

ABSTRACT

In this paper, I review the evidence for social contagion of gender dysphoria in adolescents and the contagion evident in associated professions and professional bodies. I begin with a review of the historical phenomenon of social contagion, demonstrating that it predated the digital age. I then review the nature of social contagion and the mechanisms by which certain phenomena are propagated through social networks. Social network analysis, the method applied to study contagions of all kinds, was first developed and used in public health as a way of determining the spread of diseases. For the spread of social phenomena among adolescents, three mechanisms - peer contagion, deviancy training and co-rumination in peer groups - have been identified as “spreaders.” Four possible causes of peer effects – endogenous, exogenous, correlated and social media – all amplify the spread of information in a social network. Four areas of empirically established social contagion in adolescents - marijuana use, eating disorders, suicide and emotion – are presented as a prelude to the discussion of how the same processes are at work in the social contagion of gender dysphoria in adolescence. Specific mechanisms of transmission such as low gender typicality, peer victimization, ingroups, the trans-lobby, and the role of social media in rapid onset gender dysphoria (ROGD) in adolescents and the role of social media are proposed. Preliminary statistical support for social contagion in gender dysphoria are presented. I conclude with a discussion of how social contagion affects medical, legal educational and sporting institutions and their role in the propagation and perpetuation of gender dysphoria in young people.

Keywords: social contagion, gender dysphoria, transgender, adolescents, professional bodies

Introduction

“Gender identity” [is defined] as “a person’s internal sense of being male, female, *or something else* [author’s italics] (American Psychological Association).

Although it is tempting to blame the phenomenon of social contagion on the digital age, in which people, young and old, remain symbiotically tied to their social media devices, eagerly scanning their screens for the latest news, fashion, holiday location, rave party, or dating site to assuage their “fomo” (i.e., fear of missing out), social contagion predated the advent of the cyberage, thereby placing its origins squarely in the minds of humankind, thus assigning social media to its role as one of many efficient conduits.

Social contagion before the digital age abounds. In 1774, Johann von Goethe (1990) published a novel, *The sorrows of young Werther*, in which an idealistic young man finds his actual life too difficult to reconcile with his poetic fantasies, including his unrequited love for his friend’s fiancée. He eventually becomes so depressed and hopeless by the perceived emptiness of his life, he commits suicide. Goethe was able to capture the nameless dread and endless longing of the human condition so well that his novel spawned a number of suicides, committed in the same way that Werther had killed himself, by shooting (Phillips, 1974). Such was the alarm created by this phenomenon, the book was banned in several European cities.

More than two hundred years later, in 1984, the suicide of a young Austrian businessman, who threw himself in front of a train, initiated a spate of similar suicides that averaged five per week for nearly a year. Sociologists argued that this alarming occurrence was amplified by media coverage that glamorised suicide by providing graphic images of the suicidal act and details of the young man’s life. When media exposure of the event was curtailed and then stopped completely, the suicide rate dropped by 80 percent almost immediately. Although the

influence of suggestion and imitation on suicide rates was dismissed by Durkheim (2005/1897), Phillips's (1974) work indicated that these factors do indeed play a significant role in the increase in suicides following a publicised suicide.

In 1841, a Scottish journalist, Charles Mackay (2012) wrote a book entitled *Extraordinary popular delusions and the madness of crowds*. In the preface to the first edition of the book, the aim of writing it is stated thus:

...to collect the most remarkable instances of those *moral epidemics* ... to show how easily the masses have been led astray, and how imitative and gregarious men are, even in their infatuations and crime (p. 1)...Popular delusions began so early, spread so widely, and have lasted so long, that instead of two or three volumes, fifty would scarcely suffice to detail their history... The present may be considered...a miscellany of delusions, a chapter only in the great and awful book of human folly (p. 3).

The preface to the second edition in 1852 continued this theme:

Nations,... like individuals, ...have their whims and their peculiarities; their seasons of excitement and recklessness... whole communities suddenly fix their minds upon one object and go mad in its pursuit; ...millions of people become simultaneously impressed with one delusion, and run after it, till their attention is caught by some new folly more captivating than the first. At an early age in the annals of Europe its population lost their wits about the sepulchre of Jesus and crowded in frenzied multitudes to the Holy Land; another age went mad for fear of the devil and offered up hundreds of thousands of victims to the delusion of witchcraft... the belief in omens and divination of the future... defy the progress of knowledge to eradicate them entirely from the popular mind... *Men... think in herds; ...they go mad in herds, while they only recover their senses slowly, and one by one* [Author's italics] (p. 7).

Mackay's book is about popular delusions and the madness of crowds. Today, we use the term social contagion to describe the "spread of phenomena (e.g., behaviours, beliefs and attitudes) across network ties" (Christakis & Fowler, 2013, p. 556). Using very large datasets (e.g., Framingham Heart Study) that have collected longitudinal data on original participants (Original cohort), as well as their children (Offspring cohort) and their children's children (Third generation cohort) and including their spouses, siblings, friends and neighbours, Christakis and Fowler have shown that social network effects, known as clustering, remain strong and can extend to those up to three degrees of separation from the original cohort. Such effects have been demonstrated across a large range of factors by different researchers using differing datasets. Examples include overweight/obesity, sleep patterns, smoking, alcohol abuse, alcohol abstention, marijuana use, loneliness, happiness, depression, cooperation, and divorce among others.

Social network analysis, the method applied to study contagions of all kinds, was first developed and used in public health as a way of determining the spread of diseases (e.g., influenza, HIV/AIDS) that resulted in pandemics. It was subsequently applied to the challenges of introducing changes and innovations in the health system (Blanchet, 2013). Its applications have since expanded with the advent of computers, the internet, mobile and smart phones, and social media. Members of a network play different roles in the dissemination of innovations. A small number will adopt early (i.e., early adopters). Some of these will become opinion leaders who are central to the network who contaminate their "peers" (homophily) who in turn will influence those others at different levels of the network.

There are three types of social networks; (i) egocentric (networks assessing a single individual); (ii) sociocentric (social networks in a well-defined social space, such as a hospital or a school); and (iii) open system networks (e.g., globalised markets, social media). Each network consists of nodes (members), ties (between nodes), and measures of centrality,

density and periphery or distance between the nodes. Networks with high centrality are the most effective in disseminating information or innovation. A key example with respect to this discussion is the transactivist lobby that has achieved spectacular success in a short time in changing health care, educational practices and legislation related to transgender individuals. Other characteristics of networks include cohesion (number of connections within a network) and shape (distribution of ties within the network) (Otte & Rousseau, 2002).

In this article, I explore the influence of social contagion on the disquieting upsurge in the number of children and young people whose parents are presenting to gender clinics around the world for advice regarding social transition, puberty blocking agents, cross sex hormones, and ultimately surgery in an attempt to change their gender. First, I examine the concept of social contagion and the mechanisms by which it influences behaviour and attitudes. Then I review four key adolescent behaviours that have been shown to be subject to social contagion. I then argue that the most heuristic explanation for the rapid increase of young people who believe that they are transgender and consequently seek irreversible medical remedies to assuage their gender dysphoria is social contagion. Finally, I explore the social contagion (i.e., clustering) of medical practice with respect to treatment of gender dysphoria, the precipitous policy making in professional bodies and legislation appearing in its support, and changes to policy and practice in education and sport despite our collective failure to date to fully understand the phenomenon of gender dysphoria and its rapid, epidemic-like spread in the Western world.

Mechanisms of social transmission

(i) Peer contagion

Peer contagion is a form of social contagion, defined as a process of reciprocal influence to engage in behaviours occurring in a peer dyad that may be life-enhancing (e.g., taking up a

sport, studying for exams, health screening, resisting engaging in negative behaviours, altruism) or life-compromising (e.g., illegal substance use, truanting from school, aggression, bullying, obesity). Peer contagion has a powerful socializing effect on children beginning in the pre-school years. By early childhood, the time spent interacting with same-age playmates frequently exceeds time spent with parents (Ellis, Rogoff, & Cromer, 1981). Further, characteristics of peer interactions in schools (e.g., aggression, coercive behaviours, mocking peers) are carried over into the home environment (Patterson, Littman, & Bricker, 1967). By middle childhood, gender is the most important factor in the formation of peer associations, highlighting the significance of gender as the organizing principle of the norms and values associated with gender identity (Fagot & Rodgers, 1998).

(ii) *Deviancy training as a mechanism of social contagion*

Different mechanisms of transmission of peer influence have been identified. Deviancy training, in which deviant attitudes and behaviours are rewarded by the peer group have a significant effect on the development of antisocial attitudes and behaviours such as bullying, physical violence, weapon carrying, delinquency, juvenile offending, and substance abuse (Dishion, Nelson, Winter, & Bullock, 2004). Aggression in adolescence becomes more covert and deliberate and takes the form of exclusion, spreading rumours, and suborning relational damage among an adolescent's friendship network (Sijtsema, Veenstra, Lindenberg, & Salmivalli, 2009). Interestingly, adolescents associated with peers who engage in instrumental aggression became more instrumentally aggressive, while those associated with peers who engaged in relational aggression became more relationally aggressive, demonstrating the specificity of the effects of peer contagion via the deviancy training.

(iii) *Co-rumination as a form of social contagion*

Another form of peer contagion in adolescence is co-rumination, a process of repetitive discussion, rehearsal and speculation about a problematic issue within the peer dyad or peer group that underlies peer influence on internalizing problems such as depression, anxiety, self-harm, suicidal ideation and suicide (Schwartz-Mette & Rose, 2012). Co-rumination is more common among adolescent girls (Hankin, Stone, & Wright, 2010) although a similar phenomenon among boys has been observed. Being in a friendship that engages in perseverative discussions on deviant topics has been associated with increased problem behaviour over the course of adolescence. The longer these discussions, the greater the association with deviant behaviour in later adolescence (Dishion & Tipsord, 2011).

Peer contagion may undermine the effects of positive socializing forces such as schools, rehabilitation programs for young offenders, and treatment facilities for eating disorders among others. Collecting same-minded adolescents into group programs may be counter-productive because the peer influence impacts of a homogeneous peer group to maintain disordered behaviours may be greater than the program effects of the treatment facility (Dishion & Tipsord, 2011).

Young people are particularly vulnerable to peer contagion if they have experienced peer rejection, hostility and/or social isolation from the peer group (Light & Dishion, 2007). On the contrary, protective factors against peer contagion effects include secure attachment to parents, adequate adult supervision and oversight of the young person's activities, school attendance, and the capacity for self-regulation (T. W. Gardner, Dishion, & Connell, 2008).

Does social contagion have a causal effect on behaviour uptake?

Establishing a causal role for the effect of peer behaviour on adolescents is difficult because adolescents choose their peer networks; that is, they choose to associate with like-minded adolescents and those exhibiting similar attributes (homophily). This raises the question: Do

adolescents choose their peers because they sanction and engage in similar behaviours or can peer social networks explain the uptake of (new) behaviours in individuals in the network? Sophisticated statistical models have been used to tease out the relative contributions of peer selection and peer influence. Correctly attributing the effects of these two factors has important policy implications since most interventions for reducing risky behaviour among adolescents are implemented at a school level (Ali & Dwyer, 2010).

Four possible causes of peer effects have been enumerated by Ali, Amialchuk, & Dwyer (2011):

- i. *Endogenous effect*. This effect would occur in a situation in which "...an individual is more likely to use marijuana if there is a high rate of marijuana usage among the reference group because friends' engagement in such activities could develop a social norm which might compel an individual to use drugs in order to fit in with one's peer" (p. 2), a process described as induction (Christakis & Fowler, 2013), colloquially described as "birds of a feather flock together."
- ii. *Exogenous or shared contextual effect*. This effect occurs when other social factors influence adolescent behaviour; for example, high substance abuse in a community population of adults, in which the adolescent's parents are also substance abusers. In such a scenario, adolescents whose parents abuse substances will be more likely to abuse, and contagion may occur in adolescents as a result of peer influence even in those whose parents do not abuse substances.
- iii. *Correlated effect*: These effects, known as environmental confounders, occur when adolescents in the same group behave in a similar way due to a third, perhaps unobserved factor, such as socioeconomic or demographic variables that cause their attributes to covary.

iv. The special case of social contagion via social media

In the world of social media, social contagion takes on a new, less complex and narrower meaning:

Unlike the broadcasts of traditional media, which are passively consumed, social media depends on users to deliberately propagate the information they receive to their social contacts. This process, called social contagion, can amplify the spread of information in a social network (Nathan & Kristina, 2014, p. 1).

I return to this issue later in the paper.

Evidence for social contagion among adolescents

In this section, I review the evidence for social contagion among adolescents for three key psychopathologies that arise in adolescence (eating disorders, marijuana use and suicide) and for the transmission of positive and negative emotions and compare the mechanisms of social contagion in these well documented areas with evidence for social contagion effects in gender dysphoria.

i. Anorexia nervosa

Several researchers have identified the central role of social contagion in the development and propagation of anorexia nervosa in adolescent girls (Allison, Warin, & Bastiampillai, 2014). Adolescence is a time in which the focus on oneself becomes intense, and for some, critical and unrelenting. The developing female body constitutes one of the main objects of scrutiny. When this scrutiny is compounded by the collective inspection of all of one's body's flaws, the peer group becomes a powerful crucible for both the development and maintenance of disordered eating.

Intensification of peer influence in closed communities of like individuals, such as schools, inpatient wards, residential units (Huefner & Ringle, 2012), or therapy groups often results in the advocacy of the practices (e.g., self-starvation, compulsive exercise, deceitful practices around eating) associated with anorexia nervosa (Dishion & Tipsord, 2011).

If we add social media and online networks as further sources of influence, affected adolescents can effectively surround themselves exclusively with like minds, thereby normalising cognitive distortions around eating and body image and making recovery very difficult. These effects are further compounded by the high status of thinness in western culture, and an ubiquitous focus on nutrition and exercise. Originally thought to be caused by genetics and pathological family dynamics, this view was revised with the finding, using longitudinal study designs and social network analyses, that same-gender, mutual friends were most influential in the development of obesity in adulthood, with siblings and opposite-sex friends having no effect (Christakis & Fowler, 2007).

ii. Marijuana use

Substance use amongst adolescents is a major public health issue (Fletcher, Bonell, & Hargreaves, 2008), with a population study conducted by the Center for Disease Control and Prevention showing that 10 percent of youths reported using illegal substances before the age of 13, with marijuana the most frequently used substance (Chen, Storr, & Anthony, 2009). Peer influence has long been suspected as a stimulus that amplifies risky behaviours in the social network (Clark & Loheac, 2007; Lundborg, 2006).

Using the National Longitudinal Study of Adolescent Health (Add Health) (n=20,745) representing a sample of adolescents from grades 7-12 in 132 middle and high schools in 80 communities across the USA examined the influence of peer networks in the uptake and continued use of marijuana. The peer group was identified by the nomination of close friends

and classmates within a grade were used to identify the broader social network from which friends were chosen (Ali et al., 2011).

Results showed that for every increase in marijuana use of 10 percent in adolescents in a close friend network increased the likelihood of marijuana use by two percent. An increase of 10% in usage in grade peers was associated with a 4.4 percent increase in individual use. Reporting a good relationship with one's parents, living in a two-parent household and being religious were protective against marijuana uptake. When peer selection and environmental confounders were held constant, increases in close friend and classmate usage by 10 percent both resulted in a five percent increase in uptake in individuals within those networks.

iii. Suicide

Although social ties are generally protective against loneliness, depression and suicide, social ties can be toxic and can amplify the risk of psychopathology in members of a social network (Christakis & Fowler, 2008). Exposure to the suicidal ideation or suicide attempts of significant others increases the risk of suicidality in other network members (Abrutyn & Mueller, 2014). Experiencing self-harm or suicide at close quarters may erode the emotionally regulating effects of normative moral precepts against such behaviour (Mueller, Abrutyn, & Stockton, 2015). When vulnerable individuals share “ecologically bounded spaces” (p. 205) like schools or the family home, this may increase suicide contagion if social relationships within those spaces are psychopathological. Our emotional connections to members of our social networks is the mechanism through which social learning and the development of normative behaviours and attitudes are built. However, negative emotions are more “contagious” and thus exert a greater impact on members (Turner, 2007).

Celebrity suicides also trigger spikes in suicide rates, with the greater visibility of the celebrity and prolonged coverage of the suicide triggering higher spikes and longer duration

of elevation of rates of suicide amongst fans (Fu & Chan, 2013; Stack, 2005). Similarly, Durkheim (1951) highlighted the phenomenon of suicide outbreaks or “point clusters” defined as “temporally and geographically bounded clusters” such as gaols, regiments, monasteries, psychiatric wards, and First Nations reservations (Mueller et al., 2015, p. 206). Individuals in such networks share a collective identity that appears to heighten subsequent suicides following the suicide of the first decedent (Niedzwiedz, Haw, Hawton, & Platt, 2014).

A well-documented example of a suicide “echo” cluster (an identical suicide cluster occurring within 10 years of a first cluster) occurred in two high schools in Palo Alto that, between them, had suicide rates four to five times higher than the national average. In 2009, three students committed suicide in a nine-month period by stepping in front of a commuter train. A fourth student committed suicide by hanging. In 2013 a mental health survey showed that 12 percent of students from these schools had seriously considered suicide in the previous 12 months. Thereafter, there was another spate of suicides, with three students taking their lives within three weeks of each other. A fourth committed suicide four months later by jumping off a tall building and a fifth followed shortly afterwards by walking in front of a train. Extreme perfectionism and pressure to excel at school, get into Stanford, make a lot of money, and be ostentatiously successful materially and intellectually were assessed to be far too great a burden for the more vulnerable students to withstand.

Using the same data set as the study examining marijuana use but following up four waves of these participants into adulthood, Wave IV assessed suicidality in young adults aged 24-32. This study showed that holding all other psychological risks constant, those young people having a role model who attempted suicide were more than twice as likely to report suicidal ideation in the following 12 months. Participants who had a friend or family member commit suicide were 3.5 times more likely to attempt suicide themselves compared with those who

had no close associate attempt or commit suicide in the same 12-month timeframe. These effects were enduring. Young adults who reported an attempted suicide of a role model were more than twice as likely to report a suicide attempt six years after the role model's attempt compared with their otherwise similar peers. Attempting suicide in adolescence increased suicidal ideation and suicide attempts in young adulthood. Significant risk factors for this association included experiencing emotional abuse in childhood, a diagnosis of depression, and a significant other attempting suicide. Thus, suicide contagion appears to be a significant risk factor for suicide in young adulthood but contagion in this study did not require bounded social contexts.

iv. Positive and negative emotions

An ingenious study (Kramer, Guillory, & Hancock, 2014) using Facebook (a large real-world social network) and a large dataset (N = 689,003) collected over 20 years has demonstrated how emotional states are transferred to others via the mechanism of social-emotional contagion without direct interaction between “spreaders” and recipients. The authors manipulated the amount of positively- and negatively-valenced emotional content in the News Feed. When positive and negative content was either increased or reduced, Facebook users posted more or less positive and negative posts in response to content. The relationships are shown in Figure 4.

INSERT FIGURE 1

The authors argued that emotions expressed by others on Facebook influence the reader's emotions, concluding that these results “constitute[e] experimental evidence for massive-scale contagion via social networks (p. 8788).” The study also demonstrated that direct interaction between individuals is not a necessary condition for the transmission of positive or negative emotions.

The case of gender dysphoria

Commentators on the burgeoning incidence of young people claiming that they are transgender assert that peer contagion may underlie this ominous trend. However, peer contagion as a mechanism has been vehemently decried by supporters of gender transition and sadly by professional bodies of psychologists, medical practitioners and psychiatrists. Nonetheless, given the strong evidence of peer contagion in suicide, substance abuse, eating disorders and emotion, especially among adolescents, the role of peer contagion in gender dysphoria demands urgent attention.

If we examine the upswing in gender dysphoria in social network terms, we see several features operating. It is an open-system network with nodes and ties expanding across the oceans to the US, UK, Asia, Europe, Scandinavia, and Australia. Most countries are reporting sharp increases in the number of people seeking services and treatment for gender dysphoria. Many are ramping up services and setting up new gender clinics to cope with demand. This network is highly centralised with only one voice – the transactivist lobby - being heard above the desperate whispers of terrified parents and horrified academics, doctors, psychologists and psychotherapists. Opinion leaders operating at the centre of these networks are very influential. The level of density in a network has two effects – firstly, it enhances the circulation of information between members and secondly, it blocks the introduction of dissenting ideas and evidence (Iyengar, Van den Bulte, & Valente, 2011). The trans lobby has achieved both of these outcomes by its relentless advocacy.

The field is too young to have attracted researchers to undertake social network analyses to assess peer contagion effects in gender dysphoria. Hence, formal empirical studies have not yet been conducted. However, there is evidence from several sources that peer contagion may

be a relevant factor in the sharp increases in young people presenting with gender dysphoria.

These factors include:

i. Low gender typicality, peer victimization, ingroups and the trans-lobby

Low gender typicality (i.e., perceived lack of fit within one's binary gender) has a significant impact on social acceptance within one's peer group (Sentse, Scholte, Salmivalli, & Voeten, 2007). It is strongly associated with adjustment difficulties, behavioural problems, lower self-esteem, and increased internalizing disorders (e.g., anxiety, depression) (Smith & Juvonen, 2017). As children progress to adolescence, peer as opposed to parental acceptance becomes paramount. Peers therefore take over the role of gender socializing agents from parents (Blakemore & Mills, 2014). Adolescent peers tend to be critical of behaviours, dress, mannerisms and attitudes that are not gender typical as a way of policing and reinforcing gender norms and respond with criticism, ridicule, exclusion and even intimidation of non-conformers (Zosuls, Andrews, Martin, England, & Field, 2016). The problems accruing to low gender typicality are mediated by peer victimization. Reducing peer victimization may ameliorate these difficulties (Smith & Juvonen, 2017). Conversely, peer acceptance mediated the self-worth of gender non-conforming 12- to 17- year-olds (Roberts, Rosario, Slopen, Calzo, & Austin, 2013).

Gender non-conformity and gender atypicality have also been associated with higher physical and emotional abuse by caregivers (Roberts, Rosario, Corliss, Koenen, & Austin, 2012).

Mental health is difficult to sustain in the face of caregiver abuse and peer bullying and victimization (Aspenlieder, Buchanan, McDougall, & Sippola, 2009). Indeed, gender non-conforming and gender atypical youth are at higher risk of depression, anxiety and suicidality in adulthood (Alanko et al., 2009).

It is tempting to speculate that these groups of young people, searching for homophily (i.e. like peers) started to exaggerate their points of difference from their gender-conforming peers rather than to hide and minimize them to avoid being bullied and excluded. In so doing, they left the “outgroup” of nonconformers and formed an ingroup of extreme gender-nonconformers, transcending the gender barrier altogether and declaring themselves transgender. Suddenly, the discomfort and fear of not being gender typical becomes a virtue and rather than fearing the disapprobation of their peers, their open revolt in declaring themselves transgender is valorised by a politically powerful transactivist lobby. One would expect that gender atypical children who feel both internal and external pressure to be gender conforming would experience greater discomfort (Carver, Yunger, & Perry, 2003) and therefore be more susceptible to the message of transactivism.

Ingroups behave in stereotypical ways with respect to outgroups – they favour ingroup characteristics, assigning more positive attributes to its members and derogating outgroups in order to enhance the status of their ingroup (Leyens et al., 2000). It is not surprising, then, that members of the transgender ingroup exaggerate the characteristics of the “trans” gender they take on – becoming more “feminine” or “masculine” than heteronormative groups of cis men and cis women. Transactivist groups have proliferated and consolidated in a short time by exploiting the characteristics of ingroups and outgroups. For example, social projection (i.e., the belief that other members of the group are similar to oneself) has been a powerful integrating process that simultaneously creates protection for its own members and distance from outgroup members, using the formula, “if you are not with us, you are against us” – those disagreeing with the ideology of the trans-lobby are labelled “transphobic” and publicly denounced.

ii. Rapid onset gender dysphoria (ROGD) and the role of social media

The upsurge in rapid onset gender dysphoria (ROGD) tends to occur mostly in girls at around the age of 14 years, which is an age identified by developmental psychologists to be particularly susceptible to peer influence (Steinberg & Monahan, 2007). For example, a study of peer contagion for risky behaviours found that exposure to risk-taking peers doubled the amount of risky behaviour in middle school adolescents, increased it by 50% in older adolescents and young adults, and had no impact on adults (Gardner & Steinberg, 2005). This group of young people were likely to belong to peer groups in which one or more of their friends had become gender dysphoric or transgender-identified. Their coming-out announcement to parents also tended to be preceded by recent increases in their daughters' social media and internet usage. Clinical practice also identifies peer bullying/exclusion and a romantic disappointment as possible triggers to ROGD.

Littman (2019) canvassed the perceptions of parents who had children who displayed ROGD during or just after puberty. There were 256 respondents, of whom 83% had daughters, with a mean age of 15.2 years when they declared themselves transgender, 41% of whom had previously expressed a non-heterosexual sexual orientation, and 62.5% of whom had received a diagnosis for a mental health disorder (e.g., anxiety, depression) or a neurodevelopmental disability (e.g., autism spectrum disorder). Thirty-seven percent (37%) of these young people belonged to peer groups with other members identifying as transgender. Parents also reported a decline in their child's mental health (47%) and relationship with parents (57%) after declaring themselves transgender. Thereafter, they preferred transgender friends, websites, and information coming from the transgender lobby.

An indicative case study was written up in an article for *The Atlantic* by Jesse Singal (2018), in which Claire, a 14-year-old girl decided she must be transgender because she was uncomfortable with her body even after she restricted her food intake, was finding puberty uncomfortable, had difficulty making friends, was feeling depressed and was lacking in self-

confidence. Against this backdrop of woes, she came across [MilesChronicles](#), the website of an omnipotent and histrionic transboy, now a young transman. Watching this video resulted in Claire pouring all her sadness and unease about herself into the “realisation” that she was really a “guy.” Miles made transitioning appear easy and simple, was effusive in his praise of his new self and supportive of others to follow suit. This is a very common scenario reported by parents of teenage girls with ROGD. One post dedicated to [coming out in middle school](#) attracted 695,292 views and more than 5,000 comments of the type:

“Hi I’m a trans guy in 8th grade! You’re both awesome and I love you guys cause you’ve helped me so much with dealing with dysphoria and all this crap we have to deal with Especially bullying (I’m called an “it” on a regular basis).

There are so many gay beans at my school, my school is super gay.

Another viewer came out as “trans pan” and received 34 confirmations from other trans pans young people with comments of the kind, “Trans pans, UNITE!”

Such websites, all easily accessible to vulnerable adolescents, can have a very persuasive effect on viewers. Recent studies show that contagion is enhanced when the influencer is perceived to have high credibility and reduced when the influencer is perceived to have low credibility. A similar effect is observed if the influencer belongs to an out-group or an in-group (Andrews & Rapp, 2014). Miles is the quintessential trans pinup icon with a “You can be just like me if you transition!” message.

Following YouTube posts and social media with respect to the transgender debate over the past couple of years, I have noticed that posts that depict young people struggling with their gender identity or questioning their decision to take puberty blocking agents and cross-sex hormones, or to undergo what is euphemistically called sexual reassignment surgery are

rapidly taken down so that only a homogenous message which matches the strident messaging of the transactivist lobby is on display in the ether.

iii. Empirical evidence of social contagion in gender dysphoria

There has been a sharp increase in the population estimates of those identifying as transgender. I present three sources of evidence from different populations in different parts of the world that all show the same upward trajectory in numbers identifying as transgender. The first study, a meta-regression of population-based probability samples of adults from the general population and students at colleges and universities from the USA provides compelling evidence of this trend, where estimates have more than doubled in the space of eight years from 2007 to 2015.

INSERT FIGURE 2

Data from Australia (Figure 3) also show an upward trajectory in the number of children and adolescents enrolled in gender clinics in the four states of Australia that offered a gender service at the time of writing. Three of the five states (South Australia, New South Wales, Western Australia, Victoria and Queensland) show similar increases over the six-year study period (2014-2019). Victoria had the largest numbers and the largest increases. It is also a state where the trans lobby has been particularly vocal and where the ‘safe schools’ policy (Victorian State Government, 2018) was conceived and implemented.

INSERT FIGURE 3

The third source of evidence constitutes data from the Tavistock clinic in the UK that treats gender dysphoria in children and adolescents aged three to 18 years (NHS, 2019), where there has been 3,200 percent rise in transgender declarations in children and adolescents over the last ten years, 75 percent of whom are girls.

INSERT FIGURE 4

Perusal of the graph indicates a doubling of the number of referrals in 2015-2016 compared with the previous year. There is a continuous increase until 2017, which is followed by a slowing of referral growth rates between the two years 2017-2018 and 2018-2019. Note the same pattern for the Victorian sample in the previous graph where numbers reduced from 2017 to 2018 after four years of continuous growth. The steep increase in enrolments in 2019 across four of the five states of Australia appears to be related to the increased social media, increased legal agitation of the trans lobby resulting in legislation to ban so-called “conversion therapy,” to allow transwomen to participate in female sport, to reduce the legal age at which cross sex hormones can be prescribed and sex re-assignment surgery can occur and to limit the authority of parents in transgender treatments.

In each of these samples, the numbers comprise two groups of young people, a core group of “actual” cases and the additional cases created by social contagion. Within the actual cases, there is the sub-group that declared themselves and a sub-group of latently gender dysphoric young people who have not felt able to declare themselves until recently because of greater community acceptance and support from a strident transgender lobby and social media. This latter group of “actual” cases and the ROGD group have both been affected by social contagion.

Further analysis is required to determine the nature of the clustering of these increased numbers. In school-aged children, one would expect to see multiple cases in particular high schools. If gender dysphoria referrals occurred independently of each other, one would expect to see referrals per high school follow a Poisson distribution, in which the variance is equal to the mean. A clustering effect would be hypothesised if the variance were greater than the

mean. The strongest indicator of social contagion would occur if the ROGD young people showed strong clustering effects.

Other sources of evidence of ROGD is provided by the distribution of new referrals by age in GIDS samples. In the UK GIDS, new referrals in the 12-16 age group far exceed those in younger and older age groups (see Table 1). Even more compelling, Table 2 shows the sex distribution of new referrals in England for 2019-2020. In the age group 12-16, females far outnumber males in GIDS referrals.

INSERT TABLE 1

INSERT TABLE 2

These figures are a reversal of the sex distribution of transgender identifying individuals from previous decades. For example, the DSM IV (1994) reported that five times as many boys were referred to child clinics for gender confusion compared with girls (p. 535). According to DSM 5, in children, sex ratios of natal boys to girls ranged from 2:1 to 4.5:1. In adolescents, the sex ratio was close to parity; in adults, the sex ratio favoured natal males, with ratios ranging from 1:1 to 6.1:1 (p. 454). Population estimates for natal adult males range from 0.005% to 0.014%, and for natal females, from 0.002% to 0.003%. However, about 0.7 percent of 13- to 17-year-olds living in the United States identify as transgender according to the Williams Institute at the University of California, Los Angeles, School of Law (Blad, 2017). This estimate is between 140 (males) and 350 (females) times higher than that for adult males and females.

Epidemiological studies are still lacking so that no strong conclusions about the prevalence of GID in children and young people can be drawn (Zucker & Lawrence, 2009).

Contagion effects of print and social media

A recently published paper by Pang et al. (2020) found a robust relationship between the number of positively framed media reports of transgender issues and increases in referrals of

transgender and gender diverse (TGD) children and adolescents to specialist gender services. The study used a serial cross-sectional design and covered eight years of media content during which time more than 5,242 TGD young people were referred to two paediatric gender clinics, one in the UK and one in Australia. Results showed a robust association between weekly referral rates and the number of positively valenced TGD-related items appearing within the local media one and two weeks prior to referral. Increased media coverage of TGD-related topics was associated with increased referrals in the number of TGD young people presenting to the two gender clinics. The authors somewhat disingenuously attributed the association to the disinhibiting effect of the media articles, arguing that fearful young people may have been empowered to expose and express their true transgender selves that they had kept hidden after receiving encouragement to do so by the media. Nonetheless, the authors conceded that

... increased media content (specifically via social media) might act as a ... means of social contagion, whereby some individuals erroneously come to believe through exposure to such media that their nonspecific emotional or bodily distress is due to gender dysphoria and being transgender/gender diverse (Littman, 2019; Marciano, 2017) (Pang et al, 2020, p. 7).

Pang et al dismiss this concern by arguing that one would expect to see high rates of desistance or regret in young people who made their way to gender clinics and gender transition via social contagion and that this had not been observed. However, there are major problems with the published research claiming extremely small regret rates (WordPress 2020).

Social contagion in treating practitioners, professional bodies, legislators and the courts, sporting bodies, and educators

Social contagion is by no means limited to vulnerable, suggestible children and adolescents. A few salient examples pointing to social contagion in medical practice, professional bodies, law and legislation, sport, and education include the following:

i. Treating medical practitioners, psychiatrists, psychologists and their professional bodies

An analogous example of social contagion within the medical profession occurred in the first half of the twentieth century. A surgical procedure, known as frontal lobotomy (Levinson, 2011), involved the destruction of brain tissue in people with chronic mental illnesses. It was hailed as the miracle cure for a range of previously intractable psychiatric conditions. In 1949, Egas Moniz won the Nobel Prize for inventing the lobotomy, after which it was practised on thousands of hapless patients the world over before falling out of favour in the mid-1950s when very poor longer-term outcomes were observed and the first wave of effective psychiatric drugs were developed. An eminent British neurosurgeon, Henry Marsh (in Levenson), said

[Lobotomy] reflected very bad medicine, bad science, because it was clear the patients who were subjected to this procedure were never followed up properly. If you saw the patient after the operation, they'd seem alright, they'd walk and talk and say thank you doctor. The fact they were totally ruined as social human beings probably didn't count.

This comment, taken out of the context of frontal lobotomy, could very well be a modern comment about the practice of transgenerating children and young people. It is “bad medicine, bad science” (see, for example, Biggs, 2020; Greenall, 2019) and with no long term follow up to reflect that the initial euphoria of all involved, including young people, parents, and doctors is not sustained over the longer term. These young people are also “totally ruined as social human beings.”

That the medical profession is prone to social contagion in general medical practice was demonstrated by Iyengar, Van den Bulte, and Valente (2011). They found contagion in the prescribing patterns of doctors after controlling for marketing outreach and systemic changes, such as the advent of new drugs and changes in the prevalence of diseases. Shared geographical proximity, shared group membership and self-identified ties between doctors were all factors in behavioural contagion, with self-identified ties the most compelling factor. A critical factor in marketing attempts to manipulate uptake of a new drug or medical treatment is the identification of those in the network who are influential and those who are influenceable. Without individual uptake, the marketing campaign will falter (Christakis & Fowler, 2011). Central figures in the network have a stronger tendency to adopt early. Of course, network contagion effects may be modified by product characteristics, for example, the perceived effectiveness and safety of the new drug. Part of the gender affirmative discourse emphasises the safety of puberty blocking agents as a reversible “pause” in the development of puberty that will give children time to decide in which gender they wish to reside.

The 2018 “Australian standards” for the transgendering of young people, including when to commence puberty blockers and cross sex hormones issued by Melbourne’s Royal Children’s Hospital (RCH) gender clinic were hailed by the state liberal government as “the most stringent safety standards” for children and adolescents, as well as “the world’s most progressive.” The RCH standards invoke “clinician consensus” and “increasing evidence” for “gender affirming care,” flag the need for more research but warn that withholding treatment is not “a neutral option” and may increase suicide risk (no evidence provided because research, in fact, shows it has no effect on suicide). Yet the RCH standards, hailed as unassailable and published as a peer-reviewed paper in the *Medical Journal of Australia* and praised by *The Lancet*, make no mention of a Dutch study (Vrouenraets, Fredriks, Hannema, Cohen-Kettenis, & de Vries, 2015) showing a worrying level of medical uncertainty and diametrically opposed views among 36

gender clinicians in 10 countries. This study highlights the lack of consensus regarding safety, ethics and benefit of the global trend to prescribe puberty-blocking agents to increasingly younger patients on the unfounded assumption that placing puberty on hold affords time for them to “decide” their “true identity,” while reducing suicide risk. Although the internet is replete with such claims, there have been blistering critiques of the research on this issue that shows that puberty blockers conveys no benefit in reducing suicide (Biggs, 2020).

The paper highlights seven areas of disagreement, including the cause of gender dysphoria, consent, infertility, the risks to brain development and cognitive function of interrupting puberty, and whether gender dysphoria is a mental illness or just normal gender variation pathologized by culture-driven treatment.

There is evidence of cross-contamination/social contagion between medical, psychiatric, psychological and legal, including human rights, entities. These bodies seem less concerned about scientifically verifying their stances regarding the transgenering of young people and more concerned about falling foul of the transgender lobby since they rely in a circular manner on a small oeuvre of flawed transgender affirming “research” that is underpinned by the essentialist notion propagated by trans ideologues that gender is “...a psychophysiological entity that is organismic and transhistorical, that... promotes more invasive interventions (e.g., endocrinological and surgical) and mistakenly deemphasizes psychological therapies as a clinical response to the suffering of trans children (Schwartz, 2012, p.460).

An example of the narrow circularity (i.e., social contagion) in policy formation is the RANZCP (Royal Australian and New Zealand College of Psychiatrists) Position Statement 83 *Recognising and addressing the mental health needs of the LGBTI population* (2016)¹. This position was endorsed by the former Australian High Court judge, the Hon Michael Kirby, who

¹ The RANZCP subsequently quietly dis-endorsed the RCH guidelines pending “further review” of the evidence for the standards which it now considers to be bolstered by flawed and partisan “research” (Lane, 2019).

advocated for this group to have access to [gender affirmative] healthcare in a 2014 roundtable on Gender Identity, Rights and Law convened by the United Nations (UN) Development Program (Kirby, 2014). Subsequently, the UN Committee on Economic, Social and Cultural Rights in General Comment No. 22 condemns laws that require treatment to "cure" LGBT identity. It states, "...regulations treating LGBTI persons as mental or psychiatric patients or requiring that they be "cured" by so-called "treatment" are a clear violation of their rights to sexual and reproductive health" (4 March 2016, E/C.12/GC/22. Para 23)]. The influence of the language of the trans lobby is very clear, including the use of inverted commas to express irony. What is also evident in this extraordinary statement is the logical inconsistency of its arguments. The advocated medical (puberty blocking agents and cross sex hormones) and surgical treatments for transgender individuals in fact violates transgender rights to sexual and reproductive health, given that the "so-called treatment" they are advocating renders transgendered individuals both sexually dysfunctional and infertile.

Both the American Psychological Association (APA, 2015) and the American Psychiatric Association (APA, 2012) also published position statements similarly advocating for improved access to healthcare for transgender and gender variant individuals, both endorsing gender affirmative care at younger ages. An example from the APA (Psychological) fact sheet reads:

Early intervention may improve outcomes for gender diverse and transgender youth who are experiencing distress... Early medical intervention is recommended for peri-pubertal transgender youth who have a history of gender dysphoria and a desire to live as another gender. Puberty delaying treatment, cross sex hormone treatment, and/or surgical intervention(s) may be indicated to treat gender dysphoria.

At least the American Psychological Association (APA, 2015) recognised that "[c]hildren who demonstrate gender nonconformity in preschool and early elementary years may not follow this

trajectory...” and point to research indicating that “...between 12% and 50% of children diagnosed with gender dysphoria may persist in their identification with a gender different [from] sex assigned at birth into late adolescence and young adulthood (p. 841).” However, none of these bodies explored the dire implications of automatic gender affirmation in potentially 88% of young people who may have desisted if left alone (without hormones) to mature naturally.

The Australian Psychological Society fares no better. A detailed critique is presented here as it is representative of many policies regarding transgender-identifying young people internationally. With respect to the role of social contagion in the spread of transgender identity, the APS contradicts itself. In other behavioural disorders, it is alive to the risk of social contagion among adolescents, for example, e.g., non-suicidal self-injury (NSSI) (APS, 2018), but for reasons probably due to social contagion (i.e., not wanting to be at odds with trans lobby ideology), the APS cannot admit the possibility of social contagion in transgenderism as one likely cause of the exponential increases in transgender declarations in young people in recent years (APS, 2019).

Another example, one among many, of flawed policy making that has been “infected” by trans ideology is the draft of the Australian Psychological Society’s (APS) (APS, 2020) “Ethical guidelines for psychological practice with clients with diverse sexualities, diverse genders and/or diverse bodies,” which contains illogical, capricious and unscientific assertions that are common to most policies informed by the trans lobby. These include the following:

- a. Conflation of people with intersex variations with those of diverse sexual orientation and gender identity despite an Intersex peak body, Intersex Human Rights Australia (IHRA, 2012) making explicit that intersex is an issue separate from sexual orientation and gender identity and that Intersex is not a gender identity.

- b. InterACT, another peak body for Intersex individuals, advocates reduction of genital surgeries in children because there is no demonstrated benefit to early intervention (InterACT, 2014). IHRA (2017) also deplores early surgery for young intersex people, stating that the decision should be delayed until the young person is old enough to provide informed consent for any surgical procedure. This position is in conflict with transgender advocacy for earlier and earlier hormonal treatment and sex re-assignment surgery.
- c. The term “diverse bodies” purportedly “represents clients with intersex variations... [of which] there are more than 40.” The fact that 40 intersex variations (many extremely rare) have been identified is used to underpin the transgender belief that there are multiple sexualities, genders and bodies. Intersex variations do not appear on a spectrum; they are discrete categories based on chromosomal, gonadal and genital characteristics and sex hormones and cannot be used to “prove” a gender spectrum. Again, there is a deliberate conflation of intersex with sexual orientation and gender identity. Almost all births (99.95%) are unambiguously male or female. Intersex conditions comprise the remaining 0.05% (1 in 1,500) to 0.07 (1 in 2,000) of births (InterACT, undated). These do not destabilize the foundation of biological sex.
- d. Use of the scientifically incorrect phrase “sex assigned at birth.” Historically, babies’ “birth sex” was noted at birth. The phrase “sex assigned at birth” is now mandated because it opens the door to “gender identity” as the true basis of a person’s sex. The scientific understanding that sex is a biological reality and gender is a social construct has been reversed in transgender ideology which claims that gender identity is destiny and biological sex is a social construct.
- e. Inconsistent and internally contradictory use of the term “gender” stating that it is both a “social and psychological phenomenon” and “a deeply held internal and individual

sense of [self]” (p. 2). Each characterization privileges either nurture or nature as the defining feature but one cannot invoke polar opposites to endorse a fixed position. It can only be either/or, not both/and in this instance. Further, admission that gender may be socially constructed opens the door to the possible influence of social contagion, a position that the APS and transgender lobby decry, hence their confused logic in their causal attribution of gender.

- f. Psychologists must recognise that “diverse sexualities are one variant of human sexuality and are not indicative of psychological disturbance.” How can diverse sexualities be one variant of human sexuality?
- g. Paragraph 5.1 states “Psychologists are sensitive to the ethical issues and challenges inherent in providing multiple psychological services such as psychotherapy (i.e., treatment and care) and assessment or evaluation reports that are *required* to support hormonal and/or surgical interventions (p. 9).” Not only will the practice of psychotherapy be illegal now that legislation in Australia to ban “conversion therapy” has been passed by some state parliaments, this paragraph creates confusion regarding the stance of psychologists with respect to therapy with transgender identifying young people, given that the endpoint of psychotherapy is expected to be gender affirmation (i.e., hormonal and surgical intervention). The concluding statement gives psychologists only one option, that is, to “affirm the experiences of clients with diverse genders.”
- h. In Paragraph 8.2 (p. 9), the APS views the “dysphoria paradigm as perpetuating stigma and discrimination.” If that be the case, one can only conclude that dysphoria cannot be a criterion for diagnosis despite the fact that most young people presenting for treatment claim a subjective experience of gender dysphoria. Hence, reliance on solipsistic assertions of “born in the wrong body” discourse will become the only arbiter of medical treatment decisions. Yet, how can one assert that one has been born in the

wrong body without experiencing dysphoria? If there be no dysphoria, i.e., no disturbance in the mind, one can conclude that the condition does not exist and hence any medical or psychological intervention is unnecessary and stigmatising.

On 10 August 2020, James Cantor resigned his membership of the Society for the Scientific Study of Sexuality (SSSS). In his open letter to the SSSS Board, he stated “the SSSS Board abused their authority to silence science opposing their personal political views...” He said he wanted to “...challeng[e] the extremism that has taken over public discussion of trans issues...” and was shocked that such debate was not permitted by the Society. In response to his posting an essay, he was suspended from the Society’s listserv. This triggered outrage and resignations among other society members because of the board’s “...privileging socio-political opinion over science...” Other politically, as opposed to scientifically motivated actions by the SSSS can be found in Bailey (2019).

iii. Law and legislation

Transgender activists in several countries have succeeded in persuading gender clinics to commence social transition in children as young as two and three years of age (e.g., Tavistock GIDS Clinic, Royal Children’s Hospital, Melbourne, Australia), followed by the administration of puberty blockers at nine or 10 years of age. They have also been successful in lowering the age at which young people can access sex re-assignment surgery without parental consent. For example, in Oregon, USA the lower age limit for surgery has been removed with parental consent and lowered to 15 without parental consent (Smith, 2015). It is almost commonplace to read about adolescent girls as young as 14 years undergoing double mastectomies (Rowe, 2016). Recently, a judge in Canada found a father potentially guilty of domestic violence if he continued to use his 14-year-old child’s birth name and female pronouns. This child is petitioning the court to commence cross-sex hormones in the face of his father’s strong objection (Cecco, 2019). The lower court ruled that a minor is capable of giving consent to

medical procedures. Accordingly, the child has commenced testosterone while the battle continues in the Court of Appeal.

Other legislative support (e.g., Amendments to the UK *Gender Recognition Act 2004*, *Victorian Births, Deaths and Marriages Registration Amendment Bill 2019*) for the transgender epidemic includes a bill allowing transgender people to change their birth certificates without undergoing sex-reassignment surgery (Taylor, 2019). Under the legislation a person can self-nominate their sex and list as male, female or any other gender diverse or non-binary descriptor of their choice. Children can alter the sex on their birth certificate with parental support and a statement from a doctor or registered psychologist saying the decision is in the best interests of the child.

The Family Court of Australia has a somewhat less than rational approach to its decisions regarding young peoples' applications for permission to proceed with stage 1 and stage 2 treatments. Clear evidence of social contagion in the judges' decisions in such cases is apparent. For example, in *re Jamie* (2011), the FCA decided that stage one treatment (i.e., puberty blockers) was therapeutic and reversible, [a position that was incorrect at the time and is no longer sustainable (Greenall, 2019; Laidlow, 2020)], and it would no longer require court approval. However, at that time, the Full Court found that stage two treatment continued to require court authorisation. An article published by the FCA (Strickland, 2015) provides legal reasoning and argument regarding the disposition of gender dysphoria treatment for minors that outlines the limits of legal intervention in these cases. The reasoning in this report is underpinned by current, often erroneous information about gender dysphoria.

In 2013, two cases came before the FCA [*re Sam and Terry* (2013)] (Strickland, 2014, 2015) that concerned a MtF and a FtM young person. Both were aged 16 years, and both had been

deemed Gillick incompetent.² Sam was debilitated by mental illness and unable to leave his home. Terry had what was diagnosed as Asperger's Syndrome, now known as autism spectrum disorder. A psychiatrist told the court that gender dysphoria, even in the circumstances of known serious comorbid mental health issues, did not require psychiatric treatment and that medical and surgical treatments were best practice. Consequently, the FCA approved stage 2 hormone treatments in the 'best interests' of these two young people, despite the evidence to the Court that oestrogen therapy was irreversible and "...was associated with blood clots, gallstones, abnormal liver function, weight gain, high blood triglyceride levels and cardiovascular disease" (p. 32). Despite being acclaimed to be in the child's best interest, Murphy J found that "the risks associated with Stage 2 treatment, in terms of irreversibility and possible side effects, were "significant" and "...when the consequences are expressed as being steps on the path to changing gender, the consequences can be described as *grave*" (p. 34). [author's italics]. The word "grave" is used 19 times in Strickland's report as a descriptor of stage 2 hormonal treatments.

In *re Kelvin*, a 2017 Family Court ruling (Fraser & Condello, 2017) made it easier for young people under the age of 18 years to obtain irreversible hormone treatments without judicial oversight. The Royal Children's Hospital, Melbourne gave evidence that there was growing consensus regarding medical treatment of gender dysphoria. The RCH over-stated its positive outcomes but did not refer to the uncertainty and disagreement about treatment and outcomes expressed by a growing number of researchers and clinicians. Two *Amicus* Briefs (Teufel, 2015; Wilkens, 2015) each supporting contrary arguments, were presented to the Supreme Court of the United States. The interested reader is invited to study both briefs and decide which of the two is more convincing.

² Gillick competence is a term originating in England used in medical law, initially in relation to an adolescent's use of contraceptives, to determine whether a child younger than 16 years of age is able to consent to his/her own medical treatment, without the need for parental permission or knowledge.

An example of the degree to which legal, judicial and human rights sectors have been seduced by the trans lobby is the case of Maya Forstater, a tax expert for the Centre for Global Development, who did not have her contract renewed for stating in Twitter posts that there are only two biological sexes and that these cannot be changed. Forstater was critical of the proposed reforms to the UK's *Gender Recognition Act* that would allow anyone to self-identify as a man or woman, thereby gaining access to single sex spaces. The judge hearing her case in an employment tribunal ruled Forstater's opinion "...not worthy of respect in a democratic society," asserting that belief in "...only two sexes, male and female...is incompatible with the human rights of others that have been identified and defined by the European Court of Human Rights" (The Guardian, 2019).

Hence, medicine, law and human rights organisations have been acting synchronously (i.e., contagiously) to produce their position statements, denying the science of biological sex and abrogating their duty of care to young people lest they fall foul of trans ideologues.

iv. Sport

The Australian Human Rights' Commission (2019) has provided guidelines about sports participation that clearly disadvantage natal females and which may well have a profound effect on female participation in sport. It was written with the participation of peak sports' bodies including the Coalition of Major Professional and Participation Sports (COMPS) and Sport Australia. The document claims it is a victory for "diversity and inclusion." The reality is that these guidelines neutralise the protections provided to females in the *Commonwealth Sex Discrimination Act*, 1984. Whitehall (2019) has provided a critique of the bill.

In the international sporting arena, the case of Caster Semenya, an intersex athlete raised female, created significant ethical dilemmas for both sporting and medical bodies. In February 2019, Semenya took the IAAF (International Association of Athletics Federation) to the Court

of Arbitration in Sport (CAS) on the grounds of discrimination, requesting that the DSD (Differences/disorders of sexual development) Regulations (Tulloch, 2019) which apply only to female athletes who are legally female, have 46XY, DSD, and testes, who are androgen-sensitive and have circulating testosterone above 5nmol/litre be declared invalid and void. CAS (2019) ruled that the DSD Regulations

...were discriminatory but...such discrimination ...was a necessary, reasonable and proportionate means of achieving the IAAF's aim of preserving the integrity of female athletics in the Restricted Events.

The CAS further upheld the requirement of the IAAF that female athletes with excess testosterone must lower their levels in order to compete. Semenya's legal team countered that the IAAF's requirement for athletes with DSDs to take hormone suppressants to reduce testosterone is ethically wrong and potentially poses a health risk. Why, then, is it not ethically wrong and potentially dangerous to reduce testosterone in gender dysphoric male adolescents?

The United Nations Human Rights Council argued that the IAAF ruling contravenes human rights (BBC, 2019). The World Medical Association (WMA) (2019) also condemned the IAAF rules arguing that it is unethical for physicians to prescribe treatment for excessive endogenous testosterone if the condition is not pathological. The WMA called on physicians to oppose and refuse to perform any test or administer any treatment or medicine

...which might be harmful to the athlete using it, especially to artificially modifying blood constituents, biochemistry or endogenous testosterone.

This is an interesting position given that the WMA does not condemn the prescription of testosterone to girls asserting that they are boys or to reducing testosterone in boys asserting that they are girls. Nor do they balk at the removal of healthy breasts or reproductive organs of otherwise healthy young women or the amputation of penises in healthy young men.

The WMA (2015) released a set of nine recommendations that explicitly condone all available treatments for sex reassignment, including cross-sex hormones and sex reassignment surgery for people requesting them, with the sole proviso that they give informed consent, without defining how informed consent is ascertained, particularly in young people. It appears that no-one in the WMA is troubled by the strident contradiction in their medical advice depending on whether the recipient is an athlete or a gender-confused young person.

v. Education

The NSW (Australia) Department of Education's Bulletin 55 (NSW government, undated) deprives parents of any rights in the management of their gender dysphoric child at school. Bulletin 20 (NSW government, undated) even deprives parents of parental authority regarding the registered name of their child. It states,

If either or both parents object to the change to the way the first name is recorded by the school, the *principal needs to make a decision about what is in the child's best interests* [author's italics]. This decision should have regard to the age, capability and maturity of the student and can be informed by advice from a health care professional about the potential impact on the student's wellbeing of declining to use and record the student's preferred first name.

These guidelines undermine parental authority in the child's eyes, setting a dangerous precedent allowing children to make decisions about their wellbeing for which they are not prepared.

In the USA, a number of laws have been enacted to give transgender students equal rights in schools, but they have not addressed the problems created in the day-to-day administration that these laws create. For example, Title IX of the Education Amendments of 1972 (US

Department of Education) is a federal law that bans sex discrimination in schools. Two of the rights under this law are:

You have the right to be treated according to your gender identity. That's true even if you haven't done things like changing your ID or getting medical treatment, and your school cannot require you to show proof of these things in order to have your gender respected.

You have the right to use restrooms and locker rooms that match your gender identity, and you can't be forced to use separate facilities. If you feel safer or more comfortable using a private space, or if you'd like to use a separate space for a short period of time, you can request that—but your school can't force you or pressure you into using a separate restroom or locker room if you don't want to.

The implications of these rights are concerning. The first right states that a biological male who has had no treatment for gender dysphoria and hence has intact male sexual function may enter girls' restrooms and locker rooms at will as the school has no jurisdiction over what a male self-declared trans female decides to do. This position was reinforced by the Obama administration in 2016 that affirmed that any student can use the bathroom/locker in accordance with their stated gender identity, rather than their natal sex. The Trump administration withdrew that guidance without providing further clarity on how schools should deal with transgender-identifying students.

However, in *Bostock vs Clayton* (2020), the legal judgement held that an employer who terminates an individual's employment merely for being gay or transgender violates Title VII (p. 4–33). 'Transgender' became a legally protected category for employment purposes. By analogy, this ruling implies that schools should treat trans students in a similar manner.

Similarly, in the UK, the *Equality Act* (2010) (Norton, Rose, Fulbright, 2010)

...changed the prevailing definition of “gender reassignment” by no longer requiring a person to be under medical supervision to fall within it. This means that a person who was born female but chose to spend the rest of her life as a man, without seeking medical advice or intervention, would have undergone gender reassignment for the purposes of the Act.

Kara Dansky, media director of the Women’s Liberation Front, commented to Shrier (2019) that the *Equality Act* would eliminate “women and girls as a coherent legal category worthy of civil-rights protection.” It would do so by redefining the category of “women” to include “women and those who say they are women.”

Equally worrying is that education department curricula around the Western world are now teaching children about sex and gender from the perspective of transgender ideology, commencing with very young children, who are exposed to the “Genderbread Person” presented in Figure 5, in which biologically incorrect precepts are instilled unchallenged in vulnerable receptive audiences.

INSERT FIGURE 5

Human anatomy and biological dimorphism have been abandoned in favour of characteristics like gender identity, gender expression, biological sex, sexual attraction and romantic attraction all falling along a spectrum and all being expressed in different parts of one’s body i.e., gender identity in the brain, sexual and romantic attraction in the heart, biological sex in the pelvis and gender expression, “everywhere.” It offers a tortured and incomprehensible definition of gender identity: “how you, in your head, define your gender, based on how much you align (or don’t align) with what you understand to be the options for gender.” Children are taught that there are “infinite” possibilities for gender identity but only four are specified: “woman-ness,” “man-ness,” “two-spirit,” or “genderqueer.” Children are taught that biological sex “isn’t

something we're actually born with, it's something that doctors or our parents assign us at birth.”

Interestingly, discontent arose within transgender ranks that the genderbread person appeared overly male and a breakaway group (Trans Student Education Resources) developed its own graphic – the Gender Unicorn – that eliminates reference to male and female bodies. The underlying philosophy is mostly unchanged. It has a body shape that doesn't appear either male or female, and instead of a “biological sex” it has a “sex assigned at birth.”

INSERT FIGURE 6

The incoherence of transgender ideology is breath-taking and almost too muddled to enumerate and clarify. They use and discard or change concepts opportunistically. One example is gender dysphoria. In their attempts to convince us that transgender identification is not a psychiatric disorder, but a normal variant of human gender expression, they eschew gender dysphoria; however, they coach young people to declare that their gender dysphoria is so bad that it is making them suicidal and they must have “treatment” to save their lives. They abjure biological sex and sexual dimorphism and yet are rigidly binary in their understanding of transgender, as boys trapped in girls' bodies, and vice versa. In each of their five categories in the genderbread person and the gender unicorn, they specify “male” “female” and “other” without expanding what “other” denotes. How can young children understand “other” when they have known only boys, girls, mothers, fathers, brothers, sisters? It is interesting that these graphics (curricula) specify female/woman/girl and male/man/boy and feminine/masculine yet want to assert a gender spectrum. They erroneously include other/intersex as a third or infinite category of “sex assigned at birth.”

Further, if gender identity is innate and immutable, how can young people also feel gender fluid, nonbinary or queer? It is unclear whether gender identity can be experienced

independently of biological sex. Without biological sex, how can transgender individuals have a gender “identity” since the current conception is an identity aligned or opposed to their biological sex (or sex assigned at birth). All of the errors swallowed whole and appearing in psychological societies’ position statements, discussed earlier, are on display in educational curricula.

Equally dumbfounding is that Education Departments around the world have accepted the ideology and turned it into a compulsory curriculum for children without oversight or scrutiny. Similarly, seemingly intelligent practitioners in medicine, psychology, psychiatry and education have all drunk from the same bottle of transgender ideology cool aid (i.e., have succumbed to social contagion) to produce these shameful documents. Would we not express outrage if children were taught vaccination conspiracy theories in schools? With the arrival of COVID-19, the World Health Organization (WHO) warned that there would be an “infodemic” of misinformation spawned by social contagion (Richtel, 2020). This has in fact occurred, but the false beliefs have not taken centre stage and swept all science before it in the manner of transgender ideology. Transgenderism is a cult and must be curtailed forthwith. As Anderson (2018) concluded:

The [transgender] movement has to keep patching and shoring up its beliefs, policing the faithful, coercing the heretics, and punishing apostates, because as soon as its furious efforts flag for a moment or someone successfully stands up to it, the whole charade is exposed. That’s what happens when your dogmas are so contrary to obvious, basic, everyday truths. A transgender future is not the “right side of history,” yet activists have convinced the most powerful sectors of our society to acquiesce to their demands. While the claims they make are manifestly false, it will take real work to prevent the spread of these harmful ideas.

vi. Parents

Parents are not exempt from these influences; there are numerous websites offering support to parents of transgender children (e.g., Transcend; Human Rights Campaign; Gender Centre; Gender Help for Parents). These groups provide a kind of cheer leadership to newly inducted parents, who all wear their “I have a transgender child” heart on their rainbow sweatshirts, and share information about binders and penile fillers and the magic of ‘T’ and the thrill of being part of an exclusive club who know that they would rather have a “live son/daughter than a dead son/daughter.” Transcend Australia has published a Guide for Schools, that explains to the education profession the new vocabulary that has been created in the transgender world – including concepts like misgendering, deadnaming, intersectionality, and the “rainbow” array of gender variants – pansexual, polysexual, asexual etc. All concepts are accepted unquestioningly, and the only challenge is to be the very best parent of one’s transgender child as possible.

Conclusion

During the writing of this essay over the first six months of 2020, I learned that nine secondary school students had committed suicide. I learned of this only because I was engaged therapeutically with parents from some of the schools that these students attended. There is a strict policy within the police and media that there will be no reporting in the press or digital media of youth suicide. The reason: because publication of the details of a suicide spawns copycat suicides in the same age groups of young people. So, there was no mention in the media of these tragic events. We are very aware as a society of the potential for social contagion in all our behaviours and the best way to stop the contagion is to starve it of oxygen (i.e., remove social exposure). When it comes to transgenderism, it appears that we are unable to learn from history. The transgender pandemic has spread its tendrils into all corners of

society – medical, social, legal, psychological, educational, political, ideological and philosophical. By the time the proponents of transgenderism in children and adolescents realise the far-reaching damage they have caused by their unthinking political correctness in supporting gender affirmation, the courts will be clogged with lawsuits brought by young transgender adults whose bodies and minds have been irreparably damaged as children and adolescents by the zealous compliance to the strident voices of the trans lobby trumpeting gender affirmation.

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Table 1 Age at referral to GIDS, UK
2018-2019

Age at referral	Number of referrals
3 and 4	10
5	21
6	21
7	42
8	34
9	43
10	59
11	78
12	135
13	331
14	511
15	529
16	474
17	88
18	30

Source: NHS (2019)

Table 2 Age and gender at referral
to GIDS, England only, 2019-2020

Age	FtM	MtF
3 and 4	<5	<5
5	5	12
6	7	9
7	13	16
8	17	24
9	24	21
10	22	32
11	52	23
12	127	37
13	270	45
14	404	90
15	470	152
16	350	162
17	101	67
18+	30	28

Source: NHS (2020)

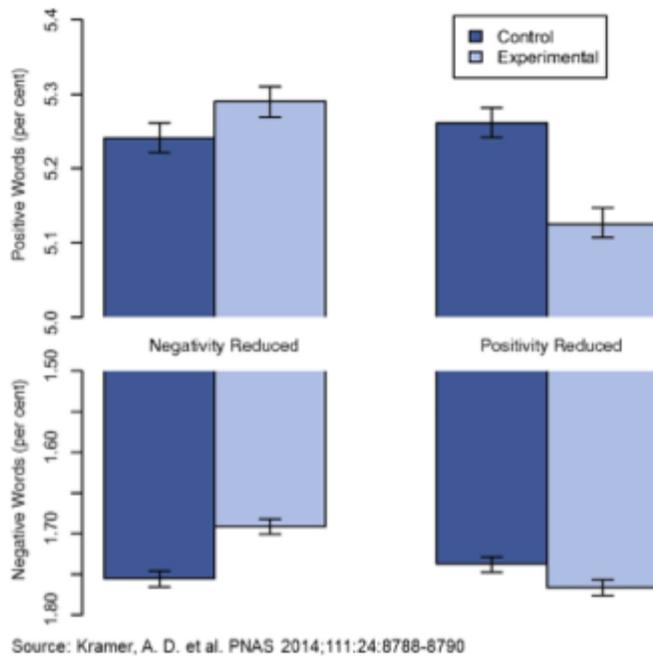


Figure 1. Mean number of positive (Upper) and negative (Lower) emotion words (percent) generated by people, by condition. Bars represent standard errors.

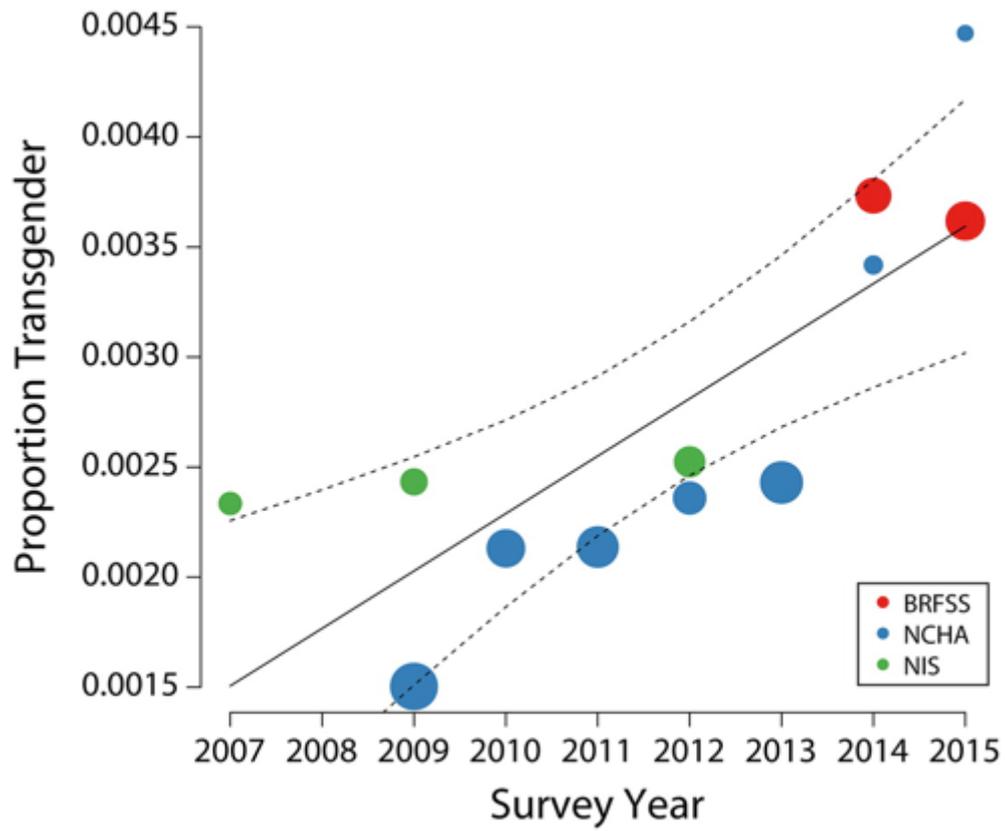


Figure 2 Proportionate increases in transgender population 2007-2015.

Source: Meerwijk & Sevelius (2017).

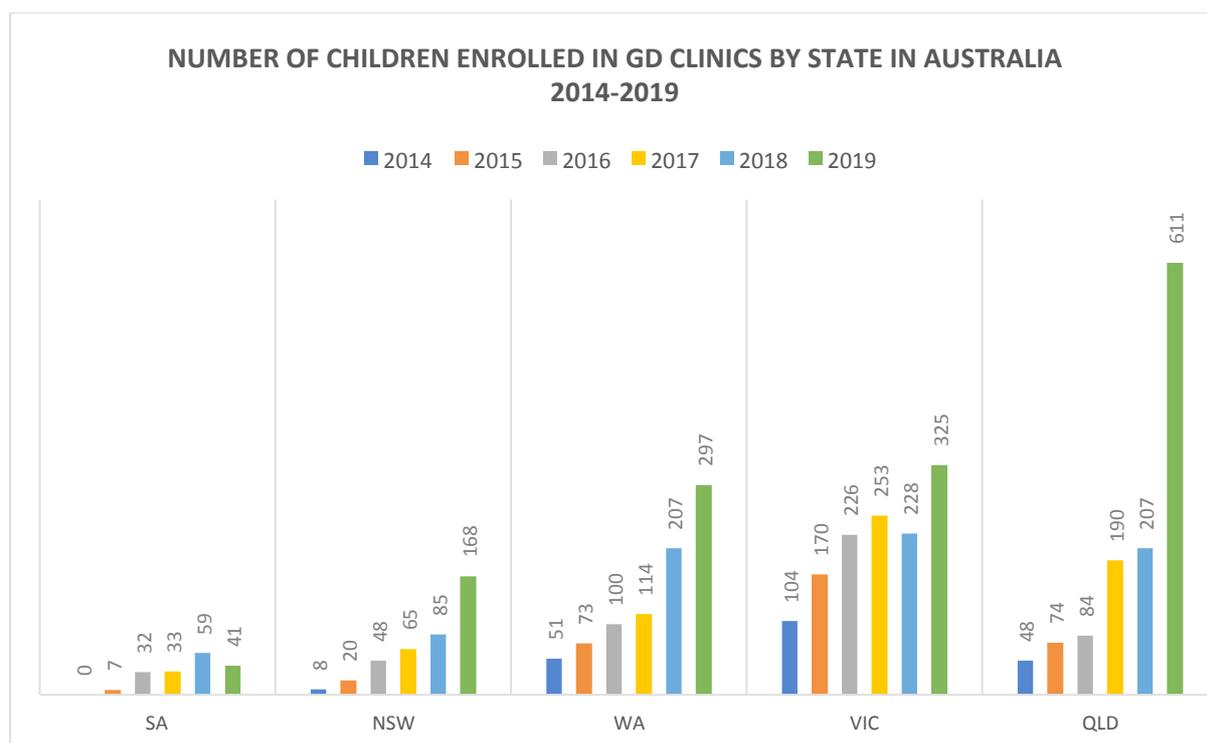


Figure 3. Source: Kenny, D.T. (2020).

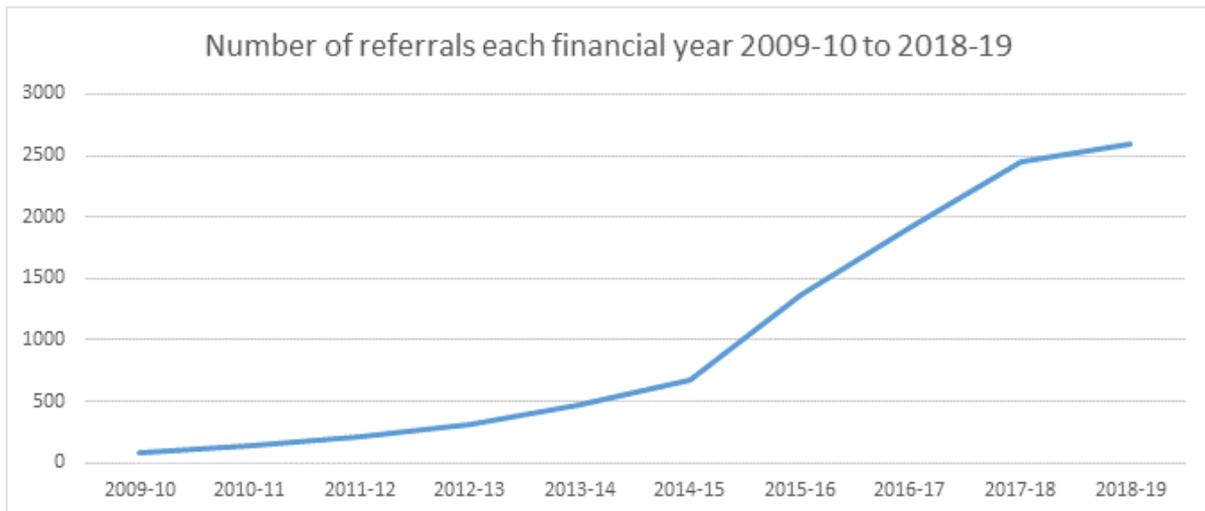


Figure 3. Number of referrals to Tavistock GIDS 2009-2019

The Genderbread Person v4 *by its pronounced METROsexual com*

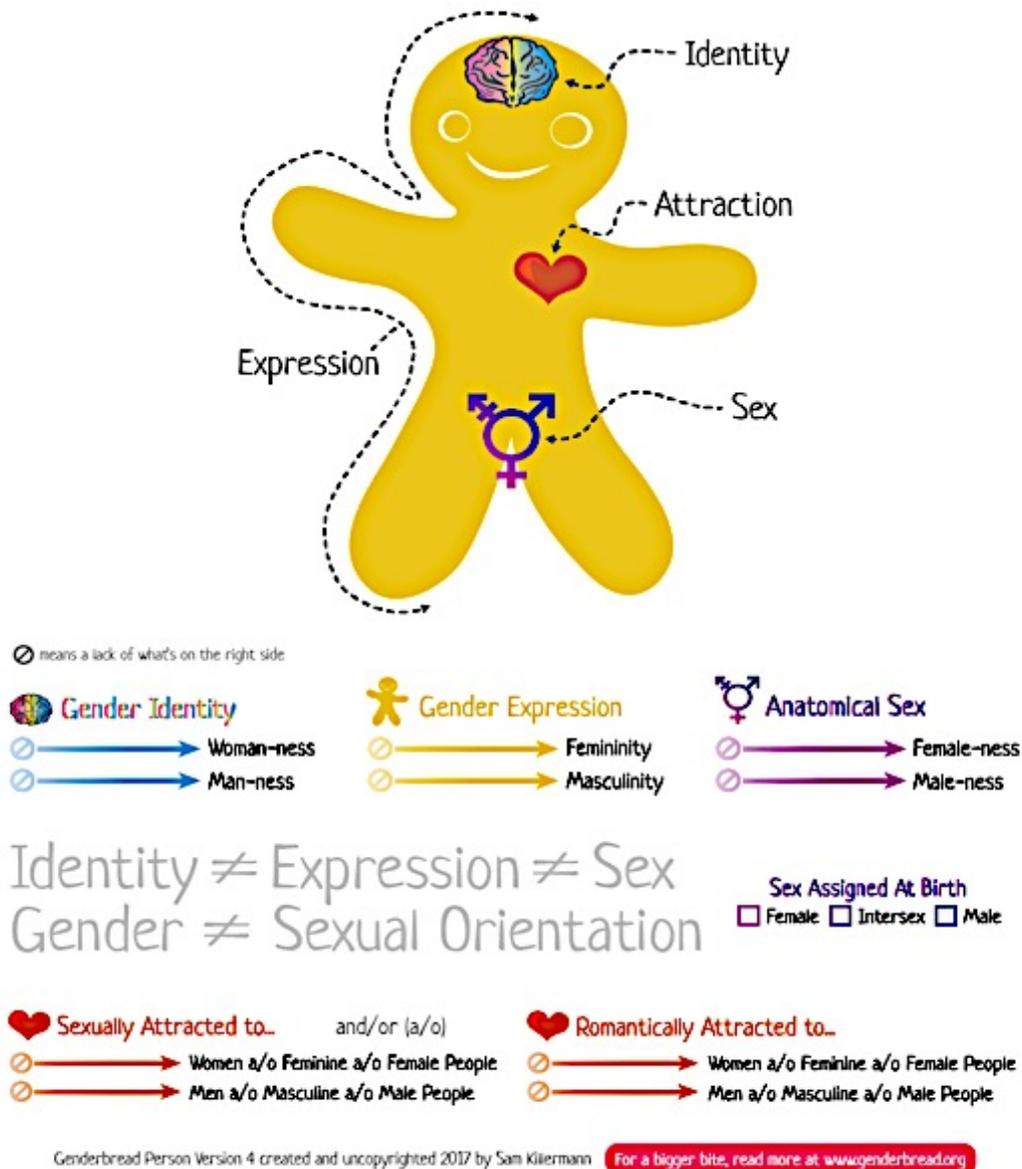


Figure 5. Genderbread person, Source: <https://www.genderbread.org/resource/genderbread-person-v4-0>

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources

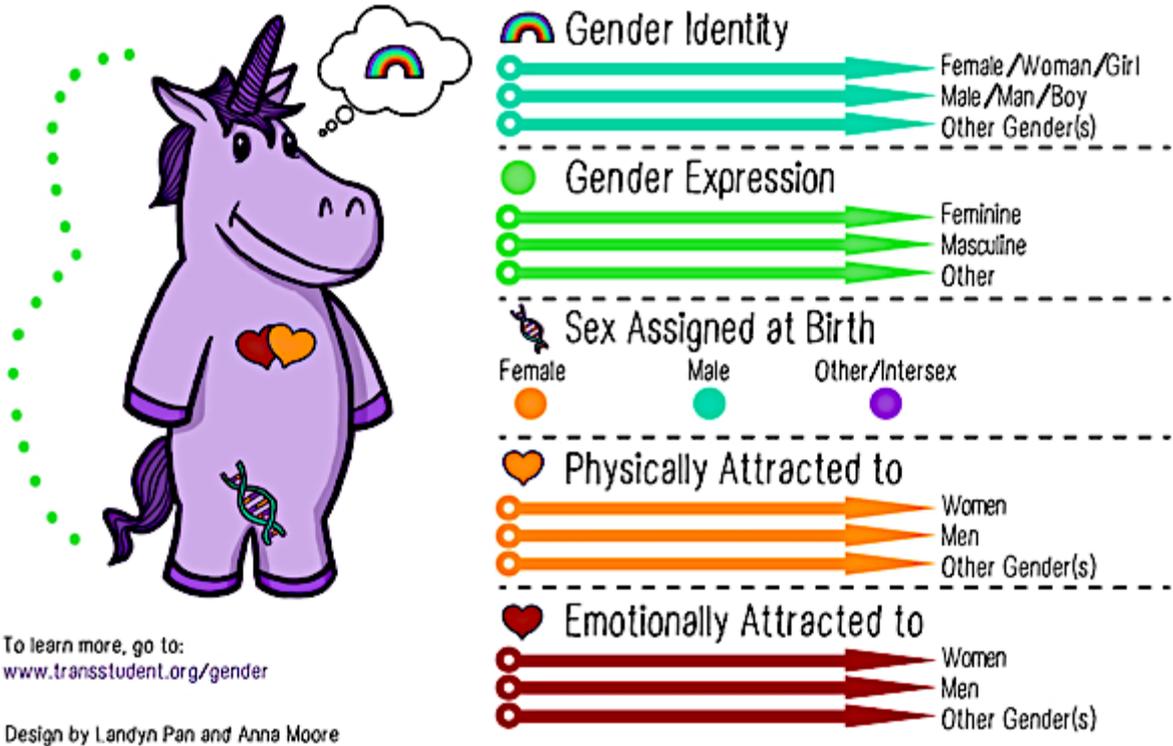


Figure 6. The Gender Unicorn