JOHN WHITEHALL

The Family Court Must Protect Gender-Dysphoric Children

Gender dysphoria is "clinically significant distress or impairment in social, school, or other important areas of functioning" due to "a marked incongruence between one's experienced/ expressed gender and assigned gender"[1]. Formerly rare, recently there has been a phenomenal increase in the numbers of children being brought to specially created gender dysphoria clinics in children's hospitals around Australia, associated with much publicity of transgender options in the media, the web and so-called "Safe Schools" programs. No one knows the cause for the epidemic but it has features of a behavioural fad. Nevertheless, it is a dangerous fad because medical treatment can involve hormones that interfere with the brain as well as the body, and progress to irreversible surgery in the attempt to mimic external characteristics of the opposite sex.

Diagnosis and management are a challenge to the medical profession: education of the courts is a responsibility. Reliance by the courts on that education is an exercise in faith. Neither profession is immune to social pressure, but the lives of children depend on their wisdom. The Family Court of Australia (hereafter simply "Family Court") has responsibility for the protection of children and its authorisation is needed for medical treatment defined as invasive, irreversible and associated with the possibility of error with drastic consequences, as instructed by a High Court decision in 1992, known as Marion's case[2]. The Full Court of the Family Court is currently considering an appeal that could remove that protective role with regard to childhood gender dysphoria, relinquishing management to the child, parents and therapists[3]. This article argues that the protective role of the Family Court should be maintained.

The legal basics

Two court cases and one law are fundamental to the current medico-legal management of childhood gender dysphoria. The first court case was the appeal to the High Court in 1992 by parents seeking authorisation to consent for hysterectomy and ovariectomy on their fourteen-year-old mentally retarded daughter, Marion, to relieve stresses of menstruation and unwanted pregnancy. The second case concerned an appeal in 2013 from the Family Court to its Full Court regarding the right of parents to consent to all stages of treatment of their natal son, Jamie, in his transition towards the opposite sex. The fundamental law is the Family Law Act 1975 and, in particular, Section 67ZC, which is the statutory basis for the court's jurisdiction regarding medical procedures that are beyond the bounds of parental consent. The law conveys to the court the "paramount" responsibility to act in the "best interests" of the child.

In Marion's case, four principles were enunciated:

- Parents could not consent to medical intervention in children which was non-therapeutic, irreversible, invasive, associated with a significant risk of the wrong decision being made and where the consequences of such a decision were grave.
- If mentally competent, a child under sixteen years could consent to medical intervention, according to precedent from a case in the House of Lords in which a Mrs Victoria Gillick contested, unsuccessfully, that children under sixteen were not competent to consent for contraception therapy[4]. The English court decided that if a child possessed "sufficient understanding and intelligence to ... understand fully what is imposed", the child could consent to medical treatment. The Australian court concluded: "This [Gillick] approach, though lacking the certainty of a fixed age rule, accords with experience and psychology" and "should be followed ... as part of the common law"[5]. Accordingly, court authorisation would not be needed for medical interventions for conditions that involved "malfunction or disease" and were given "for the traditional medical purpose of preserving life".[6]
- If traditional purposes were not obvious and the child was Gillick incompetent, authorisation by

the court was obligatory for "special cases" of "non-therapeutic, invasive, irreversible" interventions with grave risks from error.

- The court bore a protective role for children. As concluded in a previous case, *re Jane*, consequences of abrogation of that role would be "far reaching both for parents and for children. For example, such a principle might be used to justify parental consent to the surgical removal of a girl's clitoris for religious reasons or the sterilisation of a perfectly healthy girl for misguided, albeit sincere reasons."[7] Deliberations in *re Marion* went further, warning against unqualified trust in the medical profession which "Like all professions ... has members who are not prepared to live up to its professional standards of ethics ... Further, it is also possible that members of that profession may form sincere but misguided views about the appropriate steps to be taken."

In Marion's case, Brennan J emphasised the "awesome" power of the court with regard to sterilisation, warning that "its exercise is so open to abuse" with consequences that are "generally so irreversible". These consequences were not restricted to abolition of the fundamental right of procreative biology but extended to "long-term social and psychological effects". Regarding later regrets, Mason CJ, Dawson, Toohey and Gaudron JJ declared:

> Regard must also be had to the disturbance of the child's mind and the emotional aftermath of the sterilisation and a comparison must be made between her self-perception when sterilised and the perception she would have had of herself if she had been permitted to live with her natural functions intact.

Therefore, Marion's case emphasised that sterilisation should be a "step of last resort", which is "a convenient way of saying that alternative and less invasive procedures have all failed and that it is certain no other procedure or treatment will work".

The dangers of "sincere but misguided" medical advice were emphasised, particularly in regard to assessment of a child's "best interests". In the absence of "legal rules or a hierarchy of values", assessment would reflect the "value system of the decision maker ... An authorisation to sterilise might be reviewable by a tribunal, but what guidance would the best interests approach give to the tribunal?"

McHugh J declared the "best interests" approach relies on the "opinion" of a doctor and thus "transfers the issue to the medical profession for determination". Quoting a Professor Kennedy, he warned:

> The courts will be presented with a fait accompli. Those who wish to challenge it will have what amounts to a near impossible task. They will have to persuade the court to reject wholly or in part the evidence of the experts, evidence that is often unanimous and which has all the trappings of expertise. It will be too late to argue the answers were wrong because the questions were wrong.

What is the nature of the problem?

Marion's sterilisation may seem irrelevant to the management of children with gender dysphoria, but there are important similarities.

Marion's case questioned the relevance of the proposed treatment to the basic medical problem. It was decided that sterilisation was not preventive or therapeutic in accordance with traditional practice and as Marion did not possess Gillick competence, authority for the invasive, irreversible intervention would not be extended in order to protect the child.

In childhood gender dysphoria, definition of the basic problem has been convoluted, given uncertainty as to whether it is primarily or secondarily a psychiatric illness. Incongruence between mind and matter has generally been perceived as a psychiatric disorder, and early Family Court judgments reflect difficulty with claims that gender derives from feelings, not from physical facts, and whether a normal body should be rendered abnormal to make a normal mind less abnormal.

In 2004, in *re Alex*, the first of the spate of cases of childhood gender dysphoria bound by the strictures of Marion's case, Nicholson CJ can be seen to struggle with definitions concerning a thirteen-year-old girl who was convinced she was a boy. The Justice wondered if "this condition is properly described as a disorder" but, convinced that the "current state of knowledge would not ... enable a finding that the treatment would clearly be for a 'malfunction' or 'disease'", he maintained the protective role of the court because of the inherent risks of treatment.[8]

In 2010 in *re Bernadette*, concerning authorisation for puberty blockers and cross-sex hormones for a seventeen-year-old natal male identifying as a female, Collier J wondered "whether or not transsexualism is a malfunction or a disease or a natural variation to be found in human beings where brain sex and genitalia are different". The applicants argued that it did "not occur as a result of disease or malfunction" but, nevertheless, argued that its treatment should not need the authorisation of the court. Collier J was not persuaded by the "medical evidence" presented to him that transsexualism "was a normally occurring factor of human development" and therefore declared there should be a continued need for the court to authorise certain treatments so as not to "expose children ... to unwarranted risks". Collier J, however, appears to be the first judge to concur with the spirit of gender fluidity, accepting "material" which indicates that a person's sexual identity is "determined by their 'brain sex' and not by their genitalia or other aspects of their physical appearance or presentation"[9].

Ultimately, the bible of psychiatric diagnosis, *Diagnostic and Scientific Manual of Mental Health* (*DSM-5*) found compromise: Incongruity, *per se*, would not be defined as disorder, but if associated with "clinically significant stress or impairment in social, school, or other important areas of functioning" it would be defined as gender dysphoria[10].

One challenge to the "normal mind theory" is the relentless association of gender dysphoria with established mental disorders including depression, anxiety, attention deficit hyperactivity, psychosis and autism. Social ostracism is the promoted reason for these co-morbidities, but another explanation would be that they represent a global mental problem of which gender incongruence is but one symptom.

The question is whether the general mental problems of children with gender dysphoria will be improved or worsened by changing sex. The answer is that no one knows the long-term outcome.

Many clinics treating gender dysphoria emphasise the prevalence of associated mental disease. A Dutch unit reports "anxiety disorders" in 21% of adolescent sufferers, "mood disorders" in 12.4%, "disruptive disorders" in 11.4% and autism in 7.5%.[11] [12] A London unit[13] reports low mood/depression in 7.3%, autism in 12.2% (and possibly another 4.9%), attention deficit hyperactivity (ADHD) in 14.6%, anxiety in 17.1%, and psychosis in 2.4% in dysphoric children aged from five to eleven. In children from twelve to eighteen, 49.7% suffered from depression, 13.6% (and possibly another 3.6%) from autism, 6.8% from ADHD, 23.7% from anxiety, 5.7% from psychosis and 16.4% from eating difficulties. Bullying of these children was reported to be common, but whether it was provoked by transgender characteristics or those associated with autism, hyperactivity and psychosis was not discussed.

In sixty-nine decisions by the Family Court since 2004, severe mental co-morbidity is emphasised in 50% of the children concerned. These morbidities include depression, anxiety, behavioural disorder and autism.

Ostracism is argued to be a major cause of dysphoria, deserving the institution of "Safe Schools" programs to encourage social acceptance and deter bullying. However, a review of forty years of experience involving 572 gender-dysphoric children found "poor peer relations" were not a significant predictor of suicidal ideation and behaviour and, therefore could not "argue that social ostracism of gender-dysphoric children was a unique correlate of suicidality".[14]

Whatever the cause of the co-morbidity, symptoms of gender dysphoria have been reported to *follow* rather than precede other disturbances. A review of cases presenting to Finnish hospitals from 2011 to 2013 concluded that 75% "had been or were currently undergoing child and adolescent psychiatric treatment for reasons other than gender dysphoria when they sought referral"; 64% had treatment for depression, 55% for anxiety, 53% for suicidal and self-harming behaviours, 13% for psychotic symptoms, 9% for conduct disorders, 4% for substance abuse, 26% for autism spectrum disorder and 11% for ADHD. Of these children, 68% had had their first contact with psychiatric services due to reasons other than gender confusion."[15] Family Court records similarly suggest many mental problems preceded the symptom of gender dysphoria, including autism.

The question is whether the general mental problems of children with gender dysphoria will be improved or worsened by changing sex. The answer is that no one knows the long-term outcome. Therefore the medical intervention cannot be described as therapeutic, though certainly invasive and with drastic effect. Marion's need for protection remains.

Is the medical pathway necessary?

Therapy for gender dysphoria ranges from active persuasion to re-orientate to natal sex, through a middle ground of more passive "watchful waiting", to the medical pathway of transitioning towards features of the opposite sex, known as the "Dutch protocol". This pathway begins with social transitioning by adoption of names, pronouns and dress of the opposite sex, and promotion of the child as a member of the opposite sex. It may then progress to Stage 1 therapy, involving drugs that block puberty, then to Stage 2, involving administration of cross-sex hormones to evoke appearances of the opposite sex, then to Stage 3, involving surgical attempts to mimic the genitalia and other physical features of the opposite sex.

In a Special Review in the *Journal of Homosexuality* of "The treatment of gender-dysphoric/gender variant children and adolescents", a child psychiatrist from New York concluded that "the long-term psychological and physiological consequences of [the medical pathway] are unknown and, as is the case with all self-selected populations, very difficult to assess owing to problems of [lack of experimental] control and limited sample numbers". The psychiatrist highlighted concerns, including dependence on "clinical impression", "usage of anecdotal data", suspension of "natural scepticism" in favour of "literality" of children's and adolescents' claims, unquestioning "certitude", and lack of consideration of "potential disadvantages".[16]

The psychiatrist emphasised that most children suffering from gender incongruity will grow out of it without medical therapy. He referred to the conclusion of the former head of Toronto's Center for Addiction and Mental Health, Professor Kenneth Zucker, that "The majority of children followed longitudinally appear to 'lose' the diagnosis of [gender dysphoria] when seen in late adolescence or young adulthood, and appear to have differentiated a gender identity that matches their natural sex."[17] Professor Zucker thus prefers a "watchful waiting" approach to management.

DSM-5 concurs, declaring that rates of persistence of dysphoria range from only 2.2 to 30% in natal males and from 12 to 50% in natal females[18]. In "natal adult males", however, *DSM-5* declares prevalence of gender dysphoria to range from 0.005 to 0.014% and, in "natal adult females", to range from 0.002 to 0.003%[19]. Thus, if gender dysphoria exists in 1.2 to 4% of children, as claimed in Australian "Safe Schools" material, but is as rare in adults as reported in *DSM-5*, the mathematical chance of desisting is at least 99.5%. Statistics show that the medical pathway is unnecessary and should only be pursued as the rare "step of last resort", described in Marion's case.

The Family Court has been directly advised of this likelihood of desistance. For example, a medical witness declared in *re Alex* that only a minority of children with gender dysphoria "will progress towards transsexualism later on in life" and of teenagers with gender dysphoria "there is a number ... who present ... at the age of say 13 or 14 who by the age of 18, 19 no longer wish to pursue gender reassignment. Some of the features of the gender identity disorder might have disappeared."[20]

It should be noted that not all desisters emerge with heterosexual orientation. A minority emerge with homosexual orientation. Professor Zucker's declaration that life as a homosexual was much less complicated than that of a transgender appears to be the reason he was recently sacked and his unit closed.[21]

Does the medical pathway prevent self-harm?

The possibility of suicide is a weapon wielded upon a compassionate judge by fervent children, desperate parents and committed advocates. Indeed, court decisions are reported by a senior Justice "to display an acute awareness of the potentially fatal consequences of denying young people with gender dysphoria timely access to cross-hormone therapy".[22]

How valid are these concerns? Do they justify the medical pathway? The above child psychiatrist declared:

> I am aware of no controlled data to indicate that the incidence of self-harm among trans children is any greater than somewhere between infrequent and rare ... I am aware of no data to suggest [the pathway] diminishes the probability of self-harm in trans children [or that these interventions] are any better for the welfare of trans children than supportive psychotherapy and psychoeducation for adults.

Regarding anecdotal reports of threats of self-harm, the psychiatrist emphasised, "there are psychiatric protocols for addressing the patient who seems to pose the threat of self-harm that are minimally intrusive and unquestionably reversible".

Despite claims of an "alarmingly high rate" of self-harm and suicide, exemplified by the highly publicised suicide of a dysphoric youth in the US,[23] in reality "few data are available on the prevalence of self-harm and suicidality in children with gender dysphoria".[24] One London study[25] retrospectively reviewed letters from referring doctors and its own notes regarding 218 gender-dysphoric children with a mean age of fourteen. Of forty-one aged between five and eleven, it reported self-harm in 14.6%, suicidal ideation in 14.6% and suicidal attempts in 2.4%. Of 177 adolescents aged twelve to eighteen, suicidal ideation was reported in 39.5%, self-harm in 44.1% and suicidal attempts in 15.8%. The study, however, utilised no comparative groups and did not consider strength of intent which could, of course, range from seeking attention to seeking death. Finally, the authors wondered if the rates "simply reflect trends in the general population".

A review of such trends reveals the great difficulties in getting reliable data from child and adolescent interviewees, in whom rates of non-suicidal self-injury vary from 12.5 to 23.6%, and deliberate self-harm from 12.2 to 31.4%, depending on the form of assessment.[26] Other studies have confirmed that between 19[27] and 29%[28] of *all* adolescents have announced a history of suicidal ideation, and between 7 and 13% have attempted suicide, though what constitutes an attempt is not defined.

Casting doubt on the alleged high rate of suicide due to gender dysphoria in adolescents, an author in the *Journal of Homosexuality* concludes that "very few suicide decedents" have been identified as having "minority sexual orientation" in studies in North America: three of 120 adolescent suicides in New York, and four of fifty-five in Quebec. The author warns that conclusions must be regarded as tentative when based on small numbers of retrospective data that "do not effectively allow cause and effect relationships to be discerned" including "co-occurring mental disorders", are restricted in the number of questions, and are weakened by the possibility of incomprehension of the questions.[29]

Even one suicide is deplorable, and physicians are advised to "routinely screen for the presence of suicidal ideation and behaviour in children with gender dysphoria". Though data is limited, it appears they do run a higher risk when compared to children not receiving psychological or psychiatric care. Their risk, however, is similar to that of children receiving inpatient and outpatient care for mental health problems,[30] which is not surprising given the association of gender dysphoria with mental disturbances known to predispose to self-harm. For example, the association with autism is important: 14% of children with autism up to sixteen years of age are reported to experience suicide ideation or attempts, suggesting a rate twenty-eight times greater than expected (0.5%).[31]

Deliberations in Marion's case were based on the shared judicial conviction of the need of the protective role of the court against cultural influences which could lead to invasive, irreversible and grave interventions. Such judicial unanimity no longer exists.

Another factor relevant to self-harm is the family environment of the dysphoric child, which is often disrupted. In the above London study, only 36.7% of its children lived with both biological parents and, overall, the families were blighted with discord: "Domestic violence was indicated in 9.2%, maternal depression in 19.3%, paternal depression in 5%, and parental alcohol/drug abuse in 7.3%." A review of sixty-nine applications to the Family Court since 2004 suggests that at most 47% of children were living with both parents.

Finally, whereas there is no substantive evidence that the medical pathway reduces self-harm and suicide, avoidance of such treatment may be the best way to prevent it. While one Dutch unit concludes that "starting cross-sex hormones early ... followed by gender reassignment surgery ... can be effective and positive for general and mental functioning",[32] other centres report high rates of suicide in years following sex reassignment.[33] [34] To be fair, those reassigned in these studies did not have such a developed pathway of sustained encouragement and support as in Holland, but, nevertheless, suicide attempts have been confirmed to be much more common after sex reassignment surgery than in the general population in Belgium (5.1% compared to 0.15%)[35] and in Sweden.[36]

Is the medical pathway as invasive as sterilisation?

The answer is yes, and qualitatively more so because it not only involves sterilisation, but also intrusion into the brain. Medical experts informing the Family Court since 2004 have euphemistically referred to the "suppressing" effect of cross-sex hormones on fertility, avoiding the harsher terminology of chemical castration in that stage, and surgical castration in Stage 3. It is not known how long it takes cross-sex hormones to castrate but the ultimate likelihood is confirmed by the discussions therapists have with their juvenile clients, as revealed in court deliberations. They advise harvesting and freezing ova and sperm before treatment begins if procreation is of concern to the adolescent.

Stage 3 therapy involves the surgical attempt to create ersatz genitalia of the desired sex and is based on castration. In males, the testes are removed and the scrotum inverted to create a "vagina". In females, ovaries and uterus are removed in the process of closing the vagina. Though these irreversible procedures are not authorised in children under eighteen years of age, bilateral mastectomies have been approved in Australia on five natal girls aged between fifteen and seventeen who were transitioning to the opposite sex. Though not "sterilising", they do represent "irreversible invasion" in the overall reproductive capacity. Some medical experts in the Family Court have downplayed the irrevocable loss of breast tissue with the assurance that cosmetic implants are available should the transformed child change its mind.

The removal of healthy reproductive organs is a "serious intrusion into the bodily integrity" of a child which "requires examination by an objective and independent authority", according to a representative of the Human Rights Commission in Marion's case. If the Family Court abrogates its protective role, no such authority will exist.

Is there a grave risk of error in that "self-perception" might change?

Though unlikely in handicapped Marion, the concept of change in "self-perception" was emphasised in her case. Regarding childhood gender dysphoria, Dessau J, in *re Jamie*,[37] appears to acknowledge the possibility by postponing permission for Stage 2 therapy until that eleven-year-old had grown older.

Though change of mind is reported in adults after treatment for gender dysphoria,[38] not much data is available regarding children, which is not surprising given the limited time since the medical pathway began. Nevertheless, this author is aware of two Australian adolescents reported to have changed their minds: a natal girl disillusioned by hair on her chest after testosterone, and a natal male by breasts on his chest after oestrogens. Given the numbers of children now receiving cross-sex hormones, the prevalence of associated mental disease and the experimental basis of the medical pathway, more disillusion is predictable.

Are cultural influences still important?

In Marion's case, warning was given against such "cultural influences" as the tradition of female circumcision (which, incidentally, does not involve sterilisation or drugs that might alter the brain). Since Marion's case, a new cultural influence has entered "social policy" and inspired a new "value system": it claims gender identity is not determined by inherent chromosomes and their orchestration of hormonal and chemical events to produce the binary groups of male and female; it insists gender is inspired by mental feelings, which may be flexible. This ideology of gender fluidity declares a man may exist in the body of a woman and vice versa and urges that social policies (including medical and legal practice) should accommodate such belief, underpinned by its new system of values. This ideology appears to have been embraced by some medical therapists, as well as children and their parents, and, not surprisingly, has entered judicial consideration, as revealed by Collier J's early acceptance of "brain sex".[39]

Deliberations in Marion's case were based on the shared judicial conviction of the need of the protective role of the court against cultural influences which could lead to invasive, irreversible and grave interventions. Such judicial unanimity no longer exists. Justices themselves have questioned the need for their protection of children from the medical pathway for gender dysphoria, and called for legislative change to remove the role of the Family Court.[40]

Is the warning about sincere but misguided therapists still relevant?

As early as 2008 in *re Brodie*, Carter J declared fulsomely, "I have confidence in and place great reliance on the evidence of Professor W and Associate Professor P. They are clearly experts in their respective fields. It is clear from their evidence they continue to keep up with research ..."[41] What was that evidence the doctors presented regarding this twelve-year-old natal girl from a disrupted family who was enraged by the "betrayal" of her father, "very angry about everything and towards everyone" and whose life "appeared to be almost out of control" according to her mother? Professor W declared blockers would reduce "the level of hostility and anxiety" and though administered "for a year or so" the effects would be "fully reversible". The experts emphasised that "there are no long term effects" of treatment and its denial "could quite literally endanger" her life. They did not confirm that a standard approach of psychotherapy had been tried and that blockers were a last resort. Nor did they refer to research which suggested a widespread role of GnRH on the brain and behaviour, as discussed below.

Jamie's case

Jamie's case before the Full Court of the Family Court in 2013 concerned a natal male wanting to transition. The saga had begun in 2011 when Jamie's parents applied for authority to consent to their ten-and-a-half-year-old son receiving both Stage 1 and 2 therapies in order to transgender. It was declared that Jamie had identified as female from around three years of age, as exemplified by the statement, "Mummy, I don't want a willy. I want a vagina."[42] Despite his young age, authority was extended for Stage 1 treatment with "puberty blockers" on the assurance that their effects were reversible. Though the court was convinced there was a natural progression from Stage 1 to Stage 2 as part of the one regime, authority was not given for Stage 2 (the administration of cross-sex hormones), on the understanding that some of its effects were irreversible, thus defining it as a "special medical procedure" needing authorisation according to the strictures of Marion's case. It was argued that administration of cross-sex hormones should be considered closer to their time of initiation, judged to be five or six years away, because circumstances might change in that lengthy period.[43] Whether cross-sex hormone treatment was "a special medical procedure" needing court authorisation was contested in 2012[44], examined in the Full Court in 2013, and finally authorised in 2015.[45]

In 2013, in *re Jamie*, four principles were defined:

1. Regarding Stage 1 therapy: because it was believed the effects of blockers were "fully reversible" it was concluded their administration was not a "special case" as defined in Marion's case. Therefore, administration did not need authorisation by the court unless disputed, in which case determination of the child's "best interests" would be effected under section 67ZC of the Family Law Act.

2. Regarding Stage 2 therapy: because of irreversible aspects, its administration did fall "within the ambit of Marion's case because there is a significant risk of the wrong decision being made as to the child's capacity to consent [Gillick competence] and the consequences of such a wrong decision would be particularly grave". Therefore, the decision for treatment could not be left to the child, parents and therapists. That the proposed therapy would be proportional to its presumed advantages and disadvantages was fundamental.

3. Regarding Gillick competence, it was decided, "if a child is not Gillick competent, the court must determine whether or not to authorise Stage Two". If competent, the child "can consent to Stage Two treatment and no court authorisation is required".

4. The court concluded that "the question of whether or not a child is Gillick competent, even when the parents and treating doctors agree, is a matter to be determined by the court". Gillick competence was thus intended to remain a "threshold" for authorisation of "special procedures".

Conclusions of the Full Court in *re Jamie* allowed subsequent cases to minimise theoretical consideration of gender dysphoria by concentrating on the practical issues of management, thus ensuring the court's dependence on medical "evidence". From the diagnosis, management and prognosis of gender dysphoria to the assessment of Gillick competence, the medical pathway would be proclaimed by a small group of protagonists with certitude unusual in other branches of medicine. The declaration in Marion's case by Brennan J regarding the "awesome responsibility" of the court would remain an understatement. One judge, without jury, would be responsible for the imposition of medical intervention that would most likely sterilise, certainly transform the body, invade the brain, and commit the child to a lifetime of dependence on medical care. And all this "capital therapy" would be inflicted on a child likely to be afflicted with serious mental co-morbidity, at the insistence of a few therapists.

This "awesome responsibility" should be shared with the medical profession, but therein lies the essential weakness of *re Jamie* and all subsequent cases. The word *witness* implies proof which implies fact. But, as revealed in judgments, medical "evidence" has rather resembled strong opinion, with certitude often related indirectly to scientific proof. Warnings in Marion's case remain apposite: a tribunal is only as good as the information it receives.

Stage 1 therapy: puberty blockers

Puberty is induced by a cascade of hormones with various checks and balances. Near its beginning, chemical messengers direct nerve cells in the hypothalamus to release hormones, known as gonadotrophin-releasing hormones (GnRH) which stimulate the pituitary gland to release other hormones which travel in the blood to stimulate maturation of the gonads, with subsequent release of the sex hormones, testosterone and oestrogen, which evoke secondary sex characteristics.

Analogues of GnRH have been manufactured which are similar to the original. They are known as puberty blockers because, after first stimulating the pituitary to release its hormones, they will not "let go" of the receptors, remaining in place to interrupt subsequent stimulation, thus blocking the process of puberty.

Since the 1980s, "blockers" have been used in adults to block the production of sex hormones in diseases they stimulate, such as prostate cancer in men and endometriosis in women. They have also been used to treat rare cases of precocious puberty in children. Though they block the effect of GnRH on the pituitary, no lasting effect on the function of that gland has yet been reported and, cautiously, the International Endocrine Society declares that "prolonged pubertal suppression ... should not prevent resumption" upon cessation.[46] The Society warns, however, there are no data regarding how long it might take for active sperm and ova to appear after prolonged blockage of their stimulating hormones.

Initially, deliberations in the Family Court were cautious regarding blockers. In *re Alex*[47], the court considered an application for authority for medical treatment to transgender by a thirteen-year-old natal girl under guardianship because of pitiable family dysfunction. Nicholson J authorised consent for the contraceptive pill to suppress menstruation but delayed consideration of the "irreversible effect" of blockers and testosterone until Alex turned sixteen. Regarding blockers, Dr C declared "he had not seen any major problems" but stated, "there had been no formal research".[48] Dr G opined, "it is difficult to predict the extent of side effects"[49] and blockers were not usually given "below the age of sixteen" and for no longer than one year.[50]

The possibility of GnRH affecting more than the pituitary has never been interrogated in the courts despite increasing reports from international research. In 2010, in *re Bernadette*, some misgivings were expressed about the effects of blockers on the brain but Collier J declared he was "satisfied" their effect was reversible, despite the "British [medical] view ... that brain development continues throughout adolescence" and blockage may incur "potential damage".[51] Collier J concluded that "this aspect" is dealt with by Dutch professors who "comment on the need for a study on the brains of adolescent transsexuals to endeavour to detect functional effect and difficulties". He said "this potential aspect of the matter" would not cause him to deny treatment. Collier J appeared satisfied there would be no brain damage in the present on the basis of research to be pursued in the future.

Collier J was also optimistic about the use of cross-sex hormones, declaring, "so far as stage 2 is concerned, I am satisfied that it would be possible to reverse that treatment ..." Regrettably, it appears Collier J had been misinformed on both accounts, as discussed below.[52]

> *As revealed in judgments, medical "evidence" has rather resembled strong opinion, with certitude often related indirectly to scientific proof. Warnings in Marion's case remain apposite: a tribunal is only as good as the information it receives.*

Effects of GnRH beyond the hypothalamic-pituitary axis had been revealed thirty years before *re Bernadette* by Pfaff[53] and others who had found a facilitating role in sexual behaviour by GnRH when injected beyond the pituitary in brains of laboratory animals. Rats exhibited sexualised behaviour even when their gonads had been removed, thus negating the secondary influence of sex hormones. The effect of blocking this sexualising influence in human children should have been considered.

Some twenty years later, anatomical bases for widespread effects of GnRH were found: nerves which carried the hormone to the anterior pituitary also extended to other brain sites, including the limbic system, which co-ordinates emotions, memory and cognitive information, and therefore influences behaviour and executive function.[54] GnRH mechanisms were then found in forebrain, amygdala and midbrain[55] and in neural tissue of the gut[56] and the spinal cord[57].

The role of GnRH at a molecular level in the nervous system is not clear but may be linked to the endogenous production of neurosteroids such as oestradiol,[58] [59] which seem to be neuroprotective. Neurosteroids appear, for example, to maintain the integrity of the communicating extensions of nerve cells, known as dendrites. Recent reports that GnRH blockers are associated with degeneration of nerve cells in the gut support the concept that GnRH is necessary for the health of nerve cells[60].

Evidence of neuronal disruption has been sought in adult men and women receiving blockers for medical conditions worsened by sex hormones. In 2007, as animal and behavioural studies suggested, it was found that blockers "may have significant effects on memory". Studies were performed on women receiving blockers for gynaecological reasons, in which abnormal cerebral functioning was found.[61] [62] In 2008, a review of their effect in men with prostatic cancer raised the "strong argument" for a "subtle but significant cognitive decline".[63] In both studies the secondary effect of blocking sex hormones could not be discounted: controlled laboratory research was needed.

In 2009, researchers in Glasgow and Oslo began to examine the effect of blockers on the brains of peri-pubertal sheep, finding exposure resulted in increased size of the amygdala[64], alteration in activities of multiple genes in the amygdala and hippocampus[65] [66] and disturbance in brain functioning[67] [68]. Female sheep had less emotional control and were more anxious. Males were more prone to "risk taking" and alterations in emotional reactivity. Both suffered sustained reduction in spatial memory.[69] [70]

In the language of *re Marion*, laboratory research had revealed an invasive, probably irreversible and certainly grave effect of puberty blockers on the nervous system.[71] It should be noted that the administration of blockers to sheep and adult humans was limited in time whereas, despite the advice given in *re Alex*, their administration to children may be continued for years, spanning a period of great cerebral development.

Puberty blockers are administered on the assumption that their effects will give confused children more time to contemplate their sexual future without the distraction of the appearance of secondary sex characteristics. Whether any peri-pubertal child can possess such wisdom has been questioned in court. In *re Darryl*, Dr N declared, "I am not persuaded most minors would be in the position to fully understand the implications of irreversible hormone treatment over the entire lifespan."[72]

Moreover, how can such a future be evaluated with a limbic system disordered by chemicals? And, if the cerebral effect of GnRH on sexualisation is blocked, together with the ordinary effect of sex hormones, how can a child be expected to evaluate its gender when such influences are denied to a brain that was designed to receive them from the earliest weeks of foetal life?

Stage 2 therapy: cross-sex hormones

In Stage 2 therapy, hormones of the opposite sex are administered to evoke its secondary sexual characteristics. International organisations have advised that these hormones should be reserved until sixteen years of age but current practice involves their use at decreasing ages. In a review of sixty-nine Family Court decisions, four authorisations for children under sixteen are revealed.

Courts have concluded that the effects of cross-sex hormones are only partially reversible, with permanent changes including laryngeal and bodily growth in a natal female, and the development of breast tissue in a male. In both sexes, chemical castration is probable.

Because of irreversibility, the Family Court concluded in *re Jamie* that authorisation remained necessary for Stage 2 therapy according to the strictures of Marion's case. Subsequent courts have been supplied with growing lists of possible side effects of cross-sex hormones, from metabolic and haematological disturbance to effect on mood and behaviour, but have not been informed of the possibility of structural effects on the brain. Three studies have, however, compared the effects of cross-sex hormones on adult brains, before and after administration. One, in which oestrogen and an added anti-testosterone drug were given to transgendering males, found a reduction in brain "ten times the average annual decrease in healthy adults" after only four months. After a similar time, the brain volume increased in females receiving testosterone. Others confirm that the shrinkage of male brains on oestrogen is associated with reduction in the size of grey matter after only six months[73], and that increased size of grey matter in females on testosterone is associated with altered microstructure of neurons[74]. It must be emphasised that these adult brains were affected after only several months of exposure: transgendering children may take cross-sex hormones for life. A 2016 review warns that "long-term clinical studies are yet to be published ... risks may become more apparent as the duration of hormone exposure increases".[75] Again, the court has been under-informed.

Surgery

According to international guidelines, "sex reassignment surgery" should not be performed on anyone under eighteen years of age. There are, however, reports of this extremely invasive procedure[76] occurring earlier in private clinics in the US.[77] Australian courts have authorised irreversible mastectomies on five natal females.[78]

Social transitioning

This first step on the medical pathway has often been taken by children and parents before consultation with therapists. In it, children impersonate their chosen gender by adopting its names, pronouns, dress and behaviour, despite international advice to limit the process. The Endocrine Society declares, "Given the high rate of remission ... after the onset of puberty, we recommend against a complete social role change and hormone treatment in prepubertal children."[79] The psychological pressure of impersonation may sustain confusion and facilitate progression to the medical stages described above. The "worst thing", according to one (anonymous by request) therapist is for the child to become the "poster child" of the school or media, encouraged by an "enmeshed" "cheer-leading mother". There is no evidence that social transitioning is therapeutic in the long term. There is, however, evidence that once the medical pathway has been entered, it is difficult to exit.

Even if the Family Court abrogates its role in the management of gender dysphoria, other courts may become increasingly involved with therapists and parents who do not appear to be supporting the transition of gender-dysphoric children. The Victorian Health Complaints Act 2017 has the potential to punish therapists who are deemed to be opposed to transitioning, and similar ground work for regulatory intervention has been revealed in New South Wales in *Legal Issues Bulletin* 55. In this publication by the state Department of Education, "a parent's unfavourable response to a child declaring itself transgender ... could give rise to a reasonable suspicion that the student is at suspected risk of harm", obliging consideration of reporting the possibility of child abuse.[80]

What happened to Gillick competence?

Established in Marion's case with the aim of protecting unwitting children from invasive medical intervention, this "threshold question" has failed. Lack of Gillick competence has been declared in eleven of the sixty-nine Family Court judgments since 2004. Nevertheless, all of these children have been consigned to the medical pathway in their "best interests" as declared by parents and therapists.

At first, deliberations were lengthy. Latterly, they appear perfunctory. In any case, although the court has declared itself to be the adjudicator of Gillick competence, it relies on reports from committed therapists. As warned in Marion's case, assessment has become a *fait accompli* and the "opportunity for reasoned analysis and scrutiny" has been forsaken. Justices now accept declarations of competency from involved therapists and declare that the medical pathway *may* be entered. Conversely, Justices have declared that, in the event of error regarding Gillick competence, the child *should* enter that pathway in its "best interests". For example, Tree J, in *re Kaitlin*, declared, "The material satisfies me that Kaitlin is Gillick competent ... If I am wrong as to that, the material is unanimous in concluding that the benefits of the proposed treatment so significantly outweigh any risks associated with it, that it is in Kaitlin's best interests to undergo the treatment ..."[81]

Should the Family Court maintain its protective role?

Some commentators, Justices, parents and transgendering children are in vociferous agreement that the role of the Family Court in childhood gender dysphoria should be rescinded. Dr Felicity Bell, an academic lawyer from the University of Wollongong, claims that the lack of any alternative therapy, inevitable worsening, risk of harm and suicide, absence of side effects of blockers, growing medical consensus and "the absence of alternative viewpoints and evidence in reported cases ... all mitigate [*sic*] against the court continuing to play *any* role in determining whether treatment can proceed".[82] In *re Lucas*[83], Tree J, acknowledging the influence of Bell's claims, declared there was "an urgent need for statutory intervention in order to undo the consequences of *re Jamie*". Transgendered Georgie Stone, the youngest child to receive puberty blockers in Australia, has launched a petition against the role of the court, securing thousands of signatures. Are they right?

Certainly, the role of the court *could* be regarded as an expensive irrelevancy. It accepts as evidence the strong opinion of a few therapists in the evaluation of Gillick competence and gender dysphoria. And on that certitude of opinion no court has yet refused to enter the child on the pathway of medical intervention.

This is not to criticise the Family Court but to empathise with its "awesome" responsibility, and to sympathise that its role for "reasoned analysis and scrutiny" appears to have been reduced to a rubber stamp. It is, however, to criticise the failure of medical practitioners for misinforming the court: for underplaying the natural orientation to natal sex through puberty in most confused children; for under-informing the court of published side effects of the medical pathway; for unwarranted certitude of success with the medical pathway and unwarranted certitude of failure without it; for manipulation of the court for authorisation of invasive, irreversible, grave intervention by the fear of suicide, without mention of the established high rate of suicide in adults who have completed the pathway.

Instead of rescinding their protective role, courts should call for the regulation of unproven, invasive, irreversible therapy on unwitting children.

A protective role for the court remains paramount, even if for no other reason than hundreds of disturbed children are now being brought to gender clinics around Australia each year. This populism should promote protection.

Gender dysphoria is a recent phenomenon. A medical expert giving evidence in *re Brodie* in 2008 declared his "great surprise" that the number of teenagers presenting to clinics could reach eighty a year. He declared that in his experience only a small number "trickle through" and it therefore "appeared to be quite rare".[84] When asked why it appeared rare, he concluded, "They just suffer out there, I think."

I do not believe confused children "just suffer out there". Paediatricians are privy to all kinds of confidences from parents worrying about the sexual behaviour of their children. It is unimaginable that gender confusion would not have been mentioned had it been a problem. When I questioned twenty-eight generalist paediatricians regarding their experience with gender dysphoria, from a cumulative experience of 931 years, only twelve cases could be recalled: ten with severe associated mental illness, and two with sexual abuse.

There is no substance to Felicity Bell's claim of growing consensus for medical intervention. As Collier J declared in *re Bernadette* in 2010, "there still remains grave dispute within the medical community as to the best treatment that can be offered".[85] Certainly, little alternative opinion is expressed in courts, but how could that opinion be secured in the face of a small group of protagonists who have applied for unsupervised rights to therapy? Also, given the direction of clients to specialised units, how can general paediatric consensus be secured? Moreover, can alternative opinion and management be expressed freely? In Victoria, the recent Health Complaints Act has the potential to deregister any therapist not actively supporting transition to the opposite sex. Intimidation by this Act is heightened by reversal of the customary onus of proof: a therapist will be guilty until proven innocent.

The courts should realise that their trust in information from some members of the medical profession has been misplaced. The courts should demand independent appraisal of scientific knowledge and the experimental nature of current therapies. Instead of rescinding their protective role, courts should call for the regulation of unproven, invasive, irreversible therapy on unwitting children. If Gillick competence is to remain a threshold, courts should insist on rigorous, independent assessment. They should also insist on independent assessment of a child's best interests. Given restricted resources, including the unfamiliarity of the medical profession with the new phenomenon, such assessments will be difficult to secure. The Family Court, however, is aware of vested interests and though financial matters are unlikely to feature in gender dysphoria, commitment to an ideology may be fundamental.

The Family Court should view with scepticism the role of physical intervention as treatment for mental disturbance, no matter how passionately promoted. The history of medicine has been blighted by such ventures. Not long ago, lobotomies to improve mental function were performed on thousands, and castration was prescribed for homosexuality. Now, psychosurgery can begin with hormones and progress to the knife. Maintenance of the protective role of the court remains paramount.

Dr John Whitehall is Professor of Paediatrics at Western Sydney University. A footnoted version of this article appears at Quadrant Online. His article "Childhood Gender Dysphoria and the Responsibility of the Courts" appeared in the May 2017 issue.

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