From: Sandra Pertot
To: TGD Submissions
Subject: TGD rights
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I am a recently retired clinical psychologist. For 50 years I worked in the area of sexuality, sexual orientation and gender questioning clients, in addition to a more general clinical caseload.

In the second half of last century, gender questioning clients were few and far between, and all were males who were seeking or had had hormone therapy and sex reassignment surgery to feminise their body; they had to meet strict criteria to be eligible for this treatment. Their main concern was to pass as a woman and to live an ordinary life in peace. None believed that they changed sex, only that they preferred to live as women. This position is common among the older group of transwomen and many of the younger trans clients I worked with in more recent years.

About 10 years ago, working in a rural area, I began to see adolescent females who stated they had gender dysphoria and want to be a boy. I took my usual approach of conducting an assessment to determine whether they met the criteria of persistent and consistent gender dysphoria. Some appeared to, but some didn't, and therefore I did not "affirm" the latter group but worked with them, typically with their parent's involvement, to address other presenting issues. None of these clients threatened suicide.

In 2019 I saw two females who caused me some considerable concern. They were both 18, both had only recently decided they were trans, both had "discovered" they were trans by on-line forums, both had mental health issues, depression, anxiety, social isolation. Because I did not take the view that these two met the criteria for gender dysphoria, I consulted some colleagues who worked in the area. One psychiatrist assured me that if they said they were trans, they were, and another group of colleagues told me I was transphobic for even considering not affirming them.

My concerns led me to participating in a podcast for the Clinical College of the Australian Psychological Society (APS), in which I discussed my view that there needed to be research to develop a differential diagnosis for gender-questioning clients in order to make a safe diagnosis as to who might benefit from gender affirming care, and who might not. This led to a complaint to the APS, stating I was transphobic, the podcast needed to be taken down, I needed to be re-educated as, indeed, did the APS Board.

Fortunately the Board took the view that clinical opinions often differ, and I had the right to my clinical position. To my knowledge the APS was the first professional body in the world that did not yield to the demands of the trans group.

This complaint led me to research what was happening in the wider world in the clinical approach to gender-questioning clients, and I was alarmed at what I discovered: denial of the role of social influence on young people, denial of biological reality that sex is binary and a person's sex cannot change, and the

demand that a gender-questioning client's statement they are trans must be accepted regardless of other presenting mental health problems.

I also had some older clients, a few males wanting to transition to live as a woman. Given their age and their history I was more confident to support their desire to pursue medical and surgical treatment.

There is evidence that support for the trans community is dropping, and in my view there are two reasons for this:

1. The current management of gender-questioning young people with (GAC), which typically leads to affirmation of the young person despite absence of long term persistent gender dysphoria and the presence of co-morbid mental health problems. The decision to ignore the mental health problems is based on the unproven theory that these problems are the result of their stated gender dysphoria, not the cause of it. There is also the unethical practice of pressuring parents to agree to gender-affirming care by telling them their child will suicide if they don't.

   In addition, there is increasing disquiet about school policies which allow a student to socially transition at school without the parent's knowledge or consent. As the general community learns about the continuing increase in young people regretting their transition and the associated lawsuits, this disquiet will grow.

2. I have always felt it was appropriate to refer to transwomen as women and to use feminine pronouns. Then I learnt about self ID and how easy it is now for a man to claim to be a woman, and, in the absence of any medical or surgical treatment, demand access to female spaces such as change rooms, associations, work roles and so on. This is supported by the new policy of self-identification (self ID), which is now law in many Australian states, and is up for consideration in NSW.

   Decisions such as the recent Australian Human Rights position that a person with a penis is a lesbian if he says he is just one of many that is causing significant disquiet in the general community. Reports of male sex offenders being housed in female prisons because after conviction they suddenly "discover" they are a woman is another example that is causing significant doubt, even ridicule, in the general community. Further, if an exhibitionist, voyeur or paedophile identifies as a woman, it seems that gives him the legal right to undress in female change rooms or watch females of any age undress. Essentially, under self ID, voyeurism and exhibitionism is essentially made legal.

   Discussing these issues is sometimes seen as accusing transwomen of being sex offenders, but the reverse is the case. I know from my clinical experience that men with a paraphilia and sex offenders will use any opportunity they can to get access to victims, and self ID is a gift to them. This benefits offending males but can only harm the trans community.

A key argument put forward by trans activists to underpin these laws is that the concept of biological sex is a meaningless social construct, and there is no reliable way to distinguish a female from a male. Consequently, if a male says he is a woman, he is, even if he retains male genitals.

The theory challenging the biological reality of sex is easily disputed.

The first question I ask these biology denying people is, “How are babies made? How would you teach kids about this without referring to biological sex?” It seems to bother some people to acknowledge that sex in all species is about reproduction. In humans, every person on earth, including trans people, exists because sex is binary: a female egg was fertilised by male sperm. The long-accepted definitions of the partners in this activity are:

The male sex is the phenotype (or structure) that produces the smaller gametes (sperm), and the female sex is the phenotype (or structure) that produces the larger gametes (eggs).

Trans activists respond with: *what about a person who isn’t fertile: how can they be one of these sexes?*

This type of argument trivialises the complexity of biology in general, and sex in particular. Applying this reasoning to the definition of a human, that is, *a bipedal primate mammal,* a person born without two limbs cannot be regarded as human.

The next argument is to use the existence of people with disorders of sexual development (DSDs) to suggest there are more than two sexes: amongst these rare disorders in males and females, some infants have ambiguous genitalia. However, sex is about reproduction, not about outcomes which include disorders across many human characteristics: every person with a disorder of any kind exists because sex is binary.

The final argument to deny that sex is binary is to claim that sex is a spectrum, again falsely relying on the existence of people with DSDs. While some sex characteristics such as hormone levels, height, strength etc may overlap, leading to a bimodal distribution of “femaleness” and “maleness”, sex itself cannot possibly be a spectrum. A spectrum is something that changes subtlety from one point to the next, like height or weight, and DSDs don’t demonstrate that.

I am in a difficult position in this cultural conflict. Recently a previous client, a transman who did much research and took his time before embarking on medical and surgical transition, saw me in a service station and with a big grin on his face, told me his wife is pregnant. There is a transwoman who transitioned years ago who lives in our community, just getting on with her life. I will always respect these people and use their preferred pronouns, which upsets some gender critical associates.

However I cannot support what in my view are the dangerous health practises of the current GAC model or the trend for self ID where any man can demand access to female spaces, associations, work roles, sports and so on. The view that a transwoman is a woman is new, older transsexuals and many younger transwomen know this, but now stating that a woman is an adult human female is, apparently, transphobic, and puts me at odds with the transgender community.

In my view, the biggest threats to TGD human rights are gender affirming care as it is currently practised, and self ID which undermines the rights and safety of females. After years of “no debate” and silencing anyone who dissents, the general community are realising that supporting “trans rights” is very different to supporting gay rights, despite attempts to link the two.

Given the brief timeframe for this submission, I have not included references but can supply them on request.

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