Recommendations from Genspect in response to Call for inputs on rights of the child and inclusive social protection to inform the High Commissioner's report on the rights of the child and inclusive social protection to be presented at the 54th session of the Human Rights Council in September 2023.

April 26, 2023

A number of leading liberal and medically advanced countries have conducted systemic reviews of available medical interventions for the treatment of gender dysphoria in children,[1] and have found that the medical interventions are not supported by high quality evidence of effectiveness, with unknown and known harmful and irreversible effects. In the United States, however, it is widespread practice to rush children into the medical process.

1. Genspect is a nonprofit nonpartisan organization organized under the laws of the Republic of Ireland. It is an international alliance of professionals, parent groups, trans people, detransitioners, and others who seek high quality care for gender distressed people.
2. The definition of transgender has expanded from a narrower definition derived from the description o gender dysphoria in the DSM to an all encompassing undifferentiated definition that includes anyone who does not conform to extreme and regressive stereotypes culturally associated with their sex.
3. The stereotypes taught in some schools describe boys as cruel and girls as submissive. The teaching of these regressive stereotypes coupled with labeling of their rejection as transgender can be confusing to children and can lead to inappropriate internalization and peer bullying. We have knowledge of a case where a 12 year old girl in middle school was bullied by her peers to identify as a boy solely on the basis that she plays jiujitsu and likes the color brown. To escape this pressure, the girl eventually asked her parents to home school her, and they agreed. Nonetheless, she felt so distressed by her experience in school that she attempted suicide a short while later. Currently, she is attending a school that does not have a curriculum similar to her previous school and is in good health.[2] Other similar reports also have been received.
4. Lessons that promote stereotypes as the foundation of identity are not factual, neutral, and pluralistic.[3] These teachings violate the US obligation to combat sex stereotyping in education. Teaching of stereotypes and the ever expanding definition of transgender are derived from post-modern

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[1] The terms child and children used in this letter refer to any person under the age of 18.

[2] Her parents, together with other parents with similar experience, are in the process of preparing a lawsuit against the first middle school, therefore we are unable to disclose identifying information at this time.

[3] *Kjeldsen v. Denmark*, 23 Eur. Ct. H.R. 22, § 53 (1976). Education that is not factual, neutral and pluralistic constitutes indoctrination.

philosophy. Children do not possess the critical skills to engage with abstract subjects, and have the right to be free of ideological indoctrination, and to enjoy their right to free development of their personality.[4] More appropriate methods exist for the important teachings of tolerance, nondiscrimination, and equality.

5. These lessons also attempt to undermine the child's right to parental protection in three ways: (i) the parents are not informed of these lessons; (ii) if parents learn about these lessons, they are not afforded the possibility of opting out; and (iii) children are told by teachers that they should not discuss gender lessons with their parents because their parents are not safe. Such general statements can drive a wedge between children and parents, cause confusion and distrust, and lead to significant psychological distress. Adversely influencing children's judgement in communicating with their parents is an attempt to undermine children's right to parental protection.
6. If a child identifies as transgender, the child is affirmed by teachers without informing parents. Affirmation is a medical intervention with iatrogenic effect, and it is not a neutral act.[5] Some schools also provide information to facilitate the child's access to puberty blockers and hormones. In some states, parents are denied access to their child's medical records. This approach not only violates the child's right to parental protection, it also violates the child's right to health.
7. Approximately 80% of children with GD desist from their confusion if they are treated with "watchful waiting."[6] A study by the University of Toronto found that 63.6% of boys with early onset dysphoria, who were treated with "watchful waiting" and no social transition, grew up to be gay or bisexual. Only 12% of the participant persisted.[7] But, they are less likely to desist if they go through social transition. It has been observed that social transition itself contributes to the persistence of dysphoria in children.[8]
8. The automatic affirmation approach does not explore co-existing mental health conditions and the role of peer influence. It relies heavily on self-diagnosis by a child who has likely gathered information from unreliable sources such as peers and social media.

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[4] *Lautsi v. Italy*, no. 30814/06, § 48, ECHR 2009. Children's capacity for critical thinking is a significant factor in determining whether education is indoctrinating.

[5] Kenneth J. Zucker, *Debate: Different Strokes for Different Folks,* 25:1 Child and Adolescent Mental Health 36-37 (2019). https://doi.org/10.1111/camh.12330 The Cass Review, Independent Review of Gender Identity Services for Children and Young People (Feb. 2022). https://cass.independent-review.uk/wp-content/uploads/2022/03/Cass-Review-Interim-Report-Final-Web-Accessible.pdf

[6] Riittakerttu Kaltiala-Heino, Hannah Bergman, Marja Työläjärvi, et. al., *Gender Dysphoria in Adolescence: Current Perspectives*, 9 Adolesc Health Med Ther 31–41 (2018). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5841333/

[7] Devita Singh, Susan J. Bradley & Kenneth J. Zucker, *A Follow-Up Study of Boys With Gender Identity Disorder*. Frontiers in Psychology (29 Mar. 2021). https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full

[8] Annelou L. C. de Vries & Peggy T. Cohen-Kettenis, *Clinical Management of Gender Dysphoria in Children and Adolescents: The Dutch Approach*, 59:3 J. Homosex. 301–320 (2012). https://pubmed.ncbi.nlm.nih.gov/22455322/ Zucker, *supra* note 5.

9. Much is unknown about the balance of harm and benefit of the medical interventions carried out in "gender affirming care", and there is significant disagreement within the medical profession about the best course of treatment for adolescents. Evidence does not support the position that medical and surgical interventions have resulted mental health improvements.[9]
10. Systemic reviews of evidence in a number of European countries failed to find material benefits and revealed significant health risks.[10] Consequently, Finland, Sweden, England, and Norway offer psychotherapy as the first and only available treatment for gender dysphoria in children.
11. The affirmation only approach rests upon a number of unproven and disproven assumptions such as the belief that children's identity is fixed at a very young age; that "gender identity" is rooted in biology; and that psychotherapy is harmful.[11] It further assumes that children have the capacity to comprehend the complex impact of these irreversible interventions.
12. It should not be assumed that parents have the capacity to fully comprehend the irreversible consequences of affirming medical interventions. Applying the criteria of consent comprising of understand, appreciate, communicate, and reason, a recent study found that "most adolescents, both continuers and discontinuers, and parents felt they did not have a full understanding and appreciation of all consequences, [nevertheless] they thought that they were able to make the decision to start [puberty blockers]. Parents' support of their child was considered essential in the decision-making process. However, several parents and clinicians wondered to what extent they themselves, and adults in general, are able to understand and appreciate certain consequences, let alone adolescents."[12]

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[9] Levine, S.B., Abbruzzese, E., *Current Concerns About Gender-Affirming Therapy in Adolescents. Curr Sex Health Rep* (2023). https://doi.org/10.1007/s11930-023-00358-x

[10] National Institute for Health and Care Excellence (NICE). Evi- dence review: gonadotrophin releasing hormone analogues for children and adolescents with gender dysphoria. 2020 https:// cass.independent-review.uk/nice-evidence-reviews/
National Institute for Health and Care Excellence (NICE). Evi- dence review: gender-affirming hormones for children and ado- lescents with gender dysphoria. 2020. https://cass.independent- review.uk/nice-evidence-reviews/

SBU [Swedish Agency for Health Technology Assessment and Assessment of Social Services]. Hormonbehandling Vid Köns- dysfori - Barn Och Unga En Systematisk Översikt Och Utvär- dering Av Medicinska Aspekter [Hormone Therapy at Gender Dysphoria - Children and Young People A Systematic Review and Evaluation of Medical Aspects].; 2022. https://www.sbu.se/ contentassets/ea4e698fa0c4449aaae964c5197cf940/hormonbeha ndling-vid-konsdysfori_barn-och-unga.pdf

Pasternack I, Söderström I, Saijonkari M, Mäkelä M. Lääke- tieteelliset menetelmät sukupuolivariaatioihin liittyvän dysfo- rian hoidossa. Systemaattinen katsaus. [Medical approached to treatment of dysphoria related to gender variations. A sys- tematic review.]. Published online 2019:106. Accessed March 1, 2021. https://app.box.com/s/y9u791np8v9gsunwgpr2kqn8s wd9vdtx

Pasientsikkerhet for barn og unge med kjønnsinkongruens [Patient safety for children and young people with gender incongruence], 09 March 2023.
https://ukom.no/rapporter/pasientsikkerhet-for-barn-og-unge-med-kjonnsinkongruens/sammendrag

[11] Levine, *supra* note 6.

[12] Lieke J.J.J. Vrouenraets, Annelou L.C. de Vries, Marijn Arnoldussen, et al. *Medical Decision-Making Competence Regarding Puberty Suppression: Perceptions of Transgender Adolescents, Their Parents and Clinicians.* Eur Child Adolesc Psychiatry (2022). https://doi.org/10.1007/s00787-022-02076-6

13. Gender physicians rely on children's subjective preferences and self-diagnosis as the basis for medical decision making. This attitude directly conflicts with the essential requirement of free and informed consent, which imposes upon the physician the ethical responsibility and legal obligation to ensure that the patient is fully informed of the risks of treatment and the availability of alternative treatments, and has the capacity to consent. The law of consent does not allow for the shifting of the responsibility to obtain informed consent from physician to patient by hollowing out the meaning of patient autonomy and turning it into a mindless consumer choice.
14. Gender affirming care has many serious, harmful and irreversible consequences, such as infertility, sexual dysfunction, and adverse effect on bone development as well as cognitive development. Children lack the emotional maturity, intellectual capacity, life experience, and temporal perspective necessary to understand and critically examine these consequences. Neuroscience has established that "adolescents have difficulty with emotion regulation and impulse inhibition, as well as appearing to be inordinately susceptible to peer pressure and social rejection."[13] Dr. Jay Giedd, a neuroscientist at the National Institute of Mental Health who led a study of adolescent brain development, has stated: "At different ages of life certain parts of the brain have much more dynamic growth than at other times. And so for very early in life we have our five senses where our visual system and audio system is getting established and optimized for the world around us. In adolescents, the key changes are in the frontal part of the brain involved in controlling our impulses, long range planning, judgment, decision making.... The most surprising thing has been how much the teen brain is changing. By age six, the brain is already 95 percent of its adult size. But the gray matter, or thinking part of the brain, continues to thicken throughout childhood ... this process of thickening of the gray matter peaks at about age 11 in girls and age 12 in boys, roughly about the same time as puberty....But another part of the brain -- the cerebellum, in the back of the brain -- is not very genetically controlled....is very susceptible to the environment. And interestingly, it's a part of the brain that changes most during the teen years. This part of the brain has not finished growing well into the early 20s, even.[14]
15. The foregoing information supports the position that the inclusive protection of children needs to encompasses respect for a number of rights for all children without regard to any type of classification.

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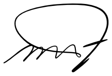
[13] Gina Rippon, *The Gendered Brain*, 348 (2019).

[14] Interview: Dr. Jay Giedd, *Inside the Teenage Brain*, PBS (2014) http://www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html

16. We respectfully request consideration of the following inquiries regarding children's rights to:
    - **parental protection in education and healthcare;**
    - **factual, neutral, and pluralistic education;**
    - **free development of personality;**
    - **be free of stereotyping;**
    - **healthcare that is evidence based; and**
    - **healthcare that considers their vulnerabilities and limited capacity for complex decision making.**

Sincerely,



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