (n=133)] who had undertaken sex reassignment surgery (Dhejne et al., 2011) revealed that their overall mortality was three times higher and the death by suicide rate was 19 times higher than for the general population matched for age and sex. Transgender individuals were also five times more likely to attempt suicide, and three times more likely to become a psychiatric inpatient.

Social contagion in treating practitioners, professional bodies, legislators and the courts, sporting bodies, educators, and parents

138. Social contagion is by no means limited to vulnerable, suggestible children and adolescents. Using an *in vivo* randomized experimental design and a representative sample of 1.3 million Facebook users, Aral and Walker (2012) identified the characteristics of influential and susceptible people. Younger users were more susceptible to influence than older users, men were more influential than women, women influenced men more than they influenced other women, and married individuals were the least susceptible to influence in the decision to adopt an advertised product. Further, influential individuals tended to cluster within a network and demonstrated less susceptibility to influence than non-influential individuals who did not cluster. They concluded that influential people with influential friends are key to behavioural uptake in online social networks.

139. A few salient examples pointing to social contagion in medical practice, professional bodies, law and legislation, sport, and education include the following: Treating medical practitioners, psychiatrists, psychologists, and professional bodies

140. Social contagion within the medical/psychiatric profession occurred in the first half of the twentieth century. A surgical procedure, known as frontal lobotomy (Levinson, 2011), involved the destruction of brain tissue in people with chronic mental illnesses. It was hailed as the miracle cure for a range of previously intractable psychiatric conditions. In 1949, Egas Moniz won the Nobel Prize for inventing the lobotomy, after which it was practised on thousands of hapless patients the world over before falling out of favour in the mid-1950s when very poor longer-

term outcomes were observed, and the first wave of effective psychiatric drugs were developed. An eminent British neurosurgeon, Henry Marsh (in Levenson), said

[Lobotomy] reflected very bad medicine, bad science, because it was clear the patients who were subjected to this procedure were never followed up properly. If you saw the patient after the operation, they'd seem alright, they'd walk and talk and say thank you doctor. The fact they were totally ruined as social human beings probably didn't count.

141. This comment, taken out of the context of frontal lobotomy, could very well be a modern comment about the practice of transgendering children and young people. It is “bad medicine, bad science” (Biggs, 2022) and with no long term follow up to reflect that the initial euphoria of all involved, including young people, parents, and doctors is not sustained over the longer term. These young people are also “totally ruined as social human beings,” suffering “pervasive mistreatment and violence, severe economic hardship and instability,” discrimination, and significant negative physical and mental health impacts, “despite increased visibility and growing acceptance” (James et al., 2016).

142. That the medical profession is prone to social contagion more broadly in general medical practice was demonstrated by Iyengar, Van den Bulte, and Valente (2011). They found contagion in the prescribing patterns of doctors after controlling for marketing outreach and systemic changes, such as the advent of new drugs and changes in the prevalence of diseases. Shared geographical proximity, shared group membership, and self-identified ties between doctors were all factors in behavioural contagion, with self-identified ties the most compelling factor. A critical factor in marketing attempts to manipulate uptake of a new drug or medical

treatment is the identification of those in the network who are influential and those who are influenceable. Without individual uptake, the marketing campaign will falter (Christakis & Fowler, 2011). Central figures in the network have a stronger tendency to adopt early.

143. Of course, network contagion effects may be modified by product characteristics, for example, the perceived effectiveness and safety of the new drug. Part of the gender affirmative discourse emphasizes the safety and reversibility of puberty blocking agents that “pause” the development of puberty thereby giving children time to “decide” in which gender they wish to reside. Yet, the alternative discourse, that puberty blockers are neither safe nor reversible, has been largely silenced. For example, both the Mayo Clinic and the U.S. Food and Drug Administration warn that PB (GnRHa) may cause pseudotumor cerebri – increased pressure inside the skull that mimics a brain tumor. Other documented adverse effects of GnRHa include fatigue, insomnia, muscle aches, headaches, rashes, restlessness, acne, hot flushes, mood alterations/disorders, weight gain, changes in breast tissue, loss of genital tissue, osteopenia/osteoporosis (loss of bone density), chemical castration, and neurological damage resulting in impaired pituitary function. It has been approved to treat prostate cancer, endometriosis, and central precocious puberty, but not gender dysphoria. At the time of writing, their use was off-label in gender-affirming care because it lacked the support of clinical trials to establish its safety in this treatment context.

144. Another example of network contagion is the unified stance regarding the value and effectiveness of “gender affirming care” of many peak medical bodies including The American Medical Association, The American Academy of Pediatrics, The American Psychiatric Association, The American College of Physicians, The American Academy of Family Physicians, The American Academy of Child & Adolescent Psychiatry, The Endocrine Society, The Pediatric Endocrine Society, The World Professional Association for Transgender Health, and the United States Professional Association for Transgender Health. Turban (2020, 2023, exhibit 3) uses this unanimity to argue that the case is settled. If all these peak medical bodies agree, ergo, the position must be correct.

145. One could equally argue that this is a case of “groupthink,” a social phenomenon related to social contagion (Janis, 1972). Groupthink is an extreme form of conformity in which people are prepared to keep the peace at all costs. It tends to occur more in homogenous groups, when a powerful and charismatic group leader is insistent on the preferred course of action, when the group is under stress, where significant moral dilemmas are part of the decision matrix and where objective outside experts are not called upon.

146. The consequences of groupthink include the illusion of invulnerability, collective rationalization, stereotyping of out-groups, self-censorship, belief in the inherent morality of the group, poor information search, incomplete survey of alternatives, failure to appraise the risks of the preferred solution, selective information

processing, and conflation of ethics and expedience (Kenny, 2015; Turner & Pratkanis, 1998), factors all on display in the gender debate. The only group speaking outside the confines of this medical herd was The American College of Paediatricians, who issued a statement in March 2016 stating that the transgender agenda harms children:

Educators and legislators should reject all policies that condition children to accept as normal a life of chemical and surgical impersonation of the opposite sex. Facts — not ideology — determine reality... Conditioning children into believing a lifetime of chemical and surgical impersonation of the opposite sex is normal and healthful is child abuse.

147. The groupthink continues in the transgender standards of care provided by WPATH (world standards) and AusPATH (Australian standards). The 2018/2020 Australian standards for the transgenering of young people, including when to commence PB and CSH issued by Melbourne’s Royal Children’s Hospital (RCH) gender clinic were hailed by the Victorian state liberal government as “the most stringent safety standards” for children and adolescents, as well as “the world’s most progressive.” However, the RCH standards are not evidence-based. Rather, they invoke “clinician consensus” and “increasing evidence” for “gender affirming care,” flag the need for more research but warn that withholding treatment is not “a neutral option” and may increase suicide risk. Yet these RCH standards, which were published as a peer-reviewed paper in the *Medical Journal of Australia* and praised by *The Lancet*, claiming consensus, make no mention of a Dutch study (Vrouenraets, Fredriks, Hannema, Cohen-Kettenis, & de Vries, 2015) showing a worrying level of medical uncertainty and diametrically opposed views among 36 gender clinicians in

10 countries. This study highlighted the lack of consensus regarding safety, ethics, and benefit of the global trend to prescribe PB to increasingly younger patients on the unfounded assumption that pausing puberty affords time for them to “decide” their “true identity,” while reducing suicide risk. Although the internet is replete with such claims, there have been blistering critiques showing that PB conveys no benefit in reducing suicide (Biggs, 2022). The Dutch paper highlights seven areas of disagreement, including the cause of gender dysphoria, consent, infertility, the risks to brain development and cognitive function of interrupting puberty, and whether gender dysphoria is a mental illness or just normal gender variation pathologized by culture-driven treatment.

148. There is evidence of cross-contamination/social contagion between medical, psychiatric, psychological, and legal, including human rights, entities. Note, for example, the definitions of gender identity provided by these bodies:

“Gender identity” [is defined] as “a person’s internal sense of being male, female, *or something else* [author’s italics] (APA, 2022).

This definition emanates from a peak body for psychologists in the USA. It is elegant in its brevity and simplicity, is easily remembered and highly transportable across international social networks that include trans-friendly sites, academia, the online media, interactive social media, and other professional societies. Yet, the meaningless phrase “something else” is nowhere defined or challenged.

149. These bodies seem less concerned about scientifically verifying their stances regarding the transgendering of young people and more concerned about falling foul of the transgender lobby since they rely in a circular manner on a small

oeuvre of flawed transgender affirming research that is constantly recycled and adopted uncritically in professional bodies and government. Some of this research is described below.

150. Dr. Jack Turban has been a major contributor to the production and dissemination of flawed research upon which erroneous conclusions about the efficacy of gender affirming treatment in children and young people have been drawn.

His opening paragraph states:

Existing research shows gender-affirming medical treatments for adolescents with gender dysphoria are consistently linked to improved mental health, and denial of such care is expected to lead to adverse mental health outcomes, including, in some instances, worsening suicidality. Declaration of Jack Turban at 4 (2023).

151. Several scholarly critiques of Turban et al., (2022) have challenged his assertions (e.g., Biggs, 2022, D’Angelo, R. et al., 2021, Ludvigsson, et al., 2023). To begin, six of Turban’s publications use the same data source – The *United States Transgender Survey* (USTS), which has serious methodological deficiencies, including that it is a retrospective convenience sample, and not representative of the transgender population. As so often happens in “gender affirming” research, proponents, including Turban and colleagues repeatedly use the category “transgender” (a term that lacks clinical specificity) rather than the category “gender dysphoric.” This is deliberate because GD is too easily associated with a mental health condition (as it is a DSM 5 diagnosis) and transgender ideologues walk a tightrope between demanding medical care without conceding that there is a medical condition to be treated. Ironically, the outcomes assessed in these studies are depression, substance

use, and suicidality, inter alia (all classified mental health conditions). Consequently, we can never be sure about the delimitations of the population under study. The population in the USTS relied upon by Turban were recruited from transgender-friendly community events or gender affirming web sites that would not be frequented by those who regretted, detransitioned, spontaneously desisted, or were assisted with ethical psychotherapies to desist from engaging in medicalized gender treatment. The control group i.e., those who wanted CSH but did not receive them, is a poor comparison to illuminate the purported benefits of CSH. It is likely that this group was more disadvantaged than the group receiving CSH. They may have been deemed too mentally unwell to undergo transition or they may have had financial difficulty or inadequate medical insurance to cover the cost of treatment. Although CSH (referred to by Turban as gender affirming hormones - GAH) are intended to treat gender dysphoria, the survey did not include any questions to ascertain the number of respondents who had experienced gender dysphoria. Nor did the survey identify how many had desisted or regretted their gender transition nor whether any had been diagnosed with a mental health condition.

152. Further, Turban frequently assumes equivalence between the effects of estrogen on men with the effects of testosterone on women, when the effects and outcomes are demonstrably different. Of significance is the elevated suicidal risk in men taking estrogen. Turban's own results demonstrate that men choosing not to take estrogen had better mental health outcomes than those who did (Biggs, 2022). Not so for women taking testosterone, who had better mental health outcomes, but

this finding is confounded by the inherent antidepressant effects of testosterone (Walther et al. 2019). One would hope that women experiencing depression could use an effective alternative antidepressant that did not simultaneously masculinize their bodies.

153. Turban frequently omits results from his own studies that do not accord with his biases. For example, adult respondents taking CSH were much more likely to engage in binge drinking and illegal substance use but these results do not appear in the study's abstract or conclusions, the parts of journal articles most frequently read. The correct conclusions for this study are that estrogen worsens mental health in males, testosterone improves depression and suicidality in women but only because testosterone is an antidepressant as well as a male sex hormone, and PB offers no benefit to mental health.

154. Indeed, a rigorous study (n=3352) assessing the psychotropic medications taken by young people before and after prescription of CSH over an eight-year study period found that medication use increased after CSH (Hisle-Gorman et al., 2021). SSRI use increased 1.72 times, SNRI, 2.59 times, anti-psychotics, 1.77 times, sleep medications, 2.23 times, and benzodiazepines, 3 times, after CSH, results that objectively indicate worsening of mental health after CSH.

155. Evidence is also emerging that PB may exert negative impacts on executive function in children having their puberty suppressed. One study (Staphorsius, et al., 2015) conducted an fMRI-study on adolescents aged, on average, between 15–16 years and compared them with age- and sex-matched peers who were also

gender dysphoric but not undergoing puberty suppression. Results indicated that for the executive function tasks, suppressed adolescents scored below age norms and below the unsuppressed comparison group for accuracy on the Tower of London task (ToL)²³; MtF had slower reaction times; and FtM adolescents had worse psychological functioning as assessed on the *Child Behavior Checklist*.

156. Consequently, cautious clinicians must remain sceptical of any results reported in the gender affirming literature, given its very low quality, but nonetheless wide dissemination and uptake. This position has been confirmed by the most recent systematic review that assessed the effects on psychosocial and mental health, cognition, body composition, and metabolic markers of hormone treatment in children with gender dysphoria. It found the reverse of Turban’s conclusions (Ludvigsson, et al., 2023). The review identified 9,934 potential studies, of which only 24 met PRISMA standards for inclusion. There were no randomised controlled trials. The few longitudinal observational studies available were rendered unreliable due to definitional creep of key terms, small numbers, sample selection bias, and high attrition rates. The study authors concluded that there was no empirical basis upon which to accurately assess the long-term effects of hormone therapy on psychosocial health. Hence, the current situation is that the available research on the effects of GNRHa and CSH treatment on the mental health of children and adolescents presenting with gender dysphoria are insufficient. This renders current gender affirming treatments experimental.

²³ ToL task measures planning ability. Testees given colored disks stacked vertically in three possible positions (the “start” state) and are instructed to move them one at a time until they match a given configuration (the “goal” state).

157. Another example of the narrow circularity (i.e., social contagion) in policy formation is the RANZCP (Royal Australian and New Zealand College of Psychiatrists) Position Statement 83 *Recognising and addressing the mental health needs of the LGBTI population* (2016)²⁴. This position was endorsed by the former Australian High Court judge, the Hon Michael Kirby, who advocated for this group to have access to [gender affirmative] healthcare in a 2014 roundtable on Gender Identity, Rights and Law convened by the United Nations (UN) Development Program (Kirby, 2014). Subsequently, the UN Committee on Economic, Social and Cultural Rights in General Comment No. 22 condemns laws that require treatment to "cure" LGBT identity. It states, "...regulations treating LGBTI persons as mental or psychiatric patients or requiring that they be 'cured' by so-called 'treatment' are a clear violation of their rights to sexual and reproductive health" (4 March 2016, E/C.12/GC/22. Para 23). The influence of the language of gender ideology is very clear, including the use of quotation marks to express irony. What is also evident in this extraordinary statement is the logical inconsistency of its arguments. The advocated medical (PB and CSH) and surgical treatments (e.g., double mastectomies, vaginoplasty, penectomy, orchiectomy, etc.) for transgender individuals in fact violate transgender rights to sexual and reproductive health, given that the treatment they are advocating renders transgendered individuals both sexually dysfunctional and infertile. Critically, "[...gender affirming treatment] ... promotes more invasive

²⁴ The RANZCP subsequently quietly dis-endorsed the RCH guidelines pending "further review" of the evidence for the standards which it now considers to be bolstered by flawed and partisan "research" (Lane, 2019).

interventions (e.g., endocrinological and surgical) and mistakenly deemphasizes psychological therapies as a clinical response to the suffering of trans children” (Schwartz, 2012, p. 460).

158. Both the American Psychological Association (APA, 2015) and the American Psychiatric Association (APA, 2012) also published position statements similarly advocating for improved access to healthcare for transgender and gender variant individuals, both endorsing gender affirmative care at younger ages. An example from the American Psychological Association fact sheet reads:

Early intervention may improve outcomes for gender diverse and transgender youth who are experiencing distress... Early medical intervention is recommended for peri-pubertal transgender youth who have a history of gender dysphoria and a desire to live as another gender. Puberty delaying treatment, cross sex hormone treatment, and/or surgical intervention(s) may be indicated to treat gender dysphoria.

159. According to DSM 5 (APA, 2013), 98 percent of gender confused boys and 88 percent of gender confused girls eventually accept their biological sex after naturally passing through puberty. The American Psychological Association (APA, 2015) quoted lower figures, stating that:

[c]hildren who demonstrate gender nonconformity in preschool and early elementary years may not follow this trajectory...” and point to research indicating that “...between 12% and 50percent of children diagnosed with gender dysphoria may persist in their identification with a gender different [from] sex assigned at birth into late adolescence and young adulthood (p. 841).

However, few of these bodies explored the implications of early gender affirmation in potentially 88–98 percent of young people who may have desisted if left alone (without hormones) to mature naturally.

160. A final example will suffice. Without calling it by its name, Dr. David Bell (2021) who wrote a critical report on the Tavistock gender identity development service (GIDS) in 2018, described the social contagion in this high-profile service provider in the UK.

[I was] shocked as to how a “treatment” that has no evidence, for which no reasonable consent can be given by children (because of their age and because of the lack of any evidence on which such consent might reasonably be given), and which has such damaging consequences, could possibly have been continued for so long and could have had such success in terms of professional and institutional capture (p. xiii) ... I have never encountered a movement that has spread so swiftly and successfully and has so fiercely rejected any challenge to its orthodoxy... The transgender movement has advanced through Britain’s institutions with extraordinary speed. The only thing more extraordinary than the spread of this new orthodoxy is how little scrutiny it has faced, and the aggressive intolerance directed towards those who question it (p. xiv).

Law and legislation

161. Transgender activists in several countries have succeeded in persuading gender clinics to commence social transition in children as young as two and three years of age (e.g., Tavistock GIDS Clinic, Royal Children’s Hospital, Melbourne, Australia), followed by the administration of PB at nine or 10 years of age. They have also been successful in lowering the age at which young people can access sex re-assignment surgery without parental consent. For example, in Oregon, USA the lower age limit for surgery has been removed with parental consent and lowered to 15 without parental consent (S. Smith, 2015). It is almost commonplace to read about adolescent girls as young as 14 years undergoing double mastectomies (Rowe, 2016). Recently, a judge in Canada found a father potentially guilty of domestic

violence if he continued to use his 14-year-old child's birth name and female pronouns. This child petitioned the court to commence cross-sex hormones in the face of his father's strong objection (Cecco, 2019). The lower court ruled that a minor is capable of giving consent to medical procedures. Accordingly, the child has commenced testosterone while the battle continues in the Court of Appeal.

162. Other legislative support (e.g., Amendments to the UK *Gender Recognition Act 2004*, *Victorian Births, Deaths and Marriages Registration Amendment Bill 2019*) includes a bill allowing transgender people to change their birth certificates without undergoing sex-reassignment surgery (Taylor, 2019). Under the legislation a person can self-nominate their sex and list as male, female or any other gender diverse or non-binary descriptor of their choice. Children can alter the sex on their birth certificate with parental support and a statement from a doctor or registered psychologist saying the decision is in the best interests of the child.

163. The Family Court of Australia (FCA) has a somewhat less than rational approach to its decisions regarding young peoples' applications for permission to proceed with stage 1 and stage 2 treatments. Clear evidence of social contagion in the judges' decisions in such cases is apparent. For example, in *Re: Jamie* (2011), the FCA decided that stage one treatment (i.e., PB) was therapeutic and reversible, a position that was incorrect at the time and is no longer sustainable (Greenall, 2019; Laidlaw, 2020), and it would no longer require court approval. However, at that time, the Full Court found that stage two treatment continued to require court au-

thorisation. An article published by the FCA (Strickland, 2015) provides legal reasoning and argument regarding the disposition of gender dysphoria treatment for minors that outlines the limits of legal intervention in these cases. The reasoning in this report is underpinned by current, often erroneous information about gender dysphoria.

164. In 2013, two cases came before the FCA [re *Sam and Terry* (2013)] (Strickland, 2014) that concerned a MtF and a FtM young person. Both were aged 16 years, and both had been deemed Gillick incompetent.²⁵ Sam was debilitated by mental illness and unable to leave his home. Terry had what was diagnosed as Asperger’s Syndrome, now known as autism spectrum disorder. A psychiatrist told the court that gender dysphoria, even in the circumstances of known serious comorbid mental health issues, did not require psychiatric treatment and that medical and surgical treatments were best practice. Consequently, the FCA approved stage 2 hormone treatments in the ‘best interests’ of these two young people, despite the evidence to the Court that oestrogen therapy was irreversible and “...was associated with blood clots, gallstones, abnormal liver function, weight gain, high blood triglyceride levels and cardiovascular disease” (p. 32). Notwithstanding assertions that this ruling was in the child’s best interest, Murphy J found that “the risks associated with Stage 2 treatment, in terms of irreversibility and possible side effects, were “significant” and “...when the consequences are expressed as being steps on the path

²⁵ Gillick competence is a term originating in England used in medical law, initially in relation to an adolescent’s use of contraceptives, to determine whether a child younger than 16 years of age is able to consent to his/her own medical treatment, without the need for parental permission or knowledge.

to changing gender, the consequences can be described as *grave*” (p. 34) [author’s italics]. The word “grave” is used 19 times in Strickland’s report as a descriptor of stage 2 hormonal treatments.

165. For more than 15 years, medical treatment for trans youth was classed a ‘special medical procedure’ requiring Family Court of Australia (FCA) approval before treatment could proceed. However, in 2013 the FCA removed this requirement for PB (*Re: Jamie*).²⁶ In 2017, in the case of *Re: Kelvin*, young people were no longer required to appear before the FCA to obtain approval for treatment. *Re: Kelvin* made it easier for young people under the age of 18 years to obtain irreversible hormone treatments without judicial oversight or even parental involvement in decision-making (Fraser & Condello, 2017). The Royal Children’s Hospital (RCH), Melbourne gave inaccurate evidence that there was growing consensus regarding medical treatment of gender dysphoria. The RCH over-stated its positive outcomes but did not refer to the uncertainty and disagreement about treatment and outcomes expressed by a growing number of researchers and clinicians. Two instructive *Amicus* briefs (Teufel, 2015)²⁷ and (Wilkins, 2015)²⁷, each supporting contrary arguments, were presented to the Supreme Court of the United States, outlining the chasm between opposing points of view and lack of consensus.

166. However, in the 2020 trial decision of *Re: Imogen*²⁸, the court walked back from the exclusion of parental authority for their minor children when Watts J

²⁶ *Re: Jamie* (2013) 50 Fam LR 369 (‘Re: Jamie’)

²⁷ In the Supreme Court of the USA NO. 18-107 (Harris v Stephens)

²⁸ *Re: Imogen* (No 6) [2020] FamCA 761 (‘Re: Imogen’)

held that both parents must consent before any “gender-affirming” medical treatment could be undertaken, even when the young person was deemed competent. In cases of disagreement between parents about treatment, the matter would be adjudicated by the Family Court. The *Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents* published and endorsed by the Australian Professional Association for Trans Health (Telfer et al., 2018b) reflected the *Re Kelvin* decision. Watts J (*Re: Imogen*) stated that these treatment guidelines were incorrect, and the consent of both parents was always needed.

167. Telfer, in the *Australian Professional Association for Trans Health* (AusPATH, 2020) was “disturbed” by the Family Court’s ruling, claiming, erroneously, that it would result in increases in morbidity and mortality of trans youth, arguing that the treatment is “lifesaving” (no evidence presented).

168. In other legal, judicial, and human rights sectors, there is evidence of social contagion in policy adoption of gender ideology. For example, Maya Forstater, a tax expert for the Centre for Global Development, did not have her contract renewed for stating in Twitter posts that there are only two biological sexes and that these cannot be changed. Forstater was critical of the proposed reforms to the UK’s *Gender Recognition Act* that would allow anyone to self-identify as a man or woman, thereby gaining access to single sex spaces. The judge hearing her case in an employment tribunal ruled Forstater’s opinion “...not worthy of respect in a democratic society,” asserting that belief in “...only two sexes, male and female...is incompatible with the human rights of others that have been identified and defined by the

European Court of Human Rights” (Bowcott, 2019). Note the circularity in the judge’s definition of sex.

169. Hence, medicine, law and human rights organisations have been acting synchronously (i.e., contagiously) to produce their position statements, denying the science of biological sex, and abrogating their duty of care to young people lest they fall foul of trans ideologues. In no position statement from any organisation have I read any reference or critical analysis of the research upon which they have based their position statements.

Sport

170. The Australian Human Rights’ Commission (AHRC, 2019) has provided guidelines about sports participation that clearly disadvantage natal females, and which may well have a profound effect on female participation in sport. It was written with the participation of peak sports’ bodies including the Coalition of Major Professional and Participation Sports (COMPS) and Sport Australia. The document claims it is a victory for “diversity and inclusion.” The reality is that these guidelines neutralise the protections provided to females in the *Commonwealth Sex Discrimination Act*, 1984. Whitehall (2019) has provided a critique of the bill.

171. In the international sporting arena, the case of Caster Semenya, an intersex athlete raised female, created significant ethical dilemmas for both sporting and medical bodies. In February 2019, Semenya took the IAAF (International Association of Athletics Federation) to the Court of Arbitration in Sport (CAS) on the grounds of discrimination, requesting that the DSD (Differences/disorders of sexual

development) Regulations (Tulloch, 2019) which apply only to female athletes who are legally female, have 46XY, DSD, and testes, who are androgen-sensitive and have circulating testosterone above 5nmol/litre be declared invalid and void. CAS (2019) ruled that the DSD Regulations:

...were discriminatory but...such discrimination ...was a necessary, reasonable and proportionate means of achieving the IAAF's aim of preserving the integrity of female athletics in the Restricted Events.

172. The CAS further upheld the requirement of the IAAF that female athletes with excess testosterone must lower their levels in order to compete. Semenya's legal team countered that the IAAF's requirement for athletes with DSDs to take hormone suppressants to reduce testosterone is ethically wrong and potentially poses a health risk. Why, then, is it not ethically wrong and potentially dangerous to reduce testosterone in gender dysphoric male adolescents?

173. The United Nations Human Rights Council argued that the IAAF ruling contravenes human rights (BBC, 2019). The World Medical Association (WMA, 2015) also condemned the IAAF rules arguing that it is unethical for physicians to prescribe treatment for excessive endogenous testosterone if the condition is not pathological. The WMA called on physicians to oppose and refuse to perform any test or administer any treatment or medicine ...which might be harmful to the athlete using it, especially to artificially modifying blood constituents, biochemistry, or endogenous testosterone.

174. This is an interesting position given that the WMA does not condemn the prescription of testosterone to girls asserting that they are boys or to reducing

testosterone in boys asserting that they are girls. Nor do they balk at the removal of healthy breasts or reproductive organs of otherwise healthy young women or the amputation of penises in healthy young men.

175. The WMA (2015) released a set of nine recommendations that explicitly condone all available treatments for sex reassignment, including CSH and sex reassignment surgery for people requesting them, with the sole proviso that they give informed consent, without defining how informed consent is ascertained, particularly in young people. It appears that no-one in the WMA is troubled by the contradiction in their medical advice depending on whether the recipient is an athlete or a gender-confused young person. Hence, these sporting and medical bodies have accepted these profound contradictions in their policies and practices in order to remain compliant with gender ideology precepts, which are themselves fallacious and illogical and subject to a separate submission.

Education

176. Two avenues of social contagion are evidence within the education sector – curricular and the management of self-declaring transgender children at school. Children are being exposed to gender ideology commencing in kindergarten/elementary school. A stark example (Rufo, 2022; Salai, 2023) of the scientifically bankrupt curriculum on gender is being propagated by the Portland Public Schools system (USA). It includes anatomy lessons with anatomically explicit drawings of children’s genitalia. The lessons refer to “person with a penis” and “person with a vulva,” and children are taught that some girls have penises, and some boys have

vulvas. The curriculum states that “any gender and child can have any type of body.” Teaching slides commence instruction on queer theory in grades one and two and contain the following text: “Many people think there are only two genders, girls and boys, but this is not true. There are many ways to be a boy, a girl, both or neither. Gender identity is about how you feel about yourself inside.”

177. The New South Wales (Australia) Department of Education’s (NSWDE) Bulletin 55 (NSWDE, undated-b) deprives parents of any rights in the management of their gender dysphoric child at school. Bulletin 20 (NSWDE, undated-a) even deprives parents of parental authority regarding the registered name of their child. It states,

If either or both parents object to the change to the way the first name is recorded by the school, the *principal needs to make a decision about what is in the child’s best interests* [author’s italics]. This decision should have regard to the age, capability and maturity of the student and can be informed by advice from a health care professional about the potential impact on the student’s wellbeing of declining to use and record the student’s preferred first name.

178. These guidelines undermine parental authority in the child’s eyes, setting a dangerous precedent allowing children to make decisions about their wellbeing for which they are not prepared.

179. Similarly, in the UK, the *Equality Act* (2010) (Norton, Rose, & Fulbright, 2010),

...changed the prevailing definition of “gender reassignment” by no longer requiring a person to be under medical supervision to fall within it. This means that a person who was born female but chose to spend the rest of her life as a man, without seeking medical advice or intervention, would have undergone gender reassignment for the purposes of the Act.

180. Kara Dansky, media director of the Women’s Liberation Front, commented to Shrier (2019) that the *Equality Act* would eliminate “women and girls as a coherent legal category worthy of civil-rights protection.” It would do so by redefining the category of “women” to include “women and those who say they are women.”

181. Reversal of these policies and programs has been slow. However, some states are now allowing parents to opt their children out of classes teaching gender-related curricula (Yu, & Mangrum, 2021).

Parents

182. Parents are not exempt from these influences; there are numerous websites offering support to parents of transgender children (e.g., Emerging Minds; A Gender Agenda; Gender Centre; Gender Help for Parents; Healthy Children; Human Rights Campaign; Parents of Gender Diverse Children; Transcend; Transhub; Trans Youth Equality Foundation). These groups provide a kind of cheer leadership to newly inducted parents. Transcend Australia has published a Guide for Schools that explains to the education profession the new vocabulary that has been created in the transgender world – including concepts like misgendering, deadnaming, intersectionality, and the “rainbow” array of gender variants – pansexual, polysexual, omnisexual, asexual, and redefinitions of “man” and “woman” to remove any implied sexual dimorphism (e.g., penis haver, cervix haver, chest feeder etc). All concepts are accepted unquestioningly, and the only challenge is to be the very best parent of one’s transgender child as possible.

Are we recovering our senses?

183. Indeed, evidence is mounting that individuals and nations are starting to recover their senses. For example, in 2018, a proposal in Sweden before the Swedish parliament was about to debate lowering the age for transgender surgery from 18 to 15, and to allow children from 12 years to legally change their gender, without parental consent. These proposals sparked an outcry and the country's broadcaster SVT produced a documentary "The trains train" prompting further scrutiny of the evidence base for gender treatments. Four years later, in 2022, the Swedish National Board of Health and Welfare (NBHW) (SBU, 2022) issued an update to its health care service guidelines for children and youth aged 18 years or younger with gender dysphoria/gender incongruence. The most significant changes in the recommended guidelines include the following: Exploratory psychological therapies will be the first line of treatment, and hormonal interventions "last resort." These will be applied only in research settings under rigorous guidelines; eligibility criteria will return to the "Dutch protocol." Capacity to consent will be assessed by an interdisciplinary clinical team. Only those meeting DSM 5 criteria for gender dysphoria (GD), including pre-pubertal onset of at least five years duration will be considered for hormone treatment. Those identifying as nonbinary or transgender without gender dysphoria will not be eligible. The minimum age for PB will be Tanner stage 2 (minimum age 12 years) and the minimum age for CSH will be 16 years. Young people with comorbid diagnoses (e.g., ASD, ADHD, depression, anxiety, etc) will be

treated with great caution and may be required to undergo intensive psychiatric/psychological intervention prior to assessment for GD. An under-served group are gender-dysphoric 18–25-year-olds with significant mental health comorbidities. This cohort has increased markedly in recent years as have reports of regret and detransition.

184. Similar changes are underway in Finland, France, Norway, and the UK. For example, Finnish Health Authority (PALKO/COHERE, 2020) state that psychotherapy, and not puberty blockers and cross-sex hormones, should be the first-line treatment for gender-dysphoric youth. The GIDS, UK has closed following the Cass report (Cass, 2022) and now a class action of 1,000 families whose children have been irreparably harmed by the automatic gender affirmation and medicalisation practised in that service has commenced in the UK against GIDS (Meredith, 2022, August). There has also been a recent successful legal challenge in the Family Court of Australia to the prescription of PB to a minor by a leading children’s gender service (RCH, Melbourne) in Australia. Further, in one of the first significant systemic gestures of caution in Australia regarding the treatment of young people under 18 years, the Medical Defence Association (MDA) has advised its members with an update to their professional indemnity insurance. MDA has informed all insured private medical practitioners that it:

... will limit cover for certain claims arising from the treatment of gender dysphoria in children and adolescents. In response to the high risk of claims arising from irreversible treatments provided to those who medically and surgically transition as children and adolescents, MDA National is restricting cover for practitioners in private practice. From 1 July 2023, MDA National

will introduce the following exclusion in your Professional Indemnity Insurance Policy. We will not cover you or make a payment when the claim against you arises in any way out of: (i) your assessment that a patient under the age of 18 years is suitable for gender transition; or (ii) your initiating prescribing of gender affirming hormones for any patient under the age of 18 years. We consider it appropriate that the assessment and initial prescribing for patients transitioning under the age of 18 years occurs with the support and management of a multi-disciplinary team, in a hospital setting.

Conclusion

185. I conclude from the evidence that social contagion must be at least partially responsible for the upsurge in gender dysphoria among our youth in the past three decades. Notwithstanding, social contagion as a possible causation is vehemently denied by most social institutions charged with the safeguarding of children and young people, including governments, universities and schools, human rights commissions, legal institutions, and sporting bodies. The reason that this phenomenon can never be debated openly is that it provides the detonator upon which the edifice of gender ideology would implode.

186. Like all social contagions throughout history, this one will eventually end but not before hundreds of thousands of young people and their families have been devastated by one of the most widespread psychic epidemics in history. The social contagion of gender dysphoria will only cease when responsible adults and social institutions come to their senses and provide appropriate boundaries around this generation of young people who have been told that there are no limits to the fulfilment of their wishes and fantasies and that they should be granted all that they desire, including a gender (and body) in opposition to their natal sex.

CHAPTER 2

CLINICAL REVIEW OF THE FOUR PLAINTIFFS' CASES

Preamble

187. I commenced this clinical review with the intention of ascertaining whether any or all four of these young people truly met the criteria for diagnosis of gender dysphoria (GD) in the Diagnostic and Statistical Manual Fifth Edition (DSM-5, 2022, Text revision). The DSM-5 argues that being transgender or gender non-conforming²⁹ is not a medical condition to be treated. Rather the diagnosis and treatment should be “focus[ed] on dysphoria as the clinical problem, not identity per se” (DSM-5, p. 451). Because the DSM-5 contends that “being transgender” is not a pathological condition, it has accordingly revised the diagnostic criteria (and name) of gender identity disorder to GD to “recognize” the clinical distress as the focus of the treatment, not the patient’s transgender status per se.³⁰ I briefly summarize those criteria below. There are two subcategories for diagnosis – one for children and one for adolescents and adults.

²⁹ Conflating transgender with gender nonconforming is a grave conceptual error in this writer’s opinion. Their aetiologies, trajectories, and outcomes cannot be assumed to be analogous. There is no clinical taxonomy that pathologizes gender nonconformity.

³⁰ This author has serious concerns with respect to the wording and the implied concepts in that wording used in the DSM 5 to describe GD. It assumes that gender is primary, that sex is “assigned at birth,” and that sex is not dimorphic. It further assumes that there are alternative genders that cannot be described but that are neither male nor female. All these propositions are empirically scientifically fallacious, but as a clinician reviewing cases, one is required to ascertain a diagnosis based on DSM 5 criteria. Similar criticisms have been launched at other sections of the DSM 5, amid claims that new diagnoses have arisen from the “pet interests” of participating clinicians, particularly among the personality disorders, the creation of new disorders that are really aberrant behaviours or indicators of existing disorders (e.g., hoarding disorder, excoriation disorder) and that many new categories lack validity and are not based on scientific evidence. For a summary of some of the issues, see Gornall, J. (2013). DSM-5: a fatal diagnosis? *BMJ: British Medical Journal*, 346 (7909), 18–20. <http://www.jstor.org/stable/23494723>. Further concerns pertain to the absence of diagnostic tests for many of the conditions, which is unlike almost any other field of medicine, and nowhere more problematic than in the area of gender dysphoria, that overly relies on patients’ subjective reports and reconstructed memories that are “culturally conditioned” leading to the over valuation of rating scales and diagnostic lists. [See Pearce, S. (2014). DSM-5 and the rise of the diagnostic checklist. *Journal of Medical Ethics*, 40(8), 515–516. <http://www.jstor.org/stable/43283058>].

188. Gender Dysphoria in Children is a diagnosis applied to pre-pubertal children. The criteria are:

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 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 circles, school, or other important areas of functioning.

189. Gender Dysphoria in Adolescents and Adults list the following criteria:

A. A marked incongruence between 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 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 feelings³¹ and reactions³² 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.

190. Had the clinical notes been sufficiently detailed, I would have proceeded to assess two of the plaintiffs against criteria for children (K.C. and A.M.) and two against criteria for adolescents (M.W. and M.R.). However, the information made available to me, in my opinion, provides an inadequate basis upon which to determine whether these children are gender dysphoric or transgender, both or neither. Across the four cases, there is sparse psychological assessment, almost no case formulation, nor is there evidence that a psychotherapeutic process has been undertaken, other than vague references to "receiving gender counselling", one reference to "play therapy", one reference to "therapy for PTSD," one reference to trauma-focused cognitive behaviour therapy and several references to "gender affirming therapy" and "counselling" but no description of content, process, or outcome of such therapeutic efforts. Further, there is no discussion or formulation regarding the

³¹ How are "typical" feelings of different genders defined?

³² What are the typical reactions of males and females? e.g., boys don't cry, girls are more sensitive and emotional?

highly significant comorbidities with which each of these children presented or how these comorbidities might have interacted with their body perceptions and discomforts. They were merely listed but not integrated into the case histories or presentations.

191. The “voices” of the young people could barely be discerned in the material provided. The affidavits of the parents were meagre and sparse in detail, and in many respects their opinions were duplicated across affidavits by their legal representatives. Just two days before this report was due, I was provided with the more detailed depositions of two of the parents (K.C. and M.W.) and was able to expand on my clinical assessment of these two young people. I begin each case review with a summary of each young person’s current circumstances provided by one or both of their parents in their affidavits. I then review all medical records and present my opinions based on the information provided. Were further information made available or had I had the opportunity to interview the young, I may have modified the opinions expressed in this report, although I consider this unlikely.

CASE³³ REVIEWS BASED ON COMPUTERIZED CLINICAL NOTES PROVIDED BY THE PLAINTIFFS

Case 1: K.C. [MtF 10 years Redacted (DOB ^{Redacted}/Redacted/2012)]

192. K.C.’s parents declared K.C. has lived as a girl since “before she was four” years old. Declaration of Nathaniel Clawson and Beth Clawson (Clawson Decl.) at 1. Mother asserts in her deposition that K.C. was starting to show that he identified as a girl when he was a toddler. Deposition of Beth Clawson (B. Clawson

³³ I refer to all young people according to their natal sex.

Dep.) at 17. K.C. asked at the age of three whether he could cut off his penis. Clawson Decl. at 1. Mother stated that the paediatrician identified K.C.'s transgenderism at the first appointment to discuss his insistence on wearing female clothing.. The paediatrician informed mother that “‘it was real’ ...So we just had an open line of communication from that moment on.” B. Clawson Dep. at 21. In other words, the paediatrician foreclosed the diagnostic process at the first visit. K.C.'s parent changed K.C.'s pronouns immediately after that visit.

193. I find the gaps in knowledge evinced by K.C.'s mother's testimony disturbing. For example, she testified that she does not really know the content of her child's internet viewing, although she said that she tried to limit time spent online. B. Clawson Dep. at 31–34. She further testified that she did not know how many of K.C.'s friends were transgender until pressed by counsel: “‘She has some. I don't know how many... K.C. has had trans... friends her whole life.” *Id.* at 34–35. She did not know who had diagnosed K.C. with gender dysphoria but it was “‘probably...her paediatrician in Bloomington...perhaps in September 2016 (again uncertain) following her request for a letter from this doctor in case she had “‘to use it if someone questioned us and didn't agree with the way that K.C. was being raised.”” *Id.* at 35–36. The paediatrician wrote the letter “‘after talking, taking a history and hearing our concerns.” *Id.* at 27. K.C. was referred to “‘play therapy” but it is not clear regarding the purpose or content of this therapy (other than “‘it was for her emotional well-being...”) nor for how long it continued. *Id.* at 37–38. When asked what co-morbid diagnoses K.C. experienced, Mother replied, “‘depressive disorder,

(diagnosed in August 2022) blah, blah, blah, I don't remember how it is worded; and...generalized anxiety...ADHD (diagnosed 2019, on medication since 2020) ... assessed for dyslexia (not confirmed) and dysgraphia (confirmed)...” *Id.* at 39–40. K.C. had suffered long standing bouts of “prolonged sadness and depression.” *Id.* Antidepressants were prescribed but had no effect after six months and were discontinued. *Id.* at 42. Mother disclosed that they “rarely saw the paediatrician... if ever” and visited the gender clinic once a year for K.C.’s gender dysphoria (GD)...K.C. had already socially transitioned before our first visit there.” *Id.* at 51, 54.

194. K.C.’s birth certificate has been changed to reflect that “she” is female. K.C. commenced Supprelin LA, a puberty blocker, in March 2023, aged 10. Clawson Decl. at 2. K.C. had become distressed at the appearance of male puberty markers such as increased body odour and deepening voice and expressed a wish to proceed to estrogen.

195. There are several red flags regarding appropriateness of gender affirming treatment for K.C.:

196. First, there is considerable psychological morbidity in this family. Mother suffers from anxiety, and father has ADHD. A sister, 17, has anxiety, ADHD, and OCD, a brother, 19, has anxiety and ADHD, an uncle engaged in substance use and committed suicide. One grandmother has bipolar disorder. Additionally, at the time of K.C.’s social transition, three family members died – a great grandmother, a grandfather, and an uncle. “She was very sad; they were very close.” This was a tumultuous time in this young child’s life – the death of three significant

attachment figures, concurrent with diagnoses of type 1 diabetes mellitus (T1DM) and celiac disease.

197. Second, it is reported that before he could talk, K.C. manifested GD through wearing his sister's clothing and making long hair out of towels. Deposition of Nathaniel Clawson (N. Clawson Dep.) at 21–22. When K.C. could talk, he would say, ‘I'm a girl,’ and state that he didn't like his penis. *Id.* There was a very short period of watchful waiting. The family was quickly supportive of the idea that he was transgender, and he socially transitioned at age 4. *Id.* However, it is common for younger opposite sex siblings to imitate the behaviour and appearance of older siblings. It is generally a transitory phase and should have been monitored via active watchful waiting for a longer length of time before social transition was considered. The decision seems to have been primarily parental with one visit to a paediatrician who precipitously diagnosed GD without any formal assessment.

198. Third, the doctor managing K.C.'s T1DM during a visit commented that the child was “alert and oriented, with no acute distress, and no dysmorphic features³⁴, sweet transgender girl. Tanner Stage 1.” According to WPATH and DSM 5, children should only be treated for GD, not for the state of being transgender which they claim is not a medical or psychological problem. If this child had no GD or body dysmorphia/dysphoria, he would not meet criteria for gender affirming treatment.

³⁴ It is unclear whether he meant “dysmorphic” or “dysphoric” or is using the words interchangeably.

199. Fourth, precipitous social transition may foreclose any further gender exploration. K.C. “came out” to both his kindergarten and 1st grade classes and has completed all legal name and gender marker changes. K.C. has a valid passport and social security card in his transgender name.

200. Fifth, of great concern is the fact that all of K.C.’s other diagnoses (T1DM, celiac disease, depression, anxiety, ADHD, dyspraxia) came after the child had been socially transitioned. Mother indicated that the anxiety and depression were related to the GD, implying that social transition had no effect on these conditions, and later stating that it was the puberty blockade (PB) that resulted in a miraculous improvement in these conditions (“I see it decreasing every day”). Asked whether PB eased K.C.’s GD, mother replied “I think so.” B. Clawson Dep. at 75–76.

201. Most of K.C.’s medical file related to the treatment and management of his unstable T1DM diagnosed in December 2017, followed by a celiac disease diagnosis in the following year (2018) when he was five years old. As he presented as transgender to the endocrinology clinic when first diagnosed with T1DM, his transgender status was accepted without question by the treating professionals and barely commented upon (which is the accepted current standard of medical practice).

202. In one of the few studies of its kind, Logel et al.³⁵ examined the co-occurrence of GD and T1DM in a child and adolescent population. Using an electronic data extraction method of cases from the University of Wisconsin Hospital

³⁵ Logel, S. N., Bekx, M. T., & Rehm, J. L. (2020). Potential association between type 1 diabetes mellitus and gender dysphoria. *Pediatr Diabetes*, 21(2), 266-270. doi:10.1111/pedi.12947

and Clinics from November 1, 2007 to November 1, 2017, prevalence rates were calculated for T1DM and GD. The prevalence for T1DM was 2.69 per 1000; the prevalence for GD was 0.42 per 1000. Eight adolescents had both T1DM and GD. In adolescents with GD, the prevalence of T1DM was 9.4-fold higher than the prevalence of T1DM alone (24.77 vs 2.69 per 1000). The authors hypothesised a role for severe psychological stress in the aetiology of T1DM in genetically predisposed young people. Almost all, like K.C., had multiple psychiatric comorbidities.

Case 2: A.M. [MtF 11 years Redacted (DOB ^{Red: Redacted}/2012)]

203. **A.M.’s** mother declared that A.M. informed her that he was female at four years of age and that he wanted to cut off his penis. Deposition of Emily Morris (E. Morris Dep.) at 21. A.M. socially transitioned at this time and only family members know that he was born male.³⁶ *Id.* at 24. He has had a name and sex change on his birth certificate. *Id.* at 18. A.M. reportedly suffered PTSD, anxiety and depression and has been in counselling since he was six years of age. Declaration of Emily Morris (Morris Decl.) at 2. He was prescribed Zoloft 25mg. E. Morris Dep. at 22-23. Mom stated that they had noticed significant improvement since the medication was started, but A.M. continued to hit herself as a form of punishment. Depression increased at the first signs of puberty and A.M. again threatened to harm his genitals. Morris Decl. at 1. In August 2021, he commenced PB (Leuprorelin) by three

³⁶ This situation of secrecy is similar to that of children who have been “protected” from the reality of having been adopted and been led to believe through omission of disclosure that their adoptive parents are their biological parents. Such children often discover the truth inadvertently and this may cause serious psychological harm. The fact that his transgender status is a burdensome secret for this young child to hold and protect may be adding trauma to his already very troubled life.

monthly injections and subsequently was reported by mother to have experienced a decrease in depression. Mother worries that if PB ceased and A.M. developed male characteristics, the world would discover, according to his mother, that “he is not a real girl.” Morris Decl. at 4. Mother intends to allow A.M. to proceed to estrogen and progesterone in July 2023.³⁷ *Id.* at 5.

204. A.M. has experienced multiple, prolonged, severely adverse childhood events (ACE) since infancy. There are wide-ranging psychopathologies in all first-degree family members, including significant gender identity disorders/confusion/dysphoria in both parents and both siblings. There is major transgenerational psychopathology in first degree relatives on both sides. There is generational transmission of serious mental health conditions including suicide in first degree relatives which have seriously affected A.M.’s mother (see below). A.M. also had a minor MVA (8/29/18) with no lasting physical sequelae.

205. Regarding A.M.’s family and social history, A.M. is living with his single mother after a no contact order was awarded against father for extreme domestic violence, and physical and sexual abuse of A.M. and his older sister. Mother is transgender/nonbinary (they/them pronouns), has PTSD, borderline personality disorder, and depression, with a suicide attempt at age 17. Mother presented to the emergency department with A.M. 8/29/18 due to worsening aggression, self-injurious behaviour, and threats of suicide and homicide (wanting to kill the whole family). Mother indicated that the behavioural outbursts started two years ago during the

³⁷ Surely this is an error as the child will only be 11 years of age?

family break up, with mother leaving A.M.'s physically, sexually, and verbally abusive father.

206. Despite a full social transition and cessation of paternal abuse, A.M.'s behaviour and mood continued to worsen.

207. Evidence for an early history of gender dysphoria is scant. Starting at age 4, A.M. reportedly "seemed depressed about body," expressing an impulse to cut off his penis [Note: this is the age at which A.M.'s father physically and sexually abused A.M. and specifically his penis]. A.M. purportedly expressed to his older sibling that he was sad he couldn't be a girl; and expressed to his mother a desire to develop breasts and to grow 'like a girl.' A possible disidentification with an abusive father as causative factor in this child's rejection of his natal sex was never hypothesized or explored.

208. I submit that the diagnostic process was grossly inadequate, and no conclusions can be drawn from the recorded information. Notwithstanding, A.M. was considered appropriate for PB at age nine, having been assessed at Tanner Stage 2. Mother reported increased dysphoria around this time and following the first injection of Lupron (PB).

209. The effects of Lupron on A.M. were concerning. In an early consultation prior to commencement of Lupron, the doctor recorded that A.M. was a "**THIN** white transgender male, with long, purple-tinted hair, casual clothing." After commencing Lupron in November 2021, A.M.'s BMI and weight were recorded at the 99.74th percentile. With reported height at 137.5cms, this places A.M. into the

OBESE weight category. Weight gain is a well-known side effect of PB³⁸ and it is startling that no-one commented upon or expressed concern about this child's extreme weight gain. Mother and doctors reported dysphoria on 2/4/2022 but did not inquire as to its cause. Perhaps it was body dysmorphia as a result of rapid and extreme weight gain. Alternatively, it could have been due to the fact that A.M. had an expressed wish to be taller but was advised that Lupron blocks height development.³⁹ Deplorably, none of these issues were of clinical interest to the treating team and were not explored with A.M. or his family.

210. There are several other red flags regarding the appropriateness of gender affirming treatment for A.M.

211. First, A.M.'s mother is nonbinary/transgender (they/them pronouns), who sought a hysterectomy to resolve her own GD. Father was described as gender dysphoric and A.M.'s older sister (10 years) has self-declared as "queer." Their four-year-old sibling is reported to be "exploring." This family constellation with all members experiencing gender confusion, including both parents and all three children leads to the hypothesis that these children are acquiring non-normative gender and sexual identity confusion through modelling, social imitation, and reinforcement of "transgender" behaviour rather than accessing an "intrinsic sense of gender." One

³⁸ Censani, M., Feuer, A., Orton, S., Askin, G., & Vogiatzi, M. (2019). Changes in body mass index in children on gonadotropin-releasing hormone agonist therapy with precocious puberty, early puberty or short stature. *Journal of Pediatric Endocrinology and Metabolism*, 32(10), 1065-1070. doi:doi:10.1515/jpem-2019-0105.

³⁹ Hruz, P. W., Mayer, L. S., & McHugh, P. R. (2017). Growing pains: problems with puberty suppression in treating gender dysphoria. *The New Atlantis*, 3-36.

could hypothesize an over-identification with mother of all three children; alternatively, there may be a “folie à cinque” pathology.⁴⁰

212. Second, Mother advised doctors that she wished A.M. to commence PB upon reaching puberty. There was no evidence in the clinical notes that A.M. had expressed this wish. On another occasion (8/30/2018) when asked to express therapeutic goals, mother replied on behalf of A.M. that she wanted A.M.’s suicidal ideation to decrease but “A.M. remained quiet and didn’t answer.”

213. Third, A.M. has PTSD from physical and sexual abuse from his father.

Redacted

214. Fourth, A.M. has made threats of self-harm directed at his penis (he'd like to use a knife to cut off his penis) and to kill himself. He had been hitting himself in the head daily. There did not appear to be any clinical curiosity from the treating doctors/therapists as to whether there was a link between father’s abusive behaviours towards A.M.’s mother and his children and A.M.’s self-harm or gender confusion. It was neither noted nor explored.

215. Fifth, at a physician review 8/29/18, when A.M. was 6 years of age, during a MMSE, a physician judged the child to have “questionable insight and impaired judgment.”

⁴⁰ Like folie à deux involving five people (both parents and three children).

216. Sixth, in a therapy session on 8/30/2018, A.M. stated that he wanted to change his "private front parts" and add "boobs," along with dragon ears, dragon wings, and dragon feet. This comment demonstrates that A.M. is still in a phase of pre-operational cognitive development that is characterized by magical thinking, an inability to separate fantasy from reality, and animism.⁴¹

217. Seventh, at a review as recently as 2/4/2002, A.M. identified as a **witch**.¹³

218. Lastly, A.M. was never assessed for ASD despite some indicators (e.g., feels overwhelmed with loud sounds and large crowds, peer difficulties, e.g., has been bullied since day-care, classmates "don't like me even when I'm nice to them," need to put things in rows, only wanting to drink and wear things blue, and various other behaviours related to organizing and categorizing) that should raise a question as to the presence of autistic traits and processes.

219. These presentations and facts of the case highlight this child's significant psychopathology, particularly for internalizing disorders, self-harm, suicidal ideation, homicidal rage, and cognitive immaturity, which, at six years of age is entirely appropriate and expectable, and far too young to be permitted to undertake permanent life changing decisions about his body, at least until the individual and family pathologies have been appropriately addressed and the child is more developed intellectually to grasp the enormity of the undertaking to feminize his body.

Case 3: M.R. [FtM 15 years Redacted (DOB ^{Redacted}/Redacted/2007)]

⁴¹ Animism is the belief that inanimate objects, such as dolls or toys, have feelings and intentions

220. **M.R.**'s mother stated that M.R. experienced GD, anxiety, and depression "for quite some time" and became suicidal and self-harming, requiring hospitalization (for depression). Declaration of Maria Rivera (Rivera Decl.) at 1. Eighteen months ago, at 13.6 years of age, M.R. began social transition and received "mental health treatment." *Id.* at 2. In January 2023, M.R. commenced testosterone (aged 15). *Id.* There was apparently an immediate positive effect on her anxiety, depression, and willingness to leave the house. Mother implausibly asserts that now that M.R. is on testosterone, all her mental health issues have receded.

221. A red flag regarding appropriateness of gender affirming treatment for M.R. is that M.R. may be lesbian, and this possibility needs to be fully explored before any consideration of medical transition. Like many gender-confused young people, M.R. stated that she is bisexual, but she is sexually active currently only with females. It does not appear to be the case that M.R.'s sexual orientation has been sufficiently explored or clarified with her. Many young people who are latently homosexual experience internalized homophobia and prefer to change their bodies rather than accept their sexual orientation. This is a possible hypothesis in this case - that internalized homophobia is a contributor to her declared transgender status, as has been found clinically in many gay young people.

Case 4: M.W. [FtM 16 years Redacted (DOB ^{Redacted}/_{Redacted}/07)] Identifies as a homosexual male.

222. The first major indicator that her parents had regarding M.W.'s strivings regarding sexuality and gender was a letter she sent at the age of 12, in which

she stated that she was bisexual. Deposition of Lisa Welch (L. Welch Dep.) at 23–24. When parental acceptance was forthcoming, M.W. decided that she was pansexual. *Id.* Mother believed that this label demonstrated a conflation between sexual orientation and gender identity and said that her child did not yet have the “language” to describe herself as transgender. *Id.* When asked how many genders there were, mother replied that “gender is on a spectrum. I don’t actually know how many genders there are.” *Id.* at 25.

223. According to her parents, M.W. socially transitioned at 14 years, including changing her name and pronouns, wearing a chest binder, and male clothing. She commenced taking testosterone at 15 years of age. Declaration of Lisa Welch and Ryan Welch (Welch Decl.) at 1–2. M.W.’s parents stated that she has been receiving “mental health therapy” to cope with the anxiety and depression purportedly caused by GD. *Id.* They claimed “profound positive changes” since starting testosterone over a year ago and beginning to develop male characteristics such as development of facial hair, changes to musculature, and voice deepening. *Id.* at 2–3. They further asserted alleviation in her depression and anxiety and improved peer relationships. *Id.* Red flags regarding appropriateness of gender affirming treatment for M.W. abound:

224. First, M.W. started to question her gender identity in 7th grade (age 11–12), so she would be classified as ROGD (rapid onset gender dysphoria), a group that I have argued are highly susceptible to social contagion. She questioned her sexual orientation before gender and originally identified as bisexual, then pansexual

and non-binary before transgender [Note: identification as bisexual and non-binary is code for “I am confused; I don’t know what my sexual orientation or gender really are”]. M.W. told a physician that her gender exploration led to her identify as a demi girl, then as nonbinary, then as a demi boy, and then as a transgender boy/man. Her gender identity has been unstable from the outset, with clear evidence of acculturation to gender ideology, like her mother. In a later consultation, M.W. identified as “gay, I like dudes.” As M.W. is biologically female and likes “dudes” (guys), in a saner world, her sexual orientation would be described as heterosexual. She disclosed that she had no “romantic relationships but engaged in masturbation.” In mother’s deposition, it states that M.W. is not currently in a relationship but has had four (later corrected to three) previous relationships. L. Welch Dep. at 31. The first at age 12 lasted a few weeks and was “puppy love;” the second lasted a month, the third relationship at 16 years of age was “a little more serious” and lasted a few months. It was with a natal female, so it was a lesbian relationship, supporting M.W.’s earlier contention that she was “gay.” *Id.* at 29–32. The relationship occurred after her transgender declaration, thus, if she is now male, the relationship would be characterized as heterosexual. This history strongly indicates that M.W. is not mature enough or settled enough in her core identity to be able to give informed consent to cross sex hormones.

225. Second, M.W. has had longstanding internalizing mood disorders (depression, anxiety – both unspecified) that have not responded to treatment with Fluoxetine and several other medications (all of which caused side effects), as well

as ADD. Her mother described her as “gloomy, gloomy mood, isolation, pessimism, struggling to enjoy things, withdrawing from friends, withdrawing from family, withdrawing from activities and interests.” L. Welch Dep. at 36. Clinicians should explore what is driving these mood disorders. It is not acceptable to start cross sex hormones when the psychiatric history is so unclear. Fluctuation in mood suggests environmental, including interpersonal, familial or social triggers. One lapse in mood was precipitated by a relationship breakdown which had not been processed with a therapist. Of even greater concern is that the question of whether M.W. is on the autism spectrum has been raised but she has only recently been assessed for this condition, long after starting testosterone. *Id.* at 35. This constitutes very poor medical management of a vulnerable adolescent who should have completed a full psychological/psychiatric assessment before being considered suitable for cross sex hormones.

226. Third, mother understood GD was indicated because M.W. “wasn’t comfortable with her body, withdrew from swimming because [s]he was self-conscious and uncomfortable... then he began to explain it [GD] to me.” L. Welch Dep. at 38. Discomfort with one’s body is very common during puberty in many adolescents and should not be confirmed as gender dysphoria until all other developmentally normal options have been explored. M.W. reported to a physician in an early interview that she experienced significant dysphoria related to chest, voice, and menstrual periods and felt that dysphoria affected her emotional functioning (e.g., anxiety, depression) and behaviour (e.g., discomfort in PE, does not like being in public).

At the time of the interview, M.W. had social transition goals that had not yet been enacted. M.W. was waiting to do this after moving to a new school in the following year (i.e., notifying of pronouns and preferred name, pursuing legal name change, and legal gender marker change in the future).

227. Fourth, despite not having socially transitioned, M.W., with parental support, and despite maternal misgivings (“anxieties and concerns about what would await my son...fears for his safety, that he won’t be accepted, that he won’t have a sense of community...” which providers “normalized” for mother and suggested she contact GenderNexus), wanted to pursue hormonal intervention as soon as possible, encouraged by her medical providers, after the first or second appointment, without question, very shortly after purchasing a chest binder but before any legal name and gender marker changes. L. Welch Dep. at 48. Norethindrone was prescribed on the first visit to suppress menstruation aimed at treating the GD arising. The drug caused serious side effects and had to be discontinued and she was thereafter commenced on testosterone at the age of 15. *Id.* at 59–60. She had been taking it for a year at the time of the deposition without ever having undertaken a “biopsychosocial” assessment. *Id.* at 73. It is concerning that mother had so little understanding of the potential harms of testosterone before consenting to its prescription for her child. She is currently researching double mastectomy surgery for her 16-year-old daughter but could not answer a question regarding whether M.W. would be able to breast-feed a baby after top surgery. *Id.* at 95.

228. Fifth, mother partially rewrites the historical narrative, which is somewhat confused and self-contradictory, asserting that M.W. played with stereotypically male toys during early childhood after previously testifying her GD started at 11–12 years. L. Welch Dep. at 36; 62. She then qualifies her statement by saying “there were no strong indications of gender identity... So there were dolls. Cars and trucks were fleeting. Building sets, science kits, plushies, you know, anything that seemed to spark an interest, he was provided with. But I wouldn't say that he strongly identified with his birth gender or as a boy...” *Id.* at 62–63. Later mother states, “As soon as he could express it (at 3-4 years), he let me know in no uncertain terms of his distress for dresses.” *Id.* Mother then reverts to her adolescent onset narrative. *Id.* at 72. Similarly, M.W.’s mental health issues, despite appearing much earlier than any description of gender dysphoria, are now asserted to be due to her GD. This reversal of causation, or at least the timeline of events, is common in families with transgender children as they strive to find a rationale for their decisions regarding medical transition. Although mother acknowledges that the mental health problems predated the GD, she says it is perhaps because no-one yet had the “language of gender dysphoria” with which to explain M.W.’s presentation. *Id.* at 77. She then qualifies her statement further and says the mental health conditions and the GD are a “Venn diagram,” disclosing that she too suffers from anxiety but does not have GD. *Id.* at 56.

229. Sixth, at an assessment on 1/4/22, although M.W. agreed completely with statements indicating dysphoria with assigned sex and reported feeling very

dissatisfied with female-designated primary sex characteristics (i.e., genitals or gonads), and very dissatisfied with breasts or chest size, M.W. was neutral about secondary sexual characteristics (i.e., chest, hips, or other gendered features such as buttocks, thighs, waist, or figure) and satisfied with non-gendered physical characteristics (e.g., nose, feet, weight). M.W. was also neutral about characteristics such as hair, voice, and general appearance and felt satisfied with facial features, muscularity, and posture. M.W. did not want to pursue menstrual suppression at the time of the above appointment. These responses do not indicate clarity regarding gender identity. Although it is concluded by her treating physician that M.W. met DSM 5 criteria, there is no evidence of a marked incongruence between M.W.'s experienced/expressed gender and (all) primary and/or secondary sex characteristics, a strong desire for the primary and/or secondary sex characteristics of the other gender or a strong desire to be of the other gender, a strong desire to be treated as the other gender or a strong conviction that one has the typical feelings and reactions of the other gender. None of these criteria were in evidence in the clinical notes, nor was there any evidence that they had even been discussed.

230. Sixth, it is possible that M.W. is troubled by the development of the sexed body and her progression into adulthood. She may be conflicted over her sexual orientation. None of these alternative hypotheses were noted or explored. Yet, at 15 years of age, this child's health team was talking about top and bottom SURGERY as a goal when she has an unstable gender identity, is unsure of her sexuality,

and remains depressed, with no lasting relief from antidepressants and other interventions such as “therapy” for depression and anxiety that have not been effective in alleviating her symptoms.

231. Seventh, there has been no case formulation – i.e., no attempt to understand the relationship between GD and other psychological and neurological comorbidities. The assessing physician briefly considered the direction of aetiology but concludes:

These symptoms may be partially attributable to genetic vulnerability and history of psychosocial stressors but also to M.W.’s experience of GD and are likely exacerbated by related minority stressors; therefore, it is possible that these symptoms will improve as M.W. is able to make progress in his goals for gender affirmation.

Further, there were questions regarding ASD, but the physician concludes:

...based on patient presentation and history these concerns may be largely due to his anxiety, depression, and ADHD.

232. I consider the decision to progress to irreversible body changes through medicalized gender treatment without questions of aetiology and comorbidity explored and settled to be skating very close to medical negligence.

233. Eighth, on 05/18/2022, M.W.’s mother contacted the service to express concern that:

“...things are going too quickly, and she doesn't feel as though M.W. has been evaluated for the diagnosis of gender dysphoria vs maybe body dysmorphia. She feels like this is new over the last few years and doesn't feel ready as a parent to make the decision to start hormones with permanent changes at this time.”

234. I fully concur with mother’s concerns. Despite this, M.W. was commenced on testosterone and by the 7/1/2022 appointment had observed significant

changes in her body including bottom growth and increased sex drive, deepening voice, facial hair, and growth of body hair. There does not appear to be any integrated assessment of psychological functioning, family factors, or school environment issues in this case. The medical team claimed M.W. had capacity for informed consent but how this was tested and ascertained is not made explicit.

CLINICAL ISSUES RELATED TO THE FOUR PLAINTIFFS

True transgender and non-persistence of gender dysphoria in early childhood

235. There is no evidence provided by the documentation to which I have had access that any of these plaintiffs belong to that previously very rare group of “true transgender” children – that is, those who have an innate and immutable gender identity that does not align with their natal sex and is largely independent of the effects of environment. The children in this case have had no opportunity to explore their perceived gender dysphoria, to identify its true causes, or to determine whether it will naturally resolve had it not been subject to precipitous external medical and social influence/interventions. Although rates of persistence vary across studies, most place the estimate at between 10–27 percent, making it a statistical likelihood that children will naturally resolve their gender confusion/dysphoria if not subjected to medical interference.^{42,43,44} A significant proportion will be gay adults.⁴⁵

⁴² 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.

⁴³ Steensma, T. D., McGuire, J. K., Kreukels, B. P., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(6), 582-590.

⁴⁴ Wallien, M. S., & Cohen-Kettenis, P. T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 47(12), 1413-1423.

⁴⁵ Cantor, J. (2016). Do trans- kids stay trans- when they grow up? *Sexology Today* http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow_99.html

236. Brunskell-Evans argues⁴⁶ that the transgender child has been “constructed” rather than identified and liberated to express his/her authentic self:

...the construction of the transgender child identity is not progressive and humane but on the contrary binds children to traditional gender stereotypes, medically harms them through life-changing irreversible procedures, and renders clinicians unable to operate within the medical ethos to which they aspire, namely to ‘first do no harm.’ The law is complicit in the derogation of children’s human rights to adult oversight, to bodily integrity, and to have their best interests served (p. 641).

Incipient homosexuality

237. It is highly possible that in the two MtF cases, the manifestation of their gender variant perceptions and behaviours may be construed as a precursor to later homosexual orientation.

238. There are very few studies detailing the natural history of homosexual orientation in the normal childhood development of gay and lesbian young people. It is possible that this subgroup may be expressing their embryonic sexual attraction for same-sex children and expressing preference for the play activities of the opposite sex. Many gender dysphoric children who are unhappy about their core gender identity choose same-sex partners later in life.^{47,48}

239. Because young children have neither the life experience, the cognitive development nor the appropriate language to express their sexual preferences, and

⁴⁶ Brunskell-Evans, H. (2019). The medico-legal ‘making’ of ‘the transgender child.’ *Medical Law Review*, 27(4), 640-657. doi:10.1093/medlaw/fwz013.

⁴⁷ Byne W, Bradley SJ, Coleman E, Eyler AE, Green R, Menvielle EJ, Meyer-Bahlburg HF, Pleak RR, Tompkins DA. (2012). Report of the American Psychiatric Association task force on treatment of gender identity disorder. *Archives of Sexual Behavior*, Aug; 41:759-96.

⁴⁸ Byne W, Bradley SJ, Coleman E, Eyler AE, Green R, Menvielle E, Meyer-Bahlburg HF, Pleak RR, Tompkins DA. Treatment of gender identity disorder. *American Journal of Psychiatry*. 2012 Aug;169(8):875-6.

⁴⁹ van der Miesen, A. I. R., Hurley, H., Bal, A. M., & de Vries, A. L. C. (2018). Prevalence of the wish to be of the opposite gender in adolescents and adults with autism spectrum disorder. *Archives of Sexual Behavior*. doi:10.1007/s10508-018-1218-3

given that we live in a society that is reluctant to consider the possibly normative incipient homosexual development in a small minority of young children, “pregay” children could present with GD, not understanding that they have a concordant core gender identity but incipient fantasies, desires, and gender role performances that are not consonant with gender social roles for their natal sex. These issues should have been explored in depth before precipitating them into social transition followed by the prescription of puberty blockade as soon as Tanner Stage 2 was reached at 9-11 years of age. Such action forecloses on any further gender exploration.

Assessment for Autism Spectrum Disorder (ASD)

240. The possible presence of autistic traits or a diagnosis of ASD was signalled in all of these young people but there was no evidence that any formal assessment of same had occurred. The co-occurrence of ASD and GD has been reported to be high in a number of studies^{49, 50} and that further, the rate of positive ASD diagnoses in young people with GD far exceeds population prevalence of ASD in age and sex matched non-GD young people.⁵¹

241. Strang et al.,⁵² in a consensus statement from multiple experts, provided assessment guidelines for co-occurring ASD and GD, stressing the need to assess

⁴⁹ van der Miesen, A. I. R., Hurley, H., Bal, A. M., & de Vries, A. L. C. (2018). Prevalence of the wish to be of the opposite gender in adolescents and adults with autism spectrum disorder. *Archives of Sexual Behavior*. doi:10.1007/s10508-018-1218-3

⁵⁰ May, T., Pang, K., & Williams, K. J. (2017). Gender variance in children and adolescents with autism spectrum disorder from the National Database for Autism Research. *International Journal of Transgenderism*, 18(1), 7-15.

⁵¹ Strang, J. F., Kenworthy, L., Dominska, A., Sokoloff, J., Kenealy, L. E., Berl, M., . . . Wallace, G. L. (2014). Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder. *Archives of Sexual Behavior*, 43(8), 1525-1533.

⁵² Strang JF, Meagher H, Kenworthy L, et al. (2018). Initial clinical guidelines for co-occurring autism spectrum disorder and gender dysphoria or incongruence in adolescents. *J Clin Child Adolesc Psychol.*, 47(1):105- 115. doi:10.1080/15374416.2016.1228462.

and confirm ASD diagnoses if warranted, as ASD may have a significant impact on the young person's ability to understand and correctly interpret the meaning of GD symptoms. ASD evaluations should include an assessment of general cognitive skills, executive function skills (impulse control, flexibility, planning, future thinking), communication skills, emotional functioning, self-awareness/social cognition, and capacity for self-advocacy. I did not discern evidence of any coordinated contact between these young people's schools other than to ascertain whether they were being automatically affirmed at school, and not being bullied etc. There was no inquiry regarding their scholastic performance or cognitive functioning.

242. Further, Cooper et al.⁵³ helpfully suggested that the heightened sensory overload experienced by young people with ASD may affect how well they cope with the changes at puberty. Many are more likely to become distressed by the onset of menses, breast growth, increased body odour, increased libido, sexual stimulation, and sexual attraction, and more likely to misinterpret the meanings of these bodily changes. Clinicians need to discern "... how much this distress is about the gender signifying body, as opposed to just the change of puberty itself being distressing for young autistic patients."

GD as a secondary manifestation of causative mental health presentations and/or social factors

243. In the majority of GD presentations, including the four plaintiffs, GD might be considered more a secondary psychological phenomenon arising from a

⁵³ Cooper K, Mandy W, Russell A, Butler C. (2022). Healthcare clinician perspectives on the intersection of autism and gender dysphoria. *Autism*. 2022 Mar 14:13623613221080315. doi: 10.1177/13623613221080315. Epub ahead of print. PMID: 35285287

complex interaction of biopsychosocial factors such as genetics, ASD,⁵⁴ attachment patterns, ACE, and social influences such as social contagion effects – including from peers/media/internet engagement/social media/treating system, and emerging as part of a complex psychiatric presentation (mood disturbances, anxiety, anger, emotional dysregulation, identity disturbance/GD, self-harm, and suicidal ideation.

244. For example, a recent Finnish study found that 75 percent of young people presenting for gender affirmation surgery were also seeking psychiatric services for concurrent mental health issues.⁵⁵ In one study of GD youth, 32 percent had at least one Axis 1 (DSM 5) diagnosis,⁵⁶ in another, 47 percent of transgender girls met criteria for an additional diagnosis.⁵⁷ Depressive, anxiety, self-harm and suicidal ideation, poor school performance, disruptive behaviour, ADHD, and ASD are all frequent co-occurrences in this population.^{58,59}

245. Some commentators argue that the source of psychopathology arises more from minority stress and parental rejection generally or in response to the

⁵⁴ Strang JF, Meagher H, Kenworthy L, et al. Initial Clinical Guidelines for Co-Occurring Autism Spectrum Disorder and Gender Dysphoria or Incongruence in Adolescents. *J Clin Child Adolesc Psychol.* 2018;47(1):105-115. doi:10.1080/15374416.2016.1228462

⁵⁵ Kaltiala-Heino, R., Sumia, M., Tyolajarvi, 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, 9. <https://doi.org/10.1186/s13034-015-0042-y>.

⁵⁶ de Vries, A. L., Doreleijers, T. A., Steensma, T. D., & Cohen-Kettenis, P. T. (2011). Psychiatric comorbidity in gender dysphoric 2008 Archives of Sexual Behavior (2019) 48:2003–2009 13 adolescents. *Journal of Child Psychology and Psychiatry*, 52(11), 1195–1202. <https://doi.org/10.1111/j.1469-7610.2011.02426.x>

⁵⁷ Wallien, M. S., Swaab, H., & Cohen-Kettenis, P. T. (2007). Psychiatric comorbidity among children with gender identity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(10), 1307–1314. <https://doi.org/10.1097/chi.0b013.e3181373848>.

⁵⁸ Janssen, A., Busa, S., & Wernick, J. (2019). The complexities of treatment planning for transgender youth with co-occurring severe mental illness: A literature review and case study. *Archives of Sexual Behavior*, 48, 2003-2009.

⁵⁹ Reisner, S. L., Vettters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health*, 56(3), 274–279. <https://doi.org/10.1016/j.jadohealth.2014.10.264>.

child's transgender declarations,⁶⁰ and the debate becomes one of “chicken and egg.” In the case of these four plaintiffs, the mental health issues and ACEs both predated and post-dated their GD, so the process is iterative. I have seen this pattern many times in my clinical work. However, for these young people, their parents were compliant and supportive of the young person's wishes, perhaps overly so in a well-intentioned but misguided way based on the prevailing zeitgeist about how parents of GD young people should manage their gender dysphoric young people.⁶¹

246. Koslowska et al.⁶² highlighted the importance of attending to these complex issues with appropriate comprehensive assessment, child psychotherapy, and parent/family psychotherapy before prematurely embarking on social transition in the preschool years followed by medicalization with GnRHa and cross sex hormones (CSH). Kozlowska et al. from the Westmead Multidisciplinary Children's Gender Service, New South Wales, Australia emphasized the need:

...to confront the complexity of the clinical presentations and to use a broad, holistic, systemic (i.e., biopsychosocial) framework that takes into account the full range of interacting factors—social, economic, relational, family, psychological, and biological—that have defined the life circumstances of the child and the family seeking care for GD...some clinicians...function within a non-holistic (non-biopsychosocial) framework where the child's developmental experiences are disconnected from their clinical presentation. This non-holistic framework is likely to promote a healthcare delivery model that dehumanizes the child...that promotes medical solutions (correcting the identity/body mismatch) for a problem that is much more complex...insofar as the

⁶⁰ Bauer, G. R., Scheim, A. I., Pyne, J., Travers, R., & Hammond, R. (2015). Intervenable factors associated with suicide risk in transgender persons: A respondent driven sampling study in Ontario, Canada. *BMC Public Health*, 15, 525. <https://doi.org/10.1186/s12889-015-1867-2>.

⁶¹ As I argue in my previous submission, parents and indeed physicians, legislators, teachers, etc are not immune to the strident messaging and implied threats of the transgender movement.

⁶² Kozlowska, K., et al. (2021). Australian children and adolescents with gender dysphoria: Clinical presentations and challenges experienced by a multidisciplinary team and gender service. *Human Systems*, 26344041211010776. doi:10.1177/26344041211010777

gender affirmative model [is concerned] it becomes a tick-the-box treatment process... and puts patients at risk of adverse future outcomes.

This is the process that I have observed in the clinical management of these four young people who have been prematurely precipitated into a treatment path which is currently and will likely continue to result in future adverse outcomes.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed on May 26, 2023.

A handwritten signature in blue ink that reads "Dianna T. Kenny". The signature is written in a cursive style with a large, stylized 'K'.

Dianna T. Kenny, Ph.D.

References for Chapter 1

1. Abrutyn, S., & Mueller, A. S. (2014). Are suicidal behaviors contagious in adolescence? Using longitudinal data to examine suicide suggestion. *American Sociological Review*, 79(2), 211-227.
2. AHRC. (2019). Guidelines for the inclusion of transgender and gender diverse people in sport. Retrieved from <https://www.humanrights.gov.au/ourwork/lgbti/publications/guidelines-inclusion-transgender-and-gender-diverse-people-sport-2019>
3. Aitken, M., Steensma, T. D., Blanchard, R., VanderLaan, D. P., Wood, H., Fuentes, A. ... Zucker, K. J. (2015). Evidence for an altered sex ratio in clinic-referred adolescents with gender dysphoria. *Journal of Sexual Medicine*, 12, 756–763.
4. Ashley, F. (2019). Shifts in assigned sex ratios at gender identity clinics likely reflect changes in referral patterns [Letter to the Editor]. *Journal of Sexual Medicine*, 16, 948–949.
5. Alanko, K., Santtila, P., Witting, K., Varjonen, M., Jern, P., Johansson, A., . . . Kenneth Sandnabba, N. (2009). Psychiatric symptoms and same-sex sexual attraction and behavior in light of childhood gender atypical behavior and parental relationships. *Journal of Sex Research*, 46(5), 494-504.
6. Alfonseca, K. (2023, April). Map: Where gender-affirming care is being targeted in the US. <https://abcnews.go.com/US/map-gender-affirming-care-targeted-us/story?id=97443087#:~:text=At%20least%2013%20states%20%2D%2D,the%20threshold%20for%20legal%20adulthood.>
7. ALHR. (2021). Submission to the review of Queensland’s *Anti-Discrimination Act*: Discussion paper. *Queensland Human Rights Commission*. Retrieved from https://www.qhrc.qld.gov.au/data/assets/pdf_file/0020/38522/Sub.140-Australian-Lawyers-for-Human-Rights-ALHR_Redacted.pdf
8. Ali, M., Amialchuk, A., & Dwyer, D. (2011). The social contagion effect of marijuana use among adolescents. *PloS one*, 6(1), e16183. doi:10.1371/journal.pone.0016183
9. Ali, M., & Dwyer, D. (2010). Social network effects in alcohol consumption among adolescents. *Addictive behaviors*, 35(4), 337-342.
10. Allison, S., Warin, M., & Bastiampillai, T. (2014). Anorexia nervosa and social contagion: Clinical implications. *Australian & New Zealand Journal of Psychiatry*, 48(2), 116-120. doi:10.1177/0004867413502092
11. American College of Paediatricians (2016). [http://www.acpeds.org/the-college-speaks/position-statements/gender-ideology-harms-children.](http://www.acpeds.org/the-college-speaks/position-statements/gender-ideology-harms-children)

12. Anderson, R. T. (2018). Transgender ideology is riddled with contradictions. Here are the big ones. *The Heritage Foundation*.
13. Andrews, J. J., & Rapp, D. N. (2014). Partner characteristics and social contagion: Does group composition matter? *Applied Cognitive Psychology*, 28(4), 505-517. doi:10.1002/acp.3024
14. APA. (1994). *Diagnostic and Statistical Manual (DSM IV)*. Washington, DC: American Psychiatric Association.
15. APA. (2012). Position statement on access to care for transgender and gender variant individuals. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.692.7501&rep=rep1&type=pdf>
16. APA. (2013). *Diagnostic and Statistical Manual (DSM 5)*. Washington, DC: American Psychiatric Association
17. APA. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. Retrieved from <https://www.apa.org/practice/guidelines/transgender.pdf>
18. APA. (2022). Transgender people, gender identity and gender expression. Retrieved from <https://www.apa.org/topics/lgbtq/transgender#:~:text=Gender%20identity%20refers%20to%20a,hairstyles%2C%20voice%20or%20body%20characteristics>.
19. APS. (2018). Retrieved from <https://www.psychology.org.au/formembers/publications/inpsych/2018/October-Issue-4/Hidden-side-of-a-visible-problem>
20. APS. (2019). Retrieved from <https://www.psychology.org.au/About-Us/newsand-media/Media-releases/2019/APS-Refutes-%E2%80%99Social-Contagion%E2%80%99-Arguments>
21. APS. (2020). Ethical guidelines for psychological practice with clients with diverse sexualities, diverse genders and/or diverse bodies. Retrieved from <https://psychology.org.au/getmedia/1ddc65a5-442f-411c-b0b7-e765819a6cbf/ethical-guideline-gender-diverse.pdf>
22. Aral, S., Muchnik, L., & Sundararajan, A. (2009). Distinguishing influence-based contagion from homophily-driven diffusion in dynamic networks. *Proceedings of the National Academy of Sciences of the United States of America*, 106(51), 21544-21549.
23. Aral, S., & Walker, D. (2011). Creating social contagion through viral product design: a randomized trial of peer influence in networks: Special issue on marketing within the enterprise and beyond. *Management Science*, 57(9), 1623-1639.

24. Aral, S., & Walker, D. (2012). Identifying influential and susceptible members of social networks. *Science*, 337(6092), 337. doi:10.1126/science.1215842
25. Arnoldussen, M., Steensma, T. D., Popma, A., van der Miesen, A. I. R., Twisk, J. W. R., & de Vries, A. L. C. (2020). Re-evaluation of the Dutch approach: are recently referred transgender youth different compared to earlier referrals? *European Child & Adolescent Psychiatry*, 29(6), 803-811. doi:10.1007/s00787-019-01394-6
26. Aspenlieder, L., Buchanan, C. M., McDougall, P., & Sippola, L. K. (2009). Gender nonconformity and peer victimization in pre-and early adolescence. *International Journal of Developmental Science*, 3(1), 3-16.
27. AusPath. (2022). AusPath Standards of Care. Retrieved from <https://auspath.org.au/standards-of-care/>
28. Bailey, J. M. (2019). How to ruin sex research. *Archives of Sexual Behaviour*, 48, 1007–1011.
29. Bailey, J. M., Pillard, R. C., Dawood, K., Miller, M. B., Farrer, L. A., Trivedi, S., & Murphy, R. L. (1999). A family history study of male sexual orientation using three independent samples. *Behavior Genetics*, 29(2), 79-86. doi:10.1023/A:1021652204405
30. Bailey, J. & Zucker, K. (1995). Childhood sex-typed behaviour and sexual orientation: a conceptual analysis and quantitative review. *Developmental Psychology*, 31, 43-55.
31. Baller, R. D., & Richardson, K. K. (2002). Social integration, imitation, and the geographic patterning of suicide. *American Sociological Review*, 873-888.
32. Bapna, R., & Umyarov, A. (2015). Do your online friends make you pay? A randomized field experiment on peer influence in online social networks. *Management Science*, 61(8), 1902-1920.
33. BBC (Writer). (2004). One life: Make me a man again. In.
34. BBC. (2019). Caster Semenya: United Nations criticises ‘humiliating’ IAAF rule Retrieved from <https://www.bbc.com/sport/athletics/47690512>
35. Becker, I., Gjergji-Lama, V., Romer G., & Möller, B. (2014). Characteristics of children and adolescents with gender dysphoria referred to the Hamburg Gender Identity Clinic [German]. *Prax Kinderpsychol Kinderpsychiatr*, 63, 486–509.
36. Bell, D. (2021). Preface. In M. Evans & S. Evans (Eds.), *Gender dysphoria: A therapeutic model for working with children, adolescents, and young adults* (pp. xii- xvi). Oxford: Phoenix Publishing House.
37. Benedetti, F. (2013). Responding to nocebos through observation: Social contagion of negative emotions. *Pain*, 154(8), 1165-1165. doi:10.1016/j.pain.2013.05.012

38. Biggs, M. (2022). Suicide by clinic-referred transgender adolescents in the United Kingdom. *Archives of Sexual Behavior*, 51(2), 685-690.
39. Biggs, M. (2022). Estrogen is associated with greater suicidality among transgender males, and puberty suppression is not associated with better mental health outcomes for either sex. *Plos One*, <https://journals.plos.org/plosone/article/comment?id=10.1371/annotation/dcc6a58e-592a-49d4-9b65-ff65df2aa8f6>
40. Bindel, J. (2022). The toppling of the trans extremists: My Nottingham win is another blow for Stonewall. Retrieved from <https://unherd.com/2022/10/the-toppling-of-the-trans-extremists/>
41. Blad, E. (2017). How many transgender children are there? *Education Week*. Retrieved from <https://www.edweek.org/ew/articles/2017/03/08/how-many-transgender-children-arethere.html>
42. Blakemore, S.-J., & Mills, K. L. (2014). Is adolescence a sensitive period for sociocultural processing? *Annual Review of Psychology*, 65, 187-207.
43. Blanchet, K. (2013). How to facilitate social contagion? *International Journal of Health Policy and Management*, 1(3), 189-192. doi:10.15171/ijhpm.2013.35
44. Block, P., & Burnett-Heyes, S. (2020). Sharing the load: Contagion and tolerance of mood in social networks. *Emotion*.
45. Blosnich, J. R., Brown, G. R., Shipherd, J. C., Kauth, M., Piegari, R. I., & Bossarte, R. M. (2013). Prevalence of gender identity disorder and suicide risk among transgender veterans utilizing veterans health administration care. *American journal of public health*, 103(10), e27-e32.
46. Bodenner, C. (2016). Is the 'Trans Lobby' Disproportionately Strong?
47. Borreli, L. (2017, 10 March). Transgender surgery: Regret rates highest in male-to-female reassignment operations. *Newsweek*. Retrieved from <https://www.newsweek.com/transgender-women-transgender-men-sex-change-sex-reassignment-surgery-676777>
48. Bowcott, O. (2019). Judge ruled against researcher who lost job over transgender tweets. *The Guardian*. Retrieved from <https://www.theguardian.com/society/2019/dec/18/judge-rulesagainst-charity-worker-who-lost-job-over-transgender-tweets>
49. Branigin, A. & Kirkpatrick, N. (2022). Anti-trans laws are on the rise. Here's a look at where — and what kind. From bans on gender affirming care to restrictions on names changes, state lawmakers across the country have introduced a slew of anti-trans legislation. *Washington Post*, <https://www.washingtonpost.com/lifestyle/2022/10/14/anti-trans-bills/>

50. Brown, R. C., Fischer, T., Goldwisch, A. D., Keller, F., Young, R., & Plener, P. L. (2017). Cutting: Non-suicidal self-injury (NSSI) on Instagram. *Cambridge University Press*.
51. Brown, R. C., Fischer, T., Goldwisch, D. A., & Plener, P. L. (2020). "I just finally wanted to belong somewhere"—Qualitative analysis of experiences with posting pictures of self-injury on Instagram. *Frontiers in psychiatry, 11*.
52. Cantor, J. (2016). Do trans-kids stay trans-when they grow up? Retrieved from <http://www.sexologytoday.org/2016/01/do-trans-kids-stay-trans-when-they-grow-99.html>
53. Carver, P. R., Yunger, J. L., & Perry, D. G. (2003). Gender identity and adjustment in middle childhood. *Sex Roles, 49*(3), 95-109. doi:10.1023/a:1024423012063
54. CAS. (2019). CAS Arbitration: Caster Semenya, Athletics South Africa (ASA) and International Association of Athletics Federations (IAAF): Decision. Retrieved from https://www.tas-cas.org/fileadmin/user_upload/Media_Release_Semenya_ASA_IAAF_decision.pdf
55. Cass, H. (2022). Review of gender identity services for children and young people. In (Vol. 376): *British Medical Journal*.
56. Cecco, L. (2019). Court backs trans teen who feared being 'stranded' by father's bid to stop transition. *The Guardian*. Retrieved from <https://www.theguardian.com/world/2019/sep/06/trans-teenager-case-canada-father-halts-treatment>
57. Chen, C.-Y., Storr, C. L., & Anthony, J. C. (2009). Early-onset drug use and risk for drug dependence problems. *Addictive behaviors, 34*(3), 319-322.
58. Christakis, N., & Fowler, J. (2008). The collective dynamics of smoking in a large social network. *New England journal of medicine, 358*(21), 2249-2258.
59. Christakis, N., & Fowler, J. (2011). Contagion in prescribing behavior among networks of doctors. *Marketing science, 30*(2), 213-216.
60. Christakis, N., & Fowler, J. (2013). Social contagion theory: examining dynamic social networks and human behavior. *Statistics In Medicine, 32*(4), 556-577.
61. Clark, A. E., & Loheac, Y. (2007). "It wasn't me, it was them!" Social influence in risky behavior by adolescents. *Journal of health economics, 26*(4), 763-784.
62. Coleman et al., Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, World Professional Association for Transgender Health (WPATH), *Intern. J. of Transgenderism, 13*(4), 165-232, 2012, pp. 15, 24.

63. Cook, C. (2021). The causes of human sexual orientation. *Theology & Sexuality*, 27, 1, 1-19, DOI: 10.1080/13558358.2020.1818541.
64. Coviello, L., Sohn, Y., Kramer, A. D., Marlow, C., Franceschetti, M., Christakis, N. A., & Fowler, J. H. (2014). Detecting emotional contagion in massive social networks. *PloS one*, 9(3), e90315.
65. Dallas, K., Kuhlmann, P., Zhao, H., Scott, V., Eilber, K., Reyblat, P., & Anger, J. (2021). Complications after gender affirming vaginoplasty in a large population-based cohort. *Journal of Urology*, 206(Supplement 3), e541-e542. doi:10.1097/JU.0000000000002032.08
66. D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50(1).
67. de Graaf, N. M., Giovanardi, G., Zitz, C., & Carmichael, P. (2018). Sex ratio in children and adolescent referred to the Gender Identity Development Services in the UK (2009–2016) [Letter to the Editor]. *Archives of Sexual Behavior*, 47, 1301–1304.
68. de Kovel, C. G. F., Carrión-Castillo, A., & Francks, C. (2019). A large-scale population study of early life factors influencing left-handedness. *Scientific Reports*, 9(1), 584. doi:10.1038/s41598-018-37423-87-16.
69. Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PloS one*, 6(2), e16885.
70. Diaz et al. (2023). Rapid onset gender dysphoria: Parent reports on 1655 possible cases. *Archives of Sexual Behavior*, p. 11.
71. Dishion, T. J., Nelson, S. E., Winter, C. E., & Bullock, B. M. (2004). Adolescent friendship as a dynamic system: Entropy and deviance in the etiology and course of male antisocial behavior. *Journal of Abnormal Child Psychology*, 32(6), 651-663.
72. Dishion, T. J., & Tipsord, J. M. (2011). Peer contagion in child and adolescent social and emotional development. *Annual Review of Psychology*, 62, 189-214.
73. Djordjevic, M. L., Bizic, M. R., Duisin, D., Bouman, M.-B., & Buncamper, M. (2016). Reversal surgery in regretful male-to-female transsexuals after sex reassignment surgery. *The journal of sexual medicine*, 13(6), 1000-1007.
74. Durkheim, E. (1897/1951). *Suicide: A study in sociology*. New York: The Free Press.
75. Eisenberg, M. E., Gower, A. L., McMorris, B. J., Rider, G. N., Shea, G., & Coleman, E. (2017). Risk and protective factors in the lives of transgender/gender nonconforming adolescents. *Journal of Adolescent Health*, 61(4), 521-526. doi:<https://doi.org/10.1016/j.jadohealth.2017.04.014>

76. Ellis, S., Rogoff, B., & Cromer, C. C. (1981). Age segregation in children's social interactions. *Developmental Psychology*, 17(4), 399.
77. EMERGENCY RULE - 15 CSR 60-17.010 Experimental interventions to treat gender dysphoria [2023-04-13---emergency-reg.pdf \(mo.gov\)](#)
78. Fagot, B., & Rodgers, C. (1998). Gender identity. *Encyclopaedia of Mental Health*, 2, 267-276.
79. Finnish Health Authority (PALKO/COHERE, 2020). Medical treatment methods for dysphoria related to gender variance in minors. https://www.segm.org/sites/default/files/Finnish_Guidelines_2020_Minors_Unofficial%20Translation.pdf
80. Fischer, S., & Peterson, C. (2015). Dialectical behavior therapy for adolescent binge eating, purging, suicidal behavior, and non-suicidal self-injury: a pilot study. *Psychotherapy*, 52(1), 78.
81. Fletcher, A., Bonell, C., & Hargreaves, J. (2008). School effects on young people's drug use: a systematic review of intervention and observational studies. *Journal of Adolescent Health*, 42(3), 209-220.
82. Fraser, K., & Condello, M. (2017). Victory for transgender children in recent Family Court decision, (2017). <https://www.claytonutz.com/knowledge/2017/december/victory-for-transgender-children-in-recent-family-court-decision>.
83. Frisén, L., Söder, O., & Rydelius, P. A. (2017). [Dramatic increase of gender dysphoria in youth]. *Lakartidningen*. Retrieved from <http://lakartidningen.se/Klinik-och-vetenskap/Klinisk-oversikt/2017/02/Kraftig-okning-av-konsdysfori-bland-barn-och-unga/>.
84. Fu, K.-w., & Chan, C. (2013). A study of the impact of thirteen celebrity suicides on subsequent suicide rates in South Korea from 2005 to 2009. *PLoS one*, 8(1), e53870.
85. Fulcher, J. A., Dunbar, S., Orlando, E., Woodruff, S. J., & Santarossa, S. (2020). Selfharm on Instagram: Understanding online communities surrounding non-suicidal self-injury through conversations and common properties among authors. *Digital Health*, 6. doi:2055207620922389
86. Gardner, M., & Steinberg, L. (2005). Peer influence on risk taking, risk preference, and risky decision making in adolescence and adulthood: An experimental study. *Developmental Psychology*, 41(4), 625.
87. Gardner, T. W., Dishion, T. J., & Connell, A. M. (2008). Adolescent self-regulation as resilience: Resistance to antisocial behavior within the deviant peer context. *Journal of Abnormal Child Psychology*, 36(2), 273-284.

88. Golder, S. A., & Macy, M. W. (2011). Diurnal and season mood vary with work, sleep, and daylength across diverse cultures. *Science*, 333(6051), 1878–1881.
89. Golding, J., Pembrey, M., Jones, R., ALSPAC Study Team. ALSPAC--the Avon Longitudinal Study of Parents and Children. (2001). I. Study methodology. *Paediatric and perinatal epidemiology*. 15(1):74-87. DOI: 10.1046/j.1365-3016.2001.00325.x. Also, see <http://www.bristol.ac.uk/alspac/>
90. Gould, M. S. (2001). Suicide and the media. *Annals of the New York Academy of Sciences*, 932(1), 200-224. doi:<https://doi.org/10.1111/j.1749-6632.2001.tb05807.x>
91. Change or Suppression (Conversion) Practices Prohibition Bill 2020, (2020).
92. Greenall, J. (2019). Puberty blockers: a transgender experiment built on sand. *Mercatornet*.
93. Ha, J., & Yang, H.-S. (2021). The Werther effect of celebrity suicides: Evidence from South Korea. *PloS one*, 16(4), e0249896.
94. Hall, R., Mitchell, L., & Sachdeva, J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: retrospective case-note review. *BJPsych Open*, 7(6), e184. doi:10.1192/bjo.2021.1022
95. Hankin, B. L., Stone, L., & Wright, P. A. (2010). Corumination, interpersonal stress generation, and internalizing symptoms: Accumulating effects and transactional influences in a multiwave study of adolescents. *Development and Psychopathology*, 22(1), 217-235.
96. Hawton, K., Hill, N. T. M., Gould, M., John, A., Lascelles, K., & Robinson, J. (2020). Clustering of suicides in children and adolescents. *The Lancet Child & Adolescent Health*, 4(1), 58-67. doi:[https://doi.org/10.1016/S2352-4642\(19\)30335-9](https://doi.org/10.1016/S2352-4642(19)30335-9)
97. Hisle-Gorman, E., Schvey, N. A., Adirim, T. A., Rayne, A. K., Susi, A., Roberts, T. A., & Klein, D. A. (2021). Mental healthcare utilization of transgender youth before and after affirming treatment. *Journal of Sexual Medicine*, 18(8), 1444-1454.
98. Huefner, J., & Ringle, J. (2012). Examination of negative peer contagion in a residential care setting. *Journal of Child and Family Studies*, 21(5), 807-815. doi:10.1007/s10826-011-9540-6
99. IHRA. (2012). Inersex for allies. Retrieved from <https://ihra.org.au/allies/>
100. IHRA. (2022). Intersex Human Rights Australia - Resources. Retrieved from <https://ihra.org.au/allies/>
101. Indremo, M., Jodensvi, A. C., Arinell, H., Isaksson, J., & Papadopoulos, F. C. (2022). Association of media coverage on transgender health with referrals to

- child and adolescent gender identity clinics in Sweden. *JAMA Network Open*, 5(2), e2146531-e2146531.
102. Iyengar, R., Van den Bulte, C., & Valente, T. W. (2011). Opinion leadership and social contagion in new product diffusion. *Marketing Science*, 30(2), 195-212.
103. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The report of the 2015 US transgender survey*. <https://www.ustranssurvey.org/reports>
104. Janis, I.L. (1972). *Victims of groupthink: A psychological study of foreign-policy decisions and fiascos*. Boston: Houghton Mifflin.
105. Jannini, E. A., Burri, A., Jern, P., & Novelli, G. (2015). Genetics of human sexual behavior: where we are, where we are going. *Sexual Medicine Reviews*, 3(2), 65-77.
106. Jarvi, S., Jackson, B., Swenson, L., & Crawford, H. (2013). The impact of social contagion on non-suicidal self-injury: A review of the literature. *Archives of Suicide Research*, 17(1), 1-19.
107. Jung, C. (2014). *The spirit in man, art, and literature (Collected works of Jung)* (Vol. 15, CW 15, para 339).
108. 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, 9.
109. Kaltiala, R., Bergman, H., Carmichael, P., de Graaf, N. M., Egebjerg Rischel, K., Frisen, L., ... & Waehre, A. (2020). Time trends in referrals to child and adolescent gender identity services: a study in four Nordic countries and in the UK. *Nordic Journal of Psychiatry*, 74(1), 40-44.
110. Kauth, M. R., Blossnich, J. R., Marra, J., Keig, Z., & Shipherd, J. C. (2017). Transgender health care in the US military and Veterans Health Administration facilities. *Current Sexual Health Reports*, 9(3), 121-127.
111. Kenny, D. T. (2022). Number of children enrolled, receiving puberty blockade and cross sex hormones in five gender clinics in Australia, 2014-2021. Retrieved from <https://www.diannakenny.com.au/k-blog.html>
112. Kirby, M. (2014). *Transgender law reform: Ten commandments of Hong Kong*. <https://www.Michaelkirby.Com.Au/images/stories/speeches/2014/2745%20-%20speech%20-%20united%20nations%20development%20programme%20-%20high%20level%20roundtable%20on%20gender%20identity%20rights%20and%20the%20law%20in%20asia%20and%20the%20pacific%20-%202%20october%202014.Pdf>

113. Kramer, A. D., Guillory, J. E., & Hancock, J. T. (2014). Experimental evidence of massivescale emotional contagion through social networks. *Proceedings of the National Academy of Sciences of the United States of America*, 111(24), 8788-8790.
114. Laidlaw, M. K. (2020). The Pediatric Endocrine Society statement on puberty blockers isn't just deceptive: It's dangerous. *Public Discourse: Journal of the Witherspoon Institute*.
115. Lane, B. (2019). Psychiatrists push for enquiry into transgender treatment. *The Australian*. Retrieved from <https://www.theaustralian.com.au/nation/psychiatrists-push-for-inquiry-into-transgender-treatment/news-story/c77ce6baf3f4857e85760b4c529e0347>
116. Levinson, H. (2011). The strange and curious history of lobotomy. *BBC News*.
117. Leyens, J.-P., Paladino, P. M., Rodriguez-Torres, R., Vaes, J., Demoulin, S., Rodriguez-Perez, A., & Gaunt, R. (2000). The emotional side of prejudice: The attribution of secondary emotions to ingroups and outgroups. *Personality and social psychology review*, 4(2), 186-197.
118. Li, G., Kung, K. T. F., & Hines, M. (2017). Childhood gender-typed behavior and adolescent sexual orientation: A longitudinal population-based study. *Developmental Psychology*, 53(4), 764-777. <https://doi.org/10.1037/dev0000281>
119. Light, J. M., & Dishion, T. J. (2007). Early adolescent antisocial behavior and peer rejection: A dynamic test of a developmental process. *New Directions for Child and Adolescent Development*, 2007(118), 77-89.
120. 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.
121. Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, 50(8), 3353-3369.
122. Lloyd-Richardson, E. E., Perrine, N., Dierker, L., & Kelley, M. L. (2007). Characteristics and functions of non-suicidal self-injury in a community sample of adolescents. *Psychological medicine*, 37(8), 1183.
123. Ludvigsson, J. F., Adolfsson, J., Höistad, M., Rydelius, P. A., Kriström, B., & Landén, M. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica*.
124. Lundborg, P. (2006). Having the wrong friends? Peer effects in adolescent substance use. *Journal of health economics*, 25(2), 214-233.
125. Mackay, C. (2012). Extraordinary popular delusions and the madness of crowds. Retrieved from <http://www.econlib.org/library/Mackay/macEx1.html>

126. McConaghy, N., Buhrich, N. & Silove, D. (1994), Opposite sex-linked behaviour and homosexual feelings in the predominantly heterosexual male majority. *Archives Sexual Behavior*, 23:565-577.
127. McManus, C. (2004) *Right hand, left hand: The origins of asymmetry in brains, bodies, atoms and cultures*. Cambridge, MA: Harvard University Press.
128. Meerwijk, E. L., & Sevelius, J. M. (2017). Transgender Population Size in the United States: a Meta-Regression of Population-Based Probability Samples. *American journal of public health (1971)*, 107(2), e1-e8. doi:10.2105/AJPH.2016.303578
129. Meredith, S. (2022). 1000 Families to sue Tavistock Gender Service. Medscape UK News, <https://www.medscape.co.uk/viewarticle/1000-families-sue-tavistock-gender-service-2022a10021ac>.
130. Michel, G. F., Babik, I., Nelson, E. L., Campbell, J. M., & Marcinowski, E. C. (2013). How the development of handedness could contribute to the development of language. *Developmental Psychobiology*, 55(6), 608-620.
131. Meili (2023). A.I. Mapping gender & social contagion rumors online are true. <https://pitt.substack.com/p/ai-mapping-gender-and-social-contagion>
132. Moynihan, C. (2021, October 1). Panic and threats as a small fraction of British doctors dissent from LGBTQ+ orthodoxy British doctors are being monstered by the trans lobby. *Mercaotnet*.
133. Muehlenkamp, J. J., Hoff, E. R., Licht, J.-G., Azure, J. A., & Hasenzahl, S. J. (2008). Rates of non-suicidal self-injury: A cross-sectional analysis of exposure. *Current Psychology*, 27(4), 234-241.
134. Mueller, A. S., Abrutyn, S., & Stockton, C. (2015). Can social ties be harmful? Examining the spread of suicide in early adulthood. *Sociological Perspectives*, 58(2), 204-222. doi:10.1177/0731121414556544
135. Nathan, O. H., & Kristina, L. (2014). The simple rules of social contagion. *Scientific Reports*, 4. doi:10.1038/srep04343
136. NHS. (2019). Referrals to the Gender Identity Development Service (GIDS). Retrieved from <https://tavistockandportman.nhs.uk/aboutus/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/>
137. NHS. (2020). Referrals to the Gender Identity Development Service (GIDS). Retrieved from <https://gids.nhs.uk/number-referrals>
138. NICE (2021). New systematic reviews of puberty blockers and cross-sex hormones https://segm.org/NICE_gender_medicine_systematic_review_finds_poor_quality_evidence

139. Niedzwiedz, C., Haw, C., Hawton, K., & Platt, S. (2014). The definition and epidemiology of clusters of suicidal behavior: a systematic review. *Suicide and Life-Threatening Behavior*, 44(5), 569-581.
140. Norton, Rose, & Fulbright. (2010). The Equality Act 2010 - one statute to cover all discrimination laws. Retrieved from <https://www.lexology.com/library/detail.aspx?g=7d353d53-b503-4e4a-b86c-c13940875143>
141. NSWDE. (undated-a). Bulletin 20 - Changing the way a student name is used and recorded by schools. Retrieved from <https://education.nsw.gov.au/about-us/rights-and-accountability/legal-issues-bulletins/bulletin-20-changing-the-way-a-student-name-is-used-and-recorded-by-schools>
142. NSWDE. (undated-b). Bulletin 55 - Transgender students in schools. Retrieved from <https://education.nsw.gov.au/about-us/rights-and-accountability/legal-issues-bulletins/bulletin-55-transgender-students-in-school>
143. Open Access Government. (2022). Study finds 2.5% of transgender kids go through detransition. Retrieved from <https://www.openaccessgovernment.org/study-finds-2-5-of-transgender-kids-go-through-detransition/135029/#:~:text=The%20research%20found%20that%202.5,gender%20identity%20after%20five%20years>
144. Otte, E., & Rousseau, R. (2002). Social network analysis: a powerful strategy, also for the information sciences. *Journal of information Science*, 28(6), 441-453.
145. Pang, K. C., de Graaf, N. M., D., C., & al., e. (2020). Association of media coverage of transgender and gender diverse issues with rates of referral of transgender children and adolescents to specialist gender clinics in the UK and Australia. *JAMA Netw Open*, 3(7), e2011161. doi:10.1001/jamanetworkopen.2020.11161
146. Papadatou-Pastou, M., Ntolka, E., Schmitz, J., Martin, M., Munafò, M. R., Ocklenburg, S., & Paracchini, S. (2020). Human handedness: A meta-analysis. *Psychological Bulletin*, 146(6), 481.
147. Patterson, G. R., Littman, R. A., & Bricker, W. (1967). Assertive behavior in children: A step toward a theory of aggression. *Monographs of the Society for Research in Child Development*, 32(5), iii-43.
148. Phillips, D. P. (1974). The influence of suggestion on suicide: Substantive and theoretical implications of the Werther effect. *American Sociological Review*, 39(3), 340-354.
149. Porac, C. (2015). *Laterality: Exploring the enigma of left-handedness*. Academic Press.

150. Reisner, S. L., Conron, K. J., Tardiff, L. A., Jarvi, S., Gordon, A. R., & Austin, S. B. (2014). Monitoring the health of transgender and other gender minority populations: validity of natal sex and gender identity survey items in a US national cohort of young adults. *BMC public health*, 14(1), 1-10.
151. Respaut, R. & Terhune, C. (2022, October 6). Putting numbers on the rise in children seeking gender care. *Reuters*, <https://www.reuters.com/investigates/special-report/usa-transyouth-data/#:~:text=Puberty%20blockers&text=Their%20off%2Dlabel%20use%20in,a%20prior%20gender%20dysphoria%20diagnosis>.
152. Richtel, M. (2020). W.H.O. Fights a Pandemic Besides Coronavirus: An 'Infodemic'. *New York Times*. Retrieved from <https://www.nytimes.com/2020/02/06/health/coronavirus-misinformation-social-media.html>
153. Roberts, A. L., Rosario, M., Corliss, H. L., Koenen, K. C., & Austin, S. B. (2012). Childhood gender nonconformity: A risk indicator for childhood abuse and posttraumatic stress in youth. *Pediatrics*, 129(3), 410.
154. Roberts, A. L., Rosario, M., Slopen, N., Calzo, J. P., & Austin, S. B. (2013). Childhood gender nonconformity, bullying victimization, and depressive symptoms across adolescence and early adulthood: an 11-year longitudinal study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(2), 143-152.
155. Rowe, P. (2016). How a girl born at 2 pounds became a happy boy. Retrieved from <http://www.sandiegouniontribune.com/lifestyle/people/sdut-transgender-teensnew-life-2016apr07-story.html>
156. Rufo, C. (2022). Portland Public Schools curricular on gender <https://twitter.com/realchrisrufo/status/1552391305778860032>
157. Salai, S. (2023). Portland Public Schools defends teaching transgender ideology to kindergartners.
158. <https://www.washingtontimes.com/news/2022/aug/1/portland-public-schools-defends-teaching-transgend/>
159. Savin-Williams, R. C., Cash, B. M., McCormack, M., & Rieger, G. (2017). Gay, mostly gay, or bisexual leaning gay? An exploratory study distinguishing gay sexual orientations among young men. *Archives of Sexual Behavior*, 46(1), 265-272.
160. SBU. (2022). Hormone therapy in gender dysphoria - children and adolescents: a systematic review and evaluation of medical aspects. Stockholm: The National Committee for Medical and Social Evaluation (SBU); SBU Evaluates 342. <https://www.sbu.se/342>.

161. Schwartz-Mette, R., & Rose, A. (2012). Co-rumination mediates contagion of internalizing symptoms within youths' friendships. *Developmental Psychology*, 48(5), 1355-1365. doi:10.1037/a0027484
162. Schwartz, D. (2012). Listening to children imagining gender: Observing the inflation of an idea. *Journal of homosexuality*, 59(3), 460-479.
163. Sentse, M., Scholte, R., Salmivalli, C., & Voeten, M. (2007). Person–group dissimilarity in involvement in bullying and its relation with social status. *Journal of Abnormal Child Psychology*, 35(6), 1009-1019.
164. Shrier, A. (2019). The transgender war on women: The Equality Act sacrifices female safety in restrooms, locker rooms and even domestic-violence shelters. *Wall St Journal*.
165. Siddique, H. (2021, 5 June). Stonewall is at centre of a toxic debate on trans rights and gender identity. *The Guardian*. Retrieved from <https://www.theguardian.com/society/2021/jun/05/stonewall-trans-debate-toxic-gender-identity>
166. Sijtsema, J. J., Veenstra, R., Lindenberg, S., & Salmivalli, C. (2009). Empirical test of bullies' status goals: Assessing direct goals, aggression, and prestige. *Aggressive Behavior: Official Journal of the International Society for Research on Aggression*, 35(1), 57-67.
167. Singal, J. (2018, July/August). When children say they're trans: Hormones? Surgery? The choices are fraught—and there are no easy answers. *The Atlantic*. Retrieved from <https://www.theatlantic.com/magazine/archive/2018/07/when-a-child-says-shes-trans/561749/>
168. Smith, D. S., & Juvonen, J. (2017). Do I fit in? Psychosocial ramifications of low gender typicality in early adolescence. *Journal of Adolescence*, 60, 161-170. doi:<https://doi.org/10.1016/j.adolescence.2017.07.014>
169. Smith, S. (2015). Gender reassignment surgery is now available to oregon minors without parental consent. *Medical Daily* Retrieved from <https://www.medicaldaily.com/gender-reassignment-surgery-now-available-oregon-minorswithout-parental-consent-342670>
170. Socialstyrelsen NBHW (2022). Care of children and adolescents with gender dysphoria. p. 3, <https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2022-3-7799.pdf>.
171. Stack, S. (2005). Suicide in the media: A quantitative review of studies based on nonfictional stories. *Suicide and Life-Threatening Behavior*, 35(2), 121-133.
172. Staphorsius, A. S., Kreukels, B. P., Cohen-Kettenis, P. T., Veltman, D. J., Burke, S. M., Schagen, S. E., . . . Bakker, J. (2015). Puberty suppression and executive functioning: an fMRI-study in adolescents with gender dysphoria. *Psychoneuroendocrinology*, 56, 190-199.

173. Steinberg, L., & Monahan, K. C. (2007). Age differences in resistance to peer influence. *Developmental Psychology*, 43(6), 1531-1543. doi:10.1037/0012-1649.43.6.1531
174. Strickland, S. (2014). *To treat or not to treat: Legal responses to transgender young people -Navigating the waters of shared parenting: Guidance from the harbour*. Paper presented at the Association of Family and Conciliation Courts 51st annual conference, Toronto.
175. Strickland, S. (2015). *To treat or not to treat: Legal responses to transgender young people revisited*. Paper presented at the Association of Family and Conciliation Courts Australian Chapter Conference, Sydney, Australia.
176. Sun, T., Viswanathan, S., & Zheleva, E. (2021). Creating Social Contagion Through Firm-Mediated Message Design: Evidence from a Randomized Field Experiment. *Management Science*, 67(2), 808-827. doi:10.1287/mnsc.2020.3581.
177. Swedish Public Service Television Co. April 3, 2019. Mission: Investigate. The trans train and the teenage girls. Tranståget och tonårsflickorna. Video in Swedish. Accessed December 28, 2021. <https://www.svtplay.se/video/21717158/uppdrag-granskning/uppdrag-granskning-sasong-20-avsnitt-12a>
178. Tavistock and Portman NHS Foundation Trust. (2019). Referrals to the Gender Identity Development Service (GIDS) level off in 2018–19.
179. Taylor, J. (2019). Bill to allow transgender people to change birth certificate without surgery clears first hurdle in Victoria. *The Guardian*. Retrieved from <https://www.theguardian.com/australia-news/2019/aug/15/bill-to-allow-transgender-peoplechange-birth-certificate-without-surgery-clears-first-hurdle-in-victoria>
180. Telfer, M., Tollit, M., Pace, C., & Pang, K. (2021). *Australian standards of care and treatment guidelines for trans and gender diverse children and adolescents*. Version 1.3. Melbourne: Royal Children’s Hospital.
181. The Lancet, Editorial (2021). *A flawed agenda for trans youth*. [https://www.thelancet.com/pdfs/journals/lanchi/PIIS2352-4642\(21\)00139-5.pdf](https://www.thelancet.com/pdfs/journals/lanchi/PIIS2352-4642(21)00139-5.pdf)
182. Teufel, G. (2015). Brief of Walt Heyer, Jamie Shupe, Linda Seiler, Hacs Horvath, Clifton Francis Burleigh, Jr., Laura Perry, Jeffrey Johnston, Jeffrey McCall and Kathy Grace Duncan. https://www.supremecourt.gov/DocketPDF/18/18-107/113528/20190824011904782_18-107%20Amicus%20Brief%20of%20Walt%20Heyer%20et%20al..pdf
183. Tulloch, L. (2019). Athletes with differences of sex development (DSD). Retrieved from <https://www.acsep.org.au/page/news/blog/athletes-with-differences-of-sex-development-dsd>

184. Turban, J. L., Carswell, J., & Keuroghlian, A. S. (2018). Understanding pediatric patients who discontinue gender-affirming hormonal interventions. *JAMA Pediatrics*, 172(10), 903-904. doi:10.1001/jamapediatrics.2018.1817
185. Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS one*, 17(1), e0261039.
186. Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors leading to “detransition” among transgender and gender diverse people in the United States: A mixed-methods analysis. *LGBT Health*, 8(4), 273-280.
187. Turner, J. H. (2007). *Human emotions: A sociological theory*. London: Routledge.
188. Turner, M.E. & Pratkanis, A.R. (1998). Twenty-five years of groupthink theory and research: Lessons from the evaluation of a theory. *Organizational Behavior and Human Decision Processes*, 73, 105–115.
189. Vandebussche, E. (2022). Detransition-related needs and support: A cross-sectional online survey. *Journal of homosexuality*, 69(9), 1602-1620. doi:10.1080/00918369.2021.1919479
190. Vrouenraets, L. J., Fredriks, A. M., Hannema, S. E., Cohen-Kettenis, P. T., & de Vries, M. C. (2015). Early medical treatment of children and adolescents with gender dysphoria: An empirical ethical study. *Journal of Adolescent Health*, 57(4), 367-373.
190. Walther, A., Breidenstein, J., & Miller, R. (2019). Association of testosterone treatment with alleviation of depressive symptoms in men: a systematic review and meta-analysis. *JAMA psychiatry*, 76(1), 31-40.191. Whitehall, J. (2019). Guidelines for the destruction of female sport. Retrieved from <https://quadrant.org.au/magazine/2019/09/guidelines-for-the-destruction-of-female-sport/>
191. Wiepjes, C. M., den Heijer, M., Bremmer, M. A., Nota, N. M., de Blok, C. J. M., Coumou, B. J. G., & Steensma, T. D. (2020). Trends in suicide death risk in transgender people: results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017). *Acta Psychiatrica Scandinavica*, 141(6), 486-491. doi:https://doi.org/10.1111/acps.13164.
192. Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., . . . Cohen-Kettenis, P. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *The Journal of Sexual Medicine*, 15(4), 582-590.
193. Wilkens, S.B. (2015). Brief of the American Medical Association, the American College of Physicians and 14 additional medical, mental health and health care organizations as Amici Curiae. Supreme Court of the United States,

https://www.supremecourt.gov/DocketPDF/18/18107/107178/20190703172653326_Amicus%20Brief.pdf.

194. WMA. (2015). World Medical Association (WMA) statement on transgender people. Retrieved from <https://www.wma.net/policies-post/wma-statement-on-transgender-people>
195. Wood, H., Sasaki, S., Bradley, S. J., Singh, D., Fantus, S., Owen-Anderson, A., ... & Zucker, K. J. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy*, 39(1), 1-6.
196. WordPress. (2020). Activist-driven transgender research methods are reckless and will lead to harms. Retrieved from <https://stoptransingkids.wordpress.com/>
197. WPATH. (2022). WPATH Standards of Care Version 8. Retrieved from <https://www.wpath.org/soc8>
198. Yu, S., Mangrum, M. (2021). Bill allowing parents to opt children out of LGBTQ-related curriculum passes state legislature. Nashville Tennessean. <https://www.tennessean.com/story/news/politics/2021/04/14/tennessee-passes-bill-letting-parents-opt-out-lgbtq-related-school-lessons/7219254002/>
199. Zhang, Q., Goodman, M., Adams, N., Corneil, T., Hashemi, L., Kreukels, B., . . . Coleman, E. (2020). Epidemiological considerations in transgender health: A systematic review with focus on higher quality data. *International journal of transgender health*, 21(2), 125-137. doi:10.1080/26895269.2020.1753136
200. Zosuls, K. M., Andrews, N. C., Martin, C. L., England, D. E., & Field, R. D. (2016). Developmental changes in the link between gender typicality and peer victimization and exclusion. *Sex Roles*, 75(5-6), 243-256.
201. Zucker, K. (2008). Reflections on the relation between sex-typed behavior in childhood and sexual orientation in adulthood. *Journal of Gay & Lesbian Mental Health*, 12,1 -2, 29-59.
202. Zucker KJ. (2017). Epidemiology of gender dysphoria and transgender identity. *Sex Health*, 14(5):404–411.
203. Zucker, K. J., Bradley, S. J., Owen-Anderson, A., Kibblewhite, S. J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex & Marital Therapy*, 38, 151–189.

Exhibit A

Professor Dianna Theadora KENNY

Mob: [REDACTED]

E: diannatkenny1@gmail.com

ABN [REDACTED]

Professor of Psychology (rtd)

Consultant Psychologist and Psychotherapist

Registered psychologist (No. 0005390)

AHPRA number PSY0001136350, specialist endorsements: developmental, educational, and counselling psychology

Medicare Provider No 2876971T

Marriage and Family Therapist (Relationships Australia)

Nationally Accredited Mediator (Australian Dispute Resolution Association)

Family Dispute Resolution Practitioner (No. R1005291) (NSW College of Law)

ABBREVIATED CURRICULUM VITAE

Current	2019 -	Principal, DK Consulting (Psychology, psychotherapy, family dispute resolution, and medico-legal services)
Previous appointments	2013-2019	Hon Professor of Psychology, Professor of Music, The University of Sydney
	2006-2013	Professor of Psychology, The University of Sydney
	1988-2006	A/Professor, Senior Lecturer, Lecturer in Psychology, The University of Sydney
	1986-1987	Psychologist in private practice
	1986-1987	Lecturer in School Counselling, School of Counselling and Disabilities Studies, The University of Western Sydney
	1983-1985	Regional Specialist Counsellor for Emotionally Disturbed Children, Liverpool region, Division of Guidance and Special Education, NSW Department of Education
	1978-1983	District School Counsellor, NSW Department of Education
	1976-77	Teacher, Haberfield Demonstration School, Haberfield, NSW

University Qualifications

1988	Doctor of Philosophy (PhD) (Developmental and Educational Psychology), Macquarie University (School of Behavioural Sciences)
1980	Master of Arts (School Counselling), [M.A. (Sch. Couns.)], Macquarie University (School of Behavioural Sciences)
1974	Bachelor of Arts (Honours - Psychology) [B.A. (Hons)] The University of Sydney

Other Qualifications

2016	Postgraduate Diploma in Family Dispute Resolution (PG Dip FDR) (NSW College of Law)
2015	Nationally accredited mediation training – Resolution Institute
1986	Diploma in Clinical Hypnotherapy (DCH), Australian Society of

1982	Clinical Hypnotherapists Certificate in Marriage and Family Therapy, Marriage Guidance Council, N.S.W. (now Relationships Australia).
1977	Associate Diploma in piano (ATCL), Trinity College of Music, London
1975	Diploma in Education, (DipEd) Sydney Teachers' College

Registrations and Accreditations

Psychology Board of Australia (No.0005390)
Australian Health Practitioner Regulation Agency (PSY0001136350)
Approved Medicare provider (No 2876971T)
Nationally accredited Mediator (LEADR, Australian Dispute Centre)
Family Dispute Resolution Practitioner (NSW College of Law)(Registered with Attorney General Department) (No. R1005291)

Membership of professional societies

Member, Australian Psychological Society: Specialist Accreditations
Academic Member, College of Developmental and Educational Psychologists
Fellow, APS College of Counselling Psychologists
Member, American Psychological Society
Member, Society for Psychotherapy Research
Member, International Association of Relational Psychoanalytic Psychotherapy
Elected Member, New York Academy of Sciences
Member, Australian Dispute Resolution Association
International affiliate, American Psychological Association

Consultancies relevant to psychology and the law, transgender issues in children and adolescents (informed consent, assessment and suitability, family conflict, comorbid conditions), child sexual abuse, sex offending, and sexual misconduct

Expert report writer, Human Rights Law Alliance
Expert report writer, Amicus Briefs for cases occurring in Australia, Canada, and USA
Expert reviewer/report writer, Office of the Director of Public Prosecutions, Armidale, Gosford, Lismore, Parramatta, Penrith, Sydney, Tamworth, Wagga Wagga, Wollongong
Expert reviewer /report writer, Crown Solicitors' Office, Sydney
Expert reviewer/report writer, Victorian Government Solicitor's Office (VGSO)
Expert reviewer/report writer, Joint Investigative Response Team (JIRT), NSW Police – Blacktown, Chatswood, Coffs Harbour, Manly, Penrith, Tamworth
Expert reviewer/report writer, Health Care Complaints Commission (HCCC) – NSW, Victoria, and Western Australia
Expert developmental psychologist, various Barristers chambers
Assessment psychologist, Aboriginal Legal Service
Research consultant, *NSW Department of Juvenile Justice*
Research consultant, *Justice Health NSW*
Research consultant, *Youth Justice Coalition* (pro bono)

Research consultant, *Public Interest Advocacy Centre* (pro bono)
Consultant investigative psychologist (of alleged child sexual abuse), *St Joseph's College, Hunter's Hill*
Consultant psychologist, *Tribunal of the Catholic Church*

Expert reviewer for Joint Investigative Response Team, NSW Police

- Provide advice and court reports on cases related to child sexual assault, including reports of historical child sexual abuse
- Appraise the quality and plausibility of disclosures made by complainants in cases of current and historical sexual abuse
- Provide literature reviews and advice on the status of recovered memories, the reliability of childhood memory, and memory processes over time and factors that can alter or affect memories
- Provide advice on language development, children's use of and understanding of sexual language
- Provide expert advice on other matters related to criminal offending against children.
- Provide expert advice on the nature of psychopathologies arising from child sexual abuse

Expert developmental psychologist for various Barristers chambers, Crown Solicitor, and Office of the Director of Public Prosecutions

- Provision of expert reports on matters pertaining to child development
 - credibility and reliability assessments of disclosures of child sexual abuse
 - Reasons for delay of disclosures of child sexual abuse
 - memory and language development as it pertains to child sexual abuse disclosures
 - evaluation of "recovered memories"
 - Long term impacts of child sexual abuse
 - Capacity for consent

Court referred clients

- In cases of parental alienation, assess the quality and veracity of accusations of emotional, physical and sexual abuse of children in divorcing couples undergoing family court proceedings for custody and access of the children of the marriage, and report these findings to the court.
- Assess parenting capacity in separating and divorcing parents to ascertain child safety and capacity of parents to undertake shared parental responsibility.
- Where mandated by the court, provide assessment, counselling and therapy for accused fathers and report on the alleged risks to their children while in their care.

Expert reviewer for the Health Care Complaints Commission

- Investigate complaints against psychologists for malpractice and misconduct, including sexual misconduct, and other conduct that falls below the standard expected of the profession.
- Undertake review and critical appraisal of treatments offered by psychologists and whether those treatments have been collusive, coached, suggestive or in other ways biased with

respect to issues of child sexual abuse, including historical sexual abuse.

- Evaluate psychologists' psychological practice, evidence-base for therapeutic interventions, and competence in implementing psychological therapies.
- Undertake file review of documents (letters, submissions, complaints, statements, accounts of therapy, therapy case notes) from complainants and defendants, report writing, participation in conclaves, and court appearances.

Consultant Psychologist to the Tribunal of the Catholic Church

- Assessment of marriages for annulment
- Assessment of claims of sexual abuse within marriage and non-consummation of marriage, among other relationship issues.

Research on sexual offending in young sex offenders

- Extensive research undertaken on sexual offending examining life histories and precursors to sexual offending, young offenders' experience of sexual abuse, and other forms of maltreatment for the NSW Department of Juvenile Justice.

Ministerial and other Appointments in Psychology and the Law

2013 Board Member, Daystar Foundation (a foundation for the provision of vocational training and employment to 'at risk' young people)

2003-2009 Chair, Ministerial Steering Committee, NSW Department of Juvenile Justice Collaborative Research Unit

2003-2009 Member, Ministerial Steering Committee on Sexual Offending, New South Wales Department of Corrective Services

2002 A/Chair, Ministerial Reference Group on Sexual Offending, New South Wales Department of Corrective Services

2001 Member, Ministerial Reference Group on Sexual Offending, New South Wales Department of Corrective Services

2003 COCQOG (Commonwealth Cost and Quality of Government): External Reviewer of Psychological Services and Specialist Programs, NSW Department of Juvenile Justice

1996-2002 Deputy Chair, Ministerial Steering Committee, NSW Department of Juvenile Justice Collaborative Research Unit

1997-2003 Chair, Research and Ethics Subcommittee, NSW Department of Juvenile Justice Collaborative Research Unit

Expertise

I divide my expertise into five key areas –

- (a) Gender dysphoria (GD) in children and adolescents including a clinical practice working with young people with GD and their parents/families and schools. I bring my decades of experience working with children and families to my practice in working with young people with GD (key areas b, c, d, and e are all relevant to my clinical practice in gender dysphoria).

- (b) Child development – including children’s social, emotional and cognitive development, assessment of children’s attachment to primary care givers, peer relationships, cognitive abilities including intelligence, memory and language; assessment of developmental psychopathologies and behavioural disorders and provision of therapy for same.
- (c) Matters pertaining to child sexual abuse, including the disclosure of child sexual abuse, the impact of sexual abuse on children, historical child sexual abuse and its reporting, and issues of repressed or false memory, grooming by paedophiles, and counter-intuitive behaviour.
- (d) Matters pertaining to school performance and achievement, psychometric assessment of intelligence, assessment of literacy and numeracy and specific learning disabilities.
- (e) Family dispute resolution (I am an FDRP registered with the Attorney General’s Department) in which role I assess alleged offences of one parent against another and/or their children in the context of family court proceedings. I report on issues such as access, parental alienation, and child stress in the context of contested divorce and custody disputes.

(a) Gender dysphoria in children and adolescents

I have a busy clinical practice specializing in the treatment of gender dysphoric children and young people, their parents and families. I have contributed invited submissions to government here in Australia and overseas on matters relevant to education policy on transgender declaring children and adolescents and acceptable therapies with which to treat them. I have published in the area and provided expert reports on disputes regarding treatment of gender dysphoric young people whose cases reach the Family Court.

Key publications (Books, edited books, book chapters, journal articles)

Kenny, D.T. (2020). *Gender dysphoria in children and young people: Collected papers on the psychology, sociology and ethics of gender transitioning*. Germany: Scholars Press.

This book critiques gender dysphoria in young people and its current treatments that include gender affirmation therapy involving puberty blocking agents, cross sex hormones and sex reassignment surgery. I examine the safety of these treatments, evidence of efficacy, capacity of children and young people to give consent to life altering treatments, the social impacts of transgender individuals, particularly in women’s sport, and the social contagion of gender dysphoria.

D’Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., **Kenny, D. T.**, & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50(1), 7-16.

Holloway, G., **Kenny, D.T.**, Deves, K., ...Parkinson, P., Morris, P., & Halasz, G. (2021). Australian perspectives on transgendering children and adolescents: Implications for policy and practice. Hobart: Author.

Kenny, D.T. (2020). Gender development and the transgendering of children. In H. Brunskell-Evans and M. Moore. *The fabrication of the transgender child*. Cambridge: Cambridge Scholars Press.

D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., **Kenny, D.T.**, and Clarke, P. (November 2020). Jack Turban's dangerous campaign to smear ethical psychotherapy as anti-trans 'conversion therapy'. *Quillette*. <https://quillette.com/2020/11/01/jack-turbans-dangerous-campaign-to-smear-ethical-psychotherapy-as-anti-trans-conversion-therapy/>

Kenny, D.T. (2021). *Opposing the teaching of gender fluidity ideology: The Education Legislation Amendment (Parental Rights) Bill 2020* (pp. 13-22). In Holloway, G., **Kenny, D.T.**, Deves, K., ...Parkinson, P., Morris, P., & Halasz, G. (2021). *Australian perspectives on transgendering children and adolescents: Implications for policy and practice*. Hobart: Author.

Kenny, D.T. (2021). *The social contagion of gender dysphoria: a theoretical and empirical proposition* (pp. 56-70). In Holloway, G., **Kenny, D.T.**, Deves, K., ...Parkinson, P., Morris, P., & Halasz, G. (2021). *Australian perspectives on transgendering children and adolescents: Implications for policy and practice*. Hobart: Author.

Submissions to government inquiries

Kenny, D.T. (2021). Submission to the NSW Parliamentary Inquiry: Education Legislation Amendment (Parental Rights) Bill 2020.

<https://www.parliament.nsw.gov.au/lcdocs/submissions/70648/0005%20Professor%20Diana%20Kenny.pdf> and

[https://www.parliament.nsw.gov.au/lcdocs/inquiries/2610/Report%20No%2044%20-%20PC%203%20-%20Education%20Legislation%20Amendment%20\(Parental%20Rights\)%20Bill%202020.pdf](https://www.parliament.nsw.gov.au/lcdocs/inquiries/2610/Report%20No%2044%20-%20PC%203%20-%20Education%20Legislation%20Amendment%20(Parental%20Rights)%20Bill%202020.pdf)

Kenny, D.T. (2020). Submission and invited presentation to the Queensland government Inquiry into the proposed *Health Legislation Amendment Bill 2019* to outlaw conversion therapy.

[https://diannakenny.com.au/images/pdfs/Submission to the Queensland Inquiry into Outlawing Conversion Therapy.pdf](https://diannakenny.com.au/images/pdfs/Submission%20to%20the%20Queensland%20Inquiry%20into%20Outlawing%20Conversion%20Therapy.pdf) and
<https://documents.parliament.qld.gov.au/tableOffice/TabledPapers/2020/5620T328.pdf>

Kenny, D.T. (July 2020). Submission to the ACT government into proposed amendments to outlaw conversion therapy.

Clinical guidelines

... **Kenny, D.T.** (November, 2022). *A clinical guide for therapists working with gender-questioning youth*. Co-published by GETA (Gender Exploratory Therapy Association) and SEGM in 2022.

https://www.genderexploratory.com/wp-content/uploads/2022/12/GETA_ClinicalGuide_2022.pdf

Morris, P. **Kenny, D.T.**..... (May, 2021). *Managing Gender Dysphoria/Incongruence in Young People: A Guide for Health Practitioners*. National Association of Practising Psychiatrists. <https://napp.org.au/2021/05/managing-gender-dysphoria-incongruence-in-young-people-a-guide-for-health-practitioners/>

Keynote and invited presentations, and podcasts

Kenny, D.T. (2023, April 2-3). *Gender exploratory dynamic and systemic psychotherapy for gender dysphoric young people and their families*. Keynote presentation to the Coalition Advancing Scientific Care (CASC), Adelaide, Australia.

Phil Dye Podcast

Kenny, D.T. (2023). Pushing back against the madness
https://open.substack.com/pub/phildye/p/ep-4-pushing-back-against-madness?r=207ikj&utm_campaign=post&utm_medium=web

John Uhler Podcast

<https://www.youtube.com/watch?v=ihoglmv-E>

Kenny, D.T. (2023). The medical scam of the century (Parts 1 and 2)
[Episode #22 - Part 1 - Jon Uhler and Dr. Kenny Discuss Medical Scam Of The Century On Children](#)

[Episode #22 - Part 2 - Jon Uhler and Dr. Dianna Kenny Discuss The Crime Of The Century On Children](#)

TERF Talk

Kenny, D.T. (2022). The psychology of gender dysphoria
<https://www.youtube.com/watch?v=sZbEsaJMvRU>

Kenny, D.T. (2022). Gender development and sexual orientation. *Proceedings of the CATA Gender Conference: Children, adolescents and gender—Impacts of transgender ideology*.
<https://www.youtube.com/playlist?list=PLhQF8k91j3KjjHSzOlq-A0iUqLSD3OhIY>

Kenny, D.T. (2022). Exploratory therapies for young transgender declaring children and adolescents: There are sane alternatives to gender-affirmation treatment:
https://www.youtube.com/watch?v=sZbEsaJMvRU&ab_channel=TERFTalkDownUnder.

Kenny, D.T. (November 2022). Presentation to the Tasmanian parliamentary forum on the proposed legislation to ban conversion therapy proposed by the Tasmanian Law Reform Institute (TLRI).

Kenny, D.T. (5 August 2022). Gender development and sexual orientation. Keynote presentation to the Child and Adolescent Therapists Association of Aotearoa New Zealand.

Kenny, D.T. (12 November 2022). Presentation to the *no sex self-identification in Queensland*, public meeting, Brisbane, hosted by feminist group IWD Brisbane Meanjin.

Kenny, D.T. (26 February 2022). ROGD, faulty science and social contagion: Origins of a psychic epidemic, Invited presentation to Tasmanian forum on gender identity, Hobart Town Hall, for Coalition for Biological Reality.

Kenny, D.T. (2021). *Transgendering our young people: Faulty science, psychic epidemic*. Invited lecture to the Faculty of Medicine, Notre Dame University, Sydney, Australia.

Kenny, D.T. (April 2021). The social contagion of transgenderism in adolescents and social institutions. Presentation to PRCP Conference.

Kenny, D.T. (2020). *Affirmation only: Where's the evidence*. Invited presentation to the Catholic Medical and Bioethical Conference, 30 May.

Kenny, D.T. (18 February 2020). *Is gender dysphoria socially contagious?* Invited presentation to the NSW Parliamentary Forum on gender dysphoria in our young people.

Kenny, D.T. (2020). *Transgender ideology and the trans-gendering of young people*. Invited presentation to the Northern Area Mental Health Network, NSW Department of Health, 12 February.

Kenny, D.T. (2019). *Children and young people seeking and obtaining treatment for gender dysphoria in Australia: Trends by state over time (2014-2018)*. Paper presented at the Forum on transgender children and adolescents at the Parliament of NSW, 2 July 2019. [Children and young people seeking and obtaining treatment for gender dysphoria in Australia: Trends by state over time \(2014-2018\) - Professor Dianna Kenny](#)

Kenny, D.T. (2019). Female sport participation and gender affirmation: A collision course for medical ethics. Invited presentation to Melbourne consortium of parents of transgender declaring children. 12-13 October. [Female sport participation and gender affirmation: A collision course for medical ethics - Professor Dianna Kenny](#)

Kenny, D.T. (2015). The talking cure, ABC Radio National. <https://www.abc.net.au/radionational/programs/allinthemind/the-talking-cure/6478848>
For other contributions to the gender dysphoria debate, go to <https://www.diannakenny.com.au/>

(b) Child and adolescent development

- (i) I commenced my professional life as a primary school teacher, then became a school counsellor, and specialist counsellor for emotionally disturbed children with the NSW Department of Education. I held these positions for 10 years before joining The University of Sydney, where I rose to the rank of Professor of Psychology in 2006.
- (ii) I hold a PhD in developmental and educational psychology, a master's degree in School Counselling, an honours degree in psychology and postgraduate diplomas in education and family dispute resolution.
- (iii) I am a recognised expert in child development. I have designed and lectured in a range of courses at undergraduate and postgraduate levels pertaining to child development including: Developmental psychology; developmental psychopathology; infant and child study (with a focus on language and cognitive development); attachment theory; the psychological and cognitive assessment of children; and the developmental foundations of stress and coping.
- (iv) I have major publications in the area of child development.
- (v) I have provided reports on children to the courts and police, including on issues in child development such as language and cognitive development, childhood memory and its

reliability, and adverse experiences that impair normal development such as attachment trauma and environmental risks to safety and security.

- (vi) I am able to provide comprehensive literature reviews on most subjects related to child development.

Key publications:

Kenny, D.T. (2013). *Bringing up baby: The psychoanalytic infant comes of age*. London: Karnac.

This book examines the development of children, from birth to adolescence. It provides a detailed analysis of all modes of development including cognitive and social development, language development, the development of memory, the role of secure attachments in emotional development and the contribution of developmental neuroscience to our understanding of infant and child development.

Kenny, D.T. (2007). *Lifespan development: Theories and research*. The University of Sydney: Author.

This comprehensive manual describes how people develop and change throughout the lifespan, critically evaluates how cultural, historical, and economic factors influence development, presents the major psychosocial, emotional, and cognitive developmental theories, discusses the major controversies in developmental psychology, integrates different theoretical perspectives on development, and applies developmental theory to healthcare practice. It includes a critical review of the methods and research approaches (including genetic, comparative, cross cultural, ethological, and ecological) in developmental psychology and research designs (including cross-sectional, cohort and longitudinal, time lag and sequential).

Schofield, P., Mason, R., Nelson, P.K., **Kenny, D. T.**, & Butler, T. (2018). Traumatic brain injury is highly associated with self-reported childhood trauma within a juvenile offender cohort. *Brain Injury*, DOI: [10.1080/02699052.2018.1552020](https://doi.org/10.1080/02699052.2018.1552020).

Kenny, D.T. (2016). The adolescent brain: Implications for assessing young offenders' legal competence. *Judicial Officers' Bulletin* (Judicial Commission of NSW), April 28, 3, 23-27.

Kenny, D.T., Blacker, S. & Allerton, M. (2014). *Reculer pour mieux sauter: A review of attachment and other developmental processes inherent in identified risk factors for juvenile delinquency and juvenile offending*. *LAWS*, 3, 439–468; doi:10.3390/laws3030439.

Kenny, D.T., & Nelson, P.K. (2008). *Young offenders on community orders: Health, welfare, and criminogenic needs*. Sydney, Australia: Sydney University Press. ISBN 978-0-9804117-0-6.

Kenny, D.T. (2001). Cognitive-developmental theory. In Carol Jones (Ed). *Readers' Guide to the Social Sciences Volume 1*, pp. 230-231. London, United Kingdom: Fitzroy Dearborn Publishers.

Kenny, D.T. (2001). Nature and nurture. In Carol Jones (Ed). *Readers' Guide to the Social Sciences Volume 1*, pp 1105-1106. London, United Kingdom: Fitzroy Dearborn Publishers.

Kenny, D.T. (2000). Psychological foundations of stress and coping: A developmental perspective. In Kenny, D.T., Carlson, J. G. McGuigan, F. J. & Sheppard J. L. (Eds.). *Stress and health: Research and clinical applications*. Ryde, NSW: Gordon Breach Science/Harwood Academic Publishers (pp. 73-104).

Kenny, D.T. & Waters, B. (1995). Current issues in adolescent mental health. In D.T. Kenny and R.F.S. Job (Eds). *Australia's Adolescents: A Health Psychology Perspective*. Armidale: University of New England Press (pp 68-88).

Kenny, D.T. & Job, R.F.S. (Eds.) (1995). *Australia's adolescents: A health psychology perspective* (272 pages). Armidale: University of New England Press ISBN 1 875821 24 4.

(c) Child sexual abuse (CSA)

I provide expert reports on child complainants and alleged adult sex offenders to Joint Investigative Response Teams and Child Abuse Teams within the NSW Police. I have current experience:

- (i) in counselling CSA victims.
- (ii) providing structural and psychological analysis of CSA victim statements. I have developed specific expertise in the assessment of child testimony in sexual abuse cases.
- (iii) reviewing video recordings of police interviews with alleged victims of CSA and providing commentary on the pertinent psychological issues.
- (iv) providing expert statements and reviews of literature on matters pertaining to child development in general and CSA in particular, for the ODPP, Police, JIRT, barristers, and court.
- (v) acting as an expert witness in cases of child sexual abuse, historical child sexual abuse, and paedophilia.
- (vi) I have given evidence in court and have been cross-examined.
- (vii) I have extensive knowledge of the child abuse literature and have written a book on the subject (see below).
- (viii) I am able to provide comprehensive literature reviews on most subjects related to child sexual abuse.
- (ix) I have publications – book, journal articles, monographs – on sex offending and have served on ministerial committees within the NSW Department of Juvenile Justice and the NSW Department of Corrective Services.

Key publications:

Kenny, D.T. (2018). *Children, sexuality, and child sexual abuse*. East Sussex, UK: Routledge.

This book has become a seminal text in the field because of its wide-ranging coverage and attention to all the recent research in the field, including the *Royal Commission into Institutional Responses to Child Sexual Abuse*. It covers all the key topics in child sexual abuse, including the nature of disclosures, both immediate and delayed, and their reliability; normal memory development and distortions of memory that can occur from a range of environmental influences including leading and suggestive interviewing; impacts of child sexual abuse, including short- and long-term consequences; assessment and forensic analysis of witness statements, and psychological analysis of CSA victim statements.

Kenny, D.T. (1997). Opinion, policy and practice in child sexual abuse: Implications for detection and reporting. In M. James (Ed.). *Paedophilia: Policy and prevention*. Research and Public Policy Series No 12: Australian Institute of Criminology, Sydney, Australia. ISSN 1326-6004. (pp 14-31).

In addition, last year I wrote a major report on paedophilia for the Child Abuse Squad, Ballina, addressing the question as to whether an individual in possession of child abuse material is a paedophile. This question had not been explicitly dealt with in the literature. Accordingly, I undertook

major research on the subject and produced a report that the presiding judge allowed to be admitted into evidence to demonstrate tendency. The solicitor for the ODPP advised me that my report “may create a precedent for use in future similar matters.”

(d) Juvenile offending and juvenile sex offending

For a number of years, I chaired or was a member of several committees within the NSW Department of Juvenile Justice and the New South Wales Department of Corrective Services, including Chair, Ministerial Steering Committee, NSW Department of Juvenile Justice Collaborative Research Unit, Chair, Research and Ethics Subcommittee, NSW Department of Juvenile Justice Collaborative Research Unit, Chair, Ministerial Steering Committee on Sexual Offending, New South Wales Department of Corrective Services, A/Chair and Member, Ministerial Reference Group on Sexual Offending, New South Wales Department of Corrective Services.

Kenny, D.T., Seidler, K., Keogh, T., & Blaszczynski, A., (2000). Offence and clinical characteristics of Australian juvenile sex offenders. *Psychiatry, Psychology, and the Law*, 7, 2, 212-227.

Kenny, D.T., Keogh, T., & Seidler, K. (2001). Predictors of recidivism in Australian juvenile sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 13, 2, 131-148.

Kenny, D.T., & Nelson, P.K. (2008). *Young offenders on community orders: Health, welfare and criminogenic needs*. Sydney, Australia: Sydney University Press. ISBN 978-0-9804117-0-6.

Kenny, D.T. & Lennings, C. J. & Nelson, P. (2008). Mental health of young offenders serving orders in the community: Implications for rehabilitation. In Daniel W. Phillips III (Edited). *Mental Health Issues in the Criminal Justice System*. New York: Haworth Press.

Kenny, D.T. (2014). Mental health concerns and behavioural problems in young offenders in the criminal justice system. *Judicial Officers' Bulletin (Judicial Commission of NSW)*, 26 (4), 29-33.

Kenny, D.T. (2013). Violent young offenders in the criminal justice system. *Judicial Officers' Bulletin (Judicial Commission of NSW)*, 25 (3), 19-24.

Kenny, D.T. (2015). Juvenile sex offenders in the criminal justice system. *Judicial Officers' Bulletin, (Judicial Commission of NSW)*, 27 (4), 31-34.

(e) Educational psychology

During my earlier professional life, I worked as a school counsellor and specialist counsellor for emotionally disturbed children within the Division of Guidance and Special Education, NSW Department of Education. I was responsible for assessing children whose psychological difficulties were such that they could not be managed within the mainstream classroom. I undertook detailed assessments of their educational, social, and cognitive development in order to provide appropriate school placements for children who had significant trauma histories and intellectual disabilities.

Key publications:

Kenny, D.T. (2016). The adolescent brain: Implications for assessing young offenders' legal competence. *Judicial Officers' Bulletin (Judicial Commission of NSW)*, 28 (3), 23-27.

Kenny, D.T. (2012). Young offenders with an intellectual disability in the criminal justice system: Prevalence, profile, policy, planning and programming. *Judicial Officers' Bulletin (Judicial Commission of NSW)*, 24, 5, 35-42.

Jensen, P. Stevens, S., & **Kenny, D.T.** (2012). Effects of yoga breathing on the behaviour and attention

of boys with ADHD. *Journal of Child and Family Studies*, 2, 4, 667-681. DOI 10.1007/s10826-011-9519-3.

Kenny, D.T. & Frize, M. (2010). Intellectual disability, Aboriginal status and risk of re-offending in young offenders on community orders. Special Edition, *Indigenous Law Bulletin*, 7, 18, 14-19

Kenny, D.T., & Faunce, G. (2004). Effects of academic coaching on elementary and secondary school students. *Journal of Educational Research*, 98, 2, 115-126.

Kenny, D.T. (1992). Can teachers be tests? A comparison of teacher ratings and test assessments of early reading performance. In H. Motoaki, J. Misumi, J. B. Wilport (Eds). *Social, Educational and Clinical Psychology*, Vol 3, pp 177-178. London: Lawrence Erlbaum Associates.

Kenny, D.T. (1989). The effect of grade repetition on the academic performance and social/emotional adjustment of infant and primary students. In Luszcz M. and Nettlebeck T. (Eds). *Psychological development: Perspectives across the lifespan*, pp. 261-271. North Holland: Elsevier Science Pub. B.V.

(f) Family Therapy and Family Dispute Resolution

I assist parents to reach parenting agreements with respect to shared parental responsibility of their children following separation and divorce. I also undertake mediation with respect to property settlements. I undertook an 18-month training program with Relationships Australia in marriage and family therapy, in which capacity I work with families to resolve conflict, attachment ruptures, relationship stresses, and behavioural difficulties.

Having dual qualifications in both family therapy and family dispute resolution places me in an ideal position to assess families in custody disputes in relation to parenting capacity, shared parental responsibility and allegations of emotional, physical and sexual abuse. In these capacities I have provided parenting capacity reports to both family law solicitors and barristers, the Family Court and the Children's Court.

Key publication:

Kwok, E. & **Kenny, D.T.** (2015). The application of collaborative practice to misattributed paternity disputes. *Australasian Dispute Resolution Journal*, 26, 127- 136.

Other Major Consultancies, Invited Commissioned Reports, and Invited Submissions to Government Inquiries

Kenny, D.T. (April 2011). The NSW Law Reform Commission (NSW LRC). Consultation Paper 11. *Young people with cognitive and mental health impairments in the criminal justice system*, Roundtable.

Kenny, D.T. (2009). Submission on bullying to the NSW Legislative Council General Purpose Standing Committee No 2.

Kenny, D.T. & Lennings, C. (2007). *Provisional sentencing of serious young offenders*. NSW Sentencing Council. Department of the Attorney General.

Kenny, D.T., Nelson, P., Butler, T., Lennings, C., Allerton, M., & Champion, U. (2006). *Young people on community orders health survey: Key findings report*. Sydney, Australia: University of Sydney ISBN: 1 86487 845 2

Allerton, M., Champion, U., Kenny, D.T., Butler, T. et al (2003). 2003 *Young people in custody health*

survey. NSW Department of Juvenile Justice ISBN 0 7347 6518 5

Kenny, D.T. & Hunter, J. (2003). *Review of psychological services and specialist programs in the NSW Department of Juvenile Justice*. Commonwealth Cost and Quality of Government (Internal Audit Bureau). (170 pages).

Kenny, D.T. (1996). *The effects of television/movie/video violence on the behaviour of children and adolescents*. Invited submission from the Australian Family Association (NSW Branch) to the Federal Government's Committee of Ministers on the 'Portrayal of Violence.'

Professional contributions in Psychology and the Law

Journal Reviewer

1. Frontiers in Psychology
2. Journal of Child Sexual Abuse
3. Sexual Abuse: A Journal of Research and Treatment
4. Psychology and the Law
5. International Journal of Offender Therapy and Comparative Criminology
6. Clinical Psychology Review
7. Journal of Sexual Abuse and Treatment
8. Behavioral and Brain Functions
9. Archives of Clinical Psychiatry
10. Australian Psychologist

Other invited presentations (selected)

Kenny, D.T. (2017). *Institutional Child Sexual Abuse*. Invited paper to the Local Court of NSW Annual Conference (2-7 August), Sydney, Australia.

Kenny, D.T. (2013). Young offenders in the juvenile justice system: A story of violence, intellectual disability, substance abuse, alienation, and social disadvantage. Invited paper to *The Children's Court Magistrates' Section 16 meeting* (2 November). Sydney, Australia.

Kenny, D.T. (2011). Risks and needs of indigenous offenders: physical and mental health. Invited paper to A weekend conference for judicial officers and Aboriginal community members, *Judicial Commission of NSW* (10-11 September). Sydney, Australia.

Kenny, D.T. (2009). Intellectual disability and Indigenous status are predictors of recidivism in young offenders. Invited paper to the *Australian Institute of Criminology Conference* (1 September), Parramatta, Australia.

Kenny, D.T. (2009). Young offenders: the importance of compensatory attachments and the role of teachers. Keynote paper to the *NSW Department of Education Principals' Conference* (April), Sydney, Australia.

Kenny, D.T. (2007). Juvenile sex offenders: Theory into practice. Invited paper to the *Australian and New Zealand Association for the Treatment of Sex Abuse* (21 June). Blacktown, Sydney.

Kenny, D.T. (2007). Cognitive and educational problems of young offenders. *School Education Directors of Education Twilight Seminars* (26 June). Sydney, Australia.

Kenny, D.T. (2006). Physical and mental needs of young offenders. *Disability Strategic Group*, NSW Department of Juvenile Justice (August). Sydney, Australia.

- Kenny, D.T. (2005). Impact of violence classification on its relationship to psychological factors and mental health. *Prisoner Health Research Symposium*, JusticeHealth (18 February). Sydney, Australia.
- Kenny, D.T., Vecchiato, C., Allerton, M., Kenny, D.T. (2003). Young People in Custody Health Survey: Mental health. *Australian Institute of Criminology Conference* (1-2 December). Sydney, Australia.
- Kenny, D.T. (2002). Predictors of recidivism in juvenile sex offenders: Lessons for prevention. *Jocelyn Wale Distinguished Scholar Series* (23 June). James Cook University, Queensland.
- Kenny, D.T., Keogh, T., & Seidler, K. (2001). Developmental and clinical characteristics of juvenile sex offenders: Predictors of recidivism and implications for treatment. *Inaugural Australian Forensic Psychology Conference* (February). Sydney, Australia.
- Kenny, D.T. (1999). *Recidivism prediction model for juvenile sex offenders*. Invited presentation to the Minister for Juvenile Justice, Carmel Tebbutt MLC, and the Collaborative Research Unit, NSW Department of Juvenile Justice.

Exhibit B

Pages 161 - 319 redacted

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., *et al.*,

Plaintiffs,

v.

THE INDIVIDUAL MEMBERS OF THE
MEDICAL LICENSING BOARD OF
INDIANA, in their official capacities, *et al.*,

Defendants.

No. 1:23-cv-00595-JPH-KMB

Order

The Court, having reviewed the submissions of the parties, orders as follows:

As to docket entries 48-1, 48-2, and 48-4 through 48-17, the Court **DENIES** defendants' motion (Dkt. 50) to maintain those filings under seal. The Clerk is hereby directed to unseal these docket entries.

As to docket entry 48-3, the Court concludes that good cause exists to maintain this document under seal. The Court therefore **GRANTS** defendants' motion (Dkt. 50) to maintain this document under seal. The Court also **ACCEPTS** for public filing the redacted version of this document, docketed at 64-1.

As to docket entry 54, the Court **DENIES** defendants' motion (Dkt. 54) to maintain this filing under seal. The Clerk is hereby directed to unseal this docket entry.

Date

United States Magistrate Judge

To: All ECF-registered counsel of record