

Gender Identity

(A report from the Social Issues Committee. Revised 21 November 2017.)

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PLEASE NOTE:

This report may contain material and express views that could cause distress to some readers, particularly those experiencing gender identity issues, and their families. The report also contains medical terminology, and reference to sexual body parts, and suicide. The authors have sought to be sensitive to these considerations, and urge any readers who experience distress to seek appropriate help and support.

Introduction

(1) In April 2016, the Social Issues Committee of the Diocese established the Gender Identity Subcommittee to examine questions of gender identity. Its aim was to develop a theologically supported framework for application to diocesan organisations, schools, parishes and individual ministry. This work was supported by Synod Resolution 40/16.

(2) This Report seeks to provide the necessary biblical, medical and legal material to help inform future policy development, public engagement and pastoral care. It seeks to do so with as much pastoral sensitivity as the format allows. However, the content may still be confronting or distressing for those dealing personally with gender identity issues. This is not intentional on the part of the Gender Identity Subcommittee or the Social Issues Committee.

(3) This Report is part one of a multi-layer body of work. This paper briefly outlines the context of 'gender identity' in Australia including the use of language and definitions; the biblical framework of sex and gender; a review of medical literature on gender non-conformity; and finally, a summary of the current legislative framework in this country. The Report concludes with recommendations for further work to be considered by the Synod.

(4) Part two of the Subcommittee's work is still in progress. A mixed-methods study aimed at collecting first-hand experiences of gender non-conformity within the church is currently underway. From this work, and informed by biblical teaching, detailed pastoral and policy responses will be developed in consultation with Anglican stakeholders. This work will be completed in 2018.

(5) There are those within our churches and broader community who experience deep distress associated with their gender identity or who have loved ones who do so. Our churches should be places where *all* people are welcomed, loved, and nurtured with care that is shaped by the love of Christ, and informed by the word of God. Those experiencing gender identity issues should be treated with dignity, generous love, compassion, and pastoral humility.

(6) This Report engages with ideas and practices that increasingly find acceptance in society. Scripture teaches that God's purposes for humanity lead to human flourishing, and Jesus calls those who follow him to speak the truth in love. It is our conviction that upholding and speaking God's truth on these matters best serves and loves those experiencing gender identity issues, and the broader community.

What is Transgender?

(7) The rise in gender identity issues and the transgender phenomenon mean that individual Christians, and Christian organisations, such as churches, schools, health care professionals, counsellors, and welfare and residential care providers, need to understand the complex issues involved and formulate responses that are shaped by the Bible's teaching, and which can best serve affected individuals and communities.

(8) The theological and pastoral questions are new, and result from developments in medicine and far-reaching ideological and cultural changes around questions of sexual orientation and gender identity (sometimes referred to in the literature as SOGI).

(9) For decades now, the impact of feminism has made debates about gender and gender roles commonplace both outside and inside the church. More recently, questions about human sexuality and same-sex relations have occupied society. Yet for all their differences, virtually all participants in these debates have agreed that human beings are either male or female, and that a person's biological sex determines their gender.

(10) However, it is this binary distinction of male and female, and the correspondence of biology and gender, that are now in question with transgenderism or the 'T' in the LGBT acronym.

(11) 'Transgender' is an umbrella term for people who were born either male or female, but whose psychological or emotional gender identity differs to some extent from their biological sex. These people may express their felt gender through gender bending and/or cross-dressing, and sometimes through cross hormone therapy and/or sex reassignment surgery. This gender expression is an attempt to bring their body into alignment with their felt gender.¹

(12) There are two main groups under the transgender umbrella. Firstly, there are gender experimenters, ideologues and activists who attempt to challenge conventional expressions of gender. They believe that gender is simply a social construct, which is chosen and fluid (i.e., subject to change within an individual) and not tied to biology. For them, transgender identity is a form of protest. By contrast, the second group has a binary view of sex and gender (i.e., male and female) but experiences varying levels of distress from a felt incongruence between their gender identity and biological sex.

(13) Within these two groups there is great variety. There are differing, even opposing, ideologies driving the first group. In the second group, there are different degrees and experiences of gender incongruence, and different ways of managing any distress. For this reason, we are sensitive to making any simplistic generalisations. However, all those under the transgender umbrella share a common belief, namely, the de-coupling of bodily sex and gender in human personhood.

(14) Transgender is not to be confused with 'intersex' (the 'I' in LGBTI). Intersex describes those rare conditions where a person is born with biological or physical ambiguity in their sex characteristics, genes or anatomy. These are physical not psychological and emotional conditions.² This report will not address intersex issues, except to say that although such conditions are rare we should expect to have those with intersex conditions in our church communities, and although they may choose to keep their experience private, our teaching and pastoral ministry must be sensitive to and seek to address their needs. Further explanation of intersex conditions can be found in Appendix 2.

Gender Identity - The Current Context

1.1 Biblical and Contemporary Lenses

(15) In April 2015 Bruce Jenner, American TV personality and Olympic gold medal-winning decathlete, announced to the world that he wished to identify as a woman and, from thereon, be known as 'Caitlyn'. The mainstream media were, in the main, eager to affirm this decision and Jenner appeared on the cover of *Vanity Fair* magazine's June 2015 edition, dressed in female underwear that emphasized cosmetically enhanced breasts. The photographer for that shoot, Annie Liebovitz, declared, "Jenner is finally herself for the first time publicly."³

(16) Jenner's announcement brought questions of gender identity to the forefront of popular debate. It also carried with it troubling signs that any dissenting view would not be tolerated. Even famous feminist author and activist Germaine Greer found herself disinvited from delivering a British University lecture as a consequence of questioning Jenner's decision to transition genders, and for objecting to the suggestion that Jenner might be nominated as 'woman of the year'.⁴

¹ The older term 'transsexual' refers to someone who has/wants to change their body. <http://www.glaad.org/reference/transgender>. [Accessed 7 June 2017.]

² Intersex Society of North America. Online: <http://www.isna.org/faq/transgender>. [Accessed 7 June 2017.]

³ Capehart, J. 'Caitlyn Jenner comes out in Vanity Fair.' *The Washington Post* (1 June 2015). Online: <http://www.washingtonpost.com/blogs/post-partisan/wp/2015/06/01/caitlyn-jenner-comes-out-in-vanity-fair/>. [Accessed 5 June 2016.]

⁴ Aubrey, S. 'Feminist Germaine Greer sparks freedom of speech debate for views of transgender women and Caitlyn Jenner'. *news.com.au*. Online: <http://www.news.com.au/lifestyle/real-life/news-life/feminist-germaine-greer-sparks-freedom-of-speech-debate-for-views-on-transgender-women-and-caitlyn-jenner/news-story/dd81143d20f4633527b73c9ea350e707>. [Accessed 20 November 2016.]

(17) Here in Australia, the Safe Schools Coalition program has been aggressively championing this new gender ideology. Students have been taught that non-acceptance of alternative sexual and gender ethics is “phobic” and hateful and must be fiercely rejected.⁵ Students who express contrary or conservative opinions, no matter how politely, have been made to feel “excluded, disrespected and inferior”.⁶

(18) Both South Australia’s 2016 Transgender and Intersex Student Support Procedure⁷, and a 2014 NSW Department of Education & Communities Legal Issues Bulletin⁸ affirm transgender ideology, and recommend and require its practical application. This includes discipline of staff or students who deliberately or repeatedly (even unintentionally, it seems) fail to use a student’s chosen name or gendered pronoun, including, in SA, the mandatory use of the Education Department’s Sexual Harassment Policy and a school’s anti-bullying and harassment policy.

(19) These are only a few of the countless examples of the emerging gender ideology, which holds that gender identity need not necessarily correspond with biological sex, and which serves to promote and impose this new understanding on our society’s common life.

(20) For the Christian, there are some immediately obvious questions to be addressed. We believe the Bible is our final authority in matters of doctrine and life and yet these ideas about gender fluidity and a spectrum of gender identities stand in stark contrast to the simple binary model of male and female set out in Scripture (Gen. 1:27, 2:24-28). Which is right? And how are we to live in a society that accepts these new gender norms?

1.2 Language and Definitions – How we arrived here

(21) Emerging gender ideology has been advanced using, and is evident in, a host of new terms and in the redefinition of existing vocabulary. According to this new set of definitions, the once-assumed clear bond and correlation between sex, gender, sexual orientation, and gender expression is no longer a given.

(22) This new vocabulary has quickly been popularized and entered the mainstream, through entertainment and the media, for example, with social media platform Facebook recently giving users over 70 gender options for their personal profiles.⁹

(23) It is increasingly evident that this new vocabulary is shaping the reality we are operating in. The nature of language is that it names and shapes our perception of reality as well as our ability to speak of things. Those who would engage in the debate are, by nature of the case, forced to use the new vocabulary (with its meanings) or go to great lengths to define their own.

(24) The following table, identifies some of this new vocabulary, and clarifies how it will be used in this report.

Word or Term	Definition
Biological sex or *birth sex or *natal sex	This has to do with biology; a person’s chromosomes, gonads, genitals, their primary and secondary sex characteristics – like body shape, voice pitch, hair distribution. This answers the question: what is male and what is female. *The terms ‘birth sex’ or ‘natal sex’ are sometimes also used, but they are avoided in this report, as they seem to allow the possibility of a sex other than that with which a person is born.

⁵ Student Wellbeing Hub, ‘Resource Detail.’ Online: <https://www.studentwellbeinghub.edu.au/resources/detail?id=f0774c22-d5c5-6d32-997d-ff0000a69c30#/>. [Accessed 15 November 2016.]

⁶ Brown, G. ‘Safe Schools anti-bullying “forcing us to go private,”’ *The Australian* (4 May 2016). Online: <http://www.theaustralian.com.au/national-affairs/state-politics/safe-schools-antibullying-ruling-forcing-us-to-go-private/news-story/976000edca567f75633e45d91f0995d6>. [Accessed 10 March 2017.]

⁷ South Australian Department for Education and Child Development, ‘Procedure: Transgender and Intersex Student Support.’ Online: <https://www.decd.sa.gov.au/sites/g/files/net691/f/transgender-and-intersex-support-procedure.pdf?v=1480468803>. [Accessed 21 June 2017.]

⁸ New South Wales Government Education and Community. ‘Transgender Students in School – legal rights and responsibilities.’ *Legal Issues Bulletin*, 55 (December 2014). Online: https://www.det.nsw.edu.au/media/downloads/about-us/how-we-operate/legal-issues-bulletins/number_55.pdf [Accessed 18 November 2016.]

⁹ These included ‘F2M’, ‘T* woman’, ‘Two-spirit person’, ‘Gender Variant’, ‘Neutrois’ and simply ‘Other’. Facebook now offers just three options, however, with infinite possibilities, i.e., ‘Male’, ‘Female’ and ‘custom’ where a person can can ‘write their own’ gender identity. Similar options are now provided by many government agencies when official forms are completed.

Word or Term	Definition
Assigned sex	Assigned sex is a term that is changing. Until recently, it was used for assigning sex to those with intersex conditions at birth where there was biological ambiguity. Increasingly though, as part of the trend to see gender as a social construct, it is being used for the so-called 'label' given at birth: "it's a girl", "it's a boy" – often with the notion that this assigning of sex is arbitrary, and imposed on the infant without their knowledge or permission, and without seeing which gender the child wants to be. This is in contrast to the traditional idea that sex is 'acknowledged' at birth, based on the observed anatomical sexual characteristics of the newborn.
Sex and sexuality	These terms often get confused. Sex refers to a person's biological sex, whereas <i>sexuality</i> refers to their sexual and/or romantic attraction (orientation) or practice. The first is about objective facts of a person's body; the second is about whom we subjectively find sexually and/or romantically attractive.
Gender or gender expression	This is the psychological and social aspect of how sex is presented in things like dress and demeanour, social conventions, and cultural gender norms. These vary in different cultures. The distinction between 'sex' and 'gender' is relatively recent (circa 1963). The question here is: what is 'masculine' and what is 'feminine'?
Gender identity	In recent times, this has come to be about how a person feels or experiences themselves. It is a private and subjective sense of identity and experience. The question here is: Who do I feel that I am?
Gender roles	These are the common socially-accepted behavioural expectations of maleness or femaleness. They change from culture to culture – although some are biologically-based, for example, pregnant women.
Cisgender	This is another new term (approx. 1990s) where a person's gender identity and gender roles align with their biological sex and/or with society's expectations of that biological sex. <i>Cis</i> comes from Latin, meaning 'on this side of'. It's the opposite of ' <i>trans</i> ' – and arguably assumes the existence of ' <i>trans</i> ' as a normal and natural phenomenon. Accordingly, it is not used in this report.
Heteronormativity	The belief that sex is binary (male or female) and gender is determined by biology, and that only sexual orientation and sexual relations with the opposite sex are good and right and 'natural'. It is not usually used as a neutral term but is understood negatively, as oppressive, homophobic and transphobic. Accordingly, it is not used in this report.
Gender bending	This is intentionally crossing or 'bending' accepted gender norms and roles, either by adopting the dress or roles of the alternative binary gender, or through androgyny or obscuring gender.
Gender dysphoria	This is the medical term for the experience of <i>distress</i> associated with having a psychological or emotional gender identity that does not match a person's biological sex. It is discussed at length below.
Transgender	An umbrella term for people who were born either male or female, but whose gender identity differs from their biological sex (to varying degrees), and who want to express the gender with which they identify, through gender bending and/or cross-dressing, and/or cross-hormone therapy, and/or sex reassignment surgery. Transgender is about gender identity <i>not sexual orientation</i> . Transgender people can be straight, lesbian, gay or bisexual (in relation to their subjective gender identity not biological sex).
Gender non-conforming	An alternative way to describe those who are 'transgender' that stresses their non-conformity to gender norms irrespective of whether they chose to identify as having a gender other than their biological gender. We have chosen to use this term throughout the rest of the report to describe those experiencing the issues addressed in this paper.

Word or Term	Definition
Queer	Queer is a political or ideological term that rejects binary notions of gender, and holds to gender diversity (i.e., an infinite number of genders across the population) and the fluidity or non-fixity of gender (i.e., subject to change within an individual). Genderqueer is used by some who experience their gender identity as being outside the categories of man and woman. Sometimes the acronym 'Q' means not 'queer' but 'questioning', i.e., someone who's trying to work out who they are and to whom they're attracted.

(25) The new terminology seeks to establish and enforce a revised framework for understanding gender, sex, and sexuality. For example, just because a person has a set of XY chromosomes and male gonads and genital organs (i.e., their 'sex'), that person may not necessarily have a subjective male 'gender' identity. Nor is that person's sexual orientation governed by any of these factors.

(26) In fact, the role of language to name and categorise sex and gender, and to establish norms, is itself being brought into question. So is our ability to refer to universally-received norms or 'common sense'. Increasingly, any reference to norms or 'common sense' is seen to be oppressive and discriminatory. Each individual, is said to have the right to identify themselves however they choose, independently of anything else – their objective biology, earlier life, existing official documents (e.g., birth certificate), or how others regard the person.

(27) These challenges and changes are most evident in the work of queer theorists. Queer theory involves the questioning and deconstruction of previously-assumed norms and the structures which support them, of which language is one. It has also had profound influence on academia, especially in the fields of philosophy and biological sciences.

Queer theorists see gender as an institution, by which they mean a social convention or arrangement sustained by a set of accepted determinative ideas – norms. It is for this reason that gender must be queered because it is a harmful institution that forcibly frames (constructs or makes) society's subjects. Queer theory seeks to undermine (deconstruct) the view that the only existence is that which falls within the boundaries set by the institution of gender that is ordered by nature or biology

... Put crassly, queer theorists reject the fact that men have a penis, are masculine, and desire and have sexual relations with women; and they reject the fact that women have a vagina, are feminine, and desire and have sexual relations with men. Human gendered and sexuality experience, they argue, is much more diverse. Queering gender is therefore an attempt to reveal and legitimise other liveable gendered and sexuality realities apart from or besides those prescribed by the bio-logical man/woman gender binary.¹⁰

(28) Simply put, in this new 'queered' understanding there is no 'normal' so that every possible expression is normalised:

There is an infinite diversity of genders in the world. Each person has a totally unique interpretation and relationship with any gender they inhabit. There are at least as many genders as there have been humans who have lived.¹¹

(29) Any talk of norms or common sense based on biology, is seen as meaningless, and (worse still) oppressive and phobic, because it seeks to impose on others what they themselves have not chosen.

(30) Safe Schools Coalition Australia (whose program is implemented in many Australian schools and in Victoria is state-funded) provides the following advice regarding use of pronouns on its 'Student Wellbeing Hub' website¹²:

¹⁰ Patterson, D. 'A brief history of gender and its significance.' *EFAC Essentials*, (Spring 2016), Online: <https://www.efac.org.au/index.php/essentials-58/general/598-a-brief-history-of-gender>. [Accessed 9 August 2017.]

¹¹ Crofton, J. 'What It Means To Be MultiGender: The Questions Many Have, But Are Afraid To Ask.' *The Body is not an Apology*, Online: <https://thebodyisnotanapology.com/magazine/what-it-means-to-be-multigender-the-questions-many-have-but-are-afraid-to-ask>. [Accessed 28 July 2017.]

¹² Safe Schools Coalition Victoria and Minus18 (2016), *All of Us: Health and Physical Education Resource - Understanding Gender diversity, Sexual diversity and intersex topics for years 7 and 8*. Online: <https://www.studentwellbeinghub.edu.au/docs/default-source/all-of-us-online-version-may-2016-v3-pdf/a8c146fe405c47b9989542b9040a5b90.pdf?sfvrsn=0> [Accessed 18 August 2016.]

It's ok to ask people about their preferred use of pronouns. Where possible, ask privately. Some people use gender-neutral pronouns such as 'they' (singular) or 'ze', while others use no pronoun or may wish to be addressed by their name only. It is important not to make assumptions about people's gender identity and to be respectful when using pronouns.

(31) While at first sight this appears entirely appropriate, in that it seeks to uphold the dignity of the individual, and seeks to alleviate the distress of those with gender identity issues, it also represents a 'queering' of language as it decouples gendered pronouns from biological reality.

(32) The shift in language is impacting the development of legislation on human rights and discrimination. In Canada, for example, recent changes in legislation may compel the use of genderless pronouns and classify misgendering as discrimination against transgender people. See section 8.7 for further information.

(33) The shift in language and understanding has also impacted the field of medicine. Prominent medical bodies now no longer regard an incongruence between biological sex and self-perception of gender as necessarily problematic. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition ('DSM-5', 2013)¹³ replaced the previous clinical entity 'Gender Identity Disorder' (as seen in DSM-4, 1994) with the diagnosis of 'Gender Dysphoria'. This change represents a significant shift from recognising the *experience* of gender incongruence as pathological (abnormal) to labelling it pathological only if it is associated with *distress*. This change in nomenclature appears not to have been a response to new medical research, but the result of ideological shifts regarding sex and gender, and a (commendable) desire to destigmatize the experience of gender incongruence.¹⁴ The report addresses the diagnosis and treatment of gender dysphoria in some detail below (Section 5).¹⁵

(34) A discussion about language might seem a strange place to start a report like this. However, this new language is a significant part of the changes and challenges to views of sex and gender, both as an agent of change and a result of change. While we must be sensitive to the difficulties some language poses to those who struggle with gender nonconformity, we must also be aware of the ideological undercurrents and implications of the changes to language we are seeing.

Biblical view of sex and gender

(35) While the social phenomenon of transgender activism may be new, and present fresh challenges, it has highlighted the needs of those within society and the church who suffer from gender identity issues or incongruence. God's living word must be our guide as we seek to respond to transgender activism, and as we seek to love and care for those personally affected by Gender Dysphoria.

1.3 Humanity as male and female in the image of God

(36) The first chapter of the Bible tells us that God made humanity male and female. While other creatures are implicitly also created male and female (cf. Gen. 1:22), with humanity this binary sexual distinction is explicitly part of being made in his image, and his good purpose for us (Gen. 1:26–28). This sexual distinction and its association with being made in God's image remains after the Fall (Gen. 5:1–2).

(37) Genesis 2 develops this distinction between male and female, when we meet the first man and woman and they are joined in a life-long one-flesh union. The correlation and alignment of biological sex and gender is seen as the 'male' and 'female' (adjectival nouns) of Genesis 1 become the persons of 'man' and 'woman', 'husband' and 'wife', and 'father' and 'mother' (gendered personal nouns) of Genesis 2 and beyond.

(38) Jesus affirms the divine design of this binary sex-gender distinction as the basis of his understanding of marriage (and the effect of divorce), saying "at the beginning of creation God made them male and female" (Mark 10:6–7; Matt. 19:4–5).

¹³ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5®). American Psychiatric Pub, 2013.

¹⁴ Zucker, K. 'The DSM-5 Diagnostic Criteria for Gender Dysphoria.' In *Management of Gender Dysphoria: A Multidisciplinary Approach*, edited by Carlo Trombetta, et al., (pages 33–37, here 33–34). Springer Milan, 2015. See also Lawrence, A. A., 'Gender assignment dysphoria in the DSM-5.' *Archives of sexual behavior*, 43/7 (2014): 1263-1266.

¹⁵ See section 5.2 "Incidence and prevalence of Gender Dysphoria | Definitions".

(39) Scripture is clear that male and female, man and woman, are equally human, equally blessed and equally charged to “fill the earth and subdue it.” Yet they are sexually distinct with different roles. They are equal and similar, yet different and complementary, and their relationship is one of otherness but as corresponding not contradictory polarities. This binary sex-gender distinction is part of the good of God’s creation (Gen. 2:18, cf. Gen. 1:31).

(40) The sex and gender differences of man and woman are not incidental to their personhood. Woman is a new entity. She is not a deviation of the norm or form of ‘man’ even though in the Genesis 2 creation account she was formed out of him. Neither is there a neutral human template to which different body parts or gendered attributes are added. Man and woman are distinct in their essence.¹⁶ They *are* in their beings ‘man’ and ‘woman’. There is no abstraction of humanity independent of sex and thus gender. Also, their identity as man and woman is not subjectively chosen. It is an absolute state that is given by God, and realized and experienced in their embodied selves.

(41) In the Genesis account, the differences between the sexes can be seen in their respective origins, their distinct names, the order in which they are created, and in their complementary purposes and roles, and the expression of their relationship.

(42) They are the first man and woman, and the first husband and wife, and yet not all that is true of their married selves and relationship applies to all men and women or all interactions between males and females. Moreover, the implications of their differences should not go beyond the explicit teaching of the New Testament on women and men, which focuses on the realms of marriage and the gathered Christian community (1 Cor. 11:3–16; 1 Cor. 14:26–40; Eph. 5:21–33; Col. 3:18–19; 1 Tim. 2:1–15; Tit. 2:2–5; 1 Peter 3:1–7).

(43) Apart from their biological differences, the Bible does not locate the differences between the sexes in universal characteristics of men or women or of ‘manhood’ or ‘womanhood’. Rather, the differences are found in distinct gendered roles and relationships. Indeed, there is great breadth and diversity in the biblical portrayal of the sexes (e.g., *women*: Gen. 27:14; Num. 27:1–4; Judg. 4:4–6, 18–21; Neh. 3:12; Prov. 31:10–31; Luke 10:38–41; Acts 9:36–39; *men*: Gen. 4:2, 20–22; 27:31; 45:14–15; Deut. 28:54; 1 Sam. 16:18; 17:33; 1 Tim. 3:3). This is significant for Christians experiencing gender identity issues, because the Bible does not prescribe narrow or rigid gender stereotypes. Rather—alongside explicit teaching on some different roles and responsibilities in marriage and ministry—there is a great variety in what it can look like to live faithfully as a man or a woman.

(44) At the same time, the Bible recognises that gender is expressed culturally, and differently in different cultures, and expects that a person’s sex and corresponding gender will be embraced, and expressed through culturally appropriate symbols (e.g., clothing) and behaviour that aligns with their binary sex (e.g., Gen. 17:10; Deut. 22:5; 1 Cor. 11:4–5; 1 Tim. 2:9–10).

(45) Notwithstanding God’s original purposes, since the Fall of Genesis 3, the sad reality is that all creation bears the consequences of our rebellion against God. The harmony of God’s creation has been lost at every level. Our relationship with God is now broken. All human relationships are broken, including our relationship with our ‘self’, and our relationship to the created world. Even the wellbeing of creation is affected (Rom. 8:19–26), and our bodies are no exception to this. They are subject to frustration, death and decay, through afflictions of the body and the mind, and subject to hurt inflicted by ourselves and others. The experience of felt incongruence between biological sex and subjective gender identity is one such consequence. Another consequence of the Fall is that, in addition to our natural human limitations, our emotional, psychological, intellectual and spiritual faculties are affected by sin, and are unreliable guides. This means our subjective ‘identity’ must always be subject to the word of God and the objective givenness of the sexed body God has given us, no matter how strongly we might feel otherwise.

(46) Another consequence of the Fall evident in Scripture is that there are those whose bodies do not display all the usual characteristics of their biological sex (cf. 2 Kings 9:32; 20:18; Esth. 1:10, 15; 2:3; Isa. 39:7; 56:3–4; Acts 8:26–40) but there is no suggestion that this represents a third sex or that God intended such. In fact, in the same conversation where Jesus mentions those who were “born” eunuchs¹⁷ or “made eunuchs by others”¹⁸ he also restates God’s original creation design and purposes for humanity as male and female, and the implications of this for marriage (Matt. 19:12). Jesus’ comments, and the conversion

¹⁶ Blocher H., *In the Beginning: The Opening Chapters of Genesis*, (Leicester: IVP, 1984), 100–101.

¹⁷ These would likely be regarded as Disorders of Sexual Development (DSD) or ‘intersex’ conditions today.

¹⁸ The conversion of the Ethiopian eunuch in Acts shows that the ceremonial exclusion of the Old Testament law no longer applies under the new covenant, as promised in Isaiah (Acts 8:26–40; cf. Deut. 23:1; Isa. 56:3–4).

of the Ethiopian eunuch (Acts 8:26–40) demonstrate that those with these conditions are fully accepted and welcome among the people of God.

(47) Despite the effects of the Fall, God’s complementary-binary design of humanity as male-men and female-women remains. This is evident in Jesus’ affirmation of God’s original creation design and purposes. It is evident in the gendered relationships that God has established for human society, where we are daughters or sons, sisters or brothers, wives or husbands, mothers or fathers, nieces or nephews, and so on. It is evident in prohibitions in both the Old and New Testaments against blurring the distinctions between men and women through cross-dressing and cross-gender behaviour (Deut. 22:5; 1 Cor. 6:9 cf. *malakoi* and *arsenokoitai*; 11:4–15). And it is evident in the distinct and non-interchangeable roles of husband and wife as human marriage functions as a signpost to the eternal marriage of Christ and the church (Eph. 5:21–33).

1.4 Humanity as embodied beings

(48) Our bodies, and what we do with our bodies, matter to God.

(49) He made us, male and female, as embodied beings, who come into being as we are formed in our mothers’ wombs, and who will inherit imperishable bodies at the resurrection of the dead (Pss. 51:5; 139:13–16; Rom. 8:23; 1 Cor. 6:12–20; 15:50–55). There is not a pre-existent soul (gendered or otherwise) that is joined to a body, but soul and body grow together and exist together.¹⁹

(50) The goodness and dignity of embodied sexed and gendered human experience is seen in Jesus’ incarnation as a biological male, whose experience and identity as a boy and a man were shaped by his biological sex, and the gendered relationships in which he found himself (e.g., ‘man’, ‘son’, ‘brother’, cf. Matt. 12:46–50; Luke 2:21, 23, 43, 48; John 19:26; and ‘Son of Man’ and ‘Son of God’). Jesus was also subject to bodily experiences common to us all: birth, growth, maturity, hunger, tiredness, emotion, tears, and even death.

(51) We are to love and care for our bodies, because God made them and gave them to us, and he sets love of oneself as the high measure for loving our neighbours, and love of oneself *includes* loving our bodies (Eph. 5:28–29).

(52) That is, while we are more than our bodies, we are not less than them, and human identity is in part determined by the body God gives to each person—a body which places us in a specific time and place, and reveals our biological sex, race, and other distinctives. God makes each person a self-body or ‘psychosomatic’ unity, even if we are not fully conscious of being so. It is this ontological psychosomatic unity that transgenderism denies when it de-couples bodily sex and gender.

(53) For all humans, while there is a subjective element to human identity, and a sense in which our identity is informed and formed by lived experience and by social conventions and interaction with others, these factors are additional to the objective givenness of our bodies, and our *being* as male and female in God’s image. Despite changes to our bodies, personalities, intelligence, abilities, self-image, and so on—some of which, for Christians, are due to the renewing power of the Spirit—there is a continuing embodied-self, who came into being at conception, and who will stand before the Lord at the last day, to receive eternal life or death (Dan. 12:1–3; Acts 10:42; Rev. 20:11–15). And while Scripture does not give us much detail about our resurrection bodies and life, there is good reason to believe that biological differentiation of male and female will continue (Matt. 22:30–32²⁰; Luke 24:15–51; John 20:15–21:14; Article 4²¹).

(54) All Christians are to be thankful and content with their bodies, knowing they are a gift from our heavenly Father, in which to serve him (2 Cor. 5:9). We are to be faithful stewards of our bodies, recognising they are members of Christ and temples of the Holy Spirit, and that we are to glorify God in our bodies (1 Cor. 6:13–20; 9:27). For those with gender incongruence this may present particular challenges, as it might to others with disorders of ‘self’ and body (e.g., anorexia nervosa, body integrity identity disorder, body dysmorphic disorder).

¹⁹ This not to deny that all who die before the return of Jesus will experience a separation of body and soul. But this is a temporary separation, not a permanent one (Matt. 10:28).

²⁰ The reference to “neither marry nor be given in marriage” suggests that both men and women are on view, whereas the statement “they will be like angels in heaven” refers to their unmarried state not sex or gender.

²¹ “Christ did truly rise again from death, and took again his body, with flesh, bones, and all things appertaining to the perfection of Man’s nature; wherewith he ascended into heaven, and there sitteth, until he return to judge all Men at the last day”. Article 4 of *The Articles of Religion*.

(55) Biblical pastoral care of such people must be informed by, and sensitive to, the depths of these challenges for some sufferers. Scripture recognises and addresses the extreme human experiences of despair, depression, trial and suffering, common to us all, and that may be experienced by those with gender incongruence (cf. Job 1:1–2:10; Ps. 88; 2 Cor. 1:8–9). Jesus himself was in such anguish that his sweat fell like drops of blood (Luke 22:44).

(56) Yet alongside its acknowledgement of the groaning and pain of life in this fallen world, the Bible consistently upholds the dignity, blessing, value and sanctity of human life, and God's love and concern for all he has made. For instance, while the Bible does not directly address the difficult topic of the morality of suicide, it uniformly presents it in a negative light, and in the context of shame (Judges 9:52–54; 1 Sam. 31:3–5; 2 Sam. 17:23; 1 Kings 16:18–19; Matt. 27:3–5), as might be expected given that the sixth commandment forbids the taking of innocent human life (Exod. 20:13; Rom. 13:9). When others in Scripture ask God to end their lives, God does not fulfil their request (Num. 11:12–15; 1 Kings 19:4; Jonah 4:1–11). Instead, in the face of all trials and despair, God promises sufficient grace to meet every test we may face to act contrary to his intentions for human flourishing (cf. Ps. 116:1–9; 1 Cor. 10:13; James 1:12–15).

(57) Any Christian response to gender identity issues will seek to restore and preserve the integrity of body and self, and honour and protect the biologically sexed body that God has given. Significantly, in Christian medical ethics, the ultimate goal is the wholeness and welfare of the whole person: body, mind and spirit. Hence, any treatment of gender dysphoria that seeks to relieve *mental* suffering by inflicting harm on an otherwise healthy *body* cannot be deemed ethical.

(58) Christians are to seek the good of all people (Gal. 6:10), and uphold the dignity of all those made in the image of God (cf. Gen. 9:5–6). In particular, this calls for active love and care of the vulnerable. Accordingly, Christians should be concerned for the welfare and best treatment of all people with gender identity issues, not just Christians. We are to show practical love and care of children and adults so affected, and of their families, and condemn all bullying, ridicule, mistreatment, and abuse of gender non-conforming people. We are also to contribute to public debate and policy deliberations to seek the good of affected persons and the wider society.

1.5 Identity in Christ

(59) In addition to being embodied creatures, made in the image of God, Scripture tells us there is an even more significant aspect of human identity. It is our relationship to God himself. Those who know and trust in Christ Jesus as Saviour are given a new identity: we are *in Christ*, and *children of the Father*. In this regard, there is in Christ neither male nor female, as all who believe are equally adopted with the full rights of sonship (Gal. 3:27–4:7). This does not mean the distinctions of male and female are removed, but that our heavenly Father loves us now all equally as full heirs with Christ. *He* is our new identity and hope.

(60) As those *in Christ*, whose lives are hid *with him*, we are to be conformed to *his* image, through the power of the Spirit. We are called to put off the old self, with its sinful practices, disordered thinking, wrongful desires, and idols (Col. 3:1–10).

(61) As God's children, we are to replace disguise and falsehood with truthful self-understanding and living (Lev. 19:11; Prov. 26:24; Rom. 12:3; 1 Cor. 3:18; Eph. 4:25; Gal. 6:3; Col. 3:9). We are not to be envious of others, but rather we are to find contentment in the providence of God towards us (Phil. 4:11–12; 1 Tim. 6:6, 17). We are not to be impatient and expect a resolution of all our trials in this life. Rather we are to endure with prayerful perseverance (Rom. 5:3–4).

(62) If we have faith in Christ, we can know that a complete resolution of all our trials and suffering is coming in the new creation—where there will be no more death, mourning, tears or pain or gender identity issues, and where everything will be made new, including ourselves (Rev. 21:4–5)—but for now we live by faith in hope, not by sight (2 Cor. 5:7). It is here, in the now and the not yet, that the tragic difficulty of living with a gender identity disorder must be worked out.

(63) This does not mean the burden of gender identity issues will be lifted from all who experience it. While *nothing* is impossible for God, complete relief from such incongruence is reportedly uncommon if it persists into adulthood.²²

²² See Sections 5-7 below.

(64) The experience of gender non-conformity or gender dysphoria, to the extent that it is non-volitional, unwanted, and unbidden, is best regarded as an affliction, and so, in this respect, the person is not culpable.²³ It is part of life this side of the Fall: a consequence of universal human rebellion, but not such in and of itself. The indications are that no one chooses this affliction, and most sufferers would do almost anything to find relief from it. The experience itself is not sin.

(65) Nevertheless, how a person responds to their felt gender non-conformity or dysphoria does have a moral dimension.

(66) The current trend in treatment is to 'transition' or change the person's appearance and real lived experience (RLE)—socially, hormonally, and surgically—to that of their felt gender identity.

(67) Yet such an approach is at odds with God's sovereign purpose in creating us as sexed, embodied beings with psychosomatic unity, whose bodies will be perfected in the new creation, and who are now to serve God and his world with our bodies, in gendered relationships, even while we are subjected to the groaning and limitations of this present age. The experience of felt incongruence between the objective givenness of our sexed bodies and subjective gender identity belongs to the groaning of this creation as it waits for the return of Christ and the new creation (Rom. 8:20–23).

(68) In this way, the current trend in treatment offered by healthcare professionals, and promoted by transgender activists, creates additional strains on those with gender identity issues, as it promises a resolution of this tension that is at odds with God's purposes, and offers false hope, as biological sex cannot be changed.

(69) Moreover, the Bible addresses some practices involved in gender transitioning. Cross-gender dressing and behaviour, and blurring the distinctions between male and female are condemned in both Old and New Testaments (Deut. 22:5; 1 Cor. 6:9; 11:4–15). Presenting oneself as the opposite sex necessarily involves disguise and falsehood (viz; the intention to "pass" as the opposite sex) which are likewise condemned (Lev. 19:11; Eph. 4:25; Col. 3:9). Wilfully depriving one's spouse of their conjugal rights (e.g., as a consequence of male-to-female cross-hormone therapy in an otherwise healthy body, or in the mistaken belief it is 'same-sex sexual activity') is also sin (1 Cor. 7:3–5; Heb. 13:4). Sexual relations between people of the same biological sex is same-sex sexual activity—even if those involved regard themselves, and are legally regarded, to be of opposing gender—and is therefore sinful (e.g., Lev. 18:22; 20:13; Rom. 1:26–27; 1 Cor. 6:9–10; 1 Tim. 1:10).

(70) In short, Scripture speaks clearly, even if not explicitly, against gender transitioning, even in the least invasive 'social' form.

(71) Also, as will be evident below, there is a firm medical opinion, including those who pioneered sex change treatment, that has reservations about transition as a treatment approach, and instead seeks first to align the mind with the body, not the body with the mind.²⁴ The current medical landscape is reviewed below (see Sections 5–7).

1.6 The body of believers: the church

(72) In light of the above, it will be evident that salvation in Christ, while securing peace with God and offering eternal hope, does not immediately or always provide existential peace for those with gender identity issues. The reality is for some the burden of gender dysphoria is real and may even seem overwhelming.

(73) We have noted already how God's grace is abundantly able to meet all trials and temptations that might come to us. He does this through the power of his Spirit at work in us, to transform us into the image of Christ (Heb. 13:5; Tit. 3:6). He does this through his Spirit-inspired word that speaks into our lives, instructing, encouraging, comforting, and rebuking (2 Tim. 3:16). And he does it through the body of Christ, the gift of Christian community with brothers and sisters in Christ, who likewise are being transformed into the image of his Son.

²³ This does not include those in the first 'group' identified in 1.1, whose 'transgender' identity is a form of protest, and so volitional, wanted and bidden.

²⁴ McHugh, P. 'Transgender surgery isn't the solution.' *The Wall Street Journal* (13 May 2016). Online: <http://www.wsj.com/articles/paul-mchugh-transgender-surgery-isnt-the-solution-1402615120>. [Accessed 10 November 2017.]

(74) That is, while gender non-conformity or gender dysphoria can be a heavy burden, that might seem to overwhelm the sufferer, it is a burden that need not be carried alone. This requires us to enter into Christian fellowship with love, openness and generosity, willing to be known and to know others deeply. Jesus says that his yoke is easy and his burden is light (Matt. 11:28–30), but this present life has trials, temptations, and burdens. Out of love for Christ and each other, we are to restore those who have given way to temptation and have sinned, and we are to carry each other's burdens (not just 'help' them to carry them) and thus fulfil the law of Christ (Gal. 6:1–2). We are to be like God, to show self-sacrificial love, care, and compassion, and we are to be patient with each other as he is patient (Ps. 86:15; Gal 5:22; Eph. 5:1–2; 2 Pet. 3:9). His transforming and renewing work takes place in a believer's life over the course of a lifetime, and will only be complete on the last day.

(75) There are a number of things that churches, organisations, and individuals can do (or perhaps, not do) to love Christians affected by gender non-conformity, and ease the burden of living with it. The long-term goal is for the person to live faithfully and contentedly as their biological sex, to belong actively to a Christian community, and to contribute as a valuable and loved member of the body of Christ. Ministering to all people within our Christian family is essential.

(76) However, churches and Christian people are first and foremost to be concerned for the salvation of all men and women, girls and boys. While the gospel has implications for social transformation and gender conformity, it is about Christ crucified, and the need for all people everywhere to repent and believe in him for eternal life. It is good news for those experiencing gender non-conformity and dysphoria, and for all those in the transgender community; good news we all need to hear.

(77) Accordingly, while there is a need for all those who own the name of Christ to work out how to respond to the transgender phenomenon and, as we have opportunity, to seek the common good in public policy and the public square in a way that is winsome and builds bridges, this should not distract us from or compromise the priority of proclaiming the gospel to all people everywhere.

What is Gender Dysphoria? – the medical view

(78) This section of the report reviews the current medical and scientific landscape regarding gender identity issues.

1.7 Definitions

(79) **Biological sex** refers to the external and internal anatomy that develops in utero. This is *acknowledged*, not 'assigned', at birth. There are rare Disorders of Sex Development (DSD) where a newborn infant is found to have ambiguous genitalia (i.e., it is not clear whether the child has male or female genitalia, that is, whether they are male or female). These are recognised²⁵ medical deviations from the binary male-female normal genital development. This condition is also called 'intersex' or 'hermaphrodite' in non-medical settings, and is further described in Appendix 1. DSD does not indicate a third sex but lack of clarity as to whether male or female sex applies. The Intersex Society of North America makes a point of separating DSD from transgender, noting that the majority of people with DSD conditions identify as either male or female, not transgender.²⁶ Members of *Intersex Australia* prefer non-medical terminology²⁷. People who say that their brain feelings of gender are opposite to that of their body, or even something in-between are not a third sex. They remain biologically male or female. There is no third biological sex.

(80) Historically, **gender** has been synonymous with biological sex. We have already mentioned the move to separate gender from biological sex. Yet it is still the norm²⁸ (in that it is the case for the majority of humans) for a person's thoughts to align with the physical reality of their body and their core identity of gender to align with their biological sex.²⁹

²⁵ Hughes, I. A. 'Disorders of sex development: a new definition and classification.' *Best Pract. Res. Clin. Endocrinol. Metab.*, 22/1 (2008): 119–34.

²⁶ Intersex Society of North America. Online: isna.org. [Accessed 15 February 2017].

²⁷ Organisation Intersex International Australia, *What is Intersex?* Online: <https://oii.org.au/18106/what-is-intersex/> [Accessed 12 May 2017.]

²⁸ Note that the term 'normal', when used in medicine, refers to the statistical majority and does not hold moral connotations, i.e., it is not seen as good or bad.

²⁹ De Vries, A. L. C. Cohen-Kettenis, P. T. 'Gender dysphoria in children and adolescents.' In *Principles of Transgender Medicine and Surgery*. (Ed.) Monstrey, S., Ettner, R., Coleman, E. Taylor and Francis, 2016. ProQuest Ebook Central. Web. 29 September 2016.

(81) People with a felt gender identity, behaviours, and expression that deviate from what is culturally expected from their biological sex, have been labelled **gender non-conforming**, **gender variant**, or **transgender**. Note that there will be cultural differences regarding what is outside of normally acceptable gender behaviour. Within our society, for example, a 'tomboy' or a boy who likes to play with dolls may be viewed as 'gender non-conforming', which highlights the need to assess such behaviour carefully before labelling it pathological. This would be an example of not conforming to a stereotype, which may or may not be associated with a belief that one should have a body of the opposite sex.

(82) Of those who do believe they have been born with the 'wrong' body, some people experience **gender dysphoria**, that is, ongoing distress that arises from the incongruity of biological sex and felt experience of gender. Gender dysphoria is considered to be a psychiatric disorder, described in the DSM-5. As mentioned above, it replaces the previous clinical entity, 'Gender Identity Disorder'. This significant alteration therefore moves from recognising the *experience* of incongruence as pathological to labelling it pathological only if it is associated with *distress*. The change in terminology has led to a false perception that transgenderism is a normal phenomenon which should be accommodated in normal life. Some commentators are concerned that by removing Gender Identity Disorder from the DSM-5, the mental health support required by these people may be insufficient.³⁰

1.8 Incidence and prevalence of Gender non-conformity and Gender Dysphoria

(83) It is difficult to obtain reliable data regarding incidence of gender non-conformity and gender dysphoria for the general population. This is due to several factors: most epidemiological studies are conducted on populations presenting to gender identity clinics rather than the general population,³¹ and when studies have been done on general populations, differing definitions regarding who should be included as transgender make them difficult to compare.³²

1.9 Gender non-conformity in children

(84) Self-awareness of gender identity develops over time, as growing children gradually learn the differences between males and females and the fact that gender is stable.³³ Gender role is shaped by both nature and nurture (see below), and adults and other children influence gender development directly by reinforcing or discouraging gender behaviours, and by offering role models. Sex hormones also play a role. For these reasons, the DSM-5 criteria for childhood gender dysphoria have been criticised for being in the DSM at all because exploration of gender roles in childhood is normal, and in most children, gender non-conformity is part of the normal variation of childhood gender behaviour, and resolves without treatment.³⁴

(85) No epidemiological studies on the prevalence of childhood gender dysphoria exist. Gender non-conforming behaviour has been assessed in children in terms of 1) cross-gender behaviour and 2) cross-gender wish. Only cross-gender wish is relevant for diagnosis by the DSM-5 criteria. For cross-gender behaviour, rates have been found to be up to 23% for biological males and up to 39% for biological females, dropping to 0.6% and 0.2% for cross-gender wish.³⁵ There is debate in the medical community over whether any sort of psychiatric diagnosis should be available for gender non-conforming children prior to puberty; firstly, it pathologises normal behaviour and secondly, a medical diagnosis is not necessary as no treatment such as hormone therapy or surgical procedures are even considered for this age group.³⁶

³⁰ Lawrence, A. A., 'Gender assignment dysphoria in the DSM-5.' *Archives of sexual behavior*, 43/7 (2014): 1263-1266.

³¹ Zucker, K. J., Lawrence, A. A. 'Epidemiology of gender identity disorder: Recommendations for the standards of care of the World Professional Association for Transgender Health.' *Int. J. Transgender*, 11 (2009): 8–18.

³² Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., et al. 'Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7.' *Int. J. Transgenderism*, 13/4 (2012): 165–232.

³³ Ruble, D. N., Martin, C. L., Berenbaum, S. A. 'Gender development.' In *Handbook of Child Psychology: Vol. 3, Social, Emotional, and Personality Development*. (Ed.) N. Eisenberg, W. Damon, R. M. Lerner. (6th ed. pages 858–932). Hoboken, NJ: John Wiley.

³⁴ De Vries, A. L. C. Cohen-Kettenis, P. T. 'Gender dysphoria in children and adolescents.' In *Principles of Transgender Medicine and Surgery*. (Ed.) Monstrey, S., Ettner, R., Coleman, E. Taylor and Francis, 2016. ProQuest Ebook Central. Web. 29 September 2016.

³⁵ Costa, R., Carmichael, O., Colizzi, M. 'To treat or not to treat: puberty suppression in childhood-onset gender dysphoria.' *Nature Reviews Urology*, 13 (2016): 456-462; Achenbach, T. M., Howell, C. T., Quay, H. C. Conners, C. K. 'National survey of problems and competencies among four- to sixteen-year-olds: parents' reports for normative and clinical samples.' *Monogr. Soc. Res. Child Dev.* 56/3 (1991): 1–131; Sandberg, D. E., Meyerbahlburg, H. F. L., Ehrhardt, A. A., Yager, T. J. 'The prevalence of gender atypical behavior in elementary-school-children.' *J. Am. Acad. Child Adolesc. Psychiatry*, 32/2 (2993): 306–314.

³⁶ De Vries, A. L. C. Cohen-Kettenis, P. T. 'Gender dysphoria in children and adolescents.' In *Principles of Transgender Medicine and Surgery*. (Ed.) Monstrey, S., Ettner, R., Coleman, E. Taylor and Francis, 2016. ProQuest Ebook Central. Web. 29 September 2016.

1.10 Gender non-conformity and gender dysphoria in adolescents

(86) Both cross-gender behaviours and cross-gender wish reduce when children become teenagers. Adolescents reporting discontent with their gender or seeking hormone or surgical management at clinics have been reported as 0.6% of biological males and 0.2% of biological females,³⁷ although estimates vary widely and no-one really knows. More adolescents are reported to behave like the other sex than to state that they wish they were the other sex.³⁸

(87) In a much-quoted study involving questioning of a large cohort of New Zealand high school students who were asked 'Do you think you are transgender?' 94.7% said they were not, 1.2% reported being transgender, 2.5% were not sure, and 1.7% didn't understand the question.³⁹ The estimate of 1.2% is promoted by leaders of the gender dysphoria service at Melbourne Children's Hospital,⁴⁰ but the progenitors of the 'Safe Schools' program appear to have inflated the figure to 4% by adding the unsure 2.5%.⁴¹ Note also that, although this survey has been considered authoritative in some circles, 36.5% of adolescents in the same survey declared they did not understand the question: have you ever been "hit or physically harmed by another person?". The unreliability of such questionnaires has been emphasised in the literature and the figures should be reviewed with circumspection. As a prominent Australian paediatrician has suggested, 'It is false to claim 1.2 per cent of the population is transgender on the basis of the survey. It is wrong to conflate the figure to 4 per cent for the 'Safe Schools' program. That would mean one in twenty-five of all children would be transgender.'⁴²

(88) Therefore, although rates of gender non-conforming behaviour and transgender are unclear, reliable surveys consistently report that it is a small percentage of the population that is affected.

1.10.1 The percentage of gender non-conforming minors who display persistence of the condition

(89) The terminology for ongoing behaviour is as follows:

Persisters: Gender dysphoric children who go on to have gender dysphoria and/or transgender identities in adulthood.

Desisters: Gender dysphoric children who do not go on to have gender dysphoria and/or transgender identities in adulthood.

(90) Persistence rates vary, but it is thought that less than 2.3% of gender dysphoric children will be persisters as adults.⁴³ This likelihood of 'growing out of it' is declared even in the DSM-5,⁴⁴ and is supported by a number of independent studies.⁴⁵

1.10.2 What influences persistence?

(91) Predictors associated with the persistence of gender dysphoria in the Netherlands include intensity of gender dysphoria in childhood, older age of presentation to the clinic, biologically female at birth, and, notably, social transition to the asserted gender in childhood. There is **no clear indicator** at an individual level by which to identify, prospectively, the difference between desisters and persisters, i.e., there is no

³⁷ Kuyper, L., Wijzen, C. 'Gender identities and gender dysphoria in the Netherlands.' *Arch. Sex. Behav.* 43/2 (2014): 377–85.

³⁸ Beijsterveldt, van, C. E., Hudziak, J. J., Boomsma, D. I. 'Genetic and environmental influences on cross-gender behavior and relation to behavior problems: A study of Dutch twins at ages 7 and 10 years.' *Archives of Sexual Behavior*, 35/6 (2006): 647–658.

³⁹ Clark, T. C., Lucassen, M. F., Bullen, P., Denny, S. J., Fleming, T. M., Robinson, E. M., Rossen, F. V. 'The health and well-being of transgender high school students: Results from the New Zealand adolescent health survey.' (Youth'12). *Journal of Adolescent Health*, 55/1 (2014): 93–99.

⁴⁰ Telfer, M., Tollit, M., Feldman, D. 'Transformation of health-care and legal systems for the transgender population: The need for change.' *JPCH*, 51/11 (2015);1051-1053.

⁴¹ All of Us: 8. Online: <https://www.studentwellbeinghub.edu.au/resources/detail?id=72144922-d5c5-6d32-997d-ff0000a69c30#/>. [Accessed 17 July 2017.] See also Patrick Parkinson, *The Controversy over the Safe Schools Program – Finding the Sensible Centre*, Legal Studies Research Paper 16/83, University of Sydney, September 2016, p. 17. Online: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2839084 [Accessed 15 November 2017.]

⁴² Whitehall, J. 'Gender dysphoria and surgical abuse.' *Quadrant* (15 December 2016). Online: <https://quadrant.org.au/magazine/2016/12/gender-dysphoria-child-surgical-abuse/>. [Accessed 9 August 2017.]

⁴³ Coolidge, F. L., Thede, L. L., Young, S. E. 'The heritability of gender identity disorder in a child and adolescent twin sample.' *Behavior Genetics*, 32/4 (2002): 251–257.

⁴⁴ American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. Fifth Edn (2013): 451-459.

⁴⁵ Drummond, K. D., Bradley, S. J., Peterson-Badali, M., Zucker, K. J. 'A follow up study of girls with gender identity disorder.' *Developmental Psychology*, 44 (2008): 34-45.; Wallien, M. S., Cohen-Kettenis, P. T. 'Psychosocial outcome of gender dysphoric children.' *J. Am. Acad. Child. Adolescent Psych.*, 47 (2008): 1413-1423.

way to predict who will persist and who will not, despite claims of adult transgender persons that they knew they were transgender from early childhood.⁴⁶ Childhood gender non-conformity does not necessarily link to adolescent/adult gender non-conformity.⁴⁷

(92) Researchers also suggest that homosexuality or bisexuality is a more likely outcome of childhood gender dysphoria than transgender.⁴⁸

1.11 Prevalence of adult transgender and gender dysphoria

(93) The prevalence of transgender and gender dysphoria in the general population is unknown. It is not clear what criteria should be used to measure the population, as transgender people are a very diverse group, with variation in trajectories and outcomes. “Some live with their gender incongruence, but decide not to transition. Some make a social transition only, without accessing any gender-affirming health care. Some buy hormones from non-medical providers or on the internet, or visit their local doctors rather than attending specialised clinics. In many parts of the world, stigma discourages transgender people from making their transgender status known to others or accessing health care of any sort. These and other considerations present challenges to the researcher attempting to ascertain the size of the transgender population.”⁴⁹

(94) Prevalence is therefore not reported consistently and studies are difficult to compare. A recent review suggested that fewer than 1 in 10,000 adult biological males and 1 in 30,000 adult biological females experience gender dysphoria, but estimates vary widely.⁵⁰

Aetiology (origins) of transgender and gender dysphoria

(95) Gender identity development is most likely a reflection of complex interplays between biological, environmental, and cultural factors. It is still unclear to what extent gender identity is influenced by biological factors (nature), or life experiences (nurture). While some links have been identified, we do not know which relationships are causal, and which ones are merely associations (i.e., by chance), as there are no longitudinal or prospective studies examining gender non-conforming children through to transgender adulthood.

1.12 Is it biological (Nature)?

(96) With respect to evidence supporting biological underpinnings of gender identity, data are derived primarily from three biomedical disciplines: endocrine (hormones), genetic, and neuroanatomical (brain structure).

1.12.1 Pre-biological hormone hypothesis

(97) Developing infants' brains are imprinted prenatally (before birth) by their own endogenous (inner) sex hormones, which are secreted from their gonads beginning at approximately eight weeks' gestation⁵¹ (in human development, the time window for prenatal development of the genitals precedes the time window for brain sexual differentiation). Later, during life outside the womb, circulating hormones influence

⁴⁶ Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., Cohen-Kettenis, P. T. 'Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study.' *J. Am. Acad. Child Adolesc. Psychiatry*, 52 (2013): 582–90; Singh, D. 'A follow-up study of boys with gender identity disorder.' PhD Thesis, Univ. Toronto. 2012.

⁴⁷ De Vries, A. L. C. Cohen-Kettenis, P. T. 'Gender dysphoria in children and adolescents.' In *Principles of Transgender Medicine and Surgery*. (Ed.) Monstrey, S., Ettner, R., Coleman, E. Taylor and Francis, 2016. ProQuest Ebook Central. Web. 29 September 2016.

⁴⁸ Drummond, K. D., Bradley, S. J., Peterson-Badali, M., Zucker, K. J. 'A follow up study of girls with gender identity disorder.' *Developmental Psychology*, 44 (2008): 34-45; Wallien, M. S., Cohen-Kettenis, P. T. 'Psychosocial outcome of gender dysphoric children.' *J. Am. Acad. Child. Adolescent Psych.*, 47 (2008): 1413-1423.; Steensma, T. D. 'From Gender Variance to Gender Dysphoria; Psychosexual Development of Gender Atypical Children and Adolescents.' PhD Thesis. Amsterdam: VU University Medical Center.

⁴⁹ Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., Wylie, K. 'Transgender people: health at the margins of society.' *The Lancet*. Published Online. 17June 2016. [http://dx.doi.org/10.1016/S0140-6736\(16\)00683-8](http://dx.doi.org/10.1016/S0140-6736(16)00683-8).

⁵⁰ Zucker, K. J., Lawrence, A. A., Kreukels, P. C. 'Gender Dysphoria in Adults.' *Ann. Rev. Clin. Psychol.*, 12 (2016): 217–47; Kuyper, L., Wijzen, C. 'Gender identities and gender dysphoria in the Netherlands.' *Arch. Sex. Behav.* 43/2 (2014): 377–85.; Winter, S., Diamond, M., Green, J., Karasic, D., Reed, T., Whittle, S., Wylie, K. 'Transgender people: health at the margins of society.' *The Lancet*. Published Online. 17June 2016. [http://dx.doi.org/10.1016/S0140-6736\(16\)00683-8](http://dx.doi.org/10.1016/S0140-6736(16)00683-8).

⁵¹ Gu, J., Kanai, R. 'What contributes to individual differences in brain structure?' *Front. Hum. Neurosci.*, 8 (2014): 262.

activation of the brain. Hormone levels may fluctuate or change during puberty, the menstrual cycle, menopause and hormone treatment.

(98) A prominent hypothesis or theory for the mechanism behind feelings of gender incongruence is that exposure to sex hormones during prenatal development has led to atypical sexual differentiation of the brain, with the body and genitals developing in the direction of one sex, and the brain and gender in the direction of the other sex.⁵² Research has demonstrated a limited, but significant role of prenatal (before birth) and potentially postnatal (after birth) androgens in gender identity development.⁵³

1.12.2 Genetic hypothesis

(99) It has been suggested that genetic factors may be responsible for the development of gender identity and gender incongruence. The genetic background of gender non-conformity is largely unidentified, but in twins, monozygotic (identical) twin pairs show a higher concordance of gender non-conformity than dizygotic (non-identical) twin pairs.⁵⁴ However, the largest study of monozygotic twins showed only a 20% concordance in transsexual behaviour, suggesting genetic involvement in the development of gender non-conformity is minimal.⁵⁵ Studies aimed at identification of individual candidate genes have been inconsistent.⁵⁶

1.12.3 Brain development and structure

(100) Another theory is that gender incongruence develops as a result of brain structure. Neuroimaging studies focusing on brain structure show conflicting results. There is evidence that the brain appearance for gender non-conforming individuals differs in various ways from gender conforming men and women, and bears some resemblances to that of the chosen gender both in structure and in function.⁵⁷ However, brain-activation patterns in these studies do not offer support for associations between brain activation and sexual identity or arousal. Furthermore, it is not clear whether the anatomical changes are produced by, or rather influence, behaviour. Neuroplasticity is the well-established biological phenomenon in which long-term behaviour alters brain microstructure.⁵⁸ Neurological differences might be due to biological factors such as genes or prenatal hormone exposure, or a result of environmental factors (see Section 6.2), or possibly some combination of the two. But if, and when, valid gender non-conforming brain differences are identified, these will be more likely the *result* of long term transgender behaviour than its cause.⁵⁹

1.13 Is it environmental (Nurture)?

(101) There is evidence that environmental factors predominate in the development and persistence of gender non-conformity. No single factor has been linked to the development of gender non-conformity, but twin studies referenced below suggest that a number of social or family situations may lead to gender non-conformity in biologically vulnerable⁶⁰ children. Contributing factors may include social reinforcement of gender roles, child and/or parent psychopathology, abuse, family dynamics, and the influence of social media. No studies have been done on parents of children presenting to gender clinics, so no firm evidence is available.

⁵² Swaab, D. F., Garcia-Falgueras, A. 'Sexual differentiation of the human brain in relation to gender identity and sexual orientation.' *Funct. Neurol.*, 24 (2009): 17–28.

⁵³ De Vries, A. L. C., Doreleijers, T. A. H., Cohen-Kettenis, P. T. 'Disorders of sex development and gender identity outcome in adolescence and adulthood: understanding gender identity development and its clinical implications.' *Pediatr. Endocrinol. Rev.* 4 (2007): 343–351; Berenbaum, S. A., Meyer-Bahlburg, H. F. L. 'Gender development and sexuality in disorders of sex development.' *Horm. Metab. Res.*, 47 (2015): 361–66.

⁵⁴ Heylens, G., De Cuypere, G., Zucker, K. J., Schelfaut, C., Elaut, E., et al. 'Gender identity disorder in twins: a review of the case report literature.' *J. Sex. Med.* 9 (2012): 751–57.

⁵⁵ Diamond, M. 'Transsexuality Among Twins: identity concordance, transition, rearing, and orientation.' *International Journal of Transgenderism*, 14/1 (2013): 24–38.

⁵⁶ Baudewijntje, P.C., Kreukels, B. P., Guillamon, A. 'Neuroimaging studies in people with gender incongruence.' *International Review of Psychiatry*, 28/1 (2016): 120-128; Heylens, G., De Cuypere, G., Zucker, K. J., Schelfaut, C., Elaut, E., et al. 'Gender identity disorder in twins: a review of the case report literature.' *J. Sex. Med.* 9 (2012): 751–57.

⁵⁷ Baudewijntje, P.C., Kreukels, B. P., Guillamon, A. 'Neuroimaging studies in people with gender incongruence.' *International Review of Psychiatry*, 28/1 (2016): 120-128.

⁵⁸ Gu, J., Kanai, R. 'What contributes to individual differences in brain structure?' *Front. Hum. Neurosci.*, 8 (2014): 262 .

⁵⁹ Mayer, L. S., McHugh, P. R. 'Sexuality and Gender: Findings from the Biological, Psychological and Social Sciences.' *The New Atlantis: A Journal of Technology and Society*, 50 (2016): 4-143.

⁶⁰ E.g., see paragraph 98.

1.13.1 Social reinforcement of gender roles

(102) There is evidence that gender identity is malleable and influenced by psychosocial experiences, including therapeutic interventions.⁶¹ This suggests that whether we choose to reinforce the biological or nonbiological gender will make a difference to the development of a gender non-conforming individual. Anecdotally, many parents of children with gender non-conformity report supporting their child in the nonbiological gender role prior to presentation to medical services. In contrast, as mentioned above, encouragement in the biological sex role usually leads to resolution of gender non-conformity.

1.13.2 Psychopathology

(103) There are many reasons why a child with gender identity issues might have an associated mental disorder. The gender non-conformity may be either a symptom or a cause of such a problem, or the mental distress could result from others' response to the gender non-conforming experience. Both may contribute. While much of the research on psychopathology that can occur in association with gender non-conformity has significant limitations in terms of methodology, and the cause is unknown, it is important to be aware of the nature of these conditions when attempting to understand the causes and consequences of gender non-conformity and its treatment.

(104) High levels of psychiatric disease have been reported in both pre-pubertal gender dysphoric children,⁶² and adolescents.⁶³ These include anxiety disorders, phobias, mood disorders, depression, and attention deficit disorder (ADHD), suicidal and self-harming behaviours, psychotic symptoms, behavioural problems, substance abuse, and anorexia nervosa. There is increasing evidence of links between gender dysphoria and autism spectrum disorder.⁶⁴

(105) Depression, anxiety disorders and suicidal ideation are significantly more prevalent in adults with gender dysphoria than in the general population,⁶⁵ with up to 2/3 of adults experiencing depression and almost half experiencing anxiety disorder.⁶⁶ About one in three adults with gender dysphoria has

⁶¹ Zucker, K. J. 'Gender identity development and issues.' *Child and Adolescent Psychiatric Clinics of North America*, 13/3 (2004): 551-568.

⁶² Wallien, M. S., Swaab, H., Cohen-Kettenis, P. T. 'Psychiatric comorbidity among children with gender identity disorder.' *J. Am. Acad. Child. Adol. Psych.*, 46 (2007): 1307-1314.

⁶³ Kaltiala-Heino, R., Sumia, M., Työläjärvä, M., Lindberg, N. 'Two years of gender identity service for minors: overrepresentation of biological girls with severe problems in adolescent development.' *Child and Adolescent Psychiatry and Mental Health*, 9/1 (2015): 1-9.; Children and adolescents with gender identity disorder referred to a pediatric medical center. Spack, N. P., Edwards-Leeper, L., Feldman, H. A. et al. 'Children and adolescents with gender identity disorder referred to a pediatric medical center.' *Pediatrics*, 129/3 (2012): 418-425.; Steensma, T. D., Zucker, K. J., Kreukels, B. P. et al. 'Behavioural and emotional problems on the Teacher's Report Form: a cross national, cross-clinic comparative analysis of gender dysphoric children and adolescents.' *J. Abnorm. Child. Psycho.*, 42 (2014): 635-647.; Hewitt, J. K., Paul, C., Kassianan, P. et al. 'Hormone treatment of gender identity disorder in a cohort of children and adolescents.' *MJA*, 196/9 (2012): 578-581.; De Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T. et al. 'Autism spectrum disorders in gender dysphoric children and adolescents.' *J. Autism Dev. Dis.*, 40/8 (2010): 930-936.; Holt, V., Skagerberg, E., Dunsford, M. 'Young people with features of gender dysphoria: demographics and associated difficulties.' *Clin. Child. Psychol. Psychiatry*, 16/1 (2016): 108-118.

⁶⁴ De Vries, A. L., Noens, I. L., Cohen-Kettenis, P. T. et al. 'Autism spectrum disorders in gender dysphoric children and adolescents.' *J. Autism Dev. Dis.* 40/8 (2010): 930-936.; Strang, John F., et al. 'Increased gender variance in autism spectrum disorders and attention deficit hyperactivity disorder.' *Archives of sexual behaviour*, 43/8 (2014): 1525-1533.; Van Der Miesen, A. I., Hurley, H., De Vries, A. L. C. 'Gender dysphoria and autism spectrum disorder: A narrative review.' *International Review of Psychiatry*, 28/1 (2016): 70-80.; Cook, M. 'Autism, gender-dysphoria link: The evidence mounts.' *News Weekly* 2989 (2017): 5. Similar links have been identified between autism spectrum disorders and anorexia nervosa, Westwood, H., Tchanturia, K., 'Autism Spectrum Disorder in Anorexia Nervosa: An Updated Literature Review.' *Curr. Psychiatry Rep.*, 19/7 (2017): 41.

⁶⁵ Zucker, K. J., Lawrence, A. A., Kreukels, P. C. 'Gender Dysphoria in Adults.' *Ann. Rev. Clin. Psychol.*, 12 (2016): 217-47.

⁶⁶ Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., Landén M. 'Long-term followup of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden.' *PLOS ONE*, 6(2) (2011): e16885. Affiliation: Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet, Stockholm, Sweden); Heylens, G., Elaut, E., Kreukels, B. P., Paap, M. C., Cerwenka, S., et al. 'Psychiatric characteristics in transsexual individuals: multicentre study in four European countries.' *Br. J. Psychiatry*, 204/2 (2014): 151-56.; See also Auer, M. K., Fuss, J., Stalla, G. K., Athanasoulia, P. 'Twenty years of endocrinologic treatment in transsexualism: analyzing the role of chromosomal analysis and hormonal profiling in the diagnostic work-up.' *Fertil. Steril.*, 100/4 (2013): 1103-10; Davey, A., Bouman, W. P., Arcelus, J., Meyer, C. 'Social support and psychological well-being in gender dysphoria: a comparison of patients with matched controls.' *J. Sex. Med.* 11/12 (2014): 2976-85; Haraldsen, I. R., Dahl, A. A. 'Symptom profiles of gender dysphoric patients of transsexual type compared to patients with personality disorders and healthy adults.' *Acta Psychiatr. Scand.*, 102/4 (2000): 276-81; Heylens, G., Verroken, C., De Cock, S., T'Sjoen, G., De Cuypere, G. 'Effects of different steps in gender reassignment therapy on psychopathology: a prospective study of persons with a gender identity disorder.' *J. Sex. Med.* 11/1 (2014): 119-26; Simon, L., Zsolt, U., Fogd, D., Czobor, P. 'Dysfunctional core beliefs, perceived parenting behavior and psychopathology in gender identity disorder: a comparison of male-to-female, female-to-male transsexual and nontranssexual control subjects.' *J. Behav. Ther. Exp. Psychiatry*, 42/1 (2011): 38-45.

experienced suicidal ideation, attempted suicide, or engaged in self-harm.⁶⁷ Opinions as to whether these conditions are involved with the cause or experience of gender dysphoria differ.⁶⁸

(106) The rate of psychiatric illness in this population should be kept in mind when any intervention is claimed to lead to mental wellness. Studies are limited regarding methodology and the true rate of self-harm in this population is unknown. One study reported around 15% prevalence of self-harm and suicidal ideation, with actual suicide attempts much lower.⁶⁹ Whatever the case, those affected are clearly a vulnerable part of our community, needing care and compassion. Management is discussed below.

1.13.3 Family dynamics

(107) Gender dysphoria in boys was found to develop in association with an overly close relationship with their mother and a distant relationship with their father.⁷⁰ Systematic studies involving girls with gender non-conformity and the parent-child relationship have not been conducted to investigate whether they are associated with aetiology.

(108) Parental psychopathology has also been reported in association with development of gender nonconformity, with high rates of depression, bipolar disorder and sexual abuse.⁷¹ One study found that over half the children with gender dysphoria had parents who were separated, with domestic violence indicated in 9.2% and drug abuse in 7.3% of families.⁷² No causative link has been verified but there is clearly scope for further research.

1.13.4 Influence of social media

(109) Clinicians working with adolescents report anecdotally of an increasing trend for self-diagnosis as 'transgender' in this group both individually and in peer groups, suggesting an element of social contagion.⁷³

Medical Approach to Gender Dysphoria

1.14 Referral to gender clinics

(110) There is a significant increase in the number of children and adults seeking treatment in gender clinics. It is too early to assign reasons for this increase, but possible factors include the following.

- Increased visibility of transgender people in the media (Caitlyn Jenner, Transparent, The Danish Girl) has led to transgender issues entering the societal consciousness as an increasingly mainstream phenomenon, thus contributing to at least a partial de-stigmatization. Political moves to enforce acceptance of transgender behaviour in institutions further 'normalises' transgender and reduces reluctance to present for treatment.
- The wide availability of information on the internet and other communication channels about gender dysphoria and gender non-conformity are also likely to contribute to de-stigmatization.
- As being transgender enters societal consciousness, more people reflect on their biological and experienced gender, and some may feel an incongruence and therefore possibly question their gender status which had previously always been taken for granted as being aligned with their biological sex.
- The increased awareness of the availability of biomedical treatment.

⁶⁷ Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., Landén M. 'Long-term followup of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden.' *PLOS ONE*, 6(2) (2011): e16885. Affiliation: Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet, Stockholm, Sweden.):

⁶⁸ Zucker, K. J., Lawrence, A. A., Kreukels, P. C. 'Gender Dysphoria in Adults.' *Ann. Rev. Clin. Psychol.* 12 (2016): 217–47.

⁶⁹ Holt, V., Skagerberg, E., Dunsford, M. 'Young people with features of gender dysphoria: demographics and associated difficulties.' *Clin. Child Psychol. Psychiatry*, 164/1 (2016): 108-118.

⁷⁰ Zucker, K. J., Bradley, S. J. 'Gender Identity and Psychosexual Disorders.' *FOCUS*, 3/4 (2005): 598-617.

⁷¹ Youth Trans Critical Professionals. Professionals Thinking Critically about the Youth Transgender Narrative. Online: <https://youthtranscriticalprofessionals.org/about/>. [Accessed 9 August 2017.]

⁷² Ibid.

⁷³ Youth Trans Critical Professionals. Professionals Thinking Critically about the Youth Transgender Narrative. Online: <https://youthtranscriticalprofessionals.org/about/>. [Accessed 9 August 2017.]

1.15 Management of Children with Gender Dysphoria

(111) The following section describes the common management approaches to gender dysphoria. It does not provide a biblical response about the merits of such approaches. Advice to Christian healthcare professionals is given in 7.7.

1.15.1 Approaches

(112) Three paths of management are currently recognised: 'Living in your skin', 'Watch and wait', and 'Affirmative therapy'.⁷⁴

1. Living in your skin (also known as 'Conversion' or 'Reparative' Therapy): The first approach focuses on working with the child and caregivers to lessen cross-gender behaviour and identification with the opposite gender, to persuade the child that the 'right gender' is the one acknowledged at birth. The aim is to decrease the likelihood that gender dysphoria will persist into adolescence, and prevent adult transgenderism. **Until recently, this was the standard approach.**⁷⁵ The goals of therapy were to address familial pathology if it was present, to explore the reasons for the gender dysphoria, to treat any psychosocial morbidities in the child, and aid the child in aligning his or her gender identity with his or her biological sex.⁷⁶ Experts on both sides of the pubertal suppression debate agree that within this context, 80% – 95% of children with gender identity disorders accept their biological sex and achieve emotional well-being by late adolescence.⁷⁷ Despite this, interventions aimed to lessen gender dysphoria by this method are referred to as unethical by organisations such as the World Professional Association for Transgendered Health (WPATH), and political campaigns have led to their being banned in some countries.
2. 'Waiting and watching': The second approach focuses on addressing the potential social risks for the child. Its aim is to make the child comfortable in the child's biological sex role, hoping that he or she will 'grow out of it', and to allow the progress of the gender dysphoria in the child to unfold in a 'natural' (uninfluenced) way with the expectation that it will dissipate. Counselling based on this approach may include interventions that focus on the co-existing problems of the child and/or the family; helping parents and the child to bear the uncertainty of the child's psychosexual outcome; and providing psycho-education to help the child and the family to make 'balanced' decisions regarding topics such as the child's 'coming out', early social transitioning, and/or how to handle peer rejection or social ostracism. In practice, the child and parents are encouraged to find a balance between an accepting and supportive attitude toward gender non-conformity, while at the same time protecting the child against any negative reactions and remaining realistic about the chance that gender dysphoric feelings may desist in the future. Parents are encouraged to provide enough space for their child to explore their gender non-conforming feelings, while at the same time keeping all future outcomes open. Cross-gender behaviour is thus permitted but not encouraged, and generally allowed only in the home.⁷⁸ Note that, although this is labelled (by promoters of transgender) as 'watching and waiting', the known impact of environmental factors on child development means that even this degree of support for the gender non-conforming position will potentially influence outcomes **in favour of persisting**.
3. 'Affirmative' therapy: The third approach focuses on affirming the child's (trans)gender identification and helps the child to build a positive self-identity and gender resilience within that role. In particular, the child is supported in transitioning to the desired gender role.

⁷⁴ Ristoria, J., Steensma, T. D. 'Gender dysphoria in childhood.' *International Review of Psychiatry*, 28/1 (2016): 13-20.

⁷⁵ Shechner, T. 'Gender identity disorder: a literature review from a developmental perspective.' *Isr. J. Psychiatry Relat. Sci.*, 47/2 (2010): 132-138; *American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders*. 5th ed; 2013:451-459.

⁷⁶ Zucker, K. J., Bradley, S. J. 'Gender identity and psychosexual disorders.' *FOCUS*, 3/4 (2005): 598-617; Zucker, K. J., Bradley, S. J., Ben-Dat, D N., et al. 'Psychopathology in the parents of boys with gender identity disorder.' *J. Am. Acad. Child Adolesc. Psychiatry*, 42 (2003): 2-4.

⁷⁷ Cohen-Kettenis, P. T., Delemarre-van de Waal, H. A., Gooren, L. J. 'The treatment of adolescent transsexuals: changing insights.' *J. Sexual Med.*, 5/8 (2008): 1892-7.

⁷⁸ De Vries, A. L., Cohen-Kettenis, P. T. 'Clinical management of gender dysphoria in children and adolescents: The Dutch approach.' *Journal of Homosexuality*, 59/3 (2012): 301–320.

1.15.2 *The case for early social transition*

(113) The rationale given for supporting social transition before puberty is that children can revert to their biologically-aligned gender if necessary since the transition is solely at a social level and without medical intervention, and the child can explore gender identity free from the emotional distress triggered by the onset of secondary sexual characteristics.

(114) In addition, adult transgender activists have promoted early identification, affirmation and hormonal pubertal suppression to save children from the suffering they themselves experienced during development, citing risks of suicide and violence for the untreated person.⁷⁹ The only study on pre-pubertal children who received pubertal suppression and social affirmation found that 100% of participants eventually embraced a transgender identity (instead of the usual 2.3%),⁸⁰ suggesting that the protocol itself may lead the individual to identify as transgender. As previously mentioned, currently no tests can pre-determine which children will persist if not encouraged in cross-sex behaviour.

1.15.3 *The case against early social transition*

(115) Critics of this approach refer to the evidence that supporting gender transition in childhood may indeed relieve short-term distress for children with gender dysphoria, but is also likely to influence future development. The debate thereby focuses on whether transition may increase the likelihood of persistence because, for example, a child may 'forget' how to live in the original gender role and no longer be able to feel the desire to change back; or that transitioned children may repress doubts about the transition out of fear that they have to go through the process of making their desire to socially (re)transition public for a second time, a process that can be difficult, even when desired by the child, due to fear of peer group reactions.⁸¹ Brain plasticity will play a part in reinforcing the new role and making change difficult.

(116) In summary, childhood gender dysphoria is a rare condition with unknown prevalence. As most gender non-conforming children desist without treatment, intervention is unnecessary, and support of transition has been referred to as 'abuse' by a growing number of commentators in the field.⁸²

1.16 Management of Adolescents

(117) Current management of gender dysphoric adolescents recommends transitioning. 'Transition' involves several stages: social transition; puberty blocking with drugs; development of cross-sex features through use of sex hormones; and surgery. There are no long-term studies that compare the alleged benefits and potential harms to gender non-conforming children who undergo hormonal suppression of puberty and long-term hormone use, nor has there been rigorous research comparing this approach to psychotherapeutic interventions for childhood gender non-conformity.⁸³ This means we do not know whether transitioning leads to better outcomes than supporting the adolescent in the gender of their biological sex. The current ideology has led to the supportive option being criticised, despite the health risks involved in transition.

(118) Pubertal suppression from around 11 years of age followed by use of cross-sex hormones from age 16 years (oestrogen for biological boys and testosterone for biological girls) will leave the child sterile and without gonadal tissue or gametes (sperm, eggs) available for cryo-preservation (freezing).⁸⁴ An alternative

⁷⁹ Sadjadi, S. 'The endocrinologist's office—puberty suppression: saving children from a natural disaster?' *J. Med. Humanit.*, 34/2 (2013): 255-260.

⁸⁰ De Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., Cohen-Kettenis, P. T. 'Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study.' *J. Sex. Med.*, 8/8 (2011): 2276-2283.

⁸¹ Steensma, T. D., Cohen-Kettenis, P. T. 'Gender transitioning before puberty?' *Archives of Sexual Behavior*, 40/4 (2011): 649–650.

⁸² Whitehall, J. 'Gender dysphoria and surgical abuse.' *Quadrant* (15 December 2016). Online: <https://quadrant.org.au/magazine/2016/12/gender-dysphoria-child-surgical-abuse/>. [Accessed 9 August 2017.]; Cretella, M. 'I'm a Pediatrician. How Transgender Ideology Has Infiltrated My Field and Produced Large-Scale Child Abuse.' *The Daily Signal* (3 July 2017). Online: <http://dailysignal.com/2017/07/03/im-pediatrician-transgender-ideology-infiltrated-field-produced-large-scale-child-abuse/> [Accessed 10 July 2017.]; Cook, M. "Autism, gender-dysphoria link: The evidence mounts." *News Weekly* 2989 (2017): 5.

⁸³ Hayes, Inc. 'Sex reassignment surgery for the treatment of gender dysphoria.' *Hayes Medical Technology Directory*. Lansdale, Pa.: Winifred Hayes; 15 May 2014.

⁸⁴ Eyer, A. E., Pang, S. C., Clark, A. 'LGBT assisted reproduction: current practice and future possibilities.' *LGBT Health*, 1/3 (2014): 151-156; Schmidt, L., Levine, R. 'Psychological outcomes and reproductive issues among gender dysphoric individuals.' *Endocrinol. Metab. Clin. N. Am.*, 44/4 (2015): 773-785; Jeffreys, S. 'The transgendering of children: gender eugenics.' *Women's Studies International Forum*, 35 (2012): 384-393.

protocol suggests putting children as young as 11 years old directly onto cross-sex hormones⁸⁵ with the rationale that that the child will experience pubertal development of the desired sex and thereby avoid the emotional stress of remaining pre-pubertal in appearance while their peers are moving along the normal pubertal developmental trajectory. It should be noted that one reason suggested for growing use of this protocol is parental demand for hormonal treatment.⁸⁶

1.16.1 Reversible treatment

(119) Pubertal suppression with gonadotropin releasing hormone agonists (GnRHa) is promoted as a reversible hormonal intervention that prevents the development of 'unwanted' secondary sexual characteristics of an adolescent's biological sex. According to the WPATH Standards of Care, adolescents should be considered eligible for puberty suppression based on five criteria: evidence of gender dysphoria from early childhood onwards, an increase in the intensity of gender dysphoria after the first pubertal changes, no signs of psychiatric comorbidity, provision of adequate psychological and social support during the treatment, and demonstration of knowledge and understanding of the effects of puberty suppression by the patient.⁸⁷ If the hormones are discontinued, theoretically, puberty will ensue.⁸⁸

(120) Whether or not this treatment is 'reversible', there is evidence that irreversible side-effects of treatment exist, including abnormalities of bone growth, impaired brain development and reduced fertility.⁸⁹ There is a high risk of medical complications in both male to female (thromboembolism, liver dysfunction), and female to male (breast and uterine cancer, liver dysfunction) with cross gender hormone treatment.⁹⁰ Long term safety issues have not been fully assessed, and potential risks for children and adolescents are based on the adult literature due to lack of research in paediatric populations.⁹¹

(121) And although, as mentioned above, theoretically puberty should resume if hormone blockers are stopped, the international Endocrine Society is cautious, as there is no research evidence to support this claim. The Society recommends against social role changes and hormone therapy in prepubertal children in view of the high rate of remission for gender non-conforming behaviour in those left untreated.⁹²

(122) Furthermore, the impact of impersonation of the opposite sex is likely to impact on brain neuroplasticity to make identity alignment with the biologic sex less likely and/or more difficult. Brain changes do not remove the necessity to take hormones continuously. Note above that the only study of puberty blocking found that all participants eventually embraced transgender identity and requested cross-sex hormones,⁹³ and a protocol that leads to a single inevitable outcome (transgender identification) and lifelong use of toxic synthetic hormones is suggested to be neither fully reversible nor harmless.⁹⁴ Anecdotal evidence regarding the role of parents in promoting varying levels of transition range from active encouragement to fear of losing custody if they do not comply with transitional steps.⁹⁵

⁸⁵ Keleman, M. 'What do transgender children need?' *Houstonia Magazine* (3 November 2014). Online: www.houstoniamag.com/articles/2014/11/3/what-do-transgender-children-need-november-2014. [Accessed 15 November 2017.]

⁸⁶ Farwell, S. 'Free to be themselves: Children's Medical Center Dallas opens clinic for transgender children and teenagers, the only pediatric center of its type in the Southwest.' *Dallas Morning News* (4 June 2015). Online: <http://interactives.dallasnews.com/2015/gender/>. [Accessed 15 November 2017.]

⁸⁷ Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J, et al. 'Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7.' *Int. J. Transgenderism*, 13/4 (2012): 165–232.

⁸⁸ Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L.J., Meyer, W. J. 3rd, et al. 'Endocrine treatment of transsexual persons: an Endocrine Society Clinical Practice Guideline.' *J. Clin. Endocrinol. Metab.*, 94/9 (2009): 3132–54.

⁸⁹ Kreukels, B. P., Cohen-Kettenis, P. T. 'Puberty suppression in gender identity disorder: the Amsterdam experience.' *Nature Reviews Endocrinology*. 7/8 (2011): 466–72.

⁹⁰ Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L.J., Meyer, W. J. 3rd, et al. 'Endocrine treatment of transsexual persons: an Endocrine Society Clinical Practice Guideline.' *J. Clin. Endocrinol. Metab.*, 94/9 (2009): 3132–54.

⁹¹ Hayes, Inc. 'Sex reassignment surgery for the treatment of gender dysphoria.' *Hayes Medical Technology Directory*. Lansdale, Pa.: Winifred Hayes; 15 May 2014.

⁹² Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L.J., Meyer, W. J. 3rd, et al. 'Endocrine treatment of transsexual persons: an Endocrine Society Clinical Practice Guideline.' *J. Clin. Endocrinol. Metab.*, 94/9 (2009): 3132–54.

⁹³ De Vries, A. L. C., Steensma, T. D., Doreleijers, T. A. H., Cohen-Kettenis, P. T. 'Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study.' *J. Sex. Med.* 8/8 (2011): 2276–2283.

⁹⁴ American College of Pediatricians. *Gender Dysphoria in Children*. Position statement. August 2016. Updated and revised version online: <https://www.acpeds.org/the-college-speaks/position-statements/gender-dysphoria-in-children>.

⁹⁵ Anon. 'A Christian mother shares her family's fears of losing their "gender-confused" daughter.' *ChristianConcern* (28 October 2016). Online: <http://www.christianconcern.com/media/christian-mother-shares-her-family-s-fears-of-losing-their-gender-confused-daughter> [Accessed 3 May 2017.]

(123) Neuroscience clearly documents that the adolescent brain is cognitively immature and lacks an adult capacity for risk assessment prior to the early to mid-twenties. There is therefore a serious ethical problem with allowing either social or irreversible, life-changing treatments to be performed on minors who are too young to give valid consent themselves.⁹⁶

(124) It is also argued that suggested risks of suicide as a result of withholding treatment may be misleading in view of the high rate of resolution of gender dysphoria in untreated adolescents and the prevalence of psychiatric disorders in persons who successfully suicide.⁹⁷

1.16.2 Partially reversible interventions

(125) In older adolescents with gender dysphoria, cross-sex hormone therapy is often used to promote the secondary sexual characteristics of the sex most compatible with the individual's declared gender identity. These interventions also suppress the effects of an individual's endogenous (inner) hormones. Adults using oestrogen and/or testosterone are known to be at risk of multiple side-effects, as mentioned above, and worsening of psychiatric disorders.⁹⁸

(126) Older adolescents who have not undergone puberty suppression but are contemplating use of cross-sex hormone use are advised to freeze gametes (eggs and sperm) prior to commencing treatment, as treatment will make them sterile.

1.16.3 Irreversible surgical interventions

(127) This is known as sex reassignment surgery (SRS), or, more recently, is also called gender-confirming, gender affirming, or realignment, surgery. (See Section 7.5). Girls as young as 15 years have had mastectomies under this protocol.⁹⁹

(128) In summary, gender non-conformity in adolescence is uncommon, and with encouragement, the majority will embrace their biological sex role by the time they become adults. In view of the risks of treatment and the inability to make mature judgements regarding irreversible therapeutic outcomes, despite its political and cultural popularity, transition is not universally recommended by health professionals.¹⁰⁰ Research has not been done to assess whether it is more likely to alleviate distress than supportive care in the biological sex role.

1.17 Management in Adults

(129) Treatment of gender dysphoria in adults is largely standardized in developed countries. The most influential guidelines are *Current Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, Version 7, (SOC-7)*¹⁰¹ devised by WPATH, although others also exist. It is expected that treatment is likely to evolve in response to the increasing diversity of persons seeking treatment, demands for greater client autonomy, and improved understanding of the benefits and limitations of current treatment modalities.¹⁰²

(130) SOC-7 suggests that the ability to diagnose gender dysphoria and any associated psychopathology should not be limited to mental health experts, but extended to any health professional. This apparently

⁹⁶ Johnson, S. B., Blum, R. W., Giedd, J. N. 'Adolescent maturity and the brain: the promise and pitfalls of neuroscience research in adolescent health policy.' *J. Adolesc. Health*, 45/3 (2009): 216-221. See also World Health Organisation. *Eliminating forced, coercive and otherwise involuntary sterilization. Interagency statement*; (2014), concerning lack of informed content to sterilization, even as a secondary consequence of medical treatment. Online: http://apps.who.int/iris/bitstream/10665/112848/1/9789241507325_eng.pdf?ua=1. [Accessed 10 August 2017.]

⁹⁷ Bertolote, J. M., Fleischmann, A. 'Suicide and psychiatric diagnosis: a worldwide perspective.' *World Psychiatry*, 1/3 (2002): 181-185.

⁹⁸ Moore, E., Wisniewski, A., Dobs, A. 'Endocrine treatment of transsexual people: a review of treatment regimens, outcomes, and adverse effects.' *J. Clin. Endocrinol. Metab.*, 88/8 (2003): 3467-3473.

⁹⁹ Overington, C. 'Mastectomy win for girl, 15, after sex-change plea.' *The Australian* (9 August 2016). Online: <http://www.theaustralian.com.au/business/legal-affairs/mastectomy-win-for-girl-15-after-sexchange-plea/news-story/84e412c33547ad4cdd81e746e5a5abb3>. [Accessed 15 November 2017.]

¹⁰⁰ Hembree, W. C., Cohen-Kettenis, P., Delemarre-van de Waal, H. A., Gooren, L.J., Meyer, W. J. 3rd, et al. 'Endocrine treatment of transsexual persons: an Endocrine Society Clinical Practice Guideline.' *J. Clin. Endocrinol. Metab.*, 94/9 (2009): 3132-54.

¹⁰¹ Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., et al. 'Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7.' *Int. J. Transgenderism*, 13/4 (2012): 165-232.

¹⁰² Zucker, K. J., Lawrence, A. A., Kreukels, P. C. 'Gender Dysphoria in Adults.' *Annu. Rev. Clin. Psychol.*, 12 (2016): 217-47.

was an attempt to reduce stigma¹⁰³ as well as being ideologically driven.¹⁰⁴ Involvement of mental health practitioners is no longer required for prescribing of hormones (although in Australia, endocrinologists are often involved for safety reasons). This attempt to reduce barriers to care risks under-diagnosis and under-treatment of associated psychopathology but reflects the reality of many persons with gender non-conformity taking non-prescribed hormones without medical supervision.

(131) It has been suggested that the least invasive treatment option available which enables the patient to live with their gender non-conformity should be used. As many as 50% of those who commence treatment drop out due to ambivalence or frustration with the process. It is not known what happens to this subgroup, but they may find ways to compartmentalize the gender dysphoria sufficiently to be able to function, for example by cross-dressing.¹⁰⁵

(132) Current treatment options, from the least to most invasive, include the following:

1.17.1 Counselling and psychotherapy for adults with Gender Dysphoria

(133) Gender dysphoria in adults sometimes remits spontaneously,¹⁰⁶ and there would seem to be a role for psychotherapy to help adults with gender dysphoria accept their biological sex, although this approach is considered futile and unethical by the SOC-7.¹⁰⁷ This view is disputed.¹⁰⁸ The aim of such treatment is for purposes of exploring gender identity, role and expression; mental health impact; alleviating distress; enhancing social and peer support; improving body image; or promoting resilience. Due to the SOC-7 position, there has been little research in this area, so here also the outcome compared with transitioning is not known.

1.17.2 Real-life experience in the preferred gender role

(134) Some adults find relief from gender dysphoria with real-life experience with or without hormone therapy, without proceeding to surgery. In view of the risks of surgery, eligibility requirements in the SOC-7 do not allow sex re-assignment surgery without a 12-month full-time real-life experience, even if the patient does not want one. This requirement is currently under review. Changes may involve living part- or full-time in another gender role.

(135) Real-life experience carries significant psychosocial risks, including loss of employment, impaired relationships with family and friends, and gender-based discrimination and physical and mental abuse,¹⁰⁹ as well as the impact of neuroplasticity on the brain.

1.17.3 Hormone therapy

(136) Hormone therapy aims to feminize or masculinize the body. Adult biological men may receive a form of estrogen and testosterone suppression in the form of cyproterone acetate, spironolactone, or GnRH agonists. Adult biological women may receive a form of testosterone.

(137) A long-term comparison of gender non-conforming adults who were receiving treatment with feminizing or masculinizing hormones with the general population reported the following changes. Women receiving testosterone experienced dramatic masculinising effects (e.g., beard growth and a marked increase in libido), while biological males receiving feminizing hormones experienced only minimal bodily effects (e.g. small breasts), as well as a significant decrease in libido. The number of deaths in male-to-female transgender adults was five times the number expected, due to suicide and death of unknown cause. They had a 45 times increased risk of thromboembolic events, a 400 times increased risk of hyperprolactinaemia, a 15 times increased risk of depressive mood changes, and elevation of liver

¹⁰³ De Vries, A. L. C., Cohen-Kettenis, P. T. 'Gender dysphoria in children and adolescents.' In *Principles of Transgender Medicine and Surgery*. (Ed.) Monstrey, S., Ettner, R., Coleman, E. Taylor and Francis, 2016. ProQuest Ebook Central. Web. 29 September 2016.

¹⁰⁴ Lawrence, A.A., 'Gender assignment dysphoria in the DSM-5.' *Archives of sexual behavior*, 43/7 (2014): 1263-1266.

¹⁰⁵ Yarhouse, M. A. *Understanding Gender Dysphoria: Navigating Transgender Issues in a Changing Culture*. Downers Grove, IL.: IVP, 2015.

¹⁰⁶ Marks, I., Green, R., Mataix-Cols, D. 'Adult gender identity disorder can remit.' *Compr. Psychiatry*, 41/4 (2000): 273-75.

¹⁰⁷ Zucker, K. J., Lawrence, A. A., Kreukels, P.C. 'Gender Dysphoria in Adults.' *Annu. Rev. Clin. Psychol.*, 12 (2016): 217-47.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

enzymes. Female-to-male transgender adults experienced a more than 10% weight increase, and acne. The association with heart disease was not clear.¹¹⁰

(138) Hormone-treated adults with gender non-conformity who have **not** undergone sex-reassignment surgery demonstrate significantly better quality of life, self-esteem, mood and less psychological distress than persons who have not yet begun hormone treatment.¹¹¹ Hormone therapy is considered an effective and 'reasonably safe' treatment in adults with gender dysphoria by proponents of transition.¹¹²

1.18 Sex reassignment surgery

(139) Sex reassignment surgery to change primary and/or secondary sex characteristics includes vaginoplasty or phalloplasty (creation of a vagina or penis by cosmetic surgery) and removal of biological sex organs. Surgery eligibility criteria usually requires a period of living full-time in the preferred gender.¹¹³ Note that artificial body parts do not function with normal physiology.

(140) Few controlled studies have examined the psychosocial outcomes of sex-reassignment surgery. Recent evidence has suggested that sex reassignment is associated with more serious psychological sequelae and more prevalent regret than had previously been supposed. Large studies have shown that in most cases, such surgery had diminished the distress of gender dysphoria, but the mortality rate was still higher than in the general population. Long-term follow-up of sex-reassigned persons show an increased risk for death from suicide, suicide attempts, psychiatric inpatient care and criminal convictions.¹¹⁴

(141) It appears that 20% of patients do not experience significant benefit from sex reassignment surgery. As criteria for potential surgical candidates becomes less stringent, this percentage could increase. A review of research in 2014 found only weak evidence to support sex reassignment surgery in adults.¹¹⁵ Surgery does not result in a level of health equivalent to that of the general population.¹¹⁶ Despite its limitations, the political support for transition is such that no other management strategy is being pursued at the present time.

(142) This means that people with gender dysphoria are usually told that transitioning is the best treatment available, and it is held up as a solution to all their problems. However, as seen above, this is not the case for most people, but the lack of research into alternatives means there is no evidence to support other treatment options either.

1.19 Understanding the medical schism

(143) It may seem odd that aggressive interventions to 'treat' gender non-conformity continue to be recommended in view of the lack of medical evidence for their effectiveness. In order to understand how this has come about, it is necessary to understand an historical note.

(144) Dr Kenneth Zucker led the Child Youth and Family Gender Identity Clinic in Toronto, an internationally renowned clinic for children and youth with gender non-conformity and gender dysphoria, for decades. He spent years helping his patients align their subjective gender identity with their biological sex, with much success. His view was that gender is quite malleable at a young age and gender non-conformity usually resolved itself with time. He was influential in research, diagnostic and treatment development for gender non-conformity and gender dysphoric individuals, and headed the group which developed the DSM-5's criteria for gender dysphoria. On December 15, 2015, he was fired for refusing to change his treatment

¹¹⁰ Asscheman, H., Gooren, L. J. G., Eklund, P. L. E. 'Mortality and morbidity in transsexual patients with cross-gender hormone treatment.' *Metabolism*, 38/9 (1989): 869-873.

¹¹¹ Murad, M. H., Elamin, M.B., Garcia, M.Z., Mullan, R.J., Murad, A., et al. 'Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes.' *Clin. Endocrinol.*, 72/2 (2010): 214–31; Zucker, K. J., Lawrence, A. A., Kreukels, P.C. 'Gender Dysphoria in Adults.' *Annu. Rev. Clin. Psychol.*, 12 (2016): 217–47.

¹¹² Zucker, K. J., Lawrence, A. A., Kreukels, P.C. 'Gender Dysphoria in Adults.' *Annu. Rev. Clin. Psychol.*, 12 (2016): 217–47.

¹¹³ Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., et al. 'Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7.' *Int. J. Transgenderism*, 13/4 (2012): 165–232.

¹¹⁴ Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., Landén M. 'Long-term followup of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden.' *PLOS ONE*, 6/2 (2011): e16885. Affiliation: Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet, Stockholm, Sweden.

¹¹⁵ Hayes, Inc. 'Sex reassignment surgery for the treatment of gender dysphoria.' *Hayes Medical Technology Directory*. Lansdale, Pa.: Winifred Hayes; 15 May 2014.

¹¹⁶ Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., Landén M. 'Long-term followup of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden.' *PLOS ONE*, 6/2 (2011): e16885. Affiliation: Department of Clinical Neuroscience, Division of Psychiatry, Karolinska Institutet, Stockholm, Sweden.

policy in response to political pressure,¹¹⁷ despite the support of his colleagues.¹¹⁸ Since then, those agreeing with his approach have hesitated to speak out for fear of similar reprisals, with subsequent skewing of the public debate.

1.20 Christian healthcare approach to gender non-conforming individuals

(145) All healthcare providers have an obligation to care for individuals struggling with gender identity issues with understanding, sensitivity and compassion. This area is challenging as attempts to undergo gender transition are opposed to Christian teaching.

(146) Biological sex is an objective biological fact which cannot be altered at will. Anomalies of human biological sex (i.e., DSD) do not invalidate God's good design in creation. As outlined above, there is evidence that reinforcement of the biological sex role improves the likelihood of resolution of gender nonconformity. This is standard medical practice for individuals with other forms of disordered thinking: e.g., when a person presents with anorexia, medical professionals do not support weight loss but seek to encourage a normal body image.

(147) Continuing the long-standing practice of recognising the distress, supporting it with psychotherapy to the best of our ability, and encouraging uniformity in the embodied self will therefore be the recommended therapeutic pathway in the Christian context. This is because Christians believe that finding one's identity within God's design will ultimately result in a healthier and more fulfilling life. Given the high prevalence of psychiatric disease in this population, any management approach should also include treatment of such conditions.

(148) The case for medical support of sex transitioning before adulthood is not evidence-based and should not be supported by Christian healthcare providers. This will put the Christian healthcare provider at odds with evolving views of gender identity in the current medical culture. However, there is scientific evidence that to avoid gender transition in the management of gender dysphoria is a reasonable choice. There is particularly good scientific evidence to reinforce the biological gender in young people, especially before puberty.

(149) Social pressure to impose a transgender ideology on those who do not support transitioning is unjust and undemocratic, as well as threatening professional integrity. The purpose of medicine is to heal the sick, not to collaborate with psychiatric disorders. Interventions to alter normal sexual anatomy to conform to transgender desires are disruptive to health.

(150) Management for gender dysphoric adults is more complex, partly because spontaneous resolution of the dysphoria is less common, and also because steps may have been taken towards transition (socially, hormonally, surgically) prior to coming to the Christian healthcare professional. The recommendation here would be to treat any comorbid conditions (e.g., depression, anxiety), and seek to support the person to find contentment with their biological sex, over time, and as much as this is possible. For those who have not begun gender transition, it needs to be made clear that, because of prevailing ideology, transition has been held up as a solution for all the problems confronting the individual with gender dysphoria. However, research clearly shows that, even with full transition, psychiatric morbidity persists. We would caution against even social transitioning because the neuroplasticity of the brain suggests that such behaviour would reinforce gender nonconformity rather than resolve it.

(151) The rare situations of DSD are categorically different from transgender interventions, and are not addressed here but are briefly outlined in Appendix 2.

(152) Management of a person's experience of gender non-conformity or gender dysphoria should therefore include all efforts to support them in their psychological distress and affirm them in their biological sex role. Within the current healthcare system, mentally competent adults make their own choices with which we may not agree, however they do not have the right to coerce Christian healthcare providers to prescribe medication or perform surgery which they believe to be harmful.

¹¹⁷ Singal, J. 'Culture wars. How the Fight Over Transgender Kids Got a Leading Sex Researcher Fired.' *Science of Us* (7 February 2016). Online: <http://nymag.com/scienceofus/2016/02/fight-over-trans-kids-got-a-researcher-fired.html>. [Accessed 21 April 2017.]

¹¹⁸ Anonymous. 'Open Letter to the Board of Trustees of CAMH'. Online: <https://www.ipetitions.com/petition/boardoftrustees-CAMH>. [Accessed 15 July 2017.]

Gender Identity and the Law in Australia

(153) The following overview of the current legal landscape was prepared by Steve Lucas (Legal Counsel and Corporate Secretary, SDS), with contributions from Associate Professor Neil Foster (Faculty of Law, Newcastle University). The authors of the report are grateful for their contributions.

1.21 Recognition of ‘transgender status’

(154) The test for whether a person is recognised as ‘transgender’ will vary according to the purpose for which the question is asked and the jurisdiction in which it is being asked.

Birth certificates

(155) The particulars on a person’s birth certificate will usually determine if a person is recognised as male or female (or their sex otherwise categorised) under the law.

(156) In NSW, the alteration of birth certificates with respect to sex is regulated under Division 5A of the *Births Deaths and Marriages Act 1995* (NSW).

(157) Under s 32B, an adult person may apply to alter their birth certificate, if they –

- (a) were born in NSW¹¹⁹,
- (b) can demonstrate that they have undergone a ‘sex affirmation procedure’, and
- (c) are not married.

(158) The application must also be supported by statutory declarations from 2 registered medical practitioners that verify the person has undergone a ‘sex affirmation procedure’ (s 32C).

(159) The same requirements apply in the case of a minor, but the application must be made by the child’s parents or guardians.

(160) The Act defines ‘sex affirmation procedure’ to mean –

...a surgical procedure involving the alteration of a person’s reproductive organs carried out:

- (a) for the purpose of assisting a person to be considered to be a member of the opposite sex, or
- (b) to correct or eliminate ambiguities relating to the sex of the person.

(161) Under s 32I, if a birth certificate has been changed in this way, the person is deemed to be of the changed sex for the purposes of NSW law.

(162) In some jurisdictions it is not necessary for a person to have undergone a medical procedure in order to have their birth certificate changed.

(163) In the ACT, there is no explicit requirement for surgery, only that the person believes their sex to be the sex nominated in the application and that “appropriate clinical treatment for alteration of the person’s sex” has been carried out or the person is intersex.¹²⁰

(164) At the end of 2016, South Australia amended its laws to provide explicitly that “invasive medical treatment” is not a requirement to change a person’s sex on their birth certificate.¹²¹ A person only needs a signed verification from a medical practitioner or psychologist that they have “undertaken a sufficient amount of appropriate clinical treatment in relation to the person’s sex or gender identity”.¹²² This clinical treatment “need not involve invasive medical treatment and may include or be constituted by counselling”. If the clinical treatment *only* involves counselling a “sufficient amount” is “at least 3 separate counselling sessions totalling 135 minutes or counselling sessions occurring over a period of at least 6 months”.

¹¹⁹ A person who was born outside NSW can also apply for registration of their sex in the Register if they meet the same requirements and are an Australian citizen or permanent resident, live in NSW (and have done so for at least one year) and their birth is not registered under the Act or in any corresponding law in a State or Territory (s 32DA).

¹²⁰ s 25, the Births, Deaths And Marriages Registration Act 1997 (ACT)

¹²¹ *Births, Deaths and Marriages Registration (Gender Identity) Amendment Act 2016 (SA)*. This Act has also expanded the categories available on the register to include male, female, non-binary and indeterminate/intersex/unspecified.

¹²² s 29K, Births, Deaths and Marriages Registration Act 1996 (SA).

(165) The Commonwealth government departments primarily rely on state and territory birth records. The Australian Government's *Guidelines on the Recognition of Sex and Gender*, which apply to all Commonwealth government departments and agencies, note that:

Sex reassignment surgery and/or hormone therapy are not pre-requisites for the recognition of a change of gender in Australian Government records.¹²³

(166) Assoc. Prof. Neil Foster observes that it seems that this policy was introduced following the decision of *Abrams and Minister for Foreign Affairs and Trade* [2007] AATA 1816; (2007) 98 ALD 438 (28 September 2007) in which the Commonwealth Administrative Appeals Tribunal over-turned a prior refusal to issue a passport in a revised gender to a person who had been born male, and ordered that a revised passport be issued identifying the applicant as female. The prior refusal had been based on the fact that the relevant State, NSW, only allowed a change of gender on a birth certificate where the applicant was unmarried, but this applicant had been married to a woman prior to undergoing surgery. The Tribunal Member, Deputy President Purvis, held, at [27]:

The Tribunal is satisfied, and so finds, that she is a female person and has the identity that she contends. Her inability to provide a birth certificate from the Registrar of Births, Deaths and Marriages that records her female gender, in circumstances where the obtaining of the same is prevented by state legislation, is not a valid ground for rejecting her passport application, where her identity can be satisfactorily established by other means.

(167) This decision was not the subject of an appeal. An AAT decision is not binding as legal precedent in Australian courts, but has so far formed the basis for Commonwealth policy. It is at least arguable that the AAT decision was wrong, and that a person's sex for the purposes of a passport ought to be governed by the primary identity document, the birth certificate.

(168) In some parts of Australia, it is therefore possible for a person to be legally recognised as being of a gender that does not correspond to their biological sex without undergoing any form of physical change.

Discrimination

(169) Discrimination law may define a person as being 'transgender' without there having been any alteration in the person's sex on their birth certificate.

(170) The *Anti-Discrimination Act 1977* (NSW) includes a person who is a 'recognised transgender person' for the purposes of the *Births Deaths and Marriages Registration Act 1995*, but goes further, recognising in s 38A as 'transgender', a person who –

- (a) identifies as a member of the opposite sex by living, or seeking to live, as a member of the opposite sex,
- (b) has identified as a member of the opposite sex by living as a member of the opposite sex, or
- (c) being of indeterminate sex, identifies as a member of a particular sex by living as a member of that sex.¹²⁴

(171) It also includes a reference to the person being thought of as a transgender person, whether the person is, or was, in fact a transgender person.

(172) The *Sex Discrimination Act 1984* (Cth) protects against discrimination on the grounds of a person's 'gender identity', which is defined to mean –

the gender-related identity, appearance or mannerisms or other gender-related characteristics of a person (whether by way of medical intervention or not), with or without regard to the person's designated sex at birth.

(173) This Act also includes 'intersex status' as a protected attribute.

1.22 Regulation of gender reassignment

(174) Gender reassignment refers to surgery, hormone therapy or invasive medical procedures that a person may undertake as part of transitioning to another gender.

¹²³ <https://www.ag.gov.au/Publications/Documents/AustralianGovernmentGuidelinesontheRecognitionofSexandGender/AustralianGovernmentGuidelinesontheRecognitionofSexandGender.pdf> (paragraph 25, page 5)

¹²⁴ For a case in which a prisoner in jail was found to be 'transgender' because they had begun "seeking to live" as a woman before they entered jail, see *Lawarik v Chief Executive Officer, Corrections Health Service* [2003] NSWADT 16 (24 January 2003).

(175) In general, an adult person of sound mind may consent to undertaking procedures or treatment. Parents and guardians may consent to procedures or treatment on behalf of their children at a young age where the procedures or treatment are, on medical opinion, “beneficial” or “necessary”. If procedures or treatment may be merely optional or non-therapeutic, parental consent will usually not be sufficient and an application will need to be made to the Family Court.¹²⁵ However particular considerations apply in the case of children (under 18 years) who are old enough to understand the procedures or treatment. The wishes of a child may prevail over those of their parents if the child is found to possess sufficient understanding and intelligence to understand fully what is proposed.¹²⁶

(176) The most recent authoritative decision in Australia regarding procedures and treatment for gender reassignment by a minor is *Re: Jamie [2013] FamCAFC 110* (31 July 2013). This case considered the two common forms of gender reassignment treatment for children, with stage 1 being the provision of puberty blocking medication and stage 2 comprising cross-sex hormone treatment. It was held that while parents are generally capable of consenting to stage 1 treatments, stage 2 treatments, considered to be irreversible, can only be consented to by the child when they are determined by a court to be of sufficient “understanding and intelligence”.

(177) Issues of capacity in relation to gender reassignment are likely to continue to be tested before the courts given demands from certain sections of the community for gender dysphoria to be normalised and not treated as a disorder, notwithstanding that it will usually require medical intervention.¹²⁷

1.23 Discrimination

(178) Discrimination arises where a person is treated differently in certain areas of public life on the grounds of a personal attribute that is protected by the law. This can involve less favourable treatment or being subject to requirements or conditions that are not applied to others in similar circumstances who do not possess the protected attribute.

(179) Discrimination against persons on the grounds of ‘transgender status’ or ‘gender identity’ is prohibited in most jurisdictions in Australia in certain areas of public life.¹²⁸

New South Wales

(180) Under the *Anti-Discrimination Act 1977 (NSW)*, discrimination on transgender grounds is prohibited in relation to –

- (a) work/employment,
- (b) education (admission and the terms of admission),
- (c) the provision of goods and services,
- (d) accommodation, and
- (e) membership and participation in registered clubs.¹²⁹

(181) There are exemptions –

- (a) section 38K, which concerns discrimination in education, does not apply to a “private educational authority”,
- (b) a transgender person can be excluded from participation in sporting activities for members of the sex with which they identify, but this does not extend to coaching or administration of a sporting activity, only participation, and
- (c) the administration of superannuation.

(182) There are also exemptions (or “balancing clauses”) which apply to religious bodies and faith-based adoption agencies.

(183) Section 56 of the Act provides that –

Nothing in this Act affects:

¹²⁵ Department of Health and Community Services (NT) v JWB (1992) 175 CLR 218.

¹²⁶ Secretary, Dept of Health and Community Services v JWB and SMB (1992) 175 CLR 218.

¹²⁷ Whitehall, J. ‘Childhood Gender Dysphoria and the Law.’ *Quadrant* (10 May 2017). p. 6.

¹²⁸ See above for definitions of these terms in NSW and Commonwealth discrimination legislation.

¹²⁹ Part 3A, Anti-Discrimination Act 1977 (NSW).

- (a) the ordination or appointment of priests, ministers of religion or members of any religious order,
- (b) the training or education of persons seeking ordination or appointment as priests, ministers of religion or members of a religious order,
- (c) the appointment of any other person in any capacity by a body established to propagate religion, or
- (d) any other act or practice of a body established to propagate religion that conforms to the doctrines of that religion or is necessary to avoid injury to the religious susceptibilities of the adherents of that religion.

(184) The scope of the exemption in paragraph 56(d) was considered by the NSW Supreme Court in *OV & OW v Members of the Board of the Wesley Mission Council* [2010] NSWCA 155 (6 July 2010). The following points can be made in relation to that litigation -

Religion: The court held that what is taught by a religion may include doctrines that are only taught by a sub-group, they do not have to be “universally” held by all adherents.

Doctrine: The word ‘doctrine’ is broad enough to encompass, not just formal doctrinal pronouncements such as the Nicene Creed, but also that which is commonly taught or advocated by a body, and includes moral as well as religious principles.¹³⁰

Religious susceptibilities of adherents: In the specific case, it was held that requiring fostering services be offered to a same-sex couple would be unacceptable to adherents. The Rev Dr Keith Garner gave evidence in para [62] of his submission as follows:

62 If Wesley Mission was required to appoint homosexual foster carers, this would make our provision of foster care services unacceptable to those who support the ethos of Wesley Mission.

(185) At para [34] of its decision resolving the litigation the Appeal Panel commented:

it would also follow from our acceptance of Dr Garner’s evidence particularly paragraph 62 of his affidavit that the second limb [i.e., “necessary to avoid injury to the religious susceptibilities of the adherents of that religion”] was made out. The defence provided by s56 having been proved the complaint must be dismissed.¹³¹

(186) Part 3A of the Act, which deals with transgender discrimination, does not apply to the provision of adoption services by an organisation that is established or controlled by a religious organisation and accredited to provide adoption services.¹³²

Commonwealth

(187) At the Commonwealth level, the *Sex Discrimination Act 1984* regulates discrimination on the grounds of ‘gender identity’ and ‘intersex status’.¹³³ The areas of public life in which discrimination is unlawful are much the same as in the NSW legislation, except that they also include access to facilities and conferring interests in land. It is also unlawful to request or require a person to provide information if the information is being sought for the purpose of committing an unlawful act of discrimination on the grounds of gender identity or intersex status.¹³⁴

(188) There is an exemption for religious bodies that is in very similar terms to the exemption in s 56 of the *Anti-Discrimination Act 1977* (NSW), except that the exemption does not cover the provision of

¹³⁰ This was the interpretation given by the Tribunal following a direction from the Court for a new hearing. See *OW & OV v Wesley Mission*, 2010 [ADT], [32]-[33]. In *Christian Youth Camps Limited & Ors v Cobaw Community Health Service Limited & Ors* [2014] VSCA 75 (16 April 2014), the Victorian Court of Appeal found that the words “conform to” in the equivalent Victorian legislation meant that the doctrine must be such that there is no alternative but to commit the act or practice giving rise to discrimination. This matter was not directly considered in *OW & OV* but the findings in that case are not consistent with the approach to doctrine in *Cobaw*.

¹³¹ See *OW & OV v Members of the Board of the Wesley Mission Council* [2010] NSWADT 293 (10 December 2010).

¹³² s 57A, *Anti-Discrimination Act 1977* (NSW).

¹³³ ss 5B and 5C, *Sex Discrimination Act 1984* (Cth).

¹³⁴ s 27, *Sex Discrimination Act 1984* (Cth).

Commonwealth-funded aged care (although it **does** cover the employment of persons to provide that aged care - see s 37(2)(b)).¹³⁵

(189) There is also exemption for educational institutions conducted in accordance with the doctrines, tenets, beliefs or teachings of a religion or creed in relation to employment and enrolment/expulsion etc.¹³⁶ However the exemption is slightly narrower than the NSW legislation in that the discriminatory act or practice must be done “in good faith” to avoid injury to the religious susceptibilities of adherents of that religion or creed.

(190) Discrimination questions arise in relation to single-sex schools, uniforms, sports teams, the use of bathrooms/change rooms, sleeping accommodation and the use of pronouns, among others. A church may also wish to restrict or place conditions on a transgender person’s participation in its activities, such as in relation to dress or appearance and the congregation that the person is to attend. Generally, such discrimination by religious bodies and faith-based schools in NSW will be lawful, subject to the act conforming to doctrine or being necessary to avoid injury to the religious susceptibilities of adherents of the religion.

(191) The legal arguments in relation to matters like the use of bathrooms are very complex, even in non-religious or faith-based school contexts, and almost every step of the argument that discrimination arises could be subject to challenge.¹³⁷ Professor Patrick Parkinson has outlined the difficulties with respect to uniforms as follows –

*If a boy who has desires to cross-dress is required to wear the school uniform of his gender, he is not thereby being treated differently from any other boy. Does he have the right to be treated as if he were female? Were it so, then boys would be entitled to enrol in girls’ sports, and attend all-girls’ schools. Men who have a mental state of wanting to be female, or considering themselves to be so, would be entitled to join all women’s gyms or to apply for jobs that are for women only. That would be an extreme and unreasonable position.*¹³⁸

(192) For these and other reasons, the legal arguments in relation to gender identity in schools are often expressed by reference to risk of harm and duty of care issues rather than discrimination.

(193) The guidance issued by some government departments in relation to gender identity goes beyond what is required by anti-discrimination law, yet is expressed in legal rather than policy language. Consider for example, *Legal Issues Bulletin*, No.55 issued to public schools by the Legal Services Directorate of the NSW Department of Education and Communities.¹³⁹ This document requires a transgender student to be offered the use of unisex toilets or the toilets of their identified gender, and that if other students “indicate discomfort” sharing these facilities with a transgender student this is to be addressed through the school learning and support team. It also provides that a student under 12 years of age should be permitted to engage in competitive sports with other students of their identified gender.¹⁴⁰ It is not at all clear that any of these obligations are actually imposed by the legislation. Arguments that have not been addressed by the courts, and need to be, include the following –

- Might not the legislation simply forbid discriminatory treatment that is based *simply* on transgender ‘identity’, rather than even-handed treatment based on a person’s physical sexual characteristics?
- The NSW Anti-Discrimination Act 1977, sets out separate grounds of discrimination which are applicable to ‘recognised transgender persons’, in s 38B(1)(c), and are not the same as the grounds which are expressed to apply in relation to a person who is simply described as ‘transgender’. The difference, as noted above, is that a ‘recognised’ transgender person will be one who has undergone a medical ‘sex affirmation procedure’. It is only such persons for whom, under s 38B(1)(c), it would be discriminatory to treat them “as being of the person’s former sex”. Given this, it seems fairly clear that by implication treating a ‘transgender’ person,

¹³⁵ s 37, Sex Discrimination Act 1984 (Cth).

¹³⁶ s 38, Sex Discrimination Act 1984 (Cth).

¹³⁷ Foster, N. ‘Bathrooms and Discrimination.’ *Law and Religion Australia* (24 April 2016). Online: <https://lawandreligionaustralia.blog/2016/04/24/bathrooms-and-discrimination/>. [Accessed 15 November 2017.]

¹³⁸ Parkinson, P. *The Controversy over the Safe Schools Program*, p. 28

¹³⁹ New South Wales Government Education and Community. ‘Transgender Students in School – legal rights and responsibilities.’ *Legal Issues Bulletin*, 55 (December 2014). Online: https://www.det.nsw.edu.au/media/downloads/about-us/how-we-operate/legal-issues-bulletins/number_55.pdf [Accessed 18 November 2016.]

¹⁴⁰ *Ibid.* p. 3.

who has not had the formal medical procedure, as if they belong to their biological sex, does **not** amount to unlawful (or “less favourable”) treatment *per se*.

1.24 Vilification and offence

(194) It is unlawful to vilify a person or group of persons in NSW on the grounds of transgender status. Section 38S of the *Anti-Discrimination Act 1977* provides –

It is unlawful for a person, by a public act, to incite hatred towards, serious contempt for, or severe ridicule of:

- (a) a person on the ground that the person is a transgender person, or
- (b) a group of persons on the ground that the members of the group are transgender persons.

(195) The section goes on to provide that nothing in the section renders unlawful –

- (a) a fair report of a public act, or
- (b) a communications that would be subject to a defence of absolute privilege in proceedings for defamation, or
- (c) a public act, done reasonably and in good faith, for academic, artistic, scientific, research or religious discussion or instruction purposes or for other purposes in the public interest, including discussion or debate about and expositions of any act or matter.

(196) Similar but more widely-drafted legislation in Tasmania prohibits engagement in “conduct which offends, humiliates, intimidates, insults or ridicules another person” on the grounds of their gender identity or intersex status “in circumstances in which a reasonable person, having regard to all the circumstances, would have anticipated that the other person would be offended, humiliated, intimidated, insulted or ridiculed”.¹⁴¹ This is subject to exceptions in relation to –

- (a) a fair report of a public act; or
- (b) a communication or dissemination of a matter that is subject to a defence of absolute privilege in proceedings for defamation; or
- (c) a public act done in good faith for –
 - (i) academic, artistic, scientific or research purposes; or
 - (ii) any purpose in the public interest.

(197) The law in Tasmania extends to certain conduct which a reasonable person would anticipate would cause offence to another person. This conduct need not necessarily be public, and there is no exception in Tasmania for religious discussion or instruction (other than generally as purpose in the public interest). A complaint was made against Archbishop Julian Porteous for distributing a booklet regarding the Roman Catholic Church’s teaching on marriage in a Catholic School. The Anti-Discrimination Commission of Tasmania accepted the complaint, though it was subsequently withdrawn. More recently the Commission has accepted a complaint against a Presbyterian minister concerning comments made by him on a blog site about health risks associated with “the homosexual lifestyle”, and a complaint against a street preacher by an atheist offended by comments made at the Hobart Mall “speaker’s corner”.¹⁴²

1.25 Human right to gender transition in Australia

(198) Australia does not have a national Bill of Rights, either as part of the Constitution or statute law. Some rights are expressly protected by the Constitution, namely the right to vote, protection against the acquisition of property on unjust terms, trial by jury, freedom of religion and prohibition on discrimination based on State residency. Some are implied, such as a right to freedom of political communication which arises out of our parliamentary democracy.

(199) Both Victoria and the ACT have a Charter of Human Rights which requires the government and public servants to take human rights into consideration when making laws, setting policies and in the provision of services. There is also capacity under the Commonwealth *Australian Human Rights*

¹⁴¹ s 17, Anti-Discrimination Act 1998 (Tas).

¹⁴² Denholm, M. ‘Preachers in free speech test on atheists and gays.’ *The Australian*, 28 July 2017. Online: <http://www.theaustralian.com.au/business/legal-affairs/preachers-in-free-speech-test-on-atheists-and-gays/news-story/c6039963d5224a7922a8f5cbdd65755e>. [Accessed 15 November 2017.]

*Commission Act 1986*¹⁴³ to make complaints to the Australian Human Right Commission about conduct constituting human rights violations by or on behalf of the Commonwealth. However, at most, the Commission can report to Parliament in respect to these matters and has no power to make orders or award compensation.

(200) Australia is a signatory to certain international human rights conventions. This international law does not form part of the laws of Australia unless it is given effect through domestic legislation. However, the High Court has held that where there is ambiguity in a statute of an Australian Parliament, which deals with a matter affected by an international covenant, a construction that is consistent with international law obligations is to prevail (*Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273 at 287)¹⁴⁴. This rests on an assumption that the Parliament does not intend to legislate against these obligations unless the Parliament expressly indicates to the contrary.

(201) Australia is a signatory to the Optional Protocol to the *International Covenant on Civil and Political Rights*.¹⁴⁵ Under the Optional Protocol individuals can make complaints to the United Nations Human Rights Committee (UNHRC) alleging they are victims of violations of the ICCPR. While the Optional Protocol commits Australia to various processes in relation to these matters, Australia is not required to comply with any directions given by the UNHRC. Recently, a transgender woman who is resident in NSW brought a complaint against the Australian government concerning a requirement that she must divorce her spouse before making a change to her birth certificate. The UNHRC found that the requirement breached Article 17 as an “arbitrary or unlawful interference with her privacy and family”, and Article 26 as discrimination on marital status and gender identity grounds. Notwithstanding, the law in NSW remains unchanged.

(202) There are international legal principles on the application of international law on sexual orientation and identity in the form of the *Yogyakarta Principles* (2007)¹⁴⁶ and the *UN Declaration on Sexual Orientation and Gender Identity* (2008).¹⁴⁷ However, there is no UN convention that provides a framework for assessing sexual and gender rights claims.

1.26 Overview of laws in other States and Territories

(203) This document has primarily focussed on the law of NSW and the laws of the Commonwealth that apply in NSW. A brief overview of the laws in other states and territories, the European Union and USA in respect to gender identity is outlined below. The information contained is current as at 28 July 2017.

State and Territory Laws

Legislation	Key Provisions
NSW	
NSW Anti-Discrimination Act 1977	Part 3A Discrimination on transgender grounds: <ul style="list-style-type: none"> • Section 38K public school educational facilities to unconditionally enrol students • Section 38K(3) excludes private educational authorities
Births, Deaths and Marriages Registration Act 1995	Part 5A Change of Sex: <ul style="list-style-type: none"> • s32A: Sex “affirmation” (change) procedure is one where a surgical procedure involving the alteration of a person’s reproductive organs has been carried out in order to (a) be considered a member of the opposite sex or (b) to correct ambiguities relating to the sex of a person • s32B a person who has undergone sex affirmation procedure can apply to record a change of sex but must be: <ul style="list-style-type: none"> ○ over 18 years (or with parents authority) ○ born in NSW

¹⁴³ Legislation.gov.au. (2017). *Australian Human Rights Commission Act 1986*. Online: <https://www.legislation.gov.au/Details/C2017C00143>. [Accessed 17 August 2017.]

¹⁴⁴ Jade.io. (2017). *Minister of State for Immigration and Ethnic Affairs v Ah Hin Teoh 1995*. Online: <https://jade.io/article/67887>. [Accessed 17 August 2017.]

¹⁴⁵ Office of the United Nations High Commissioner for Human Rights (OHCHR). (2017). *Optional Protocol to the International Covenant on Civil and Political Rights*. [online] Available at: <http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCCPR1.aspx>. [Accessed 18 August 2017.]

¹⁴⁶ Yogyakartaprinciples.org. (2017). *Yogyakartaprinciples.org – The Application of International Human Rights Law in relation to Sexual Orientation and Gender Identity*. [online] Available at: <http://www.yogyakartaprinciples.org/> [Accessed 18 August 2017.]

¹⁴⁷ Office of the United Nations High Commissioner for Human Rights (OHCHR). *LGBT UN Resolutions* [online] Available at: <http://www.ohchr.org/EN/Issues/Discrimination/Pages/LGBTUNResolutions.aspx> [Accessed 18 August 2017.]

Legislation	Key Provisions
	<ul style="list-style-type: none"> ○ not married ○ must have had the reassignment surgery (proofs submitted and two doctors' declarations) ● s32E new certificate to be issued without reference to sex change ● s32F the child of a person who has had their birth certificate altered may apply to receive a copy of the old birth certificate of the parent. ● S32I – the person is legally considered the gender on their birth certificate (or a recognised interstate certificate) <p>http://www.austlii.edu.au/au/legis/nsw/consol_act/bdamra1995383/</p>
Key pressure points in NSW:	<p>Ability to change sex on birth certificate without the gender reassignment surgery. Grounds advanced: it's discriminatory and inhumane to force a person to become sterile so that a change of sex status can be made (http://www.starobserver.com.au/news/national-news/new-south-wales-news/trans-rights-get-a-boost-in-nsw-parliament/142984)</p> <p>Ability for a married person to change sex on birth certificate without getting a divorce: see recent decision of the UN Human Rights Committee recommending change of NSW law on this point.¹⁴⁸</p>
Victoria	
Equal Opportunity Act (2010)	<p>"Gender identity":</p> <ul style="list-style-type: none"> ● Part 2, s6(d) makes unlawful to discriminate on the basis of gender identity ● Part 4 identifies when discrimination is prohibited ● s82 religious bodies exemption – as per the NSW exemption ● s83 faith-based schools exemption – the act must conform to doctrines, belief or principles of the religion or be reasonably necessary to avoid injury to the religious sensitivities of adherents of the religion. ● s84 exemption for a "person" where discrimination is reasonably necessary for them to comply with the doctrines, beliefs or principles of their religion.
Births, Deaths and Marriages Registration Act 1996	<p>Similar to NSW laws. The persons must have undergone a surgical procedure involving the alteration of a person's reproductive organs carried out for the purpose of assisting the person to be considered to be a member of the opposite sex and provide statutory declarations from two doctors.</p>
Vic Education & Training Policy on 'Gender Identity'	<p>Principals to respect a student's choice to identify as their desired gender when it does not align with their designated sex at birth.</p> <p>http://www.education.vic.gov.au/school/principals/spag/health/Pages/genderidentity.aspx#related (As with NSW, it may be doubted whether this guidance accurately reflects the requirements of the legislation.)</p>
South Australia	
Births Deaths Marriages 1996	<ul style="list-style-type: none"> ● A person's sex on the register can be changed upon providing a signed verification from a medical practitioner or psychologist that they have "undertaken a sufficient amount of appropriate clinical treatment in relation to the person's sex or gender identity". This clinical treatment "need not involve invasive medical treatment and may include or be constituted by counselling". If the clinical treatment <i>only</i> involves counselling a "sufficient amount" is "at least 3 separate counselling sessions totalling 135 minutes or counselling sessions occurring over a period of at least 6 months".
Sexual Re-assignment Act of South Australia (1988)	<ul style="list-style-type: none"> ● The Act was repealed by the Births, Deaths and Marriages Registration (Gender Identity) Amendment Act 2016 with effect from 23 May 2017. ● The Act regulated gender reassignment procedures and the process for applying for recognition certificates. The latter is now regulated by the Births Deaths Marriages 1996. Gender reassignment procedures are no longer specifically regulated by statute.

¹⁴⁸ See Foster, N. 'Birth certificate alteration for a married person?' *Law and Religion Australia* (27 June 2017) Online: <https://lawandreligionaustralia.blog/2017/06/27/birth-certificate-alteration-for-a-married-person/> for comment.

Legislation	Key Provisions
<p>Equal Opportunity Act 1984 (3/10/13)</p>	<ul style="list-style-type: none"> • Part 3, Division 2 prohibits discrimination on the grounds of gender identity in relation to employment. s 34(3) exempts a faith-based educational authority if the discrimination is undertaken pursuant to a written policy and the policy is disclosed. • Section 35(2b)- allows associations to discriminate “on the ground of sexual orientation or gender identity if the association is administered in accordance with the precepts of a particular religion and the discrimination is founded on the precepts of that religion” • s37 prohibits discrimination in education on the basis of gender identity • s50 exemptions for religious bodies for ordinations; training of those seeking ordination; administration of a body established for religious purposes and acts or practices to confirm to doctrine or avoid injury to the religious susceptibilities of adherents of the religion.
<p>SA Law Reform Institute</p>	<ul style="list-style-type: none"> • Audit Paper into discrimination on the grounds of sexual orientation, gender, gender identity and intersex status in South Australian legislation (September 2014) • This is a major review and will constitute a significant reworking of up to “140 South Australian Acts and Regulations that discriminate...on the grounds of sexual orientation, gender identity and intersex status.” p. 11
Western Australia	
<p>Gender Reassignment Act 2000</p>	<ul style="list-style-type: none"> • Gender Reassignment Board: <ul style="list-style-type: none"> ○ Establishes the Gender Reassignment Board which is tasked with issuing Recognition Certificates (in Adult and Child categories). This is the certification which gives legal standing to the new sex. ○ Recognition certificates can be used to amend the Birth Certificate. • Applicants must have undergone a “reassignment procedure”, adopted the lifestyle of that gender and received counselling in relation to their gender identity. In <i>AB v Western Australia</i> [2011] HCA 42, the High Court determined that the Act did not require a person to undergo genital reassignment surgery (in this case a hysterectomy and phalloplasty) to obtain a gender recognition certificate as a man. • There is a bill before the Parliament to abolish the Gender Reassignment Board and confer the responsibilities on the State Administrative Tribunal.
<p>Equal Opportunity Act 1984</p>	<ul style="list-style-type: none"> • Part IIAA Discrimination on “gender history” grounds in certain cases. In essence it is the same as “gender identity”. • s 72 – religious bodies exemption – as per the NSW exemption. • s 73 – educational institutions established for religious purposes exempt in relation to employment if the discrimination is in good faith in order to avoid injury to the religious susceptibilities of adherents of that religion or creed, and exempt in relation to the provision of education or training in a manner that discriminates in favour of adherents of that religious or creed.
<p>Births, Deaths and Marriages Registration Act 1998</p>	<p>No opportunity for change of gender</p>
Northern Territory	
<p>Births, Deaths and Marriages Registration Act 2015</p>	<p>Part 4A. As per Victorian laws</p>
<p>Anti-Discrimination Act</p>	<ul style="list-style-type: none"> • s19 – “sexuality”, which is defined in s4 to include “transsexuality”. • s29 – exemption for educational authority operated wholly or mainly for students of a particular sex or religion which permits the exclusion of persons not of that sex or religion. • s37A – exemption in relation to employment for faith-based educational institutions if the discrimination is on the grounds of religious belief or sexuality

Legislation	Key Provisions
	<p>and the act is done in good faith to avoid offending the religious sensitivities of people of the particular religion.</p> <ul style="list-style-type: none"> • s51 - religious bodies exemption – ordination, training/appointment of ministers of religion, and acts, except there is no doctrine exemption and the discriminatory acts that are done as part of religious observance or practice.
Queensland	
Births, Deaths and Marriages Registration Act 2003	As per NSW – surgery required
Anti-Discrimination Act 1991	<ul style="list-style-type: none"> • s7 gender identity • s41 educational authority operated wholly or mainly for students of a particular sex or religion permitted to exclude persons not of that sex or religion. • s109 religious bodies exemption similar to NSW, except the doctrine and religious susceptibilities limb of the exemption does not apply in the case of employment or education.
Qld Dept of Education, Training & Employment	'Diversity in Queensland Schools – Information for Principals' covering: name, toilet/change rooms, dress code, camps
ACT	
Births, Deaths and Marriages Registration Act 2013	<ul style="list-style-type: none"> • The applicant must believe their sex to be the sex nominated in the application and must provide a statement by a doctor of psychologist certifying that they have received "appropriate clinical treatment" for alteration of their sex or that they are an intersex person. • There is no definition of "appropriate clinical treatment". There is no requirement for surgical genital reassignment.
Discrimination Act 1991 No42	<ul style="list-style-type: none"> • s7 notes gender identity and intersex status as a grounds on which discrimination is prohibited • Areas of public life in which discrimination is unlawful is similar to NSW. s18 prohibits discrimination of students on the grounds noted in s7 • s32 religious bodies exemption similar to NSW • s33 exemptions for educational institutions for religious purposes: employment of staff and in the provision of education and training, but the discrimination must be done in good faith to avoid injury to the religious susceptibilities of adherents of that religion or creed.
Tasmania	
Births, Deaths and Marriages Registration Act 1999	As per NSW – surgery required
Anti-Discrimination Act 1998	<ul style="list-style-type: none"> • s16 (ea) gender identity, 16(eb) intersex • Pt 5, Div 8: exceptions allowing discrimination on the <u>grounds of religious belief</u>: <ul style="list-style-type: none"> ○ s51: employment based on religion ○ s51A: admission of a person as a student in a faith-based educational institution – but not students already enrolled and discrimination can only be on the grounds of religious belief or affiliation ○ s52: ordination/priests, participation in religious observance, doctrine, injury to religious susceptibilities • s17 conduct which offends, humiliates, intimidates, insults or ridicules another person on the basis of gender identity or intersex status, is unlawful

1.27 International Laws

European Union

(204) Legal and scientific bodies are moving at a fast pace to de-pathologise transsexualism. The NGO Transgender Europe reported that in 2014, 24 EU Member States required diagnosis of a gender identity disorder in order to access surgery and/or legal recognition. However, the need for a medical diagnosis is being removed in some countries, in favour of a person's self-determination.¹⁴⁹

(205) Two primary legal considerations:

1. Access to sex reassignment treatment and its legal recognition.
2. Ability to rectify one's recorded sex and name on official documents, which has legal consequences in respect to the ability to enter or maintain a marriage.

(206) "In EU Member state legislation, sex reassignment and the legal recognition of gender are often dealt with in parallel. However, from a legal perspective they remain two different steps in a trans person's life. For example in a 2013 ruling the Tribunal of Reggio Emilia in Italy clarified that, as long as a trans person does not request a change of personal data to reflect his/her gender identity, his/her marriage will remain valid in the country, despite same-sex couples not having access to marriage." (Protection Against Discrimination Legal Update 2015, 18)

(207) However, "forced divorce or marriage annulment is still required for legal gender recognition in EU Member States that do not allow same-sex marriage" (Protection Against Discrimination Legal Update 2015, 20)

(208) Recent EU state developments:

- Movement towards self-determination of one's gender:
 - Denmark legalised gender recognition for transgender people based only on their self-determination (no medical diagnosis required). As long as the person is aged 18 and over, they may request a legal change of gender and will be asked to confirm the change 6 months later.
 - In Malta, changing legal gender requires declaring before a notary that one's gender identity does not correspond to the sex assigned in the birth registry
 - In Ireland legal change of gender is based entirely on self-determination.
- Issues regarding interested third parties are causing issues for legislators. For example in Poland:
 - A married trans person must divorce if wishing to undergo gender reassignment
 - If a trans person is the sole guardian of a child, they must wait to undergo gender reassignment until the child is of age
 - If there is another parent, the court will transfer custody of the child to that other parent
- Recognition of transgender children:
 - Ireland – children 16 years and older
 - Malta – children can access through a court order
 - Poland – children over 16 years can commence the process

USA

(209) Procedures for legalising sex change through a birth certificate vary from state to state. However, a general process for changing involves the following steps:

1. Must have had vaginoplasty or orchiectomy (irreversible genital surgery)
2. Signed, dated notarised letter from the surgeon confirming date of procedure(s)
3. Write letter to the Department of Health and Human Services to the relevant birth state detailing transsexual, wanting to change name and sex on birth certificate and to have the original impounded. Trans person will receive written instruction of requirements of the birth state.

¹⁴⁹ FRA – European Union Agency for Fundamental Rights. *Protection against discrimination on grounds of sexual orientation, gender identity and sex characteristics in the EU: Comparative legal analysis. Update 2015*. Luxembourg: Office of the European Union. 2015. pp. 16–17. Online: fra.europa.eu/sites/.../fra.../protection_against_discrimination_legal_update_2015.pdf. [Accessed 15 November 2017.]

4. If residential state laws permit impounding of certificates in other states, the trans person will need to attend court to make the request. The judge will sign the order.
5. Send the court authorised paperwork to the Birth state.
6. New birth certificate will be printed and dispatched.

(210) The year 2015 has been dubbed the “year of the transgender tipping point”. However, increasing resistance to the normalisation of transgender is being reported:

- 2015 there were 21 anti-trans bills which covered: bathrooms/change rooms/sports; health, marriage and discrimination carve outs
- 2016 as at February there were 44 anti-trans bills which cover: bathroom/change rooms/sports, health, anti-trans marriage, discrimination carve out, birth certificates, first amendment defence acts

(211) Such moves appear to be at odds with the Federal Government’s position. For example, Title IX which is the federal civil rights law prohibits discrimination in education. The Federal Government has previously interpreted this to include discrimination protections on the basis of gender identity. However, in more recent times the current Federal Government has indicated that it does not believe that Title IX covers either transgender discrimination¹⁵⁰ or sexual orientation discrimination.¹⁵¹

(212) A special note on “First Amendment Defence Acts”. These Bills would, if passed, exempt persons/bodies from being deemed to have undertaken discriminatory acts if they act in accordance with sincerely held religious beliefs. The exemption applies even if the person/body is in receipt of public funds.

(213) The Bills appear to all be premised on the belief that sex is fixed as determined at birth and noted on the birth certificate.

Canada

(214) The Canadian Parliament has recently passed legislation with respect to transgender rights. Bill C-16, also known as *An Act to amend the Canadian Human Rights Act and the Criminal Code* of the Statutes of Canada 2017¹⁵², received Royal Assent on 19 June 2017. It will soon become law in Canada.

(215) The Bill amends the *Canadian Human Rights Act* to add “gender identity” and “gender expression” to the list of prohibited grounds of discrimination. These terms are not defined and it is not clear what they encompass.

(216) The Bill also amends the Canadian Criminal Code to prohibit “hate propaganda” against groups that are identifiable based on gender identity or gender expression, and allow longer sentences for criminal offences motivated by hate based on gender identity or gender expression. The Canadian Department of Justice has commented that, “This amendment concerns extremist literature or information that aims to incite hatred against a particular group and that is far outside what Canadian society will tolerate.”

(217) There has been considerable debate within Canada regarding the effect of the amendments. In relation to the use of bathrooms, the Canadian Department of Justice has commented that: “Transgender persons have a right to be treated according to their deeply-felt gender identity. In many situations, that includes the right of a person who lives as a woman to use women’s facilities, even if she has some male anatomical characteristics. These amendments will codify that right.” There have also been suggestions from some quarters that the legislation will compel the use of genderless pronouns. It is unlikely that a failure to use genderless pronouns would amount to hate speech, though what constitutes “hate speech” may change over time. Causing offence is considered a form of hate speech in certain jurisdictions. The claim may be more relevant in respect to discrimination. The Ontario Human Rights Commission (in commenting on the equivalent provisions in its provincial code) has stated: “Refusing to refer to a trans

¹⁵⁰ See Vogue de, A., Mallonee, M. K., Grinberg, E. ‘Trump administration withdraws federal protections for transgender students.’ *CNN Politics* (23 February 2017) Online: <http://edition.cnn.com/2017/02/22/politics/doj-withdraws-federal-protections-on-transgender-bathrooms-in-schools/index.html>. [Accessed 15 November 2017.]

¹⁵¹ See, Barbash, F. ‘Trump administration, intervening in major LGBT case, says job bias law does not cover sexual orientation.’ *The Washington Post*. (27 July 2017). Online: https://www.washingtonpost.com/news/morning-mix/wp/2017/07/27/trump-administration-intervening-in-major-lgbt-case-says-job-bias-law-does-not-cover-sexual-orientation/?utm_term=.f80d1f2e857c. [Accessed 15 November 2017]

¹⁵² Canada. Department of Justice, *Bill C-16: An Act to amend the Canadian Human Rights Act and the Criminal Code*. (2016). [online] Available at: <http://www.justice.gc.ca/eng/csj-sjc/pl/i/identity-identite/statement-enonce.html>. [Accessed 17 August 2017.]

person by their chosen name and a personal pronoun that matches their gender identity, or purposely misgendering, will likely be discrimination when it takes place in a social area covered by the *Code*, including employment, housing and services like education.”¹⁵³ This indicates that the not using or misusing pronouns will, in some contexts, be considered discrimination by some human rights bodies within Canada.

(218) The Canadian Province of Ontario has passed even more far reaching legislation. Bill 89, *Supporting Children, Youth and Families Act, 2017*¹⁵⁴ received Royal Assent on 1 June 2017. The Bill changes what is considered to be in the best interests of the child. The child’s religious faith has been removed from the list of factors to be considered. The list now includes “race, ancestry, place of origin, colour, ethnic origin, citizenship, family diversity, disability, creed, sex, sexual orientation, gender identity and gender expression.” There have been suggestions that the legislation will allow the government to remove a child from their family if the parents do not support the child’s gender identification. It turns on what constitutes “abuse” of a child. The Bill regards a child in need of protection under the law if that child is deemed to be suffering or “at risk of suffering” mental or emotional harm and the parents do not provide “treatment or access to treatment.” It is conceivable that on this basis a parent could be accused of “abuse” if they will not facilitate their child having access to treatment for gender transition. The Bill will also have implications for determining which family environments are in the best interests of the child when placing a child in foster care or adoption.

Conclusion

(219) Our churches, schools, and organisations should be places where those dealing with gender identity issues are welcomed, loved, and nurtured with generous care shaped by the love of Christ, and informed by the word of God. All those who have faith in Christ belong to the body of Christ, regardless of their personal trials and afflictions. It is our hope that those dealing first-hand with gender identity issues might find the love and support they need within our fellowship.

(220) This Report is the first step in a Diocesan response to gender identity issues. It seeks to provide the biblical framework and medical background for these issues and outlines the current Australian legal situation. A basis is thus provided from which to address the pastoral care of those experiencing gender non-conformity in an informed way, and to engage with developments in society.

(221) Our commitment to the good of all people also means we should be concerned for the welfare of all those with gender identity issues, not just those within our churches. Equipping Christians and churches to appropriately reach out with the gospel and love of Jesus to those who suffer gender identity issues requires further careful reflection.

(222) The next stage of this work entails the development of detailed policies and a pastoral care practice framework for entities within the Diocese. These entities include schools, community service organisations, and youth ministries. The task of caring for people – church communities, families, children and individuals – also requires sensitive consideration.

(223) In the meantime, the following Initial Principles of Engagement are offered, as an indicative response to the complex pastoral issues involved, taking into consideration the teaching of Scripture, medical and legal considerations, and personal responses from the mixed-methods study undertaken by the committee. These principles reflect the main contours of this report.

1.28 Initial Principles of Engagement

1.28.1 General Principles

- (a) The promise of the gospel is that all who trust in Christ are assured of existential peace and wholeness in the resurrection life of the new creation.
- (b) All those who have faith in Christ are loved by God and belong to the body of Christ, including those whose personal trials and afflictions in this life include gender identity issues or gender incongruence.

¹⁵³ Ontario Human Rights Commission. (2017). *Questions and answers about gender identity and pronouns*. [online] Available at: <http://www.ohrc.on.ca/en/questions-and-answers-about-gender-identity-and-pronouns>. [Accessed 1 September 2017.]

¹⁵⁴ Legislative Assembly of Ontario, (2017). *Bill 89, Supporting Children, Youth and Families Act, 2017* [online] http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=4479&detailPage=bills_detail_the_bill. [Accessed 17 August 2017.]

- (c) Those who experience gender identity issues or incongruence deserve our compassion, love, and care.
- (d) In the beginning, God made humanity male and female, and, in his creative purposes, biological (bodily) sex determines gender.
- (e) Human nature was damaged and distorted by the Fall but not destroyed. All people continue to be made in the image of God. The experience of incongruence between objective biological sex and subjective gender identity is one consequence of that damage and distortion but in no way diminishes a person's full humanity.
- (f) God has compassion on the weak and vulnerable, and is able to bring healing to the experience of gender incongruence, however in his sovereign wisdom, that healing might not be fully experienced in this life.
- (g) The human person is a psychosomatic unity, where body and soul come into being at the same time and, in this life and the next, exist together. Embodiment is integral to human identity, and biological sex is a fundamental aspect of embodiment. Preserving the integrity of body and soul, and honouring and protecting the biologically-sexed body that God has given are necessary for human flourishing.
- (h) The binary distinctions of male and female are to be embraced and upheld in the lives of Christian men and women respectively, and expressed in culturally appropriate ways that conform to Scripture.
- (i) Churches, schools, and other Anglican organisations are to be places where all people, including those who experience gender identity issues and incongruence, are welcomed, loved and supported and helped to live in obedience to Christ.
- (j) Practical love of those experiencing gender identity issues and incongruence entails:
 - faithfulness to the teaching of the Bible
 - compassion, and active love, care, and support
 - rejection of all bullying, ridicule, mistreatment, and abuse of gender non-conforming people
 - evidence-based pathways for treatment, which are consistent with Scripture
 - ensuring that churches and organisations are adequately informed about gender identity issues and incongruence, and the relevant teaching of the Bible.

1.28.2 Those experiencing gender incongruence

You are made in the image of God and you will find your identity in Christ. Therefore, we encourage you:

- (a) to seek treatment options that aim for the integrity of psycho-somatic unity;
- (b) to seek regular Christian fellowship;
- (c) to share your struggles with some mature Christian people so you can receive Christian compassion and support, as well as accountability and encouragement;
- (d) to know that while gender dysphoria may be a lifelong battle for you, nothing can separate you from the love of God in Christ Jesus, and God will be patient with you, and his grace will sustain you; and
- (e) to fix your eyes on Jesus and look forward to wholeness and relief of suffering in the new creation.

1.28.3 Family and Friends of those experiencing gender incongruence

Family and friends are encouraged:

- (a) to be informed about and embrace the teaching of Scripture on sex and gender;
- (b) to be educated in the various aspects of gender identity and expression (biology, identity, orientation, roles) so you are able to distinguish between sexual orientation (same sex attraction, same sex behaviour) and gender identity (gender dysphoria, transgender) and the different responses each requires;
- (c) to demonstrate gospel grace by loving and caring for the person even if you do not approve or celebrate their behaviour or choices;
- (d) to be honest about your concerns;

- (e) if appropriate, to provide information about alternative treatment approaches to those which promote transitioning;
- (f) not to make your love conditional upon acceptance of your views;
- (g) to be patient and sensitive, and seek to alleviate the person's distress; and
- (h) to be committed in prayer for the person: their physical and psychological wellbeing, and their salvation (if not a Christian).

1.28.4 Christian parents

Christian parents are encouraged:

- (a) to be informed about and embrace the teaching of Scripture on sex and gender
- (b) to be educated in the various aspects of gender identity and expression (biology, identity, orientation, roles) so you are able to differentiate between sexual orientation (same-sex attraction, same-sex behaviour) and gender identity (gender dysphoria, transgender) and the different responses each requires;
- (c) to understand that your own identity is found in Christ and not in any other source, and make opportunities to explain this to your children;
- (d) to seek mature Christian counsel and pastoral care if your child has gender identity issues that cause you concern, and seek to support the child in their biological sex role;
- (e) to demonstrate gospel grace by loving and caring for your child even if you do not approve of or celebrate your child's behaviour or choices; and
- (f) to build support networks and be actively involved in your Christian community.

1.28.5 Counsellors, teachers, doctors (those with secular professional relationships)

Christian professionals are encouraged:

- (a) to be informed about and embrace the teaching of Scripture on sex and gender;
- (b) to be educated in the various aspects of gender identity and expression (biology, identity, orientation, roles) so you are able to differentiate between sexual orientation (same-sex attraction, same-sex behaviour) and gender identity (gender dysphoria, transgender) and the different responses each requires;
- (c) to understand the biblical view of personhood, and identity in Christ, both for yourself and your clients;
- (d) to differentiate between compassion for the person and understanding the distress of their situation/condition and agreeing with and validating a treatment protocol to transition; and
- (e) to build support networks for consultation, possibly including legal contacts.

1.28.6 Ministry Staff

Ministry staff are encouraged:

- (a) to be informed about and embrace the teaching of Scripture on sex and gender;
- (b) to provide public teaching about the Bible's instruction on these matters;
- (c) to have compassion for those who experience gender incongruence, and teach and model such compassion;
- (d) not to make insensitive or uncaring comments or jokes about gender nonconforming people;
- (e) to build a church culture where all people are actively welcomed, knowing that Jesus bids us all 'come as we are', but that he does not leave any of us 'as we are';
- (f) to encourage a church culture of openness that would allow a person to begin a conversation with ministry staff about their gender identity issues;
- (g) to listen carefully to the person, and not doubt, minimise or dismiss their experience;
- (h) to be concerned for the whole person, not just their gender issues;
- (i) to be patient and committed to the person long-term;
- (j) to respect the person and their family's privacy and confidentiality;
- (k) to ensure church facilities provide a public access uni-sex toilet;
- (l) to provide some non-gendered church activities, e.g., mixed Bible study groups ;
- (m) do not have rigid, unbiblical gender stereotypes, especially for children;

- (n) to encourage others to reach out with friendship and support, especially in children's and youth ministries.
- (o) to ensure that gender non-conforming children and youth are not bullied, teased, excluded, or abused; and
- (p) to consider the pastoral care needs of those close to the gender nonconforming person, especially family.

1.28.7 Congregations

Congregations are encouraged:

- (a) to be informed about and embrace the teaching of Scripture on sex and gender;
- (b) to show love, compassion, hospitality, and welcome to gender nonconforming people;
- (c) to be concerned for the whole person not just their gender issues;
- (d) to offer companionship to the person and their family;
- (e) to be patient and committed to the person and their family for the long-term;
- (f) to respect the person and their family's privacy and confidentially;
- (g) not to stare, exclude or isolate gender nonconforming people;
- (h) not to bully, tease, exclude, mistreat, or abuse gender nonconforming people;
- (i) not to make the person into a celebrity or spectacle for their gender incongruence;
- (j) not to make jokes about gender nonconforming people;
- (k) to be aware that taking or displaying photos or images of a person with gender incongruence might cause them distress;
- (l) to avoid rigid and unbiblical gender stereotypes; and
- (m) to uphold the goodness of God's design of male and female, and provide healthy role models of living faithfully as Christian men and women.

1.28.8 Public engagement

Those participating in public engagement are encouraged:

- (a) to be informed about and embrace the teaching of Scripture on sex and gender;
- (b) to seek the common good of all people, through concern and involvement in public debate and policy formation;
- (c) to show grace, by being loving, gentle, courteous, wholesome, and humble, this may include recognising the good in our interlocutor's arguments;
- (d) to affirm what is true. God's truth is good, and applies to all people, whether or not they accept or recognise its wisdom. Cultural awareness and effective communication may shape how we express our viewpoint, but it cannot alter our adherence to biblical truth;
- (e) to show love, as public engagement is an expression of love for neighbour, and withdrawal from it may signify a failure to love;
- (f) to be informed about the different dimensions of the public debate, as there are those who promote transgender ideology, and those who suffer from gender incongruence, who are vulnerable members of our community, yet the needs and claims of the two groups are different, and must be considered in any public engagement on these matters;
- (g) to ensure that your presuppositions and expectations of the role of the state are informed by and consistent with the Scriptures; and
- (h) to be courageous, knowing that God is sovereign over all.

Recommendations

1. Synod receives the Report.
2. Synod agrees to approve in principle the Initial Principles of Engagement at 9.1 of the Gender Identity Report as a policy of the Synod.
3. Synod affirms that:

- (a) The promise of the gospel is that all who trust in Christ are assured of everlasting peace and wholeness in the resurrection life of the new creation.
 - (b) All those who have faith in Christ are loved by God and belong to the body of Christ, including those whose personal trials and afflictions in this life include gender identity issues or gender incongruence.
 - (c) Those who experience gender identity issues or incongruence deserve our compassion, love, and care.
 - (d) In the beginning, God made humanity male and female, and, in his creative purposes, biological (bodily) sex determines gender.
 - (e) Human nature was damaged and distorted by the Fall but not destroyed. All people continue to be made in the image of God. The experience of incongruence between objective biological sex and subjective gender identity is one consequence of that damage and distortion but in no way diminishes a person's full humanity.
 - (f) The human person is a psychosomatic unity, where body and soul come into being at the same time and, in this life and the next, exist together. Embodiment is integral to human identity, and biological sex is a fundamental aspect of embodiment. Preserving the integrity of body and soul, and honouring and protecting the biologically sexed body that God has given are necessary for human flourishing.
 - (g) The binary distinctions of male and female are to be embraced and upheld in the lives of Christian men and women respectively, and expressed in culturally appropriate ways that conform to Scripture.
 - (h) We deeply regret that, in the past, some gender non-conforming people have experienced rejection or lack of compassion in our churches and ministries.
 - (i) Churches, schools, and other Anglican organisations are to be places where all people, including those who experience gender identity issues and incongruence, are welcomed, loved and supported and helped to live in obedience to Christ.
4. Synod commends the Gender Identity Report to all Anglican schools and other agencies in the diocese which are called upon to care for people with gender identity issues and asks the governing boards and councils, and the heads and chief executive officers of such schools and agencies to –
- (a) ensure that any policies, guidelines and procedures which they draft to address this issue are consistent with the Initial Principles of Engagement approved in principle as a policy of the Synod at its session in 2017, and
 - (b) consult with the Archbishop about the final form of such policies, guidelines and procedures before they are published, and
 - (c) commit to reviewing such policies, guidelines and procedures in light of any revised form of policy adopted by the Synod following its session in 2017,.
- and requests that the Standing Committee bring to the Synod session in 2018 a revised form of the Initial Principles of Engagement with a view to the revised form being adopted as a policy of the Synod.

Acknowledgement

Members of the Gender Identity Subcommittee

Dr Claire Smith (Chair)	Dr Megan Best	The Rev Nicholas Moll
Dr Patricia Weerakoon	The Rev David Ould	

Members of the Social Issues Committee

Dr Karin Sowada (Chair)	Dr Megan Best	The Rev Dr. Chase Kuhn
The Rev Dr Andrew Ford	The Rev Dr Michael Jensen	Mr Darren Mitchell
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Table of Acronymns

ACL	Australian Christian Lobby
AIDS	Acquired Immune Deficiency Syndrome
DSD	Disorders of Sex Development
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-4	Diagnostic and Statistical Manual of Mental Disorders 4 th Edition
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5 th Edition
F2M	Female to Male
GD	Gender dysphoria
GNC	Gender nonconformity
GnRH	Gonadotropin-releasing hormone
HP	Healthcare providers
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
RLE	Real life experience
SOC-7	Standards of Care for the Health of Transsexual, Transgender, and Gender-nonconforming people, Version 7
SRS	Sex reassignment surgery
TG	Transgender
WPATH	World Professional Association for Transgender Health

Disorders of Sexual Development

Disorders of Sex Development (DSD) describe the rare situation where a newborn infant is found to have ambiguous genitalia (ie it is not clear from observation whether the child has male or female genitalia – whether they are male or female). These are established medical deviations from the normal binary male-female genital development. This condition is also called 'intersex' or 'hermaphrodite' in non-medical settings, but these terms are considered unhelpful, and perceived to be pejorative by some.

In determining whether someone is male or female, we can observe their physical characteristics, such as genitalia (their phenotype) – the usual process at birth; or we can examine their genetic characteristics (their genotype) – by using simple laboratory tests. Most people are born with either two X chromosomes (XX = genotypic female) or one X and one Y (XY = genotypic male). This does not change through life. Usually the genotypic and phenotypic sex are in alignment at birth, and development at puberty is in consistent. In DSD, variations may be minor (such as individuals with genetic variations XO (Turner's Syndrome), or XXY (Klinefelter's Syndrome) which each has a particular phenotype different from the norm. Other variations may be more severe, such as in the case of children born without the ability to produce an enzyme (5- α -reductase) which leads to ambiguous but generally female-appearing genitalia at birth (labia with an enlarged clitoris and undescended testes) and therefore may be raised as girls, but the genitalia then turn into a penis with descended testes at puberty, resulting in a phenotypic male. The most common DSD, accounting for the majority of ambiguous genitalia in the newborn, is congenital adrenal hyperplasia.

The presence of DSD in a newborn requires urgent medical treatment to ensure the safety of the child, as some may have conditions that are life-threatening. Treatment involves a team of professionals who can provide appropriate medical care and counselling for the parents. The topic of early gender reassignment is currently under debate.

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