Supplementary Submission

on the

Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Bill 2013

to the

Senate Legal and Constitutional Affairs Committee

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1 Introduction

On 21 March 2013 the Senate referred the *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Bill 2013* for inquiry and report.

The Bill would amend the *Sex Discrimination Act 1984* to include sexual orientation, gender identity and intersex status as grounds on which discrimination would be unlawful. The Bill would also replace the existing ground of "*marital status*" with "*marital or relationship status*", defined so as to cover same-sex de facto couples.

The Committee has called for submissions which are due by 26 April 2013. The Committee is due to report by 17 June 2013.

FamilyVoice Australia made an earlier submission on 15 April 2013, pointing out that the Commonwealth has no head of power to pass this Bill, since it has no basis in the Constitution or international covenants. The FamilyVoice submission also argued that prohibiting discrimination on the grounds of sexual orientation, gender identity and intersex status, as well as other grounds, breaches the right of Australians to freedom of association.

This supplementary submission explains in more detail why a law including "sexual orientation", "gender identity" and "intersex status" as protected attributes is not justified and would not be in the public interest.

2 Attributes of intersex status, sexual orientation and gender identity

Discrimination law is a blunt instrument for trying to deal with the treatment of different people and groups in society. Even with established protected attributes, such as sex and race, exceptions are needed and may always be needed. And anti-discrimination laws frequently conflict with fundamental freedoms such as speech, association, contract and religion.

The proposal to extend the coverage of anti-discrimination law to new protected attributes is fraught with the risk of unintended consequences. It is nigh impossible to conceive of all the possible consequences of such broad ideologically-inspired laws, let alone the damage they could do to people and society.

2.1 Intersex status

"Intersex status" is genetic in origin – referring to the very tiny percentage of the population (fewer than two in 10,000) whose bodies are not easily classifiable a male or female because their external genitals are inconsistent with their chromosomal sex or they have both male and female genitals or gonads (testes or ovaries).

Some babies are born with more or fewer than two sex chromosomes, such as those with Klinefelter's syndrome (XXY) and Turner 's syndrome (X). These people have some unusual characteristics, but nevertheless identify as male (Klinefelter's) or female (Turner's). Their sex is not in dispute, so these conditions are not "intersex".

The submission by the Organisation Intersex International Australia Ltd (OII Australia) quotes Dr Anne Fausto-Sterling whose 2000 book claims that 1-2% of the population are intersex.

However this claim is strongly disputed. Two years later US psychologist Dr Leonard Sax responded to Dr Fausto-Sterling, noting that her definition of "intersex" includes Klinefelter's, Turner's and several other conditions that are genetically or hormonally anomalous, but do not lead to sex ambiguity at birth. They not qualify as "intersex". [1]

Dr Sax points out: "More than 99.98% of humans are either male [XY] or female [XX]. If the term intersex is to retain any clinical meaning, the use of this term should be restricted to those conditions in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female. The birth of an intersex child is actually a rare event."

The OII submission seems most concerned with discrimination against people who have AIS (Androgen Insensitivity Syndrome – frequency, one in 13,000 births). These people are genetically male (XY) but, because of a defect in their androgen receptors, their cells do not respond to the sex hormone testosterone or other androgens. As a result AIS people do not develop male genitalia and are generally raised as girls – only to discover at puberty that they do not menstruate, do not have a uterus or ovaries, but have undescended testicles.

People with AIS raised as girls are generally are happy to continue identifying as women, albeit knowing that they cannot have children. The main problem is that they are over-represented in elite sports – one in 400 top women competitors may have AIS. Some have been banned from competition when chromosome tests reveal their male genotype.

The OII argues that intersex women with AIS should be allowed to compete as women, despite the apparent advantage conferred by the Y chromosomes in all their cells.

Sporting associations need the freedom to decide on participation rules for particular sports or events. Allowing people with AIS, who are genetically male but present as female, to participate in women's sports or sporting events could disadvantage genetically female women in some cases. And different decisions may be made in different sports or events. Sporting associations are best placed to make such decisions since they know the rules of the games and the personal qualities that help players to succeed.

Furthermore, the fundamental human right of freedom of association means that sporting associations should be able to determine their own rules for participation. Organisations such as the International Olympic Committee should be free to determine what restrictions, if any, should apply to those who compete in men's and women's events. Adding "intersex status" as a protected attribute under the Sex Discrimination Act would deny members of sporting associations their fundamental freedom of association and could unfairly disadvantage some of their members.

Numerous congenital defects are known, including:

- Hemochromatosis (1/450 individuals)
- Down syndrome (1/600 live births and increases with advanced maternal age)
- Klinefelter syndrome (XXY) (1/1,000 births)
- Turner syndrome (X) (1/2000 births)
- Cystic Fibrosis (1/2500 Caucasian Americans)
- Intersex syndrome (1/5,000 births)
- Androgen insensitivity syndrome (1/13,000 births)

All people with congenital defects, including the relatively rare intersex syndrome, encounter problems associated with their condition. Protecting one such congenital defect in anti-discrimination law while neglecting others, is unreasonable.

At birth, all people are assigned a sex – either male or female. Noticeably atypical genitalia are encountered in about 1 in 1500 to 2000 births.[2] In such cases, a specialist in sex differentiation is usually consulted for advice on the best decision. If in adulthood a person considers that the wrong decision was made at birth in a case of ambiguous genitalia, a court order can be obtained to change the person's legal sex.

Some people, for ideological or other reasons, are XY or XX but decline to identify as male or female. They do not have genuine "intersex" status and do not warrant special or privileged treatment to accommodate their wishes.

Recommendation 1:

"Intersex status" does not warrant inclusion as a protected attribute in the Bill because it would deny to sporting bodies justifiable freedom of association, could disadvantage other male and female people, and would unreasonably protect one congenital defect while ignoring others.

2.2 Sexual orientation

Sexual orientation is defined in the Bill as:

> a person's sexual orientation towards:
>
> (a) persons of the same sex; or
>
> (b) persons of a different sex; or
>
> (c) persons of the same sex and persons of a different sex.

This definition would include persons attracted to persons of their own or a different sex within their close family – that is, incest. It would also include persons attracted to other persons under the age of 18 – paedophilia.

It is clearly undesirable for the Bill to protect such a broad range of attractions – and for this reason alone the Bill should be rejected.

However there are other good reasons for rejecting the inclusion of sexual orientation as a protected attribute.

2.2.1 Sexual orientation is not determined genetically

While the pop singer known as Lady Gaga has sold millions of copies of her song, *Born this way* – claiming that being "gay, straight or bi" is equally genetic in origin as being "black, white or beige", the evidence shows this is not the case.

Skin colour and racial attributes are certainly inborn – where one identical twin has dark skin, the other will have skin of exactly the same colour in 100% of cases.

But a study based on a large register of twins born in Australia found that where one identical twin is homosexual, the other is homosexual in only 11% of cases.[3]

This and two more recent studies found that the dominant influence on same-sex attraction is not genes, but unique life experiences.[4,5]

Moreover, unlike sex or race, sexual orientation has been known to change over time. A study of Dutch adult males found that, of those who had experienced same-sex attraction at some stage of their lives, about half reported that those feelings disappeared later in life.[6]

A New Zealand cohort study found that one half of females and one third of males with occasional same-sex attraction at 21 years had only opposite-sex attraction a 26 year olds.[7]

2.2.2 Health risks linked with homosexual activity

Males who are sexually attracted to other males are more likely than other males to be at risk of contracting sexually-transmitted infections. Male-to-male sexual activity is disproportionately associated with several serious health problems. The inclusion of sexual orientation as a protected attribute in the Sex Discrimination Act could endanger public health by prohibiting health and safety measures deemed to be discriminatory.

For example, homosexual activists continue to press for a removal of the Red Cross ban on blood donations by males who have had sex with males during the previous year. This campaign continues despite a 2009 ruling by the Tasmanian Anti-Discrimination Tribunal upholding the ban.

The Tribunal's 120 page decision[8] quoted evidence from expert witnesses and noted that:

- Condoms do not guarantee "safe sex" and are only about 80-90% effective.
- While all blood donations are tested for HIV, there is a period of time after infection when the test is unreliable.
- Unprotected receptive anal intercourse is responsible for by far the greatest number of HIV infections in Australia. The insertive partner is also at risk, but to a lesser extent.
- A homosexual man may believe his relationship is monogamous, but he cannot guarantee his partner's fidelity.
- A homosexual man who always uses condoms in an apparently monogamous relationship is nevertheless still at risk of HIV because condoms do not give 100% protection and there is a relatively high prevalence of HIV (5-10%) in the Australian homosexual community.
- Men who have sex with men are at higher risk from other blood-borne diseases such as syphilis and hepatitis B and C.
- The Red Cross does not accept blood from other groups at higher risk of blood-borne diseases such as HIV.
- The estimated incidence of HIV per year in Australian homosexual men in general is between 60 - 121 times greater than for Australian heterosexual men in general.
- The HIV incidence for monogamous homosexual men who always use condoms is nearly twice as great as for heterosexual men who never use condoms.
- Australia has one of the safest blood supplies in the world. The blood supplies in Spain and Italy, where homosexual men are allowed to donate blood in some circumstances, are less safe than in Australia.

The complaint determination lasted nearly four years, at great cost to the taxpayer. But despite the ruling, the homosexual lobby is not giving up. Mr Cain says he will continue to fight for the

homosexual "right" to give blood[9] – even though the evidence clearly shows that blood banks need to discriminate in the interests of public health and safety.

Recommendation 2:

The Bill should not include sexual orientation as a protected attribute because sexual orientation is not determined genetically, may change over time, is associated with serious health risks and its inclusion would undermine justifiable freedom of association.

2.3 Gender identity

Gender identity is a relatively new term, to describe people who have been born male or female, but have come to "feel" that they belong to the opposite sex.

In the past, people with this condition – often called gender *dysphoria* ("unhappiness") – have been given therapy to encourage them to accept their biological sex.

These days such people commonly demand that their desired sex be accepted by all others, and even for taxpayers to fund expensive surgery and hormone treatment to change their outward appearance.

Many psychiatrists reject this approach. On 11 January 2013, Dr Joseph Berger of Toronto, a Distinguished Life Fellow of the American Psychiatric Association, testified before the Canadian House of Commons Standing Committee on Justice and Human Rights about a federal bill (C-279) to ban discrimination on the ground of gender identity. He said (in part):

> It appears to me that this bill requests that some special allowances or attitudes or possibly even "rights" be given to people who identify themselves as being "transgendered". From a scientific perspective, let me clarify what "transgendered" actually means.
>
> "Transgendered" are people who claim that they really are or wish to be people of the sex opposite to which they were born as, or to which their chromosomal configuration attests. Sometimes, some of these people have claimed that they are "a woman trapped in a man's body" or alternatively "a man trapped in a woman's body".
>
> Scientifically, there is no such thing. Therefore anyone who actually *truly believes* that notion is by definition deluded, psychotic. The medical treatment of delusions or psychosis is not by surgery.
>
> On the other hand, if these people are asked to clarify exactly what they believe, that is to say do they truly believe whichever of those above propositions applies to them and they say "no", they know that such a proposition is not true, but that they "feel" it, then what we are talking about scientifically, is just unhappiness, and that unhappiness is being accompanied by a wish – that leads some people into taking hormones that predominate in the other sex, and even having cosmetic surgery designed to make them appear as if they are a person of the opposite sex.
>
> The proper treatment of emotional unhappiness is not surgery.
>
> Cosmetic surgery will not change the chromosomes of a human being. Cosmetic surgery will not make a man become a woman, capable of menstruating, ovulating, and having children. Cosmetic surgery will not make a woman into a man, capable of generating sperm that can unite with an egg or ovum from a woman and fertilize that egg to produce a human child.

These are the scientific facts. There seems to me to be no medical or scientific reason to grant any special rights or considerations to people who are unhappy with the sex they were born into, or to people who wish to dress in the clothes of the opposite sex – which I believe is not illegal.

I have read the brief put forward by those advocating special rights, and I find nothing of scientific value in it. Words and phrases are used that have no objective scientific basis such as "the inner space".

The committee examining these proposals should be aware that there are indeed some quite rare examples where the sex of a baby at birth is uncertain. Two particular conditions are well recognized. One is where the child is a boy, but the testes have not descended into the testicular sac, but remain somewhere "stuck" in the abdomen. The other well-recognized condition is where the child is a girl, but because of some abnormal hormonal levels as the baby was growing in the mother's uterus, the clitoris of the baby girl is unusually large, and might at first be mistaken for a penis. Both these conditions are now diagnosed earlier, chromosome testing to confirm the genetic sex is widely available. They should not nowadays lead to any confusion about the real sex of the baby.

Other than these and possibly even rarer abnormalities, the so-called "confusion" about their sex that a teenager or adult has is purely psychological. As a psychiatrist, I see no reason for people who identify themselves in these ways to have any rights or privileges different from everyone else in Canada.[10]

2.3.1 The story of 'John'

"John", aged 28 and single, enters the psychiatrist's office. He is intelligent and successful in his professional career. He is not attracted to women, but is only partly satisfied by homosexual activity. He tells the doctor that for as long as he can remember, his body has not felt "right". He believes he is really a woman, trapped in a man's shape.[11]

Psychological tests show that John's responses are in the normal range for everything except his body image. The psychiatrist agrees to help him change into a "woman".

John begins to dress as a woman and use make-up. He has laser treatment to remove his facial hair and takes female hormones, growing breasts. Later, plastic surgeons remove his genital organs and use some of the tissue to create artificial female organs. He changes his name to Joanne – even on his birth certificate.

Joanne is now regarded as a woman, as she has long wanted to be. But although she is glad she had the surgery, a year later she still does not feel "right". Her hips are too small. Her arms and legs look wrong. She keeps asking for more operations.

The surgeons believed they had done a good job of turning John into a nice-looking woman. They are perturbed by Joanne's continuing dissatisfaction. They send her back to the psychiatrist.

John's story is typical of a group of transsexual (or transgendered, as they are now called) people studied by US psychoanalyst Dr Sander Breiner.[12] Dr Breiner, like a number of other professionals, has come to understand that gender identity disorder or gender dysphoria is largely caused by psychological problems rather than genes or aberrations in physical development. John's disturbed body image cannot be solved by organic manipulation such as surgery or hormones, no matter how well-intentioned or brilliantly successful.

"In psychologically evaluating any patient, it is always important to understand how the patient sees himself," Dr Breiner says. "There are certainly age variations as well as gender and cultural elements involved in this evaluation. However, when an adult who is normal in appearance and functioning

believes there is something ugly or defective in their appearance that needs to be changed, it is clear that there is a psychological problem of some significance."

Dr Breiner says the more the patient is willing to do extensive surgical intervention (especially when it is destructive), the more serious is the psychological problem.

"It may not be psychosis," he says. "It may not require psychiatric hospitalisation. But the significance of the psychological difficulty should not be minimised by a patient's seeming success, socially and professionally, in other areas. This principle of isolated significant psychopathology indicating serious psychological problems (despite the ability to function in all other areas of life) is well known psychiatrically, historically, and by the judiciary.

"This conclusion became so well established at Wayne State University that the [sex reassignment] program was eventually discontinued. The much larger and more extensive program at the Johns Hopkins University and medical school in Baltimore, Maryland, was discontinued for the same reason. The psychological problems that are focused on issues related to gender need to be better understood – not denied," Dr Breiner says.[13]

2.3.2 'Boy interrupted'

"John/Joanne" was not completely satisfied after sex reassignment surgery, but the outcome for Alan Finch was far worse. His case history was shown on national television on the ABC's *Australian Story,* under the title "Boy interrupted".[14]

Alan, who migrated to Australia with his mother and sister as a teenager, decided at age 19 to become a woman. His decision was supported by health-care professionals and his mother. But it took him on a journey from which he has painfully discovered there is no sure way back. [15]

Alan's problems began in his earliest years. His father, a coal miner from the north of England, was violent and abusive. Alan feared and shrank from him.

Psychiatrist Dr Byron Rigby said Alan's identity problems stemmed from his lack of a positive father figure. "He never had any positive role modelling. The whole reason that he attempted to take refuge in womanhood was that he simply couldn't learn from his father how to be anything that he wanted to be," Dr Rigby said.

As an adolescent, Alan thought he may have been homosexual. He tried that experience but it did not satisfy. Like John, he then thought he was "trapped" in the wrong body.

After taking female hormones for some years, he underwent surgery in his 20s to remove his male organs and create an artificial vagina. He changed his name to Helen.

"My focus was to be the best-looking woman I could be," Alan told *Australian Story*. "I got a job. I was getting attention from men. I felt powerful."

As "Helen", Alan married illegally, but that relationship broke down. Helen was hoping a later relationship would work, but that too fell apart when Helen had to confess that children were not possible because "she" was born a boy.

Then Helen/Alan fell in love with a woman, who encouraged him to become the man Alan again. "I knew with my whole being that was what I wanted to do," Alan, now aged 36, told *Australian Story*.

He began taking male hormones, "a roller-coaster ride emotionally", and felt angry at himself for having been deluded into thinking that becoming a woman would solve his identity crisis. "There was

this total confusion again, wondering if I could function as a man, let alone function as a man who has been mutilated to this degree," Alan said.

About 10 per cent of those who have the sexual reassignment operation in Australia (about 80 a year in Sydney, Melbourne and on the Gold Coast) are "desperately unhappy" with the result.[16]

Alan Finch said: "Anatomically, I was never a woman. [The surgery] was creating a battleground within my own body. It's just rearranging flesh, but the tissue that's used is still male tissue. I was never able to have any sexual pleasure. Everything was fake about it, from top to toe." He said he was considering further plastic surgery to change his sexual organs back to male.

2.3.3 Renée Richards

Tennis star and eye surgeon Dr Renée Richards, born Richard Raskind in New York in 1934, is one of the best known transgenders. In a precedent-setting 1977 New York State Supreme Court ruling, Renée was declared legally a woman because hormones and sex reassignment surgery in 1975 had made her look like one. She was allowed to play professional tennis against other women who, unlike her, were born that way and did not possess Renée's male skeleton, brain and upper body strength.

But her surgery and legal victory did not make Renée happy. She called the 2004 decision of the International Olympic Committee, which allowed transsexuals to compete, "a particularly stupid decision". She said: "Better to be an intact man functioning with 100 percent capacity for everything than to be a transsexual woman who is an imperfect woman."[17]

In an earlier magazine article, Renée said of her sex reassignment surgery: "I wish that there could have been an alternative way, but there wasn't in 1975. If there was a drug that I could have taken that would have reduced the pressure, I would have been better off staying the way I was – a totally intact person. I know deep down that I'm a second-class woman.

"I get a lot of inquiries from would-be transsexuals, but I don't want anyone to hold me out as an example to follow. Today there are better choices, including medication, for dealing with the compulsion to cross-dress and the depression that comes from gender confusion. As far as being fulfilled as a woman, I'm not as fulfilled as I dreamed of being. I get a lot of letters from people who are considering having this operation … and I discourage them all."[18]

Renée's early life experiences may have been the source of her gender confusion. Her autobiography *Second Serve*[19] tells of a stressful childhood with a dominating psychiatrist mother who was disappointed that her first child was a girl. Richard's older sister "Mike" was a tomboy who dressed her little brother in girls' underwear, forced his penis into painful inversions and encouraged him to explore her body. Richard began to cross-dress in secret and invented an alternative identity named Renée.

In adulthood, Richard Raskind went to Yale medical school and became an eye surgeon, served in the US Navy, married, fathered a child and competed in US Open tennis. Then, after ten years of psychoanalysis and a divorce, Richard (41) underwent surgery to become "Renée". She now warns others with gender dysphoria not to take this drastic step if at all possible. [20]

2.3.4 The Meyer study

Dr Paul McHugh was appointed chief psychiatrist at the Johns Hopkins Hospital in Baltimore in 1975. He was puzzled by gender dysphoria patients he interviewed after their sex reassignment surgery. They were generally men, and although they claimed they were happy after their operation, he was not convinced. They were "caricatures of women", wearing high heels, copious make-up and flamboyant clothing. Their large hands, Adam's apples and thick facial features were incongruous. [21]

Those he interviewed before surgery seemed even more strange. "They spent an unusual amount of time thinking and talking about sex and their sexual experiences; their sexual hungers and adventures seemed to preoccupy them … they seemed indifferent to children … many of these men-who-claimed-to-be-women reported that they found women sexually attractive and that they saw themselves as lesbians," Dr McHugh said. He decided more research was needed.

The Johns Hopkins Hospital study was conducted by psychiatrist and psychoanalyst Jon Meyer, who was already developing a system for following up adults who had received sex-change operations at the hospital. Dr Meyer found that most of the patients he tracked down some years after their surgery were happy with the operation.

"… only a few regretted it. But in every other respect, they were little changed in their psychological condition," Dr McHugh said. "They had much the same problems with relationships, work, and emotions as before. The hope that they would emerge now from their emotional difficulties to flourish psychologically had not been fulfilled.

"We saw the results as demonstrating that just as these men enjoyed cross-dressing as women before the operation so they enjoyed cross-living after it. But they were no better in their psychological integration or any easier to live with … I concluded that Hopkins was fundamentally cooperating with a mental illness. We psychiatrists, I thought, would do better to concentrate on trying to fix their minds and not their genitalia.[22]

2.3.5 Amputee Identity Disorder

Some professionals have compared gender identity disorders with other conditions, such as *apotemnophilia* (also referred to as Amputee Identity Disorder or Body Integrity Identity Disorder). [23] Men suffering this condition appear otherwise mentally healthy, but desire the amputation of a normal limb. They have an idealised body image of themselves as amputees. They say it began early in life, before puberty. They experience sexual pleasure from pretending to be an amputee. They typically experience an intense desire to change their bodies to match this image. A Scottish surgeon controversially performed amputations on two patients suffering this disorder in the late 1990s.[24]

Then there is anorexia nervosa, where the patient believes he or she is grossly overweight, even though the opposite is true. Should doctors reinforce this false belief by prescribing a minimal diet and extreme exercise? Dr Paul McHugh has written: "It is not obvious how this [gender dysphoria] patient's feeling that he is a woman trapped in a man's body differs from the feeling of a patient with anorexia nervosa that she is obese despite her emaciated, cachectic state. We don't do liposuction on anorexics. Why amputate the genitals of these poor men? Surely, the fault is in the mind not the member."[25]

2.3.6 Not 'born that way'

The exact causes of transgenderism or transsexuality are unclear, but early life experiences seem to play a significant part. Transgendered people do not have hormone abnormalities. They need to take artificial hormones to help them appear like the opposite sex.

NZ researcher Dr Neil Whitehead[26] says: "Only about five per cent of cross-dressers, or transvestites, have any desire to be the opposite sex, but those who do are often convinced they are a woman in a man's body. Fewer women believe they are men trapped in a woman's body. Both are usually called transsexuals and are perhaps one in thirty thousand of the population. At their request 10,000 sex-change operations have been performed to date [1997], creating people physically of one sex but chromosomally of the other." [27]

Dr Whitehead says most transgendered people claim they were born that way. They believe that their dysphoria is caused by genes or by hormonal influences in the womb. However this claim is not

supported by studies of identical twins, each of whom has the same genes and the same womb environment.

"Identical twins have (virtually always) identical genes," Dr Whitehead says. "This means they are identical physically, but do they have identical behaviour? If one twin is homosexual, and if homosexuality were genetically determined, all co-twins would always be homosexual. But it is now known that the percentage of homosexuality among co-twins is 11% … your genes do not make you homosexual. Can the same be said for transsexuality?

"There are far fewer studies of transsexual twins because the condition is far rarer. However of four studied identical male twin pairs, of which one was transsexual, the other twin was transsexual in only one case. Researchers concluded that genetic factors were most unlikely to be important. If genes compelled transsexuality, all the co-twins would have been identical."[28] Transgendered people are *not* born that way.

2.3.7 Family factors

Many homosexual and transgendered people have experienced a variety of family situations which may have contributed to their condition. Dr Whitehead says:

"As for homosexuality, [in transgenderism] a late birth order is common. It appears that being late, or last, in a family of children is often not optimum. A child may receive less attention from parents, and other siblings may well be dominant. Rather unusual family conditions have sometimes been implicated. In an NIMH [US National Institute for Mental Health] program, a survey of 70 clients found no obviously physical symptoms … but 80% of the mothers and 45% of the fathers had psychiatric problems of various types, which are very high incidences.

"For the most gender dysphoric, in all cases the father was absent. Overall in 54% of cases the father was absent, and in 37% of cases there was no adult male role model. If a father or role model was available, in 60% of cases he was psychologically distant...

"In some cases, sexual abuse may be involved. As in homosexuality, particularly for those subjects in clinical settings, rates of 80% have been recorded.

"When the condition is connected to other conditions, treatment of the latter sometimes causes the transsexuality to disappear. A case of Obsessive Compulsive Disorder (OCD) associated with transsexuality was treated for OCD, but the transsexual symptoms also disappeared for four years."[29]

2.3.8 Harm resulting from 'gender identity' as a protected attribute

If the Sex Discrimination Act were to be amended to include gender identity as a protected attribute, what harm could it do?

People who say they are "transgendered" are effectively living in denial about their true sex. Giving their condition the status of a protected attribute would reinforce this psychological delusion. It could also affect adolescents who are confused (possibly temporarily) about their sex, and make it more likely that those teens will themselves seek mutilating surgery and hormone treatment to become "second class" members of the opposite sex, as Renée Richards put it.

Not only would public bodies be required to allow such people to use public conveniences and change rooms reserved for people of the opposite sex, but schools and kindergartens would be required to allow teachers who have had a sudden apparent change of sex to continue teaching the same children – possibly reinforcing gender confusion and dysphoria in students from vulnerable backgrounds.

Emotional unhappiness about a biological reality should not be given special rights and status by governments. The freedom of parents not to have their children associate with people promoting such delusions should be respected.

Recommendation 3:

Transgenderism, also known as gender dysphoria, is caused by life experiences rather than genes, and should not be given special recognition or endorsement by governments. The Bill should not include "gender identity" as a protected attribute.

3 Endnotes

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[8]. *Cain, Michael v The Australian Red Cross Society 2009 TASADT 03*

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[10] http://arpacanada.ca/attachments/article/1724/Testimony%20of%20Dr.%20Berger%20re%20c279.pdf

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[12] Breiner, Sander, *loc cit*.

[13] *Ibid*.

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