Chapter 5: Transgendering the young 1: Harm and its justifications

The transgender agenda is not confined to adults, and hence to those whose capacity for making their own decisions is credible. It also engulfs children, and the harm done to children and young people by the transgender medical regime is one of its most damaging aspects. As Sheila Jeffreys said bluntly, 'The effects of the drug treatment and sexual surgeries that constitute the transgendering of children are such as to harm their reproductive rights, as well as their bodily integrity and future health, and can therefore be seen as a particularly harmful form of the abuse of children' (Jeffreys, 2014: 138).

This chapter gives a detailed account of the harm, at least insofar as it is known. Over and over again, commentators say that the effects of puberty blockers and cross-sex hormones on the bodies and minds of the young are 'unknown', but that is not quite accurate. There is evidence, suggestive rather than definitive though it might be, that these medications are harmful when they are ingested by healthy bodies. The transgender agenda either ignores this evidence, or justifies its medical interventions by saying that the benefits are worth the 'risk'. But every stage of the transgender pathway—the social 'transitioning', the puberty blockers and cross-sex hormones and surgeries, and the ignoring or downplaying of the importance of the young people's co-morbidities—is harmful, whether psychologically or physically (or both).

It attempts to catch them very young. Version 7 of the *Standards of Care*, the guidelines of the World Professional Association for Transgender Health (WPATH),[1] contains a section devoted to 'children and adolescents with gender dysphoria' (Coleman et al, 2012: 10-21, section VI), which tells us that '[c]hildren as young as age two may show features that could indicate gender dysphoria' (p.12). The American Psychiatric Association's DSM5, the bible of the psychotherapeutic industry, agrees with WPATH's estimate: 'For clinic-referred children, onset of cross-gender behaviors is usually between ages 2 and 4 years' (APA, 2013: 455).

There are clinics worldwide wholly devoted to the transgendering of the young, and a medical and psychotherapeutic profession content to 'affirm' that children are the 'gender' they say they are, while treating the sex they actually are as though it were of no account. The deception is aided by the term 'gender', so useful for obfuscation because it signifies anything and nothing. There are also innumerable resources focused on the young to convince them that 'transgender' is a real thing—television programs, mass media reports, YouTube and TikTok videos the child can watch endlessly, 'teaching' materials at every level of schooling, organisations specifically focused on children (e.g. Mermaids)—all of which constitute a barrage of manufactured 'consent'.

This is ignored by a medical profession too willing to accept medical technology as the answer life's problems. No doubt those medical professionals are sincere, and genuinely believe that they are doing their best to help the young people who present to their clinics. I am not intending to imply what Kenneth Zucker called 'clinical malevolence' (Zucker, 2018: 8). But the medical transgendering of children is a terrible mistake, only made possible by the acceptance of a lie. However well-intentioned the medical practitioners, basing one's practice on a falsehood doesn't end well.

In what follows, the transgender medical pathway for the young is examined in detail. Although the question of evidence is addressed throughout, it is discussed in more detail elsewhere (in the '… and statistics' chapter, and in the 'Research' section of the 'Evidence' chapter).

'Risk' and harm

In Version 7 of WPATH's 'standards of care' harm is sometimes called 'risk', to the extent that it is acknowledged at all. This is yet another widespread euphemism softening any notion of harm or damage by implying that it could happen but it hasn't yet and maybe it never will. It allows a parallel to be drawn between

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[1] Version 8 (Coleman et al, 2022) was released in September 2022, at which time I had already analysed WPATH's agenda using Version 7 (Coleman et al, 2012). (Version 7 had first appeared a year earlier in the *International Journal of Transgenderism*—Coleman et al, 2011). Since WPATH's position has not substantially changed in the decade between the two versions, I am keeping the points made in my original analysis throughout this chapter, and elsewhere in this present work. A specific critique of Version 8 can be found in the 'Transgendering the young 2' chapter, the critique of the transgender policy capture, as well as WPATH'S 2021 update on adolescents (WPATH, 2021). It must be noted that these 'standards' have no legal, or indeed evidentiary, standing anywhere, and yet they have had an enormous influence on the medical profession everywhere.

transgender 'medicine' and medicine in general. Under the heading 'Risks of hormone therapy', WPATH's Version 7 that says that '[a]ll medical interventions carry risks' (Coleman et al, 2012: 39).

But trans medicine is *harmful*, not risky, and it is certainly not true that all medical interventions are harmful. Version 7 mentions 'harm' only once, in the context of 'sex reassignment surgery'. They seem to acknowledge that transgender surgery is harmful, while undermining that acknowledgement by asserting that *not* doing the surgery is at least as harmful:

> The resistance against performing surgery on the ethical basis of "above all do no harm" should be respected, discussed, and met with the opportunity to learn from patients themselves about the psychological distress of having gender dysphoria and the potential for harm caused by denying access to appropriate treatments (Coleman et al, 2012: 55).

So in transgender terms, any assertion that surgically removing healthy tissue and organs is harmful should be 'met with' the claim that 'denying access to appropriate treatments' is equally, if not more, harmful.

Version 8 makes more use of the term 'harm', often in a single phrase with (unspecified) 'risks' or 'benefits' (Coleman et al, 2022: passim). It says that WPATH 'supports … the value of harm reduction approaches' (p.S6), and even acknowledges that trans medical procedures might be harmful: 'the potential harm associated with sex hormone levels that exceed expected ranges in humans' (p.S118); '[p]otential harms of pitch-raising surgery [for men's voices]' (p.S139); '[p]otential harmful effects of testosterone on the developing embryo' (p.S161). These are not reasons to discontinue the procedures, however. These harms can all be managed as just another aspect of those same procedures: 'regular testing' in the case of the hormonal levels; 'voice training' in the case of the vocal surgery; and 'discontinuing testosterone' in the case of a pregnancy.

Version 8 discusses other 'harms', either modifications of/outright objections to the trans medical process, or fantasised phenomena conjured up by transgender's favourite strategy, telling lies. One supposedly harmful modification is 'a requirement for psychotherapy'. This can be 'a barrier to care' (according to WPATH) because it 'has not been shown to be beneficial', there are those who don't need it, and sometimes it's not available. One of the fantasised phenomena is 'conversion therapy' or 'gender identity change efforts', which have also 'not been shown to be beneficial' and which "put individuals at significant risk of harm" (quoting the American Psychological Association) (Coleman et al, 2022: S176).

Another fantasy is transgender's talismanic word, 'transphobia'. Here, it seems to involve objections to the transgender process by *not* 'respecting and accommodating TGD [transgender and gender diverse] identities', since the way to 'minimize the harm done to patients' by this heinous offence is 'respecting [etc.]'. Yet another fantasy is 'minority stress and the direct effects of discriminatory societal discrimination', which supposedly 'can be harmful to the mental health of TGD people' (p.S175). This is the 'vulnerable and marginalised' trope, for which the evidence is verging on non-existent (see the '… and statistics' chapter).

So it would seem that WPATH has caught up with some of the criticisms, and managed to discredit them by incorporating them within their own framework, largely by lying. Far from not being beneficial, psychotherapy is the only ethical way to treat psychic distress, especially in the young, whatever its sources and however it manifests itself (see the 'What is to be done?' section of the 'Transgendering the young 3' chapter). Their so-called 'conversion therapy' is a strategy piggybacking on the experiences of lesbians and gays (see the 'Piggybacking' chapter); and anyway, attempts to help someone disabuse themselves of a delusion is not 'conversion'. The use of the word 'transphobia' is always, *always* a lie since there is no such thing; and there is no discrimination against 'transgender people', so the 'minority stress' is a lie too.

Who are they?

Who are these children and young people who are turning up at 'gender' clinics in ever-increasing numbers and who are being 'affirmed' in a sex they are not, or no sex at all? The DSM5 gives us the diagnostic criteria:

> A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least six of the following [eight criteria], one of which must be … [a] strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender) … [and] [t]he condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning (APA, 2013: 452, para.302.6)

'This discrepancy', says the DSM5, 'is the core component of the diagnosis' (p.453). The word 'strong' is reiterated throughout the eight criteria—11 times in all. WPATH refer to them as 'gender diverse' (Coleman et al, 2022: S67), but they don't mention 'clinically significant distress' or the strength of the desire.

Other terms used to describe such children are: 'gender creative youth' (Anderson, 2022); 'adolescents presenting with gender identity difficulties' (Churcher Clarke and Spiliadis, 2019); 'a child or young person experiencing gender-related anxiety', 'a persistent experience of identifying as the other sex and shows symptoms of gender-related anxiety' (COHERE, 2020a); 'minors suffering from dysphoria related to gender variance', 'children and adolescents [who] may identify with the opposite sex (transgender), or may identify as genderless, non-binary, or anywhere along or outside the male/female gender identity continuum (other gender)' (COHERE, 2020b: 5); 'gender dysphoric young people' (Evans, 2020); and the French National Academy of Medicine (2022):

> Gender transidentity is the strong sense, for more than 6 months, of identification with a gender different from that assigned at birth. This feeling can cause a significant and prolonged suffering, which can lead to a risk of suicide … this disharmony … [involves] a questioning of an excessively dichotomous vision of gender identity by some young people

I use none of that terminology because all of it implies that thinking one is the opposite sex, or no sex at all, is meaningful, whereas it is in fact nonsense. The sex of these children differs in no way from the sex of any other children. It can't, because there are only two sexes.

Referring to these statements of mine as 'an excessively dichotomous vision of gender identity' might be a fine rhetorical flourish but it doesn't change the reality. In other words, it's a lie. Whatever their identity, distress, hopes, dreams or beliefs, the young caught up in the transgender thing remain one sex or the other. The 'trans child' is an entirely invented concept (Brunskell-Evans, 2019; Brunskell-Evans and Moore, eds, 2019; Williams, 2020), and hence there is no such thing. Neither is there any such thing as 'gender dysphoria' or 'gender diversity'. Because I refuse to use any of the terms in the literature (unless I'm criticising them), my own terminology is 'children and young people who present at "gender" clinics'.

This is happening in ever-increasing numbers. While these children (and/or their parents) are distressed—they wouldn't be presenting themselves at medical clinics otherwise—their distress cannot possibly be that they are the wrong sex because that is impossible. What is it, then, that is distressing them? In one sense, that's the wrong question because the children are distressed for any number of different reasons. (See the 'Co-morbidities' section below). A more pertinent question is: why are distressed children and adolescents being told, whether by social media, peer groups, the mass media, their parents or the medical profession, that the solution to their distress is to change their sex? And it *is* sex, not 'gender' (whatever that is), because the medical interventions are precisely directed towards changing the young person's *sex* characteristics—their sex-specific puberty development, their sex-specific hormonal production, the excising of their sex-specific anatomy.

The answer to the 'why' question requires a longer explanation than fits in here. For the moment it is sufficient to say that the transgendering of children and the young is not separate from the transgender agenda overall. It is a crucial part of the transgender destruction of the meaning of 'sex' in the sense of two sexes, female and male. Focusing on the young is part of the acceptance of that destruction throughout society. The reason *why* it is so acceptable is male supremacy, but that's just the short answer. (For the long answer, see the 'Explaining transgender' and following chapters).

Beginnings

In the beginning the transsexual phenomenon involved only adults, mostly men, although there were a small number of women claiming to be 'men', e.g. the woman who had a mastectomy at Hirschfield's clinic in 1926 (Whittle, 2010); and 'Michael' (née Laura Maud) Dillon, daughter of an English aristocrat, who has been reported as the first woman on record to take testosterone to simulate the opposite sex (in 1938), and who underwent a series of 13 operations to construct a 'penis'. She died in 1962 (Kennedy, 2007a, b). But Hirschfeld's Institute didn't treat children (as far as I know); nor did the Johns Hopkins University Gender Identity Clinic, at first.

In the US it wasn't until 2007 that a clinic specifically for 'gender-dysphoric' children was established. Called the Gender Management Service (GeMS), it was founded by a pediatric endocrinologist, Dr. Norman Spack (among others), at Boston Children's Hospital: 'GeMS was the first major program in the U.S. to focus on treating gender-expansive and transgender adolescents. Since that time, we have expanded our program to welcome patients from ages 3 to 25'.[2] The recruitment of three-year-olds to the transgender cause (not to mention two-year-olds), despite the fact that they are not even old enough to start formal schooling, should be a warning sign, but it is not.

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[2] http://www.childrenshospital.org/centers-and-services/programs/f-_-n/gender-management-service) [viewed 8.11.'19]

Spack has been a leading light in this expansion of the transgender agenda to encompass children, and not only in the US. He has given TEDx talks advocating medical intervention for young children, and has spoken at at least one Mermaids conference. His best-known patient was the son of Mermaids' Susie Green, to whom he first gave a puberty blocker, and then estrogen at the age of 13 (Artemisia, 2019). (The genital surgery was performed in Thailand, on the boy's sixteenth birthday). Spack has been referred to as 'an evangelist', so great is his enthusiasm for the cause. He has been quoted saying that he dislikes the term 'reassignment': '"We don't reassign a person's gender … we just acknowledge what it really is and fix it."'. He has been known to disagree with the UK National Health Service guidelines, which state that no child should be given hormones until the age of 16. He sees this age as arbitrary, even cruel: '"Why wait?" he asks' (Adams, 2016). (The article in *The Guardian*, one of transgender's devoted followers, does not give any answer to that question).

'Gender' clinics for the young did not originate in the US, although the notion of 'gender identity' was invented by US psychotherapists, notably John Money (Biggs, 2022: 2). The one in the UK was founded in 1989, 18 years earlier than the one in Boston. Originally placed in the Department of Child Psychiatry at St Georges Hospital, the Gender Identity Development Service (GIDS) became part of the Tavistock & Portman NHS Trust in 1996, and is often referred to as 'the Tavistock'. It is England's clinic for the transgendering of children and young people to the age of 18 (or it was, until the clinic was closed largely in response to the findings of the Cass review—see 'The closure of GIDS' in the next chapter).

GIDS' founder, Domenico Di Ceglie, is another leading light in the recruitment of children to the transgender cause. He remained director of the service until 2009. He 'has developed models of care and treatment for children and adolescents with gender variance and dysphoria and has been involved in research projects … published papers about his work and … gives frequent lectures worldwide'.[3] (For more about GIDS, see the next chapter, 'Transgendering the young 2'). Under his direction, GIDS was not as strongly focused on medical interventions as it later became. As Hannah Barnes noted, '[t]he service in these early days was largely therapeutic: providing individual therapy, family work and group sessions'. Di Ceglie was reported to say that only around 5% of the young people who presented at the clinic "commit[ted] themselves to a change of gender", and that 60% to 70% "will become homosexual". He was even prepared to admit the possibility that it was the very existence of GIDS that was creating the problem (Barnes, 2023: 12).

Even earlier, a 'gender' clinic for the young was founded in Toronto in 1975; and in 1987, what was to become the most influential 'gender' clinic in the world was founded in Utrecht in the Netherlands, later moved to the Amsterdam Gender Clinic at the Vrij Universiteit Medical Center. Initially, the clinics only provided counselling. The children had to wait until they were old enough to be referred to an adult clinic, at either 16 or 18, where they could be dosed with cross-sex hormones. Surgery was not available under the age of 18 (Biggs, 2022: 2). The puberty-blocker regime for adolescents was a later development, introduced by the Dutch team at the Amsterdam clinic (Cohen-Kettenis, Steensma et al, 2011: 689).

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[3] http://www.sgdsco.com/portfolio-item/helen-early-backler-2/

The transgender pathway—WPATH and 'standards of care'

The WPATH Version 7 guidelines say there are three stages of physical interventions for 'gender dysphoric' adolescents who turn up at 'gender' clinics (Coleman et al, 2012: 18-21). The first stage is the puberty blockers—'GnRH analogues to suppress estrogen or testosterone production and consequently delay the physical changes of puberty'. The effects of this intervention, the guidelines say, are 'fully reversible', and it can be applied to children as young as nine, although the youngest age in the research is 12 (p.18). The second stage involves cross-sex hormones. This is called 'hormone therapy [sic] to masculinize or feminize the body' in Version 7, 'gender-affirming hormone therapy' (GAHT) in Version 8. The effects of these are 'partially reversible'.

The third stage involves 'surgical procedures', the effects of which are 'irreversible'. Although WPATH does not say it outright, excised genitals cannot be replaced, and neither can a woman's breasts—a silicon substitute is not the same thing at all. Surgical procedures involving 'genital surgery' should not be carried out, the guidelines tell us, 'until … patients reach the legal age of majority to give consent for medical procedures', but 'chest surgery in FtM patients', i.e. mastectomies, 'could be carried out earlier' (Coleman et al, 2012: 21).

That children themselves (or indeed, women) appear to be 'choosing' the trans pathway, that they themselves feel they are the opposite sex, is not the result of any recent flowering of already-existing trans 'identities', as the transgender agenda would have it. Rather, it is the result of suggestion and the contagion spread by social media, the need to belong, and a (false) guarantee of a solution to life's problems. As Sheila Jeffreys said, 'the question arises of the extent to which [the children] can be seen as uncoerced, considering that their parents, the medical profession, and the courts are advocating this treatment for them, and they are told that it will alleviate their mental distress' (Jeffreys, 2014: 137). (For a further discussion of social contagion, see the 'Social contagion' section of the 'Transgendering the young 3' chapter).

Social transition

But prior to the first of WPATH's 'physical interventions'—the administration of puberty blockers to adolescents—there is an earlier stage. Prepubescent children hardly qualify for puberty suppression after all, not to mention two-year-olds. 'Some children', the guidelines say, 'state that they want to make a social transition to a different gender role long before puberty' (Coleman et al, 2012: 17). Note that this initiative is located solely with the children.

This stage involves such behaviours as adopting the hairstyles, names and clothing of the opposite sex, and insisting on being referred to by opposite-sex pronouns (Coleman et al, 2012: 16). Version 7 acknowledges that this is 'a controversial issue'. and that 'divergent views are held by health professionals'. They heed the Dutch team's recommendation for caution (see below), advising parents 'to present this role change as an exploration of living in another gender role rather than an irreversible situation' (p.17).

But affirming small children in the belief that they can 'transition to a different gender role', or none at all (i.e. 'non-binary', etc.), can set them and their parents on the transgender pathway and prepare them for later medical interventions. Helen

Joyce said that very few children who had been 'socially transitioned' had detransitioned and come to accept their own sex. Instead, they went on to the subsequent stages. She quoted transgender-affirming doctor, Johanna Olson-Kennedy, saying that, of the more than 1,000 children she had 'supported' to 'socially transition', only one had desisted (Joyce, 2021: chapter 4). Stephanie Davies-Arai also said that support to 'social transition is the most powerful predictor of persistence of childhood gender dysphoria' (Davies-Arai, 2019b: 26). Transgender Trend commented that '"gender clinics"—along with "trans support groups"—are a strong invitation to parents, children and adolescents to frame non-conformity as a "gender" issue which needs fixing' (Transgender Trend, 2016a); and Lisa Marchiano noted, 'It's clear that social transition must be viewed as a treatment that carries with it a significant risk of progressing to medical transition' (Marchiano, 2017: 352).

But many, if not most, of the children with 'gender dysphoria' grow out of it if left alone. Transgender critics, Stephen B. Levine and his colleagues,[4] said that there had been 11 research studies indicating 'a high rate of resolution of gender incongruence in children by late adolescence or young adulthood without medical interventions' (Levine et al, 2022: 6). They hinted that the endorsing of 'social transition' by the American Academy of Pediatrics might be at least partly responsible for high persistence rates, because the high resolution rates had been recorded before that endorsement. Consequently, they believed that it was possible 'that social transition will predispose a young person to persistence of transgender identity long-term' (p.6).

Nearly 10 years earlier, the DSM5 had admitted that, among girls referred to 'gender' clinics, the rates of those who *persisted* varied only between 12% and 50%, while among boys the rates of persistence varied between 2.2% and 30% (APA, 2013: 455). Version 7 of the WPATH guidelines also tells us that ' Gender dysphoria during childhood does not inevitably continue into adulthood'. They give persistence rates of 12% to 27% for girls, and 6% to 23% for boys (Coleman et al, 2012: 11). Again, Bernadette Wren, Head of Psychology at GIDS, was cited saying, in a seminar in 2016, that only 12% to 27% of 'gender variant' children overall persisted, while 'that percentage rises to 40% amongst those who visit gender clinics' (quoted in Transgender Trend, 2016a). In the opinion of these expert sources then, the 'gender dysphoria' of most prepubescent children doesn't last beyond puberty, or even until puberty.

The quoted desistence/persistence rates are all of children who present to 'gender' clinics, since there's no way of knowing anything about the children who don't turn up to the clinics. Wren's quoted statement, that the percentage of persisters rose to 40% among those who *visited* gender clinics, is not quite accurate. Both those who persist and those who desist *visit* 'gender' clinics, but most of those who desist are those who don't go through the 'social transition' stage. Zucker said that some of the children contacted in follow-up studies had been assessed at the clinic but not seen again until their families were contacted at the follow-up. There was 'a lot of variability' in the length of time the children were in contact with the clinic, he said

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[4] Psychiatrist Stephen B. Levine used to be involved with the transsexual phenomenon. In 1998 he was Chair of WPATH's precursor, the Harry Benjamin International Gender Dysphoria Association, and one of the authors of Version 5 of the 'standards of care'. He is, however, highly critical of transgenderism, especially the medicalising of the young. His colleagues in this article are both members of the trans-critical Society for Evidence-Based Gender Medicine.

(Zucker, 2018: 8). He also said that 'implementing a psychosocial treatment … will increase the odds of long-term persistence'. He suspected that the persistence rates of those who had 'socially transitioned' would found to be 'extremely high' when more follow-up data became available (p.7). He even went so far as to call the 'social transition' process 'iatrogenic' (Zucker, 2019).

It doesn't seem as though the strength of the feelings of 'gender dysphoria' is a good indication that the feelings will last. According to the DSM5, strong feelings and persistence are only 'modestly correlated' (APA, 2013: 455). Wren said at that same seminar that 'there is no way of distinguishing the "persistors" from the "desistors"', but that those who start on puberty blockers early invariably go on to 'transition' through all the stages. She also said that at that time GIDS had 132 children under 16 on puberty blockers, and five children under 12 (quoted in Transgender Trend, 2016a).

The Dutch team recommend caution in the 'social transitioning' of young children. They suggest

> that young children not yet make a complete social transition (different clothing, a different given name, referring to a boy as "her" instead of "him") before the very early stages of puberty (de Vries and Cohen-Kettenis, 2012: 307-8).

They gave two reasons for this caution. The first reason is that most children decide as they get older that they no longer want to continue with the transgender process: 'most gender dysphoric children will not remain gender dysphoric through adolescence' ('desistance'). Presenting themselves as the opposite sex for any length of time makes it harder for them to return to their real sex.

The other reason the Dutch researchers gave in advising caution is that some of the children who present as the opposite sex '(sometimes as preschoolers)' don't know what they're doing. They 'barely realize that they are of the other natal [sic] sex', these eminent researchers say:

> They develop a sense of reality so different from their physical reality [if they 'transition' socially] that acceptance of the multiple and protracted treatments they will later need is made unnecessarily difficult (de Vries and Cohen-Kettenis, 2012: 308).

This is a very strange argument to make in the context of the transgender cause. Developing a sense of reality very different from physical reality is seen here as a *problem*, and yet it is exactly what is required by the transgender process. In order for someone to 'transition' to the opposite sex, they *must* have a sense of reality different from their physical reality. That is just what the transgender process is all about. Indeed, the children are likely to have difficulties with accepting 'the multiple and protracted treatments they will later need', if they *don't* have that different sense of physical reality. What is even more peculiar about this argument to transgender ears is that it says that sex is a physical reality. This is not something that fits in with the transgender imperative to *deny* the physical reality of sex if it is to maintain that it's possible to change sex.

As Marcus Evans (2020) has pointed out, lies ('mechanisms designed to deny or distort reality') are damaging. Because they deny reality, lies prevent us from dealing with it appropriately, and hence they stunt emotional development. '[M]aturity and psychological growth', he said, 'require us to face, rather than avoid or misrepresent, the reality of who we are and who we are not'. This is particularly the case in adolescence, with all its anxieties and struggles to come to terms with who they are, their sexed bodies and their role in reproduction. Physical damage is not the only harm done to the young by the transgender process. It causes psychic harm too.

Because 'social transition' doesn't involve any medical interventions it is regarded as something that has few, if any, long-term repercussions. But it *is* referred to as a 'transition' (to the opposite sex or none at all), with the implication that this is just the first stage in a process that will eventually include medical and surgical intervention. While the medicalising doesn't start till the puberty blockers, reinforcement of the notion that someone can change into the opposite sex embeds children (and their parents) firmly in the transgender worldview.

The fact that there are children who opt out of the transgender process, even though they (and/or their parents) initially wanted to participate, suggests that the process itself is questionable, especially as the vast majority of young children presenting to clinics with 'gender dysphoria' do eventually desist if they are not 'affirmed' as the opposite sex. If it is the 'treatment' itself that keeps them on the transgender pathway, the question arises: is 'gender dysphoria' a iatrogenic condition created by a medical profession captured by an ideology so powerful that it can convince one of the physical sciences, i.e. medicine, to deny physical reality?

Puberty blockers

The next stage, and the first stage of medical intervention on the young, is puberty suppression. This is often referred to as the 'Dutch protocol' because it originated at the Amsterdam Gender Clinic in the mid-1990s. It involves giving puberty blockers to children below the age of consent. The protocol initially set the lowest age at which adolescents could be given puberty blockers at 16, but as a result of follow-up studies that 'favored early, rather than late, interventions', the age limit was lowered to 12 (Kreukels and Cohen-Kettenis, 2011: 5/25). To start with, there were not many young children who presented to the Amsterdam clinic who were dosed with puberty blockers. By 2000, only seven children under the age of 16 had been given the medication. But between 2000 and 2008, 111 children had gone through puberty suppression, about one a month (Biggs, 2022: 4).

Once again, the responsibility for this medical intervention—being dosed with puberty blockers—rests with the children. The medical staff are simply accommodating themselves to the children's demands. Puberty blockers, GIDS staff members said, are '*requested* in early pubertal children as a way to prevent the development of those unwanted bodily characteristics that may make 'passing' in the preferred sex difficult in later life (deep voice, facial hair and changes, breasts and so on) *should this be their wish*' (Butler et al, 2018: 634—emphases added).

Dosing healthy children with puberty blockers has become standard operating procedure in the world of transgender 'medicine'. Both of the latest Versions of WPATH's 'Standards' list it among the interventions they regard as 'medically necessary'. Version 7 (Coleman et al, 2012) gives two justifications for suppressing the normal development of puberty: it gives adolescents time 'to explore their gender nonconformity and other developmental issues'; and it prevents 'the development of sex characteristics' and hence makes 'sex reassignment' easier (p.19). It also says that 'early use of puberty-suppressing hormones' (i.e. with younger children) was preferable to later use (i.e. with older children) because it 'may avert negative social and emotional consequences of gender dysphoria more effectively' (p.20). Objections to its use are either ignored, dismissed, or interpreted as 'right-wing attacks on medical care for minors … fueled by anti-trans vitriol' (Bazelon, 2022), as an article in the policy-captured *New York Times* put it.

According to Michael Biggs, the Dutch protocol of puberty suppression was largely the invention of psychologist Peggy Cohen-Kettenis, together with two colleagues, Henriette Delemarre-van de Waal, a paediatric endocrinologist, and Louis Gooren, a psychiatrist and endocrinologist and the world's first professor of transsexuality. Cohen-Kettenis had become recognised as an expert in the field of 'gender medicine' in the 1980s. She was the founder of the Utrecht children's clinic, and she had close connections to the VU Medical Center in Amsterdam. She believed that 'transsexuals' needed to start treatment before adulthood if they were to get the best outcomes. '[E]arly treatment would prevent much unnecessary suffering', she said, and 'the physical outcome can be expected to be more satisfactory … especially in male-to-female patients' (Cohen-Kettenis & van Goozen, 1997: 2/10). According to Biggs, it was Cohen-Kettenis who was mainly responsible for the lowering of the age of intervention (Biggs, 2022: 2). She was referring 16- and 17-year-olds to the adult clinic in Amsterdam for hormonal precursors to cross-sex hormones in the mid-1990s (Biggs, 2022: 2-3). (By 2022, she was retired—Bazelon, 2022).

Until the introduction of the Dutch protocol, transsexualism wasn't treated until adulthood, the first step being the administration of cross-sex hormones. 'In the first instance', said the academic article presenting the Dutch protocol to the world for the first time (Biggs, 2022: 3), 'it may be preferable to halt the own hormonal pubertal development rather than induce hormonally a cross-sex development' (Gooren and Delemarre-van de Waal, 1996).[5] Puberty suppression was at the time 'a fairly new intervention in the field of gender identity disorders or transsexualism', and it was intended to give patients 'a physical appearance that makes it possible for [them] to live unobtrusively in their desired gender role' (Kreukels and Cohen-Kettenis, 2011: 1/25).

The above-mentioned article (Gooren and Delemarre-van de Waal, 1996) is largely devoted to naming and describing the medications, originally developed to treat precocious puberty, that could be used to suppress what they referred to as 'the own puberty'. The authors acknowledged that not all 'gender atypical children' would turn out to be transsexual—most of the boys studied to date were homosexual. But some of the youngsters with 'gender problems' who come to the attention of the medical system, they said, 'will turn out to be genuinely transsexual in their mid-teen years'. In support of this contention, they cited two papers by Cohen-Kettenis (1994, 1995), both in Dutch (Gooren and Delemarre-van de Waal, 1996).

While the 1996 paper was the first, there was another academic paper published two years later that was even more influential (Biggs, 2022: 3). It was the only report of a genuinely long-term follow-up ever published in the literature (p.8), and it was a case study of a single female individual. She was the Dutch team's 'first experience with an FtM transsexual' and, the authors said, she 'responded to the

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[5] The only copy of this I could find was on a pro-transgender website

treatment exceptionally well' (Cohen-Kettenis and van Goozen, 1998: 6). This was a girl who was 16 years old at the time she arrived at the 'gender' clinic in Amsterdam in 1994. She had been taking puberty-blocking medication prescribed by a paediatric endocrinologist since the age of 13. At age 18 she started taking cross-sex hormones and underwent surgery to remove her uterus, ovaries and any breast tissue she had developed.

A year later, the researchers said (referring to her with masculine pronouns), 'he' was happy with 'his' life as a man and 'grateful that he [sic] had been given the opportunity to be treated this early'. She also scored within the normal range on psychometric tests. By the time the article was published, she had also had metaidoioplasty, i.e. the transformation of her clitoris into a micro-penis.

In 2010, in what was presented as a 22-year follow-up, this person was found to be 'functioning well in most aspects of life', according to the Dutch team (Cohen-Kettenis, Schagen et al, 2011). She showed no serious deficits in physiological measurements, including bone mass density. She also had no trouble being recognised as a man, except for her genitals, the size and shape of which meant she couldn't urinate standing up nor have sexual intercourse. It also meant difficulty in intimate relationships.

Nonetheless, the Dutch team regarded this as a highly successful example of puberty suppression: 'This first report on long-term effects of puberty suppression suggests that negative side effects are limited and that it can be a useful additional tool in the diagnosis and treatment of gender dysphoric adolescents' (p.843). After that first experience, they said, 'it was decided to start treatment in a large number of carefully selected adolescents' (Kreukels and Cohen-Kettenis, 2011: 6).

A case study of a single person hardly seems sufficient justification for introducing a medical procedure with profound effects on the normal maturation process. Neither does it justify spreading the Dutch protocol worldwide. It's true that this wasn't their only research. Commentators (Biggs, 2022; Levine et al, 2022) attribute the Dutch team's influence to two other studies, one on puberty blockers (de Vries, Steensma et al, 2011), the other on surgeries (de Vries et al, 2014). But their later research had no more validity than the single case study (see the 'Evidence' chapter).

The Dutch team also said that their decision to dose adolescents with puberty blockers was the result of two observations clinicians had made at the medical centre. The first observation was that 'gender dysphoria' among adolescents did not 'abate, often despite many years of psychotherapy'; the second was that the children's difficulties—their depression and their unhappy relationships with others—were 'the consequence, rather than the cause', of their 'gender identity disorder' (Kreukels and Cohen-Kettenis, 2011: 4/25).

Both these so-called 'observations' are suspect. It is not at all certain that 'gender identity disorder' is *sui generis* and not a reaction to something else, such as the co-morbidities discussed below; and while there might be children and young people who cling to their 'gender identity', despite the best efforts of concerned parents and psychotherapists, it is not helpful to reinforce their belief that they can turn into the opposite sex. Moreover, there are signs that the 'Dutch protocol' might finally be being shown to have been flawed all along (Abbruzzese et al, 2023; O'Malley, 2023; SEGM, 2023). (For a discussion of the increased caution around the transgender medical regime, see the 'Hopeful signs?' section of the 'Transgendering the young 3' chapter).

For a finding that the evidence for the effectiveness of puberty blockers and cross-sex hormones was of 'very low certainty', see the reviews by the UK National Institute for Health and Care Excellence, NICE, 2021a, b.

By the mid-2010s, the Dutch protocol had become the world standard for transgender 'medicine' (Biggs, 2022: 7). Despite the flimsy evidence, giving puberty blockers to children under the age of consent had gained worldwide acceptance. Cohen-Kettenis and Gooren were elected to the Board of Directors of the Harry Benjamin International Gender Dysphoria Association (WPATH's precursor), and puberty suppression was included in the 'Standards of Care', Version 6, in 2001 (Biggs, 2022: 6). Version 7 (Coleman et al, 2012) cites the de Vries, Steensma et al 2011 study of 70 adolescents neutrally as though its findings were perfectly acceptable (p.11). In 2009 the BBC reported (quoting 'NHS, Tavistock clinic') that countries where children were being treated with puberty blockers 'in the early stages of puberty' included the Netherlands, Germany, Belgium, United States, Canada and Australia (Fletcher, 2009).

Arguments for the protocol were first advanced academically in the UK, Michael Biggs said, at a conference in Oxford in 1998, where the head of the Amsterdam Clinic was the keynote speaker, although it did not immediately become standard operating procedure. However, the transgender lobby took up the cause and they had a great deal of influence with GIDS and the NHS more generally. For example, in 2005, a symposium organised by Mermaids and the self-styled Gender Identity Research and Education Society (GIRES) put GIDS management in touch with the creators of the Dutch protocol; and in 2009, Polly Carmichael, GIDS' newly appointed Director, announced that GIDS would be offering puberty blockers to children younger than 16 as part of a research study (Fletcher, 2009). (See the discussion of this study in 'The Bell case' and 'The Tavistock experiment' sections of the 'Transgendering the young 2' chapter).

Reversible?

The Dutch team stated unequivocally that 'The effects of GnRHa [puberty blockers] are reversible' (Kreukels and Cohen-Kettenis, 2011: 1). Version 7 of the WPATH guidelines (Coleman et al, 2012) is also adamant that the effects of this medication are 'fully reversible', while Version 8 refers to 'fully reversible puberty delaying blockers' (quoting Version 7—Coleman et al, 2022: S43).

In 2020, 31 experts in brain and adolescent development (among other things) could still assert decisively that, '[f]or youth who decide not to pursue [gender-affirming hormone] treatment, discontinuing GnRHa will reactivate the hypothalamic-pituitary-gonadal axis and endogenous puberty will resume' (Chen et al, 2020: 2). As their evidence for this, they cite the Dutch team (de Vries and Cohen-Kettenis, 2012). This is not surprising, as one of the named authors, Baudewijntje Kreukels, is a professor at the Amsterdam University Medical Center and author of many pro-transgender academic articles, both from the Amsterdam medical centre and from elsewhere (e.g. ENIGI Multicenter European Follow-Up Study. For references for this study, see the 'Follow-up studies' section of the 'Evidence' chapter).

Not only do trans exponents argue that the effects of puberty blockers are reversible, they also turn the concept of 'irreversibility' against the normal development of puberty. Hruz et al (2017: 22) quote from a Human Rights Campaign publication which says that normal pubertal development is "extremely distressing" and "some of these physical changes, such as breast development, are *irreversible* or require surgery to undo" (original emphasis). HRC are simply quoting the acknowledged experts, the Dutch team who pioneered the use of puberty blockers, who said, 'If treated early in puberty these youth may … be spared the burden of having to live with irreversible signs of the "wrong" [sic] secondary sex characteristics (eg, scarring because of breast removal in trans boys [i.e. girls]; having a male voice and male facial and bodily features in trans girls [i.e. boys])' (Cohen-Kettenis, Steensma et al, 2011: 697. See also: de Vries, Steensma et al, 2011).

WPATH agree: 'functioning in later life can be compromised by the development of irreversible secondary sex characteristics during [the normal changes of] puberty' (Coleman et al, 2012: 178). Version 8 doubles down on the 'puberty is irreversible' trope. Not only is normal puberty irreversible, it's probably harmful: 'allowing irreversible puberty to progress … may have immediate and lifelong harmful effects for the transgender young person' (Coleman et al, 2022: S48). So in the transgender worldview, normal, healthy pubertal development is damaging, while medicating perfectly healthy children and preventing them from developing into physiologically normal adults is a 'human right' (p.S48).

The harm—effects on bone density

But adamant statements about 'reversibility' are not evidence, and there *is* evidence suggesting that the damage puberty blockers do to the young developing body is not reversible. In relation to claims that 'hypothalamic-pituitary-gonadal axis' will be reactivated and endogenous puberty resume when the adolescent is no longer taking puberty blockers (as the 31 experts in childhood development said) (Chen et al, 2020), American endocrinologist, Dr Michael Laidlaw, said that there is evidence to suggest that this is not what happens. He cited research on the use of these drugs for endometriosis, which found that full pituitary function had not returned in the majority of cases a year after the young women had stopped taking the medication. In the case of adult men taking the drug for prostate cancer, it took an average of nine months before testosterone levels returned to the normal range, and in just over a quarter of cases, it had not returned two years later (Laidlaw, 2020).

Hruz and colleagues (2017) point out that, if certain characteristics don't develop during the years of normal puberty, they won't develop later either, because the natural sequence of events has been disrupted (Hruz et al, 2017: 23).

It would seem that WPATH know this. Despite their assurance that any changes caused by puberty-blockers are 'fully reversible', they go on to say that clinicians might need to intervene 'to establish an adequate gender appropriate height' or 'to improve iatrogenic low bone mineral density' (Coleman et al, 2012: 20). In other words, medical suppression of normal puberty development could retard a child's growth and/or cause 'low bone mineral density'.

WPATH believe that the diminution of bone density can be reversed, at least in the case of young women taking testosterone. 'Testosterone therapy [sic]', they say, 'maintains or increases bone mineral density among FtM patients prior to oophorectomy [removal of the ovaries], at least in the first three years of treatment' (Coleman et al, 2012: 225). But three years is not the long term; and as for 'an adequate gender appropriate height', WPATH have nothing to say about how to achieve that. Version 8 (Coleman et al, 2022) acknowledges 'potential [sic] bone health concerns' (passim), but says they 'require continued study' (p.S65) and recommends bone density be monitored (passim).

The first statement in English of the Dutch protocol (Gooren and Delemarre-van de Waal, 1996) was unconcerned about the possibility that suppressing puberty might weaken the bones, because the puberty blocker regime was expected to be short-term. Consequently, 'side effects such as insufficient formation of bone mass (which occurs in cases of long-term sex steroid deficiency) are of no great concern in this type of patient'.

However, either the regime didn't remain short-term, or puberty blockers were damaging even in the short-term. WPATH clearly recognise this, with their comment about 'iatrogenic low bone mineral density' (Coleman et al, 2012: 20). GIDS also mentioned it, although in a back-handed kind of way—'concerns have been raised', rather than acknowledging that they themselves are concerned (and perhaps they're not). The concerns were about 'the risks of puberty suppression—including effects on brain development and other physical issues, such as bone density alteration [sic]'. These are 'still not fully understood', they said. They went on to cite a study, the results of which suggested that the study subjects 'might experience loss of bone mass if cross-sex hormonal treatment is postponed beyond the age of 16 years' (Costa et al, 2016: 8).

This is not quite the conclusion reached by the authors of the cited study. What the study found was that the bone mineral density of the young people who had been taking puberty blockers had decreased by the age of 22, especially the boys. But although it did increase with the cross-sex hormones, it didn't even reach the levels they had before starting on the puberty blockers:

> Between the start of [the puberty-blocker regime] and age 22 years, the lumbar area [bone mass density] score … in transwomen [i.e. boys] decreased significantly … and in transmen [i.e. girls] there was a trend for decrease … This suggests that the [bone mass density] was below their pretreatment potential and either attainment of peak bone mass has been delayed or peak bone mass itself is attenuated (Klink et al, 2015: Abstract).

And the study's researchers didn't use GIDS' euphemistic 'alteration'. They said 'peak bone mass' was 'attenuated' or 'delayed' (Klink et al, 2015), i.e. the 'alteration' was in a negative direction. They also said that the young people in the study would be classified as 'osteopenic' by the WHO classification. This means that their bone density was lower than normal for their age, at levels not normally seen until late middle age or older. Thus the GIDS researchers (Costa et al, 2016) omitted what didn't suit their agenda. Although Klink et al (2015) did say that bone mass density increased with cross-sex hormones, the GIDS researchers ignored the more important information that it didn't increase to the level it would have with normal puberty, nor even to its prior level.

GIDS' own study (Carmichael et al, 2021) found that bone density in their study participants taking puberty blockers was lower than that of their age peers (although they also said it increased over time, if slowly). Michael Biggs (Biggs, 2019) cited research (Tobin et al, 2019) that found that, by the third year on puberty blockers (hardly short-term for medication that disrupts the normal process of maturation), the average girl had lower bone density than 97.7% of the population in that age group. Biggs also noted that the Tobin et al study 'state[d] reassuringly that bone density did not decline in absolute terms'. But, he said, this was misleading. Bone density should *increase* during puberty (Biggs, 2019: 5). He cited the work of Michael Laidlaw, who had been raising the alarm about the effects of puberty blockers on bone density. Puberty is the stage in life when bone density must grow rapidly if osteoporosis is to be avoided later in life (Biggs, 2020: 18).

As Biggs commented, surely information such as the above should raise serious concerns (Biggs, 2019: 5). But apparently not. Not only do transgender proponents misinterpret research (e.g. GIDS' interpretation above), when the concerns are noted, they are downplayed for lack of evidence. The Cass review (Cass, 2022), for example, acknowledged that reduction in bone density was 'a well-recognised side effect' of puberty blockers even in the short term, but the evidence of any long-term impact was 'weak and inconclusive' (p.38).

So the only conclusion that can be drawn from studies on the effects of puberty blockers, is that the research findings are 'inconclusive'. But that is not quite true. Study after study finds that bone density development in adolescents given puberty blockers decreases, or fails to increase when it should (except perhaps for the young woman studied by the Dutch team in the 1990s). There is no study that has found bone density to develop normally in those adolescents. The significance of the findings in each study might be 'inconclusive', but it is surely significant that every study to date has found deleterious effects on the bones of young people. Indeed, this is exactly what would be expected, given what is known about skeletal development during puberty.

One transgender response is simply to mention it in their 'informed consent' process. 'These anticipated changes [i.e. the reductions in bone density and also in height] had been discussed with all participants before recruitment to the study', the GIDS researchers said (Carmichael et al, 2021: 18). But this downplays the seriousness of these 'changes', as the euphemistic 'change' indicates. It is therefore unlikely that the research participants were told the full story, i.e. that the regime can cause osteopenia, which means that these young people will develop osteoporosis earlier, much, much earlier, in their life span than is normal.

Ignoring the lack of evidence and ploughing on regardless is standard operating practice in transgender-captured medical institutions. The international organisation, the Endocrine Society, tells us that one of '[t]he primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization', but the adverse effects, they tell us parenthetically, '(can theoretically be reversed with sex hormone treatment)', i.e. by dosing with cross-sex hormones (Hembree et al, 2017: 3882). The reason that the 'reversal' is only theoretical could be because there is so little reliable evidence. It could also be because what evidence there is doesn't support the transgender narrative.

The Endocrine Society made no suggestion about what to do when bone mineral denaity is found to be adversely affected, apart from continuing transgender medication—'sex hormone treatment'. Nowhere did they suggest that the adverse effects on bone density might be a good reason *not* to dose the young with puberty blockers at all. The Endocrine Society has been a stalwart trans supporter since at least 2009, when it released its guidelines for the 'endocrine treatment of transsexual persons' (Hembree et al, 2009). (See the next chapter).

The harm—other effects

Reduced bone density is not the only worrying aspect of taking puberty blockers. As Laidlaw noted, 'Puberty is more than just a process of genital maturation. It is also a critical time for bone, pelvis, brain, and psychosocial development. All of these processes are adversely affected by puberty blockers' (Laidlaw, 2020). Biggs adds that, 'there is increasing evidence for negative effects on cognitive and emotional development and on sexual functioning' (Biggs, 2022: 1).

Lesbians United listed a number of adverse effects that had been found in the research studies they investigated:

> Particularly urgent concerns for adolescents include loss of bone mineral density and increased risk of osteoporosis; potential for decreased IQ and other cognitive deficits; increased risk of depression and suicidal thoughts; and stunted sexual and reproductive development. GnRH agonists can also affect the heart, thyroid, digestive system, urinary tract, muscles, eyes, and immune system, and cause chronic pain (Lesbians United, 2022a).

This is a summary of the findings of their report on puberty blockers, released on 21 August 2022. Called *Puberty Suppression: Medicine or Malpractice*, it reviewed over 300 sources investigating puberty blockers, most of which were peer-reviewed scientific studies, and found extensive evidence of the damaging effects of puberty blockers.

By January 2023, if not earlier, this United Lesbians report had vanished from the internet. (Their Twitter account had been suspended in November 2022).[6] Clicking on the links brings up the '404 not found' message, and on at least one occasion, a message warning the searcher off with a recommendation not to proceed. Brief accounts of the contents of the report can still be found, however (Lesbians United, 2022a, b, c, d). The report concluded that there is already enough research out there, and hence there is no need for any more clinical trials targeting vulnerable children. It also said that the research shows that puberty blockers are 'really, really dangerous', and that many of the side effects are irreversible. These claims cannot be evaluated because the report is no longer available. However, Lesbians United are not the only researchers to come to the same conclusion.[7]

One irreversible effect that is rarely mentioned in the literature, and airily dismissed when it is mentioned in the transgender context, is the failure of the penis to develop to adult size when boys start puberty blockers early in puberty. Or to put this another way, 'penoscrotal hypoplasia … can be an iatrogenic consequence of feminising hormones' (Jones et al, 2019: 158). Taking puberty blockers early in puberty, Version 7 says, 'could result in insufficient penile tissue for penile inversion vaginoplasty

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[6] https://twitter.com/UnitedLesbians/status/1561775212265459716

[7] For a number of articles criticising the practice of dosing children with puberty blockers, see: https://www.transgendertrend.com/articles-relating-to-puberty-blockers/. For a number of studies exposing the damaging effects of puberty blockers, see: https://segm.org/studies

techniques'. But never mind, they assure us, 'alternative techniques, such as the use of a skin graft or colon tissue, are available' (Coleman et al, 2012: 20). There is no mention in either Version of the consequences for a man who has to go through the rest of his life with a child-sized penis if he decides he doesn't want the 'vaginoplasty techniques' after all. Despite the puerile male spam that periodically appears in email inboxes, there is nothing that will make a penis grow bigger.

Mermaids' CEO, Susie Green, has acknowledged this consequence of dosing young males with puberty-blocking hormones, but she is blithely unconcerned. In an interview in a BBC documentary about her son, Jackie, Green said:

> "The majority of surgeons around the world do something called penile inversion where they basically use the skin from the penis to create the vagina. And she[8] hadn't developed through full puberty so to not put too fine a point on it there wasn't much there to work with" [starts to smile] –; "sorry Jackie (she'll [ditto] hate that)" [turns away from camera and convulses with laughter] (Artemisia, 2019).

Presumably Jackie's surgeon was able to take advantage of those 'alternative techniques' mentioned in the WPATH guidelines, namely, 'the use of a skin graft or colon tissue'. Such an option is not available to a man, dosed with hormones in early puberty, who decides he doesn't want the surgery after all once he grows up.

Another adverse consequence that has recently come to light is a possible effect on the brain. According to the American Academy of Pediatrics (AAP, 2022), in July 2022 the US Food and Drug Administration added a warning to the labelling for gonadotropin-releasing hormone (GnRH) agonists (puberty blockers) about the risk of 'pseudotumor cerebri', i.e. pressure of unknown origin within the skull that causes symptoms such as 'headache, papilledema [pressure on the optic nerve], blurred or loss of vision, diplopia [double vision], pain behind the eye or pain with eye movement, tinnitus, dizziness and nausea'.[9]

The FDA issued the warning after they learned of six cases where there was 'a plausible association' between the brain condition and taking puberty blockers. All six were girls between the ages of five and 12, only one of whom was taking the medication for transgender reasons. The other five were being treated for precocious puberty. By the time the FDA reviewed the cases, three of the girls no longer had any symptoms, one was getting better, one hadn't improved at all, and there was no information about the other one. The FDA said they didn't know how often this might happen ('the incidence rate') because six was too small a number to make any estimates. Nonetheless, the information was sufficiently concerning to justify labelling the medication with a warning (AAP, 2022).

It would seem that the message about the irreversibility of the effects of puberty blockers might be getting across to the relevant authorities. The Tavistock Trust had included a statement on its website in April 2011 saying that GnRHa treatment 'is deemed reversible' (Biggs, 2020: 2), but by June 2020, they had withdrawn this

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[8] Note that, because this is a discussion about someone with a penis, the feminine pronoun is inappropriate.

[9] https://pedsendo.org/new-meds-and-tech/new-meds-and-tech-from-the-pes-drugs-therapeutics-committee-gnrh-agonists/

statement (Transgender Trend, 2020c). They didn't admit that they had been wrong, though.

Cross-sex hormones

As well as the damaging effects described above, there is some evidence that taking puberty blockers can inexorably lead to the next step on the transgender medical pathway, cross-sex hormones, with its own damaging tendencies. Version 7 describes cross-sex hormones as 'hormone therapy to masculinize or feminize the body' (Coleman et al, 2012: 18), while the UK Department of Health (2019: 7) describes them as 'sex steroids of the experienced [sic] gender, also referred to as gender affirming hormones'. Version 8 tells us that dosing with cross-sex hormones ('gender-affirming hormone therapy' or GAHT) 'has been accepted as medically necessary' since 1979, when the first version of their 'standards of care' was published. The reason it is necessary is to enable 'transgender and gender diverse persons … to achieve changes consistent with their embodiment goals, gender identity, or both' (Coleman et al., 2022: S110).

As mentioned above, WPATH asserts that the effects of these hormones are 'partially reversible', and the UK medical system agrees (UK Department of Health, 2019: 7). This reversibility is partial because it is not just a matter of ceasing to take the medication. Not only does it involve effects that are *not* reversible, it also involves effects that need surgery to reverse them. As Version 7 puts it, 'Some hormone-induced changes may need reconstructive surgery to reverse the effect (e.g., gynaecomastia [breast development] caused by estrogens [fed to boys]), while other changes are not reversible (e.g., deepening of the voice caused by testosterone [fed to girls])' (Coleman et al, 2012: 18). Hence, dosing the healthy young with cross-sex hormones has its own form of irreparable damage. Since both 'gender identity' and the goal to have the body of the opposite sex are based on a falsehood, this is not surprising.

Following on from puberty blockers

The UK Department of Health says that cross-sex hormones are not the inevitable next step after taking puberty blockers. They 'will not necessarily be viewed as the pre-cursor to the prescribing of cross-sex hormones' (UK Department of Health, 2019: 30). There is, however, some evidence that the majority of young people on puberty blockers do move on to cross-sex hormones. The Department quoted a study of 84 adolescents in Canada that found that 63 of them moved on to cross-sex hormones, 87% of the girls and 65% of the boys (UK Department of Health, 2016: 10). And according to one of the foremost proponents of the transgender medicalising of the young, Norman Spack, of the "about 200 children" he had dosed with puberty blockers, all had gone on to take cross-sex hormones. "No one changes their mind", he was reported saying (Adams, 2016).

The experience of GIDS staff was that the vast majority of adolescents who started on puberty blockers moved on to cross-sex hormones. Transgender Trend (2019b) quoted from a presentation by GIDS staff at a 2016 WPATH conference, which said that '[p]ersistence was strongly correlated with the commencement of [puberty blockers]' and that no 'patient' within the sample under discussion had desisted once they had been started on the medication. At the same time, however, of those who didn't start on puberty blockers, 90.3% didn't persist in the transgender process.

The Health Research Authority in the UK explicitly acknowledged that dosing with puberty blockers was the first step on what was intended to be a longer process. Commenting on the GIDS puberty-blocker study, they said that '[r]esearchers and clinical staff working in gender identity development … [should] avoid referring to puberty suppression as providing a "breathing space", to avoid risk of misunderstanding'. There was a concern, they said, that dosing with puberty blockers 'might be responsible for generating persistence, rather than "creating space to decide"'.

In response to this concern, they didn't recommend that the puberty-blocker regime be halted, but rather that the terminology be changed to more accurately reflect what it was really intended to do. 'It would have reduced confusion', they said,

> if the purpose of the treatment had been described as being offered specifically to children demonstrating a strong and persistent gender identity dysphoria at an early stage in puberty, such that the suppression of puberty would allow subsequent cross-sex hormone treatment without the need to surgically reverse or otherwise mask the unwanted physical effects of puberty in the birth gender (UK HRA, 2019).

The HRA said that the study wasn't intended to investigate the 'persistence or desistence of offering puberty suppression to a wider range of patients, it was limited to a group that had already demonstrated persistence and were actively requesting puberty blockers'. But the study *was* intended to be used as evidence for 'offering puberty suppression to a wider range of patients'—as long as the results were favourable to the transgender cause, of course, or could be made to seem so. In other words, puberty blockers are indeed intended to 'generate persistence'.

For a critical analysis of the HRA's report, see: Biggs, 2020: 10-12.

The push to lower the age

In 2019, the UK Department of Health was still quoting WPATH and the Endocrine Society recommending 'around 16 years' as the age when cross-sex hormones can be prescribed to adolescents (UK Department of Health, 2019). WPATH's Version 7 said that the age below which children should not be given cross-sex hormones was the 'age of majority in a given country', although they also left open the possibility of dosing younger children: '(if younger, follow the [standards of care] outlined in section VI)' (Coleman et al, 2012: 34). That section, consisting of two short paragraphs of five sentences altogether, doesn't say anything about starting children younger than 16 on puberty blockers.

The trans lobby object to this age restriction, and they have been doing their best to get it lowered or abolished altogether. Olson-Kennedy was reported to say that she has been giving testosterone to 13- and 14-year-old girls in her Los Angeles clinic 'frequently' and to 12 year-olds 'sometimes' (Transgender Trend, 2019a).

Mermaids has been particularly assiduous in its campaign to lower the age at which cross-sex hormones are prescribed to children. It uses the suicide trope to support its case, arguing that medical transition reduces the likelihood that a child will commit suicide (Artemisia, 2017). In her evidence to the House of Commons' inquiry into 'transgender equality' in 2015, Mermaids' CEO, Susie Green, quoted 'parents' who had supposedly told Mermaids that "We have children who are self-harming and suicidal because the wait for those cross-sex hormones is too difficult". Green also cited the director of the Tavistock saying that 'children were "upping the ante" with suicide and self-harm'. Green said she found this 'an incredibly worrying comment from the director of a service where there is a 48% suicide attempt risk' (UK Women and Equalities Committee, 2015: 91, link to Q59). This claim is actually false. There's no '48% suicide attempt risk' among children claiming to be the opposite sex. (For the evidence, see the 'Suicide' section in the '… and statistics' chapter). Green was not challenged on this by anyone on the Committee.

WPATH's Version 8 (Coleman et al, 2022), not surprisingly, wants the age limit lowered. Previous guidelines, they said, 'recommended partially reversible GAHT could be initiated at approximately 16 years of age' (p. p.S65), citing Version 7 (not entirely accurately). They go on to say that '[m]ore recent guidelines suggest there may be compelling reasons to initiate GAHT prior to the age of 16, although there are limited studies on youth who have initiated hormones prior to 14 years of age'. Among those 'compelling reasons' is the need 'to avoid prolonged pubertal suppression, given potential bone health concerns'. This could be one reason why the majority of adolescents who have been taking puberty blockers move on to cross-sex hormones. Cross-sex hormones, especially androgens, replace the bone mass lost or not gained as a result of 'pubertal suppression' (although not completely). Thus the iatrogenic damage of the first stage of transgender medical interventions on the young can be partially reversed in the second stage.

<u>The harm</u>

But no partial reversal can compensate for the adverse effects. There are indications, fairly well-established in the more general research literature, that dosing the healthy young with opposite-sex hormones is harmful. Hormones don't just have the effects transgender wants, i.e. affecting only secondary sex characteristics. As one psychologist/endocrinologist put it: 'Steroid hormones … are not limited to just those related to sex and reproduction. They modulate every cell in the body' (Marrs, 2022). This is called 'pleiotropy': 'the effect of altering sex-hormone levels, through either disease or artificial manipulation, can have pleiotropic effects throughout the body' (Hruz, 2017: 665).

Pleiotropy comes from two Greek words meaning 'more' and 'way' (Wikipedia). It refers to the fact that physiological elements, usually genes but in this case hormones, can affect the body in more ways than one. The hormones of puberty are pleiotropic in the sense that they affect not only secondary sex characteristics, but also the development of height, adult levels of bone density, maturation of the gonads and possibly brain maturation as well. It is not possible to separate out the undesirable effects from the 'desirable' ones ('desirable ' in transgender terms, that is).

Moreover, despite WPATH's insistence that transgender 'medicine' and medicine in general are similar (because they both involve 'risks'), transgender 'medicine' is a actually more like some diseases than a cure for anything. For example, there is a disease that blocks puberty. Called hypogonadotropic hypogonadism, it can occur in either sex and involves a problem with the pituitary gland or hypothalamus, which can fail to send the appropriate messages to the gonads—ovaries or testes—at the right time.[10] As Laidlaw commented, addressing his colleagues who had succumbed to the transgender phenomenon: "You blocked puberty, which is a medical disease … Then you add fuel to the fire of the disease by giving them the wrong sex hormone. What they're doing is intentionally making everything abnormal" (quoted in O'Neil, 2019).

Moreover, dosing young women with androgens can create the same conditions as another recognised disease, polycystic ovarian syndrome (PCOS), which also produces elevated levels of androgens. Females with this disease have a significantly higher incidence of high levels of cholesterol, of cardiovascular disease, and of insulin resistance and hence a tendency towards type-2 diabetes (Hruz, 2017: 666. See also: Laidlaw, 2018).

In a letter to the editor of an endocrinology journal, five concerned clinicians pointed out that the levels of testosterone recommended by the Endocrine Society for young women wanting to be 'men' were those typically produced by androgen-secreting tumours. They also said that the ovaries of the women dosed with testosterone were like those found in PCOS, which can be associated with an increased risk of ovarian cancer and metabolic abnormalities. They noted, too, that males taking estrogen were five times more likely than the general male population to develop venous thrombo-embolism (Laidlaw et al, 2019: 686).

This short letter (Laidlaw et al, 2019), of less than 500 words with eight references, succinctly drew attention to many of the objections raised to the transgender medicalising of children: that there are no objective tests to diagnose 'a "true transgender" child'; that most children grow out of it; that the sudden increase in the numbers of girls turning up to 'gender clinics' is due to social contagion; that the consequences of 'gender-affirmative therapy' are 'highly detrimental', and very few adolescents receiving it opt for fertility preservation; that there is a dearth of research using appropriate methodologies; that psychological therapy has been shown to be effective in relieving 'gender dysphoria'; and that the profession needs to examine transgender medical practices 'through the objective eye of the scientist-clinician rather than the ideological lens of the social activist'. As Michael Laidlaw commented, 'Puberty blockers are not a "pause button" … Rather they are an "eject" button for rational thinking' (Laidlaw, 2018).

Surgery

'Sex Reassignment Surgery Is Effective and Medically Necessary' Version 7 insists in a heading in chapter XI (Coleman et al, 2012: 54). From a brief discussion of studies of people who had gone through the transgender surgical process (Appendix D), Version 7 concludes that 'studies have been reporting a steady improvement in outcomes' from surgery (p.109). However, the authors are dismissive of studies that don't report positive outcomes (Coleman et al, 2012: 107-8): one of which led to the closing of the 'gender' clinic at the Johns Hopkins medical school (Meyer and Reter, 1979); two whole-population studies with none of the selection bias or drop-out rates of the transgender research (Asscheman et al, 2011; Dhejne et al, 2011); and one (Newfield et al, 2006) dismissed because 'it recruited its … participants by a general email rather than a systematic approach' (Coleman et al, 2012: 108). This ignores the

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[10] https://medlineplus.gov/ency/article/000390.htm

fact that the approach used by most, if not all, of the studies with results favourable to the transgender cause is also unsystematic in much the same way, i.e. patients presenting to 'gender' clinics or members of activist sites on the internet (see the 'Evidence' chapter).

Still, the transgender medical profession can call upon any number of published, peer-reviewed putative 'scientific' studies, which 'have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis [concern for appearance, as in 'cosmetic'], and sexual function' (Coleman et al, 2012: 107). Methodologically suspect though they might be, and a sad commentary on the academic peer-review process, they provide a veneer of plausibility to transgender claims for the benefits of its medical procedures.

The surgeries that the transgender medical profession calls 'gender-affirming procedures' include '[for men] breast augmentation, orchiectomy [removal of the testes], vaginoplasty [removal of the penis], [for women] hysterectomy, phalloplasty [creation of a penis], metoidioplasty [enlargement of the clitoris], and facial surgery [for men]' (Coleman et al, 2022: S64). As noted above, Version 7 doesn't recommend genital surgery for minors. Version 8, however, does. It says there are studies suggesting that 'there may be a benefit for some adolescents to having these procedures performed before the age of 18', despite the fact that 'the sample sizes [in the studies] are small'. 'Data are limited on the optimal timing', they say, but rates of such surgeries have increased since 2000, especially 'in the number of TGD youth seeking vaginoplasty' (Coleman et al, 2022: S66), i.e. castration.

Version 8 also mentions a 2017 study of '20 WPATH-affiliated surgeons in the US' that found that over half of them 'had performed vaginoplasty in [sic—'on'?] minors' (p.S66). Thus it would seem that the transgender medical profession is engaging in the age-old male supremacist practice of castrating boys. (This is relevant for Version 8's chapter on 'eunuchs' as a new category of individuals who 'need gender-affirming care'—see my discussion in the 'WPATH update' section of the 'Transgendering the young 2' chapter). Interestingly, the adult men who are claiming to be 'women' are not getting themselves castrated. They are clamouring for 'self-id', i.e. to be recognised as 'women' while keeping their male genitals intact. See the 'Self-identification' section of the 'Lies, damned lies …' chapter).

While ruling out genital surgery for minors, Version 7 did allow that mastectomies 'could be carried out earlier' than the legal age of majority, 'preferably after ample time of living in the desired gender role and after one year of testosterone treatment' (Coleman et al, 2012: 21). Version 7 didn't specify an age limit below which it would be inadvisable to carry out 'chest surgery' on girls, but it is being performed on girls as young as 13 and 14. In a group of girls and young women aged 13 to 25, surveyed by Olson-Kennedy and her colleagues in the second half of 2016, there were two who had had mastectomies at the age of 13, five who were 14 years old and nine who were 15 (Olson-Kennedy et al, 2018: 434, Figure). Version 7's advice about a year on testosterone before surgery had been ignored. There were nine girls in the study who had been taking testosterone for less than a year, six of them for less than six months (Table 2, p.434). So much for WPATH's 'standards of care'.

But Olson-Kennedy wants to go beyond those 'standards' anyway. In the case of genital surgery, she believes that the WPATH guidelines don't go far enough. She said on 18 March 2016 on the WPATH Facebook page that she was "wondering" if the next version [Version 8] "might be changing guidelines around genital surgery in trans women [i.e. boys] younger than 18 … [who] are forced to navigate high school with 11y/o 'male' genitals until 18" (quoted in 4th Wave Now, 2016). (Note the inverted commas around 'male', as though these children's genitals were not really male). She got her wish, not surprisingly, since she and her colleagues are quoted favourably throughout Version 8.

Part of the justification for performing mastectomies on such young girls referred to 'the negative health outcomes related to the practice of [breast] binding', among which were 'pain, rib fractures, light-headedness, weakness, skin infection, and others' (Olson-Kennedy et al, 2018: 432). But instead of recommending that the young women stop this damaging practice, these stalwart defenders of the transgender faith recommend mastectomy. After all, if the young women don't have any breasts, they won't be tempted to bind them. Such impeccable logic only works, however, by ignoring the welfare of young women.

GIDS are in favour of mastectomies for healthy young women. In 2012, two of their clinicians were publicly recommending that the NHS fund 'bilateral mastectomy [BLM] and male chest contouring for the female-to-male transsexual' (Richards and Barrett, 2013). This was justified partly by asserting that amputating girls' breasts was 'standard clinical practice' both in the UK and in 'a variety of other countries', and partly by citing a number of studies supposedly showing that BLM alleviated distress, improved functioning and enabled the young women to pass as men. In fact, the studies cited did no such thing. They simply assumed it. (For a critique of some of these studies, see the 'Evidence' chapter).

It was also justified by presenting it as a response to what the girls themselves wanted, that common justification for medically transgendering the young. Two of GIDS staff members, for example, said that 'the young person may *at their own request* be referred for surgical interventions. This can include mastectomy, *frequently requested by trans-boys*', i.e. girls (Butler et al, 2018: 635—emphases added). Unfortunately, this is true. Julie Bindel said she did a quick search of the crowdfunding site, GoFundMe, and found that more than 26,000 girls and women were asking for money so that they could pay for double mastectomies (Bindel, 2019).

An earlier Australian study (Jones et al, 2015) found that 51% of 273 girls and women wanting to be male had had breast surgery, although they were not all young, ranging in age from 16 to 64. The authors said that there was little regret, and what there was was related to botched surgery (pp.50-1). The participants also reported that their well-being had improved and that their 'mental health[11] disorders' had reduced (pp.51-3). But this research, like transgender research more generally, suffers from the usual selection bias, i.e. its recruitment methods select only those with positive reactions to their transgender experience, while ensuring the exclusion of

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[11] As an aside, it should be noted that this use of the term 'mental *health*' is a euphemism. What is of concern here is not 'health' but illness, disorder or distress. This euphemising is not confined to the transgender agenda, it is to be found anywhere psychotherapeutic issues are officially discussed. It is similar to the usages in other bureaucratic contexts, of 'challenges' instead of 'problems', 'change' instead of 'reduction' (or 'increase' if it's a reference to prices), and the use of 'may' or 'might' instead of 'this is what ought to happen' or 'this is definitely what is going to happen'. Euphemisms are intended to disguise what is really going on, and it would seem that the belief that they manage to fool most people most of the time is widespread, given how widespread is their usage.

those who regret it. (See the 'Evidence' chapter for a further discussion of selection bias).

The GIDS clinicians quoted above inadvertently acknowledged what is really behind the trans-struck girls' desire to be rid of their breasts. In a throwaway remark they said that it was 'most probably owing to the fact that these [i.e. breasts] are such a marked signifier of femininity' (Richards and Barrett, 2013). In other words, the girls want to get rid of this most obvious sign of their femaleness. The GIDS clinicians, like Olson-Kennedy and her colleagues, then go on to justify the amputation of young women's breasts by interpreting it as a solution to the harms of breast-binding. There is no acknowledgement that mastectomy is even more damaging.

The American Psychiatric Association's 'gender identity disorder' task force also acknowledged that breasts signified femaleness, again with an off-hand remark. 'It is believed', they said (although not by whom), 'that most adults who transition from FTM [female to male] have chest reconstruction surgery [i.e. mastectomy], because the visible contours of female breasts are such a powerful social cue and aspect of gender presentation as [i.e. of being] a woman' (Byne et al, 2012: 779-81) In other words, the girls were suffering from the profound hatred of their female bodies so prevalent among teenage girls growing up in the midst of a culture of pornographic brutality.

This aspect of transgender's grip on girls and young women was stated clearly by a 23-year-old woman who had been through all the surgical stages, mastectomy and the removal of her uterus and ovaries, and who now regretted it. 'I wanted to get rid of the female aspects of myself', she said. She had originally thought she wanted 'to come as close as possible to having a male body', even though she knew at the time she would 'never actually get one'. She also said that, when she was 15, she had been diagnosed with severe anorexia, which she now realised was also about hating her female body. As part of her detransitioning process, she had joined the newly-formed Detransitioner Advocacy Network, along with other young women (Bindel, 2019).

Max Robinson, too, said that she eventually realised that her primary motivation in 'transitioning' was hatred of her femaleness. 'I also thought this treatment was my only hope for coping with the intense feelings of alienation/disgust with my femaleness', she said. 'I was wrong. Transition didn't help. It did harm, harm that I now have to learn how to live with on top of all the shit I thought transition would fix' (quoted in Marchiano, 2017: 354. See also: Robinson, 2021).

As well as trying to lower the age at which the other medical interventions happen, the trans lobby is also trying to get the age lowered at which girls can legally get mastectomies. Olson-Kennedy and her colleagues tell us that 'completion of puberty is plausible even as young as 12 years', and hence that that is an appropriate age when 'transmasculine youth' [i.e. girls who want to be boys] can have 'surgical intervention for those who wish to have a masculine-appearing chest contour' (Olson-Kennedy et al, 2018: 432).

In the US, the demand to lower the age is largely addressed to the medical insurance industry and its refusal to fund transgender surgeries for under-18-year-olds. 4th Wave Now (2017b) quoted a number of members of transgender youth 'support' groups in the US fretting on Twitter about this refusal. One of them was the mother of a girl wanting to be a boy, and founder in 2007 of the Trans Youth Equality

Foundation, which describes itself as 'a national … non profit foundation that advocates for transgender, gender non-conforming, and intersex youth ages 2-18 [sic]'.[12] She said, 'for Top Surgery [i.e. mastectomy], we have many many surgeons willing and doing this at young ages when kids are ready, and yet insurance won't cover, if it does at all until 18'. Olson-Kennedy and her colleagues agree. They complain that these health insurance companies are ignoring WPATH's recommendation that 'individual minors might be candidates for chest reconstruction', the insurance companies 'continue to impose a mandatory age requirement of 18 years for chest surgery' (Olson-Kennedy et al, 2018: 432. See also: 4th Wave Now, 2017a).

The fact that mastectomy has negative, and irreversible, physical consequences gets an off-hand acknowledgement from Olson-Kennedy and her colleagues. '[T]he most common complication of surgery', we are told, is 'loss of nipple sensation'. This was temporary in 59% of the 68 post-surgical participants in this particular study, but in 32% it was permanent, i.e. it has lasted until the time of the survey (Olson-Kennedy et al, 2018: 434). We are also told that '[s]erious complications were rare' (as though loss of sensation in the nipples was not serious), and included 10% of respondents who had 'postoperative hematoma' (bleeding outside a blood vessel), and 'complications of anesthesia (7%)' (p.432).

There is also something called 'post-mastectomy pain syndrome' which is estimated to affect 20% to 50% of women at least three months after their mastectomies (Yuksel et al, 2022). Researchers from the Feinberg School of Medicine at Northwestern University reviewed 45 studies reporting ways of preventing chronic pain after mastectomy. They found that what was needed was a 'multimodal intervention' involving three stages of medication—before, during and after the operation—but that there were 'many medications' that had no effect on 'chronic neuropathic pain after breast cancer surgery'. Consequently there was a need for 'further investigation' (p.46).

Admittedly, this referred to mastectomies for breast cancer, and the chronic pain was sometimes connected to the removal of lymph nodes and to radiation therapy (which doesn't happen in transgender mastectomies). But it has other causes too, including 'anxiety' and 'younger age', both of which are prevalent among the transgender population. (See also: Larsson et al, 2017; Kenny, 2020b: 51-2). As far as I am aware, the question of ongoing pain after mastectomy is not discussed in the transgender literature on the issue. It might not happen, but whether or not it does cannot be known unless the question is asked.

As might be expected, Olson-Kennedy herself is blithely indifferent to the harms she is recommending. In a YouTube presentation where she was arguing that adolescents were perfectly capable of making decisions with life-long consequences, she said, 'If you want breasts at a later point in life, you can go and get them'.[13] Presumably she was talking about surgically implanted artificial protuberances, which might give the outward appearance of breasts, but which have no more sensation than the silicon they are made of. (See also: Horváth, 2018).

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[12] http://www.transyouthequality.org/our-mission

[13] https://www.youtube.com/watch?v=5Y6espcXPJk

For more on the harms of transgender surgery for females, see: Jeffreys, 2014: 66-9.

Rates of regret

Given that the surgery is both mutilating and unnecessary—no one can be turned into the opposite sex—it is likely that some people would come to regret it. As one of the oft-quoted experts in the area said, 'Considering the fact that, once SRS [sex-reassignment surgery] has been performed, a *restitutio ad integrum*[14] is no longer possible, regrets are a tragic outcome' (Pfäfflin, 1993: 69). It would seem, however, that all the follow-up research has found that regrets are extremely rare. Pfäfflin's estimate of the rate of regret was less than 1% for women (whom he called 'men') and between 1% and 1.5% for men (whom he called 'women'). This was based on an overview of the follow-up literature over the previous 30 years and his own clinical data for 295 individuals.

A Dutch study concluded that only 0.3% to 0.6% of those who had undergone surgery regretted it (Wiepjes et al, 2018), while Olson-Kennedy and her colleagues reported from their own study that 67 of the 68 young women who had had mastectomies 'reported no regret about undergoing the procedure', while the other one reported regretting it only 'sometimes' (Olson-Kennedy et al, 2018: 434).

It might seem at first sight that this is a vindication of the transgender agenda. Such small rates of regret must indicate that transgender surgery is fulfilling a genuine need. But such a conclusion is not justified because the quoted rates of regret are unlikely to be the actual rates. The Dutch study (Wiepjes et al, 2018) covered that proportion of the patient population who attended the largest 'gender identity' clinic in the Netherlands from 1972 to December 2015, who were over the age of 18, who had had surgery to remove their testes or ovaries, and who returned to the clinic in order to get replacement hormones in line with their actual sex. Women who had had mastectomies were excluded. More importantly, over a third of the population (36%) was lost to follow-up. How many of those were people who never went back to the clinic because they regretted the experience? The authors themselves even suggest that possibility. They 'could have missed some information', they said, on 'people with regret' (Wiepjes et al, 2018: 8/9).

As with all transgender research, generalisations about the supposed efficacy of transgender medical interventions are confidently asserted while the drop-out rate, which probably contains the evidence contradicting the generalisations, is studiously ignored. The some problem can be found in the Olson-Kennedy et al study (Olson-Kennedy et al, 2018). They reported on 68 young women, but there were 94 young women who had had mastectomies and who were eligible to be included in the study. The other 26 (nearly 28%) were uncontactable or refused to participate (p.433). Perhaps that's where the regret is to be found. Interestingly, that figure of 94 potential participants appears nowhere in the article. It consists of the 68 post-surgical patients plus the 26 who couldn't be contacted. (For a more detailed discussion of rates of regret, see the 'Detransition' section of the 'Transgendering the young 3' chapter).

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[14] 'restoration to the original condition', 'one of the primary guiding principles behind the awarding of damages in common law negligence claims' (Wikipedia).

As for the earlier study (Pfäfflin, 1993), there was no information about drop-out rates, and perhaps there were none. But the population in this study was quite different from the populations turning up at 'gender' clinics these days. Pfäfflin doesn't give an age range for any of the populations he discusses. However, he does mention that the three transgender men (whom he called 'women') who expressed regrets among his own 'patients' were aged 27, 30 and 39 at the beginning of the hormonal treatment, hence they were adults. Nowadays, 'gender' clinics are being inundated with children and adolescents (see the 'Transgendering the young 3' chapter). Rates of regret among adults may be low, but that is unlikely to be the case among those who became caught up in the transgender net when they were young.

But even if no one regretted losing their genitals and their reproductive capacity, that does not justify the surgery. It might currently have reached the point where it's some kind of cultural imperative, and hence ineradicable, at least in the case of adults who can make their own decisions. But that doesn't make the mutilation of healthy bodies any kind of social good. No matter how widespread the clamour for transgender surgery, it remains a form of dangerous medicine. This involves medical interventions that are 'invasive, risky, and lacking a rigorous evidence base, but … enthusiastically embraced and celebrated by members of the medical profession and the public'. Eventually, it 'comes to be mostly seen as misguided, occasionally even criminal' (Clayton, 2022: 691). That WPATH should be recommending surgery for adolescents under the age of 18 is scandalous, although even 18 is too young. Indeed, no one's old enough to make that decision in good faith.

Co-morbidities

The transgender medicalising of the young is worrying enough. What makes it even more worrying is that many of the children and young people presenting at 'gender' clinics have 'co-morbidities', i.e. they have psychological problems as well as their distress at being the sex they are. This is well known among the transgender medical profession. The UK Department of Health (2016: 12, 13), for example, said that 'adolescents with gender dysphoria' had a 'high prevalence of psychiatric comorbidity', especially depression and anxiety, citing studies that had found that this was the case for 22% to 44% of adolescents presenting to the clinics.[15] A more recent Australian study (Atlay, 2021), at the Children's Hospital at Westmead in Sydney, found '[h]igh rates of comorbid mental health disorders … including anxiety (63%), depression (62%), behavioural disorders (35%) and autism (14%)'.

Both Versions of WPATH's 'standards of care' acknowledge that there is a high level of co-morbidities ('mental health [sic] concerns') among those presenting to 'gender' clinics. Version 8 says that '[e]vidence indicates TGD adolescents are at increased risk of mental health challenges'. They go on to say that 'many studies reveal depression scores and emotional and behavioral problems comparable to those reported in populations referred to mental health clinics', mentioning also, 'higher rates of suicidal ideation, suicide attempts, and self-harm', eating disorders, 'ADHD, intellectual disability, and psychotic disorders', as well as autism (Coleman et al, 2022: S62).

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[15] The studies cited were: de Vries, Doreleijers et al, 2011; and Spack et al, 2012.

Examples listed in Version 7 are: 'anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders' (Coleman et al, 2012: 24). No one among the 34 people who signed their names to this latter document noticed that 'a history of abuse and neglect' is a different phenomenon from the rest of the list. Abuse and neglect are not mental disorders. They are an aspect of the external world within which the young person lives. They can certainly be the cause of the mental disorders listed (except for psychosis and autism). But they are not something that can be addressed by focusing solely on the young person.

Transgender on co-morbidities

There are conflicting accounts from the transgender agenda about how to deal with co-morbidities. Sometimes it is said that the existence of co-morbidities precludes admission into any transgender 'treatment plan'; and sometimes it is said that co-morbidities just have to be addressed within the 'treatment plan'. According to the UK Department of Health (2019: 8), the Dutch team have said that young people were only eligible for puberty blockers as long as they had 'no serious co-morbidities'.[16] So if the young person's co-morbidities are serious, they won't be accepted as a candidate for the transgender medical pathway, or they shouldn't be. This also seems to be the implication of a statement by the American Psychiatric Association's task force (Byne et al, 2012), who said, 'Recently, the option has become available for pubertal patients with severe gender dysphoria and *minimal, if any, additional psychopathology* to have puberty suspended medically' (p.764—emphasis added).

A team from GIDS (Costa et al, 2016) believed that WPATH, like the Dutch team, also advised caution in any decision to dose mentally distressed adolescents with puberty blockers. The GIDS team said that 'no signs of psychiatric comorbidity' was one of five criteria WPATH's 'standards of care' suggest should be considered when deciding if an adolescent is eligible for puberty suppression (p.458). The implication is that an adolescent showing signs of 'psychiatric comorbidity' would probably not be accepted for this first step in the medical 'transition' pathway.

However, there is no such statement in the document referenced (Coleman et al, 2011). On the contrary, what WPATH say there indicates that including adolescents with 'psychiatric comorbidities' in the transgender hormonal regime is perfectly acceptable. Far from suggesting that adolescents be found ineligible if they have comorbidities, WPATH's advice to 'mental health professionals' is to include 'coexisting mental health concerns of children or adolescents' in 'the overall treatment plan' (Coleman et al, 2011: 174; Coleman et al, 2012: 14). They admit that '[p]atients with comorbid medical conditions [adults in this case] may [sic] need to be monitored more frequently' (Coleman et al, 2011: 24, 46). (The euphemistic 'may' implies that it's not strictly necessary to monitor these people more frequently). But there is no suggestion that the presence of co-morbidities might be a good reason for not proceeding with any transgender 'treatment plan' at all. Version 8 also agrees that the 'adolescent's mental health concerns (if any)' should be addressed within the

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[16] citing de Vries, Steensma et al, 2011. See also: Cohen-Kettenis et al, 2008: 1894.

course of their 'gender-affirming medical treatment', and not taken as a reason to refrain from such 'treatment' (Coleman et al, 2022: S62).

The GIDS team did suggest that one criterion for the safety of puberty suppression might be the possibility of *delaying* it '[i]n the presence of psychiatric comorbidities' (Costa et al, 2016: 460). But again there was no suggestion that 'psychiatric comorbidities' might be a warning sign not to start a young person on the transgender medical pathway at all.

So some transgender authorities say that the existence of co-morbidities is a sign that a young person is not eligible for transgender medical procedures, others recommend that the co-morbidities be addressed within the transgender 'treatment plans'. It is even claimed that 'gender affirming healthcare' can cure the co-morbidities (Nolan et al, 2019: 186), at least the depression and anxiety, despite the fact that the 'research' that supposedly shows that is acknowledged to be of 'low quality' (White Hughto and Reisner, 2016).

But however transgender medical practice deals with co-morbidities, the official transgender line is that any psychopathology a child or young person might be suffering is the result of other people's nasty attitudes. DSM-5, the bible of the mental 'health' industry, locates the causes of any other problems the children might have firmly with 'others'. '[B]ehavioral or emotional problems' in pre-pubertal children, the American Psychiatric Association assert, are 'related to the increasing non-acceptance of gender-variant behavior by others', and '[i]n older children, gender-variant behavior often leads to peer ostracism, which may lead to more behavioral problems' (APA, 2013: 459).

Both Versions of the 'standards of care' deny that 'gender dysphoria' might be the result of the 'mental health challenges'. '[T]hese symptoms', says Version 7, 'are socially induced and are not inherent to being transsexual, transgender, or gender-nonconforming'. They are the result of 'minority stress' resulting from stigma, prejudice and discrimination (Coleman et al, 2012: 4). Version 8 agrees, repeating this point word for word as it appears in Version 7 (Coleman et al, 2022: S6-S7). Thus, WPATH acknowledges the existence of a higher level of co-morbidities than might be expected, while denying that this has any influence on the etiology of 'gender dysphoria'.

Again, the authors of an academic paper arguing that 'non-binary' and 'genderqueer genders' really do exist, said that these people suffer from

> wider psychological distress, most commonly minority or marginalization stress, which is stress caused by being in a group which is discriminated against and so may lead to psychopathology—it is the discrimination rather than the membership of this specific group which is psychopathogenic (Richards et al, 2016: 97. See also: Olson-Kennedy et al, 2019: 305; van der Miesen et al, 2018: 2314).

But interpreting co-morbidities in terms of 'minority stress', and hence as originating elsewhere than the psyche of the individual presenting with 'gender dysphoria', can mean that the co-morbidities take second place or are ignored altogether.

Dianna Kenny (2019b) said she had observed that the transgender medical process gave 'gender dysphoria' a special status whereby it overrode any other problems the young person might have. 'Gender dysphoria', she said, 'becomes the primary and urgent focus of clinical attention, with other emotional issues being viewed as coincidental comorbid conditions, or as secondary responses to the distress caused by being born in the wrong body' (p.83). Lisa Littman (2021), too, was concerned that, in some cases, co-morbidities were not being adequately addressed. '[F]ailure to explore co-morbidities and the context in which the gender dysphoria emerged', she said, 'can lead to misdiagnosis, missed diagnoses, and inappropriate gender transition'.

As for the question of whether or not 'gender dysphoria' itself was a 'morbidity' (i.e. a mental disorder), these authors insisted that there were 'no higher rates of psychopathology in this demographic' than in the wider society, citing seven references (Richards et al, 2016: 97). This question had already been answered in the negative with the DSM-5's shift from 'gender identity disorder' to 'gender dysphoria'. Or had it? Certainly, the APA task force's report (Byne et al, 2012) said that they couldn't reach agreement about 'whether or not persistent cross-gender identification … is a form of psychopathology', so they had left it out of the report (p.761). At least on this issue, the American Psychiatric Association took no notice of the reservations of some of the members of its task force.

SEND

The trans lobby's cavalier attitude to any other problems the young person might have is exemplified in Stonewall's 'advice' for schools about the most vulnerable children: those with special educational needs and disabilities (SEND). Stonewall's (2020) only interest is how best to 'explain' transgenderism to these children, at least to those with autism or intellectual disabilities, as Jane Galloway pointed out (Galloway, 2022: 47). '[A] child or young person with SEND', said Stonewall's 'guide', 'is just as likely to be LGBT as any other person' (Stonewall, 2020: 62).

Stonewall recommend something they call 'the Gender Unicorn' as 'a useful tool … when working directly with … some children and young people with SEND'. It 'could help them understand the differences between gender identity, gender expression, sex, and orientation' (Stonewall, 2020: 59). The Gender Unicorn is what transgender used to call the 'Genderbread Person'. This is a reference to the Gingerbread Man, presumably chosen to appeal to children because of the connotations of a fairy tale and a sweet biscuit vaguely in the shape of a person. The change to 'Gender Unicorn' is presumably because unicorns are more popular with small children these days. But whatever the reason, both these symbols and their accompanying descriptions are directed to very young children, hence their suitability (in transgender eyes) for children with SEND, at least for those with intellectual disabilities. The 'Gender Unicorn' graphic, as Stephanie Davies-Arai has pointed out, introduces children to the 'biologically-impossible category of being "neither male nor female"' (Davies-Arai, 2019a: 140).

That Stonewall (2020) is indifferent to the specific problems SEND children might face is also indicated by the fact that there is no discussion of the Education and Healthcare Plans that many SEND and autistic pupils have (Galloway, 2022: 48). These are a matter of official policy, and detail what each child is to be given according to their special needs. Any such discussion would need to be specific about those needs. None of these would include 'gender identity', but they might include clarity, honesty and integrity, qualities clearly lacking in the transgender agenda. Another sign of indifference in Stonewall's schools report is the lack of any discussion of the huge increase in referrals to GIDS of children with autism; nor is there any discussion of young people who desist or detransition (Galloway, 2022: 48).

There is, of course, no way to 'explain' a falsehood, and any attempt to do so can only disorient children who already have difficulty with understanding. Telling them that they can be the opposite sex if they want to, or no sex at all, contradicts what they can see with their own eyes. This deliberately misleads SEND children about what is real, and confuses them even further about a world that is already confusing enough.

As Transgender Trend pointed out, children with learning difficulties need teaching that is 'clear, unambiguous and fact-based', while children with physical disabilities really don't need to be told that there is something else wrong with their bodies (Transgender Trend, 2020a: 25. This is a detailed criticism of Stonewall's 'advice' to schools since 2015). Girls with SEND are especially put at risk by the transgender message about toilets. As Stonewall's schools 'guidance' put it: 'Some things that had to be taught to the child or young person originally – for example, the unwritten rules of using public toilets – may need to be taught again to help them as they transition' (Stonewall, 2020: 60). Stonewall expects teachers to tell the girls to ignore the rules they have already learned, and accept males in their own toilets or use men's public toilets. Given that girls with disabilities are at an even higher risk of exploitation and abuse, including sexual abuse, than other girls, this Stonewall demand is worse than indifferent. It shows utter contempt for the safety and well-being of these girls.

Autism

How many?

Autism[17] is a common co-morbidity of 'gender dysphoria'. Just how common is another of those 'unknowns' so prevalent in transgender 'medicine', but two of GIDS' staff members said in an academic, peer-reviewed article that 48% of 2,073 children and young people they saw at the clinic between April 2011 and August 2018 scored in the mild to severe range of autistic behaviours. They also said that 10% of the girls and 7% of the boys scored in the severe range (Churcher Clarke and Spiliadis, 2019: 3). The percentages they cited didn't refer to all the young people presenting to the clinic during that period, only to their own caseloads. Another group from GIDS said that around 35% of young people referred to the clinic presented with moderate to severe autistic traits (Butler et al, 2018: 632). The implication was that this percentage referred to the whole caseload at the clinic, although they didn't say so directly.

The UK Department of Health gave lower figures than those quoted above. They cited one study that found that 13.3% of referrals to GIDS in 2012 mentioned autism spectrum disorder, although they also said that this was probably an underestimate. The Finnish 'gender' service, they said, gave a figure of 26% of adolescents with autism, presumably in the same year, while the Dutch 'gender' service reported 9.4% (UK Department of Health, 2019: 7, para. 1.2.4).

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[17] DSM-5 (APA, 2013: 809) uses the terminology 'autism spectrum disorder', usually shortened to ASD. But I prefer to use the term 'autism' because it's shorter than 'autism spectrum disorder', and more immediately comprehensible than ASD.

An earlier Dutch study had found that 7.8% of 204 children and adolescents referred to 'a gender identity clinic' were identified with autism. This was, the authors said, 'ten times higher than the prevalence of 0.6-1% of ASD in the general population' (de Vries et al, 2010: 933). They also said that the actual incidence of autism among the young people presenting to 'gender' clinics was probably higher than the reported percentage (p.935). A more recent study by the Dutch team found that 6.5% of 573 adolescents wanting to be the opposite sex (the authors said 'gender') were on the autism spectrum (van der Miesen et al, 2018). But whatever the exact proportion, all the percentages quoted are higher, sometimes much higher, than the population overall. According to WHO, the prevalence of autism among children in general is around 1%,[18] and DSM-5 agrees (APA, 2013: 55).

Little official concern

There appears to be little concern about this in the official mental 'health' sector. DSM-5 simply tells us that 'Autism spectrum disorder is more prevalent in clinically referred children [and adolescents] with gender dysphoria than in the general population' (APA, 2013: 459). The figures quoted above were all the Department of Health had to say about autism and 'gender dysphoria'; and despite the information from GIDS' staff quoted above, when the High Court asked for statistics on the young people with autism presenting to GIDS, they were told by Tavistock's lawyer that there was no such information (UK High Court, 2020: para.34).

The Care Quality Commission (UK CQC, 2021) noted that the small sample of 22 of GIDS patient records they reviewed 'did not record consideration of the relationship between autistic spectrum disorder and gender dysphoria'. While this implied that there *was* such a relationship, they had nothing more to say about it. Their discussions with GIDS staff were 'focused on the communication needs of these patients' (p.11); and any failures of 'good practice' on GIDS' part were attributed to the increase in the numbers presenting to the clinic.

Autism and the trans lobby

The transgender lobby also know about this high prevalence of autism among the young presenting to 'gender' clinics. WPATH quotes the DSM-5 almost verbatim: 'The prevalence of autism spectrum disorders seems to be higher in clinically referred, gender dysphoric children [and adolescents] than in the general population (Coleman et al, 2012: 12). A pro-trans review of five independent studies asking about both autism and 'gender identity', and which together amounted to 641,860 respondents, found that those claiming to be the opposite sex or none ('transgender and gender diverse') were 3.03 to 6.36 times as likely to be autistic as those who made no such claims (who were referred to in this review by the insulting trans-speak term, 'cisgender') (Warrier et al, 2020). This review also found that the 'transgender and gender diverse' scored higher than the other respondents on autistic traits—systemising, sensory sensitivity and lack of empathy—even though they had not been diagnosed as autistic. This suggested that there might be a high level of undiagnosed autism among those presenting to 'gender' clinics (Warrier et al, 2020. See also: Dattaro, 2020).

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[18] https://www.who.int/news-room/fact-sheets/detail/autism-spectrum-disorders

The transgender lobby, as exemplified by Stonewall, are not concerned about autism for its own sake, only for the ways in which it might hinder transgender purposes. They pick up on the DSM-5's definition and say that autistic children 'may not see the need to communicate about their feelings, or may not understand that others don't already see them in the same way they see or know themselves to be' (Stonewall, 2020: 57). But the only 'feelings' Stonewall are interested in is 'LGBT [i.e. trans] identity'. 'If the people around them don't understand their LGBT identity', say Stonewall, 'this could lead to increased frustration, and impact negatively on their mental health and wellbeing' (p.57). Of course, Stonewall's reason for existence is what they call 'LGBT identity', not autism, and they are not medical personnel. But their lack of qualifications has not prevented them from giving advice to the medical profession and getting themselves involved in medical decision-making.

And there is one assertion that exposes Stonewall's utter lack of understanding. 'If [autistic children and young people] already have some understanding of autism as a spectrum', they said, 'it can help them to understand gender as a spectrum too' (Stonewall, 2020: 59). But 'autism as a spectrum' is an adult, intellectualised concept that would have no meaning to an autistic young person with the limited capacity for empathy typical of autism. A 'spectrum' implies a series of other people and their feelings, and inability to sense what other people might be feeling is one of the main characteristics of autism. That Stonewall could not see this, is one more example of the trans lobby's dissociation from reality.

Explanations

The important question is: why are autistic young people flocking to 'gender' clinics? Is there something about autism that makes people on the autism spectrum peculiarly prone to being captured by the transgender narrative? Clearly, whether the prevalence is 6.5%, 35% or 48%, there is something of grave importance happening.

Although there is no definitive answer to that question, there are a number of suggestive insights. Transgender Trend (2020a) suggested that the autistic young are especially vulnerable to peer pressure. In a world that is often confusing and where relationships can be incomprehensible, they have a strong desire to fit in (p.24). A girl on the spectrum who doesn't obey society's rules about femininity, or even to notice them, could be susceptible to messages that she is therefore a boy (p.27).

'Transition' as solution:

Another insight into why the transgender narrative might be attractive to the autistic young, and to any other of the distressed young presenting to 'gender' clinics', is that it seems to promise a solution to their life's problems. Speaking from her own experience, Jane Galloway (2022) has described a number of ways in which identifying as 'trans' might be seen as a way out of their difficulties. A 'trans' identity, she said, seems to 'encapsulate… many of the issues experienced by autistic children: feeling othered, not fitting in, feeling different to your peers, being gender non-conforming and often feeling that the social mores, behaviours and clothing attached to your sex do not "fit"' (p.7). It offers a socially recognised way of being different (p.10), a ready-made friendship group, both personal and online, and an instant sense of belonging (p.15), promising an end to the overwhelming sense of isolation. Moreover, autistic young people have a 'natural tendency to gender non-conformity', and 'trans' offers them a socially acceptable way of expressing that (p.15). (See also: Galloway, 2019).

Similarity:

Moreover, there appears to be a similarity between autism and 'gender dysphoria', in that autism and 'gender dysphoria' have many of the same symptoms (e.g. Lane, 2020b; Osborne, 2020). For example, another woman on the spectrum (Hawker, 2020) eventually realised that her belief that she was male was inseparable from her autism. 'I was unwittingly dressing up my Autism', she said, 'in the more fashionable clothing of Gender Dysphoria'. That similarity allowed her to see 'transition' as a promise to change her from 'this awkward, self-loathing autistic girl into a cool and confident man'. It also offered the kind of logical, step-by-step process that appeals to autistic people because it makes the world easier to understand. 'Could this linear thinking, and being presented with a step-by-step path to happiness', she asked, 'be another aspect that is driving autistic people to transition in their teens?'

It was her autism diagnosis that caused her to change her mind. Autism explained her non-normative behaviours, thoughts and feelings in a way that 'gender dysphoria' didn't. 'It saved me,' she said, 'from doing something I would certainly have regretted'. She noted that it was fairly common for autism in girls to go undiagnosed. She herself was not diagnosed until she was an adult. She cited a 2019 study of 177 respondents (Stagg and Vincent, 2019) that found that 14% of 'the transgender and non-binary group' had a diagnosis of autism, while another 28% scored for some autistic traits. This was particularly the case for the young women. These results, the authors suggested, indicated that that autism in girls was not being picked up, a conclusion that 'concords with current thinking', they said (Stagg and Vincent, 2019: 21).

Characteristics of autism:

Galloway (2022) also discussed aspects of the autistic experience itself that make autistic people peculiarly susceptible to the transgender message. She listed some of them as: '[reduced] interoception, alexithymia, [reduced] social understanding, literal thinking, [deficits in] theory of mind, sensory processing issues, and not easily understanding the hidden curriculum' (p.40). Interoception means perceiving our own bodily states, alexithymia means knowing what emotions we are feeling (pp.32-3). Autistic people have limited ability in both these areas, which can mean a disconnection from their own internal reality and a vulnerability to anything that purports to explain it. As for 'social understanding', again this is something autistic people struggle with. As the DSM-5 tells us, autism spectrum disorder is characterised by 'deficits in social communication and social interaction' (as well as 'restricted repetitive patterns of behavior, interests, and activities') (APA, 2013: 809). If they don't understand the norms of sex-role behaviour while being more or less subtly punished when they transgress them, transgender explanations can seem like a way out of their misery.

'Theory of mind' refers to the ability to interpret other people's mental states, difficulty with which is one characteristic of autism. For example, an autistic person might react with laughter or indifference at seeing someone in tears, not realising how inappropriate that is. It differs from empathy because empathy is about being able to *feel* what the other person is feeling, whereas 'theory of mind' is about how to *think* about it. Combined with the linear thinking characteristic of autism—thought that is purely logical, undistracted by emotion or external evidence—autism's deficient theory of mind gives little protection against the linear logic of the transgender narrative.

Some of the advice given to autistic people as a way of managing their deficiencies in the area of 'theory of mind' could have come straight from the transgender playbook. According to one site,[19] autistic people have to trick themselves into believing. The first piece of advice is 'Find your enthusiasm. Avoid [anything] that you feel lukewarm about'. Enthusiasm is certainly characteristic of transgender activism. Hawker (2020), who had been caught up in the transgender fervour between the ages of 16 and 19, said that she had reacted to it in a typically autistic way, as a 'special interest', i.e. a narrow obsession that absorbed her to the exclusion of everything else. She said she had spent hours on social media, 'researching and debating trans topics', and 'educating' everyone around her.

'Think big', the site also advises: 'Think big enough that the affirmation gets you excited, but not so big that you can't help but roll your eyes'. Thinking that you can change your sex, and that that will solve all your problems, is about as big as it gets. There is a hint that scepticism might be possible ('roll your eyes'), although that is undermined by the following exhortation: 'Suspend disbelief'. That is exactly what the transgender agenda wants people to do—to ignore any doubts they might have about the possibility of changing sex, about the interrupting or eliminating of the normal processes of puberty, about the medicalising of a healthy body, about men's claims to be 'women'. The final piece of advice, 'Say it out loud' suits transgender's purposes too. That's the reason for the neologisms ('cis-', 'transphobia', 'assigned at birth', etc.) and the circumlocutions used to avoid saying 'women' (e.g. 'birthing parent', 'people' with cervixes or who need abortions), so that it *can* be said out loud. What autistic young people need, indeed what everyone needs, are ways of telling truth from lies. At the very least that requires the truth to be said out loud too. The transgender lobby know this, hence their strategies of censorship and bullying dissenting voices into silence

Puberty:

Another reason why the transgender narrative might be attractive to the autistic young, especially girls, centres around puberty. Hawker (2020) said that she 'really struggled with [her] changing body' at puberty. She didn't cope well with change at all, she said, much less the kind of changes puberty was bringing about and the speed at which it was happening. Puberty blockers can feel like a lifeline to girls who are not only fearful of change, but also already hooked in to the bodily hatred faced by females in a male supremacist society (Transgender Trend, 2020a: 27). In that sense, transgender medical interventions can seem like a cure.

As two of GIDS' clinicians said, 'Socially transitioning might even have an iatrogenic effect on gender dysphoria as the body becomes a shameful secret that needs to be disavowed' (Hutchinson and Midgen, 2020). But this is not a solution, it is medically-induced harm. The consequence is the exacerbation of 'embodied disconnection and alienation', regret, and lesbian erasure. These authors said that

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[19] https://www.digglicious.com/types-of-essays/what-is-the-difference-between-theory-of-mind-and-empathy/

> had [these young women] not found this relatively novel way of understanding their difficulties (inevitably with the assistance of the internet) through the explanation of "trans", the natural history would suggest they would find themselves living as lesbians (Hutchinson and Midgen, 2020. See also: Griffiths, 2021).

The trans lobby's explanation:

The trans 'research' community have developed their own explanations for the high prevalence of autism among those with 'gender dysphoria', explanations that deny any connection with autism at all. One of those explanations is that autism is being wrongly diagnosed, that the instruments being used to diagnose autism are in fact measuring the symptoms of the 'minority stress' supposedly so prevalent among the so-called 'gender diverse'. It is not autism that is being measured, it is claimed, but the 'social stress and deprivation' suffered by 'transgender youth' as a result of 'high rates of peer and family rejection'. 'These 'social deficits,' this commentator said, 'may not represent true [autism] and may be reversible as patients are affirmed in their gender identities and social stress is reduced' (Turban, 2018).

Another research team (Mazzoli et al, 2022) found some evidence to substantiate this. They followed up 62 research subjects who had been taking cross-sex hormones for 12 months, and found that their scores on the Autism Spectrum Quotient measure had 'significantly decreased'. 'Overall', the authors said, 'the present results seem to … [indicate] that autistic traits in transgender people may not represent ASD per se, but could instead reflect social deficits following the social deprivation that is often observed'. Consequently autistic traits, at least as measured in their sample, 'may represent an epiphenomenon of GD ['gender dysphoria] rather than being part of an ASD condition'. However, an earlier study (Nobili et al, 2020), this time of 118 participants, had found no such improvement. There was no change in the autism traits of their research participants, women or men, after 12 months of cross-sex hormones.

One commentator interpreted such explanations as a claim that 'transition' was a cure for autism, a claim he felt was 'monstrous' (Osborne, 2020). However, that is not quite what is being argued here. Instead, the trans lobby is arguing that symptoms are being wrongly classified as 'autism'. They're caused by transgender 'minority stress', and hence can be mitigated by the transgender medical process because that is the appropriate treatment for them. This is unlikely to be true, but at least they're not saying that transgender medical procedures can cure autism.

Another transgender explanation for the connection between autism and 'gender dysphoria', this time from a giver of advice to the autism community, was that the autistic young are more likely than other young people to identify with 'gender dysphoria' because they are less likely to be inhibited in the expression of non-conforming sex roles. To quote this advice-giver (leaving all the trans-speak intact): 'those with autism won't suppress themselves in light of prevailing mores that perpetuate cisgenderism. By not hiding their preferences, children with autism are more likely to be identified as also having gender dysphoria' (Saleh, 2021).

Such 'explanations' stem from the transgender agenda's blithe indifference to any interests except their own. The denial of the existence of autism (or in the case of the last explanation above, granting it a privileged role in the transgender universe) is part of the overall strategy to deny any connection between 'gender dysphoria' and mental illness. As a mental disorder,[20] autism must not be allowed to besmirch the claimed healthy status of 'gender dysphoria'. It must be argued away, and the transgender lobby uses its usual strategy of lying to do just that.

'Gender dysphoria' as epiphenomenon:

The above explanations—that 'transition' promises a solution to life's problems, that there is some similarity between 'gender dysphoria' and autism, and that there is something in the autistic experience that makes autistic people peculiarly susceptible to the transgender message—suggest that 'gender dysphoria' might not be *sui generis* after all, but rather, an epiphenomenon of other forms of distress the young are experiencing. The APA task force (Byne et al, 2012) do say that something they call 'gender confusion' can be the result of other disorders, but only in the case of the most serious disorders, 'such as schizophrenia or psychotic depression, or emergence of the SRS [sex reassignment surgery] wish in the context of trauma'. There is no suggestion that young people might see the transgender promise that they can change their sex as a way of healing, or just managing, those other problems on WPATH's list—'anxiety, depression', etc.

The task force cited a study that argued for ways to 'distinguish… GID [gender identity disorder] with a comorbid psychiatric disorder from gender confusion that is an epiphenomenon of another disorder', i.e. the ability to tell the difference between 'gender dysphoria' coupled with a co-morbid condition, and 'gender confusion' resulting from some other psychological condition. The study concluded confidently that '[k]nowledgeable clinicians can make this distinction based on the patient's history, including collateral history from friends and family members, and longitudinal follow-up' (Byne et al, 2012: 774-5).

But assertions that clinicians are knowledgeable is not evidence that they are; and the existence of regret, desistance and detransition indicates that, no matter how knowledgeable, either they're not very good at making the distinction, or the distinction can't be made at all (because 'gender identity' is a fictitious entity). And anyway, 'follow-up' is too late. It happens after the decision has been made and the medical procedures, including the surgery, have already happened. It might give the clinicians knowledge, but it won't help those who have gone through the procedures and now regret it.

A number of psychotherapeutic professionals (D'Angelo et al, 2020) said that they had recently been seeing increasing numbers of young patients who had been diagnosed with 'gender dysphoria' as adolescents, and who had received insufficient exploratory psychotherapy which might have helped them understand their distress. The young people now regretted having undergone irreversible medical and surgical processes without any full understanding of what was involved. As well, some of these patients said that, when they voiced doubts about their 'transgender' status, their therapists told them that this was 'internalized transphobia' and encouraged them to continue with the medical interventions. This sounds more like ideology than knowledge.

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[20] I know the correct term is 'neurodiverse', but euphemising doesn't change the reality that autistic people have greater, sometimes insuperable, difficulties managing everyday life than people who are not autistic.

What Keira Bell had to say about her own experience of the transgender medical pathway also indicates that transgender clinicians are not so knowledgeable after all. This is the young woman who brought the judicial review case against GIDS to the UK High Court. (See the 'Transgendering the young 2' chapter). She said that she had so many problems when she arrived at GIDS that 'it was comforting to think I really had only one that needed solving: I was a male in a female body'. She was neither schizophrenic nor autistic, nor had she suffered any immediate trauma (although her childhood had been unhappy). The professionals ignored her co-morbidities, she said. Instead, they affirmed what she admitted was her own naïve hope at the time, that 'everything could be solved with hormones and surgery' (Bell, 2021).

The detransition phenomenon raises the possibility that young people are seeing 'transition' as a solution to their distress, whatever it's called—anxiety, depression, ADHD, personality disorder or autism—in response to the message they are being given by a medical profession captured by a non-existent 'gender dysphoria'. There is no formal research into detransition because the appropriate institutions, the universities, have been wholly captured by the transgender agenda (see the 'Research' section of the 'Strategies' chapter). The evidence is anecdotal but there is a lot of it pointing to the continuing distress of the young enmeshed in transgender's clutches. There are signs that the tide is turning (see the 'Hopeful signs?' section of the 'Transgendering the young 3' chapter), but it is too little too late for many young people.

For further discussions of autism and 'gender dysphoria', see: Glidden et al, 2016;

for further discussions of co-morbidities and 'gender dysphoria', see: Littman, 2018: 13-14/44; Transgender Trend, 2019c;

for the situation in New Zealand, see: Rivers, 2019.

Sterilising the young

One of the possible irreversible effects of transgender medical intervention is sterility. This is not one of the 'unknowns', although the details might be, e.g. at what point the effect on fertility becomes irreversible. One paediatrician (Hruz, 2017) said that the effects of cross-sex hormones are reversible if they've been administered only for a short time, but their effects on fertility are more likely to be permanent the younger the child is when they start taking them.

He cited three studies that found that taking cross-sex hormones damaged the sex cells. One study (Pache et al, 1991) found that the ovaries of 'female to male transsexuals' (i.e. girls and young women) who had been treated with androgens for an average of 21 months, had developed changes indicating they were at risk of PCOS. Sterility is one effect of this disease, because the ovarian follicles stop producing ova. The second study (Schulze, 1988) found that the sperm-producing testicular tissue of male 'transsexual patients who had been submitted to long-term estrogen treatment prior to sex-reversal surgery' lacked the cells responsible for sperm production. The third study (Walczak-Jędrzejowska et al, 2013) found that injecting rats with sex steroids inhibited the maturation of the sex cells (Hruz, 2017: 665-6, n24).

Transgender advocates are well aware of the implications for fertility. In both Versions of their 'standards of care', WPATH acknowledges the adverse effects on fertility of taking puberty blockers and/or cross-sex hormones, and but they only recommend that health care professionals discuss the options with 'patients'. One option is to retrieve sex cells before starting the hormonal regime and freezing them. It is even possible, Version 7 suggests, that stopping the hormones for a time can allow the sex cells to mature. Studies suggest, Version 7 said, 'that the ovary can recover in part from the effects of high testosterone levels', and that 'stopping estrogen may allow the testes to recover'.

Another option suggested in Version 7 is surrogacy. If a woman has had her ova frozen and then her uterus and ovaries removed, she could avail herself of a surrogate woman to carry a pregnancy to term (Coleman et al, 2012: 51). WPATH, not surprisingly, are oblivious to the dehumanising ethical implications of this 'option' for producing babies as commodities, and the misogyny of women's bodies being used as some kind of industrial resource for producing the commodity. Version 8 doesn't mention surrogacy. They assert confidently that 'Restoration of normal ovarian function with oocyte maturation after testosterone interruption has been demonstrated in transgender men [i.e. women] who have achieved natural conception' (Coleman et al, 2022: S157).

Another set of pro-trans experts said that 'Testosterone use by transgender men [i.e. women] causes ovarian stromal hyperplasia [usually found in post-menopausal women] and follicular atresia [breakdown of the ovarian follicles]' (Chen et al, 2017: 120). These effects, the experts say, 'are thought to be at least partially reversible', noting that women (whom they call 'men') who have previously used testosterone have become pregnant once they stopped taking it. 'However', they continue, 'thresholds for amount and duration of exogenous hormone exposure causing permanent negative effects on fertility have not been established' (p.120-1). In other words, no one knows how long a woman can take testosterone before it starts destroying her reproductive capacity, nor what size dose is 'safe', nor what effects it has at various ages.

But why should clinicians care about such facts when they ignore basic facts about the biological differences between the sexes? Take, for example, the casual reference above to 'men' with ovaries who become pregnant (Chen et al, 2017), as though this were a fact too obvious to need explanation. These are medical professionals, most of them working at the Ann & Robert H. Lurie Children's Hospital of Chicago. How can they not know that it's only women who have ovaries and can get pregnant, not men?

Not surprisingly, given how out of touch with reality the transgender agenda is, they are quite cheerful about the risk of infertility. All that's needed is more medical intervention (and expense). As one advocate said, 'if you have even a glimmer of an idea of wanting genetically related kids this means banking sperm and freezing eggs before you begin a medical transition (taking hormones)' (Kylstra, 2015). This was a recommendation specifically about taking cross-sex hormones, but it could also apply to puberty blockers. One of the experts quoted said that 'blocking agents' (as well as estrogen) could have deleterious effects on sperm production. Another expert is quoted saying, "'we just don't know what long-term effects testosterone would have, say, on egg production and ovarian function over the long-term'" (Kylstra, 2015).

But 'banking sperm and freezing eggs' cannot happen until puberty is completed because the sex cells are not fertile until then. WPATH do say that cell maturation can continue if the 'patient' stops taking the hormones, but not invariably. As 4th Wave Now said, 'gametes (sperm and ova) require natural, biological puberty to mature to the point that they are viable for reproduction' (2017b). There would be no point in freezing immature gametes because they wouldn't be viable. It is the process of puberty that matures the gametes so that they are capable of reproduction. As one internet resource put it:

> They're not really eggs yet, but are encased in a protective cocoon—the follicle—and suspended in a sort of sleep, waiting for the hormones of puberty to awaken them … When a primary ooctye divides, it goes from having two copies of each chromosome to having only one … This special division process begins at puberty, when the sleeping oocytes that remain awaken.[21]

Not surprisingly, most of the children choose the puberty blockers rather than time-wasting procedures for a hypothetical future: 'All published studies show that take-up … of fertility preservation options among adolescents … is very low, despite fertility counseling prior to initiation of hormone therapy' (Transgender Trend, 2018). See also: Nahata et al, 2016). Keira Bell said that she was given advice about the impact on her fertility of the puberty blockers she was given at the age of 16 (after three appointments). But she was anxious to move on to testosterone, she said, and anyway, at that age she wasn't thinking about having children. Besides, the cost of the ova retrieval and storage process wasn't covered by the NHS (UK High Court, 2020: para.79).

As well, the procedures the young people have to undergo in order to preserve their fertility options range from the unpleasant (for boys) to the dangerously invasive (for girls). For boys, the procedure is simply ejaculation. But for boys who think they are girls, masturbation with their male genitals can be repugnant. As one authoritative source put it: 'The dysphoria … may be too extreme to consider semen collection by masturbation' (Butler et al, 2018: 634). They helpfully suggested 'electroejaculation' as a solution. The set of experts quoted above, however, said that 'none of the transgender women [i.e. men] in our sample cited physical discomfort related to producing a sperm sample as a barrier to [fertility preservation]' (Chen et al, 2017: 121). Once again, this is a casual reference that defies reality. Women can't produce sperm samples. Once again, how is it that these experts do not know this?

As for the girls caught up in the transgender agenda, if they want to preserve their fertility in case the high doses of testosterone destroy their ovaries, they must go through the same procedures as women undergoing IVF do. First, they must be dosed with drugs that 'stimulate' their ovaries to produce multiple ova instead of the usual single one: 'Since the pioneering days of *in vitro* fertilization … ovarian stimulation has been an integral part of assisted reproductive techniques … The goal of ovarian stimulation is to induce ongoing development of multiple dominant follicles and to mature many oocytes [immature ova] to improve chances for conception' (Macklon et al, 2006: 170).

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[21] https://www.babycenter.com/getting-pregnant/preparing-for-pregnancy/eggs-fertility-and-age-how-it-works_10317218

The healthy female body normally produces only one ovum each time it ovulates, and one ovum would not be enough for fertility preservation (or for the IVF procedures that are still experimental after many decades). So ova production has to be stepped up so that a number can be collected all at once: '[Fertility preservation] for transgender men [i.e. women] requires 10-14 days of daily hormone injections to stimulate follicular development [and] monitoring via transvaginal ultrasounds' (Chen et al, 2017: 121). In other words, the women must undergo daily injections for up to two weeks, as well as frequent vaginal penetration with a blunt instrument.

This interference with normal ovulation, however, has created a medical condition sufficiently common to have its own name: 'ovarian hyperstimulation syndrome' (OHSS). This iatrogenic condition has effects ranging from 'mild forms' such as 'nausea, vomiting, diarrhoea, and abdominal distention', to more serious forms such as '[t]hromboembolism, renal failure, adult respiratory distress, and haemorrhage from ovarian rupture' (Beeson and Lippman, 2006: 574). One woman described the effects thus: 'The day after an increased dosage [of Pergonal, the ovarian hyperstimulation medication] my waist size increased one inch every hour. Breathing asthmatically and with my legs swelling perceptibly I was admitted to the casualty ward' (Humm, 1989: 42).

The second part of fertility preservation for girls is even more invasive. It involves surgical intrusion into the female body to collect the ova. This 'oocyte retrieval' involves 'ultrasound-guided transvaginal aspiration of follicular fluid' (Chen et al, 2017: 121). This is via a small laproscopic incision through the vaginal wall and into the ovarian follicles, but it does require a general anaesthetic. Surgery is necessary because ovulation occurs inside a woman's body and the 'oocyte retriever' has to get into the woman's body to get to the ova. This might seem too obvious to need saying, but the language used in the industry—'multiple dominant follicles … to mature many oocytes', for example—does tend to disguise the fact that all this requires surgical penetration into a woman's body. It is no wonder, then, that girls do not bother with fertility preservation. For example, a study of 105 'transgender' 14- to 20-year-olds, 77 young women and 28 young men, found that only one of the young women 'completed oocyte cryopreservation', i.e. opted to undergo the whole fertility preservation process (Chen et al, 2017: 120).

Eugenics

Faced with the evidence of the effects of the hormonal regime on the bodies of the young, the authors of the *Gender Resource Guide* for parents asked, 'Are we sterilizing children?' (MFC, 2019). This is a vitally important question (leaving aside the question of who 'we' are). Sheila Jeffreys (2014, 2012) has likened the transgendering of children to the eugenic sexual surgeries and drug treatments of the past.

A writer on one of the trans-critical websites agrees, referring to it as 'a form of proactive anti-gay eugenics—even if that is not the conscious intention' (4th Wave Now, 2017b). Jennifer Bilek, too, said that the current medicalising of children's bodies echoed the tenets of eugenics. This time the 'undesirables' to be prevented from reproducing are lesbians and gays, as well as the traditional targets, those who have disabilities resulting from autism and other mental disorders. '[E]ugenics hasn't gone anywhere', she said. It is 'currently being forwarded under the rainbow banner of "human rights"' (Bilek, 2022. See also: Osborne, 2020).

Jeffreys acknowledged that there are differences. The sterilisations of the past, for example, were largely deliberately imposed and involuntary, while transgender sterilisations are a side-effect and seemingly chosen willingly after 'informed consent'. However, both are forms of social engineering, she argued, and both assume that 'unacceptable' sexual behaviours have a biological basis and that they can be changed by medical interventions. She pointed out that transgenderism and eugenics are similar in other ways too: the same professions are involved in both (sex researchers, biologists, endocrinologists and psychiatrists); lesbians and gay men were and are a principal target of both; and both are embraced as 'progressive' causes. Sexologists, for example, were often socialists, and support for transgenderism is widely regarded as a 'progressive', leftist cause. Some of its supporters even call themselves 'feminists', even though its erasure of the female is blatantly anti-feminist. Jeffreys noted that the targets of transgenderism are principally lesbians and gays, with the aim of 'eliminating gender non-conformity through shoring up a correctly gendered and heterosexual state and citizenry' (Jeffreys, 2014: 124).

This is a suggestive insight. Certainly, the transgender enthusiasts within the profession are carelessly unconcerned about the sterilising effects on the young of their transgender 'medicine', and homophobia still exists. But the sterilisation of lesbians and gays is a side effect of a process whose main motivation is the ideological elimination of women via the elimination of sex differences. Unlike traditional eugenics, there is no particular category of persons targeted for sterilisation. That the targeted young are lesbian and gay is no accident. They are, after all, living proof that men's unimpeded sexual access to women is not absolute, especially the lesbians. But the primary target of the transgender agenda is women. It is male supremacy's ugly dream of eliminating women, symbolically and superficially but often effectively nonetheless, that leads to the widespread acceptance of male sexual fetishes as a valued part of the human condition. And that destructive targeting of women means the whole human race is targeted for destruction, not just particular categories.

Australia

Most of the examples discussed above come from the UK because that is where the transgender phenomenon has been most thoroughly documented, both by the transgender lobby and by its critics. However, although the UK is a particularly clear example of how widespread the transgender influence is, the situation in Australia is similar. What follows is mainly devoted to a discussion of the influence of the Royal Children's Hospital Gender Service in Melbourne, the leading 'gender' clinic in Australia, and its recent Director, Dr Michelle Telfer. She is also the president of ANZPATH, the Australia and New Zealand branch of WPATH.

Focusing on a single individual is not the best way to address a social problem, and Telfer herself is at least partly justified in complaining about being singled out. However, she is an emblematic figure. Not only has she presented herself as a leading spokesperson for the transgendering of children, she has found support throughout Australian society, in the mass media (except the conservative press), within the Australian government, and more widely in the academic medical literature. She is an appropriate target for a criticism of the transgendering of children, as long as the criticism is not personal, is confined to her role in purveying the line that the transgendering of children is medically necessary and wholly beneficial, and it is clear that she was never acting alone, but was surrounded and supported by a medical profession only too keen to comply with transgender demands. Telfer is not unique.

She is just one of a myriad of transgender apologists, but I spend so much time on her because her media profile means she does have special standing as a leading advocate for the transgendering of the young. Her position as head of the 'gender' clinic at the Royal Children's Hospital is an influential one, and she seizes every opportunity to publicise its work favourably.

At the time of writing, there are five 'gender' clinics for children in Australia. As well as the clinic at the Melbourne RCH, there is the Lady Cilento Children's Hospital Gender Clinic in Queensland, the Sydney Children's Hospital Westmead Gender Clinic in New South Wales, the Perth Children's Hospital Gender Diversity Service in Western Australia, and the Child and Adolescent Mental Health Service at the Women and Children's Hospital in South Australia (Kenny, 2019a, 2020a). (Data from these clinics is discussed in the 'Transgendering the young 3' chapter).

In 2020, the Royal Children's Hospital published its guidelines for the treatment of 'trans and gender diverse children and adolescents' (Telfer et al, 2020). Not surprisingly, the text reproduces the tone and substance of WPATH's 'standards of care', with the emphasis on 'gender affirming psychological and medical treatment' (Telfer et al, 2020: passim). Also in line with WPATH 'standards' is what the RCH guidelines leave out, namely, persisting high rates of distress post-'transition', and the phenomenon of de-transition (Holloway, 2019. See also: Atlay, 2021). In April 2022, Bernard Lane reported that the National Health and Medical Research Council had rejected these 'guidelines' for inclusion in its online portal of clinical practice guidelines, at least partly because there was insufficient information supporting the recommendations (Lane, 2022).

The guide (Telfer et al, 2020) is a handsomely produced document, with photos of good-looking people throughout, most of them children. On page 3, there is a full-page photo of what looks like a glamorous young woman, described by Wikipedia (on 20 July 2022) as an 'actress', a 'transgender rights activist', and 'one of the most visible transgender people in Australia'. This is a young man whose adoption of the accoutrements of femininity looks remarkable successful, at least in the posed photo. The other photos depict three children and an androgynous-looking nurse (my guess is a woman) (pp.6, 22). Two of the children are about 10 or 11 years of age, and are shown in a number of photos (pp.6, 8, 13, 22, 26). They appear to be girls (because of the long hair) but they are probably boys, given transgender's ideological reversals. There is a single photo of a small masculine-seeming child (because of the short hair) of about seven or eight who is probably a girl (p.10). Photographs of beautiful children are always a good marketing tool and Melbourne's 'gender' clinic makes good use of it (although only one of the children is shown smiling). Glossy brochures are not arguments, however, and RCH's guidelines simply reproduce WPATH's dubious 'standards'.

In her submission to the Australian Senate Inquiry on Media Diversity (see below), Telfer claimed to have had a major influence on the Australian government in relation to laws governing the dosing of adolescents with hormones—or in her words, 'to improve access to hormone treatment for trans adolescents' (Telfer, 2020: 1)—and on the UN (by way of an Australian government report). She also said that an earlier version the Australian transgender guidelines for 'treating' the young had been praised in an editorial in *The Lancet* medical journal. She had also had a positive 'personal profile' in the *Lancet Child and Adolescent Health* journal in 2019, 'celebrating [her] international influence in the field' (p.1). There is no reason to disbelieve her. The Australian government, the UN and the academic medical journal industry have all been policy-captured by the transgender agenda. Eminent though these institutions are, as is the Royal Australasian College of Physicians which she mentions favourably later, no height of eminence can make a falsehood true.

Eminent or not, Telfer and the RCH 'gender' clinic have received highly favourable treatment in most of the Australian mass media (not to mention by self-styled left-wing governments). For example, Australia's publicly-funded broadcaster, the ABC, has run a series of pro-transgender stories. Writing in the conservative national daily newspaper, *The Australian*, Bernard Lane reported that, in March 2020, the RCH 'gender' clinic was listing nine positive ABC broadcasts and reports on its website under 'media advocacy'; and while a search of the ABC website found 12,900 mentions of the word 'transgender', there wasn't a single mention of 'detransitioners' (Lane, 2020a).

One example of those positive stories was an episode of the ABC's current affairs program, *Four Corners*. Called 'Being me', it featured two 'intelligent and articulate transgender girls' (i.e. boys) gratefully discussing their experiences at the clinic. This was just before the state election in 2014, which was won by the vaguely left-wing Labor Party. Six months later, Lane reported in *The Australian*, the RCH 'gender' clinic was awarded $6 million dollars by the in-coming government. He attributed this, at least in part, to the ABC story and its timing, as well as to the clinic's lobbying of both the then-current Labor administration and the previous conservative one (Lane, 2020a).

Other examples of the ABC's pro-trans favouritism include another *Four Corners* story called 'Not a Boy, Not a Girl', in which an eleven-year-old says: "I am non-binary, which means I have no gender"; and an episode of the ABC's television series, *Australian Story*, called 'A balancing act', aired on 24 May 2021, in which the interviewer referred to Telfer as 'a lifesaving advocate for hundreds of trans children' (Cohen, 2021).[22]

Mainstream media darling though she might be, Telfer has also been criticised for her pro-trans advocacy, largely in the conservative media. The national daily newspaper, *The Australian*, has been writing about what Lane called the 'global concern about the safety and ethics of the "affirmative" transgender medical model' since at least 2014 (Lane, 2020a). When that newspaper published a series of articles in 2019 and 2020, most of them by Lane, criticising the transgender agenda in general and the transgendering of the young in particular, Telfer was deeply offended. She reacted by expressing her dissatisfaction to two mainstream organisations, the Australian Press Council, and in December 2020, the Senate Inquiry on Media Diversity. The text of her Press Council complaint is not publicly available, but the submission to the Senate inquiry is.

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[22] https://www.abc.net.au/news/2021-05-24/michelle-telfer-trans-children-health/100137192

In this submission she complained that she 'became a target of *The Australian* newspaper' in 45 articles published between August 2019 and July 2020. The articles, she said, 'were consistently of a highly critical nature and were repetitious in their false, inaccurate, unfair and unbalanced information that questioned my credibility, integrity and honesty'. She was also portrayed, she said, 'as someone who was harming children' (Telfer, 2020: 1). It was *The Australian*'s reportage that was causing the harm, she said, with its 'prejudicial language, derogatory terms and mis-gendering via the use of the wrong pronouns, designed to dismiss the identities of the young trans people portrayed' (p.4). But while this is a fine ringing endorsement of the trans position, it is not an argument. Her only counter-argument was to assert that what was said in the articles was false, citing as 'evidence' unspecified 'international, peer-reviewed evidence' and WPATH. (For a more detailed discussion of the kind of peer-reviewed evidence Telfer appealed to, see the 'Evidence' chapter).

The Senate were sympathetic towards Telfer's complaint (Australian Senate, 2021: paras.4.19-4.26), not surprisingly, since the Inquiry's Chair was Senator Sarah Hanson-Young of the Greens Party, whose commitment to the transgender cause is unwavering (see the 'Australian Greens' section of the 'Transgender and the Left' chapter). Telfer was referred to as 'an eminent paediatrician' (para.4.20), and the Press Council's adjudication was read selectively, in order to make it seem more favourable to Telfer's case. They said that the Press Council had found that *The Australian* 'had breached several standards', and named three (para.4.22).

The first involved 'one breach of accuracy standards … related to medical treatment standards'. But the only 'factual inaccuracy' the Press Council had noted related to whether the Royal Australian and New Zealand College of Psychiatrists had 'abandoned reliance' on the Australian Standards of Care and Treatment Guidelines for Trans and Gender Diverse Children and Adolescents. *The Australian* said it had, the Press Council said it hadn't (APC, 2021). Whatever the truth of the matter, the finding was not about 'medical treatment standards', but about whether the psychiatrists' organisation accepted or rejected the transgender-generated 'standards'.

The second 'breach' mentioned by the Senate was that the views *The Australian* quoted were not from specialists in the area of transgender medicine, and that therefore 'the publication failed to take reasonable steps to ensure fairness and balance'. It's true that the Press Council's adjudication did say that, but it also said that 'even medical treatment accepted as appropriate by a specialist part of the medical profession is open to examination and criticism and the difficult issues connected with treatment of gender dysphoria need to be debated to allow society to move forward' (APC, 2021). In other words, *The Australian* was quite correct to bring these issues out in the open. Still, in relation to this point, the Senate reported the Press Council (fairly) accurately.

This second breach had a second part to it: that *The Australian*'s reporting lacked fairness and balance in 'linking the criticism so personally to the complainant', i.e. to Telfer (APC, 2021). This point was reiterated in the third 'breach', again accurately—that public interest did not justify 'the extent of references to the complainant in so many of the articles'. It also added another point—that *The Australian*'s reporting said that 'the healthcare practised at the RCHGS is out of step with mainstream medical opinion', and the Press Council disagreed.

So the Press Council found against *The Australian*'s reporting on three points: that it didn't quote any transgender experts; that it shouldn't have mentioned Telfer so frequently; and that it was wrong to say that mainstream medical opinion was opposed to the Royal Children's Hospital's transgender treatment of the young.

What the Senate didn't mention was the Press Council's dismissal of some of Telfer's complaints. The Council rejected Telfer's complaint that *The Australian* had reported 'factual inaccuracies' in relation to 'regret rates for hormone therapy, high rates of de-transition and social contagion', on the grounds of 'the apparent [sic] conflict in research material relating to these issues'. The Press Council said they were 'unable to resolve this conflict' (APC, 2021).

They also found that *The Australian* did show fairness and balance when they 'repeatedly contact[ed] the complainant for comment during the series of articles', and made her an offer of an opinion piece, which she did not accept. And on the ground of public interest, they found that *The Australian*'s reportage of the issue was justified, even though it might have caused Telfer and 'transgender' people 'substantial offence, distress or prejudice, or a substantial risk to health or safety' (Principle 6):

> The Council considers, given the range of issues and concerns such as those expressed in the UK concerning the Tavistock clinic and at least some medical opinion, that the material dealing with the issues was sufficiently justified in the public interest and General Principle 6 was not breached in this respect (APC, 2021).

These aspects of the Press Council's findings undermine the Senate Inquiry's assertion that those findings were 'adverse' in relation to *The Australian*'s coverage of the transgender agenda (Australian Senate, 2021: para.4.77). In fact, in its appeal to the public interest and its acknowledgement that there was 'conflict' about the benefits of trans medicine, the Press Council's finding was more favourable to *The Australian*'s position than to Telfer's. (See also: Quillette, 2021).

For a pro-trans account of the Press Council's decision from a vaguely left-wing independent media outlet, *Crikey*, that is as biased as the Senate's, see: Wilson, 2021.

It would seem as though the Melbourne Royal Children's Hospital does take some note of the criticisms. As a consequence of the finding of a Family Court judge, that the hospital's guidelines for 'transgender health' were misleading people about what the law actually required in relation to parental consent, RCH's online legal advice section removed all references to past Family Court decisions, even those favourable to 'gender identity'. However, that has not led to any diminution in its provision of 'gender services'; nor has the criticism, including a number of peer-reviewed studies, convinced Telfer that 'treatments' such as breast amputation ('chest reconstruction surgery') might not be a good idea. Currently, the RCH 'gender' clinic does not perform mastectomies on adolescent girls, although Telfer has been reported to be lobbying for it (Lane, 2021a).

But despite the criticisms, the clinic Telfer runs goes from strength to strength. In May 2021, it was announced that the Victorian state government was going to provide a $45 million funding package for services for 'transgender Victorians': $21 million 'to strengthen the state's gender clinics and connected services'; $9 million for 'community organisations'; and $6 million for 'Rainbow Door—a free helpline providing information and referrals to the LGBTIQ+ community and their families' (9News Staff, 2021).

Telfer does not speak for everyone involved in 'gender services' in Australia. Clinicians at the Children's Hospital at Westmead in Sydney are not committed to the 'gender affirmative model'. It was evidence of a '"conveyor belt," or "tick the box," mentality', they said. They regarded it as a 'dominant sociopolitical discourse', and felt that it pressured them to abandon what they regarded as 'ethical, reflective practice in mental health' (Kozlowska et al, 2021: 92, 89). They said that the evidence base for the treatment recommended by WPATH 'was and remains sparse' (p.72), and their preferred approach was 'the holistic (biopsychosocial) model' that involved all aspects of the young person's distress, not just their 'gender dysphoria'. They quoted Keira Bell favourably on young people's need for

> "access to psychological support from impartial practitioners who do not subscribe to gender identity ideology and are able to help people explore their thoughts and feelings about their sex, sexuality and the underlying causes of their gender dysphoria" (Kozlowska et al, 2021: 73).

The Westmead team didn't reject the transgender agenda altogether. They expressed the belief that puberty blockers were reversible and that they 'afforded the child and family time for additional reflection' (p.73). Still, the emphasis on psychological support, combined with the acknowledgement that some medical practitioners subscribed to 'gender identity' ideology, is markedly different from Telfer's uncritical embrace of WPATH's standards. It is also a hopeful sign that the transgender agenda does not have it all its own way, at least insofar as the medicalising of the young is concerned.

For a discussion of this report, see: Lane, 2021b.

Justifications

As should be clear by now, the transgender agenda justifies its medical regime on the grounds that, whatever the 'risks', the benefits are worth it. Not proceeding with the medical 'treatments' is even more distressful than whatever the 'risks' might be, they say. To take one typical example, in relation to the prescribing of cross-sex hormones the UK Department of Health said,

> Gender dysphoria can be more distressing in adolescence [than at earlier ages] due to the pubertal development of secondary sex characteristics and increasing social divisions between genders. As a result, adolescents can be at risk of self-harm, despair and can become vulnerable to relationship difficulties, social isolation and stigma (UK Department of Health, 2016: 6).

The Department acknowledged that there was 'very limited evidence (including from other countries) about the effects and harms of prescribing cross sex hormones to young people under 16 years'. This was the reason, they said, why 'young people should be aged around 16 years to receive a prescription for these drugs' (p.6). That there might well be 'very limited evidence' for those over 16, too, is not mentioned.

In the case of puberty blockers, the Dutch researchers did advise caution because that 'treatment' does have 'its risks'. 'However', they say, 'it may be a physical and psychological beneficial way to intervene' (Cohen-Kettenis and van Goozen, 1998: 248). At another point they mention that 'concerns have been raised'—about the fluctuating nature of 'gender identity', about adolescents' capacity for decision-making, and about 'potential adverse effects on health and on psychological and psychosexual functioning'. But they say that 'the benefits clearly outweigh the risks', citing 'the studies that have been published thus far' (Kreukels and Cohen-Kettenis, 2011: 1).

As for the evidence for those 'benefits', according to the NICE reviews (2021a, b) published 10 years later, it is extremely weak. (For a discussion of the NICE reviews, see the 'Research' section of the 'Evidence' chapter). Moreover, the studies Kreukels and Cohen-Kettenis (2011: 7) cite (de Vries, Steensma et al, 2011, plus Annelou de Vries' academic dissertation) are both from their own clinic, the Amsterdam Gender Identity Clinic, and it is questionable that the improvements they found can be generalised to any whole 'transgender' population. Besides, this is one of the studies found to be of 'very low certainty' by the UK National Institute for Health and Care Excellence (NICE, 2020a).

The Dutch team did have other reasons (apart from their questionable 'research') 'for allowing adolescents to start with the GnRH analogs' (i.e. puberty blockers). The first reason is the one given by the UK Department of Health above, i.e. that the young people would be 'at risk' and 'vulnerable' if they weren't given puberty blockers. That is followed by the 'more time to explore their gender identity' excuse. The team then say that preventing puberty prevents the development of 'the "wrong" secondary sex characteristics', makes any subsequent surgery 'redundant or less invasive', and the earlier 'the sex reassignment procedure' happens the better the outcome. Finally, the team say that if the professionals won't supply the medication, the young people will find other, probably illegal sources. The words 'agony', 'suffering', distress' and 'torment' are scattered throughout this list, all referring to how 'gender dysphoric' adolescents supposedly feel about the normal development of puberty (Cohen-Kettenis et al, 2008: 1894-5).

But there is little or no evidence that going through the transgender medical process relieves the distress for everybody who goes through it, both because of the unreliability of the studies supposedly showing that, and because of the refusal to investigate the possibility of adverse reactions.

Leaving aside the question of evidence, transgender justifications for meddling with normal childhood development make no sense (not surprisingly, since they are trying to defend the indefensible). Under the heading *Risks of Withholding Medical Treatment for Adolescents*, Version 7 says:

> Refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. As the level of gender-related abuse is strongly associated with the degree of psychiatric distress during adolescence … withholding puberty-suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents (Coleman et al, 2012: 21).

This seems to be saying that medical interventions are necessary for adolescents because they'll be subjected to 'abuse and stigmatization' if they don't get those interventions, and 'gender-related abuse' is distressing. But although masculine-appearing girls and feminine-appearing boys might be subjected to 'abuse and stigmatization', it is not clear why that requires medical interventions. Besides, the transgender agenda is constantly complaining about the 'abuse and stigmatization' suffered by fully-transitioned adult men. It's one of their claims to vulnerability. So clearly, 'medical interventions' don't stop the 'abuse and stigmatization', and hence this is not a reason for medical interventions, timely or otherwise.

In the specific case of puberty blockers, WPATH tell us that there are

> [t]wo goals [that] justify intervention with puberty-suppressing hormones: (i) their use gives adolescents more time to explore their gender nonconformity and other developmental issues and (ii) their use may facilitate transition by preventing the development of sex characteristics that are difficult or impossible to reverse if adolescents continue on to pursue sex reassignment (Coleman et al, 2012: 19).

But in the case of the first justification, exploration is prohibited by the ban on 'express[ing] a negative attitude towards nonconforming gender identities or indications of gender dysphoria' (Coleman et al, 2012: 15). If disagreement is banned and only 'affirmation' is allowed, there can be no exploration. The children are on a medication pathway and their time is up, both because the social pressure of immersion in the transgender agenda makes escape difficult, and because the medications can have irreversible effects.

The second 'goal' mentioned above admits this: 'Puberty-suppressing hormones … prevent the development of sex characteristics'. If sex characteristics have been prevented from developing naturally, the only solution is more medication; and even that is no guarantee that the 'transition' can be adequately reversed 'if adolescents [choose not to] continue on to pursue sex reassignment'. This cavalier attitude to children's health and well-being is compounded when the guidelines admit that they don't know what are the long-term effects of these 'transition' regimes: 'The current evidence base is insufficient to predict the long-term outcomes of completing a gender role transition during early childhood' (Coleman et al, 2012: 17). And yet, medical 'gender role transitions' for children have proliferated despite the lack of evidence, with the medical profession having climbed wholly on board the transgender bandwagon.

Suicide

Another, oft-repeated justification for medicating healthy young bodies is the claim that young 'trans' people are likely to commit suicide if they are prevented from getting the medical interventions necessary to 'transition'. The implication is that, once they have 'transitioned', the young people are no longer suicidal or otherwise distressed.

Interestingly, this is one claim Version 7 doesn't make. The *Standards of Care* (Coleman et al, 2012) hardly mention suicide. On the one occasion when they do, they cite research that completely undermines the threat-of-suicide argument. That research involved two long-term observational studies that found that suicide and suicidal behaviour were *higher* among 'individuals who had received sex reassignment surgery' than among a non-transsexual control group (Dhejne et al, 2011) and than among the general population (Asscheman et al, 2011) (Coleman et al, 2012: 108).

This contradicts WPATH's own claims, which they backed up by citing a number of other studies showing 'a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery' (p.107). So they responded to the information from the two 2011 studies by criticising their methodology. Both studies', they said, 'lacked an adequate comparison group of transsexuals who either did not receive treatment or who received treatment other than genital surgery' (p.108). (For the problematic methodologies of some of the transgender research, see the '… and statistics' and 'Evidence' chapters).

WPATH's preference, not surprisingly, is for studies that show improvement, and this is the message that is vociferously conveyed to the public by the transgender lobby. Mermaids' Susie Green, for example, has been quoted saying: "Medical intervention is … absolutely vital. If they [young people] feel their body is changing against their will, that's when we get a lot of suicidality, self-harm, lots of young people talking about wanting to be dead … you've got a child who's suicidal and self-harming because their body is changing against their will" (Kleeman, 2015).

Another parent, a respondent to Lisa Littman's online survey, said,

> "The threat of suicide was huge leverage. What do you say to that? It's hard to have a steady hand and say no to medical transition when the other option is dead kid. She [her daughter] learned things to say that would push our buttons and get what she wanted and she has told us now that she learned that from trans discussion sites" (Littman, 2018: 21/44).

Again, a mother ('Annie') whose eight-year-old son was insisting he was a girl (called 'Julia' instead of his original name, Callum), with the support of both parents and, surprise! surprise! Mermaids: "'Suicide," Annie adds. "They kill themselves, you know. And I want a happy daughter, not a dead son'" (Kleeman, 2015). We are not told what happened subsequently. Did the child and his parents persist in their transgender beliefs, with the child moving on to puberty blockers when the time came—eight years old is a bit young, isn't it? Or did the child do what most seemingly transgender children do, i.e. grow out of it?

But whatever happened to this particular child, this is 'nothing short of emotional blackmail' (Transgender Trend, 2016b), directed towards the parents of the children caught up in the transgender agenda, and who are reluctant to 'affirm' the child's 'preferred gender'. Not only are the research projects cited in support of these claims about suicide either too weak methodologically to justify what is claimed for it or do not say what the trans lobby says they say, the suicide scare is thoroughly reprehensible. As Levine and his colleagues argued:

> 'the "transition or die" narrative, whereby parents are told that their only choice is between a "live trans daughter or a dead son" (or vice-versa), is both factually inaccurate and ethically fraught. Disseminating such alarmist messages hurts the majority of trans-identified youth who are not at risk for suicide. It also hurts the minority who are at risk, and who, as a result of such misinformation, may forgo evidence-based suicide prevention interventions in the false hopes that transition will prevent suicide' (Levine et al, 2022: 8)

(For a discussion of the 'evidence' cited in support of the suicide claim, see the 'Suicide' section of the '… and statistics' chapter).

Parents

Younger children do not present at 'gender' clinics all by themselves. They are brought along by their parents, and must have their parents' permission. So part of the answer to the question of who is presenting at 'gender' clinics is 'parents'. Parents are very much part of who presents at 'gender' clinics for children because they are responsible for their children's welfare and they care for and about them. They are a part of it when their children embrace the transgender cause; and they are a part of it when the transgender agenda alienates them from their children when schools don't inform them about what is happening, or when courts override their wishes. They are especially part of it in their reactions, whether with grief-stricken horror, ambivalence, confusion or outright support.

The transgender agenda prefers support of course. As the Dutch team said, even when parental consent is not required, 'it is preferred, as adolescents need the support of their parents in this complex phase of their lives' (Delemarre-van de Waal and Cohen-Kettenis, 2006: S132). Not all parents resist transgender's siren call to their children. By the time they arrive at the 'gender' clinic, many are well on the way to acceptance of the transgender cause, and the prestige and expertise of the medical profession is likely to override any residual qualms they might have.

Still, some parents arrive with lingering doubts or even with outright refusal to permit their child to be medicalised, and that has to be managed. WPATH's Version 7 (Coleman et al, 2012) advises the health professionals working with the children and adolescents to provide parents with (unspecified) 'support' and 'information'. But if the parents are baulking at giving their child permission to engage with the trans agenda—if they 'do not allow their young child to make a gender-role transition'—then 'they may need counseling'. The type of counselling needed sounds unexceptionable: 'to assist them with meeting their child's needs in a sensitive and nurturing way'. But the 'needs' listed are couched in transgender terms: 'ensuring that the child has ample possibilities to explore gender feelings and behavior in a safe environment'. The only context within which 'exploring gender feelings and behaviour' fits is the transgender one.

There is also a hint that WPATH believe that parents' reluctance to allow their child to be caught up in the transgender medical scene is a form of unjustified pressure. An adolescent deciding they don't want to be trans after all ('An adolescent's shift towards gender conformity') 'can occur primarily to please the parents'. The one specific example of advice to be given to parents who *do* support their child's involvement in the trans agenda comes straight from the transgender playbook. They, too, 'may need counseling' involving, for example, 'support in using correct pronouns' (Coleman et al, 2012: 14, 17, 18).

Version 8 (Coleman et al, 2022) has quite a lot to say about parents, including the reluctant ones, although strategic deletions of crucial information make it difficult to know exactly what is being recommended. There is a reference to parental involvement that might be 'harmful to the adolescent or not feasible' (pp.S48, S52, S58). WPATH don't specify what counts as 'harmful' or 'not feasible', but given transgender's view of what constitutes 'harm', it's likely that they are referring to parents who are trying to prevent their children from being drawn into 'gender-affirming medical or surgical treatments'.

Moreover, parental reluctance is downplayed and treated as something to be overcome with 'counselling', 'psychotherapy' and 'psychoeducation'. 'Some parents', the text says, 'may present with unsupportive or antagonistic beliefs about TGD identities, clinical gender care, or both' (p.S58). This is interpreted as support for the trans agenda nonetheless. Parents' 'concerns and feelings … may not necessarily reflect rejection or neutrality'. Rather, they may be part of a process of 'educat[ing] themselves about gender diversity … [and] represent efforts to develop attitudes and gather information that foster acceptance' (p.S53).

Health professionals should not assume that 'parent perspectives' are rigid.[23] There are many parents 'who, over time with support and psychoeducation, have become increasingly accepting of their TGD child's gender diversity and care needs'. However, if parents remain intransigent, if they are 'too rejecting of their adolescent child and their child's gender needs to be part of the clinical evaluation process', there are ways either to bring them into line ('psychoeducation') or to bypass them. WPATH is vague about how to do that, referring only to 'the engagement of larger systems of advocacy and support'. Perhaps this is a reference to the educational system (see the 'Schools' section of the 'Transgendering the young 3' chapter) or the legal system. The latter has often been sympathetic to the transgender cause, although not always (see the discussion of the Bell case in in the 'Transgendering the Young 2' chapter). This engagement is not expressed as a way of dealing with recalcitrant parents. Instead, it is interpreted as helping youth, who 'may require' it in order 'to move forward with the necessary support and care' (p.S58-S59).

Supporting parents is important in the case of prepubescent children too, because 'family factors are often [sic] central to a child's well-being' (Coleman et al, 2022: S73). Nothing is said directly about parents' reluctance, but they are advised that they 'may find it useful to seek psychotherapy for themselves' (along with 'caregivers, siblings, and extended family members'). Among the reasons why they might 'seek psychotherapy' are hints at that reluctance, e.g. they 'are experiencing significant confusion or stress about the child's gender identity, expression, or both', they 'are seeking to process their own emotional reactions and needs about their child's gender identity, including grief about their child's gender diversity and/or potential fears or anxieties for their child's current and future well-being' (p.S74).

The psychotherapy is intended to allay their confusion, stress, grief and fears, not however, by assuring them that their children are perfectly fine the way they are, but by inundating them with trans-speak until they accept the lie that it is perfectly reasonable for a small child to believe they are the opposite sex. This is brainwashing, not psychotherapy.

Nonetheless, WPATH's 'standards' in relation to parental involvement in decisions about their children's welfare have become standard operating procedure everywhere. As Laidlaw noted, in many cases,

> parents are desperate for help for their child and are pressured or duped into the affirmative pathway by doctors, therapists, and school officials. Concerns about harms are minimized, and questions are seen as

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[23] This is my rewriting of the following sentence: 'Although challenging parent perspectives may in some cases seem rigid, providers should not assume this is the case'.

> obstructive. Parents may even be threatened by the legal system and have their child removed from the home (Laidlaw, 2020).

Excluding parents

Another harm of the transgender medicalising of children is to alienate them from their parents. Transgender's preferred strategy in relation to reluctant parents is not to manage them on the actual premises of 'gender' clinics, but to exclude them from any involvement at all. This is stated clearly in a report produced by an organisation calling itself the 'International Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Youth & Student Organisation' (IGLYO, 2019).[24] (For more about this report, see the 'Piggybacking' chapter).

Called 'Only adults? Good practices in legal gender recognition for youth', it is backed by a number of prestigious and powerful organisations who gave their services for free (IGLYO, 2019: 3). It called for governments to enact legislation penalising parents who refuse to acquiesce in the transgendering of their children. States, it said, 'should take action against parents who are obstructing the free development of a young trans person's identity in refusing to give parental authorization when required' (p.14).

The report is unclear about which age the authors believe 'young trans persons' should be when they no longer require parental authorisation. At one point it says, 'by "minors" we generally, but not exclusively, refer to persons between the ages of 16 and 18' (IGLYO, 2019: 11n1). However, the report mentions approvingly the situation in Norway ('the most liberal'), where 'legal gender recognition [is] available at any age', although 'minors under the age of 6 can only have their legal gender altered if they are intersex', and parental consent is necessary for those between six and 16.

Moreover, the report refers to parental consent as 'a huge hurdle' that 'can be restrictive and problematic for minors', and it calls on states to '**Eliminate the minimum age** requirement', both for medical procedures and for parental consent, without specifying any age (IGLYO, 2019: 15-16—original emphasis). So it's not clear whether they are calling for the abolition of the parental consent requirement altogether, or only for those aged between 16 and 18. What *is* clear is their objection to any attempt on the part of parents to protect their children from the transgender process. A parent's concern for their child's welfare doesn't stop at the age of 16, but the transgender juggernaut rolls right over that concern.

Adolescents can already present themselves for medical treatment without the consent or even the knowledge of their parents. While young people below the age of 18 in Australia (16 in South Australia) must usually have their parents' permission for any medical procedures, there can be circumstances where the young person can give their own consent (Choahan, 2018). This is referred to in the legal context as 'Gillick competence', named after the complainant in a law case heard in the UK High Court.

The original legal case had nothing to do with transgenderism. It involved the question of whether a doctor could prescribe contraception to 'minors' under 16

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[24] I don't know why 'Lesbian, Gay' in the spelling out of the acronym is reversed to 'GL' in the acronym itself.

without parental consent. (The 'minors' were girls, of course, although the language was gender neutral). 'Gillick' was the married name of the Catholic mother of ten who brought the original case, arguing that girls under 16, in particular one of her own five daughters, should not be prescribed contraceptives or advised about them. The court found against her, she appealed and the decision was overturned. The case was eventually decided in 1985 in the House of Lords, where the appeals court decision was reversed and it was ruled that it was lawful for doctors to provide medical treatment to under-16-year-olds without parental consent (BBC, 1983).

Thus a legal ruling on a matter unconnected to the transgendering of children can be used to justify keeping parents in the dark about it. In fact, the two issues are not the same, and if the real issue had been addressed in the first place, that would be obvious. The real issue before the court in the Gillick case was whether underage *girls* could access medical contraception. This is a peculiarly female need. Mrs Gillick was not asking the court to prevent her sons, of whom she had five, from getting access to contraception, just one of her five daughters. The court obliterated the sex specificity of the original request by referring to degendered 'minors' and making the case all about age. Like every other institution supposedly established for all, the pattern is male. Oral contraceptives are irrelevant for males, but both sexes have age. The court could not decide the case on the rights and needs of females only (what a surprise!), even female judges, because that would transgress the law's spurious sex neutrality by giving precedence to females.

But if the Gillick case had been decided on the real issue—whether or not underage girls could get access to oral contraceptives without the permission or knowledge of their parents—it would not be so easy to use it for transgender purposes. There would be many people—I am one of them—who would agree with the Lord's ruling in the case of contraception, while strongly disagreeing with its application to the transgender case. In the contraceptive case, it's *pregnancy* that is the problem, not the medical procedure designed to prevent that problem (the contraceptive use), both for the girl herself and for any child she might bear. Gillick was trying to deny her daughter something that would protect her from unwanted consequences; in the transgender case, reluctant parents are trying to protect their children from the harmful consequences of the medical procedures. In the first case, the girl was being denied protection by a parent, in the second, the children are being protected by their parents. Viewed in this way, the two cases are not only different, they're diametrically opposed.

Examples

Nonetheless, the demand to by-pass parents has had some success. An Australian example concerns a teenage girl who was taken into care when a children's court magistrate ruled that she was at risk of self-harm because her parents' refusal to consent to her being dosed with testosterone was 'abuse'. The child protection authorities did agree to the parents' request that the child not be dosed with the cross-sex hormones until they had received a second opinion, and the parents lodged an appeal in the state's Supreme Court, the first test case in an Australian superior court. The child's lawyers also responded with further legal action, applying to the Family Court for approval to begin the hormone 'treatment' (Lane, 2020c). I have been unable to find out whether or not the child's lawyers were successful, but they probably were, given an earlier decision by the Family Court. In September 2020, the court had ruled that a boy called 'Imogen' could 'access oestrogen treatment to aid in her [sic] physical feminisation'. The boy's mother had objected to her son being subjected to the transgender process, but his father approved (Whitbourn, 2020).

It's not just happening in Australia. In 2017 the Canadian province of Ontario passed a law interpreting parents as 'child abusers' if they refused to accept their child's 'gender identity'. The legislation, *The Supporting Children, Youth and Families Act of 2017*, replaced the earlier child protection Act. This is another version of the piggybacking strategy, although the alibi here is not only sexual orientation. 'Gender identity and gender expression' are listed alongside 'race, ancestry, place of origin, color, ethnic origin, citizenship, family diversity, disability, creed [and] sex', as well as 'sexual orientation'. Thus 'gender identity' is given a legal status equivalent to race (Carr, 2017).

Again in Canada, this time in British Columbia, a Supreme Court justice ruled in February 2019 that a 14-year-old girl (called a 'transgender boy') could proceed with injections of testosterone. In this case it was her father who objected and her mother who supported her. The judge said that he was satisfied that the girl knew the risks involved, despite the fact that the consent form the girl and her mother signed made it quite clear that even the experts don't know, and hence it was highly unlikely that a 14-year-old girl would. He also repeated the transgender furphy about suicide as a reason for his decision. He ruled that the girl had to be referred to as a 'boy', and that referring to her with feminine pronouns constituted 'family violence' under the Family Law Act (Holtvluwer, 2019).

Her father appealed this decision and went on to give a number of interviews to the media where he publicly referred to his daughter as a girl. As a consequence he was brought back to the Supreme Court in April and convicted (by another judge) of 'family violence' for his 'public denial of [his daughter's] gender identity'. The judge also issued a 'protection order' preventing him from speaking publicly about the case, while denying that she (the judge) was overriding his freedom of speech (Keenan, 2019).

Initially he complied with this order, but then continued with his campaign to save his daughter's health. In March 2021, he was arrested, charged with contempt of court (because he continued to speak publicly about the case), and jailed on remand (Perse, 2021). At his trial in April he was given a six-month jail sentence (although he will probably spend less time than that because he has already served time in jail) (Goldsmith, 2021; Showalter, 2021a, b).[25] Nonetheless, the power of the transgender lobby is such that it can use the law of the land to jail anyone who disagrees with them. True, he was jailed for contempt of court because he disobeyed a court order. But that order was demanding that he comply with the transgender agenda, and he could not do that because of his concern for his daughter.

In the UK, children have been taken away from their parents by the child protection system, and put into foster care, when the parents try and prevent their children from engaging in the transgender medicalising process. This happened to an autistic teenage boy claiming to be a 'girl', when he told his school that his parents had withdrawn him from the Tavistock clinic six months earlier. Both parents were

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[25] For the 14 April B. C. Supreme Court decision in this case, see: https://www.bccourts.ca/jdb-…txt/sc/19/06/2019BCSC0604.htm

agreed that the boy was not a 'girl'. They had withdrawn him because the clinic had failed to address his autism and were on the point of dosing him with puberty blockers. The school reported the parents to children's services, claiming they (the parents) were being 'emotionally abusive'. Social workers agreed with the school, saying that the boy was likely to face 'significant harm' if he stayed with his parents, and the local authority placed him in a 'child protection plan'. He was eventually returned to his family, but his was not the only case in the UK. According to these authors, at least three children had been taken into care in 2018 because their parents didn't support their claims to be the opposite sex (Manning and Bancroft, 2019).

In an overview of family court decisions in Canada (one of which was the case of the 14-year-old girl described above), an academic in the Faculty of Law at Western University found that judges were, on the whole, more sympathetic to the parents who supported their children's 'gender identity'. They tended to find that supportive parents were acting in the child's best interests, while failure to support a child's 'gender non-conformity' was not. She also found that it was usually the mothers who were supportive and the fathers who disputed their child's 'gender identity' (although there were only a handful of decisions that had been reported). This commentator approved of this tendency of the Canadian courts because 'not favouring the supportive parent risks harming the child by failing to recognize their GNC [gender non-conformity] and fails to condemn any anti-trans bias underlying the unsupportive parent's actions' (Houston, 2019). But then it's doubtful that any Faculty of Law anywhere in the world would dare to be unsupportive of the transgender regime.

Parent support groups

To state the obvious, what is omitted from WPATH's 'standards' is any help or support for parents trying to protect their children from the harms of transgender medicine. The 'counseling' is not intended to help parents with the distress they feel because their children insist they are the opposite sex; nor is it intended to provide parents with advice on how to prevent their children being subjected to unnecessary medical procedures. WPATH, of course, regards the parents' attempts to *protect* their children as 'harmful' and their own trans medical procedures as 'beneficial'.

However, many parents have formed their own support groups, largely online, where they can find accurate information and common cause with other parents going through the same ordeal. 'These distressed parents', say Levine and his colleagues, 'want a psychotherapeutic investigation to understand what contributed to the development of this ['gender'] identity and an exploration of noninvasive treatment options. Frequently, they cannot find anyone in their community who does not recommend immediate affirmation' (Levine et al, 2022).

As far as I am aware, Transgender Trend is the earliest of these groups. Founded in 2015 by Stephanie Davies-Arai, the rest of its team have had to remain anonymous 'for the protection of their children or their jobs'. It is 'an organisation of parents, professionals and academics based in the UK who are concerned about the current trend to diagnose children as transgender, including the unprecedented number of teenage girls suddenly self-identifying as "trans" (Rapid Onset Gender Dysphoria or ROGD)'. As part of its aim of supporting parents, it has been tracking the activities of the transgender crusade in order to keep parents (among others) informed of what is happening.[26]

Two others were set up in 2017: 4th Wave Now, 'one of the few places on the open Internet that openly questions the wisdom of turning gender-questioning kids into lifelong medical patients';[27] and the Gender Critical Support Board, which 'provides support for parents and families who would like a thoughtful and cautious approach to intervention for their gender dysphoric child'.[28] Registration is necessary to get full access to the latter. Another parent-focused group, Our Duty, was started in December 2018, as 'an international support network for parents who wish to protect their children from gender ideology … [and to] facilitate peer support for parents of children with what has been called ROGD and we call transgender ideation'.[29]

At least three groups were started in 2021. There is Parents with Inconvenient Truths about Trans (PITT), 'a space for parents that have been impacted by gender ideology to share their uncensored stories, experiences, and thoughts, while remaining anonymous to protect themselves and their families';[30] Partners for Ethical Care in Boston, with a mission 'to raise awareness and support efforts to stop the unethical treatment of children by schools, hospitals, and mental and medical healthcare providers under the duplicitous banner of gender identity affirmation';[31] and Cardinal Support Network in Ohio (with 'connections outside of Ohio'), as the right place to come '[i]f you are a parent, family member or friend whose loved one is struggling with gender dysphoria, adolescent onset gender dysphoria, or the detransitioning journey'.[32] Both of the latter have raised money to put messages on billboards warning people about the dangers of transgender medicine, e.g. 'Were you or your child harmed by gender medicine? You are not alone', with contact details.

There are also a number of other parent-focused groups, although there is no readily accessible information about when they started: the Gender Dysphoria Support Network, 'an international group that aims to offer psychoeducation and support to families of individuals affected by gender dysphoria';[33] Parents of ROGD Kids, 'a group of parents whose children have suddenly—seemingly out of the blue—decided they identify strongly with the opposite sex and are at various stages in transitioning … [who] are horrified at the growing number of young people whose bodies have been disfigured, their physical and mental health destroyed by transitioning, only to discover—too late—that it did little to relieve their dysphoria';[34] and Trans-Truth, 'a

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[26] https://www.transgendertrend.com/about_us/

[27] https://4thwavenow.com/2017/09/16/new-support-forum-for-parents-of-gender-dysphoric-kids-young-adults/

[28] https://gendercriticalresources.com/Support/forumdisplay.php

[29] https://ourduty.group/

[30] https://pitt.substack.com/about

[31] https://www.partnersforethicalcare.com/

[32] https://www.cardinalsupportnetwork.com/

[33] https://genderdysphoriasupportnetwork.com/

[34] https://www.parentsofrogdkids.com/

source of information on transgender ideology and its impact on women and children'.[35]

Perhaps the best known of the online groups for parents caught up in the transgender maze is Genspect. It describes itself as 'an international alliance of professionals, trans people, detransitioners, parent groups and others who seek high-quality care for gender-related distress', combining '25 different organisations in 23 countries'. They say that they 'offer an alternative to WPATH', with 'a range of education, resources and support for anyone who has been impacted by gender dysphoria'. They urge the use of 'accurate information and terminology', reject 'regressive sex stereotypes', and insist that '[b]iological sex is real' and that there is 'no right or wrong way to be a boy or a girl'.[36]

Although not all the groups mention it upfront, anonymity is clearly necessary if their members, especially the women, are to be protected from the violent reactions of a trans mob intent on bullying critics into silence. (See the 'Violence' section of the 'Strategies' chapter).

For further critical discussions of the transgender demand that parents' wishes be overridden when they are trying to protect their children, and the collusion with that demand on the part of the legal, child protection and education systems, and the psychotherapeutic profession, see: 4th Wave Now, 2017c; Anderson, 2018: Chapter Two; Kearns, 2018; Kowalski, 2022; Lane, 2019, 2021c; Transgender Trend, 2020b.

Conclusion

There are a number of reasons for believing that transgender medical interventions are harmful, protestations such as those by Michelle Telfer notwithstanding. In the first place, there is direct evidence of the harm. The harms of breast-binding, being dosed with puberty blockers and cross-sex hormones, not to mention the amputation of young women's breasts, are all thoroughly documented, not to mention glaringly obvious. Even social 'transition' is harmful (although it involves no physical modifications), to the extent that it embeds the young and their parents deeper within the transgender process. Those procedures may not affect everyone who undergoes them in the same way, thus leaving some leeway for the transgender 'research' community to claim success. But ignoring the high drop-out rates and refusing to seek out those who now regret their transgender involvement and have desisted or detransitioned, casts doubt on those success stories.

Moreover, there is little evidence, all of it highly questionable, of transgender's main justification that such harms are compensated for by their supposed 'benefits'. While some transgender 'patients' might feel better as a result of their transgender medical experience, the studies that supposedly show this are too weak methodologically to justify any such conclusion for everybody who undergoes that experience. In particular, the high drop-out rates hide any dissatisfaction and regret there might be. Cherry-picking only those participants who are happy with their 'transition' (at least at the time of the study) does not prove that transgender medical experiences have had the same result for everyone.

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[35] https://trans-truth.com/

[36] https://genspect.org/

The transgender agenda says that the ‘gender dysphoria’ originates in the children themselves. But why is it that the adult medical profession defers to children in this area, as in no other? But of course that’s not what’s happening. ‘Gender dysphoria’ is a project of adult men. It is promulgated by institutions largely oblivious to the needs of women and children, who follow along because that’s where the power lies, including the power to define what counts as reality. Obliviousness to women means obliviousness to any genuine humanity (because without women there can be no true humanity); and it is obliviousness to what truly counts as human that provides a fertile breeding ground for the lie that is ‘transgender’.

The medical profession has been warned. As the Society for Evidence-Based Gender Medicine put it,

> The gender medicine field has a limited time to self-correct before public health authorities, and increasingly, elected officials who do not understand medicine but do understand the risks of harm to youth, step in to curb the damage (SEGM, 2023. See also: Abbruzzese et al, 2023).

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