

An autoethnographic critique of a past report of inpatient psychiatric treatment for gender diverse children

Jayne McFadyen¹, Timothy W Jones², Rowena Koek³, Fintan Harte^{4,5}, Brendan Jansen⁶, Megan Galbally⁷, Warren Kealy-Bateman^{8,9,10}, Catherine Wall¹¹, Quinnehtukqut McLamore¹², Anja Ravine^{5,13} 

The known: In 1987, the *MJA* published a report describing eight gender diverse children, who were involuntarily admitted for “inpatient therapy” aiming to achieve cisgender and heterosexual outcomes. The article is now being cited favourably by opponents of gender-affirming care in submissions to lawmakers, courts, and medical regulators.

The new: Medical records and autoethnography of a child who we believe received such treatment, now a transgender woman, reveal the use of coercive and aversive psychological practices. Her felt sense of gender/sex did not change.

The implications: Contrary to ongoing representations of efficacy, “therapy” that aimed to change or suppress a gender diverse child served to delay self-acceptance for two decades and caused long term harm.

An article by Robert Kosky published in the *Medical Journal of Australia* in 1987 reported a case series on “inpatient therapy” administered to gender diverse children, concluding that such cases might be “correctable”.¹ This work promoted the idea that “gender-disordered children” could be “treated” to achieve cisgender-typical behaviours and identity. In present political debates this article is being cited to promote bans on gender-affirmative support for minors, to uphold so-called “conversion therapy” for trans and gender diverse young people,²⁻¹⁰ and it is being quoted in current clinical guides^{11,12} and school or parent guidance documents.¹³⁻¹⁵ The report, founded on the unsupported assumption that gender diversity is inherently pathological, is also cited to promote an idea that children’s gender diversity represents a parentally induced factitious disorder.^{8,16} This representation now extends to portraying parental facilitation of their child’s social and medical transition as “child abuse”, justifying legal and procedural repercussions such as referrals to the Texas Department of Family and Protective Services¹⁷ and activation of NHS England’s safeguarding procedures.¹⁸

The 1987 report describes eight consecutively treated children who came to clinical attention because they exhibited “markedly inappropriate gender behaviour, or [rejected] their biological sex”. The diagnostic formulation theorised that they were expressing cross-gendered behaviours to meet a parent’s emotional needs. The treatment rationale was that hospitalisation, sometimes described as “milieu therapy”,¹⁹ would remove the child from “the location of the primary problem” and “develop the child’s social skills”.¹ Inpatient stays in an Australian state-funded psychiatric hospital for children and adolescents extended up to

Abstract

Objective: To review reporting on a case series of “inpatient therapy” administered to pre-pubertal children presenting with gender expansive behaviours previously published in the *MJA* and to compare this reporting to the adulthood recollections and past contemporaneous medical records of a person who had received such treatment.

Design: Retrospective analysis of autoethnography, archived mental health records, and patient details published in a 1987 *MJA* case series of eight children.

Setting: Stubbs Terrace Hospital, a Western Australian state-funded child and adolescent psychiatric hospital, no longer in operation.

Participant: Jayne McFadyen (J), a transgender woman whose recollections align with the clinical details supplied for Case 5 in the case series, and an author of this article.

Main outcome measures: Concordance and discordance among details documented in the published case series, J’s autoethnography of her hospital treatment, and archived childhood psychiatric records obtained through freedom of information.

Results: J’s recollections align closely with details in the archived records. Both align with many, but not all, published details, most notably the following published statement: “No conscious attempt was made by the staff members to encourage masculine or feminine role behaviours.” Some of the verified recollections are of psychologically coercive and aversive practices typical of sexual orientation and gender identity and expression change or suppression efforts (SOGICE). Despite inpatient treatment aimed at suppressing or changing her transgender identity and expression, J’s sense of whom she understood herself to be remained steadfast.

Conclusion: A retrospective review of “inpatient treatment” intended to re-direct gender expansive identity formation revealed pseudo-psychological strategies reliant on denial and repression. These were directed towards extinguishing childhood behaviours deemed to be socially undesirable. These practices are indistinguishable from the defining characteristics of suppression or change practices, or so-called “conversion therapy”, seeking to achieve cisgender and heterosexual outcomes, efforts which are now known to be futile and harmful.

6 months. No specific details are provided about the treatment program purporting to develop the targeted social skills. However, the report states that “No conscious attempt was made by the staff members to encourage masculine or feminine role behaviours”,¹ a point reiterated in an accompanying editorial.²⁰

This 1987 case series¹ came to the attention of the first author of this article, Jayne McFadyen (J), after renewed international interest in the report. J, a transgender woman, had received inpatient treatment for cross-gendered behaviour in the same

¹ Canberra, ACT. ² La Trobe University, Melbourne, VIC. ³ Perth, WA. ⁴ Ramsay Clinic Albert Road, Melbourne, VIC. ⁵ University of Melbourne, Melbourne, VIC. ⁶ Micoa WA, Perth, WA. ⁷ Monash Health, Monash University, Melbourne, VIC. ⁸ University of Wollongong, Wollongong, NSW. ⁹ University of Sydney, Dubbo, NSW. ¹⁰ Western New South Wales Local Health District, Dubbo, NSW. ¹¹ Virginia Commonwealth University, Richmond, (VA), United States. ¹² University of Missouri, Columbia, (MO), United States. ¹³ Murdoch Children’s Research Institute, Melbourne, VIC.  anja.ravine@mcri.edu.au • doi: 10.5694/mja2.70037

hospital and during the same period as the cases included in the report. On reading the report, J strongly suspected that she was Case 5 ([Supporting Information](#), item 1); however, some memories conflicted with the published narrative.

Concerned that hers and others' treatment experiences were being misrepresented and deployed to limit gender-affirming care and perpetuate conversion therapy, J initiated this research, which aimed to evaluate the 1987 publication¹ against her recollection of events and the details of treatment recorded in her childhood medical records. Analysis of the patient account and medical records of desistance-oriented "treatment" for pathologised gender non-conformity raises questions about the reliability of the previously published account and provides a valuable long term follow-up demonstrating inefficacy of conversion practices with transgender young people.

Methods

This study critically analyses three documents: the 1987 *MJA* article,¹ the medical records of J's inpatient treatment, and J's autoethnographic account of her treatment. The qualitative research method of collaborative autoethnography²¹ was used to produce J's account of her treatment and outcomes. In a series of ten meetings between 22 March 2024 and 5 May 2024, J related her life story to one of the authors with a clinical background, who was experienced in taking case histories (AR). After each meeting, AR wrote up that section of J's story; J reviewed the draft and corrected and elaborated the narrative. After the narrative was finalised, J's archived childhood psychiatric records were requested using a freedom of information request to Western Australia's Child and Adolescent Health Service. The request was for "the full inpatient notes, including nursing records; all medical correspondence or summaries, including the lead-up correspondence arranging the hospital admission; case-conference records; results of any investigations; results of psychological tests, and reports of medical and nursing management decisions". The supplied medical records, which were released on 19 June 2024, included redacted clinical correspondence; reports (social work, psychological and education department); hospital admission notes; weekly information sheets listing "problems with treatment", and discharge notes ([Supporting Information](#), item 2). Records of case-conference meetings and daily hospital notes from nurses or doctors were not supplied. The reason proffered for the redactions was to protect the identities of staff and members of J's immediate family. These independently produced accounts of J's treatment were then comparatively analysed by the research team members with the account published in 1987.¹ The team concurred with J's view about the high level of similarity between some specific details in the medical record, J's account and the details provided for Case 5 in the 1987 article ([Supporting Information](#), item 3). The research team comprised psychiatric, paediatric, general practice and social research experts, LGBTQ+ as well as heterosexual and cisgender researchers, including people with lived experience of LGBTQ+ change and suppression practices and people without. Ethics approval was obtained from La Trobe University's Human Research Ethics Committee (HEC25045).

Results

Characterising the "therapy", the 1987 article,¹ in the diagnostic formulation and summary of therapeutic goals put forward, blamed childhood gender non-conformity on parental "fantasy" and argued that "treatment" should distance such children from "the primary problem in the family interactions and the

unwitting, but pathological, influences of the parents". Therefore, children were removed from the home by hospitalisation. In J's instance, the representation that her gendered behaviours were induced by a parental symbiotic fantasy conflicts with both the medical record and autoethnographic account.

Beyond separating children from their parents, specific treatment goals are not detailed. Instead, there are ambiguous descriptions like: "develop the child's social skills so that he or she could make friends and cultivate resources outside the home" or "all children were encouraged to join in games with other children". However, there are other claims within the article itself that contradict these assertions. For example, the statement "No conscious attempt was made by the staff members to encourage masculine or feminine role behaviours" is made immediately before noting that "Age-appropriate behaviours were encouraged by the nursing staff members to replace the stereotyped inappropriate and isolating cross-gender behaviours" indicating that "age-appropriate behaviours" cannot be "cross-gender", but must conform to gender norms. This disambiguated conclusion is confirmed on several occasions in the medical record ([Supporting Information](#), item 3).

The 1987 report¹ did not specify the detail of "therapy" administered to the child inpatients over the course of (allegedly) 10–23 weeks or 10–28 weeks. However, several comments in the article about the early responses of children and their parents to hospitalisation, and also later developments during follow-up, confirmed the use of coercive and aversive practices. These include: overriding the developing agency and voice of the child; ongoing detention against the child's and, later, parents' wishes (medical staff advising parents against hospital discharge); hospital discharge conditional on established gender stereotypical behaviours; and fear of rehospitalisation for "recurrence of ... cross-dressing".

These insights align with the autoethnography, which contained additional details conflicting with the published claim that staff were not focused on encouraging gendered behaviours. J remembered staff actively discouraging her from wearing girls' clothes; being steered away from grouping and playing with girls; being prevented from playing with dolls; and being encouraged to play boisterously and associate with boys, and play with traditionally masculine toys. J also remembered continuing to acquire and wear feminine articles of clothing, as well as an escalating response from staff. The staff response progressed from frequent checks of clothes and belongings; to random checks of underwear; to staff accompanying J to the toilet on all occasions to check underwear, and eventually insisting that J toilet with the door open to prevent her from urinating while seated, and forcing her to urinate while standing. She recalls frequently feeling embarrassed and shamed. J reported that the punishment for wearing a feminine article of clothing was lengthy locked seclusion, followed up by a formal meeting with an authoritative figure, after which she would leave the room feeling distressed. These coercive and aversive techniques explicitly directed at changing J's gender expression and suppressing her gender identity are omitted in both the provided medical records and the published report.

The 1987 article¹ also claimed that "by the time of discharge from hospital the children were functioning socially and educationally at approximately age-appropriate levels." However, 18 days before discharge, the following was entered in J's medical record: "Seems to have no attachment to other Staff [sic] or children". Further, there was nothing in the medical record to suggest that social and educational functioning had been formally evaluated before hospital discharge. The discrepancies between the three

sources regarding aetiology, treatment and immediate health outcomes are significant and concerning.

Life course after “inpatient treatment”

The 1987 article states¹ that the findings indicate “treatment of cross-gender behaviour by means of inpatient therapy seems effective” and that “Long-term clinical evaluations suggest that initial changes can be maintained.” The table goes so far as to describe Case 5 as “happy”.

These claims conflict with details in the autoethnographic account. J’s felt sense of female gender/sex remained stable. She never felt male. Rather, her experiences — including but not limited to the inpatient “treatment” — led her to develop self-protective strategies to conceal her gendered feelings, alongside a distrust of adults in authority. She refined coping strategies directed towards suppressing her feelings and her ongoing desire to express her feminine sense of self. J’s sense of gendered discord, and associated fear and guilt, persisted into adulthood. She steadfastly maintained secrecy about these feelings and tried extinguishing them with “masculine pursuits” — predominantly alcohol-fuelled socialising in male company. Looking back, J describes these efforts as attempts to prove to all, including herself, that she was unequivocally male. And yet both her gendered feelings and desire for self-expression were unquenched. She continued to cultivate and occasionally wear a small collection of feminine garments, which was stored in a hidden cache.

At age 23 years, prompted by a third party’s discovery of the cache, J spoke for the first time of her gendered feelings and associated experiences since she was discharged as a 10-year-old. Subsequently, J’s sense of wellbeing improved for a time. As the years passed, however, her mood declined, which was later accompanied by recurring suicidal ideation. By 1997, at age 32 years, a nadir was reached and J was encouraged to move into shared accommodation with a friend. J’s recollection in the autoethnographic account was that this encouragement came with a suggestion that the move may give her space to reflect and “work out who you are”.

Soon after moving, J began disentangling her long-standing felt sense of gender and the numerous negative associations she had carried since her inpatient experiences. It was at this stage that J began to discern their lasting effects on her sense of self, self-expression, and the quality of her interpersonal relationships. A new phase of self-acceptance emerged. J resolved that she had no choice but to become “who I know myself to be” — something she’d known was possible since 8 years of age. She remembered this moment of childhood self-realisation, which occurred after reading a brief article in the daily newspaper about an adult who had hormone therapy and surgery to change from male to female. As well as comprehending that “I’m not the only one”, she recalled relief from knowing that “it can be fixed”. Twenty-two years after her release from hospital, J, with support from her general practitioner, initiated social and medical transition in accord with procedures available at the time. While J continues to report occasional struggles with mental health, her depression is now well managed, and the improvement compared with her state before transition remains.

Now, 28 years on from when she finally accepted “who I am” and began steps towards transition, J remains comfortably aligned with her unerring feminine sense of self. Although her past feelings of gendered dissonance are a faded memory, and it is now 50 years since her experience of “inpatient treatment”, J still has traumatic childhood memories. Recognising a close portrayal of herself

in the 1987 publication was distressing. We do not have access to any of the study details or approvals; however, the experience highlights several possible failures in medical ethics oversight, most notably the publication of what seemed to be a distorted representation of personal details of potentially non-consenting individuals and families. However, the processes of preparing the autoethnographic account, obtaining and reviewing the medical records and then preparing this article have yielded new helpful insights. J’s wish is that her story may protect other LGBTQA+ young people and adults from similar harms.

Discussion

Analysis of details in the 1987 publication,¹ autoethnography, and childhood medical records reveal that J’s months-long “inpatient treatment” was based on an unsupported belief that the root cause of the children’s gender expansive behaviours, disdain for genitalia and declarations that “they wanted to be of the opposite sex” was parental insecurity and anxiety about the child’s natal sex. The attitude expressed towards parental support of gender expansive youth — real or imagined — was deeply negative. The administered “therapy” included psychologically coercive and aversive practices with the goal of gender-typical, heterosexual outcomes. We recognise that J’s experience, which occurred five decades ago, was framed by both the scientific knowledge and the social values of the time. It is notable, however, that the notion of childhood gender expansive behaviours being the equivalent of a parentally induced factitious disorder was as unfounded then as it remains today. Further, it recapitulates an equivalent periodically recycled and repeatedly discredited narrative about the aetiological role of parents for same-sex attracted young people.^{22,23}

Behavioural suppression and change were achieved during J’s months-long stay in the psychiatric facility. As J progressed through adolescence, an accentuating sense of gendered discord and dysphoria was calmed by snatched secretive moments of expressing femininity, accompanying feelings of guilt, and ongoing avoidance — even of the hospital itself and the surrounding area. Although the 1987 article¹ concluded that J’s case, among others, provided evidence that such therapy can “help” similar children, J’s account indicates that all this treatment ultimately did was cause trauma and suppress her self-acceptance for 22 years. Such discrepancies between patient reports and provider accounts of what amount to suppression practices are far from uncommon across psychology and psychiatry.²⁴⁻²⁸ Too often, the appeal to authority fallacy is exercised and providers’ accounts prevail. In this instance, major discrepancies between the published account and medical record have served to privilege the patient’s account. Our findings suggest that when patient accounts raise questions about the accuracy of published details in the peer-reviewed literature, they should be privileged a priori, at least until outcomes of triangulated assessments of the published and patient accounts and contemporaneous details in the medical record are known. The passage of five decades reveals also the importance of long term health record retention backed by legislated access rights.

Study limitations

Some of J’s autoethnographic accounts of coercive and aversive treatment could not be confirmed by the medical records. Further, we could not definitively confirm that J was among the cases in the 1987 article. Notwithstanding, statements in both the publication and the medical records are evidence that the therapeutic intent was to discourage gender expansive

behaviours with the goal of decreasing the likelihood of a “transsexual” outcome, meeting the definition of change or suppression (conversion) practices, or sexual orientation and gender identity and expression change or suppression efforts (SOGICE).²⁹ Another potential limitation is that this account of “therapeutic” inefficacy and iatrogenic harm comes from a single autoethnographic report. As we do not know the experiences of other individuals who have undergone similar “treatment” protocols, most notably those reported in the 1987 case series,¹ it is impossible to know whether J’s experiences are unique.

Clinical and policy implications

Whether these experiences were unique or not, they have significant implications that must be considered by those entrusted to ensure the safety and quality of mental health services supporting gender diverse children, adolescents and their families. In keeping with the Royal Australian and New Zealand College of Psychiatrists’ recently updated position statement on the role of psychiatrists in the mental health care of gender diverse people,³⁰ which supports outcomes research, J’s experience of what some would describe as “non-affirmative interventions”³¹ or “exploratory therapy”³² confirms the importance of outcome monitoring. J’s story highlights that similar “treatment” of children may cause long term psychological harm requiring trauma-informed mental health care.

The digital age has made it easier for young people to find relevant information and connect with others. The principles of gender-affirming care are supported by most mainstream medical organisations,^{33,34} and gender identity change or suppression (“conversion”) practices are now illegal in many jurisdictions.³⁵ However, some professionals and lawmakers still advocate for practices discouraging social affirmation, withholding or delaying access to long requested gender-affirming medical treatments, and engaging trans and gender-diverse young people in protracted “exploratory” psychotherapies without a clear endpoint, and without published evidence of efficacy or safety.³⁶ While denying that these strategies equate to suppression or conversion practices, many of these individuals also actively oppose “conversion therapy” bans.

The 1987 publication¹ should not be considered reputable evidence in any debate over transgender policies — either by direct or indirect citation. And yet, this article¹ and publications of a similar age and theoretical background continue being referenced as if they were factual and reliable, by actors ranging from the Endocrine Society³⁷ and the Cass review³⁸ to a parent support group,³⁹ all cite the 1987 MJA article indirectly via a review.⁴⁰ Further, these false representations are now disseminating in other languages.^{12,41,42}

Conclusion

The balance of evidence indicates that efforts to suppress or change gender identity and sexuality are ineffective, as well as

actively harmful.^{43,44} In addition, SOGICE exercised on children, as reported in the 1987 article,¹ appears to transgress several articles in the United Nations Convention on the Rights of the Child, including the associated rights and duties of parents and legal guardians.^{45,46} Unequivocal messaging from leaders in psychoanalysis, psychology and psychiatry is required now to enable the public to recognise misinformation, which in the instances of the 1987 publication¹ and other Australian public hospital- and university-sourced reports⁴⁷⁻⁴⁹ remain influential.^{50,51} It is abundantly apparent that these and other similarly detrimental⁵² articles in scholarly journals are fuelling the current escalation in anti-trans rhetoric, which is now actively harming gender diverse children and their families.⁵³

Notice

Any trans and gender-diverse people reading this article who have endured similar experiences are encouraged to connect with trusted friends, family, and/or professionals for support if distressed. QLife (1800 184 527), Lifeline (13 11 14) and Kids Helpline (1800 551 800, for children as young as 5 years and young people up to age 25 years) are helpful supports.

Data sharing statement: For privacy reasons, J’s autoethnographic account and archived redacted childhood psychiatric records obtained through freedom of information will not be shared. In lieu, details relevant to this report are included in the [Supporting Information](#).

Acknowledgements: We are grateful for important recollections of Robyn Edwards, a long-standing friend of J’s, which catalysed events resulting in the cross-disciplinary collaborative effort required to prepare this article. We also gratefully acknowledge assistance from Zinnia Jones, an independent researcher with Gender Analysis of Seminole County, Florida, United States, regarding the guidance offered to US courts advocating for legislative or administrative bans on some or all elements of gender-affirmative care for minors or against so-called “conversion therapy” bans.

Open access: Open access publishing facilitated by The University of Melbourne, as part of the Wiley - The University of Melbourne agreement via the Council of Australian University Librarians.

Competing interests: Jayne McFadyen, an author of this article, is J, the sole study participant in this report.

Author contributions: McFadyen J: Conceptualization, formal analysis, validation, writing – review and editing. Jones TW: Methodology, project administration, formal analysis, validation, writing – review and editing. Koek R: Formal analysis, validation, writing – review and editing. Harte F: Formal analysis, validation, writing – review and editing. Jansen B: Formal analysis, validation, writing – review and editing. Galbally M: Formal analysis, validation, writing – review and editing. Kealy-Bateman W: Formal analysis, validation, writing – review and editing. Wall C: Formal analysis, validation, writing – review and editing. McLamore Q: Formal analysis, validation, writing – review and editing. Ravine A: Conceptualization, project administration, methodology, formal analysis, validation, writing – original draft, writing – review and editing. ■

Received 29 September 2024; accepted 30 June 2025

© 2025 The Author(s). *Medical Journal of Australia* published by John Wiley & Sons Australia, Ltd on behalf of AMPCo Pty Ltd.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](#) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

1 Kosky RJ. Gender-disordered children: does inpatient treatment help? *Med J Aust* 1987; 146: 565–569. <https://onlinelibrary.wiley.com/doi/epdf/10.5694/j.1326-5377.1987.tb120415.x>

2 Wilson J (General Counsel). Petition to initiate rulemaking setting the standard of care for treatment of gender dysphoria. Tallahassee: Florida Department of Health, 2022. <https://web.archive.org/web/20230502010936/https://ahca.myflorida.com/content/download/21744/>

[file/Petition_to_Initiate_Rulemaking_Setting_the_Standard_of_Care_for_Treatment_of_Gender_Dysphoria.pdf](#) (viewed Apr 2025).

3 Cantor JM. Declaration of James Cantor, PhD (Docket No. 113-3). United States of America, Petitioner v Jonathan Thomas Skrmetti, Attorney General and Reporter for Tennessee, et al, Respondents and LW Supreme Court of the United States; 2024. <https://web.archive.org/web/20250623172543/https://www.supre>

mecourt.gov/DocketPDF/23/23-477/323552/20240827210435020_27-477tsUnitedStates_.J_A_Vol.1.pdf (viewed Apr 2025).

4 Sapir L. Brief of Amici Curiae. Manhattan Institute and Dr Leor Sapir Supporting Plaintiff-Appellant and Reversal. In BATES v PAKSERESHT. Appeal No. 23-4169 (on appeal from the United States District Court for the District of Oregon Case No. 2: 23-cv-00474-AN). United States Court of Appeals for the Ninth

- Circuit, 2024. <https://web.archive.org/web/20250227113823/https://media4.manhattan-institute.org/wp-content/uploads/Bates-9th-Cir.pdf> (viewed Apr 2025).
- 5 Christian Medical and Dental Associations. Franciscan Health Inc. Specialty Physicians of Illinois LLC. In: FRANCISCAN ALLIANCE INC v BURWELL et al. Case 7: 16-cv-00108-O, Document 26. United States District Court for the Northern District of Texas. Wichita Falls Division. 2016. <https://litigationtracker.law.georgetown.edu/wp-content/uploads/2023/04/Franciscan-Alliance-26-Appendix-in-Support-filed-by-Christian-Medical-and-Dental-Society-Franciscan-Alliance-Inc.-pdf> (viewed Apr 2025).
 - 6 Kenny D. Submission to the Queensland inquiry into outlawing conversion therapy. 2019. <https://documents.parliament.qld.gov.au/com/HCDSD FVPC-48D8/RN3256PHLA-3046/tp2.pdf> (viewed Apr 2025).
 - 7 Scottish Government. *Gender Recognition Act* evidence (Document 5). 2017. <https://www.gov.scot/binaries/content/documents/govscot/publications/foi-eir-release/2020/01/foi-201900010673/documents/foi-201900010673—document-5—gra-evidence—april-2017/foi-201900010673—document-5—gra-evidence—april-2017/govscot%3Adocument/FOI-201900010673%2B-%2BDocument%2B5%2B-%2BGRA%2BEvidence%2B-%2B2BApril%2B2017.pdf> (viewed Apr 2025).
 - 8 van Gend D. Reasons why Section 5B 'Conversion Therapy' must be rejected or amended [submission to the Inquiry into the Health Legislation Amendment Bill 2019; Submission No. 119]. 2020. <https://documents.parliament.qld.gov.au/com/HCDSD FVPC-48D8/RN3256PHLA-3046/submissions/00000119.pdf> (viewed Apr 2025).
 - 9 Whitehall J. Submission to Qld Parliament re pending Health Legislation Amendment Bill 2019 [submission to the Inquiry into the Health Legislation Amendment Bill 2019; Submission No. 035]. <https://documents.parliament.qld.gov.au/com/HCDSD FVPC-48D8/RN3256PHLA-3046/submissions/00000035.pdf> (viewed Apr 2025).
 - 10 Haynes L, Davidson MR; International Federation for Therapeutic and Counselling Choice. Expert opinion on the constitutional meaning of "sex" and medical gender affirming treatment [submission to the General Assembly of the Civil Chamber of the Supreme Court of Cassation of the Republic of Bulgaria]. 2021. <https://archive.iftcc.org/wp-content/uploads/2022/08/IFTCC-Brief-for-Cassian-Constitutional-Courts-in-Bulgaria-on-Gender-2021-6-19-FINAL-Full-edits-English-Post-2021-7-2-1-1.pdf> (viewed Apr 2025).
 - 11 Morris P, Breakey C, D'Angelo R, et al; National Association of Practising Psychiatrists. Managing gender dysphoria in young people: the National Association of Practising Psychiatrists guide [submitted to NSW Parliament]. 2022. <https://www.parliament.nsw.gov.au/lcdocs/other/17953/27%20October%202022%20-%20PC%202%20-%20tabled%20by%20Hon%20Greg%20Donnelly%20MLC%20%20281%29.pdf> (viewed Apr 2025).
 - 12 Marianowicz-Szczygiel A, Margasinski A, Haynes L, et al. [Standards and guidelines of the Association of Christian Psychologists for the diagnosis and therapy of children and adolescents with gender identity problems] [Polish]. 2024. https://www.researchgate.net/publication/385172487_Standards_and_Guide_lines_of_the_Association_of_Christian_Psychologists_in_Poland_for_the_Diagnosis_and_Therapy_of_Children_and_Adolescents_with_Gender_Identity_Issues_Association_of_Christian_Psycholo (viewed Apr 2025).
 - 13 Australian Catholic Bishops Conference. Created and loved: a guide for Catholic schools on identity and gender. Canberra: ACBC, 2022. https://web.archive.org/web/20221018123450/http://cg.org.au/Portals/7/ParishData/Id310/Uploads/Type3/Created%20and%20Loved_Final_2022.pdf (viewed Apr 2025).
 - 14 Broyles V, Jacques S, McAlister M, et al. Navigating the transgender landscape: school resource guide. Johns Creek (Ga) and Monroe (Va): Child and Parental Rights Campaign, 2020. <https://www.flfamily.org/wp-content/uploads/Navigating-the-Transgender-Landscape.pdf> (viewed Apr 2025).
 - 15 Minnesota Family Council. Parent resource guide: responding to the transgender issue. 2019. <https://genderresourceguide.com/wp-content/themes/genderresource/library/documents/NPRGFullDocumentPrintV17.pdf> (viewed Apr 2025).
 - 16 Whitehall J. Request for a parliamentary inquiry into the social and medical transitioning of children with gender dysphoria [letter to the Honourable Greg Hunt, Minister of Health, Australia]. 2019. https://web.archive.org/web/20230415045840/https://thelinkbhutan.org/seminars/symposium_gender_dysphoria/program/presenters/whitehall_john/letter_to_minister_of_health_australia.pdf (viewed Apr 2025).
 - 17 Abbott G (Governor, State of Texas). Directive supported by Opinion No. KP-0401 from the Office of the Attorney General, 2022. <https://web.archive.org/web/20220222211420/https://gov.texas.gov/uploads/files/press/O-Masters/jame2022022221358.pdf> (viewed Apr 2025).
 - 18 National Medical Director for Specialised Services. Interim service specification for specialist gender incongruence services for children and young people. London: NHS England, 2024. <https://www.england.nhs.uk/publication/interim-service-specification-for-specialist-gender-incongruence-services-for-children-and-young-people> (viewed Apr 2025).
 - 19 Human Rights and Equal Opportunity Commission. Children and adolescents. In: Report of the National Inquiry into the Human Rights of People with Mental Illness. Sydney: Human Rights and Equal Opportunity Commission, 1993. <https://humanrights.gov.au/our-work/disability-rights/publications/inquiry-human-rights-people-mental-illness-report#ch20> (viewed Apr 2025).
 - 20 Adler R. Childhood gender identity disorders. *Med J Aust* 1987; 146: 561. <https://onlinelibrary.wiley.com/doi/epdf/10.5694/j.1326-5377.1987.tb120412.x>
 - 21 Ellis C. Heartful autoethnography. *Qual Health Res* 1999; 9: 669-683.
 - 22 Bieber I, Dain HJ, Dince PR, et al. Homosexuality: a psychoanalytic study of male homosexuals. New York: Basic Books, 1962.
 - 23 van den Aardweg GJ. Parents of homosexuals—not guilty? Interpretation of childhood psychological data. *Am J Psychother* 1984; 38: 180-189.
 - 24 Bryant K. Making gender identity disorder of childhood: historical lessons for contemporary debates. *Sex Res Social Policy* 2006; 3: 23-39.
 - 25 Ashley F. Homophobia, conversion therapy, and care models for trans youth: defending the gender-affirmative approach. *J LGBT Youth* 2019; 17: 361-383.
 - 26 Christian Goulding S. UCLA study tried to change children's gender identity starting in the 1960s, say two educators. *Orange County Register*, 20 Nov 2019. <https://www.ocregister.com/2019/11/18/2-subjects-discuss-trauma-as-kids-involved-in-uclas-now-defunct-gender-identity-study> (viewed Apr 2025).
 - 27 Rodriguez-Seijas C, Lorenzo-Luaces L. From allies of "conversion therapy" to accomplices of justice: invited concluding comment to the C&BP special series. *Cogn Behav Pract* 2024; 31: 26-30.
 - 28 Muse E. Testimony from Miss Erika Muse (as an individual). Standing Committee on Justice and Human Rights. House of Commons, Canada (No. 014, 2nd Session, 43th Parliament). 2020. <https://www.ourcommons.ca/DocumentViewer/en/43-2/JUST/meeting-14/evidence> (viewed Apr 2025).
 - 29 Power J, Jones TW, Jones T, et al. Better understanding of the scope and nature of LGBTQA+ religious conversion practices will support recovery. *Med J Aust* 2022; 217: 119-122. <https://www.mja.com.au/journal/2022/217/3/better-understanding-scope-and-nature-lgbtqa-religious-conversion-practices-will>
 - 30 Royal Australian and New Zealand College of Psychiatrists. The role of psychiatrists in working with trans and gender diverse people (Position Statement 103). 2023. <https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/role-of-psychiatrists-working-with-trans-gender-diverse-people> (viewed Apr 2025).
 - 31 D'Angelo R, Syrulnik E, Ayad S, et al. One size does not fit all: in support of psychotherapy for gender dysphoria. *Arch Sex Behav* 2021; 50: 7-16.
 - 32 Evans S, Evans M. Gender dysphoria: a therapeutic model for working with children, adolescents and young adults. Bicester, UK: Phoenix Publishing House, 2021.
 - 33 Australian Medical Association. LGBTQIASB+ health position statement. 2024. <https://www.ama.com.au/articles/lgbtqiab-health-position-statement> (viewed Apr 2025).
 - 34 American Psychological Association. APA policy statement on affirming evidence-based inclusive care for transgender, gender diverse, and nonbinary individuals, addressing misinformation, and the role of psychological practice and science. 2024. <https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care> (viewed Apr 2025).
 - 35 Haldernan DC. A counteroffensive against conversion therapy in the culture wars. *Cognitive and Behavioural Practice* 2024; 31: 10-14.
 - 36 Ashley F. Interrogating gender-exploratory therapy. *Perspect Psychol Sci* 2023; 18: 472-481.
 - 37 Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab* 2017; 102: 3869-3903.
 - 38 Cass H. Independent review of gender identity services for children and young people: final report. 2024. https://webarchive.nationalarchives.gov.uk/ukgwa/20250310143633/https://cass.independent-review.uk/wp-content/uploads/2024/04/CassReview_Final.pdf (viewed Apr 2025).
 - 39 Bayswater Support Group. Safeguarding trans-identified children and adolescents. <https://archive.md/hRCiv> (viewed Apr 2025).
 - 40 Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry* 2016; 28: 13-20.

- 41 Dragon Bleu TV. [Bad kind – a global epidemic] [French]. 2022. <https://www.dragonbleutv.com/documentaires/mauvais-genre-epidemie-mondiale> (viewed Apr 2025).
- 42 Vonholdt CR. [Transgender issues in children and adolescents] [interview] [German]. 2022. <https://www.christl-r-vonholdt.de/aktuelles/geschlechtsdysphorien-bei-kindern-und-jugendlichen-medizinische-und-psychologische-aspekte/> (viewed Apr 2025).
- 43 Kinitz DJ, Salway T. Cisheteronormativity, conversion therapy, and identity among sexual and gender minority people: a narrative inquiry and creative non-fiction. *Qual Health Res* 2022; 32: 1965-1978.
- 44 Anderson JR, Jones TW, Power J, et al. Engaging mental health service providers to recognize and support conversion practice survivors through their journey to recovery. *Cogn Behav Pract* 2024; 31: 20-25.
- 45 United Nations. Convention on the rights of the child. 1989. <https://ecommons.cornell.edu/server/api/core/bitstreams/c8f540df-36ad-4e6c-8dbb-7af0ab7bde7f/content> (viewed Apr 2025).
- 46 Horton C, Pearce R, Veale J, et al. Child rights in trans healthcare – a call to action. *Int J Transgend Health* 2024; 25: 313-320.
- 47 Kozłowska K, Chudleigh C, McClure G, et al. Attachment patterns in children and adolescents with gender dysphoria. *Front Psychol* 2020; 11: 582688.
- 48 Elkadi J, Chudleigh C, Maguire AM, et al. Developmental pathway choices of young people presenting to a gender service with gender distress: a prospective follow-up study. *Children (Basel)* 2023; 10: 314.
- 49 Skinner SR, McLamore Q, Donaghy O, et al. Recognizing and responding to misleading trans health research [editorial]. *Int J Transgend Health* 2024; 25: 1-9.
- 50 Kozłowska K, Ambler GR, Dechêne S, et al. Evolving national guidelines for the treatment of children and adolescents with gender dysphoria: international perspectives. *Hum Syst* 2024; 5: 89-152.
- 51 Gorin M, Smids J, Lantos J. Toward evidence-based and ethical pediatric gender medicine. *JAMA* 2025; 333: 841-842.
- 52 Kretser A, Murphy D, Bertuzzi S, et al. Scientific integrity principles and best practices: recommendations from a scientific integrity consortium. *Sci Eng Ethics* 2019; 25: 327-355.
- 53 Lee WY, Hobbs JN, Hobaica S, et al. State-level anti-transgender laws increase past-year suicide attempts among transgender and non-binary young people in the USA. *Nat Hum Behav* 2024; 8: 2096-2106. ■

Supporting Information

Additional Supporting Information is included with the online version of this article.