Conversion therapy, the ALP and gender dysphoric children.

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It appeared a victory for common sense when the Federal Australian Labor Party retreated from its publicised aim of criminalising the practice of 'conversion and reparative therapies on LGBTIQ+ people' at its National Conference in Adelaide last December. Instead, it was a victory of dialectical cunning: instead of wasting energies on pursuing criminal charges, abolition of so-called 'conversion therapy' would be more easily attained by advance along the easier route of civil proceedings with their less rigorous burdens of proof.

Louise Pratt, WA ALP Senator and leading Rainbow Labor figure, revealed the tactic was based on a La Trobe University 'study', reassuring 'the Party was more strongly committed against conversion therapy than ever'[1]. The study would have been 'Preventing Harm, Promoting Justice. Responding to LGBT conversion therapy in Australia'[2]. Released in 2018 from the Victorian Human Rights Law Centre and the Australian Research Centre in Sex, Health and Society at La Trobe, it aims to reveal the 'truth' of these therapies, 'highlight' suffering they have caused, help religious and other organisations be more supportive, and to consider 'legislative and regulatory options to restrict the promotion and provision of conversion therapies and similar practices, including by faith communities and organisations, and both registered and unregistered health practitioners'[3].

The Rights Centre promotes LGBTI rights. The Research Centre created the Safe Schools Programme with its ideology of gender fluidity. Recommendations were developed with the Victorian Commissioners for Gender and Sexuality, Health Complaints, and Mental Health, and with members of the Labor government's LGBTI Taskforce[4].

Under the rubric of 'Appropriate Sanctions and Penalties' for conversion therapists, the study recommended 'Civil penalty provisions rather than criminal offences' because they are 'more proportionate to prevent and respond to the harm'. That 'proportionate' most likely means 'effective' is revealed by the continued explanation: 'A criminal law would also require the elements (both the conduct and the mental element) of the offence to be defined with specificity and proven beyond a reasonable doubt. Such a burden of proof may be difficult to meet for these cases, particularly in circumstances where the only witnesses to the conduct are the victim and the perpetrator'.

Enforcement of civil laws would be increased by giving 'power' to a suitable 'office holder or statutory agency (whether the Health Complaints Commissioner or other body)' to 'enforce the provisions against both individuals and corporations'.[5]

What is 'conversion therapy'?

According to the study it is 'an umbrella term used to describe attempts to 'convert' people from diverse sexual and gender activities to an exclusively heterosexual and cisgender identity'[6]. In practice, regarding gender dysphoric children, it has a simple meaning: anything which reduces their distress by trying to orientate their minds to their chromosomal gender.

Until recently, non-medical psychotherapies for gender confused children and their families were standard, and many are reported to have been effective, as discussed below, but advances in

medical technologies in the 1970's led to medicalisation of treatment with drugs to block puberty, and hormones to promote features of the opposite sex. These would be associated with 'social affirmation' in a newly chosen gender, and often followed by 'cosmetic' surgery including mastectomies, and uro-genital extravaganzas to mimic the genitalia and associated plumbing of the opposite sex, under a life-time of medical dependency.

This medical pathway became known as the Dutch Protocol because it was launched in Holland, but it is now widely practiced in the Western world. It results in a superficial 'sex realignment' of the body to an image in the mind. Castration is inherent.

Such is the commitment to the Dutch Protocol that former psychotherapies are no longer considered, except to be condemned, without explanation, as 'conversion therapies'. Indeed, they are to be forbidden if Labor's policies have their way.

The first legislative attempt at abolition is contained in the Victorian Health Complaints Act 2017, whose provisions, according to then Victorian Health Minister, Jill Hennessy, will 'provide the means to deal with those who profit from the abhorrent practice of gay conversion therapy…which inflicts significant emotional trauma and damages the mental health of young members of our community'.[7] In corollary, upon victory at Federal level, its abolition will be a 'personal priority' for Labor Shadow Minister for Health, Catherine King[8].

Such a crusade has also become a personal issue for the Labor Premier of Victoria, Daniel Andrews, announcing at a Pride March in Melbourne on Feb 3, 2019, 'in an Australian first, we will introduce new legislation to ensure so-called 'conversion therapy' is against the law-once and for all'. Such activities, 'claiming to be able to change someone's sexuality or gender identity' will be dragged 'from the dark ages into the brightest of lights'. They are 'not therapy at all. It is a harmful, prejudiced and discredited practice.' With regard to children suffering from gender dysphoria, this article will draw reports of successful psychotherapies into the light and argue that the Labor government's policies may condemn a dysphoric child to the medicalised 'Dutch Protocol'.

While is it likely to become illegal even to delay referral of a child to a clinic practicing the Dutch Protocol, therapists in those clinics will be free, conversely, to direct that child towards any of the new genders promoted on the web, as often as the child feels like a change, as long as it is not re-oriented to the one in which it was born.

True, 'conversion therapy' has gained a bad name because attempts to 'convert' adult homosexuals to heterosexuality have been historically associated with instances of physical and mental brutality, as well as compassionate psychotherapies. The former have included torture, and such medical intrusions as hormones, lobotomies, and castration. But, regarding children, none of these things or any significant side effects of psychotherapeutic helping the child become comfortable in its natal sex have been reported in modern medicine. On the other hand, the experimental attempt by the Dutch Protocol to convert a child into a non-natal identity IS based on hormones, could be said to practice chemical lobotomy, and includes castration.

What evidence does the La Trobe study bring to the table?

The study claims there is 'overwhelming evidence' of harm from 'conversion therapy' as confirmed by the experiences it presents of 15 respondents recruited through 'various LGBTI, queer and ex-gay survival networks'. Ranging from 18 to 59 years, nine identified as male and gay, two as transgender, one as female and bisexual, and one as non-binary. Thirteen were from Christian backgrounds, one Jewish and one Buddhist.

All had participated in ‘spiritual healing’, including individual and group counselling, theological discussion and prayer, but this was reported to have failed to influence sexual orientation, while increasing misery through intensification of conflict with traditional theological beliefs. Accordingly, the study proclaims conversion therapy is futile, harmful, deserves to be banned, and churches, especially Christian Protestant ones, should be taught or forced to embrace differing sexual behaviours.

One of the fifteen testimonies, requires special mention because the torture she, Jamie, allegedly experienced is permitted if not encouraged to colour the whole discussion. At 17, in the late 80’s, in Australia, after confessing she had ‘fallen in love with a Christian woman’, she alleges being awakened at night and taken to a psychiatric unit for two weeks where she was forced to ‘sit in a bath full of ice cubes while Bible verses were read over her, to being handcuffed to her bed at night and deprived of sleep, to being interrogated and bated by a man in a dog collar’ and to having been ‘restrained…having an electrode attached to my labia, and images projected onto the ceiling; a lot of pain from the electrodes and being left there for quite a long time afterwards; exposed and alone’.

The La Trobe study rightly condemns such treatment, needlessly referring to international obligations against torture. But, is this uncorroborated account convincing? Could such abuses remain hidden in Australia after revelations of the ‘deep sleep’ scandals in Chelmsford Hospital, Sydney, in the 60’s and 70’s, or the Ward 10B abuses in Townsville in the 70’s and early 80’s? Jamie’s allegations demand official investigation before promotion in the interests of amending or creating legislation. Psychiatry was blighted by the vogue for releasing ‘repressed (but spurious) memory’. In Jamie’s case, we are in danger of adding the pathology of unrepressed credulity.

What is weak about this La Trobe study which is so influential for Labor? Jamie’s case appears more propaganda than evidential. Fifteen recruits is a very low number. Self-selection is not representative. There is no mention of a denominator: how many people have been helped by ‘spiritual counselling’? Recruitment after advertising in an established cohort is biased. Inconsistently, a review of experiences of American mothers of teenage daughters with Rapid Onset Gender Dysphoria which concluded they were suffering from ‘social and peer contagion’, a contagious psychological phenomenon, from which they might recover, and not a biological disorder, was derided by gender activists, disowned by a university and pulled from a website for its ‘unscientific recruitment’ from pre-selected sites[9].

Perhaps the most unscientific aspect of the study is its extrapolation of adult experiences to children. While it is recognised it is difficult to alter adult orientation, it is also recognised that the large majority of confused children will naturally re-orientate to natal gender through puberty. The study compares apples with oranges. Yet it appears to have a defining influence on the Labor Party and its National Platform.

What does the La Trobe study recommend?

Given the study influenced a public retreat from the proclaimed Labor objective of criminalising conversion therapy, and that the retreat was accepted unanimously at the recent National Conference, further influence is likely: perhaps it is a blue print for action after electoral victory. Its recommendations should, therefore, be scrutinised by the medical, educational and theological professions.

The study calls for the Victorian Health Complaints Act (2017) to be strengthened, and to become instructive for the rest of Australia. It should be emphasised (because it still appears unnoticed) that the Act already possesses the power to reverse the traditional onus of proof in which innocence is presumed until guilt is proven. Ms Hennessy declared the need for 'reverse onus' in which 'the accused is required to prove matters to establish, or raise evidence to suggest, that he or she is not guilty of an offence.' The Minister sought to reassure, however, she was 'of the view that there is a negligible risk that these provisions would allow an innocent person' to be found guilty and declared them 'compatible' with the 'Charter of Human Rights and Responsibilities Act 2006'[10]. This 'reverse onus' may apply to anyone even reluctant to refer a confused child to a clinic practicing the Dutch Protocol: from medical doctors to psychologists, school counsellors, principals and pastors.

It could be argued the Complaints Act already possesses enough power to intimidate and punish but the study demands more. It wants to replace the unspecified intention to abolish conversion therapy with specific 'legislation that categorically outlaws (it) …that unequivocally prohibits conversion practices, whether or not an individual complaint is made'. And it wants to ensure action by obliging 'a legislator to intervene to protect children from conversion practices, regardless of the setting or level of formality'. Already, the Victorian Health Complaints Commissioner is 'investigating' conversion practices without prompting by complaints.

It demands thought control and obedience of all therapists of gender confused children by the creation of a special registration (monopoly) whose membership will be 'subject to training requirements and professional codes', supplemented by 'relevant guidance materials' which emphasise 'conversion therapies' are 'not consistent with their professional obligations' and warn that 'disciplinary actions' will apply.

Obedience to the Party Line will be enhanced by delegation of policing powers and responsibilities to 'Associations of Health Professionals', such as Medical Boards, whose 'codes' should be 'strengthened' to 'specifically and explicitly prohibit conversion practices and ensure that enforcement action is available and actively pursued by the relevant professional body'. Relevantly, the Australian Health Practitioners' Registration Agency (AHPRA) is reviewing a new 'code of conduct' in which a doctor could be found 'unprofessional' by making public statements that challenged perceived beliefs, thus reducing community trust and causing some to feel 'culturally unsafe'. Penalties include deregistration.

The study demands school funding be dependent on prohibition of 'conversion therapies' by counsellors, provision of 'training' on their harms, and demonstrated awareness of obligations to report 'unlawful' behaviour to 'child protection services'. Such behaviour includes reluctance to refer a child to a gender clinic.

It also demands government funding for sufferers from conversion therapies, and for research into these practices in 'faith based organisations' especially 'Protestant Christian communities'.

Finally, it demands restrictions of public broadcasts that promote 'conversion therapy' which, coupled with accusations of 'unprofessionalism' by AHPRA, would ensure immediate trouble for any practitioner inclined to speak favourably of psychotherapies, let alone question the experimental Dutch Protocol.

Looking back at past psycho-therapies, now to be outlawed as 'conversion therapies'. Are they abhorrent?

Childhood gender dysphoria was rarely documented before the 1970's and, before the Dutch Protocol was developed in the late 80's, was managed by a variety of non-medicinal therapies. According to Zucker and Green, these included 'behaviour therapy, psychotherapy, parent counselling, family therapy and group therapy' whose emphasis reflected 'conceptual orientations' of the cause of gender dysphoria: was it a primary problem of the child, or secondary to issues in its family.

Most earlier therapists emphasised family influences, especially the interaction of boys and mothers which had developed into a 'symbiotic' relationship perpetuating the feminine identification of the boy. That emphasis, of course, confronts current ideology which insists gender identification arises within the child: irrelevant to chromosomes, there arises a kind of Gender Spirit which, sadly, may find itself in the wrong body.

In 1971, Spensley and Barter reviewed 18 adolescent boys with a mean age of 14.9, concluding ' all mothers and 77% of fathers played active and passive roles…in encouraging their sons' crossdressing'.

In 1975, Bates et al reviewed experience with 29 'gender-disturbed boys' and their families, during which they developed 'procedures that seem(s) to be effective' in improving a child's repertoire of masculine behaviours, social skills, and family relationships. They concluded 'the behavioural problems… are often formed, and are almost always maintained as a function of family relationships'. Eighteen months after treatment, 17 mothers had reported 'moderate increases in masculinity', and improvements in social skills and behaviour.

From the 70's Rekers and co-workers at the University of Florida reported regularly on their behavioural and psychotherapeutic management of gender dysphoria. Essentially, they rewarded masculine behaviour while ignoring feminine behaviour in dysphoric boys. Rekers maintained 'gender disturbed children who completed their therapies 'experienced significantly greater long term improvement' for at least four years[11]. Younger children were most responsive.

Rekers was criticised for allegedly promoting hyper masculine traits but responded by declaring 'the most adaptive psychological state appears to be the one in which the essential (biologically mandated and sexually defined) distinctions between the male and female roles are mastered by the child. Beyond that point, there should be sex role flexibility'[12].

Foreshadowing claims of current transgender activists, Rekers wondered if his critics believed 'transexualism' is 'deviant or undesirable only in the eyes of a skewed society with distorted and antiquated social standards'. He replied 'it is clearly deviant for a boy to state repeatedly that he can bear children, and to wear maternity clothes compulsively. It is pathological for a person to state his genitals are not rightfully his property, thereby requesting that they be surgically removed'. Even more controversially, Rekers reported one set of parents believed something more persuasive than rewards should be instituted and, consequently, delivered four 'swats' to the child for gender related behaviour during the treatment, plus two for general misbehaviour.

In 1974, Pauly summarised world literature on 80 cases of female transsexualism concluding: 'Parents ought to be more aware of the need to positively reinforce all infants for those gender characteristics which are consistent with their biological identity. I can think of very few worse fates than to be the life-long victim of the kind of family discord or ignorance with breeds gender identity problems'[13]. Re-enforcement of natal gender is, of course, anathema to the current belief in early affirmation of its opposite.

In 1976, Stoller stated 'simply …most feminine boys result from a mother who, whether with benign or malignant intent, is too protective, and a father who either is brutal or absent (literally or psychologically'[14]. He concluded, starting early, psychotherapy has 'regularly been able to diminish or remove' cross gender behaviour. Psychotherapy included 'uncovering, interpretation and the resolution of conflict by insight' plus the encouragement of 'masculinity' and discouragement of 'femininity' in the child. This therapy might result in a mother realising her dependency on a feminised son as 'the only good male in the world', and a distant father increasing 'commitment to his son, wife and family'.

In 1977, Davenport and Harrison reported a 14 ½ year old girl with marked gender dysphoria who 'convincingly presented herself as a boy in dress, voice, movement, interests, and orientation', while hiding her developing breasts. She insisted on sex change surgery (of which she understood little) but was admitted to a psychiatric hospital and underwent regular psychotherapy for some twenty months. 'Geared specifically for adolescents', this included 'active intervention, therapeutic school, recreational and occupational therapy'. Gradually, she reorientated to her natal gender and two years after discharge 'appeared to have adopted a feminine identity.' 'Understanding the family constellation' had been important in the treatment.

In current Australia, such dysphoria with aversion of breasts and desire for surgery could have led to bilateral mastectomies, as experienced by five local girls under the age of 18: 2 at 15. Progress of puberty would have been blocked by drugs, and facial and body hair inspired by testosterone. She would have been given a new name and identity, and could have anticipated uro-genital rearrangement, sterility and a life-time of medical dependency.

In 1978, Zuger reported a 10 year follow up of dysphoric boys who had undergone psychological and psychiatric care. He noted 'a kind of 'decay' or burning out of these symptoms, completely in some, partially in others, and not at all in a few'[15].

In 1980, Lothstein reported a five year follow up of 27 cross dressing adolescents with mean age of nearly 17, identifying major 'stressors' associated with their request for sex realignment surgery. These included a recent change in a relationship, physical maturation, and stigmatized homosexuality. He reported 'urgent demands for surgery often decrease' with psychotherapy. He concluded 'gender dysphoria conflicts in adolescents have their roots in psychological conflicts' and, 'given the irreversibility of surgery and perhaps even some hormone effects', a trial of psychotherapy is the initial treatment of choice'. Lothstein warned 'surgery should only be considered towards the end of adolescence (age 21) after extensive psychological assessment, a lengthy evaluation and trial psychotherapy'[16].

Relevant for the current practice of 'affirmation' of a child's new gender identification by parents and other authorities, Lothstein observed 'an encouraging parent, or compassionate sibling, who supports the patient's cross dressing and wishes (for surgery), may make any psychotherapeutic intervention difficult'.

In current Australia, adolescents may undergo sex change surgery when 18, and mastectomies even earlier under the fatuous argument such surgery is reversible, given the availability of silicone sacs. Prior counselling is reported to be perfunctory: nothing remotely similar to the psychotherapy of Lothstein's day appears to exist. Indeed, under a Labor government, even broadcasting about it will be restricted.

Lest it be construed such psychotherapies were only practiced overseas, in 1987, surely their most dramatic account appeared in the Medical Journal of Australia, when Robert Kosky, Director of

Psychiatric Services at the Perth Princess Margaret Hospital for Children, and WA State Director of Child and Adolescent Psychiatry Services, answered the question 'Gender-disordered children: does inpatient treatment help?'[17]

From experience with 8 primary aged children, seven boys and one girl, referred between 1975 and 1980, Kosky reported the problem of cross-gendering usually began 'around two years of age' when the parent had 'with delight, found that, when the child was dressed in clothes of the opposite sex, play together was fun'. Later, 'the child cross dressed on his or her own.'

Kosky observed 'unhappy (parents)…especially the parent of the opposite sex who seemed tied to the home, lonely and with few school contacts' but who claimed 'a close emotional bond' with the child. The parent of the same sex was usually 'absent'.

He concluded cross-dressing was 'not the only, or indeed the central problem…Unhappiness, anxiety, suicidal thoughts, aggressiveness and failure to learn adequately at school were features present in most. As were the cross-gender behaviours, these features appeared to be secondary to the pathological parent-child relationships'. He found 'the essential disturbance in these cases was the inability of the parent of the opposite sex to accept the child, except on the conditional basis that the child met certain of their needs'. He explained that to overcome their own mental issues, the parents 'developed a fantasy about the child…(denying) the child's biological sex' and encouraging 'their notions of opposite sex behaviours in their child (such that) when the child adopted these behaviours, the parent changed from a cold mechanical interaction with the child to warmth and affection.' This 'symbiotic relationship' isolated the child from its peers: 'the mutually sustaining relationship precluded the development of ordinary social skills, reinforcing dyadic dependence'.

Treatment involved admission to a 'psychiatric unit' while attending the local school. In both places the child was encouraged to play with other children and to adopt 'age appropriate behaviours' but 'no conscious attempt was made by the staff members to encourage masculine or feminine behaviours. The only injunctions were that the children had to respect the privacy of others, and not steal 'underwear'. Parents were encouraged to visit regularly and join activities with their children.

What happened? 'Cross dressing ceased very quickly after admission…Many of the other behaviours, which had been present for years, vanished after several weeks. Improvement in 'general mood' was noted and 'school achievements and social behaviour improved steadily…' By the end of the average stay of 18 weeks, 'the children were functioning socially and educationally' for their ages.

Kosky reports, however, that 'such dramatic changes in the children's behaviour produced anxiety for all the parents'. One mother had 'panic attacks' after which her 10 year old son reverted to cross dressing. When she 'settled down', he 'ceased cross-dressing'. She then began 'sabotaging the treatment by bringing in female clothes… and isolating herself with him in his room'. Finally, she discharged the child against medical advice. He was never seen again.

Progress of the remaining children was reviewed one year after discharge but with continued psychiatric therapy. School, social progress and general maturation were judged reasonable. Cross dressing had resumed in one six year old in association with long periods of paternal absence, warranting re-admission for 2 weeks. He was last seen at 16 years when he identified as a male of heterosexual orientation without any cross gender behaviour.

Eight years after discharge, but with continued psychiatric contact, one 17 year old declared he was 'mixed up' about his sexuality, believing he had been 'programmed into homosexuality by his mother'. None of the others 'expressed homosexual feelings, was transvestite or transexual'.

Kosky declared 'an overemphasis on the biological model of gender dysphoria' may lead to 'therapeutic pessimism': some of the parents had been told there was 'no hope'. One was advised 'the child would have to go to New York for a sex change operation'. Kosky concluded 'the treatment of cross gender behaviour by means of inpatient therapy seems effective' and the 'emphasis on the familial and social context of the disorders…should counteract undue emphasis on the behaviours themselves…(which)…seemed relatively superficial manifestations of disordered personal interactions and an inadequate repertoire of social skills on the part of both parents and child.'

In 2012, Zucker and associates reviewed their counselling experiences with 590 children from 2-12 years referred to their Center for Addiction and Mental Health since establishment in Toronto in the 70s.[18] After a lengthy, introductory phone interview, if warranted, the child and family would be invited for assessment during 3-4 visits. If merited, according to the Diagnostic and Scientific Manual for Mental Health, the child and family would be invited to undergo psychotherapy which might continue for years with an intensity revealed by one 5 year old who had his 112th therapeutic session when 9.

The dysphoric child would be encouraged to become 'comfortable in its own skin', that is, to re-orientate to natal gender. This would not only reduce individual and family stress, but avoid the 'complexities of sex-reassignment surgery and its biomedical treatment'. If, however, 'a particular adolescent…is very much likely to persist down a pathway toward hormonal and sex-reassignment surgery', Zucker declared 'our therapeutic approach is one that supports this pathway'[19]. Zucker had reported a persistence rate of 12% of affected girls and 13.3% of boys but it is not clear how many continued to hormonal and surgical intervention, or whether it was helpful. [20]

Psychotherapy included '(a) weekly individual play psychotherapy for the child, (b) weekly parent counselling or psychotherapy, (c) parent guided interventions in the naturalistic environment (eg determining limitations for time and place of cross dressing) and (d) when required… psychotropic medication.' Biopsychosocial factors would be identified, explored and addressed: in a boy naturally disinclined to rough and tumble, self-esteem might be enhanced by introduction to boys with similar interests. Psychosocial factors might include the perpetuating influences of parental neutrality or actual encouragement of cross dressing. Social cognition might be limited: disinclination to rowdiness might make a boy think he is a girl. Co-occurring psychopathology such as autism might engender obsession with cross dressing activities. Psychodynamic factors might involve a transfer of unresolved distress from parent to child.

The aim of the psychotherapy was not to establish 'right or wrong' but to help parents understand 'why their child feels the way': to explore and consider 'how best to help them and their child'. Therapy would aim to reduce the child's dysphoria, whether or not it turned out to be heterosexual or homosexual. Zucker emphasised 'our approach with parents is to make the point that the surface behaviours of (gender dysphoria) are, in effect, 'symptoms' and that symptoms can best be helped if the underlying mechanisms are better understood.'

In 2015, Zucker's therapy was condemned as 'conversion therapy' by activists and this Professor who had lead the international field for decades was stood down and his unit closed.. Such is the power of the ideology of gender fluidity.

Summary.

Some earlier features of childhood gender dysphoria differ markedly from today. It was then rare: now it is not. Kosky reported 8 referrals over 5 years: now the equivalent hospital reports 2-3 referrals a week. None of Kosky's patients received hormones. Now, a few hundred Australian youths appear to be on regular therapy. Over 30 may have undergone irreparable surgery which many more are reported to be contemplating[21].

Once, confused boys predominated. Now, vulnerable teenage girls appear susceptible to a psychological phenomenon: a 'social and peer contagion'[22]. The psychological impact on gender identity of social media and the internet should, therefore, be researched (before Australian Protestant churches) and appropriate psychotherapy employed. Are girls recoiling from hard-core pornography?

No current sufferer appears to have been offered the once standard, non-medical treatment. Indeed, despite reports of therapeutic benefit, if a victorious Labor Party proceeds to legislate declarations in its newly minted National Platform, even positive discussion of psychotherapies will be illegal.

Does the great party of the working class really want its workers to know it no longer believes they produce boys and girls, merely loci on a flexible Rainbow? Does it really want them to know that if an offspring suffers gender confusion the Party will have legislated against discussion and practice of any alternatives to hormones and surgery?

Finally, isn't the current 'transitioning' of a child to an alternate gender just another form of 'conversion therapy', using the old and abhorrent means of psychological pressure, hormones and surgery, the ALP wants to abolish?

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[2] Jones T, Brown A, Carnie L et al. Preventing Harm, Promoting Justice. Responding to LGBT conversion therapy in Australia. Melbourne: GLHV@ARCHS and Human Rights Law Centre, 2018.
[3] Ibid, p 3.
[4] Ibid, p 9.
[5] Tomazin F. Religious leaders and health practitioners could face prosecution for gay 'conversion'. Sydney Morning Herald. May 16, 2018
[6] Ibid, p 5.
[7] Ms Hennessy. Health Complaints Bill Second Reading. Parliament of Victoria. Hansard. Feb 10, 2016.
[8] https://www.sbs.com.au/news/ban-on-gay-conversion-therapy-will-be-a-priority-for-labor
[9] Littman L. Rapid onset gender dysphoria in adolescents and young adults: A study of parental reports. PLoS ONE 13(8):e0202330. https://doi.org/10.1371/journal.pone.0202330.
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