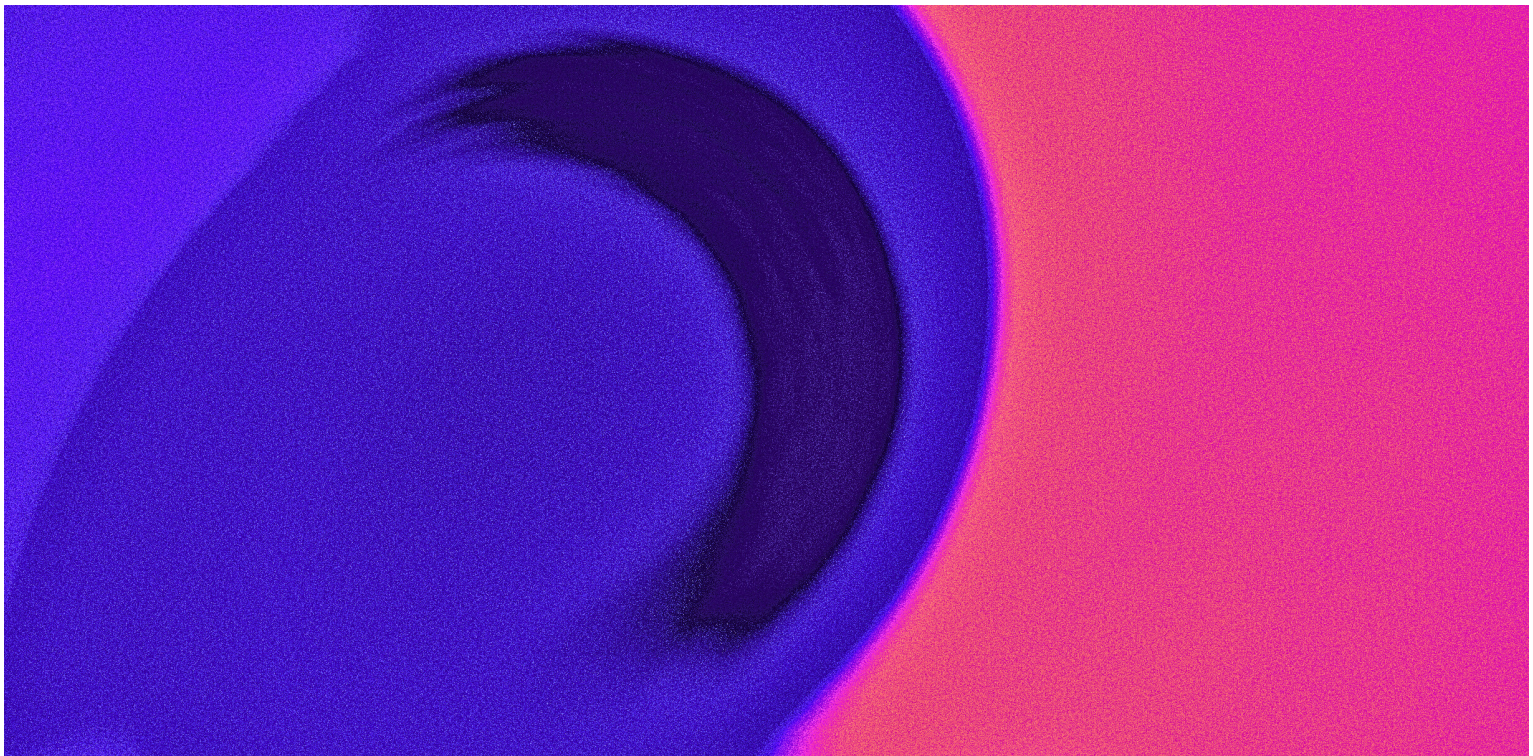

Trans Talking Points

**AN EVIDENCE-BASED EXPLORATION OF SIX
PREVALENT ISSUES THAT IMPACT THE HUMAN
RIGHTS OF TRANSGENDER, GENDER-DIVERSE
AND NON-BINARY PEOPLE**



Acknowledge of Country

Transgender Victoria works and organises on land belonging to the Wurundjeri, Boonwurrung, Taungurong, Dja Dja Wurrung, and Wathaurung peoples of the Kulin Nation. Transgender Victoria pays its respects to Elders past and present, and acknowledges that sovereignty has never been ceded.

We acknowledge the custodianship of this land's people and the privilege and responsibility to Connect with Country. We acknowledge and honour the unbroken spiritual, cultural and political connection Aboriginal and Torres Strait Islander peoples have had to this unique place for more than 2000 generations and the continuation of cultural, spiritual and educational practices of First Nation communities.

We would also like to highlight that many of our resources draw largely on colonial language, and this may not reflect the way that Aboriginal and Torres Strait Islander peoples describe their gender identity and sexuality across 250+ language groups.

First Nations culture has always recognised and involved much more diverse presentations of gender identity that cannot be encapsulated within the social concept of a binary system of gender that has been dictated by Western societies and enforced by colonisation. It is important to respect and acknowledge diverse representations and descriptions of gender identity, especially from our First Nations, BIPOC communities around the world.

Content Warning

This document includes reference to ideas and messaging that may be triggering or hurtful to transgender, gender diverse and non-binary people. A list of affirming trans-led support services are included on the final page.

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Overview

Context

This report examines common arguments about trans issues, the evidence relating to these arguments, and some sources that are often cited to support these arguments. As there are more and more discussions about trans issues in politics and the media, this resource provides easy-to-understand, clear, and well-researched information for people involved in these discussions.

Transgender Victoria (TGV) acknowledges that many advocates for transgender human rights avoid talking about myths and stereotypes, because these myths and stereotypes can be distressing or and harmful to transgender, gender diverse and non-binary people. However, we also recognise the reality of political debate at this time. Those wishing to be confident and effective in advocating for transgender human rights need to understand the arguments and evidence used to argue against transgender people's rights, so they can effectively address them. For this reason we present and explore them here with a view to empowering informed debate. As such, **this report has a content warning for transphobia**. Trans and gender diverse people who do not wish to be unnecessarily exposed further to these arguments may wish to forward this resource to colleagues and allies to use.

For those who do find reading this resource raises difficulties, please refer to the addendum for transgender, gender diverse and non-binary and other LGBTQIA+ support services.

The report was prepared by Dr Gene Lim and Aoife Dermody of the Australian Research Centre in Sex, Health and Society, with support from En Wong, Dr Natalie Amos, Dr Ruby Grant and Professor Adam Bourne. Additional guidance and contextual information was provided by Transgender Victoria.

Content

Each section is presented with an overview of the argument, a presentation of evidence relevant to the issue. Sections exploring specific papers or reports describe the claims the research or report is often used to support, explores if such claims are substantiated, and summarises other evidence or interpretations.

Caveats and limitations

In order to ensure the arguments and the supporting evidence behind them are understood by the reader, this document includes reference to ideas and messaging that may be triggering or hurtful to transgender, gender diverse and non-binary people. To mitigate this, each section is entitled with a

non-discriminatory framing with the arguments and their sources explored in the body of each sub-section, and concludes with a reframe of the issue.

This research is a high-level exploration of common arguments used in current debates regarding trans people's rights. It is not a comprehensive survey of all supporting evidence, nor all talking points against trans rights.

This briefing paper focuses upon recent academic peer reviewed literature published in English, which cannot capture a diversity of gender identities in colonised cultures across history. In Australia we acknowledge histories of gender diversity in First Nations cultures, including Sistergirls, Brotherboys and non-binary Aboriginal peoples. The impacts of multiple intersecting forms of discrimination and stigma is poorly documented in academic research pertinent to the included 'Talking Points' in this report and we call for greater commitment and resourcing of community led research that canvases intersectional complexities.

1 Questioning Trans Identities

1.1 Claim

An argument is made or implied that transgender, gender diverse and non-binary identities are a social invention and that indulging people's desire to transition is harmful. These ideas tend to reference a need to protect people, in particular children, from 'harmful, unscientific' ideologies, and undermine human agency and bodily autonomy. This intersection of implied frivolity and protecting children and vulnerable people appears frequently in popular media discussions, political discourse and other public fora. This argument is not commonly supported with evidence, but rather stated as an accepted fact.

1.2 What does the research say?

Children's well-being is not harmed from learning about trans and gender diverse identities:

Where the priority issue of concern is protecting children's well-being, it is helpful to examine research on the impact of trans-inclusive environments or education for children (e.g. environments where trans and gender diverse identities are included and acknowledged). There is no evidence that teaching children about gender diversity is harmful to any children.

Trans and gender-diverse children do better in environments where their identities are discussed and affirmed: Research also demonstrates that many parents in Australia are supportive of relationship and sexuality education which includes discussions about gender diversity (1,2). Meanwhile un-affirming and heteronormative educational environments are linked to experiences of discrimination and prejudice^{vi}, and increase negative health outcomes for trans populations. Evidence shows that when trans adults (3) and young people feel included and affirmed, they have improved social and health outcomes (4,5).

Transgender, non-binary and gender-diverse identities are normal, valid and recognised:

Contrary to claims about these identities being recent, being invented or not accepted as normal, there is an abundance of evidence that transgender, gender diverse and non-binary identities are valid, recognised and a normal human experience:

- There is ample evidence across time and cultures that the existence of more than two genders (6–10)
- There is ample evidence that for many people, their felt sense of gender is distinct from their biological functions (11,12)
- Professional psychological (13–16), psychiatric (17–20) and medical (21–23) bodies recognise trans identities as valid.

- Being transgender, gender diverse or non-binary is simply a normal human variation, for example, neural imaging research shows that some trans individuals differ in brain structures from their cisgender peers (24,25). Evidence also shows that these differences are often present in trans people even *before* hormonal intervention (26).

Including trans and gender diverse identities in relevant education is in line with evidence and good standards in education: Denying children access to age-appropriate, accurate and up-to-date information about diverse genders, in line with up-to-date evidence and accepted clinical definitions, is contrary to commitments to educational in Australia and Victoria. Australian curriculum frameworks explicitly require that teaching content be grounded in current scientific research and disciplinary knowledge. This mandate applies not only to pedagogy but also to the accuracy and inclusivity of what is taught, including in relation to gender and sexuality (27,28).

2 Trans People and Bathrooms

There is a discourse that states that if women's bathrooms include trans women, that cisgender women will be in danger of physical and sexual harms from trans women or men pretending to be trans women. This argument is frequently supported by unverified anecdotal evidence or appeals to 'common sense' (29) that imply, sometimes explicitly and sometimes subtly, that trans people enter such spaces with predatory intentions towards cisgender women (30). This is underpinned by the false notion that transgender women (as well as other gender diverse and non-binary people) are 'men' trying to have easy access to women's spaces.

2.1 What does the research say?

This claim lacks evidence. There is evidence to support contrary claims; that there is general support for trans-inclusive bathrooms, that there is no increased harm to cisgender women in inclusive bathrooms and other such spaces, and that there is increased risk of violence to trans people by cisgender women in these gender-segregated spaces:

On violence and harm:

There is an absence of empirical evidence for increased violence: a 2018 study in the United States gathered empirical evidence to examine the link between trans-inclusive bathroom policies and public records of criminal incident reports relating to assault, sex crimes and voyeurism found no link between these factors (31).

There is evidence that trans people, rather than cisgender women are at increased risk of violence in gender-inclusive facilities: available evidence also suggests that the idea that women's

safety is jeopardised when trans individuals are allowed into such spaces is not only untrue, but in fact it is trans individuals who are less safe in inclusive bathrooms. Empirical evidence suggests that it is far more common for trans people to be attacked by cisgender women within these spaces. This is true for bathrooms (32,33), women's shelters (34), and homelessness services.

There is evidence that cisgender women are harmed by anti-trans vigilantism, rather than protected by it: Fixation on policing trans people's access to public toilets (including policing people *perceived to be trans*) subjects women in general (including majority cis women) to an increased regulatory social and cultural environment in general, making women *less safe* (35). There is anecdotal evidence of individual instances of vigilantism which have wrongly targeted cisgender women in bathrooms or other gendered spaces on suspicion of being trans (36–41). Many of these reported attacks have targeted cisgender lesbian women who are 'butch', or who aren't stereotypically feminine.

There is evidence that those who are against trans-inclusive bathrooms are driven by prejudice against trans people: recent empirical evidence suggests that while opponents of inclusive bathrooms often claim to be motivated by concerns about women's safety, their views on the matter could not be predicted by concerns about such violence (42). Instead, opposition was strongly predicted by prejudicial attitudes towards trans people (43).

Public hostility is compromising trans people's dignity: Research has argued that legislation and public discourse about trans people in bathrooms emboldens and enables discrimination against trans people in public spaces generally, and functions to erase transgender, gender diverse and non-binary people from public life (43). Like other communities at the centre of public hostility or moral panics before them, trans people's access to basic dignity is being compromised by unevicenced claims, most recently with similar claims/panics relating to same-sex attracted individuals in bathrooms (44–46).

The impact of anti-inclusive rhetoric in relation to bathrooms

Trans people avoid bathrooms in fear of their safety and suffer health difficulties as a result:

Research shows that many transgender, gender diverse and non-binary people regularly avoid using bathrooms, avoid eating and drinking so they don't have to use a bathroom, with almost one in ten trans people having experienced urinary tract infections or kidney-related difficulties due to bathroom avoidance (47).

Reduced access to bathrooms compromises trans people's access to their human rights:

Access to bathroom facilities is recognised as a basic human right, and a key determinant of health

(48) and proponents of sanitation justice have detailed the detrimental effects of lack of bathroom access on the health of trans people and other communities who experience reduced access to public bathroom facilities (49).

The evidence tells us we have a different problem to solve:

Evidence shows the key challenge to solve is how trans and gender diverse people can have their right to feel safe in facilities: The absence of evidence supporting claims of harm and violence to cisgender women posed by inclusive bathroom policies or facilities, and indeed ample evidence to the contrary, highlights the importance of focussing on the real challenge to be solved – how can transgender, gender diverse and non-binary people feel safe and have their human right to sanitation facilities realised? How can providers create inclusive spaces, including traditionally gender-segregated spaces, that meet the needs of a more diverse range of individuals to promote dignity for all? This is a journey many organisations are currently engaging in, seeking to create safety and promote the personal dignity of transgender, gender diverse and non-binary people in their care.

There is evidence that trans-inclusive bathrooms are supported: large-scale studies show that most people are in favour of inclusive bathroom policies (50). While similar research has yet to be undertaken within Australia, recent scholarship with a smaller group of educators and school administrators showed robust support for such policies (51).

There is evidence that trans-inclusive facilities are interpreted by other minoritised communities as a sign of an organisation/community's overall inclusiveness: Such efforts have benefits beyond those for trans individuals; organisations with inclusive bathrooms are perceived to be safer by other minorities (52).

3 Inclusion of Trans people in Women's sport

3.1 Claim

Arguments are made that trans women should not be included in women's sport because they have an unfair advantage. This rests on several assumptions:

- That natural androgen levels before hormonal intervention give trans women higher lean muscle mass and superior athletic performance than cisgender women.
- That cisgender men will pretend to be trans women to dominate in women's competitions.

- That trans inclusion in sex-segregated sports could lead to safety issues in women-only spaces like changing rooms (addressed in another section).

3.2 What does the research say?

Arguments rely on unsubstantiated beliefs about the role of gender, sex and hormones:

The role of androgens in performance in trans women post-transition is unclear: higher circulating androgens in cisgender women athletes are associated with increased muscle mass and red blood cell production (53). This is often used to argue that trans women, having gone through male puberty, retain permanent advantages. However, it remains **unclear** whether such traits endure after hormone replacement therapy and how they affect performance in practice (54). This includes changes to skeletal structure, bone architecture, maximum aerobic capacity and myonuclear density.

Cisgender women athletes vary significantly, physiologically: Cisgender female athletes are different from their non-athlete counterparts in terms of their endocrine profiles, and existing research suggests that conditions or variations associated with hyperandrogenism are up to 140 times more prevalent among athletes than non-athletes (53). These conditions and variations are highly diverse and include relatively common conditions like polycystic ovary syndrome (PCOS), and variations which can broadly be termed ‘Differences of Sex Development’ (DSD), which occur even among individuals with common chromosomal phenotypes (e.g., XX and XY) (55). These variations are accepted by sporting bodies, even though they produce significant physiological differences.

Testosterone levels do not predict performance in a straightforward way: Associations between serum androgen levels (such as testosterone) and athletic performance are straightforward (56). For example, a 2022 study showed that elite female endurance athletes had *lower* androgenic and progestin levels than *non*-athletes (57). Likewise, existing research demonstrates considerable variability in androgen receptor in/sensitivity in both cisgender men and women alike (58), such that the link between exposure to androgens and performance enhancement in sporting activity can vary greatly. For example, an individual with high levels of endogenous serum testosterone, but who experiences androgen receptor insensitivity will likely be less ‘masculinised’ than an individual with average levels of endogenous serum testosterone production, but whose androgen receptors are particularly sensitive. Consequently, the links between testosterone levels and athletic performance is neither as direct nor unambiguous .

Reactive rules based on hormone levels have racist and sexist implications:

‘Normal’ testosterone levels were established using data from white women, and have been shown to disadvantage Black athletes: concern surrounding the inclusion of trans women in

sports has spurred World Athletics to implement policies that restrict participation in women's sport to athletes whose serum testosterone levels fall within so-called 'normative ranges'. This has had the impact of excluding cisgender women who have high endogenous testosterone levels. Such was the case for two Namibian women, Christine Mboma and Beatrice Masilingi, whose serum testosterone levels were above the normative range and were disqualified from participating in the Tokyo Olympics in 2021(56), and more recently two cisgender women in the 2024 Paris Summer Olympics, Algerian boxer Imane Khelif and Taiwanese boxer Lin Yu-Ting (59). The racialised elements of these rulings are difficult to ignore. Much of this normative data is derived from white western women (60) and implicitly considers bodies that do not fall within this classification as being suspect or 'less' feminine. Further, it should not escape our notice that the 'gender critical' movements which have either directly or indirectly advanced the implementation of this policy are dominated by white women (61–64) who thus far appear unperturbed by the treatment of these athlete women of colour.

The application of this logic results in highly sexist rules implemented in non-physical sports:

The impetus to ensure 'fair' competition by enforcing strict sex-segregation within competitive events has also spread over to non-sporting competitions. Institutions such as the International Chess Federation have banned trans women from participating in women's events, citing how 'masculinised' brains demonstrate superior visuospatial processing ability which persists beyond hormonal gender affirmation to advantage trans women (65). This is despite considerable debate over whether such differences truly exist, and recent evidence which suggests that such differences are the result of researcher or investigator biases (66). Likewise, other competitive authorities have also attempted to prevent trans women from participating in women's e-sporting events (67). While the stated intention of such decisions is to preserve 'fairness' and 'equality' in competitive events, the underlying implication is one which is undeniably misogynistic – e.g., that women are ill-equipped to compete with their male counterparts in events which are predominantly cerebrally-oriented.

The evidence tells us we have a different problem to solve:

Like all people, trans people need access to sports due to the mental and physical health

benefits: Access to sports and community organisations that support them have significant benefits for the mental and physical health of all people (68), and trans people experience significant benefits to their mental and physical health when involved in these programmes (69–71).

Trans people in communities are being disadvantaged by public discourse around their right to

participate in sports: Unfortunately, there is evidence that school sporting environments can often be unsafe for trans students, and that transgender, gender diverse and non-binary pupils may avoid participating in both Physical Education (P.E.) and sports as a result (72–74), despite having a strong desire to participate in these activities (75), denying them the benefits on their physical and mental

health and well-being afforded by such activities. The public debates in relation to professional athletics trickle down into other contexts, such as educational institutions and community sporting organisations (76).

Organisations need support to ensure they can be inclusive and not influenced by spurious and stigmatising public debates: It is crucial to focus efforts on ensuring local groups, schools etc. can include trans individuals. Given the stark disparity in outcomes for trans people, opportunities to promote parity of outcomes in this way are invaluable for governments and communities wishing to ensure trans people can enjoy active, healthy, connected lives like their peers. This is not just in the interest of trans and gender diverse people. Previous points in this report have highlighted the positive benefits of trans inclusion for all, and the negative impacts of anti-trans measures on cisgender women, cisgender women of colour, women who do not conform to gendered stereotypes and women generally.

4 Ease of Access to, and Reversibility of Gender-Affirming Care

4.1 Claim

A common claim is made that affirming medical and surgical treatment is easily obtained, and young people are liable to undertake these procedures without proper oversight. It is also alleged that these procedures are irreversible, causing permanent damage and long-term harm.

4.2 What does the research say?

Puberty blockers

Puberty blockers have been prescribed for decades and have well-evidenced positive effects:

Puberty blockers are not a novel treatment, and have been prescribed for young people experiencing gender dysphoria since the 1990's (77). The positive effects of puberty blockers in terms of mental health and well-being in the 'evidence informed summary' of this section.

Puberty blockers effects are largely considered reversible: There is some evidence that puberty blockers may reduce bone density, decrease bone turnover, and slower growth in treated adolescents (78). However, pubertal suppression is largely considered to be reversible (79). Additionally, the side-effects of pubertal suppression may be offset by masculinising or feminising hormone therapies (80). While some commentators have begun to suggest that usage of puberty blockers can cause irreversible cognitive side effects, there is a lack of clinical evidence demonstrating this to be the case. These assertions appear to stem from findings from animal

studies, and to date there is *no* direct evidence that puberty blockers causes any detrimental impacts to cognitive development in trans and gender diverse youth (81).

There is overwhelming evidence on the benefits of puberty blockers in the context of

gender-affirming care: Recent research has shown that although in general young trans people who have higher levels of suicidality and self-harming behaviours than the general population, those who receive puberty suppression / puberty blockers subsequently achieve comparable mental health to their cisgender peers (82). In other longitudinal research with young people, studies have found that after two years on hormone therapy, the young trans people had significant improvements in their appearance congruence and life satisfaction, and significantly decreased depression and anxiety (83).

Puberty blockers would benefit from additional research to confirm their safety:

Puberty blockers remain under-researched, with an absence of data available from human studies on their negative impacts. Mouse/rat models demonstrate minimal long-term impacts on reproductive health for both female mice treated with a combination of puberty blockers and testosterone therapy (84) and in female rats treated with puberty blockers alone (85).

Transition in adulthood:

Gender affirming care has a range of positive outcomes for those who need it: There is a wealth of evidence that access to gender-affirming care including social affirmation, and surgical and hormonal interventions has been overwhelmingly associated with positive outcomes for transgender, gender diverse and non-binary people (86–93) with analyses demonstrating the correlation between social and medical gender-affirmation being associated with improved mental health and reduced suicidality in trans people (94).

Social transition does not inevitably lead to medical transition: The notion that all forms of gender-affirming interventions will eventually lead to surgical intervention is not supported by research. Affirmation needs and transition desires within trans populations are highly diverse – for example, Australian research found that 72% of trans people expressed a desire to medically (hormonal or surgically) affirm their gender while 28% did not desire medical gender affirmation (95). Recognising this, Australian (96) and international standards of care (97) recognise the need for any medical or surgical treatment to be individualised.

Masculinising and feminising hormones are safe, with most effects reversible in the context of short to medium term use: Clinical evidence suggests that within the context of short- and medium-term use, the effects of feminising hormones are generally reversible once discontinued. As

with long-term use in any medication there is some uncertainty about the reversibility of these effects on adults with long-term use (98). Cessation of hormone therapies can lead to a reversal of changes observed in hair-growth and fat distribution (99) , spermatogenesis (100,101), bone and mineral metabolism (102) and fertility (103,104). Additionally, trans individuals who desire genetically related children have the option of undertaking fertility preservation options (105); and experimental techniques involving the cryopreservation of ovarian and testicular tissue are also being optimised (106).

Gender-affirming surgical (GAS) procedures remain relatively uncommon, and are performed on people usually well into their adulthood: Gender-affirming procedures have indeed increased significantly in recent years (107) , however – at least in data from the US – trans patients comprise an exceedingly small number of the procedures. For example, trans men comprise less than 1% of all the hysterectomies conducted in any given year (108) . Additionally, available evidence suggests that the mean age of trans individuals who undergo these procedures is significantly higher than typically implied by such statements, being 32.0 years in one large study (109), contrary to claims that children are most commonly accessing such procedures.

There are robust procedures for assessing and progressing someone toward surgical interventions: In Australia, AUSPATH (110) guidelines require individualised care, an assessment of psychological and neurodiversity support needs (to evaluate strengths based communication and decision-making processes), and family centred care that encourages family discussions to support treatment decisions. Transgender Victoria notes that, due to the politicisation of trans identities and gender-affirming care, state jurisdictions, hospitals and individual medical practitioners can ignore these research validated and well considered standards of care.

Gender-affirming surgical interventions are by no means easy to access, often involving long waiting lists and high costs: The assumption that gender-affirming care is easy to access is not borne out by research or policy and barriers in terms of cost, access to providers, and family support are documented. In terms of cost; in jurisdictions where GAS is subsidised, individuals pursuing GAS are often required to pay expensive out-of-pocket costs (111,112). In Australia, specifically, these costs are not defrayed by public health insurance (Medicare), and transgender, gender diverse and non-binary individuals are restricted from accessing surgical interventions by prohibitive costs (113). Likewise, the available evidence demonstrates that while hormonal interventions are more accessible, trans young people face significant barriers to timely access – such as cost (114), difficulty accessing gender-affirming health providers (115) and lack of support from parents or guardians (116).

Even some surgical procedures are reversible: The irreversibility of surgical procedures like mastectomy, penectomy, hysterectomy and orchiectomy is often cited as an argument against the provision of such services. The forthcoming section details data on rates of regret, and the diversity of affirmation needs including and beyond surgical intervention. Nonetheless, there are isolated instances within the literature where surgeons have been at least partially successful in the reversal or certain procedures such as vaginoplasty (117) and facial feminisation procedures (117). Similarly, reconstructive procedures are possible for cisgender individuals who have undergone mastectomy (118,119), with significant variability in recovery of bodily function.

The problem the evidence tells us we should solve:

We need wider access to care for a broader range of trans people: It is widely understood both here in Australia, as well as previously documented in other jurisdictions, that the major challenge we face is expanding access to evidence-informed clinical care for trans people, not restricting it (120). The evidence for its benefits are overwhelming, and the current infrastructure we have in place for assessing and providing social, psychological and medical care is robust enough to ensure this is done in line with appropriate evidence and protocols.

5 Prevalence of ‘Detransition’

Claim

Claims have been made that ‘de-transitioning’ (Transgender Victoria prefer the terms - ‘re-identifying with sex assigned at birth’ or ‘retransition’) is prevalent among individuals who undergo gender-affirming treatments, that current clinical protocol to identify individuals for whom surgical and hormonal interventions are most appropriate are overly lax, and, that pursuing gender-affirming care will invariably lead to regret, and a desire to reverse the bodily changes induced by these interventions.

What does the research say?

Rates of regret are low: Prevalence figures relating to regret, desistance or detransition are still emerging. However, existing clinical data demonstrates an exceedingly low rate of regret in trans patients. Recent research in Western Australia showed that reidentification with gender assigned at birth was a reason for case closure in 5% of cases (n=548), of whom only 2 cases had initiated hormonal interventions – these 2 patients comprised only 1% of all people who had initiated hormone treatment (121,122). A meta-review from 2021 reported that rates of regret were <1% for both transmasculine and transfeminine patients within a sample of 7982 participants. Likewise, a

review of existing literature points to single-digit percentages of regret in all reviewed GAS patient cohorts (123).

Rates of regret for gender-affirming surgery are significantly lower than rates of regret for elective surgeries: In contrast, a recent meta-review placed the rate of regret for among cisgender people with elective surgery (including common procedures like breast reconstruction) at 21%, vs 1% for gender affirmation surgeries among transgender people (124). A recent Canadian study (125) highlights the lack of high-quality research on people who have discontinued or reversed a gender transition and offers guidance on better design for future studies and support services.

Those warning against the harms of transition and rates of detransition often cite one unreliable study or author: Discussions of detransition often cite one study (126) conducted by Littman in 2021. This study was a U.S.-based online survey of 100 individuals who had medically and/or surgically transitioned and later detransitioned. Using self-reported data collected via social media and listservs, the study explored reasons for detransition, including re-identifying with birth sex, medical concerns, and mental health factors. This study has garnered critique, including:

- **Participants from anti-trans/detransition spaces:** The sample of 100 individuals were drawn from online forums, social media platforms, blogs and closed online groups which were entirely dedicated to topics relating to de-transitioning. In several instances, the author opted to advertise her study through 'gender critical' blogs and reddit communities (one now banned) which are openly hostile to trans individuals (127). Littman's attempts to recruit participants from other channels (e.g., clinical patient rolls and online communities of transgender, gender diverse and non-binary individuals) appeared to have failed, according to her own admission. Participation in the study was entirely remote, anonymous, and relied entirely on prospective participants to self-determine eligibility.
- **Data collection instruments and discussions used debunked, anti-trans concepts:** Littman used a variety of leading questions in her proprietary instrument. Several of these appeared to reference concepts like 'autogynephilia', as seen in questions such as "I had erotic reasons for wanting to transition" and "I realized that my desire to transition was erotically motivated". Central to this concept is the view of trans identity as a paraphilia, a concept rejected by most scholars and clinicians (129–131). Littman has been a key driver (132) in the largely debunked (133) and heavily critiqued (134) 'rapid onset gender dysphoria' that sought to push the narrative of a contagion effect among young people identifying as trans and gender diverse

- **Findings are not in line with other research:** while statistical prevalence is difficult to determine, studies conducted with clinicians (135,136) and utilising more representative samples (137) suggest that rates of 'detransition regret' are much lower than may be implied by studies like Littman's.
- **Findings neglect to effectively connect detransition to external factors:** Littman's study has been used to conflate the transition regret with 'de-transition', and research conducted with larger sample sizes (in the reference cited, $n=2242$ individuals with a history of detransition) (138) suggest that these are two highly distinct concepts, and do not necessarily overlap. In the larger study, 82.5% of individuals who 'de-transitioned' cited one external factor such as pressure from one's family, and societal discrimination as factors which motivated their decision to desist from gender-affirming care. Littman does concede that the responses of 'de-transitioners' within her sample suggested that most of these respondents reported less than ideal outcomes of the medical and surgical interventions they had undertaken, and their dissatisfaction with these results are likely to have influenced their responses. She also neglects to include other factors like political or ideological shifts – which other similar research has identified as important motivators for 'de-transition'.

A note on who is included: Transgender Victoria notes that the research that canvasses 'detransition' often lumps together people who stop and/or start hormone treatment for a variety of reasons, including identity shifts from binary to non-binary genders, conception and other health-oriented considerations.

6 Autism and Gender-Diversity

Claim

It has been argued that since autistic traits are more prevalent among trans individuals, gender dysphoria and gender incongruence are simply a manifestation of Autism and will resolve with appropriate management of Autism. This can lead to undermining, dismissing or not believing gender-related distress.

What does the research say?

Many autistic people¹ are trans or gender diverse: literature commonly concludes that autism or autistic traits are more common among transgender, gender diverse and non-binary people than cisgender people (139).

Most autistic people are not transgender or gender diverse: The literature confirms that autism diagnoses or autistic traits are more common among people who are trans than people who are not. However, it is important to note that most trans people are not autistic, and most autistic people are not trans (140).

Being trans or gender divers is not caused by autism: That autism causes transness is not supported in evidence. As with earlier claims, this claim is often supported by one study that has a number of methodological and conceptual flaws (141). There are a number of critiques that are levelled against this study and the claims it is used to support:

- Study authors themselves noted that in one of their five data sets, the relatively low numbers of trans individuals within their sample (n=13) meant that they did not have sufficient power to detect statistically significant effects.
- Participants from the largest dataset used in these analyses were recruited online via a Channel 4 programme about Autism. A link to participate in a survey was advertised in conjunction with the TV programme. Autistic traits were assessed via AQ-10. Researchers neither mention nor attempt to correct for the priming effects of the related TV programme.
- Authors used two self-report measure (AQ-10 & AQ-50) which has been found to be of unsatisfactory and unsound psychometric validity within non-clinical settings (142). Other research has raised issues with the internal reliability of the AQ-10 measure (143).

¹ We use the term 'autistic person' rather than 'person with autism'. This is 'identity-first' language to describe autism, which aligns with language used by the Australian Bureau of Statistics autism (<https://www.abs.gov.au/articles/autism-australia-2022>), and autism advocacy and service organisations, including Aspect - Autism Spectrum Australia (https://www.aspect.org.au/blog/how-do-we-describe-autism_)

These concerns may lead to a high occurrence of 'false positives' when using these measures (144).

- Authors also claim to have addressed self-selection bias by using a second, unrelated dataset, but do not actually detail the extent of these biases within their dataset. They also do not describe the techniques used to account for such biases in their analyses. This is *not* standard practice and bias-handling is usually reported extensively in most study's Methods section.
- In analyses relating to autism diagnosis, study authors controlled for age and educational attainment but not income. Individuals with higher income are more likely to have access to psychological and psychiatric care, and hence, to obtain an official diagnosis.

The association between autism and being trans or gender diverse is still not well understood,

but there are theories: While the literature offers no clarity on the directional relationship between the two experiences (e.g. does one cause the other?), there are many important considerations it raises (139), including the possibility that autistic people are already less attached to many behavioural norms, and so when they feel less identified with gender norms, they may find it easier to explore their gender identity.

The literature points us to an important challenge:

Autistic transgender or gender diverse people have unique, intersecting needs that should be

explored and understood: There are implications for people with responsibility for providing services to autistic people; studies highlight that autistic people may be more at risk of not being believed about their gender identity, and may need specialised tailored gender-affirming interventions to meet their needs in relation to their autism. This co-occurrence urges us to consider the unique, intersecting needs and strengths of trans people and autistic people. In particular, it is important to recognise that Autistic people, like all humans, have the right to bodily autonomy and should be supported to make decisions about their health, wellbeing and gender expression. It is also worth noting that the link between autism and gender diversity is often explored in a way that reinforces transphobic or ableist tropes – that being autistic or transgender/gender-diverse is a problem that must be solved. Any research on causal links should be with a view to better understanding the needs of and services to autistic trans and gender diverse people, not to pathologise or erase either or both of these aspects of their identity

Trans Orgs and Trans Resources in Australia:

- Transgender Victoria
- Trans Justice Project
- Zoe Belle Gender Collective
- Transcend Australia
- A Gender Agenda
- Trans Folk WA
- The Gender Centre
- ACON - Trans Hub

Helplines

QLife - 1800 184 527 (*Calls are not traced*)

QLife provides anonymous and free LGBTI peer support and referral for people wanting to talk about sexuality, identity, gender, bodies, feelings or relationships.

Rainbow Door - 1800 729 367 (*Option to remain anonymous*)

LGBTIQA+ specialist family violence, relationships, suicide prevention and mental health helpline. A service to support all LGBTIQA+ Victorians during and after COVID 19.

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