LupronGate :: the truth about puberty blockers

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life-saving | affirming | experimental | osteopoenia | chemical castration | identity | adolescence

LUPRONGATE

The Truth About "Puberty Blockers"

BY:

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“You have to kinda nip puberty in the bud, you want to block it.”
—Jeanette Jennings, mother of Jazz Jennings

““I went to the doctor, suicidal, insane, and with ‘gender dysphoria’. They experimented on me! They punished me for being different! For daring to ask for help!”
—Prisha Mosley, age 25

“We were wrong, [Puberty blockers] are not as reversible as we always thought, and they have longer term effects on kids’ growth and development, including making them sterile and quite a number of things affecting their bone growth.”
—Dr Susan Bradley, Canadian pioneer in Paediatric Gender Psychiatry

AUTHOR'S NOTE

I wrote LupronGate in an attempt to reveal the sinister web of Gender Affirmationism that has captured Canada, spreading across all institutions and levels of regulation from the federal level down to local authorities. The 130 page document covers a wide range of interconnected subtopics, including pharmaceutical company malpractice and corruption, the impact of gender affirmation care on children, parental rights, and political and societal influences.

I delve into the legal actions taken against TAP Holdings for price-fixing and fraud, the pharmaceutical industry's focus on profit over patient well-being in the wake of Bahy-Dole, and the role of patent thickets in maintaining monopolies. I highlight the importance of parental guidance, and unveil hidden challenges families face in a society moving away from attachment orientation and toward peer orientation related to gender affirmation care, a shift driven by the technological revolution that scholars like Jon Haidt and Lisa Littman are warning us about. I detail the fiscal and political machinery driving Gender Affirmationism in Canada.

As an approach to care, Gender Affirmation enhances the disembodying and dissociative impact modern digital culture imposes on families, and it does so whilst removing parental influence, thereby thwarting parental efficacy to address developmental concerns in their children. In LupronGate I mention a couple of devastating stories of young girls affected by a reckless domination of gender affirmation in paediatric psychiatric care. I express a profound concern for the well-being of children and families, for ethical considerations in medical and societal practices, and I make an impassioned argument for a careful approach to addressing the issues of gender discordance and all dissociative behaviour and for healthcare delivery for the paediatric and vulnerable patient populations.

I crafted LupronGate from the POV that parental influence + authority play a critical role in the lives of children. My concern remains that Canada has a radical pedagogical culture dominated by normalisation of parental alienation. I question the role of the education system + the state in family decisions related to gender identity and sexuality of young people. How can parents limit the reach of the education system and state in raising their children? How can the state limit the reach of parents in perpetrating real abuse against their children? Where do we find balance between the two, as technological innovation shifts society and foreign interference complicates things? Where do the limits lie for Canadians? Gender Affirmation and the medical scandal revealed by LupronGate, by The WPATH Files, by Hannah Barnes, and by the Tavistock whistleblowers, should cause us as a society to get serious about our duty to young people, and ask these questions, discussing them like mature and emotionally regulated adults.

I received no funding from any person or organisation to research, develop and write this report. I am the sole researcher and author of this work, I consulted many references, and you can consult the full reference list at the end of the document.

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gender affirmation

Gender Affirmation includes social, psychological, medical and surgical interventions in support of the way a person feels about their reproductive class. It includes pronouns and name change and people affirming those, it includes hormone therapy and it also includes body modification surgery.

Gender Affirmation requires a complete submission to the patient's will and whim and it demands dispensing with the medical assessment model of differential diagnoses, called *gatekeeping*. Gender Affirmation demands clinicians dispense with all they know about trauma care, DBT + suicidal threats, personality disorders, as well as dissociative disorders and follow the patient's desire to modify themselves to become the opposite sex.

DEFINITION

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Prologue

I had never heard of Lupron before. I had no idea what Dr. Oakes had prescribed for me to take pre-ablation. No clue. She told me it would reduce the risk of bleeding, a concern for me because of my significant iron deficiency anemia. She did tell me *are you sure you are done, you cannot undo this*. She could have meant the ablation, a fancy term for laser-ing the lining of your uterus to hasten menopause, and she could have meant the Lupron. Combined, the two together spelled the permanent closure of my uterus for baby-making business.

I had no idea she had prescribed a hormone agonist. Lupron sounded like some benign pharmaceutical that would reduce endometrial blood flow. I didn't think because I trusted this doctor to do her own clinical thinking. I felt so anemic in those days I wanted to lick cast iron pans—at one point in my perimenopausal journey my haemoglobin was dangerously low at 11, so Lupron sounded ok if it helped me keep my iron levels from plummeting to those depths again.

Lupron is the trade name for GnRH agonist. Agonist means working against, so like an anti-hormone. This means blocking a natural physiological process in body —like a chemical dam to stop the flow of a chemical or chemicals in a particular tributary of the body. GnRH agonist means blocking the flow of GnRH, which triggers the release of sex hormones — GnRH agonist means blocking the physiologic flow of sex at the brain.

Dr. Oakes did not impress that upon me when she wrote that script and handed it to me. That seems kind of serious to mess around with a hypothalamic hormone for a surgical convenience. As I recall Dr. Oakes made the laser surgery sound risky and she made it sound like the Lupron could reduce the risk. She understated the risks of Lupron. She did not consider the risks for my particular patient profile — according to the AbbVie drug monograph for Lupron, someone with a history of psychiatric events makes a poor candidate for GnRHa therapy.

I did not have a clue that Lupron had become the doorway to many women's secret autonomic nervous system hell. It never occurred to me. A rare trusted doctor recommended Lupron and I didn't question it. Dr. Oakes never warned me about the known severe

autonomic side effects I could experience. It's highly likely she did not know herself, thanks to a thing called Bahy-Dole.

I only received two doses of Lupron and at one point I thought I would die, when inexplicably and temporarily I lost the ability to swallow and had to go to the ER twice in a week. The first time the male MD at St. Paul's Hospital rolled his eyes and dismissed me with Benadryl. The second time, a few days later, the female MD at Vancouver General Hospital listened to me and gave me Decadron and had the respiratory therapist assess me for puffers and a chamber. The Decadron felt like very strong cocaine and the effect lasted for a few days and it felt unpleasant.

I chalked up the strange physiologic effects I felt after receiving Lupron to menopause, remembering that my own mother struggled terribly with menopause at a time when hormone replacement therapy (HRT) did not exist as widely accessibly as it does today. I never for a moment imagined that the severe and sudden autonomic failure and challenge I experienced had anything to do with those 2 doses of Lupron given me. It never even occurred to me that a drug so powerful only certain nursing staff in the clinic can administer it would try to kill me in such a profoundly subversive manner. I only realised very recently, as in within the last few weeks, whilst compiling the research for this book, that my severe and debilitating symptoms most likely happened as a result of taking GnRHa.

I fully recovered and I have no lasting effects, and this story of Lupron is not my story and I did not take an interest in Lupron for my own experience. That I have my own personal experience with Lupron seems to underscore the need to make this information widely available to the masses, to reach as many Canadians as possible.

I have a nursing background and the capacity to conduct research and learn things and this book exists as a result. If I did not know about Lupron, and if I personally felt sidelined by the awful side effects, then how can anyone expect a child going through puberty would or could endure Lupron? I honestly wonder how many Canadians do not know what they do not know. How many doctors do not know what they do not know? How many parents? How many educators and allied professionals?

In my research I discovered an entire treasure trove of evidence that Lupron has harmed many and that AbbVie and the FDA know about the harm and the falsification of and general weakness of the supporting clinical data. I also discovered that one of the most fiercely vocal opposers of Lupron, Dr. Rita Abend, simply vanished from the internet, only to reply “I don’t do that anymore” when an intrepid independent reporter tracked her down to ask her about her work gathering evidence of harm for victims of Lupron. The attempt to promote innovation through the marriage of science and industry has created a medical science landscape where health care has become iatrogenic harm and profits have become more important than people.

Regulators have become desensitized to the harm done to human beings. Doctors have become unwitting victims or deliberate accomplices of the system created by medical science and research controlled by profit incentive and not human progress. Some of us who have awareness of the dangers of Lupron still cling to an idealistic naïveté that pointing out the harm or opposing Lupron in the current antagonistic political process will have any kind of long lasting impact. I encounter many on the frontlines who still believe that we only need to reveal the harm done and everything will magically end and get fixed. The more I dive into Lupron and learn about GnRHa, the more I see misguided nature of this vision.

Look at the Sec 10-K Reports for AbbVie, a thoughtful and sensible American clinical psychologist recently hinted in a discussion about puberty blockers. I took that advice. I took a peak at the Sec 10-K reports. You know what I found, just on initial inspection?

Lupron is the most versatile product in AbbVie’s drug portfolio. Anti-neoplastic, fertility drug, Central Precocious Puberty suppressant, endometriosis treatment, prophylaxis to prevent bleeding for uterine ablation and fibroid removal — that seems like a dream pharmaceutical, doesn’t it? When you consider that patents for it’s biggest money making drug will expire soon, AbbVie likely has no interest in protecting children with depression + anxiety + post trauma stress + “gender dysphoria” as well as women with endometriosis, from severe the iatrogenic harm of Lupron chemotherapy.

On September 18th, 2023, CBC published a piece written by Paige Parsons entitled, *Trans teens and youth say gender-affirming care is 'life-changing.' So why is it so hard to find in Canada?* When the state-funded broadcaster promotes a severe cult-like bias on a vital political, social and health care issue, I believe it's time for independent researchers and writers and journalists to buckle up and somehow find a way to get the facts to the people on the ground. I think far more than "gender ideology", "queer theory", or "cultural Marxism" or "postmodernism" drives the demand for synthetic children and Lupron as a means to create those synthetic children. I hope I can elucidate some of the forces I have observed over the past several years driving this movement, through my work on LupronGate.

A Note About Language Usage

As Helen Joyce and other writers have noted, gender radicalism has waged a war of words upon western society. In an effort to dominate and control institutions in a tyrannical fashion, the Queer Movement has waged a battle over words and their meanings. This impenetrable wall of psyops has proven the most frustrating and refractory force Canadians face. This report details facts hidden, it describes science suppressed and relegated to the proverbial *Pile 13*. That said, I will use language that accurately describes the physical and biological reality, not the whimsical mythical abstraction the progressive mob demands I and others use.

I use the terms *Gender Affirmationism* and *Gender Zealotry* and *Gender Radicalism* interchangeably throughout this document to describe what the extreme *far left* calls *Gender Affirming Care* and *Gender Self ID*. These terms all refer to the distorted belief that humans can change sex because sex doesn't exist except as colonial concept to enslave black and brown people and industrialise the world into misery. Conservatives and other critics of queerification use the term Gender Ideology — it all refers to the same distorted misanthropic dualistic view of the human body. I do not subscribe to the religious belief that says human reproductive biology and physiology doesn't exist, therefore I reject that religious dogma's catechetics for the purposes of this report.

Also note, in the interest of clinical medical accuracy and rigour, in the interest of clarity and of honouring the essence of First, Do No Harm, for this report I utilise pronouns that capture reproductive class and physiologic reality of individuals described in clinical cases and not their chosen self described social identities. The primary values governing this document are *Reveal The Truth Always* and *First Do No Harm*.

Introduction

In the early 1970s GnRH analogue made a revolutionary impact when it provided a safe and effective alternative to surgical amputation of the testicles, known as orchiectomy or simply, castration. Analogue means synthetic formulation of an endogenous hormone. Hormone means a chemical secreted by a gland, defined as a body of secreting cells. Lupron originally and primarily prevented surgical removal of the genitals. Licensed as an anti-neoplastic, GnRH analogue worked by preventing the secretion of endogenous sex hormones, starving the gonads, and shrinking them.

Most importantly, GnRH analogue worked by starving malignant cells that need sex hormones to survive and grow. GnRH analogue has an nearly identity chemical signature as GnRH made by the hypothalamus, with a small tweak that enables it to mimic GnRH enough to occupy the receptor at the cellular level and that's different enough to shut down sex hormone production at its neuronal source.

Today a major off-label use of Lupron involves treating children with emotional dysregulation and dissociative disorders to induce pubertal suppression, in tandem with synthetic cross sex hormones, which induces a synthetic opposite sex faux-puberty. This inevitably leads to a clinical outcome that almost always necessitates surgical removal of the sex organ, aka gonads. Read that again. Today, a major off-label use of Lupron involves stopping sexual maturity in children in order to turn them in to asexual blanks onto which doctors can force a false sexual maturity with opposite sex hormones.

Lysenko tried to make spring wheat into winter wheat and Gender Affirming doctors try to make girls into boys and boys into girls. Lysenko destroyed a lot of important research work and many lives too, and hopefully Gender Radicalism does not create the same damage. Mary Shelley's great work provides a more tragic and poetic analogy, perhaps. The arrogance of doctors who lack the moral compass for their position harm the innocent.

The dominant dualistic philosophy that guides western medicine, i.e. mind versus body, has rendered our society vulnerable to cult movements such as the Gender Affirmation movement. Gender

Affirmation advances the Harry Benjamin argument that medicine must make the body match or conform to the mind. Affirmation therefore happens when doctors make the body match the feeling about the body. Gender Affirming Care describes the industry of medical care which has built itself around providing experimental medical care to children experiencing puberty in order to make their bodies match their thoughts about their bodies.

People genuinely believe the story that a child can receive this miracle drug which will "pause" their natural growth without effect so they can be a kid a bit longer and decide whether they like their natural sex or want to have a synthetic one instead. Parents and teachers and doctors too all believe that the paediatric endocrine system can function like Netflix show you watch and pause to get a snack and then unpause with no disruptions or ill effects. It betrays a deep ignorance about the human body and human sexuality. Kids now seem like streaming social media platforms, you can plug and play and switch programmes anytime you feel like it. Affirming thoughts, no matter how bizarre and unhinged, has now become an objective of medical care.

I began this research in response the bewildering cult of body modification identity that has swept across Canada like a powerful religion. I found it absolutely baffling that legislators embedded a concept into the human rights codes across the country which essentially has no definition beyond the thoughts and feelings individual has about their reproductive class. I continued to find it baffling when I watched 338 seemingly intelligent humans purporting to represent Canadian voters pass legislation that makes "gender identity conversion therapy" illegal because they want to ban gay conversion therapy.

Do we know what specifically gender identity conversion therapy looks like or means? Do the MPs who voted to make gender identity conversion therapy illegal have a clear conception of what they criminalised? What does gender identity conversion therapy look like? Can any of the MPs who voted YEA tell me what they stopped by passage of that law? I continue to wonder what the heck is going on, as I watch public sector unions gather and castigate concerned parents as fascists and bigots. "Gender

identity conversion therapy" does not exist except in the minds of zealots who treat puberty like a disease and dissociation like an identity that needs human rights protection. Parental inclusion does not limit a child's rights, in fact it ensures and protects them.

The mainstream media long ago abrogated its duty to inform the Canadian public. Today, and for several years now, the media in Canada chooses to misinform and manipulate when it comes to the topic of puberty suppression and gender affirmation offered as a solution for children. I decided to learn about Lupron out of necessity — if you want something done and all that. What I uncovered shocked me. Drug companies routinely take risks with human lives. They choose profit over person — why remove a product from the market when you can lawyer up and then throw money at the problem repeatedly?

I began writing this body of work as a report and one third of the way through it became apparent LupronGate will end up more than a report — it will become a book. *LupronGate: The Truth About Puberty Blockers* explores the origin story and reality of "puberty blockers". I don't think or believe that Canadians know the answer to these questions, nor do we have anyone willing to provide us with the information.

1. What are puberty blockers?
2. What do we know about them?
3. Are they safe?
4. Are they reversible?

Gender clinicians tell patients and their parents they have nothing to worry about when it comes to puberty blockers. Why don't we hear more balanced stories in the mainstream news media about the dangers of puberty suppression? Why does the ACLU oppose mandatory chemical castration of pedophiles and sex offenders and also promote the mandatory chemical castration of kids with psychiatric distress?

Why have we regressed back to Victorian times, when doctors treated mood disorders in women by giving them hysterectomies and conducting reproductive experiments on them? Did you know Canada led the world in that medical practise? Why do we forget history — this dooms us to repeat it, doesn't it? Why do we live like tea bags steeping in a brew of obvious lies conjured by industry and its accomplices?

LupronGate explores the origin story of Lupron and it's profile as a

pharmaceutical, the business landscape medical research and pharmaceutical regulations exist within, the development of gender medicine as a medical field and also an industry, and the origin story of pubertal suppression as a treatment regime in for children diagnosed with a questionable psychiatric disorder.

LupronGate explores the origin story of the questionable psychiatric disorder — Gender Dysphoria. LupronGate explores the discovery of sex hormones and reveals some of the animal and human experimentation it triggered, in addition to insight about the the men who conducted these experiments.

Finally, LupronGate will provide a picture of the degree of accessibility of Lupron in Canada.

1. What system exists in Canada to provide Gender Affirming Care to kids?
2. How easily can an impulsive kid get access to Lupron?
3. How much power do parents have to stop their impulsive children from taking Lupron?
4. Who is promoting pubertal suppression in Canada, and how and why?

LupronGate will explore and highlight the capture of medical and allied professions by Gender Radicalism and the very weak evidence they rely upon.

Sex Begins in Your Brain

Sex begins in your brain. The human brain's hardwiring has a built-in programme that sets a course for the development of it's neural network, which supports and drives and sustains life to such a degree we often have blissful unawareness of these delicate mechanisms driving every moment of our existence. In Figure 1 you can see the amygdala + hypothalamus + pituitary gland to scale. This tiny portion of the brain, of which you never think, governs your experiential existence. Cool, huh?

Sex begins in the brain. It starts it's journey in the hypothalamus, the brain's control centre, located deep in the centre of the brain, which secretes gonadotropin-releasing hormone (GnRH) in pulsatile fashion. Then the pituitary, a pea-shaped gland

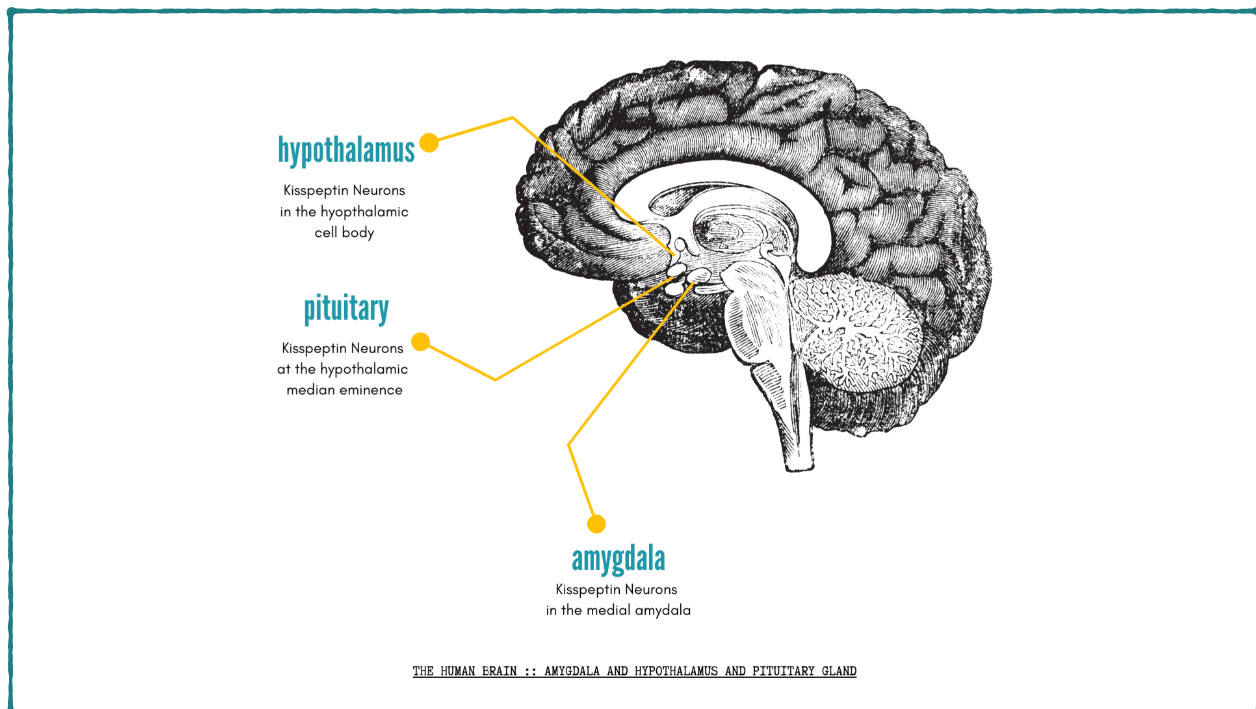


Figure 1 :: The Human Brain :: Amygdala + Hypothalamus + Pituitary

and the master gland of the body that sits just beneath the hypothalamus, wakes up. The pituitary secretes chemicals that wake up the sex organs. We call these chemicals gonadotropins, more commonly leutinising hormone (LH) and follicle stimulating hormone (FSH). Gonadotropins stimulate the gonads — ovaries in a female human and testes in a male human, to produce sex hormones, estrogen (E) + progesterone (P) and testosterone (T).

Fun Fact — Your reproductive system belongs to your neuroendocrine system! Reproductive health vitally impacts the central nervous system and therefore brain health. Descartes was wrong, there is no mind-body dichotomy, the mind is matter we simply cannot see, the mind is a composite of our body's felt sense in addition to our thoughts which emotions generate — a byproduct of physical and electrical energy fusing inside the human shell case we call the body. Puberty is no more a disease than childbirth or menopause, and it's important to always remember that we can trigger disease states when we manipulate these three developmental reproductive events irresponsibly.

In the female reproductive system, FSH stimulates an ovarian follicle to ripen, the level of E rises and an ovum is released. P rises to prepare the uterus for implantation. FSH levels fall and LH levels rise to assist the maturation of the ovum and trigger ovulation and the release of the ovum. This happens around day 14 and it is when the fertile period begins, ie when a woman can get pregnant. The phase governed by LH we call the luteal phase (it is the second half of a 28 day cycle). It involves the build up of the endometrium—this is when uncomfortable premenstrual symptoms occur—and ends with menstruation. Day 1 of the period is the beginning of the cycle—E is low and therefore FSH rises and the cycle repeats.

In the pituitary, GnRH regulates the cells that secrete FSH and LH. So, if you want to shut off the reproductive hormone tap, you need to suppress GnRH, which happens in the neurons of the anterior hypothalamus, you can desensitise the pituitary and force it to stop producing gonadotropins. The hypothalamus is considered part of the limbic system, a central command post for coping with the challenges of living within our complex social networks.

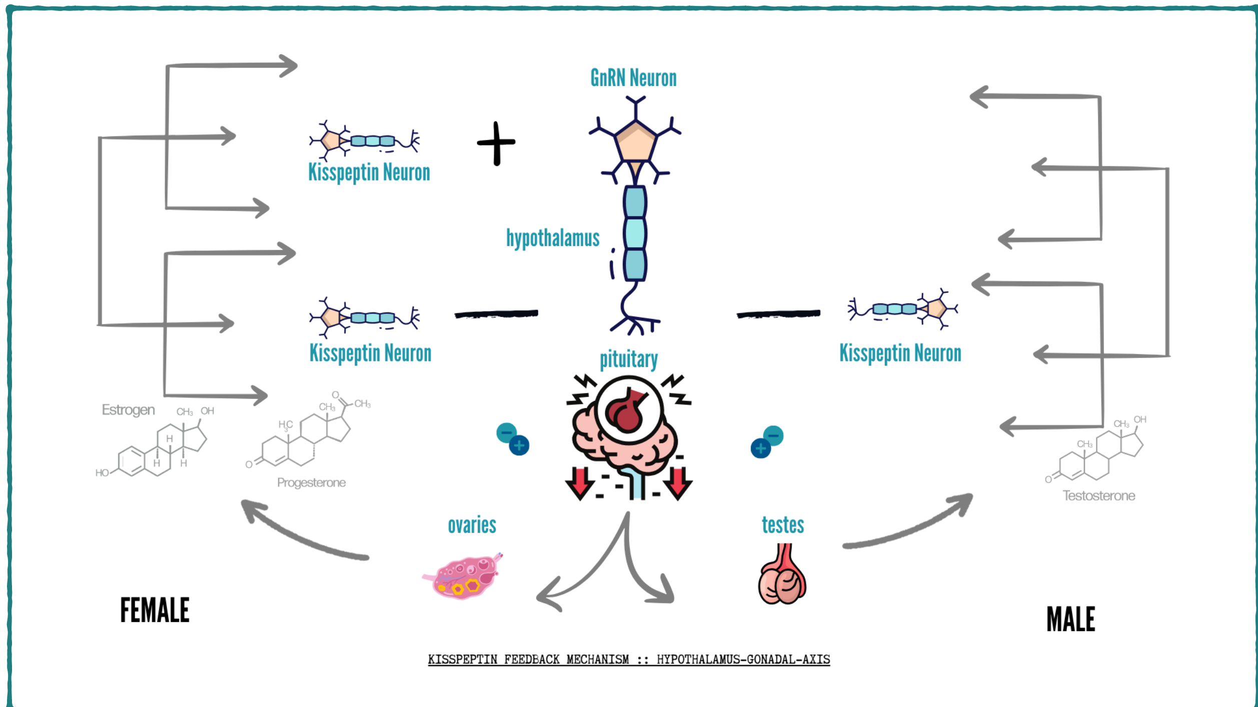


Figure 2 :: Kisspeptin Protein :: A Key to Puberty and Brain Health

Kisspeptin For The Win

The hypothalamus is part of the mood + emotion regulation centre of the brain known as the limbic system. Neurons in a particular region of the anterior hypothalamus secrete GnRH to the pituitary gland. A chemical reaction involving a protein called Kisspeptin wakes up these neurons so they can secrete GnRH. A feedback loop exists between sex hormone + the Kisspeptin mechanism. You can see the complexity of the female hypothalamic-gonadal axis see Figure 2. Where you see the plus sign, high E an P levels stimulate the kisspeptin neurons, and where you see the minus signs they suppress the kisspeptin neurons. What's Kisspeptin and what's it do for the human brain? Why do we need to care about Kisspeptin?

Kisspeptin plays an important role in limbic system activity, behaviour, and modulation of sex hormones … [and has] antidepressant-like effects. Kisspeptin … activates components of the reward system such as the hippocampus, amygdala and the cingulate and enhances the activity of this system … increases emotional and sexual processing and decreases sexual aversion. (Melka et al, 2021)

Okay, what's that mean, in plain language?

Bluntly, it means we need to care about Kisspeptin because without it sexual development becomes disordered. It means that we need to care about Kisspeptin because it plays a crucial role in brain health, especially during puberty, when lots of intense functional pruning and transformation and growth of neurons and their networks and pathways happens. Kisspeptin plays a role in the basic functional brain wiring that govern emotional response such as the reward circuitry and the social circuitry and it augments the brain's capacity for emotional processing and for sexuality and sexual expression and connection and desire. Kisspeptin plays a role in the transformation of the adolescent brain—modulating neuronal processes critical for the health of neural pathways laid down during puberty that govern compulsion, habit formation, and relationships with others. Puberty does far more than give a child secondary sex characteristics and the capacity to reproduce. Puberty provides the mechanism through which the child

physiologic BIOS metamorphoses into an adult physiologic BIOS. When you disrupt power to your computer system during a BIOS upgrade, you risk bricking your system. Why would you think humans would react any differently to interruptions in their BIOS upgrade?

Sex hormones function not only as reproductive messengers but also as neuromodulators—powerful chemical signals that help neurons in the brain grow, prune themselves, and connect. Adolescents exhibit drastic and dramatic intense and erratic and often irrational and impulsive behaviour. Like the terrible twos, adolescence developmentally brings on profound changes in the brain. Growth of the amygdala, and synaptic changes therein, are amongst the functional brain changes that happen during puberty.

Kisspeptin decreases sexual aversion seems like a fairly clear statement. *Do puberty blockers de-sex children?* Aside from this obvious and urgent question, the link between Kisspeptin and puberty blockers concerns me far beyond the reproductive realm. According to the scholarly research I consulted, **Kisspeptin is expressed in the medial nucleus of the amygdala only during puberty**. The amygdala grows in size and undergoes synaptic pruning as the result of sexual maturation. This seems kind of important —**the amygdala determines how a person will emotionally respond in any situation** — fear and anger stimulate the amygdala, which secretes chemical signals that warn the body of impending danger.

Kisspeptin is one of the main modulators of the axis that connects the sex organs and the brain and it plays a role in the structure and function of multiple neuronal circuits in the limbic system, a major emotional regulation and control centre in the brain. The limbic system is a part of the brain involved in behavioural and emotional reactions, and disturbances in its functioning may be the source of some psychiatric as well as degenerative disorders. Successful and healthy human interaction and relationships requires a healthy limbic system. Social connection being a biological imperative like food and water means the limbic system has an important role to play in childhood growth and development. Kisspeptin has a neuroprotective effect, has positive effects on learning + memory + cognitive functions, and might be implicated in

neurogenesis, that is the birth of neurons. Decreased kisspeptin signalling decreases brain metabolism. (Melka et al, 2021)

So, we learned that blocking puberty does more than stop sexual maturation. Blocking puberty also has the effect of blocking the temporal pubertal expression of Kisspeptin Proteins in the amygdala and other parts of the brain's reward circuitry. This has the effect of reducing the brain's own capacity for self regulation and self soothing. What other effects does blocking Kisspeptin have on the paediatric brain? What effect does blocking puberty have on the paediatric brain? We have no idea, we still have a lot to discover about Kisspeptin Proteins and we still have a lot to learn about puberty as a neuroendocrine process.

“Puberty Blockers” Means Chemical Castration

“The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.”

— Nuremberg Code "Permissible Medical Experiments." Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10.

Chemical castration severs the connection between the sex organs and the brain. We see the obvious sexual and physical effect of rupturing the axis connecting the hypothalamus and the gonads and that overshadows the invisible effects of chemical castration. Hormones drive brain health differences between men and women, according to the American Heart Association.

Estrogen is a well-known "master regulator" of the metabolic system of the female brain and body. Within the brain, estrogen regulates glucose transport, aerobic glycolysis, and mitochondrial function to generate ATP in multiple brain regions involved in cognitive functions, such as medial temporal, posterior cingulate and frontal cortex, wrote Mosconi et al in their 2018 paper on the connection between menopausal transition and Alzheimer’s Disease (AD). Depleted estrogen triggers functional changes in the brain. Women can experience noticeable neural changes such as decreased brain metabolism, shrinking hippocampus, and appearance of amyloid plaque that predicts AD.

In fact in her research Mosconi identified a unique neuroendocrine state during the transition from perimenopause to menopause that renders women particular vulnerable. Preclinical studies identified the perimenopause to menopause transition, a neuroendocrine transition state unique to the female, as a sex-specific risk factor for AD. In animals, estrogenic regulation of cerebral glucose metabolism falters during perimenopause.

Women begin to experience a brain energy drop at the cellular level around menopause, triggered by the rapid hormone depletion related to the end of menarche. Pituitary desensitization without a feedback loop from the gonads (ie in the case of

chemical castration or menopause) results in a higher plasma level of FSH (because it has a higher half life than does LH) — FSH levels have an inverse correlation with mood — higher levels of FSH have an association with low mood such as depression + anxiety + irritability.

What does this mean in plain language? It means that shutting of the sex hormone tap in the brain of children the way the Gender Affirming Care does could trigger a decline in brain metabolism, it could put them at risk for cognitive decline, it could impair their glucose metabolism, it will almost certainly create chemical changes that result in decreased mood. Nature has constructed itself with mechanisms to self regulate, to promote homeostasis, the natural state of balance of all things. The neuroendocrine system functions this way — with checks and balance. It means Gender Affirming Care zealots have disturbed a hornets nest without having any idea what they have done and without any plan to fix the fallout. In fact Susan Bradley, a pioneer in the field of paediatric gender medicine, now admits that pubertal suppression did indeed have harmful long term effects.

We now have sufficient evidence to prove the iatrogenic harm of puberty blockers. We now go forward knowing fully that anyone still promoting puberty blockers to kids and their parents and teachers as the panacea to childhood trauma and pubertal angst and even eating disorders that plague adolescent girls promotes an unattainable objective and panacea, also a negligent one.

We are used to thinking of sex hormones as important for fertility and reproduction and we ignore the crucial role hormones play in brain health. Artificially manipulating hormone levels in adolescent brains will indeed have irreversible effects — puberty blockers cannot possibly be harmless and reversible, as Jack Turban, Tyler Black, Meridithe McNamara and the rest of the Paediatric Gender Affirming Care zealots claim. Tinkering with GnRH hormone production + secretion in the body has a far more complex and diffuse effect than the mere shutting off of sex and making a human into a perfectly asexual blank onto which any gender identity can stamp itself via synthetic hormones mass produced by powerful and bloated pharmaceutical companies.

The medical and allied professionals promoting puberty blockers as harmless and reversible really have no idea how Gender Affirming Care will impact kid's brains. Chemical castration of children for the purposes of synthetically transforming them into the opposite sex will not relieve any emotional distress they have over the long term, it has no long term benefit to the child, nor to the larger society. Pubertal suppression advances no clinical scientific objective. It does not meet the criteria set out by the Nuremberg Code.

Gender Affirming Care zealots focus on children who have a complex psychiatric profile that includes suicidality and they treat them with GnRH agonist and they call it life-saving and they call it affirming an innate identity. What human being has an innate identity that requires that human to chemical and surgically destroy their physical form into order to survive and thrive in existence and life? Read that sentence and think carefully what it asks you. Then ask yourself what is a *trans kid*, why do you expect me to believe that stopping a natural growth process in a child will be the life saving long term solution for this child?

Zealots promoting Gender Affirming Care have concocted dramatic and elaborate lies to justify experimenting on very vulnerable children, some with developmental disabilities and challenges such as autism. Poor study design and cumbersome statistical methods that amount to torturing data sets to render the desired outcome dominate the field of paediatric gender medicine. Certainly hundreds of studies exist to extoll the virtues of paediatric Gender Affirming Care, none of them valid and reliable, none of them able to provide causative evidence of the efficacy of puberty blockers to prevent kids from suffering depression, anxiety, and suicidal ideation and behaviour.

According to Andrew and Tierney, estrogen has been described as being neuroprotective; this is thought to accrue through various mechanisms, including supporting growth and development of cholinergic neurons, increasing cholinergic activity, antioxidant properties, and alternative metabolism of amyloid.

I have questions about "puberty blockers" and gender affirming chemotherapy.

1. How does a gender affirmation chemotherapy regime of GnRH agonist puberty suppression + cross sex hormone therapy impact functional restructuring of an adolescent brain?

2. How does desensitising hypothalamic GnRH neurons impact the kisspeptin neurons?

3. How does suppressing endogenous sex hormone and elevating cross sex hormone impact kisspeptin neurons and the feedback mechanism? How do we account for the impact of circulating gonadotropins on psychological wellbeing?

4. What will happen to these young people who have been "gender affirmed" to the point of a distorted synthetic menopause during puberty?

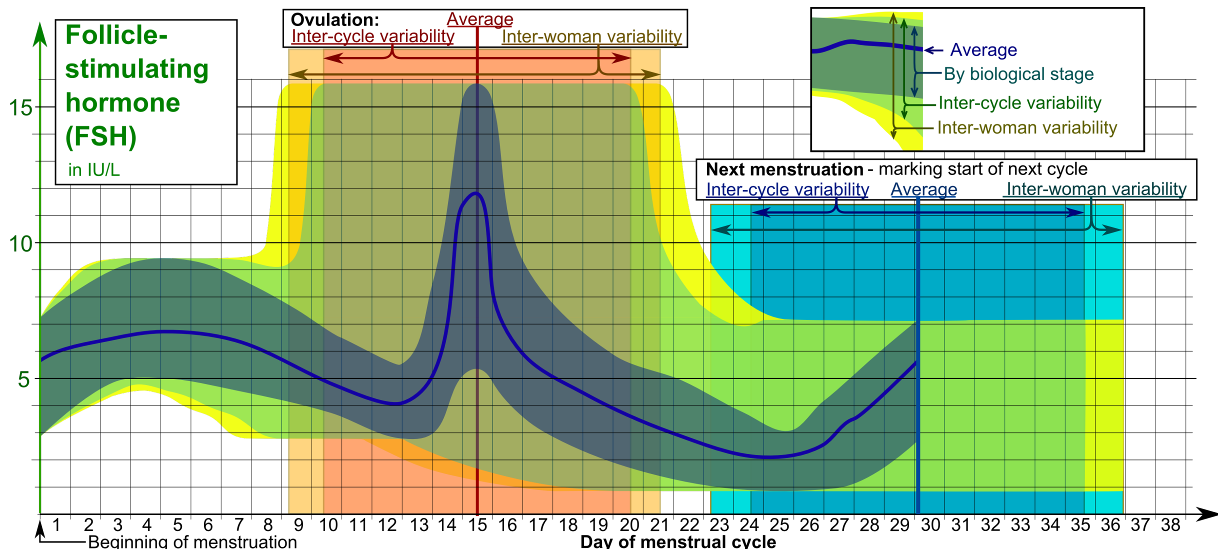


Figure 3 :: FSH Levels and the menstrual cycle :: Häggström 2014

Go back a few paragraphs and reread and review what I wrote. *FSH levels have an inverse correlation with mood*. Think about what it means. High unchecked levels of FSH mean low mood—FSH drives depressed mood and irritability and anxiety. So women, think about your menstrual cycle—look at Figure 3. You know when you are PMSing in that awful week or two of your menstrual cycle and you feel angry and irritated and sad and hateful from the inside of your body, like you want to set stuff on fire and fiddle whilst it burns? That is FSH rising creating those icky and unpleasant emotions. Now think about the fact that puberty suppression does this to children

already struggling with emotional regulation issues and crises in their lives. Also consider that we don't know how long it lasts and what other cascading effects will happen. Does that sound affirming to you? It doesn't sound affirming to me.

Researchers only recently discovered the Kisspeptin Protein and its neural signalling mechanism, so we obviously have not considered how gender affirming care disrupts Kisspeptin signalling and how this will impact children taking Lupron in the long term. There is so much we do not know. We presume a great deal. We have chosen to discard all we know about paediatric physiological development, about basic human reproduction. Why? What if we thought of the pubertal intersection of reproductive and neuroendocrine biochemistry as a very complex spaghetti junction in a motorway?

Profits and Plaintiffs and Patent Thickets, Oh My!

"The corporation's legally defined mandate is to pursue, relentlessly and without exception, its own self-interest, regardless of the often harmful consequences it might cause to others."

— Joel Bakan, The Corporation: The Pathological Pursuit of Profit and Power

Profits

TAP Holdings, a joint venture between an American pharmaceutical company called Abbot and a Japanese pharmaceutical company called Takeda, gave the world Lupron, the trade name for synthetic GnRHa. Takeda Holdings developed the synthetic version of GnRH analogue in 1973. In 1985 Takeda sought to access the American market via a partnership with Abbot Pharmaceuticals, TAP standing for Takeda Abbot Partnership. Takeda manufactured the drug and Abbot distributed it. TAP Holdings developed a reputation for aggressive marketing tactics, including managing clinical data to overstate benefit and understate risk. Thanks to American oligarchic capitalism which created a climate that invites and incentivizes the sacrifice of scholarly statistical research rigour for profit, we have a society of synthetic children.

In 1980 the American Congress passed a law still in effect today called the Bahy-Dole Act. Bahy-Dole removed the structure of controls that protected scientists from the influence of financial incentives which could compromise their work. Bahy-Dole transformed medical science into "a culture of collaboration between scientists and their corporate partners ... the problem with this setup is that the main aim of pharmaceutical companies is to make money, not advance scientific knowledge." (Bakan 2011)

What does this mean for Lupron? It means weak clinical data support Lupron as a treatment for children. The FDA approved Lupron for Central Precocious Puberty based on a study of 55 children who received monthly injections of Lupron until they reached the appropriate age for puberty.

Also, in 1980 The American Psychological Association released its

Diagnostic and Statistic Manual III, thereby establishing child psychiatry. Bob Spitzer had a dislike for Freudian psychology and psychoanalysis and he sought to purge their influence from psychology by introducing a system of biologically informed and evidence-based diagnostic concepts.

Spitzer worked in the biometrics division of the Psychiatric Institute, he did not have a strong clinical background, he had his own strong vision of how he wanted to shape psychiatry away from Freud. The DSM-3 purged all the Freudian ailments in favour of disorders more favourable to the pharmaceutical industry. Diagnoses carry dollar signs — profits before people.

Takeda Pharmaceuticals

Chobei Takeda I opened a shop to sell his Japanese and Chinese herbal medicines in 1781 and a hundred years later expanded into Western medicines such as anti-Malarial medications after purchasing a pharmaceutical company with its own laboratory. Takeda gained exclusive contracts for production in Japan with Bayer in the early 1900s and in 1914 established a research and testing division.

In 1925 Takeda incorporated, in 1933 it established a medicinal plant conservatory, and in 1944 it changed its name to Takeda Pharmaceuticals. In the post war period Takeda's production facilities manufactured vaccine whilst Takeda establishing a joint venture which would become the precursor to Wyeth KK in Japan.

Takeda became a leader in biosynthesis as a result of it's vitamin division and it made sense to branch out to the production of enriched foods including a Vitamin C enriched soft drink called Plussy, and a B1 derivative called Alinamin, which would mitigate the effects of malnourishment. Following the discovery of cephalosporin antibiotics Takeda expanded its facilities to include their manufacture, and also produced a number tranquilizers and sedatives for "nervous disorders".

By 1978 Takeda had established a research foundation, and had begun expansion into the Asian as well as the European markets. In 1985 Takeda established a joint venture with Abbot called TAP Holdings to promote Lupron, a revolutionary drug, to the American Market. In 1988 Takeda opened a second lab, several overseas operations, and an

R&D centre in Europe to expand its portfolio into geriatric areas such anti-diabetic agents and anti-hypertension drugs. Takeda dominates the pharmaceutical industry in Asia and occupies a spot in the top 20 largest pharmaceutical companies across the globe. Possession of fermentation technology positions Takeda as a leader in biotechnology.

Abbot Laboratories

"We sincerely hope that the physician will eventually awake to realize where he stands. Then, there will not be a drug store for every five or six hundred population, growing rich out of refilling prescriptions, counter prescribing patent medicines, while the hard working doctor in the same locality can scarcely make both ends meet. . . . Let the ordinary 'drug store' become what it now really is, a patent medicine stand, a soda water booth and smokers' headquarters, and let the doctor practice medicine, please his patients, fill his pockets and dispense, if he likes, medicines bought where he pleases."
—Dr. Wallace Abbot

Dr. Wallace Abbot established Abbot Laboratories in 1888 to prepare medications in the dosimetry method — meaning isolate the active ingredient in the medicinal plant and then process it into a granule, ie preparing medications in precise + measured (pill) form. Prior to this technological innovation in the preparation of medication, the delivery of medication involved a very imprecise method via fluid extract. In 1916 Abbott synthesized its first medicine, an antiseptic developed by British chemist Doctor Henry Dakin to treat World War I wounded soldiers. During the 1920 through to the early 40s discoveries revolutionizing anesthesia medicine establish a productive development pipeline that created big name chemicals such as Pentothal.

Like Takeda, Abbot got into the production of cyclamates (ie saccharin) and at the time of the FDA cyclamate ban they accounted for one-third of all sales. Abbot established joint ventures with Japanese pharmaceutical companies and expanded into Europe. It established a diagnostics division and was a leader in AIDs diagnostics. Abbot boosted its

diagnostics division with diabetic testing technology. Development of anti-AIDs drugs, and acquisition of nutritional divisions as it built its anti-diabetic product lines, the acquisition of anti-lipid drugs and a proliferation of its research-based hematological pharmaceutical division contributed to Abbot's lengthy history in America as a leading industrial healthcare company. In 2012 divested itself of its pharmaceutical research division.

Plaintiffs

Takeda Pharmaceuticals and Abbot Laboratories formed a joint venture called TAP Holdings to distribute and sell Lupron in America. The company developed aggressive tactics for recruiting doctors and this created a scandal which led to the (at the time) largest payout of any pharmaceutical company.

"I was scandalized," Gerstein said ... "I had a strong motivation to expose these inducements."And so, Joe Gerstein, medical director at Tufts University, wore a wire for the FBI to obtain evidence of TAP employees bribing him with $65,000 in "educational grants," to use for whatever he wanted if he would simply reverse his decision to keep the less costly GnRHa-alternative Zoladex on the preferred drug list and choose Lupron instead. Gerstein's righteous indignation triggering an investigation + a legal action that yielded at that time the largest legal pay out in a health care fraud case, close to a billion dollars. The unsealed indictment charged TAP Holdings with fixing prices and conspiring with physicians to defraud the government.

The indictment charges that the TAP defendants offered to give things of value, including free drugs, so-called educational grants, trips to resorts, free consulting services, medical equipment, and forgiveness of debt, to physicians and other customers to obtain their referrals of prescriptions for Lupron to Medicare program beneficiaries, in violation of the anti-kickback statute. The indictment also charges that the TAP defendants aided and abetted, and caused the billings to hundreds of elderly Medicare program beneficiaries and to the Medicare program directly, for thousands of free samples of Lupron, used in the treatment of prostate cancer, in violation of the Prescription Drug Marketing Act.

Patent Thickets

In 2013 AbbVie became a publicly traded biopharmaceutical company and currently focuses its research pipeline in the areas of cancer, hematology, endocrine and aesthetics. Humira certainly did not disappoint it's makers, becoming the biggest selling drug of all time and even holding a monopoly in sales for seven years beyond the expiration of patent.

For example, an early Humira patent, which expired in 2016, claimed that the drug could treat a condition known as ankylosing spondylitis, a type of arthritis that causes inflammation in the joints, among other diseases. In 2014, AbbVie applied for another patent for a method of treating ankylosing spondylitis with a specific dosing of 40 milligrams of Humira. The application was approved, adding 11 years of patent protection beyond 2016.

Meet the patent thicket, a favourite technique pharmaceutical companies employ to extend their patents, and to block innovation that drives competition. Remember when Joel Bakan diagnosed the corporation as psychopath? Lack remorse for harm they cause, deflect and project blame rather than accept responsibility, act entirely from self interest all describe the character profile of a psychopath. Have we become the bastards of corporations and businesses about whom Bakan wrote two decades ago?

Pharmaceutical companies promote societal and economic harm in their bid to make a profit developing and distributing medicines to make people better and hopefully live longer and higher quality lives. Patent thickets provide a convenient means for AbbVie to artificially prop up drug prices and block generic drug makers from providing patients with affordable alternatives to Humira! Humira accounts for one-fifth of AbbVie's annual revenue.

Look at the Sec 10-K Annual Reports. Competition stimulates innovation, protecting innovation benefits society because it encourages research and development which drives innovation. So, how did we get to this point where Big Pharma has lawyered up to protect itself from the exacting rigours of competition, using the laws that exist to promote competition and innovation? What is the cost of pharmaceutical innovation? Who must pay that cost? For

how long? People must delay retirement to pay AbbVie for innovation? Really? Why?

How do we feel about AbbVie blocking competition from rival companies eager to make generic versions? Under the terms of the legal settlements it reached with rival manufacturers from 2017 to 2022, AbbVie will earn royalties from the knockoff products that it delayed.

Can corporate self interest co-exist with medical scientific innovation? Because right now it's harming scientific innovation with it's patent-extension strategy. Can corporate self-interest co-exist with any kind of intellectual and technological innovation in a corporate culture where we experience a dearth of Level 5 Leadership?

Can egoistic leaders afflicted with the greed mind pathogen really lead large companies and the societies which feed them to create progress through R & D innovation? Because right now *narcissists running the asylum,* i.e. *the corporation as psychopath,* is going to destroy humanity whilst we watch live action video on Twitter. The law as it exists supports the AbbVie's Humira patent-extension strategy, as the District Court ruled and the Seventh Circuit Appellate Court affirmed in its decision. AbbVie's competitors argued that the patent thicket technique, in which AbbVie obtained and asserted large swaths of patents against biosimilar manufacturers, violated Section 2 of the Sherman Act.

Does having many weak patents on one drug constitute anti-trust behaviour? The Appellate Court said *no it does not*, also suggesting that patent disputes happen at the patent office and not in a wannabe edgy an anti-trust lawsuit. Did this decision protect innovation? Did it simplify the pay to delay controversy? Did it dismiss the connection between European settlements and the delay in the American market?

These are valid questions legal and business analysts have asked. For whom is the innovation when people have to cancel retirement to be able to afford this drug? How do we balance innovation and compassion? How do we create an economy in which innovation serves compassion, not thwarts it?

Having a system that forces people with autoimmune disorders such as arthritis to cancel their retirements so they can pay for their medication seems the opposite of compassion. Having 132

patents on the world's largest selling drug because it accounts for 30% of the company's income seems lazy not innovative. Each improvement represents a new innovation that AbbVie spent time and money to achieve. And each improved the patient experience, something that should be celebrated, writes Andrei Inacu in Bloomberg Law.

In sharp contrast, Ikdiko Mehes, former pharmaceutical patent litigant and now a parent of a child afflicted with IBD tweets that an extreme of patent protection *is massively anti-innovation, and this is actually exactly what happened in #IBD with, for eg, the record-breaking 100+ patents on Humira. There's good reason we saw little innovation for 10-20 yrs and are seeing new approvals now as patents expire*.

In his written decision Circuit Judge Easterbrook of the Seventh Circuit Court seemed to open the door for an anti-trust via patent thicket argument. *As it happened, none of Abbvie's potential competitors chose to launch at risk, even after the FDA's approval. This sets of the payers' contention that the sheer number of arguably applicable patents scared off the competitors' and enabled AbbVie to collect monopoly profits not authorized by the expired '382 patent*.

However Easterbrook did note that tech companies like Apple and Microsoft have vast patent portfolios. Lee et al estimate that the delaying Humira biosimilar availability because of these patent disputes has cost Medicare nearly $3 billion. The questions begs asking though in the final analysis, will savings realized by the uptake of biosimilar Adalimumab—or any biosimilars—be passed on to patients in any meaningful way?

The Bastards of Business are Children, Of Course

Why am I going to the trouble of tell you this? Why do you need to know this? How does this matter? How on earth does this relate to puberty blockers? The truth about puberty blockers exists far beneath anything you can see or touch or taste in the public discourse.

The truth about puberty blockers goes beyond gender ideology, SOGI, Queer capacity building. The truth about puberty blockers thrums in these mundane details about the legal infrastructure of corporate business operations. AbbVie faces a credible threat to its cash cow in the wake of Humira patent expiration taking effect in 2023.

Perhaps promoting Lupron more widely to increase demand for a popular off-label use could make up for the profit loss? Promoting Natrelle breast implants and other aesthetic health care products whilst also promoting GnRHa aka puberty blockers to LGBT youth seems like a strategy AbbVie has chosen to employ.

Would this explain why *The Trevor Project* received grants from both the AbbVie Foundation and the Allergan Foundation to save LBGTQ lives? Yes aesthetic pharmaceuticals products are the suicide prophylactic of choice these days for young people apparently. Okay, let's go with that—suicidal kids need breast implants and other aesthetics to feel affirmed. This sounds very 90210esque but okay, *This Is America*.

What about Lupron? Why on earth would the maker of a prostate cancer drug want to donate to a transgender organisation? Lupron is FDA approved to treat disorders in adults involving hyperplasia (overgrowth of cells and other tissue in the reproductive tract) disease processes driven by sex hormones, and central precocious puberty (a glandular endocrine disorder) in children.

Lupron does not have FDA approval to block puberty in children with psychiatric disorders. Central Precocious Puberty (CPP) is not Gender Dysphoria. Marketing a drug for an off-label use of a drug constitutes fraud. Some fraud gets a pass, it depends on the context. Similarly, fighting to keep synthetic hormones out of the meat supply means you care about social justice and fighting to keep synthetic

hormones away from kids means you hate social justice.

GnRHa alternatives to Lupron include Supprelin, Triptorelin, Fensolvi, Gosrelin and only Lupron comes in both 1 and 3 month dose options, in addition to the 6 month dose option. Gosrelin comes in a 3 month dose option however it is a subcutaneous implant.

Services targeted toward families dealing with CPP have a vastly different tone and flavour than do those targeted toward families dealing with GD. Parents of kids with CPP receive a solution and answers whereas parents with GD receive endless emotional manipulation and useless if not harmful advice.

Imagine yourself buying a car, and think of the types of sales people you encounter. Think of the information for CPP parents as the low pressure sales person who makes the purchase easy and painless and think of the information for the GD parents as the sleazy polyester suit wearing dude who sees an opportunity to run a scam. Treatment versus recruitment — gender dysphoria + gender affirming care looks like a recruitment method into a body modification cult and not primary health care.

Many gender clinics offer puberty blockers in 1 and 3 month dosing options —does AbbVie fund any of the gender care facilities offering GnRHa in 1 or 3 month depot shots? Dr. Julia Cartaya of Cleveland Clinic recommends puberty blockers as safe + reversible for kids, and effective in providing relief of gender dysphoria, she does not mention the recent evidence challenging the efficacy of gender affirming care and the mounting evidence challenging the safe + reversible claims.

AbbVie Foundation has provided corporate sponsorship as well as grants to Cleveland Clinic. Does a link between a pharmaceutical company and fraudulent marketing + promotion of a drug need to be direct? How many degrees of separation between the pharmaceutical company and the fraud before it no longer constitutes fraud? The state of Texas plans to investigate.

What situation exists in Canada? Do provinces fund experimental pubertal suppression with GnRH Agonist for children that clinically present with psychiatric distress? The answer to this question seems affirmative. Canadian taxpayers do fund medical experiments on children with psychiatric disorders.

Taxpayers approve of these experiments because activists drive health policy and they have decided to call these paediatric medical experiments Gender Affirming Care.

Since Gender Expression and Gender Identity have now become protected characteristics in Human Rights laws across Canada, the medical community seems to have committed itself to treating pubertal suppression like a legal obligation they have to the state. Before we get to that, let me tell you about what led to the birth of Lupron, let's talks about sex, baby.

Let's Talk About Sex, Baby

"In contrast to the human female, the monkey was, of course, highly tractable to experimental manipulation, and the stage was thus set for what became a remarkable phase of linear scholarship by the Knobil laboratory that spanned close to a decade"

—Tony Plant, Recognition that sustained pituitary gonadotropin secretion requires pulsatile GnRH stimulation: a Pittsburgh Saga

If radical gender activists knew the degree of animal torment and suffering that went into the discovery of sex hormones and the innovation of synthetic sex hormones, they might have a catastrophic meltdown. Doing the research for this stuff, sometimes I found that I had to stop and take a break after reading a medical paper so casually describe the details of the animal torture they conducted to make their discovery. I take HRT for menopause, how much responsibility do I bear for that suffering? How do we balance the harm we participate in through the mere act of trying to survive our own physiologic challenges? How can we ever repay the animals who endured torture so we can have comfort? We cannot. How does the universe balance that horror?

Let me tell you about the things I read about when I researched Lupron and the discovery of sex hormones. I read about experiments conducted on Rhesus Monkeys, who had their ovaries surgically removed and then had makeshift injectable devices implanted into them so scientists could inject steroid hormones into them to measure the effect and trace

the mammalian menstrual cycle. I read about experiments conducted on rats involving severing connections to the medial basal hypothalamus — yes, lobotomies on rats.

I read about a scientist who developed a special scalpel shaped like a monkey's medial basal hypothalamus. I read about stereotactic lesioning of a monkey's hypothalamic arcuate nucleus. I read about surgically inducing endometriosis in monkeys. I read about countless invasive experiments conducted on monkeys whose ovaries scientists removed simply for the purpose of invasive experimentation. I read about experiments conducted on ewes and wallabies to stop lactation.

The most ghastly experiments I read about involve Eugene Steinach, the man who really gets the credit for discovering sex hormones and laying the foundations for that branch of neuroendocrinology. "Between a real man and a real woman there are innumerable others, some of which are significantly characterized as belonging to the 'intermediate sex,'" wrote Steinach. For those still interested in the pointless exercise of laying blame for Gender Radicalism at the feet of any historical scholar, you can strike the name Michel Foucault from your list of scapegoats and replace it with Eugene Steinach.

A scientist named Berthold who castrated roosters and then reattached the testes to other parts of the body to observe the effects inspired Steinach to conduct similar experiments in rodents. Steinach switched the gonads of male and female rodents to observe the effect. He demonstrated the existence of the physiologic axis linking the brain and the gonads.

Despite their controversy, his experiments laid the foundation for decades of research that led to the development of synthetic sex hormones. We have the torture of monkeys, rats and guinea pigs to thank for birth control and HRT and puberty blockers. Readers might take interest in the fact that Steinach sought to cure homosexuality by surgically attaching testicles to the bodies of gay men. Steinach's experiments proved that sex hormones play an integral part in shaping the brain and also behaviour.

The Birth of Leuprolide Acetate

In 1971 Andrew Schally and Roger Guillemin discovered the chemical structure of Gonadotropin-releasing hormone, a molecule comprised of 10 amino acids which "serves as the conductor of the reproductive system and arguably life itself ... The elucidation of the amino acid sequence of GnRH was one of the most important events in the field of reproductive medicine."

A key finding in the discovery of GnRH involved the activation of GnRH neurons—activation of the reproductive system required a pulsatile stimulation whereas continuous stimulation suppressed the reproductive system. In 1973 Takeda Chemical Industries successfully created a synthetic version of GnRH by altering the endogenous molecular amino acid structure, producing a chemical analogue with a longer half life.

In plain speak, this means Takeda created a chemical that looks molecularly similar to endogenous GnRH and has a longer acting time—Leuprolide Acetate has many times the potency of endogenous GnRH. This gave scientists the ability to suppress the production of sex hormones from the pituitary gland. This gave scientists the ability to manipulate the Hypothalamic-Pituitary-Gonadal Axis.

Takeda revolutionised the treatment of prostate cancer with the discovery of Leuprolide Acetate because it provided the means for chemical castration, enabling many men to avoid the emotional and psychological effects of surgical castration. Leuprorelin Acetate had no oral efficacy and in 1985 began patients received their dosage via daily SC or IM injection. The presently established dose, the one-month depot shot, reached market in 1989.

At this point Takeda partnered with Abbot to form Takeda-Abbot Partnership (TAP) Holdings to promote Leuprorelin to the American Market. Takeda handled synthesis + manufacturing of the drug and Abbot handled marketing + distribution. TAP Holdings received FDA approval to market + distribute Leuprorelin for the treatment of Prostate Cancer, Endometriosis and Central Precocious Puberty (CPP). TAP received FDA

approval for Lupron Depot-Ped in use for CPP in 1993.

Discoveries about the unique pulsatile nature of hypothalamic GnRH-secretion to the pituitary led to an investigation in the use of Leuprorelin as a fertility agent — as part of IVF protocols that would replace HcG as the first line of ovulation stimulation and therefore dramatically reduce the risk of dangerous side effect of ovarian hyper-stimulation syndrome (OHSS). The fascinating complexity of human reproduction and endocrinology can be summed up in the fact that Lupron can stop reproductive function and it also can enhance it, depending on dosage and administration protocol.

It can obviously not perform both chemical objectives at once—function as a chemical castrating agent (in the case of ongoing administration to trigger down-regulation of sex hormones) and also as a fertility agent (in the case of timed administration to trigger a surge). That fact alone should tell you how much complexity puberty represents as a developmental landmark—how much we do not know ought to leave you feeling worry and thinking of the many unanswered questions that remain suspended in the air. Yet Gender Affirming Care zealots would have you believe in "case closed the science is settled".

Remember when Lysenko did that to Russian science? Remember when Lysenko said 'the science is settled' and cancelled everyone who disagreed, destroying their work? Also, do you remember how that went for Russian science?

From Psychopathia Transsexualis to Gender Dysphoria

Pioneering physician and sexologist Magnus Hirschfield first coined the term transsexual in the 1940s and in 1949 David Cauldwell first proposed the diagnostic term *psychopathia transsexualis* in one of the earliest medical conceptualisations of gender identity. Harry Benjamin popularised the term transsexual and pioneered treatment regimes for transsexual patients that became the precursor to present day Gender Affirming Care, as directed worldwide by WPATH, an American non profit activist and lobbyist organisation with low clinical credibility.

Hirschfield was a *closeted* gay man who sought to remove the stigma from same sex attraction, having theorised about the immutability of sexuality and sexual orientation in the late 1800s. Hirschfield lobbied for the decriminalisation of homosexuality, specifically, he argued for the revision of Paragraph 175, a German statute that predated the NSDAP regime, who expanded its reach to capture and punish even more men. He argued no just society could punish a man for something inborn. The Jewish German Hirschfield rose to popularity in Weimar Germany, however the subsequent collapse of the Weimar government and the rise of the NSDAP resulted in the destruction of his scholarly work and his exile to France, where he died in 1935.

Cauldwell borrowed the term Psychopathia Transsexulialis, from a 19th century German doctor named Richard von Krafft-Ebing, who witnessed a phenomenon amongst the gay male population, in which a gay man became convinced he was the opposite sex. He believed this resulted from cognitive distortion, ie a delusional disorder. Krafft-Ebing also considered same sex attraction a mental disorder.

Cauldwell believed in a biological sex and a psychological sex, and he believed that childhood events and other social conditioning shaped psychological sex, and that it had a kind of malleability to it, therefore he did not advocate for invasive procedures like sex reassignment surgery. The term Gender Dysphoria emerged in 1994, with the DSM-4. By this time corporate pharmaceutical interests had begun infiltrating the APA.

MENU UNITED STATES HOLOCAUST MEMORIAL MUSEUM HOLOCAUST ENCYCLOPEDIA MUST READS

PARAGRAPH 175 AND THE NAZI CAMPAIGN AGAINST HOMOSEXUALITY

Paragraph 175 was a German statute that criminalized sexual relations between men. It did not criminalize sexual relations between women. Paragraph 175 predated the Nazi regime. However, the Nazis revised Paragraph 175 in 1935 to make it broader and harsher. It was one of the main tools that the Nazis used to persecute gay men and men accused of sexual relations with other men.

KEY FACTS

1. Paragraph 175 became part of the German Empire's criminal code in 1871. This statute built on a long tradition of criminalizing and punishing sexual relations between men across Europe. It remained a part of German criminal codes in various forms until 1994.
2. In 1935, the Nazi regime revised Paragraph 175. The Nazi version of the statute allowed the regime to target far greater numbers of men than previous governments.
3. Most men arrested under Paragraph 175 were given fixed prison sentences. Some of these men, however, were sent to concentration camps for indefinite terms.

Der Stürmer

Nürnberger Wochenblatt zum Kampfe um die Wahrheit

HERAUSGEBER: JULIUS STREICHER

Nummer 8 | Nürnberg, im Febr. 1929 | 7. Jahr 1929

Wurstjud Bauernfreund

Er betrügt das arme Volk um das verbilligte Fleisch und den Staat um den Zoll

Die Judenfirma

„Unsere Losung ist: Gewalt und Täuschung. Darum dürfen wir mit Betrug, Fälschung und Verräterei nicht aufhören, bis das Ziel unser ist."

Existenz der Bauern.

Fürther Wurst- und Konservenfabrik

betrügerisch

Apostel der Unzucht

Sozialistische Kinderversammlung in Berlin — Der Jude Dr. Magnus Hirschfeld predigt talmudische Lehren

Dr. Magnus Hirschfeld

„Jedes nichtjüdische Mädchen ist als eine Hure zu betrachten."

„Wenn ein Mädchen drei Jahre (!!! D. Sch. d. St.) und einen Tag alt ist, so ist es reif zur Beiwohnung"

Die Juden sind unser Unglück!

Abb. 8 Magnus Hirschfeld — verleumdet, verfemt, verfolgt

Quelle: Der Stürmer (1929)8 — Titelblatt

Front Page of the Nazi paper Der Stürmer, featuring Hirschfield :: "The Jews are our misfortune!" :: the Nazis attacked Hirschfield's idea about sex, his sexuality and his Jewish ancestry

Going Dutch

Gender Affirming Care originated in the Netherlands in the 1980s and 90s. During his 1993 speech at the Council of Europe Dutch endocrinologist Dr. Louis Gooren described gender dysphoria (ie the desire to be the opposite sex) as similar to intersex, a sex error of the body, which psychotherapy could not remedy: *reassignment of transsexuals is a medical intervention on a sliding scale. It is … a contradiction between the genetic, gonadal and genital sex on the one hand, and the brain sex on the other*.

Gender Affirming Care emerged from the erroneous belief in mind-body dualism — ie the notion that the brain and the body do not have a connection. This scientifically debunked vision of human physiology and behaviour remains a powerful philosophical underpinning of modern psychiatry, despite much evidence to the contrary.

In 1996 Gooren and Delemarre de Waal published their study proposing the use of GnRHa to “delay puberty”, ie “with no permanent effect”, in children with gender dysphoria. It is illegal for a pharmaceutical company to promote any drug for an off-label use. Reading this paper 25 years later seems comical, the researchers truly thought they were delaying puberty—Gooren and Delemarre de Waal honestly thought blocking GnRH would simply pause the hypothalamus-pituitary-gonadal (HPG) axis with no other effect.

In 1998 Cohen-Kettenis published the second paper promoting GnRHa as a remedy for gender dysphoria. Prior to 1998 a minimum age of 16 existed for puberty blockers. In his 2022 paper Biggs describes the case of FG from Cohen-Kettanis’s 1998 paper —a lesbian getting a sex change because her father is a homophobe constitutes gay conversion therapy not gender affirming care.

Several Tavistock whistleblowers reported observing homophobia driving the demand for paediatric gender transitioning care. Administering GnRHa to minors remained a true exception at this time and Cohen-Kettenis did advocate for lowering the age of administration, in order to bypass puberty altogether and affirm the opposite sex. In 2006 she published a widely read paper, the makers of Triptorelin, an alternative to Lupron, funded the paper.

The Dutch Protocol emphasized two main selling features:

1. fully reversible
2. puberty suppression as a diagnostic aide + treatment

In his 2022 paper Biggs describes some disturbing failures of the Dutch clinicians to consider minimum age and parental consent for hormone therapy rigourously. As the Cohen-Kettenis puberty blocking protocol began to make headlines worldwide, around the mid-90s, a British documentary called *The Wrong Body* took three young English people to Amsterdam to see the Dutch gender specialists.

Fred Foley, age 13, met Gooren to learn about puberty suppression … After returning to England and being refused GnHa by the London clinic, Foley's mother telephoned Gooren who agreed to write a three-month prescription of triptorelin. "If your child knows for sure he is transsexual" he said, "I would not let puberty happen."

Some would argue that this example characterises the lack of clinical and diagnostic as well as ethical rigour that characterises gender medicine — very little assessment because of commitment to a particular treatment modality in the face of no valid and reliable evidence for that preference.

American endocrinologist Norman Spack opened the first gender clinic for kids at the Boston Children's Hospital in 2007. He established puberty suppression at Tanner Stage 2, which denotes pubertal onset, so age range 8 to 13. Spack set no minimum age, either. *Some of the people who oppose this have accused doctors of playing God. How do you respond*, asked Allison Keyes, 2011 host of *Tell Me More.*

Appealing to a religious text as justification for his zealotry in suppressing child puberty, Spack says the following in this interview with NPR: *I go back to the text that guides me in this and that is Leviticus, that says if your neighbour is bleeding by the side of the road, you should not stand idly by.*

Gonna go out on a limb and disagree with Spack, and add that I doubt the Leviticus quote means *when you see*

an upset child offer pubertal suppression immediately. Spack developed a reputation as a gender affirmation evangelist. To use the evangelical nomenclature of Islam, Spack established his clinic in order to conduct some widespread Gender Identity Dawah in children and adolescents.

In 2011 Oprah did what she does best when she made the paediatric gender movement explode in America, with her feature on Jazz Jennings, then 11 years old. Within a few years the number of paediatric gender clinics surged, from 1 in 2007 to 40 in 2017. SEGM notes there are 60 paediatric gender clinics in the USA and estimates close to 300 clinics and hospitals and medical offices in total deliver puberty suppression to American kids.

Spack and his followers truly believe that kids with gender dysphoria, called "trans kids" by Gender Radicals, have opposite sex brains and therefore justify invasive + experimental hormone and surgical treatments on children to mimic the appearance of opposite sex, which they call gender affirming care. I will ask you to stop here and think for a moment about the level of dehumanisation required to justify medical experimentation and torture by invoking an invisible trait about a human. No evidence exists that humans who present as socially atypical for their reproductive class actually have an altered neuroendocrine sex — when you break it down physiologically it makes no sense, it's misanthropic.

A student of Cohen-Kettenis by the name of De Vries wrote the foundational 2011 + 2014 paediatric gender medicine studies, which catapulted the Dutch puberty suppression Protocol to fame and put child sex change (aka *trans kids*) on the map globally. Despite their designation as gold standard in gender medicine, the De Vries Studies have flaws.

First of all subject selection and study design favoured the outcome they wanted — to affirm gender affirming care as an effective treatment for gender dysphoria. Second, the study evaluating the effectiveness of puberty blockers in treating gender dysphoria employed circular logic in evaluating effectiveness. Third the Dutch researchers ignored physical effects (iatrogenic harm) of hormone therapy.

Peggy Cohen-Kettenis wrote about the protocol she developed in 2015, on

reading the paper her bias toward gender affirming care for children becomes clear. According to Biggs, the pedophile doctor John Money, who had a reputation for clinical recklessness, praised Cohen-Kettenis in the 80s when she first developed the Dutch Protocol. Having discovered more about the neural origin of puberty, including Kisspeptin Protein, today we know better—in 2024 Lupron does not seem like the fabulous magical Peter Pan remedy for gender discordant kids that it did in 1996 or 1998 or 2006 or even 2017.

In January of this year Abbruzzese, Levine + Mason published a critical evaluation of the foundational De Vries Studies. They justify their claims about the flaws in the foundational Dutch research, they discuss the concept of runaway diffusion in the field of paediatric gender medicine, and they offer suggestions for remedying the research weaknesses and flaws in structure. Of particular interest, Abbruzzese et al note that the Dutch researchers applied the UGDS assessment scale in reverse for their post treatment evaluation.

The fact that after gender reassignment, the UGDS scores were low on the opposite-sex scale indicates that the subjects would have scored high on the natal sex scale, which corresponds to a persistence in transgender identity. The finding of persistence of transgender identity is not unexpected, especially since the Dutch researchers selected subjects with lifelong extreme cross-sex identification and follow-up was only 1.5 years post-surgery.

What it does not mean is that the feeling of “incongruence” resolved. *This point is underscored by the long-term follow-up data on male-to-female Dutch transitioners … Nearly a quarter of the participants have felt that their bodies were still too masculine, and over half have experienced shame for the "operated vagina" and fearful their partner will find out their post-surgical status--despite registering low "gender dysphoria" UGDS scores*.

So, to explain in plain language—what the Dutch researchers did to measure the efficacy of their treatment was to have a gender dysphoric female to male patient who at pre-treatment said she felt good when people treated her like a boy score high for dysphoria and then at post treatment the same patient would score low for gender dysphoria still

reporting she felt happy when people treated her like a boy.

A measurement tool designed to measure the variance between natal sex and gender identity in assessing for treatment cannot then be applied in reverse to determine the efficacy of that treatment. Further, the validation studies for this measurement tool cannot provide the research evidence which then appeals to the validation study — this is circular reasoning! They could not measure their outcomes! Also, was the goal transforming the child to fit the identity or was it assisting the child to live in his or her body with minimal medical intrusion? The former affirms a construct projected onto a child and the latter affirms the human child.

Any discussion of paediatric gender affirming care and paediatric gender dysphoria often overlooks the very specific conditions established in the Dutch Protocol Studies. In a recent interview about the fall of Tavistock Clinic, investigative journalist Hannah Barnes said the following:

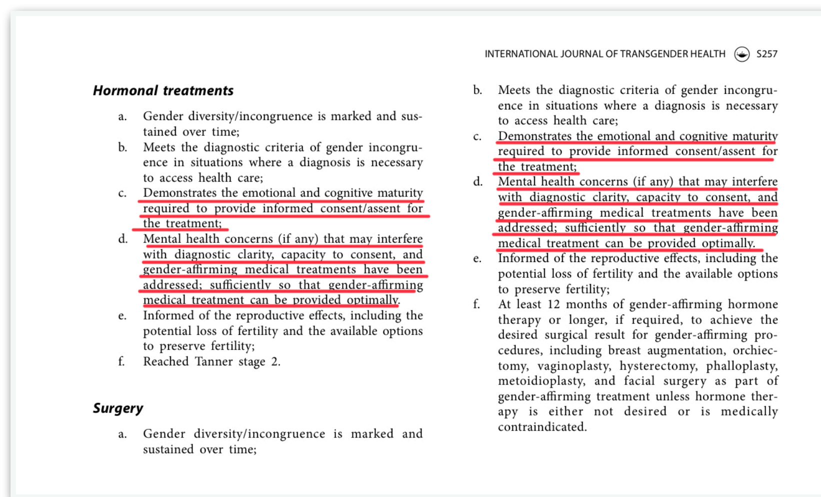
And I think what you saw, what they did was they started to apply an albeit quite limited evidence base from these two early Dutch studies, which only allowed young people who had lifelong gender dysphoria, a very stable, supportive environment in which they lived and who was psychologically stable. They applied that to a completely different cohort of young people. And they didn't pause to reflect on what was happening.

In describing the outcomes at the UK's Gender Identity Development Service (GIDS) which operated Tavistock, Michael Biggs wrote *there was no statistically significant difference in psychosocial functioning between the group given blockers and the group given only psychological support. In addition, there is unpublished evidence that after a year on GnRHa children reported greater self-harm, and that girls experienced more behavioural and emotional problems and expressed greater dissatisfaction with their body-so puberty blockers exacerbated gender dysphoria.*

A pre-print of a secondary analysis of Tavistock data on puberty blocker and 12 to 15 year olds just appeared in my Twitter feed recently and the results confirm this conclusion — puberty blockers do not relieve Paediatric Gender Dysphoria. Several countries have

conducted systematic reviews and found none to uncertain evidence for the claim that puberty blockers relieve distress in children and youth. In fact all reviews have discovered that harm far outweighs any benefit. GnRHa does not provide relief of gender dysphoria or any other psychiatric event, valid and reliable evidence exist to affirm this statement, multiple systematic reviews exist to affirm this statement.

The human neuroendocrine system has so many complex moving parts, we really cannot say that we can



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Hormonal treatments

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. Reached Tanner stage 2.

Surgery

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

WPATH SOC 8 :: HRT for Paediatric Gender Affirming Care

isolate one of these parts during puberty to affirm an adolescent feeling. Why does anyone take that claim seriously and offer so many kids up for that experimentation? Why do we have an entire professional mob and industrial force poised to fight for the power to set vulnerable children and youth up with false hopes that they can attain the unattainable?

What is the goal of treatment — to please the clinician or to eradicate the ailment afflicting the patient? According to the UK GIDS, GnRHa therapy has as its objective to *pause puberty*, to give children a break from the natural growth cycle by preventing *unwanted body changes*. How can we eradicate the ailment when we have made it a protected human rights category?

As of the date of this writing, Norway, Sweden, Finland, and the UK have all pulled back after conducting systematic reviews, in favour of more conservative approaches to care. Canada remains stubborn in its commitment to the suboptimal faux science of Gender Affirming Care. The Clinical Advisory Network on Sex and Gender held its first Do No Harm conference to discuss the way forward in gender medicine.

The conference featured leaders in the field of paediatric psychiatry and

gender medicine research such as Riittakerttu Kaltiala, founder of one of the first gender clinics in Finland, and Michael Biggs, Oxford researcher who extensively researched the scandal at GIDS in the UK. Valid and reliable scholarly research, evidence from systematic reviews, and the clinical principal of Do No Harm provided clinicians and other interested parties an opportunity to equip themselves to better separate science from ideology in an culture that hastens invasive and impulsive options for children against their parents best thinking.

The Lupron Protocol for Autism

The Lupron Protocol for Autism stands out in my mind because of the reaction it received from progressives who today fully support the puberty suppression of the Gender Affirming Care protocol. Dr. Mark Geiers had some whack ideas about Autism and mercury and testosterone and he believed GnRHa could cure Autism, or so he told his patients, desperate parents of Autistic kids. The exact protocol matters less than the contradictory reactions that progressives have to the Autism Protocol and the Dutch Protocol.

Dr. David Gorski, writing for Science-Based Medicine heavily criticized the Geier's protocol and today writes about GnRHa as a safe and reversible and effective treatment. The available clinical information point to the rebranding of Autism to Gender Dysphoria and now GnRHa has become just fine to administer to kids.

Also precocious puberty is rare. Autism is not … if you're going to give a potent drug like Lupron to children, a drug that can almost completely shut down the synthesis of both male and female steroid hormones, you'd better have damned good evidence that it's likely to help make it worth the risk. **Dr. David Gorski, MD writing in Science-Based Medicine in May of 2009, vehemently opposed the use of Lupron for children with Autism.** Dr. Mark Geiers developed an Autism protocol which involved Lupron to suppress levels of sex steroid and lost his licence to practice medicine as a result. In it's suspension order the Maryland State

Board of Physicians stated the following about Lupron.

1. It is a potent anti-androgen; that is, it reduces the amount of testosterone the body produces.
2. It is used to treat adult males with metastatic prostate cancer and adult females with endometriosis and uterine fibroids.
3. It is also used to chemically castrate sex offenders.
4. The only medically accepted use of Lupron in children is precocious (or "premature") puberty. In this context, Lupron delays the progression of puberty by inhibiting the release of the Gonadotropin Releasing Hormone ("GRH"), which affects the development of ovaries and testicles. Lupron is not approved for the treatment of autism. With regard to administering Lupron to autistic children, [Geiers] has been quoted as saying, "If you want to call it a nasty name, call it chemical castration. If you want to call it something nice, say you are lowering testosterone."
5. Adverse side effects of Lupron in children include, but are not limited to, risk of bone and heart damage. Lupron is not recommended for individuals with heart disease, kidney disease, asthma or seizure as it may worsen those conditions. Autistic children are prone to seizures. No clinical studies have been completed in children to assess the full reversibility of fertility suppression.

Nearly a decade and a half later, Gorski decided that Lupron was okay for kids after all, citing that "trans kids" (who are overwhelmingly autistic, by the way) have used Lupron since the 1980s and that off label use happens routinely, and denied the experimental nature of it's use as part of a Gender Affirming Care protocol. (Remember a few pages back when I explained the history of Lupron? Lupron Depot has only been licensed for kids since the early 90s.)

Off-label use of gender-affirming treatment, such as puberty blockers in youth, does not make the treatment "experimental". Again, GnRH analogs have been the gold-standard treatment in children with central precocious puberty since the 1980s and used in trans youth since the late 1980s. When used in cis children, puberty blockers "have an enviable track record of safety

and efficacy". Puberty blockers are used similarly in trans youth once they hit puberty to halt permanent changes. It should be emphasized that the effects of blockers are both temporary and reversible. — Dr. David Gorski, MD, PhD + Dr. AJ Ekert, MD, in Science-Based Medicine, May, 2022

Interesting how Gorski seems unaware of the weak clinical research underpinning of FDA approval of Lupron for treatment of CPP. At any rate, The New England Skeptical Society, which operates the *Science-Based Medicine* website, had its exempt status revoked for failing to report financials to the IRS.

Links to several SBM articles appear on the *Anchor Health Centre* website, which has many programs for the LGBTQ community including one it calls GLAM, *Gender & Life-Affirming Medicine*. GLAM sounds super edgy and affirming, doesn't it, if you are a kid living in the chaotic deluge of American culture? At Anchor Health Centre GLAM means you need synthetic sex hormones and their suppressant to live. ***Our providers don't blame everything on your hormones***, states the Anchor Health website.

Welcome to GLAM, Gender & Life-Affirming Medicine, the love child of AJ Ekert, Connecticut's first out non binary trans doctor, and a member of WPATH. You sign up, get your informed consent all lined up, and you can be on your way to your fabulous new synthetic sex hormone fuelled life. Given the heavy degree of capture in the State of CT regarding Gender Affirmationism, it would not be difficult for a kid to get hormone and blockers even when their parents oppose the treatment option.

A quick search leads me to *CT Voice*, where Jane Latus writes about puberty blockers, insisting that we only need know 3 things about puberty blockers: they save lives and improve mental health, they make transitioning markedly easier later, they are reversible. All claims untrue, of course.

Though the common word is plural, puberty "blockers" are actually just one drug, Leuprolide. It is a gonadotropin-releasing hormone agonist, which works by suppressing the release of sex hormones including estrogen and testosterone. If taken early enough in puberty, it prevents breast and genitalia development, stops facial and body hair growth, stops

menstruation, and prevents voice deepening. To transgender or gender nonconforming children, the development of sex characteristics that are opposite of their identity is intensely distressing.

Hormone blockers don't "turn" kids into the opposite gender they were assigned at birth; they put a pause on puberty, giving youths and their families time to decide whether to pursue any other steps. If blockers are stopped, natal puberty resumes. But it's not so much the physical result of puberty blockers that stands out to those who care for trans kids—it's the emotional impact that's most impressive. "I see happier kids," says Britta Shute, APRN, family nurse practitioner at Middlesex Health.

The entire write-up lures readers into a false sense of security about GnRH analogue. The FAQ tells kids they need a parent or guardian to sign the consent form with them — how difficult would it be for a kid to become an emancipated minor in a state governed by Gender Radicalism? Would they simply resort to emotional blackmail in coercing parents to consent, as we currently hear from parents and detransitioners going public?

"We have witnessed an unprecedented number of attacks on trans people, most frequently targeting trans youth. Going after trans youth is cruel and part of a larger right-wing agenda. In the same way it was never about restrooms, today's fight is not about sports or health care. It's about erasing and excluding trans people. And as certain lawmakers advance anti-trans legislation to cause us harm, others promote and spread hateful anti-trans rhetoric. There's so much negativity in the media about trans people and our lives. Misinformation about what it means to be trans is rampant, which makes our continued joy an act of resistance." — Anchor Health Centre

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Who in The World is Harry Benjamin?

WPATH, the World Professional Association of Transgender Health, changed its name from the Benjamin International Gender Dysphoria Association in 2007. Harry Benjamin founded WPATH to promote transsexualism, his particular vision of humanity and human sexuality. An endocrinologist and Sexologist, Benjamin had some whack ideas. From the time he graduated from medical school in 1912, he glommed onto oddball and charlatan medical claims, one of which involved his work with Eugene Steinach, who convinced Benjamin that vasectomies could invigorate men.

Benjamin also enjoyed Steinach's experimental sex changes in guinea pigs. Steinach sought to discover a biological basis for homosexuality so he could cure it, and published a paper in 1917 claiming to have done so based on experimentation with rat testes. Benjamin seemed to derive inspiration from Steinach for his work in transitioning and sex changes. Like Steinach, he may have held the medical and personal belief that human possessed the capacity to become the opposite sex. Did this reflect his misanthropy? Did it reflect some kind of innate homophobia? Did it simply reflect the moral mindset of the era? That's for my reader to decide.

Benjamin had a conversation with Freud, and in an exchange confessed his impotence. Freud asked Benjamin *could you be latent homosexual?* Benjamin cringed at the thought and hated psychoanalysis ever after. In his work with transsexuals, Benjamin's bias against psychoanalysis led him to affirm the entrance complaint of those patients who reported feeling like the opposite sex without exploration of the reasons for their dissociative feelings.

This is the origin of the inherent bias of Gender Affirming Care. The exchange between Benjamin and Freud influenced the direction taken by Benjamin in his work, it fuelled growth of a movement that rose in opposition to a proven primary care model, psychoanalysis. Certainly we can point to a foundation in sociopolitical atmosphere of sexual inversion and medical homophobia. How much Jew hatred fuels the animosity towards Freud?

Ethel Person, MD, at once a sexologist in the tradition of Alfred C.

Kinsey, a psychoanalyst in the tradition of Freud and a writer sympathetic to feminist critique who knew a sexist culture could change, wrote about Harry Benjamin and his approach to human sexuality in 2008.

In essence, the identification of transsexualism as a separate entity took place in the context of an ongoing liberalization of sex practices and increasing fascination with studies of sex. In turn, the very discovery (or invention) of transsexualism fostered a change in the way we regard gender. ***Thus, the discovery (or invention) of transsexualism is both a product of and a contribution to our shared cultural fantasy of living without limits****, of aspiring to the Godhead, a fantasy wish that draws illusory credibility from our technological wizardry.* (Person 2008)

The philosophical underpinnings of transsexualism, now called transgenderism, as written by Ethel Person, seem important to include in this report about puberty blockers and Lupron because they reveal the belief system and vision of human beings the informs the approach. It's important for me to mention that the transgender and transsexual communities might receive Person's psychoanalysis with much intellectual resistance. The uncomfortable truths about our subconscious self often feel like a poison pill, we very often shoot the messenger. Does gender identity offer a means for individuals to avoid the uncomfortable work of having to train the mind to accept painful material reality-based limits they cannot change?

"I have one transition friend/colleague who, after about 8-10 years of T. developed hepatocarcinomas. To the best of my knowledge, it was linked to [her] hormonal treatment. [She] was in [her] midlife. Unfortunately I don't have much more details since it was so advanced that [she] opted for palliative care and died a couple months after."— page 92, WPATH Files

WPATH is the Unofficial Standards of Care Across Canada

All of Canada, every province and territory, and every LBGTQ+ NGO, follows and promotes the guidelines written by WPATH, an approach to human behaviour and sexuality erected around living without limits. Toronto PFLAG described the SOC 8 changes as *exciting changes that will increase accessibility to gender affirming care, and reduce gatekeeping*.

The Province of New Brunswick assures prospective patients that *a patient considering gender-confirming surgery … would be assessed for clinical eligibility using criteria established by the World Professional Association for Transgender Health (WPATH). This assessment is also required by other Canadian jurisdictions that insure these surgeries. The WPATH assessment involves a comprehensive psychiatric assessment and prolonged medical management before surgery is considered an option.*

In a submission to the House of Commons Standing Committee on Health, CPATH, the Canadian Professional Association for Transgender Health, encourages access to Gender Affirming Care under the guise of the so-called informed consent model that WPATH has offered "transgender patients" as an alternative to the standards of care offered by mainstream medicine. CPATH encourages a movement away from clinical safeguards and *First Do No Harm* ethics in favour of affirming impulsive patient desires for questionable care procedures.

Clinicians' use of the informed consent model enables them both to attain a richer understanding of transgender and gender diverse clients and to deliver better care in general. CPATH holds the position that a more responsive informed consent model of care gives patients permission to accept or decline possibly stigmatizing diagnoses as well as potential treatments that are available to them, while ensuring gender-affirming care is accessible in an environment that expresses respect for patient autonomy. The informed consent model offers less dependence on health professionals in a "gate-keeping" role that has been perceived as unnecessarily pathologising and may limit access to care.

A professional society founded in Benjamin's honour to carry on his work would do so espousing his clinical values —primarily **change the body to meet the mind**. I focus on three chapters of the WPATH SOC 8 for LupronGate — Chapter 18 on Mental Health, Chapter 6 on Adolescents, and Chapter 7 on Children.

Recently Mia Hughes released her report on the leaked WPATH recorded conversations between clinicians discussing the WPATH "Standards of Care" through Environmental Progress. Essentially Mia Hughes' analysis reveals what I myself have claimed in this report:

1. WPATH is not a clinical science organisation
2. WPATH has abandoned the ethical principle *first, do no harm*
3. WPATH promotes human experimentation in line with past psychiatric and reproductive human experimentation

It's not my intention to duplicate anyone else's work—you can access the full WPATH Files report here. You should access them, to witness WPATH clinicians nonchalantly discuss the metastatic liver disease that resulted from toxic levels of gender affirming testosterone administered to a young female patient. A quick search in scholarly literature will reveal much evidence for an association between high serum levels of androgen hormone in females and higher levels of liver cancer. Despite the widespread shock about the revelations of the WPATH Files, Canada remains sheltered from the unsettling realities by a wall of state-funded legacy media which refuses to report facts, thereby grossly and gravely misleading the country.

Statements of Recommendations

18.1- We recommend mental health professionals address mental health symptoms that interfere with a person's capacity to consent to gender-affirming treatment before gender-affirming treatment is initiated.
18.2- We recommend mental health professionals offer care and support to transgender and gender diverse people to address mental health symptoms that interfere with a person's capacity to participate in essential perioperative care before gender-affirmation surgery.
18.3- We recommend when significant mental health symptoms or substance abuse exists, mental health professionals assess the potential negative impact that mental health symptoms may have on outcomes based on the nature of the specific gender-affirming surgical procedure.
18.4- We recommend health care professionals assess the need for psychosocial and practical support of transgender and gender diverse people in the perioperative period surrounding gender- affirmation surgery.
18.5- We recommend health care professionals counsel and assist transgender and gender diverse people in becoming abstinent from tobacco/nicotine prior to gender-affirmation surgery.
18.6- We recommend health care professionals maintain existing hormone treatment if a transgender and gender diverse individual requires admission to a psychiatric or medical inpatient unit, unless contraindicated.
18.7- We recommend health care professionals ensure if transgender and gender diverse people need in-patient or residential mental health, substance abuse or medical care, all staff use the correct name and pronouns (as provided by the patient), as well as provide access to bathroom and sleeping arrangements that are aligned with the person's gender identity.
18.8- We recommend mental health professionals encourage, support, and empower transgender and gender diverse people to develop and maintain social support systems, including peers, friends, and families.
18.9- We recommend health care professionals should not make it mandatory for transgender and gender diverse people to undergo psychotherapy prior to the initiation of gender-affirming treatment, while acknowledging psychotherapy may be helpful for some transgender and gender diverse people.
18.10- We recommend "reparative" and "conversion" therapy aimed at trying to change a person's gender identity and lived gender expression to become more congruent with the sex assigned at birth should not be offered.

Recommendations from WPATH Standards of Care 8 :: Chapter 18 Mental Health

SUMMARY CRITERIA FOR ADOLESCENTS

Related to the assessment process

- A comprehensive biopsychosocial assessment including relevant mental health and medical professionals;
- Involvement of parent(s)/guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible;
- If written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST), only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical and mental health professionals (MHPs).

Puberty blocking agents

a. Gender diversity/incongruence is marked and sustained over time;
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care;
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
e. Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
f. Reached Tanner stage 2.

WPATH SOC 8 Chapter 18: Mental Health

The Chapter on Mental Health opens by acknowledging the high incidence of mental illness in the transgender and gender diverse population relative to the general population and attributes this to complex trauma, stigma, and discrimination. Correlation and causation differ and proponents of transgenderism do not consider the distinction between the two approaches to analysis.

Taking a cluster of people with high ACE Scores, with strong history of PTSD, with strong evidence of a chronic established pattern of Cluster B personality traits and tendencies, taking individuals with poor vagal tone and diminished interoceptive capacity and diminished sensory tolerance and giving them a label called transgender seems unhelpful and quasi-religious, doesn't it?

WPATH asserts transgender identity is not a mental illness and also erroneously asserts that medically necessary gender affirming care reduces psychiatric symptomology as well as minority stress. Interestingly the WPATH SOC 8 document acknowledges the problems of generalising the results of studies to the whole of the transgender population and does just that throughout with claims that gender affirming care reduces suicidal ideation and other psychiatric symptomology. Why does an identity need medical care if it isn't a mental illness?

The study by Grannis et al given as evidence that gender affirming care reduces psychiatric symptoms involved 19 female children who received testosterone and 23 which did not and comparatively the testosterone group reported a reduction in anxiety and depression, so called internalised symptoms of their transgender identity.

Testosterone is a known mood enhancer and that accounts for the reduction of negative mood symptoms observed by this study. The study by Aldridge et al shows a very weak improvement in psychiatric symptomology in response to gender affirming hormones for 178 individuals over an 18 month period.

We have no way of knowing the clinical situation in the USA (or Canada), since WPATH has not considered the data from gender clinics to evaluate treatment modality outcomes and

determine the actual efficacy of gender affirming care. WPATH is not a serious clinical organisation which serves the wellbeing of individuals, but rather, the world HQ of a body modification and self hatred movement. WPATH glorifies invasive medical procedures + treatments as a means to self-actualisation. Meaning WPATH only cares about gender affirming care + not the best interests of actual human beings.

When I look at the literature on transgender identity I see an identity created from the pathologisation of trauma responses and a distortion of emotional dysregulation. I see an identity created from the interoceptive challenges that comes with autism. I see a modern day redux of hysteria and an identity that's arisen out of celebrity culture and exposure to porn and the normalisation of sexual fetish and their conflation with being gay.

There really is no valid and reliable evidence that supports chemical castration, hysterectomy, orchiectomy, mastectomy, and cross sex hormone as an effective and safe treatment for psychological distress or any mental illness (DSM) diagnosis. In the case of children, removing sexual function and reproductive capacity to relieve emotional distress seems particularly irresponsible and cruel. It promises an unattainable outcome, absolutely the opposite of affirmation.

Removing nature's most powerful neuromodulator from a human's grasp forever seems quite evil, to put it quite bluntly. Sex, the act of achieving an organism, remains the most powerful neuromodulator know to humankind. How can affirmation deny a person this forever?

The recurring theme throughout this chapter remains the obvious psychological origin of this phenomenon. Activists have cultivated a culture of education and psychology that reinforces discomfort in one's own body and created an identity out of this discomfort — encouraging a distorted form of self indulgence, which reduces nervous system resilience and capacity. Gender Affirming Care affirms a fundamental disconnect with the self via a lobotomising of the endocrine system. It strikes me foolishly + primitively dualistic.

Statements of Recommendations

6.1- We recommend health care professionals working with gender diverse adolescents:
6.1.a- Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.
6.1.b- Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.
6.1.c- Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.
6.1.d- Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
6.1.e- Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.
6.2- We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particular identity is favored.
6.3- We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.
6.4- We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.
6.5- We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.
6.6- We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including a review of the benefits and risks.
6.7- We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.
6.8- We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender- related surgery until the transition is made to adult care.
6.9- We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.
6.10- We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the reproductive effects including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.
6.11- We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):
6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:
6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.
6.12.b- The experience of gender diversity/incongruence is marked and sustained over time.
6.12.c- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
6.12.d- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.
6.12.e- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
6.12.f- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
6.12.g- The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

Recommendations From WPATH SOC 8 Chapter 6: Adolescents

WPATH SOC 8 Chapter 6: Adolescence

The Chapter on Adolescence opens with a measure of unexpected moderation that gives me momentary pause to reconsider WPATH as a professional organisation fronting for a body modification cult. Then I read about the methodological limitations of the Littman study on the social contagion factors driving the recent demand for paediatric gender medicine.

While the SOC 8 seems to represent some advancement away from a fundamentalist vision of gender medicine, it still expresses many profoundly developmentally questionable and ethically unsound ideas about medical care for adolescents. Choosing to point out methodological limits in the Littman study and choosing to ignore the grave methodological limits and flaws in the Turban studies underscores the reality of the activism bias driving WPATH. An organisation founded on a Cartesian mind-body philosophical vision of the human body and human sexuality can only take us so far, it ultimately fails to meet developmental needs.

Chapter 6 acknowledges the challenges that developmental disorders such as autism present to health care providers during the assessment period, and discusses the impossibility of discerning an innate and congenital gender identity from some developmental process taking place. Whilst this seems to represent a pulling back from gender affirming care as a first line of treatment in the guidelines, it remains woefully inadequate. Any and all ethical and safe medical care requires a thorough assessment complete with differential diagnosis, something which paediatric gender medicine lacks presently.

In Canada legislation banning conversion therapy has designated probing assessment and differential diagnosis that questions a child's expression of gender identity as illegal because it does not affirm. Equating gayness with gender identity in Canada has led to the very lazy phenomenon of equating gay conversion therapy with psychotherapy that questions a patient's fixed delusion or cognitive distortion. This law, and the public health policy that flows from it, creates harm because it prevents health care providers from investigating the source of the entrance complaint.

The end result of banning a make-believe thing called gender identity conversion therapy is limitation of health care provider ability to address all health care needs of adolescents who present with gender incongruence and dysphoria. In Western Canada that has resulted in OD deaths leading the cause of death in children and youth.

Whilst health care activists bully and threaten parents about their children dying if they don't agree to XYZ gender affirming treatment, children are indeed dying unnecessary and tragic deaths because they did not get the treatment they needed — not anything related to gender identity. Did we stop to consider that children have needs other than helping AbbVie meet it's quarterly profit goals from the sale of Lupron?

The authors of Chapter 6 point out the importance of differentiating between primary and secondary gender incongruence. An adolescent plagued by disturbing cognitive phenomena *such as obsessions and compulsions, the special interests of autism, rigid thinking, broader identity problems, parent/child interaction difficulties, severe developmental anxieties (e.g., fear of growing up and pubertal changes unrelated to gender identity), trauma, or psychotic thoughts* ought to receive the evidence-based and compassion and humane care s/he needs to have relief first and foremost.

This excludes gender affirmation, which typically means pubertal suppression and a sex change. Such an adolescent might need medication and definitely will need psychotherapy and might benefit from a rigid and exacting course of physical training. Lobotomising the hypothalamus does not seem like the appropriate first line treatment for a young person presenting with significant psychiatric distress.

In their recent scope review of the literature on paediatric gender affirming care, Saffie and Baüerle acknowledged that *in the last 24 months, several international health authorities have raised concerns over the uncertain risk-benefit ratio of using hormonal interventions (specifically "puberty blockers" and cross-sex hormones) as the first-line treatment approach for young people under 18, and are restructuring their systems to prioritize psychotherapy as the first line of treatment*. Indeed, not only international health authorities, also clinical professionals, educators, parents,

young adults with deep and severe transition regret, and most poignantly and powerfully of all parents, have begun to raise their voices and get more insistent in their skepticism of gender affirmation.

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Statements of Recommendations

7.1- We recommend health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess a general knowledge of gender diversity across the life span.
7.2- We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.
7.3- We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.
7.4- We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.
7.5- We recommend health care professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment.
7.6- We recommend health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning, and language skills.
7.7- We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).
7.8- We recommend health care professionals consider consultation, psychotherapy, or both for a gender diverse child and family/caregivers when families and health care professionals believe this would benefit the well-being and development of a child and/or family.
7.9- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.
7.10- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age-appropriate psychoeducation about gender development.
7.11- We recommend that health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.
7.12- We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.
7.13- We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.
7.14- We recommend the health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.
7.15- We suggest health care professionals consider working collaboratively with other professionals and organizations to promote the well-being of gender diverse children and minimize the adversities they may face.

Recommendations from WPATH SOC 8 Chapter 7: Children

WPATH SOC 8
Chapter 7: Children

Chapter 7 opens with a Shahada-like declaration that gender identity is a normal part of human growing and development, and also with a firm denial of any pathology. Gender identity is not a pathology, it is normal for a girl to tell her parents she feels like a boy and wants to die if female puberty becomes permanent, apparently. It is not a sign of a mental illness or pathology when your 13 year old daughter comes to you and expresses her passionate desire for a double mastectomy so she can feel affirmed in her body, claims WPATH.

Contrary to Ehrensaft's claims, the desire to destroy one's own body to attain an imagined self visual held in the mind does not form any normal part of childhood growth and development. WPATH does not seem like it will win any awards for child development scholarship, I often wonder what Piaget and Erickson would think of this Lysenkoist version of Human Development.

WPATH provides the following five guiding principles, referenced with papers by Ehrensaft, the Endocrine Society, and other pro-gender affirming care scholars and professional organisations.

1. Gender identity is part of human development
2. Dissociative events or expressions of body dysphoria, including expressions of a desire to destroy one's own body, are not pathologies
3. Not all expressions of gender diversity mean the kid is transgender
4. Mental health professionals can guide kids to make choices about the gender expression because this affirms kids and it is good for them
5. Mental health professionals cannot guide kids to feel safe and connected to their bodies because that's conversion therapy and it harms kids

WPATH laments the fact that *this research has typically relied on the assumption that child research participants are cisgender*. What does that mean? Children do not have sexual maturity, and all humans belong to one of two reproductive classes, male or female. Gender is the feeling they have about their sex role and desires. Children do not have a fully developed and stable sense of

themselves as sexual reproducing mammals because developmentally they lack the capacity. A three day old cannot speak to you in full sentences with full vocabulary. A three month old cannot walk to the fridge to get their own breakfast.

In her recent commentary Sarah Jorgensen referred to the notion of Open Future. Children have developmental limits, and therefore we limit their freedoms accordingly in order to protect their futures. Chapter 6 mentions the importance of focusing on the family's needs and goals — in Canada parental inclusion has emerged as a major goal that families have for themselves and their kids. Why can't Rainbow Activists follow the WPATH guidelines and honour the requirement of parental inclusion? WPATH cannot resist the urge to engage coercion though.

Throughout the chapter, the authors drop hints at pressuring the family to agree to their child's medical transition treatment plan. Interestingly, the first 10 of the 15 recommendations provided by Chapter 7 involve training of clinicians, conducting thorough assessments of paediatric patients and their families, including considering the family connections, as well as psychotherapy and psychoeducation. The last 4 recommendations address the reproductive and physical issues, only one recommendation mentions providing information about the effects of gender affirming chemotherapy.

The recurring theme of conflating correlation with causation presents itself throughout the chapters on children and adolescence. Noting that children who embrace identity labels have a higher incidence of trauma and attachment challenges, WPATH then uses the disparity as evidence for the existence of gender affirmation as a crucial developmental component.

WPATH begins with the belief of gender and gender expression as The First Cause, and every disparity becomes evidence for The First Cause of Gender. The established conventions and limits of clinical science and material physical reality suddenly become fluid, to accommodate The First Cause of Gender. WPATH calls this "psychosocial gender affirming care". Affirming gender takes precedence above all else, according to WPATH.

Susan Bradley, a pioneer in the field of paediatric gender affirming care

and one of the first Canadian doctors to treat children with pubertal suppression, has said she regrets ever treating gender confused children with pubertal suppression. In fact, in recent interviews Bradley referred to pubertal suppression as highly authoritarian and shared her clinical observation that pubertal suppression locks children onto a medical transition path.

Pubertal suppression removes opportunities from kids, as opposed to giving them time and expanding their options. Yet, in the chapter on children, WPATH scholars tell the readers of SOC 8 that *psychosocial gender-affirming care for prepubescent children offers a window of opportunity to promote a trajectory of well-being that will sustain them over time and during the transition to adolescence. This approach potentially can mitigate some of the common mental health risks faced by transgender and gender diverse teens*.

Remember, WPATH exists to carry on the work of Harry Benjamin, which violates every principle of human development and neurobiology, and as such cannot objectively advise on the care of children. Benjamin himself embodied deep and intense internal conflicts and his work reflects that when you look at the entire body of it. In her paper *Creative Maverick*, Dr. Person wrote about Benjamin's impotence and his disdain at Freud for having called him a latent homosexual when he disclosed his erectile dysfunction to Freud.

Dr. Person wrote about Benjamin's essential hopelessness in the human condition and how this rendered life meaningless for him. Having no hope and believing in no meaning to anything does not describe someone who feels strongly about scientific progress. Perhaps anti-establishmentism does not equate to a desire for progress? Perhaps oppositionality to convention betrays a deeper personality pattern such as narcissism and not a desire to improve the world through innovation?

Did Victor Frankenstein want to improve the world, or did he simply want to unlock the secret to life so he could make himself famous? Given the inherent and innate narcissism of WPATH and it's foundational philosophy, it seems untenable to think such an organisation could provide any kind of developmentally appropriate guidelines or standards of care for the paediatric population.

Oh Canada, Why Do We Chemically Castrates Kids

"It is a fantasy and deeply concerning that any doctor could believe a 10-year-old could consent to the loss of their fertility."

— Keira Bell

Federal Gender Self ID Legislation. Referred to as Bill C-16 or Gender Self ID, this bill brought the federal government in line with the provinces as far as Self ID, making it legal for any male tho self identify as a women to gain access to female spaces and services and funding opportunities. This includes Corrections Canada, which made the decision to house inmates *according to gender and not genitalia*.

In retrospect, aside from enabling sex offenders and other violent males by incentivising their abusive behaviour toward female people, Self-ID had the effect of enabling the flow of massive amounts of cash into queerification policies, including forcing provinces to adopt queerification by using fiscal expenditures to promote those policy objects at the expense of other crucial policy measures and objectives.

Federal Gender Identity Conversion Therapy Legislation. Referred to as Bill C-6 or C-5 or the Conversion Therapy Bill, this piece of legislation mandated the affirmation of all paediatric gender identities, irregardless of psychiatric profile vis a vis Ace Score. The legislation had the effect of designating all psychotherapy and differential diagnostics approaches to primary care as conversion therapy, and therefore criminal behaviour. Gay and autistic kids are over-represented in this cohort of kids.

Federal Drug Legislation. First let's begin with legislation that governs medication in Canada. The *Food and Drugs Act* governs the sale of food and drugs in Canada. Through a prescribed process, Health Canada grants drug companies license to sell their products. Typically Health Canada follows the American FDA policies and decisions. Each pharmaceutical product sold in Canada has its own Drug Identification Number. Prescription drugs undergo a rigorous approval process and Health Canada grants a license to a company for a particular drug for particular clinical indications.

What does Canadian law say about promoting prescription medication? Section 9(1) of the Food and Drugs Act states, *No person shall label, package, treat, process, sell or advertise any drug in a manner that is false, misleading or deceptive or is likely to create an erroneous impression regarding its character, value, quantity, composition, merit or safety*.

Health Canada lists the following examples of contravening Section 9(1): *omitting or downplaying risks, overstating the effectiveness, promoting unauthorized health products or indications (off-label): promotion of a health product prior to market authorization is not permitted because the terms of such authorization have not been established and the proposed indication(s) for use have not been verified, misleading drug comparisons*. (Government of Canada website). In plain language this means it is illegal to promote a drug falsely, this includes for off-label uses, and off label promoting also includes overemphasizing effectiveness and misleading comparisons.

Federal laundering of social policy through NGOs. Health care policy in Canada happens at the provincial level. The Canadian Confederation means power sharing under a national umbrella. In Canada the federal government funds the provinces from tax revenues collected and remitted by the provinces, through an equalization payment arrangement that accounts for regional strengths and needs. One important job of the PM involves uniting provincial leaders to accomplish national goals. Sometimes, most times in fact, this looks like herding cats, or worst, showering with cats. Justin Trudeau has never possessed the psychological profile to provide this leadership to Canada—as a leader Trudeau opts out of self analysis and collaborative solutions.

The Trudeau Regime influences provincial policy through its funding of national organisations like Egale via the Department of Women and Gender Equality (WAGE). The heavily regime-funded NGO has produced a large resource cache of propaganda to promote Gender Radicalism to Canadian kids directly and indirectly, as I will describe in more detail in a separate section of this report.

As part of its legal advocacy work Egale also funds legal challenges, such as

the current one against the Province of Saskatchewan. The Trudeau Regime has in the past funded the Canadian Anti-Hate Network (CAHN), and appears poised to once again fund their controversial work which targets and labels conservative organizations and individuals hate who dissent to gender or racial essentialism.

CAHN produced materials used by public sector unions who organised and fuelled the counter protest to the Million March for Children parent protests. The Trudeau Regime has a tight grip on social, health and education policy in Canada through its funding of NGOs which then influence provincial jurisdictional issues through their political lobby efforts, such as SOGI and related programming.

Each province has its own policy and funding delivery mechanism to make Lupron accessible to children diagnosed with Gender Dysphoria. AbbVie does not have a license to promote Lupron as a treatment for Paediatric Gender Dysphoria in Canada or anywhere in the world. No company that manufactures and distributes GnRHa has a license for the treatment of Paediatric Gender Dysphoria.

If Lupron is indeed a life saving drug for adolescents with gender dysphoria, why hasn't the AbbVie sought FDA/Health Canada approval for that clinical use? 79% of all off-label prescriptions in Canada lack evidence of efficacy and 75% of medicines prescribed to kids are off-label, according to a report of the Senate of Canada Standing Committee on Social Affairs, Science and Technology.

Activists Running the Asylum. As previously mentioned, the country follows WPATH guidelines and every province and territory except NWT has full or partial public insurance coverage for puberty blockers and hormones. According to the Trans Youth study, ten clinics across the country deliver gender affirming care to children — 4 in Ontario, 3 across the prairies, 1 in each of Québec and The Maritimes, and 1 in British Columbia. ***Investigative research can tie AbbVie three institutions offering Lupron for Paediatric Gender Dysphoria— BC Children's Hospital Foundation, Sick Kids Foundation, and Stollery Hospital Foundation***. Most clinics require a doctor's referral or have lengthy waiting lists. Some clinics instruct referring

doctors to go ahead and prescribe the puberty blockers prior to any assessment.

Of note, The Trans Youth CAN! Study refers to a study conducted based on data collected collected between September 2017 and June 2019 from 174 youth 15 and under and 160 parents/ caregivers recruited at the first appointment after referral for blockers or hormones at one of 10 medical clinics across Canada (Vancouver, Calgary, Edmonton, Winnipeg, London, Toronto, Hamilton, Ottawa, Montreal, Halifax).

The Trans Youth study infographics indicates that nearly all youth exhibited a dysfunctional relationship with food including over half of respondents engaging binging or bulimia, 92% of trans youth attend public school, that 82% are female adolescents seeking to escape their female bodies, and that three-quarters of trans youth have a psychiatric comorbidity such as anxiety or depression or mood disorder.

Trans Youth CAN! demonstrates parents' concerns as those of loving parents, debunking transactivists' harmful anti-parent rhetoric. The study shows parental concerns for their child's wellbeing, including making irreversible decisions, and facing rejection and violence from peers. Interestingly, Trans Youth CAN! also showed that parental relationship breakdown has some correlation to the development of gender confusion.

Clearly Canada has a significant mental health crisis brewing in its youth population. We have a cohort of paediatric professionals, pedagogy and early childhood professionals, psychologists and therapists, social workers and doctors, who have created a culture for children that enhances all their neuroses, driving kids to connect with and depend on things that harm them, such as social media and electronic devices.

The very people who fear monger about kids dying because they do not get the care they need have monopolized the conversation and all the institutional resources, and have gone to disturbing lengths to promote a philosophy of paediatric care that harms kids and destroys families, thereby making it harder than ever for kids to get the care they need. Recall that OD deaths are the leading cause of death in children and youth in western Canada.

The media, popular culture and SOGI create unrealistic demands that

health care infrastructure simply lacks the capacity to fulfil. Trans Youth CAN! survey results show the sharp rise in the demand for gender clinic services after SOGI became entrenched in public schools across Canada. In January 2023 *The National Post* wrote about the role schools play in transitioning children, in this piece Margaret Lawson, a doctor who works out of the CHEO clinic in Ottawa, applauded the role schools play driving kids toward medical transitioning. The article triggered a backlash, with 1200 people commenting their opinions about schools hiding gender transitioning of their students from parents.

The reasonably strict prescribing and coverage regulations regarding Lupron — in BC Special Authority for full PharmaCare requires a prescribing endocrinologist—keeps access to puberty blockers lower than they could be. Presumably families with the ability to pay the high cost of around $400 per month could receive gender affirming chemotherapy from any doctor, including their family doctor.

Zealous parents could well print off the WPATH guidelines and bring this to the doctor, like a special request list. Despite warnings about and growing concerns of social contagion, Gender Affirmation Zealots who practise medicine seem intent on ignoring the evidence and charging ahead based on their own ideologically cultivated certainty.

According to *Gender Report Canada*, paediatric health care professionals see their role as affirming every child's gender journey and general practitioners have received guidelines from gender clinics instructing them to prescribe puberty blockers prior to a full assessment work-up and referral to a specialist or clinic. Despite the weak recommendations from WPATH SOC 8 advising a full assessment with a differential diagnosis, many practitioners choose to disregard the professional advise and treat GnRHa like the Shirley Temple of pharmaceuticals, harmless fun for kids.

According to Xtra Magazine, trans health care suffers from chronic underfunding and *a total of 13 practitioners in Toronto are certified providers with the World Professional Association for Transgender Health (WPATH). According to the WPATH directory, there are just six in Saskatoon, Saskatchewan; in Saint John, New*

Brunswick, and St. John's, Newfoundland, there are none. Educating and convincing doctors to validate your identity isn't ideal and doesn't set up a safe therapeutic relationship, but that's the reality for many LGBTQ2S+ people in Canada, laments a childless adult quoted in the article, which goes on to explain that schools don't teach enough about trans health care.

CPATH claims to represent 600 professionals in a parliamentary statement it made in 2019. It appears to have no affiliation with WPATH, choosing to move away from care standards that emphasise assessment and differential diagnosis, since the culture of gender medicine has adopted the stance that assessment "pathologises trans kids". Only a handful of practitioners in Canada have WPATH credentials. Currently the CPATH website says "under construction".

Suffice it too say that CPATH seems to want its cake and eat it to. It's submission to parliament laments the stigmatization of gender and gender identity via the DSM and the diagnostics for Gender Dysphoria. It also laments a failure of accessible health care to support gender identity. We could forgive readers for their confusion — if gender identity does have a natural basis, i.e. if it is not a pathology, then why do trans people need such a high degree of medical intervention to feel like themselves? No other individuals afflicted with a dissociative disorder in which they do not connect with their physical bodies require massive doses of hormones and surgical disfiguration of genitalia in order to feel themselves balanced and healthy.

Gender Affirming Care makes no sense from a scientific perspective. Individuals requiring high degrees of complex and invasive health care interventions do indeed have an underlying pathological process — yes they have a sickness if they need high levels of invasive and expensive medical care that few practitioners have the skill to deliver in order to feel well! Gender Radicals need to pick one — identity or illness, they cannot have both — we simply cannot dismantle health care ethics for a group of deranged dualistic narcissists who want to practise experimental medicine on children without limit in order to affirm their own gender experimentation with their own adult bodies.

Recruiting Kids into the New Revolutionary Guard

"We have to be at the barracks before midnight and we can never stay out. We are forbidden to be in a couple, since marriage is only authorised for senior officers, and it is strictly forbidden to bring girls back to the barracks. We are discouraged from meeting them in town, and denunciation is sometimes encouraged," says Nathanaël, a Swiss Guard, about the lifestyle of a Swiss Guard. Recruits to the Swiss Guard become the Pope's personal guard, and the guard responsible for the security of the Vatican. As I wade through the rhetoric on Gender Radicalism, in particular the medical and pedagogical, I often feel as though I am observing a revolution and the formation of a revolutionary guard, similar to the Swiss Guard, which demands celibacy from its members.

In his *Artesh-e bis million* address, the Ayatollah Khomeini called for the

formation of a revolutionary plainclothes militia, stating that all Iranians should be equipped to defend their country. Today this unit, called the Basij has a heavy street presence and suppresses dissidents — the militia exists because the Supreme Leader needs protection from Iranians, not because Iranians need protection from invaders.

I mention the two best known imperial guards in the world because I think I am watching the formation of a revolutionary guard here in Canada, albeit informal and unarmed. Over the past several years I have observe a cluster of state-funded NGOs, the state itself, and a consortium of public sector unions in Canada—all siding together against a growing group of ordinary parents who have concerns about their kids and public education.

Recently the Canadian Anti-Hate Network announced it will siphon another $5 million from the public purse to fight "hate groups". The CAHN ignores growing terrorist threats and extreme cells of diaspora politics such as the Kalistanis, and other international extremist groups, including from the Iranian Regime. The CAHN focusses solely on domestic dissidents, having such a loose definition of hate as to render its mission as a hate fighter meaningless. Hate does matter though—it puts Canadians in physical danger. Hate does exist still, it looks less monstrous than we expect.

Hurting feelings does not equate to hate. The danger has become that a large swath of the ruling class has come to confuse hate with disobedience and rebellion and disagreement. In free and tolerant societies a passionate exchange of differing ideas happens and ultimately leads to a workable solution for all. This requires intellectual and emotional resilience and the ability to connect with humans respectfully and reasonably and rationally.

In the wake of the HateGate report on the controversial workings of the CAHN by Elisa Hategan and Caryma Sa'ad, I feel like I am seeing confirmation of a recruitment drive for a Regime Guard. Parents have real concerns about the ways public educators seek to influence their kids without parental knowledge. For these concerns, people have a genuine right to raise questions about the racial essentialism of progressive politics, and the growing psychological abuse of Critical Race

Theory (CRT) and Diversity Equality Inclusivity (DEI). The Trudeau Regime and it's NGO puppets and many public sector unions have smeared reasonable well-meaning Canadians as hateful and intolerant and abusive bigots. Skeptical Canadians, conservative-minded Canadians, religious Canadians, and parents who refuse to sacrifice their kids on the alter of SOGI have become enemies of the state.

The bulk of trans medicine happens in British Columbia, Alberta, Ontario, and Quebec, so this section focussed on Gender Affirming Care and specifically promotion and access to puberty blockers mainly in those regions of Canada. Just prior to the release of WPATHFiles and the CASS Review, Nova Scotia Health opened a brand new Gender Affirming Care Clinic in Kentville.

British Columbia. The Province of BC has adopted a public health policy that involves the active promotion of an off-label use of a chemical castration drug for the treatment of psychological distress in children and adolescents. British Columbia has long existed as a kind of Mecca and Medina (both rolled into one) of transgender public health care in Canada.

In BC promoting Lupron to the psychiatric paediatric population has a three-pronged approach: 1.) Trans Care BC, 2.) The Provincial PharmaCare Policy, 3.) the BC Children's Hospital. BC Health uses a reproductive hormone analogue as a psychiatric medication.

Paediatric endocrinologists can get a practitioner exemption to obtain a Special Authority for Lupron PharmaCare coverage. That's interesting, because Central Precocious Puberty, the only licensed use for paediatric patients, already appears as one of the criteria for Special Authority. **Why are paediatric endocrinologists authorised to prescribe Lupron, a chemical castration drug, under Plan G, as in Psychiatric Medication Coverage Plan G?** Why are BC taxpayers paying for this experimental use of a reproductive hormone analogue? Is this honestly the least invasive + least costly treatment for psychological distress in children? What does the BC policy for Lupron and kids with gender dysphoria mean when we break it down?

1. The BC Provincial Health Authority promotes Lupron as a remedy for delaying puberty in kids with gender dysphoria because it is

indicated for delaying puberty in kids with precocious puberty— this is a misleading comparison

2. The BC Provincial Health Authority misleads the public and practitioners with claims that Lupron will provide relief of adolescent psychiatric distress
3. The BC Provincial Health Authority fails to provide adequate warnings about the adverse effects and experimental nature of Lupron in children
4. BC Health gives paediatric endocrinologists carte blanche to prescribe Lupron for children without the required clinical indication under a plan designed for coverage of psychiatric patients.

Alberta. *Alberta has announced its intention to introduce safeguards to limit medical abuse committed against families and children. This section describes the pre-legislation scenario in Alberta.*

Alberta delivers Gender Affirming Care information and services through Stollery in Edmonton as well as Skipping Stone and Metta in Calgary. Neither the Stollery nor Metta gender clinics have websites, information about the clinics and the service they provide seems spartan, deliberately so. I have to wonder about the deliberate obfuscation when I try to uncover basic facts about operation and mandate and programming and meet secrecy and walls of silence.

The Stollery Foundation operates a gender clinic out of the Stollery Children's Hospital in Edmonton and also operates a satellite clinic called The Centre to service a catchment area north of Red Deer. Bob and Shirley Stollery have died over a decade ago and the operation of the foundation has fallen to their adult children and spouses.

Doug Stollery's partner Scott Graham has close ties to SOGI via the ARC Foundation and the Edmonton Community Foundation. The Stollery family ardently supports SOGI and gender affirming care and have a goal of strengthening integrated services for youth via hubs, with a focus on vulnerable populations such as LGBTQ+ homeless youth.

Simon Leboeuf, adolescent paediatrician at Stollery Hospital developed a podcast episode for a podcast called *Paeds Cases Podcast* about paediatric hormone therapy in which he normalised experimental hormone

therapy for kids with psychiatric disorders.

He equated this treatment regime with HRT for menopausal women. No balanced information was provided about the risks associated with this chemotherapy regime. The overstating of benefits combined with the suppression of adverse effects remains a recurring theme in the gender affirming care literature and content and also the professional narrative.

It's interesting how, if you believe the medical profession, there's no risk at all for teenagers to receive high doses of synthetic hormones for no valid clinical indication and there is a high risk for some women to receive low doses of synthetic hormones for replacement HRT, a valid clinical indication. It's almost like the medical professional does not actually have patient comfort as it's objective. When a teenage boy can get estrogen more easily than I, a 54 year old woman, I reserve the right to have this cynical view of medicine and doctors and health care.

Skipping Stone has an extensive website and offers a vast selection of resources for trans people and for parents wanting to raise their kids in the Gender Radicalist culture. Skipping Stone offers a wide assortment of Gender Affirmation-based programming targeting kids and families, including coaching groups for gender diverse parenting. For youth wanting to access hormone therapy or any gender affirming care services, there's an online form to book an appointment and an appointment would be available on October 4 in the AM.

Skipping Stone will gladly give out body modification devices like breast binders to youth and they will provide subsidy for those in need. Information exists linking breast binders to long term health damage that includes respiratory complications, Skipping Stone didn't seem to get that information which indicates they are promoting long term skeletal and respiratory damage and even damage to the breast tissue itself, by handing out breast binders to young women.

Male youth who wish to lose facial hair in their quest to feminise can get hair removal treatments. As a South Asian woman who endured facial hair through puberty I feel like it seems sexist to give boys all the resources to affirm their desire to feel less masculine in the male bodies and ignore the desire of female

youth who struggle to look less masculine in their FEMALE bodies. Where is the gender affirming care for young women struggling to make their bodies look more feminine?

Information available on the TransYouth website says that Metta established itself in 2014 and demand for gender services exploded from 1 request per month to 20, at the time of that website's publication Metta services 500 youth aged 5 to 18. Metta describes its mandate as seeing kids aged 5 to 18 who question their gender.

Why? Why reinforce the cognitive distortion when we know from long term valid and reliable research that in the majority of cases gender confusion resolves on its own, as a part of pubertal angst and normal growing pains all humans experience? The massive and explosive influence of SOGI as a driving force in the recruitment of kids for Gender Affirmationist medical transition goes unstated, the elephant in the room.

Ontario. The seat of Canada's Government resides in Ontario, in addition the southern Ontario belt, the largest concentration of Canadians anywhere in the country, a populace which drives most of what takes place sociopolitically in Canada. Ontario Rainbow Health provides information about available gender affirming care services.

According to Rainbow Health, the process of sexual maturation, a natural + necessary party of growing up, can pose a deadly threat to a child who is born the wrong body. " … *A child whose sex is assigned male at birth, may be a girl on the inside; a child whose sex is assigned female at birth, may be a boy; or a child assigned as male or female may not identity as either a boy or a girl …* [puberty] c*an bring unwanted body changes that can lead to severe distress, self-harm or thoughts of suicide*.

Rainbow Health promotes the Harry Benjamin approach to discomfort with one's own body — change the body to conform to the feeling about the body. Note to the reader: Gender Zealots call this *identity*.

Yes, gender identity affirmation refers to the act of imposing physical trauma on the body via experimental surgery and hormone therapy. Arguably I could refer to unnecessary surgery as violence perpetrated upon the body. Arguably I could refer to unnecessary

high doses of sex hormones as violence perpetrated upon the endocrine system.

A Guide for Families in Transition provided as a resource leads to a dead link at Central Toronto Youth Services. CTYS provides a 10-week group for FIT, families in transition. I found the FIT guide here. Skimming through, I see a piece of propaganda designed to de-sex those who read it, with the key word suicide mentioned to instil fear in kids and their parents.

The FIT guide reads like the Gender Affirmation Catechism or Shariah. FIT provides a train the trainer program. When one steps away and observes the whole of it, Gender Affirmationism looks like a disturbing pyramid scheme or multi level marketing scam on the ground.

Gender equity seems like a harmless concept the mainstream can ignore until we peak under the hood and see that gender equity means to remove the knowledge of sex distinction from our science, clinical practise, culture and media. Genderists plan to erase sex from human culture and society, whilst they try to promote medical experimentation on human reproductive organs and genitalia. They prey on the most vulnerable to conduct their experimental medicine.

The propaganda offered by the province of Ontario looks largely like a copy and paste job from BC and Alberta — the same use of euphemisms to mask atrocities offered as health care, the same war on language, the same attempt to divorce language from physical reality, the same attempt to encourage suspension of critical thinking.

Safety has come to mean holding oneself inside the echo chamber, despite the growing discomfort. Hate has come to mean challenging the delusion. It's a wall of dishonesty, a sea of mind control. The propaganda encourages families to normalise the dysfunction.

The propaganda engages in doublethink, meaning the same Genderists which tells you that chemical castration of a child as part of a sex change process will prevent suicide also tells you that this phenomenon does not constitute a mental illness. A child who needs to have a sex change to survive her suicidal ideation is not mentally ill, just exploring her true identity.

We can't tell you why some people are trans, which means they need to have a sex change in order to live, however we

don't want to call it a mental illness. The propaganda also provides the distorted studies that misrepresent their findings and over-inflate the benefits of gender affirming care, which don't exist.

The disturbing aspect of Gender Affirmationism involves the fact that Gender Radicals prey upon the most vulnerable children and youth, those with high ACE (ACE = adverse childhood experiences or events) Scores, those eating disorders, with trauma from abuse and origin family dynamics, and also from broken homes. This seems predacious to me — to use such children and lie to them and say this will fix them when it only adds further trauma they will have to unpack later in life.

The *Ontario Rainbow Health* website consists of a spartan cultish PDF and not much more that is substantial. London Health Sciences Centre offers chemical castration for children with gender discordance, the consent form states that children aged 10 or 11 can receive the chemical castration hormone analogue. It mentions nothing about cognitive effects and indicates pre existing mental illness and emotional distress must be differentially diagnosed and assessed before proceeding with care. Does this happen? We have much evidence that it does not.

Greta Bauer's activism science drives Gender Affirmation zealotry in paediatric circles. TransYouth dot ca provides a graphically appealing space in which to brainwash the unsuspecting into the cult of body modification known as gender affirming care.

Regarding protocols governing access to Lupron and cross sex hormones, the Harry Benjamin Association, now calling themselves WPATH, drives the bus. The protocol they set has become accepted as SOP across Canada. A fair amount of obfuscation exists, making it difficult to know exactly the situation inside clinics, however a recent investigation conducted by french CBC [English translation here] reveal disturbing details.

I believe it represents the delivery of Gender Affirming Care across Canada, ie in every province and territory. I was unable to uncover a policy similar to BC's with respect to pharmacare coverage of puberty blockers in the provincial transhealth policies I examined.

Quebec. On March 1, 2024 Radio Canada in Quebec published an investigative report on paediatric gender

affirming care. They had contracted a 14 year old female actress to make an appointment at private gender clinic and discuss her body dysphoria and her previously diagnosed eating disorder. She attended the clinic, telling the doctor she saw a video and thinks she might be trans.

After nine minutes of consultation, Sacha gets her prescription: 30 mg of testosterone to inject once a week … The long-term effects of testosterone on the metabolism of a 14-year-old girl will not be discussed. Before entering the doctor's office, Sacha signed a seven-page document detailing the sometimes permanent consequences of testosterone on his appearance, long-term health and fertility. In Quebec, there is no minimum age for obtaining antigenic hormones, that is to say of the sex opposite to that of one's birth. — Pasquale Turbide via *radio canada*

In a 9 minute consultation Sacha has received a prescription for a moderate dose of Testosterone, with minimal medical advice provided to her—the standard WPATH-based gender affirming care boilerplate patient-clinician interaction not uncommon in paediatric mental health care.

The swiftness of the diagnosis shocked the Radio Canada investigative team, who spoke to the parents of 14 adolescents for this investigation. Parents expressed concerns about private gender clinics, which appeal to young people who have received some measure of indoctrination online or any other form of grooming in radical genderism.

But in the rush to intervene medically on their bodies, do we give ourselves the time to evaluate everything that is going on in their heads, asks the *radio canada* piece? No we do not. Anyone who points this out receives the psychological abuse of name-calling and ad hominem along with a McCarthy cancellation from the radical anarchistic mob dominating progressive politics. Note: The weekend of March 16th, 2024, the Radio Canada building received a violent attack and threat of a rage of rage in response to this story.

Countless young people have emerged from the body modification cult of gender affirming care with intense regret and deep grief and extreme feelings of betrayal. Jane Rocheleau-Matte endured sexual assault at the age of 14. The assault left her disgusted with her

body, and she felt repulsed at being a woman.

If I had been a guy this would not have happened to me becomes a common justification many young women tell themselves to convince themselves that the YouTube or TikTok video they just saw about a person transition and living happily ever after provides the answer to their struggle.

The moment Jane woke up from her double mastectomy she regretted her transition. She stopped taking testosterone and sought advice of detransitioning. When Jane asked about breast reconstruction the clinic told her no, that she would need to go thru a process of psychological evaluation and follow-up, something she never received pre-mastectomy. Had the private clinic she attended conducted a thorough assessment complete with follow-up, Jane believes she may have avoided making this big life altering mistake.

For Jane's singular example, hundreds, maybe thousands of more young women just like her exist. Conduct an experiment for yourself and see how many young women are raising money on GoFundMe and other crowdfunding sites for breast reconstruction surgery and detransitioning rehabilitation because they regret their impulsive decision to receive coercive medical counselling to remove their body parts for an emotion they had when they struggled with post abuse trauma or some adolescent growth pangs.

I find that when we transition, there are a lot of people who welcome us, no one questions us, she notes. Whereas when we arrive to detransition [...] suddenly, we are less on the list of priorities. ***[Jane] remembers that her own surgeon told her after her mastectomy that "if it were her own children, she would do everything in her power to delay the operation as long as possible. " A statement that this doctor confirmed to us on the phone, while emphasizing that Jane was the only one of his patients to detransition.*** — radio canada

Do you see it? Read that excerpt over again until you see it. In Canada, the radical national socialist coalition ruling Canada has, through Bill C-6, forced medical professionals to deny proper medical care they would want their own

children to receive. A psychological assessment combined with a watchful waiting approach to Jane's care would have met the definition of gender identity conversion therapy, a punishable offence by law that did receive the support of the 338 and Senate and made Royal Assent.

Beyond that, do you see it? Read the excerpt again and study the logic of the clinical person's statement. Correlation is not causation. If rapes are higher when ice cream sales are increased, that doesn't mean ice cream causes rape. Similarly, if a young person suffers from psychiatric illness associated with suicide and a psychologist decides to assign to them a trans social identity ("you might be trans" is leading language, assignment of an identity), this does not mean the medical illness is caused by the social identity assigned by the psychologist.

The Trudeau Regime wants you to believe that a clinician has committed the abuse of *gender identity conversation therapy* (a made up thing) when he refuses a young woman who watched a Youtube video and then decided she was a man trapped in a female body and now demands surgery to remove her breasts, which she considers an obstacle to her becoming a man and therefore a danger to her psychological wellbeing.

The Trudeau Regime has promoted social environment dominated by a cult of radical dualistic body modification. It's done this by funnelling status of women funds (status of women is now called women and gender equality, WAGE), into radical gender NGOs. The radical NGOs create and disseminate gender extremist propaganda and fund law-fare campaigns against the provinces.

The Trudeau Regime takes a crap on jurisdictional authority, like it always has done. According to Radio Canada, in "*Quebec, the College of Physicians affirms that "health care for trans and non-binary people is currently the subject of reflection and analysis within the College*".

Publicly available gender clinics for young people have lengthy waiting lists. Per Radio Canada: *"in Quebec, a young person seeking gender-affirming care will have to wait between eight months and a year to obtain an appointment at the paediatric clinic in* Sainte-Justine *or in* Méraki*, affiliated with McGill University. These are the two main gender clinics in Quebec. The first currently follows between 600 and 700*

young people, the second treats around 400 minor patients."

Santé Trans Health operates out of Quebec, with the mission to "train" medical professionals in *gender medicine*. Per the website: *In 2011, Françoise Susset and her colleague Bill Ryan founded the Institute for Sexual Minority Health (lSMH) to bring their professional activities (consultation, supervision, training) under one banner*. The website provides a list of gender affirming medical professionals, all based in the province of Quebec and most in Montreal.

Woke Retail Therapy on the Tax Payer Dime

Right to Thrive **by Jennifer Chatsworth, BC Representative for Children and Youth**. When American GOP states began implementing legislative safeguards regarding Gender Affirming Care, the Gender Radicals in Canada doubled down. In BC this meant the favourite kind of retail therapy for socialists: a publicly funded report. Jennifer Chatsworth holds the position Representative for Child and Youth (RCY) for British Columbia and reports directly to the BC Legislature.

She released a report last summer called *Right to Thrive*. The report opens with a quote from Alok Vaid-Menon, the man who once wants to destroy the categorization of humans by sex because he thinks it was a colonial invention, the man who said *little girls are kinky*. *Right to Thrive* continues, framing itself in a false context which confuses legislated safeguards with legislated hatred. From the Executive Summary on page 4 of the report:

around the world, shaming, abuse and invalidation of 2STNBGD people has been documented and reported and is on the rise. This situation, coupled with a review of injuries and deaths of 2STNBGD children and youth reported to the Representative, provided the catalyst for this report … Under s. 20 of the Representative for Children and Youth Act (RCY Act), the Representative can release a special report with recommendations to relevant ministries.

First of all, note the acronym chosen by Chatsworth, 2STNBGD. Admittedly that represents the labels the youth in the study wish to choose to represent themselves. Notice its heavily informed by a queer, ie dehumanized and subversive, vision of human sexuality. Secondly, tax payers continue to question the ridiculous expenditures of public money to promote a radical and harmful vision of human development.

Children in western canada are dying from ODs because they cannot get the care they require, and we have the entire ruling and professional elite throwing themselves into this cult of body modification that teaches young people their natural organic sexuality will drive them to kill themselves!

Can I point out how silly this is? How on earth did we get from gay rights

to a neurosis about sexuality that creates real psychiatric illness in humans? The Representative for Child and Youth Act, Section 20(1) states the representative may make a special report to the Legislative Assembly if the representative considers it necessary to do so.

By the RCY's own admission the focus population accounts for a very small portion of the general population—1% for indigenous population and 2.5 percent for the non-indigenous population. They include kids who self-report as "gender questioning" — a meaningless projection attached to a child in care.

A child in care typically has high ACE score or a neuro-developmental disorder or both. When we encourage a child to create an identity out of the dissociative state they experience due to adverse childhood events or family of origin attachment rupture or the alexethymia and diminished interoception of autism, we remove from her the opportunity for healing a transformative growth.

When you look at the critical injuries data (page 22 of the report), you can see a glaring problem — female injuries are largely borne by the indigenous population and gender diverse injuries are largely borne by the non indigenous (ie settler) population. When you look at the selected injuries (page 25) you can see that more female children and youth have gone missing than gender diverse.

Are we really prioritising *settler colonial theybies* and ignoring indigenous girls? What happened to Missing and Murdered Indigenous Women (MMIW)? Did that token get boring and dull, so the progressives needed a new toy to play with? This sounds like colonialism 2.0 not inclusivity, doesn't it?

The report also notes that gender diverse kids are in care under voluntary orders more often than under involuntary orders. Voluntary removal typically means parents collaborating with the state to provide extensive care their child requires that lies beyond the resources of parents and families of origin. Involuntary removal indicates family of origin trauma, the most accurate and powerful predictor of negative long term outcomes such as severe mental illness, autoimmune disorders, metabolic disease, chronic physical illness and shortened life expectancy. Children in care have contexts and this report, like

everything politically leftist-progressive, strips developmental context away from children.

When you look at injuries by living arrangement (page 33) you can clearly see that gender diverse kids really belong at home with their parents and not in residential care families. We affirm no child when we pretend that the family unit is not the first thing we should try to preserve and protect and promote for each child wherever physically safe to do so.

When you look at the Complex Developmental Behavioural Conditions (CDBC) diagnoses (page 36) you can see what is going on with this supposed gender diverse group of kids. Of particular interest to me? The report noting on page 34 that eating disorders are not a lifetime issue of interest tracked in gender diverse kids.

As a young woman who suffered from disordered eating, who experienced long bouts of anorexia in my adolescence and early 20s, directly related to emotional and sexual trauma, that alarms me. Over my 8 years of monitoring Gender Affirming Care, I have heard numerous stories of young women with eating disorders and other emotional issues shunted into chemical castration and antigenic sex hormones. With little or no assessment or differential diagnosis. This approach to health care realty does great harm to any child with a high ACE score, and particularly young girls who have survived sexual abuse.

Early in my nursing career I cared for several young girls hospitalised for eating disorders. These girls deeply hated their bodies, to a frightening degree — they literally were destroying it through deprivation. To treat the female body with such contempt, to provide such a hostile remedy to a young woman whose pathology involves hostility, well to me, this approach to care expresses a deep and frightening hatred for female people.

To give the RCY credit, she did pay lip service to the fact that her fabulous report may not really be giving us the accurate picture of what is happening to kids in care in BC. She buried that important detail on page 18, though: ***It is important to note that youth participants were not sampled using a population-based approach and may not fully represent the entire population*** *of 2STNBGD young people with these experiences*. (page 18)

The critical injury data in the report do reflect the inception of self harm created inside the minds of gender diverse youth and children by the SOGI propaganda and this discourse it generates — affirm the child's gender or they will kill themselves. Kids are hearing all about how they will kill themselves if they do not get their "identity affirmed". This has devolved into the most egregious abuse of a young people.

Chatsworth buries the very important and loud part of this issue for paediatric care quietly, in a footnote of her report: ***It is important to note that it is not a young person's gender identity or expression that leads to self-harm or suicidality but their individual experiences and the situation in which they are living and growing up*** *that compounds the negative effects of stigma, contributing to a lack of gender-affirming care, support, and awareness among health care providers and society in general.* (page 5, footnote 9)

Do you notice the incessant themes of fear + shame + coercive control in the material written about and for gender diverse and discordant kid? The progressive discourse continues to take on a darkly zealous tone. Death cult much? On closer inspection the researchers behind this report look far from objective and unbiased. *The Right to Thrive* report references the Kristina Olson TransYouth data. The head of the research unit conducting *The Right to Thrive* analysis and literature review, Elizabeth Saewyc, served as a researcher on the Canadian TransYouth study.

You might recall Olson wrote in the LA Times about a young patient: when John was born his parents and his doctors said he was a girl. You might also recall that Olson reported the preliminary results of a 20 year longitudinal study after 2 years. You might also recall that Olson is plagued by a case of magical thinking or a compulsion to deliberately misrepresent the facts—a Buzzfeed article quotes her as saying the data is misleading, which indicate children grow out of their dysphoria.

Dr. Olson's study was rushed to publication after two years into the study to give the transgender activists a 'success' story. The results were anything but scientific. The assessment of anxiety and depression was done by the parents. The kids in the study were those whose families were recruited from their

transgender clinic[s] and did not include all [types of] patients and their families. . . . Olson's plan is to affirm everyone and see how they look 20 years out. The already published Swedish study has shown what will happen: appearance of happiness until 10 years out, and then a precipitous dive into depression with a 19-fold increase in suicide completion. — Dr. Quentin Van Meter

You might also recall that Olson's (American) TransYouth study, as well as data from a CIHR-funded TransYouth (Canadian) study which the report references, involve kids recruited (opt-in) from gender clinics. Elizabeth Saewyc, Director of the Stigma and Resilience among Vulnerable Youth Centre, the UBC-based policy research unit which conducted the literature review, the interviews, and wrote a companion report to The Right to Thrive, serves as Media Advisor to the UBC on Transgender Children and Education. Saewyc also served as a researcher on the Canadian TransYouth study. You may recall that the principal investigator of the Canadian TransYouth study claims to have debunked ROGD.

What's this mean?

1. It means the BC Representative for Youth and Children had uncomfortable feelings about the ongoing public backlash to the coercive control + intolerance + abuse of the SOGI ruling class and it's gender affirmation secular religious colonial project and so, decided to produce a piece of government-funded propaganda to make herself feel better. This report is the high-ranking civil servant version of woke retail therapy. Jennifer Chatsworth conducted a review of gender diverse kids in care and selected researchers with a pro gender affirmation bias—including an ROGD denialist—on the team to develop *Right to Thrive*.

2. It means stonewalling tactics to fudge the data and ensure the truth cannot emerge. **It means no transparency and a lot of fear-based secrecy. A secret circle of advisors guided the *Right to Thrive* project. The public cannot know the identity of this circle of advisors because it would trigger haters to have accountability for the taxpayers who are paying for this report.** Yes, the people paying—that's you and me, my Canadian tax paying reader—for this report cannot know the names of the

advisors circle who guided its development process and its findings.

***On Balance Choose Kindness*, by Kelly Lamrock, KC, NB Child and Youth Advocate. Lamrock wrote his report** in response to NB's announcement of a review of Policy 713, its Gender policy. The gist of his position lies in the right of the child to self determination, free from parental coercion. Imagine an oppressor-oppressed paradigm applied to the parent-child relationship and you have the Gender Radicalist view of family.

Children have the right to begin the sex change process in secret from their parents, according to Lamrock, and to prevent schools from socially transitioning children would violate the child's privacy. Parental rights have no basis in law, according to Lamrock. In the Gender Radicalist world of Kelly Lamrock and Jennifer Chatsworth men are women and children are adults.

It must also be said that the right of a parent to make decisions without state interference is somewhat different from the question of whether a parent has a right to insist that the state force the child to comply with their direction. That is an important distinction, because the child themselves is an independent actor with their own free will and their own rights to autonomy, privacy, expression, and dignity.

It has been a common thing in the debate and consultations around Policy 713 for those advocating a certain view of parental rights to assert that "the state does not own children." This is undeniably true.

There is no basis in law or morality for anyone to assert state ownership of children. Of course, it must also be added that parents also do not own their children. Nobody owns children. The basis for parental rights is not found in the law around property. It is founded in the rights to privacy, the child's right to family, and possibly within the law around conscience and expression rights. — Lamrock, 06. 2023

Lamrock notes that parental rights flow from other existing rights, and that the law leans toward centring the child, however does consider the level of state interference in a family's private affairs. He cites an excerpt from Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General), 2004 SCC 4 (CanLII), [2004] 1 SCR 76.

In this case The Canadian Foundation for Children and Youth challenged Section 43 of the Criminal Code of Canada, Correction of Child by Force: e*very schoolteacher, parent or person standing in the place of a parent is justified in using force by way of correction toward a pupil or child, as the case may be, who is under his care, if the force does not exceed what is reasonable under the circumstances*. The SCC responded to the argument that Section 43 permits behaviour toward a child that would be criminal toward an adult, stating that *the difficulty with this argument, as we shall see, is that it equates equal treatment with identical treatment, a proposition which our jurisprudence has consistently rejected*.

Lamrock wants to believe that a mature minor can make decisions about undergoing a sex change to relieve pubertal and adolescent angst. He cites the mature minor case law to drive his point home, because in his view choosing to identify as the opposite sex involves self determination that not even a parent can interfere with to protect the child from experimental synthetic and surgical body modification treatments.

When progressives use their chosen euphemism *exploring gender identity*, it masks the horror of reality — experimental sex changes on pubescent children to transform them into asexual blanks for synthetic and surgical manipulation. Lamrock discusses the marginalization of the (adult) transgender community, as if this somehow has anything to do with parents raising their children to be healthy and well adjusted in their bodies. Children do not have sexual maturity, therefore *transkids* do not exist except at the behest of the adults in their lives, who wish to project a sexual identity onto them for whatever reason. That's exploitation, isn't it?

Ultimately Kelly Lamrock fails to see that puberty is a human right, no adult has the right to lock a human into their pre-pubescent body, that's experimental and abusive to prevent a child from growing into natural adulthood. A child's right to privacy does not include the right of school teachers and administrators to keep from parents the fact that they conduct social experiments on their kids.

Gender Identity in children to solve pubertal and emotional angst has

always only ever been experimental quack medicine. Elsewhere, I have explored the impact Gender Radicalism has had on our institutional society, as it infiltrates the various layers of governance. What are parental rights and what is self determination for a child? What constitutes *reasonable limits*, as per Section 1 of the Charter of Rights and Freedoms?

What does democracy mean in Canada, when the government with a minority position in parliament has devolved into a tyrannical regime which punishes the populace and then preens in self glorify? I have long thought that the federal Gender Self ID legislation served to remind us that girls and women, girls and adult human females, are the canary in the coal mine for Canada.

The entire country accepted the edict that men who feel feminine or like a woman are women and that female people have no right to say no to these male people in our spaces. The cynics rolled their eyes and said, this is a federal law, it doesn't affect the provinces. On its face that's true, also naïve—it ignores the social and fiscal forces at play behind the scenes. Federal legislation means federal money can flow.

I confess here that I was amongst the cynics in the very early days after Bill C-16 received royal assent, not convinced at the reactionary fear mongering taking place amongst a small vocal group. I also did not believe or imagine how nefarious my country could become as a result of some twisted loyalty to an extreme ideology that castigates female self determination as white supremacy.

I explored the topic of children's right to self determination here. I wrote about parental rights in British and Canadian Jurisprudence here. I conducted an Oakes Test analysis of the challenge to parental inclusion and Gender Radicalism child safeguards legislation here.

There is no wrong puberty. Pubertal Suppression constitutes arbitrary detainment or imprisonment inside their pre-pubescent body, it impedes bone and other vital tissue growth during the physiologic maturation process. Pubertal Suppression locks a young person into their child body — social transitioning leads to pubertal suppression 94% of the time. — Rukhsana Sukhan, An Oakes Test Analysis in "Bad Hijabi"

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Commentary

Scientific Misinformation and Gender Affirming Care: Tools for Providers on the Front Lines

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The Upside Down Science of Gender Affirmationism

Definition of Gender Affirming Care. *Gender Affirming Care includes social, psychological, medical and surgical interventions in support of the way a person feels about their reproductive class. It includes pronouns and name change and people affirming those, it includes hormone therapy and it also includes body modification surgery.*

Gender Affirming Care involves a complete submission to the patient's will and whim and it involves dispensing with the medical assessment model of differential diagnoses. Gender Affirming Care demands clinicians dispense with all they know about trauma care, DBT + suicidal threats, personality disorders, as well as dissociative disorders and follow the patient's desire to modify themselves to become the opposite sex.

Piggybacking on the authoritarian narrative management that emerged in response to COVID-19, Meredith McNamara published a paper in the Journal of Adolescent Health. In the spirit of cognitive warfare, McNamara positions her piece as tools for primary providers to fight misinformation in the form of *misconception:fact*. Readers can access all the PDF and other documents mentioned in this section on the "Bad Hijabi" Substack, where the original version of this text exist, in article format.

1. **Misconception: This is Just a Mental Health Disorder. Shouldn't Kids Just Go to Therapy?** Recent legislation falsely claims that gender dysphoria is a psychiatric problem that psychotherapy alone can treat
2. **Misconception: Gender Dysphoria is a Phase and Most Youth Change Their Minds.** Recent legislation falsely asserts that most cases of gender dysphoria spontaneously resolve without treatment, otherwise termed "desistance."
3. **Misconception: Children are Started on These Medications when They are Too Young**. Legislation has falsely asserted that pubertal blockade and exogenous sex hormones are administered in pre-pubertal children
4. **Misconception: Children and Teens are Undergoing Gender Re-assignment Surgery**. Recent legislation has misrepresented the timing of surgical practices
5. **Misconception: GAC is Experimental and Unsafe**. Recent legislation has falsely claimed that GRH agonists and exogenous sex hormones are associated with adverse health outcomes, such as reduced bone density, venous thromboembolism, cardiovascular disease, and cancers
6. **Misconception: Puberty Blockers and Hormones Cause Infertility**. Recent legislation falsely asserts that medical aspects of GAC constitute sterilization of children and teens
7. **Misconception: the Risks of Adolescent Suicide and Other Mental Health Issues are Overstated**. In Fact, Transition Likely Increases Suicide in Adults. Recent legislation either omits or minimizes the risk of suicide and other adverse mental health outcomes, such as eating disorders. Misrepresentation of a single older study has led to false claims that gender affirming care causes suicide
8. **Misconception: Youth are Too Young to Engage in Medical Decision-making**. Legislation falsely asserts that minors provide consent for GAC
9. **Misconception: Guardians, Providers, and Social Media**

Pressure Young People into Transition. This misconception appears throughout the language of recent legislation, which falsely asserts that TGE youth have been coerced into expressing an alternative gender identity

Misconception 1:: Gender dysphoria is not a psychiatric problem that psychoanalysis can remedy

McNamara et al decided to play semantics and call that clearing up scientific misinformation :: Gender Dysphoria is no longer classified as a psychiatric disorder by the WHO + APA, who describe it as the distress of living with physical characteristics that do not align with one's gender identity, worsened by non affirming social factors. *Body dissatisfaction … is the root cause of gender dysphoria.*

The phrase body dissatisfaction describes a state in which the individual feels dissociated from their Self and their body. Dissociative disorders are psychiatric disorders — disconnect from one's own body is indeed a medical psychiatric condition and not the result of living in a hostile society. Psychotherapy is inadequate alone in a hostile and transphobic environment, McNamara et al write. They contend that Gender Affirming Care (GAC) helps kids overcome transphobia. Thus, puberty blockers and gender affirming hormones have an independent and positive impact on mental health.

Jack Turban's name shows up in the footnote as proof that puberty suppression and cross hormones reduce suicidality. Jack Turban, recent Harvard graduate, not a board certified specialist, has an obstinate bias toward the GAC model of medicine.

Meet Jack Turban: gender affirmation activist first, upholder of the hippocratic oath second. That makes Jack Turban a zealot. You really have to be kidding me if you are "correcting misconceptions about GAC" with any of Jack Turban's work.

For the very same citation about which 7 of the 10 comments expressed grave concern about the methodology + conclusions, of the remaining 3 comments, two were positive and from the same institution, and one was Jack Turban addressing a critic. Turban dismissed the scholarly concern during a Twitter exchange with James Cantor

because it is not published only a comment. The primary flaw in Turban's work is his use of the data from the 2015 U.S. Transgender Survey. Various writers and researchers have previously explained the problem with using this survey, and in addition cross-sectional analysis does not allow for the inference of causality.

NOTES ON THIS MISCONCEPTION

Below are some excerpts of the critical comments in the Pediatrics Journal.

This conclusion is not warranted from the article. While the authors acknowledge that, as a cross-sectional study, their data cannot establish causal relationship between pubertal blockade and suicidality, they fail to emphasize that those who received puberty blockade, AND those that did not, both had alarmingly high rates of suicidal ideation (50% or higher) within the last year, rates strikingly similar to those previously reported for transgender adults. There was no difference between the study groups when comparing a more robust measure of suicidal risk: ideation with a plan. Furthermore, those receiving GnRH agonists had higher rates of hospitalization for suicide attempts when compared to those not receiving this medication. The argument that there was a lack of statistical power is an assumed explanation for these effects, and is often used by scientists when their hypothesis is not supported by the data. An equally plausible explanation is that suicidal risk is almost independent of taking GnRH agonists because pubertal blockade fails to address important co-occurring psychological issues. — Hruz

The authors acknowledge that "the study's cross-sectional design… does not allow for determination of causation." But this caution was not conveyed in the many news reports generated by the study. "Puberty blockers reduce suicidal thoughts in trans people" ran a typical headline (LGBTQ Nation 2020).

Aside from the spurious leap from association to causation, the analysis is inevitably limited by the poor quality of the data.

Firstly, the survey's respondents are not sampled from any defined population. The convenience sample excludes those who underwent medical intervention but subsequently stopped identifying as transgender. It also

excludes those who did commit suicide. — Biggs

Nevertheless, a word of caution is in order. The authors conclude that all who wish should be given PB. Presently, however, there is no method to predict persistence in GD. Estimates vary (1), but on average only about 15% persist; in contrast, when given PB, virtually 100% persist (2). Thus, an indiscriminate prescription of puberty blockers will significantly increase the number of adolescents who continue to full transition, which may worsen long-term outcomes in attempted suicides. — Ring

The article by Turban et al. creates more confusion than clarity. The authors imply causal evidence for a reduction in suicidal ideation with transgender adolescents who received puberty suppression (PS), yet they fail to acknowledge the exceedingly high rates in both groups of suicide ideation (75% and 90%) and suicide attempts (42% and 51%). The cross-sectional design using online survey data is insufficient to validate the efficacy of such a life-altering therapy. Because the data was collected by survey, there is no way of knowing how many would-be participants in either group actually succumbed to suicide.The differences in expected outcomes if PB is or is not prescribed can be estimated. — Field + Turnbull

First, I have great concerns about the method of self reports which was used in this questionnaire. The answers might reflect the desire of the transgender social group rather than true psychological or physiological benefits … A higher odds ratio is noted; however, without significant difference (table 2). This might be attributed to the small sample size of the puberty blocker users (2, 3). Nevertheless, suicide attempts resulting in inpatient care would be an important indicator to know the true outcomes of puberty blockers. We would suggest a further investigation on this issue to clarify the outcome of puberty blockers rather than concluding based on "no significance". — Cheng

The following is a brief summary of the flaws in the Turban et al.'s study, which render their conclusions misleading.

1. The source study, the United States Transgender Survey 2015 (USTS), employed a non representative, biased convenience

sample. **The results from this survey are unreliable**.
2. Over 70% of the USTS respondents demonstrably did not know what puberty blockers were, claiming to have commenced treatment after age 18. Although Turban et al. attempted to control for this, a proper adjustment was not possible.
3. There was no control for underlying mental health. Since more stable individuals are more likely to be eligible for puberty suppression, one cannot discern mental health benefits or harms of puberty suppression without controlling for pre-treatment mental health.
4. Turban et al. ignored their own finding that a history of puberty suppression was associated with an increase in recent serious suicide attempts. — Clarke

2. **How does a medical treatment change the way people perceive you?** To undergo an elaborate + painful + expensive + invasive + irreversible experimental procedure because you hope other people will accept you the way you want seems like a recipe for heartache to give a child as affirmation. As Avi Ring wrote in his comment under the paper, without a reliable way to predict or separate out who will desist from who who persist, puberty suppressions given to all kids who present seems excessive and increases suicidal behaviour: Giving PB to all who wish it is expected to significantly increase the total number of suicide attempts, up to 240 per 1000, compared with the outcome when not giving puberty suppression to anyone, 60 per 1000.

3. **In his reply to Clarke, one of his critics, Turban**: incorrectly states that this manuscript found an increase in recent serious suicide attempts among those who accessed pubertal suppression during adolescence. Though the raw values were higher for some of these outcomes, this was not a statistically significant finding, and thus the appropriate conclusion is that the study found no statistically significant association between access to pubertal suppression and greater odds of any measure of adverse mental health outcomes. I find the arrogance stunning — everything points a correlation between

increased psychiatric distress and disorder in kids who seek GAC. Correlation is not causation and Jack Turban and the Gender Affirmation Zealots refuse to remember this important and basic fact from basic research methods.

4. **Jesse Singal did a very thorough critique of the Tordoff study last year,** I don't intend to duplicate his work, you can go read his own article about why the Tordoff study cannot be used to prove that Puberty Blockers lower the odds of depression and suicidality.

5. **I'll add this regarding Tordoff nothingburger study**. When an interrogator tortures a human being they can elicit any answer they want from their subject. Data sets are like this — you can torture them with crude statistical procedures to hide the fact that your treatment sucks balls and you got nothing and that is what Tordoff et al have done. *Puberty Blockers don't reduce depression or suicidality and the comparison group had some interesting variances in suicidality and depression* sounds different than *Puberty Blockers reduced depression and suicidality*. Amongst the questions I have after looking at the Tordoff study are what is responsible for the drop out rate of the None group? How can this be a comparative group when the raw statistics bear an untold story that is much more than Gender Affirming Care Saves Lives?

eTable 3. Prevalence of Outcomes Over Time by Exposure Group

Time Point:	**Baseline**		**3 Months**		**6 Months**		**12 Month**	
Exposure:	*PB/GAH*	*None*	*PB/GAH*	*None*	*PB/GAH*	*None*	*PB/GAH*	*None*
N	7	92	44	38	59	24	57	6
Outcomes (no.,%)								
Moderate to Severe Depression	4 (57%)	54 (59%)	24 (55%)	29 (76%)	33 (56%)	13 (54%)	32 (56%)	5 (83%)
Moderate to Severe Anxiety	4 (57%)	47 (51%)	23 (52%)	23 (61%)	28 (48%)	10 (42%)	29 (51%)	4 (67%)
Self-harm or Suicidal Thoughts	3 (43%)	41 (45%)	13 (30%)	21 (55%)	25 (42%)	11 (46%)	21 (37%)	5 (83%)

Missing eTable 3 from Tordoff Supplementary

Misconception 2 :: Gender dysphoria is not a phase or a social contagion, desistance is rare, most cases persist beyond childhood and therefore require treatment

McNamara et al assert that "well regarded research" has debunked the contagion and desistance claims. They state regret is rare.

Kristina Olson's name shows up when I check the footnote for that "well regarded research" to support the regret-is-rare-and-its-not-a-phase-claims.

First of all, Olson's TransYouth study involved kids recruited (opt-in) from gender clinics.

Second, an individual has a clear case of Sex Denialism who wrote in the LA Times about a young patient: when John was born his parents and his doctors said he was a girl.

Third, Olson reported the preliminary results of a 20 year longitudinal study after 2 years. Fourth, Olson suffers from a case of magical thinking or a compulsion to deliberately misrepresent the facts—a Buzzfeed article quotes her as saying the data is misleading, which indicate children grow out of their dysphoria. Olson claimed to debunk Littman's ROGD hypothesis, her study does no such thing.

Dr. Olson's study was rushed to publication after two years into the study to give the transgender activists a 'success' story. The results were anything but scientific. The assessment of anxiety and depression was done by the parents.

The kids in the study were those whose families were recruited from their transgender clinic[s] and did not include all [types of] patients and their families. . . . Olson's plan is to affirm everyone and see how they look 20 years out.

The already published Swedish study has shown what will happen: appearance of happiness until 10 years out, and then a precipitous dive into depression with a 19-fold increase in suicide completion. — Dr. Quentin Van Meter

What Olson did inadvertently demonstrate is the power of social transitioning — the vast majority of kids who socially transition continue on to transition, and this underscores the importance of parents and qualified clinicians and primary care providers in directing gender care for kids, not teachers and schools and SOGI lessons.

NOTES ON THIS MISCONCEPTION

1. Well-regarded research is the description for **Olson's work, a study irrelevant to the present discussion taking place about GAC**. When a Gender Affirmationist scholar tells you about well-regarded research she means *research I agree with done by people who espouse the views on Gender Affirming Care that align with my own*.

2. **Gender Affirmationists** stick firmly to the narrative that Post GAC Regret is rare. They **deliberately ignore research that challenges the GAC model**, that research is not considered well regarded research, for political reasons noted in point one above.

3. **Lisa Littman's first study on the social contagion aspect of Gender Dysphoria in young girls has received much hostility from the Gender Affirmationists**. Littman's research challenges the GAC model, and therefore does not count as *well regarded research* because it demonstrates the potential iatrogenic harm that the GAC model can inflict on young adolescent and adult female people. This study captured data from parent questionnaires and formulated a number of hypotheses to explain the rapid onset of gender dysphoria in the young female population. Systemic sexism, deeply embedded in human society, seems to be a factor driving girls and women to identify as the opposite sex.

4. **Lisa Littman's recent study captured reasons for detransitioning**. Her study captured a cross sectional analysis from anonymous survey data. Respondents were recruited through a variety of means to ensure wide capture from varying viewpoints. Littman found the reasons differed by sex and she found female children who transitioned younger were more likely to detransition. She also found vastly differing reasons for transitioning and detransitioning. Her results, being based on a more randomly recruited population sample, would represent more accurately the realistic picture for detransitoners. Her results echo the growing voice of detransitioners, the existence of whom Gender

Affirmation Zealots refuse to acknowledge.

5. **Olson specifically measured retransition. She used vague categories and had a male-dominant sample**. Edwards-Leepers + Anderson, two pioneers in the field of pediatric gender psychology, don't see much value in studies such as Olson's to elucidate why precisely the 300 gender clinics across the USA have high demands for kids wanting to become the opposite sex.

Misconception 3: There is no such thing as too young to give children puberty suppression and cross sex hormones

McNamara et al choose to avoid the question and decide to address the concern concretely, pre-pubescent kids are not given puberty suppression medication and adolescents only receive cross hormones with the supposed informed consent process together with a parent.

The authors make no attempt to address concerns about giving these drugs to kids for OFF LABEL USE. Again, GnRH agonists are not approved anywhere on the planet to delay puberty in kids with Gender Dysphoria (GD) or any kind of psychological or body dysphoria disorder. The valid and reliable evidence does not exist to support this Gender Affirming Care model. The authors provide no valid and reliable evidence that puberty suppression and cross hormone therapy have efficacious results in kids with GD because none exists to support that claim.

Puberty has a development and neurophysiologic purpose! Puberty is a human right, a necessity for all kids to experience in order to grow into healthy + resilient adults. Sexual function and experiences are integral components of human existence. To deprive a child of sexuality for life seems quite cruel and authoritarian. It is on the level of Mengele to do this experiment on children.

Misconception 4: Children and Teens are not undergoing sex re-assignment surgery

McNamara et al choose to focus on semantics and avoid addressing why the question of *'why do teenagers need surgical treatment for a psycho-emotional issue?'* Not since lobotomies and hysteria before that have we needed

to treat emotional and perceptual problems with surgery. Why is genital reconstruction and double mastectomy an affirming treatment for a human whose central nervous system has not achieved full maturity (which happens at around age 27 or so)? No answers to those questions appears in this paper. *The Endocrine Society* recommends "gender-affirming mastectomy" only when a health care provider deems it developmentally appropriate, write McNamara et al. Well that particular guideline states the following:

5.6. We suggest that clinicians determine the timing of breast surgery for [females who identify as trans] based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement.

Young people developmentally unable to consent are undergoing radical and unnecessary surgeries under false pretenses and their parents in many cases have been emotionally manipulated into consenting. Yes, this is indeed happening. When it is developmentally appropriate to perform radical unnecessary surgery on a vulnerable and emotionally disturbed 15 year old female person? When is it developmentally appropriate to bully and coerce the parents of such a girl into consenting to a double mastectomy with the line *would they rather have a dead daughter or a living son*?

Yes, this happens, read and listen to Prisha Mosley's story, she has testified for a number of American State hearings on Gender Affirming Care about the severe iatrogenic damage she suffered and ensuing trauma as a result of being shunted hastily down a medical path based on the deeply flawed GAC model of primary care.

Misconception 5: Gender Affirming Care is Safe and Not Experimental

McNamara et al write: *Recent legislation has falsely claimed that GnRH agonists and exogenous sex hormones are associated with adverse health outcomes, such as reduced bone density, venous thromboembolism, cardiovascular disease, and cancers … All medical treatments carry risk.* McNamara et al cite studies on the psychology of receiving GAC in teens as their evidence that Gender Affirming Care is safe and not experimental.

It is false to deny the severe associated side effects of both GnRH and endogenous hormones. Documented long term adverse effects and iatrogenic harm from Lupron—one of the brand names under which GnRH agonist is sold—appear on websites created by Lupron Survivor groups.

Lupron Victim Hub contains a wealth of stories of iatrogenic harm. Lupron—In Sixteen Years contains information about the raw data on the drugs trials and the suppression and manipulation of data done by the drug company. Documented evidence exists regarding Friedman's falsification of clinical data to support GnRH agonist as a treatment for gynaecological disorders.

NOTES ON THIS MISCONCEPTION

1. **You can read David Redwine's analysis of the raw data from Lupron trials here**. Redwine accessed the data at the tabular level from researchers and analysed them. Says Redwine, One of the very first studies of Lupron out of the block was this one. It was comparing Lupron given subcu[taneous] for a week, followed by about six months of Lupron nasal spray. A comparison drug was Danazol. One year after Lupron was stopped, here's what happened to the estrogen levels. 63% of women had not regained baseline. 50% had estrogen levels below 100 pg/mL and 1 out of 8 were menopausal. Yes. Small numbers.

2. **John L. Gueriguian, M.D. + former FDA officer + retired professor of pharmacology prepared an expert witness report for a product liability lawsuit**. Here's an excerpt to give you an idea how very wrong McNamara et al are about their claims that GnRH agonist is reasonably harmless for children.

Lupron should only be limited to six injections for the initial treatment, and a retreatment should not exceed six injection. Lupron cannot be given more than twelve injections per life time.

Lupron affects the autonomic nervous system. Lupron not only affects the gonadal hormones, but is also a powerful modulator of autonomic neural function. The pituitary gland is the "master gland" and is below the brain in the skull. The pituitary gland affects every physiological process of the body. — John Geuriguian

3. **In his report, Geuriguian notes that TAP Pharmaceuticals likely underreported the adverse**

reactions for children with precocious puberty, he notes that Lupron's side effects far outweigh its efficacy in treating Endometriosis, and that, when a drug's risks outweigh the drug's benefits, a drug should be banned and pulled from the market. He also notes that reports indicate a consistent (ie across sex) adverse effect of decreased and depressed mood, to the point of requiring add-back sex steroid in the chemotherapy regime.

"L" affected the hypothalamus and, indirectly, the hypophysis through which any number of endocrine functions are affected, including the thyroid. As a result, some patients were shown to develop thyroid abnormalities. Following Lupron treatments, Thyroiditis has been reported to the FDA Adverse Events Reporting System. The independent literature gave a clear signal, beginning in 2000, that such events had been caused by "L'. Despite it all, TAP neglected to perform the necessary studies to adequately study this question and, in the absence of its own studies, failed to warn prescribers and patients of the potential of "L" to cause such toxicities. Another area of unacceptable neglect concerned the use of "L" to treat endometriosis in children (i.e., those less than 18 years old). Though "L" was studied and approved for the treatment of precocious puberty, there was no study to prove the safety and efficacy of "L" in the treatment of underage females affected by endometriosis, a fact admitted by TAP in its labeling,.

"Experience with Lupron Depot 3.75 mg for treatment of endometriosis has been limited to women 18 years of age and older." TAP's safety signals observed during the precocious puberty studies should have induced it to perform proper studies of underage females treated for endometriosis. It chose not to do so, permissible only if it decided that "L" was contraindicated for the treatment of endometriosis in underage females. It could certainly do that under the "Changes Being Effected" rule of the FDA's regulation. It did not contraindicate the use of "L" in that population.

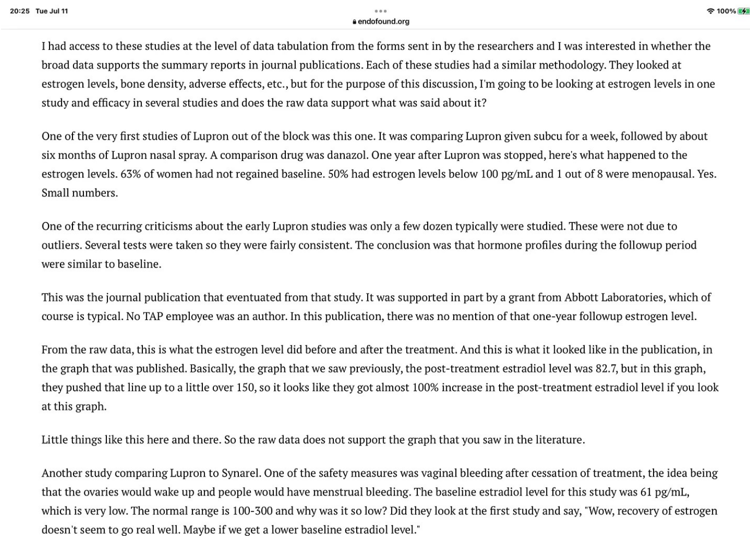
5. Documents revealed **David Redwine's testimony in the product liability lawsuit**. Here is a damning excerpt that debunks McNamara et al's claims.

It is my opinion, to a reasonable degree

of medical probability that altering [plaintiffs] pituitary gland at the age of 17 with six injections of Lupron Depot 3.75 likely did produce her current condition and her significant bone density loss. Her current condition is entirely in context with the known short and long-term effects of Lupron Depot. —David Redwine

6. **Conclusion —The FDA has not approved GnRH agonist for the treatment of children with gender dysphoria or any gender identity issues**. This is a highly experimental treatment, on the level of Mengelian experimentation. Puberty suppression is unsafe. It is a grave, grave falsehood, it is fraudulent in fact, for any clinical researcher or clinician or doctor to suggest that GnRH agonists aka puberty blockers, are safe + reversible and without adverse effect. I have shown proof positive of this here.

Not to mention that exogenous sex hormones have a definite profile of adverse side effects and medical risks, which is why menopausal women struggle to receive appropriate HRT for their physiologic condition of depleted sex hormones caused by menopause. Furthermore cross sex hormones have an



I had access to these studies at the level of data tabulation from the forms sent in by the researchers and I was interested in whether the broad data supports the summary reports in journal publications. Each of these studies had a similar methodology. They looked at estrogen levels, bone density, adverse effects, etc., but for the purpose of this discussion, I'm going to be looking at estrogen levels in one study and efficacy in several studies and does the raw data support what was said about it?

One of the very first studies of Lupron out of the block was this one. It was comparing Lupron given subcu for a week, followed by about six months of Lupron nasal spray. A comparison drug was danazol. One year after Lupron was stopped, here's what happened to the estrogen levels. 63% of women had not regained baseline. 50% had estrogen levels below 100 pg/mL and 1 out of 8 were menopausal. Yes. Small numbers.

One of the recurring criticisms about the early Lupron studies was only a few dozen typically were studied. These were not due to outliers. Several tests were taken so they were fairly consistent. The conclusion was that hormone profiles during the followup period were similar to baseline.

This was the journal publication that eventuated from that study. It was supported in part by a grant from Abbott Laboratories, which of course is typical. No TAP employee was an author. In this publication, there was no mention of that one-year followup estrogen level.

From the raw data, this is what the estrogen level did before and after the treatment. And this is what it looked like in the publication, in the graph that was published. Basically, the graph that we saw previously, the post-treatment estradiol level was 82.7, but in this graph, they pushed that line up to a little over 150, so it looks like they got almost 100% increase in the post-treatment estradiol level if you look at this graph.

Little things like this here and there. So the raw data does not support the graph that you saw in the literature.

Another study comparing Lupron to Synarel. One of the safety measures was vaginal bleeding after cessation of treatment, the idea being that the ovaries would wake up and people would have menstrual bleeding. The baseline estradiol level for this study was 61 pg/mL, which is very low. The normal range is 100-300 and why was it so low? Did they look at the first study and say, "Wow, recovery of estrogen doesn't seem to go real well. Maybe if we get a lower baseline estradiol level."

adverse effect on hepatic and metabolic health, particularly in female trans-identified people.

Misconception 6: Puberty Blockers and Hormones given to children do not cause infertility

McNamara et al falsely claim that when stopped, the effects of puberty blockers are fully reversible and sexual development catches up to chronological age quickly. Gender Affirmationists frequently cite Dutch studies as their evidence, a logical flaw because the cohort from the Dutch study does not match up with the cohort of young people presently demanding GAC across North

America. McNamara et al engage in the same kind of misleading discourse as they did under Misconception 4 — initial denial followed by partial admission. Exogenous sex hormones may affect fertility the paragraph ends. You can consult the Geuriguian report mentioned above for further evidence that GnRH agonists do affect fertility in adults. The recent pre-print from Mayo Clinic scholars reveals severe atrophying of the testes in young males exposed to GnRHa.

NOTES ON THIS MISCONCEPTION

1. **Gender Affirmationists consistently underreport the adverse effects of the Gender Affirming Chemotherapy regime**. It is medical fraud to suggest that administering GnRH agonist with an exogenous cross sex hormone to a child with GD renders no risk to fertility. No one can make this claim because we simply have no evidence to suggest it does not and a lot of evidence to suggest a high risk of infertility.

2. **Long term use of cross hormones in female identified people will result in vaginal and uterine atrophy**, necessitating hysterectomy. That is established fact.

Misconception 7: Gender Affirming Care does not increase the risk of suicide, Gender Affirming Care reduces suicidal behaviour

Correlation is not causation. Gender Radicals commit the same statistical misinterpretation of data again and again. It is deeply irresponsible to attribute suicide to a single cause. LBGT Movement Advancement Project developed a guide about Suicide + LGBT, DON'T attribute a suicide death to a single factor (such as bullying or discrimination) or say that a specific anti-LGBT law or policy will "cause" suicide, recommendation 7 begins.

Suicide deaths are almost always the result of multiple overlapping causes, including mental health issues that might not have been recognized or treated. Linking suicide directly to external factors like bullying, discrimination or anti-LGBT laws can normalize suicide by suggesting that it is a natural reaction to such experiences or laws. It can also increase suicide risk by leading at-risk individuals to identify with the experiences of those who have died by suicide. — LGBT MAP

It is a form of collective psychological abuse to weaponise child suicide to promote an experimental model of medical care. It is deeply abusive to parents to emotionally blackmail them with the death of their child to coerce them to agree to a treatment option — that is not consent that is coercion.

It is deeply irresponsible to incept the idea into a child's mind that they can claim suicidality to receive the treatment regime which they believe will give them what they think they want. The following excerpt is from a recording of Wallace Wong speaking at the Vancouver Public Library in February of 2019.

… to be sick enough, then we will give you what you need. So what you need is, you know what? Pull a stunt. Suicide, every time, they will give you what you need. They learn that. They learn it very fast, right? — Wallace Wong, page 69-70 of transcript

Misconception 8: Children do not provide consent, treatment decisions are collaborative between clinicians, parents, and the child.

McNamara et al again oversimplify the reality and minimise the gravity of the situation and fail to address the actual concern. Can children consent to pubertal suppression? Can parents? What gives the parent a right to stop a child's growth for improper medical indication for a thing that trusted and valid and reliable science and thousands of years of human history says is a phase?

The UK High Court ruled that children could not consent to puberty suppression and even though the Appellate Court overturned that ruling, Keira Bell won a victory, Tavistock closed and a review of GIDS ordered, which concluded that the NHS must ban puberty suppression.

Additionally, a lengthy and well researched investigative feature on American Transgender Youth by Reuters reported that families did more often than not feel coerced into transitioning their children.

NOTES ON THIS MISCONCEPTION

1. It should stand as common sense that **children are limited in their decision-making capacity by their developmental stage**. Children exhibit particular behaviours related to their psychological phase of

maturation, such as impulsiveness, or high temporal discounting. This means kids devalue the future consequences and overvalue present pay-off. This is why we do not let them make life-altering decisions. This is why they cannot consent to suppressing sexuality or sexual maturation.

2. **Parents cannot consent to suppressing their child's sexual function**.

3. The *UN Committee on the Rights of the Child* has identified **forced sterilization of girls with disabilities as a form of violence** and state signatories to the *Convention on the Rights of the Child*, (of which Canada is one), are expected to prohibit by law the forced sterilization of children with disabilities.

4. The *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights*, the *Committee on the Elimination of Discrimination Against Women* all address **forced sterilisation of girls and women, and of disabled people as grave human rights violations**.

5. The *Convention on the Rights of Persons with Disabilities* underscores the importance of informed consent in all health care decisions of disabled persons, including surgical procedures and affirms their rights to maintain fertility on an equal basis with non disabled persons. Given that many children who receive GAC have a neurodevelopmental disorder such as Autism, this seems relevant. Sterilising autistic children is eugenics.

6. GAC violates the bodily integrity of children and adolescents.

Misconception 9: Gender Identity is not a social contagion, children freely choose to seek GAC without external influences

Again, McNamara et al refusing to engage with reality, this is more magical thinking from Gender Affirmationists. Reality simply does not support this claim, Lisa Littman's papers demonstrate McNamara's claim simply does not align with reality. Detransitioners all report a social contagion factor, many report coercive control tactics from a gender affirming peer group, they report alienation manipulation to draw young people away from families.

In this section I share the stories of two young women drawn in by social contagion and into the cult of body modification and sex change. One family managed to extricate their daughter from the hell Gender Affirmationism plunged her into. One mother lost her daughter to suicide, the very thing that Gender Affirmation says it will prevent.

NOTES ON THIS MISCONCEPTION

1. Does McNamara and the Gender Affirmationist team of zealots know or care about the story behind Sage's Law?

The Story of Sage's Law. *The Difficult Story of Sage's Law*, the headline reads, the subtitle confirms the bias of the story I am about to read, "a harrowing story of a teenager who was allegedly a victim of sex-trafficking is being used to support a law which would force schools in Virginia to inform parents if their child identifies as transgender," the subtitle tells me. *Force schools to inform parents*.

Read that part of the sentence a few times. Subtle, huh? You would barely notice it if you didn't typically pay attention to word choices. The Assigned produces propaganda pieces that support the female-hating anti-family, anti-safeguarding, anti-science, body modification cult know as transgender journalism.

Notice the other word choices, *allegedly a victim of sex-trafficking*. There's the anti-female sentiment creeping out. The writer allegedly promotes the right of an individual's experience + feelings about that experience to dictate how that individual should receive care + treatment from others and chooses to deny the experience of a vulnerable teenaged girl's sex trafficking? What happened to

BelieveAllWomen? Oh right, for people like the Gender Radical who wrote this article I'm talking about, the only women to believe are "male women".

Can you see the only thing the writer wishes to affirm is ego?

You can search the site for yourself. *The Assigned*. I won't promote their site with a link-back. Let's return to that phrase because it's key to the mindset that promotes Gender Identity as a serious thing in children. *Force schools to inform parents*. Um, to whom do the progressive radicals believe children belong, exactly? Kids belong with their parents, that's the human condition.

No one else can provide + care for the kid better than the parents can and the job of the rest of us involves acknowledging that and supporting the attachment bond and relationship between parent and child. We have normalised Peer Orientation Culture in childhood to such a degree that we don't see how pedagogy sliding into Peer Status really poses a danger to children and their families and as result larger communities and hence all of humanity.

The propagandists clearly chose against listening to the testimony given by Sage's mum about the terrible path to trafficking and abuse into which pedagogy and the state child welfare system forced Sage, in blind worship to a cult of gender affirmation which Sage felt pressured to join to gain acceptance.

She started a public high school in 2021 and all the girls there were bi trans lesbian emo and she wanted to wear boy's clothes and be emo. At school Sage announced she was a boy named Draco and would use male pronouns and would the school please not tell her mum.

Sage had a significant history of emotional and psychological distress and her mum worked closely with the school to adjust treatment and provide support for her symptoms. Covid lockdowns combined with puberty angst had made Sage vulnerable by the time she began attending high school. Sage drifted into a SOGI-dominant culture of Peer Orientation.

Gender Affirming Care imposed unilaterally by the school (ie without parental knowledge) ended up getting Sage physically and sexually assaulted, brainwashed into fearing her parents, which drove her to run away and into the hands of sex traffickers. When found the state refused to return her to her parents because they [parents] challenged her

alleged gender identity. Parents are the experts on their kids without exception. This resulted in Sage getting placed in the boys section of a juvenile holding facility away from her parents, where she was abused again, and from which she ran away, into the arms of sex traffickers, yes for a second time.

Fear + shame based rhetoric dominate the culture of SOGI culture and abuse kids by telling them they should fear their parents because their parents will not accept them. SOGI lies to children and teaches them their parents love them with conditions. Do I have to point out how disturbed this is, to promote such parentally alienating rhetoric on an ongoing basis under the guise of tolerance and inclusivity to kids?

We have the entire education profession positioning parents as hostile visitors in the lives of their own progeny. We have pedagogy now inserting itself as more entitled to a child and more knowledgeable about a child than that child's own parents. We have the child welfare system co-signing this and the legal system also signing off. We have child welfare deciding that parents raising a child to affirm their biological sex can in some cases be considered as equivalently abusive as parents who physically abuse their child.

Is this the ultimate end of "words are violence"? Because it's unacceptable. What else do we call this now but systemic parental alienation? I see an entire system orienting children away from their parents, deliberately to alienate + isolate them. I see this as a continuation of a phenomenon Gordon Neufeld called out 20 years ago in his book Hold Onto Our Kids. Furthermore, beyond this orientation away from parents I see a collusion with child abusers and sex traffickers under the guise of Queer Theory and SOGI.

Can anyone explain how Sage was affirmed by what the school, the child welfare system and the judge did to her? They essentially handed her over to physically abusive teenage boys, then to sex traffickers, and then to more abusers. Who is gender affirmation for, anyhow? From where I sit, it is for violent boys and men, it is for rapists and sex traffickers and pedophiles. Who else was affirmed? Certainly not Sage and certainly not her family.

John Locke wrote about the parent-child connection in his Second Treatise of Civil Government, *placing the*

child's best interest at the heart of parent duties in human society. Parents know their child best, from the inside out. A child does not know best, a child cannot know best for he has not reached the age of reason. To require a child to lead limits that child and prevents her or him from achieving his true nature as a free neophyte human. Children need their parents to lead and guide them and humanity needs this too. The wellbeing of the species requires the parent-child attachment to remain solid and strong and enduring and the most dominant in their growing lives.

To turn him loose to an unrestrained liberty, before he has reason to guide him, is not the allowing him the privilege of his nature to be free; but to thrust him out amongst brutes, and abandon him to a state as wretched, and as much beneath that of a man, as their's. This is that which puts the authority into the parents hands to govern the minority of their children. God hath made it their business to employ this care on their offspring, and hath placed in them suitable inclinations of tenderness and concern to temper this power, to apply it, as his wisdom designed it, to the children's good, as long as they should need to be under it. (Locke, S. 63)

Information about Sage's Law can be found [here]. It seems clear that the teaching profession has given itself a special entitlement over children, to the extent that it feels morally qualified to orient children away from their parents and toward a sexual self-image that promotes self-loathing and self-disconnect and a rupture in family connections. Why is pedagogy and the state at war with parents?

2. Does the McNamara Gender Affirmationist Team know or care about the story of Yaeli Martinez, whom Gender Radicals essentially drove to suicide by violating every tenet of child and family development?

Gender Affirmationism Took Abby Martinez's Daughter. Abby Martinez's daughter Yaeli did not get affirmed by Gender Affirmationists, instead she ended her life as a result of receiving GAC. Yaeli Martinez was afflicted with the Gender Identity social contagion, through her new school.

She befriended a girl who identified as a boy and she joined a school LGBT club, which encouraged her gender confusion. Her teachers and counsellors

affirmed her gender confusion and socially transitioned her without parental knowledge. Abby found out from her daughter's friend about Yaeli's new identity.

When she entered high school, her mother said, Yaeli befriended another girl who identified as a boy and suggested to Yaeli that the reason for her depression might be that she was actually a boy.

Yaeli attended an LGBTQ club at school that affirmed her questioning of her own gender. Her counsellor at school also affirmed her decision to begin socially transitioning from female to male.

"I don't know if the schools, they supposed to let us know what's going on or not, but they never send me any note about telling me, 'We need to talk about your daughter,'" Martinez, who is originally from El Salvador, said.

Martinez said she found out what was happening to Yaeli through one of her other children, who attended the same high school. — Daily Signal

Abby Martinez tried to fight back when a Los Angeles school, county social workers, and an LGBT group sought to transition her confused 15-year-old daughter.

But once Yaeli Martinez was moved into foster care and later injected with testosterone, the heartbroken mother could only watch helplessly as the girl spiralled into depression that ended when she stepped in front of an oncoming train.

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"They killed my daughter," a tearful Martinez told the Washington Examiner. "They had to pick pieces of her off of the track." —from the Washington Examiner

In this section I have refuted all nine claims made in the McNamara et al commentary. The conclusion of the McNamara commentary posits that, "*legislative endorsement of misinformation harms and invalidates all Transgender and Gender Expansive Youth. Our patients are watching to see how we protect their right to exist …*"

Well, Dr. McNamara and every other Gender Affirmation Extremist Clinician, protecting the right of a child to experience puberty seems like a very good place to begin protect their right to exist. Furthermore, acknowledging the grave harmful paediatric medical experimentation of GAC would help protect children's right to exist. Finally, acknowledging and apologizing for the death of Yaeli Martinez and holding the teachers and school and state and all clinicians involved responsible for socially and medically transitioning her and from imposing an attachment rupture on her would go a long way toward protecting the right of children to live. Gender Affirming Care affirms the ego of the professionals and activist lobbyists who promote it as compassionate and life saving health care and queer acceptance.

The Health Professional Class Has Brain Worms

I'll begin with America, since the nature of the relationship between Canada and the United States means our cultures have entwined themselves, and the powerful institutions of the USA force the institutional direction of Canada on many levels.

The overall trend in North American Health Care veers toward overstating the benefits of pubertal suppression and understating the risks. Organisations employ various tactics to cultivate the support for pubertal suppression and chemical castrator hormones, such as language manipulation. *We will call them Puberty Blocker, not Chemical Castrator if you please*, state the Gender Affirmationists.

The Endocrine Society is an activist society, which has publishes biased guidelines and statements on the topic of Gender Affirming Care. The new president of The Endocrine Society, Dr. Stephen Hammes, works in a Pediatric

Gender Affirming Care clinic in Rochester, NY.

Despite calls to do so, the new Endocrine Society president refuses to adopt new guidelines for pediatric gender dysphoria. The AMA continues to promote false information that overemphasizes their benefits of pubertal suppression.

GLAAD has a list of professional associations who represent a complete capture of the medical science world by a radical movement that resembles Lysenkoism, only as applied to human beings.

As Zither mentions in his MLI Commentary on Gender Affirming Care, Marci Bowers and Erica Anderson, two transgender clinicians who have worked extensively providing gender medicine to adolescents, have expressed concerns about the rapid surge in the demand for adolescent gender transition services.

In Canada medical and health care professions involved in primary and ancillary supportive care have all embraced Gender Radicalism. Psychology + Counselling, Social Work, Nursing + Midwifery, and Medicine all have taken radical positions on Paediatric Gender Affirming Care, despite the lack of valid and reliable evidence for this approach to primary care for human beings. I'll provide some examples of the capture across health care and ancillary professionals in Canada.

In its 2022 Gender Diversity Report, The Canadian Psychological Association stated that the requirement for *individuals seeking gender affirming surgery … [to] obtain a letter of recommendation by a licensed health care professional to access essential health care service … create[s] barriers to accessing health care … [and] creates ethical challenges for health professionals like psychologists whose Code of Ethics assert the rights of individuals to self-determination, respect for the dignity of persons, and freedom of consent in any health assessment process*.

The Canadian Association of Social Workers (CASW) developed a position statement on gender diverse kids and youth, in which it states that *social workers should advocate within their profession, with other professionals, and within the broader society to ensure gender diverse young people receive affirmation in all aspects of their lives. Social workers will work with medical*

practitioners as needed to respond to young people's requests for medical treatment to suppress puberty and/or to transition to a new gender.

Barb Findlay, one of the lawyers for the BCCNM, describes the Vancouver Rape Relief, the only female exclusive rape shelter in the Lower Mainland, as a cult. Interestingly, the nursing and midwifery regulatory body has completely committed to the body modification cult of medicine known as Gender Affirming Care.The BCCNM chose to proceed with a disciplinary hearing based on public complaints about tweets made by a registered nurse in her off duty time. In a disciplinary hearing for Amy Hamm, who tweeted that men cannot be women and therefore triggered an investigation by the nursing regulatory body, BCCNM Legal counsel Barb Findlay stated that the science surrounding child sex changes is settled in Canada. During the tribunal the following exchange took place.

Barbara Findlay: Women don't want trans women in women's space because of "pathogen disgust", a concept that racists use and have historically.

Amy Hamm: That is patently false. I maintain biological males present real safety issues in women's spaces.

The Canadian medical profession has also doubled down and renewed its commitment to the dangerous and experimental approach to care known as Gender Affirming Care, stating that *the Canadian Medical Association (CMA) is deeply concerned about any government proposal that restricts access to evidence-based medical care, including the Alberta government's proposed restrictions on gender-affirming treatments for pediatric transgender patients.*

The Alberta Medical Association responded to the announcement of Alberta's parental inclusion legislation with disappointment, claiming overreach, and also claiming that new safeguards will limit parental rights. "Puberty blocking actually has benefits for gender-divergent patients …" claims paediatrician Dr. Sam Wong.

The day after the NHS announced the UK would ban pubertal suppression as a treatment for kids experiencing psychiatric distress, a group of medical

associations from across Canada released a statement renewing their commitment to Gender Affirming Care and expression concern about safeguarding measures, calling them restricting access to care. Interestingly, these doctors refer to legislated safeguards against experimental treatment as *ideological intrusions*.

In short, no professional class in Canada has indicated a willingness to detach themselves from their anchor belief that sex is a construct and that "sex changes" resolve emotional, psychological, and psychiatric issues. The professional class in Canada remains solidly and radically anchored to its cultish beliefs about human sexuality.

The Unelected Authoritarian Ruling Class

Presently parents find themselves in an awful quagmire, because the Trudeau Regime has inserted into Humans Rights legislation the right to change sex and called it Gender Expression and Gender Identity. Technically speaking, a child can choose to adopt an opposite sex pronoun + name in secret from parents and a child can demand that the school comply with those changes and a child can also demand that the school withhold that information from parents.

The Human Rights Code in each province protects the teachers from liability by making confidentiality the right of the child. The Human Rights laws of Canada seem, on surface, to protect a child's right to change their sex without parental involvement. The state cannot help you, parent, if your child decides s/he wants to change sex aka gender identity or expression — in fact the state will remove your child from your care and call you abusive for trying to stop your child from the obvious harm of a paediatric sex change.

How can this be? This seems baffling and horrific. So much so that many refuse to believe it could happen here in lovely Canada. It is happening in Canada, I'm afraid to tell you all — it is happening and it is not isolated cases, it tends toward the rule rather than an exception. The Gender Affirmationist Lobby in Canada has grown to quite a capacity and sociopolitical influence, largely because the Trudeau Regime has enabled it through lavish funding

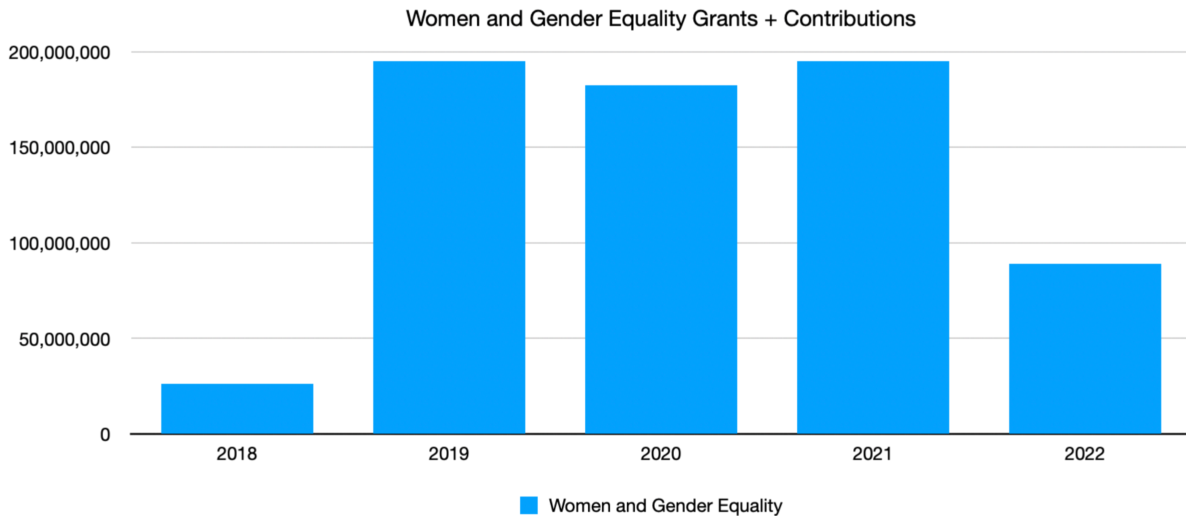

Figure 4 :: Grants + Contributions Department of WAGE

programmes which have little or no accountability process.

For Trudeau and his regime, *feminist governance* always meant *queer feminist governance*, as in subversion of established institutions in society, as in undermining the family unit, as in decoupling of the body politic from its institutional structures, as in decoupling the economy from its resource base, as in disembodying the human being for a social identity and calling it feminist gay rights.

Figure 4 reveals what I found when I conducted a search of Open Canada data on Women and Gender Equality (WAGE) contributions and grants. The data revealed that the Trudeau Regime has spent millions upon millions to fund *capacity building of 2SLGBTQ++ organisations*. A university-based Gender Radical group, the Centre for Gender and Sexual Health Equality, received a million dollars to study trauma informed supports for criminalised women survivors of GBV.

For-profit consultant lobbyist Fae Johnstone, co-owner and operator of Wisdom2Action, received 1.3 million dollars in grant and contract funding for development of materials for Bill C-6, as well as for capacity building of 2SLGBTQ+ organizations, and occupies a position of elite activist lobbyists who play a considerable role in creating the wall of gender ideology which has

descended upon Canada like a very stubborn and menacing weather system.

In fact, Johnstone also operates a non profit organisation called Society of Queer Momentum which has, in 2024 Q1, received just under half a million dollars from WAGE for capacity building. Johnstone has positioned the federally funded Queer Momentum to launch an aggressive and targeted social media smear campaign against the Conservative Party of Canada and its federal leader Pierre Poilievre, accusing them of *transphobia*.

So far this year WAGE has spent $3.5 million in grants on 2SLGBTQ++ projects, all aimed at emphasizing the radical gender policy positions of sex denialism and the cult of body modification, which the vast majority of Canadians oppose. Through unregistered lobbyists such as Johnstone and a selection of carefully selected NGOs, the federal government has management to finance a formidable wall of opposition.

Through this cabal of unelected lobbyists, the Trudeau Regime has subverted due process, shat upon the constitution and jurisdictional law. The Trudeau Regime has waged an elaborate and costly law fare campaign against Canadians. Human rights have become an elastrator, a device to transform Canadians into verbal eunuchs, to suppress and silence any expressed challenges and stated opposition to Trudeau's radical and unconstitutional transgender protocols and policies.

In 2023 grants and contributions totalled in excess of $664 million dollars, including transfers to the provinces for implementation 4 year National Action Plan on GBV.

1. What is Gender?
2. What is Gender Identity?
3. What is Gender Expression?

We don't know. The legislators never told us. They don't know either.

Depending on where you look, depending on what province you are in, the definition of gender and gender-derived words has a different verbal appearance. We are not certain what we are talking about, either. No one can answer concretely and without loaded language the question *what is gender*.

A lavishly federally funded political lobby group called Egale wants to take the province of Saskatchewan to court over a provincial education policy change approved by 78% of Canadians. Should McCarthy-Tétrault LLP get that money to

sue Canadians for a policy change they (Canadians) want, or should the Saskatchewan department of education receive that money to provide education for children via transfer payments?

A quick search on the Government of Canada website reveals that the legal firm has received over 5 million dollars in fees for consulting services since 2017, including one large contract for 5 million for legal services. Wait, doesn't then Justice Department have lawyers on staff for legal services? Why did the Trudeau Regime need to pay McCarthy Tetrault LLP for legal services?

Eva Kurilova writes in Gender Dissent, *Egale's meddling in provincial policy is eyebrow-raising when you consider that the organization has received massive amounts of federal funding over the years. A search of the Government of Canada website for grants and contributions to the organization turns up 30 entries totalling over 10 million dollars since 2017.*

Why are lobbyists getting federal funds to subvert Canadian democracy? Political lobby groups providing a government service such as education seems quite *Regimeische* to me. Naturally one of the lawyers assigned to the Egale-UR Pride challenge, Adam Goldenberg, posted on X that he supports the *Person with a Vagina* language in the recent Supreme Court of Canada decision.

I want to ask Canadian readers to reflect on Canada. Who is governing Canada? Do we live in a democratic country, or do simply tell ourselves that we do?

Why didn't the country get a chance to discuss the removal of sex categorisation from our institutions? Who decided this would serve the best interests of Canadians? Did you find it interesting that a self described feminist government dismantled women's rights and safeguarding and forced incarcerated women to shared prison cells with dangerous violent male killers and rapists who identify as women?

Do you find it interesting that a feminist government embraces the most murderous and abusive and rapey political religion on the planet? Do you find it interesting that the feminist government believes the lie of *free in hijab*?

When have you seen Prime Minister Justin Trudeau (PMJT) lead the country to a stable unity? When have you

seen him listen to Canadians and respond in the manner of a level 5 leader does? Does a skilled leader issue threats to silence dissenters? Does a skilled leader punish anyone who points out the error of the leader's ways? Does a skilled leader subvert transparency and due process and resort to coercive control?

The Trudeau Regime heavily funds Egale, which describes its main objective as *creating a Canada without transphobia*. Egale recently accused me, the author of LupronGate, of defamatory behaviour when I called out the organisation on X for misrepresenting facts and misleading Canadians. Remember, saying *sex is real and immutable* is transphobic, according to Egale and the queer activism world, Egale has an extreme objective: to eliminate sex categorization from society. Egale espouses something that resembles Woke Shariah — a thing ultimately destructive and oppressive to women.

Egale produced a *Pride Defence Toolkit*, which public sector unions and labour organizations widely promoted in preparation for the parental inclusion events. When Egale declared parental inclusion and safeguards wanted by 80% of Canadians as hateful, then labour could organise and take the day off to publicly harass parents and their allies fighting SOGI brainwashing of their kids.

As mentioned previously in this document, the Trudeau Regime funded the Canadian Anti Hate Network, which defines hate as anything critical of progressive politics. CAHN targets and smears dissidents who oppose progressive politics such as Gender Affirmation and DIE racial essentialism. HateGate covered the scandal and fraud of the CAHN, this document will not duplicate that work.

Pride Safety Toolkit, a publication written by Egale claims there is "technically" no such thing as a hate crime in Canada (see Hate Speech in Canada). Egale then goes on to cite examples of hate crime … acts intentionally target individuals or property based on the offender's hate towards the "identifiable group" [which is] … race, nationality or ethnic origin, colour, religion, sex, age, mental or physical disability, sexual orientation, or gender identity or expression.

Egale then invents a "non-criminal hate act" called a hate incident. A hate incident is a non-criminal action or behaviour that is motivated by hate

against an identifiable group. Examples of hate incidents include using racial, homophobic, transphobic or other discriminatory slurs, or insulting a person because of their ethnic or religious dress or how they identify.

A hate incident sounds a bit like when you are a kid and you give your parents lip or back-talk by asking a question and they accuse you of impertinence. A hate incident sounds a bit like when someone challenges a progressive intellectually in a way that feels uncomfortable. A hate incidents sounds like unwelcome disagreement as opposed to an expression of the desire to harm.

The BC Federation of Labour promotes material that encourages counterprotestors to engage in terrorism by using high decibel sound to harm protesters. We saw this strategy employed against Caryma Sa'ad last summer during her coverage of Pride Month protests and counter protests — "Pride Defenders" deliberately used whistles to intimidate and silence those whose message they did not like.

Seeking to harm others for a political motive describes terrorism. What's "Pride Defender", you ask? The CAHN is glad you asked, they have the answer— yet another concept they invented. The CAHN Guide for Defenders says the following.

Pride Defence is the act of going to any Pride event to protect the 2SLGBTQ+community from far-right activists who show up.

Pride Defenders are the brave people who show up to counter the far-right, using many different tactics. Some have used spectacle and created a party-like atmosphere with dancing and music to keep the far-right out, while others have blocked them from accessing events using their bodies. (page 3)

Use loud music and whistles to disrupt the hate protestors' verbal harassment. Bring and distribute earplugs to protect your hearing. (page 7)

Pride Defence describes a strategy of physical harassment and terrorising to subvert any cluster of peaceful protesters whose cause does not align with the principles of queer activism and therefore receives the label hate group. It involves physical intimidate and even attacks with high decibel sounds that register in the hearing loss range.

Trans bodies and lives are on the line, and it's up to all of us to take a

stand, urges the BC Federation of Labour in its statement Standing up against anti-trans hate on September 20, and always, which referred to the rising concern over gender extremism via SOGI sex education in public schools and in paediatric care generally as a surge of anti-trans hate speech and actions across the country — ranging from regressive and harmful provincial education policy to resolutions passed at this month's federal Conservative convention.

Pride Defence and *The Public Safety Toolkit* serve as two examples of a host of Gender Affirmationist propaganda which the Trudeau Regime pays Egale to produce and disseminate to Canadians. Figure 5 is best that the million dollar NGO Egale can do to tell Canadians about the components of human identity. You can see Egale defines gender as *the way we express ourselves through clothing, speech, body language, hairstyle, voice, and body characteristics*.

This Egale definition reminds me a lot of the Oxford definition of sexuality, which I get when I google 'sexuality definition': a person's identity in relation to the gender or genders to which they are typically attracted; sexual orientation. When you click thru on the hyperlinked word gender, you will see gender defined as the male sex or the female sex, especially when considered with reference to social and cultural differences rather than biological ones, or one of a range of other identities that do not correspond to established ideas of male and female. When you click thru the hyperlinked word identity you will see identity defined as the fact of being who or what a person or thing is, and also the characteristics determining who or what a person or thing is.

This exercise demonstrates the linguistic nature of the gender movement.

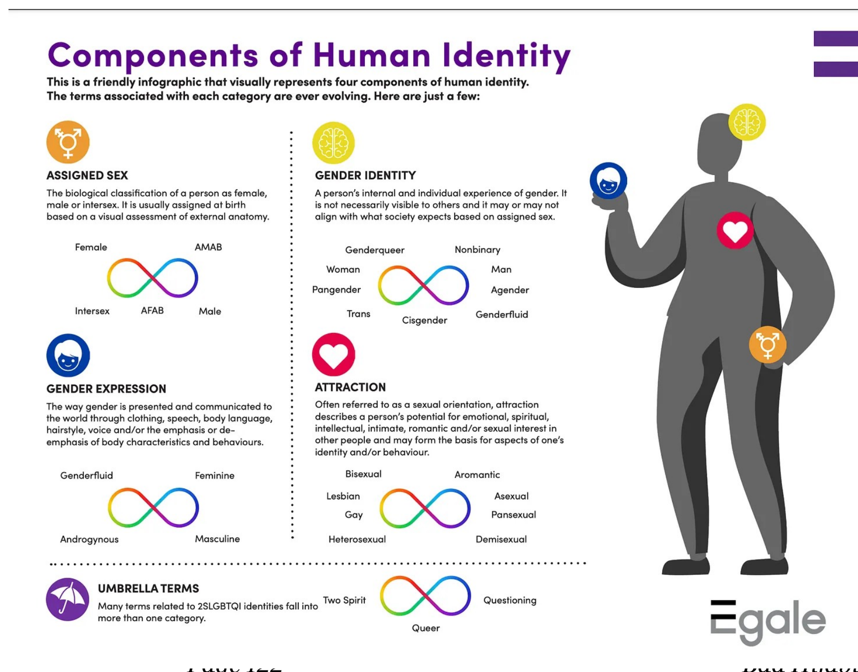

Figure 5. Egale's Components of Human Identity

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Egale Explains: Puberty Blockers

Some young people are prescribed **puberty blockers** because their puberty began much earlier than usual. Others are prescribed blockers because they experience severe gender dysphoria around puberty.

In any case, puberty blockers offer tremendous mental health benefits to a young person. They allow for extra time and capacity for them to choose the best path forward alongside their families and their medical care team without leaving the younger person in acute distress as their body changes.

Download this Resource (PDF)

Puberty blockers are a type of medication that pause or limit the effects of puberty.

Puberty blockers are only used to DELAY puberty.

Puberty blockers have no known irreversible effects and are considered very safe overall.

Upon stopping puberty blockers, puberty continues as it would have without them.

No one stays on puberty blockers permanently.

This resource is part of Egale Canada's work to combat anti-2SLGBTQI hate.
Use Egale's Rainbow Action Hub to find more resources and tools to combat the rise of anti-2SLGBTQI hate.

It points to inconsistency with respect to the use and application of the word gender. At times gender refers to sexuality. At times gender refers to our feeling about our sexuality. At times gender refers to sex aka reproductive class. We require context to determine the meaning and this impedes our ability to protect human rights if we cannot all know what anything is without a lengthy contextual explanation.

After studying this graphic in Figure 5 and perusing the Egale glossaries and charts about the new rainbow language + culture, I still do not know what gender means in the legal sense and how it differs from sex. I define sex as reproductive class, an immutable physiologic state of being established shortly after conception, in utero, i.e. during gestation,. So, I disagree that sex is "assigned at birth", as the Gender Affirmationists claim.

I still have no idea why a child who exercises his/her right to gender expression and gender identity needs to undergo a chemical hypothalamic lobotomy to affirm that choice of clothing and pronoun and other expression.

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What is Conversion Therapy?

What it is:

Conversion therapy can be a practice, treatment, or service that is designed to repress OR change either or all of the following:

- a person's sexual orientation to heterosexual
- a person's gender identity to cisgender
- a person's gender expression so that they conform to the sex they were assigned at birth

What it's not:

It's important to note that the Criminal Code also clarifies that practices, treatments, or services related to exploring or the development of someone's personal identity (such as gender transition), is not considered conversion therapy. These practices are not based on the assumption that a certain sexual orientation, gender identity, or gender expression is more acceptable over another.

Some other things to note!

The term "conversion therapy" is an inaccurate as it is not a therapeutic practice recognized by any credible organization or governing body. A more accurate term might be "conversion practices". However, we have utilized this term since it's the term that is most widely known and also the term referenced within the Criminal Code.

Keep in mind that while this is how the law defines conversion therapy, the realities of this practice are more expansive. For example, the lack of treatment or service from a healthcare provider to provide gender-affirming healthcare such as hormone replacement therapy (HRT), is also a form of conversion practice.

Check out the rest of our #EndCTForAll campaign at egale.ca/conversiontherapyban to find out more about what conversion therapy is, it's impacts, and what you can do to help support survivors.

Egale Department of Justice Canada Ministère de la Justice Canada 1

What acts related to conversion therapy are now illegal?

1 Causing another person to undergo conversion therapy; this includes being the provider of conversion therapy.

2 Any acts that are for the purpose of removing a child from Canada with the intention for that child to undergo conversion therapy elsewhere.

3 Promoting or advertising conversion therapy.

4 Receiving financial or other material benefits from the provision of conversion therapy.

All of these offenses are punishable by fines or prison time, depending on the severity of the offense.

Conversion therapy can consist of many different activities including what may look like traditional counselling such as psychotherapy methods like Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT).

It can also look like withholding necessary medical care such as hormone blockers by healthcare providers.

All efforts are governed by the belief that identities that are not cisgender or heterosexual are not preferred and thus should be changed or repressed.

Check out the rest of our #EndCTForAll campaign at egale.ca/conversiontherapyban to find out more about what conversion therapy is, it's impacts, and what you can do to help support survivors.

Egale Department of Justice Canada Ministère de la Justice Canada 1

Figure 6 :: Egale's Radical Conception of Conversation Therapy

When you visit the Egale website, a colourful hip splashy website greets you. Notice the rainbow acronym? Notice that Egale has sandwiched the LG in between the straight identities? That's deliberate, this is not about gay rights anymore. This is about sexual subversion. No information about the dangers of puberty, no news about the latest out of the NHS. Just shiny happy colourful gender affirmation screams at you from the website's landing page when you visit.

The Affirming Adults: A Guide to Supporting Gender Diverse Children and Youth will teach you all about *cisheterosexist bias* in the world of humans. Egale will tell you these biases are harmful because they offend trans people, the name given to anyone who doesn't like their reproductive class and wants to be asexual or the opposite sex and demand validation from everyone around them. The guide amounts to Gender Affirmationist catechism, outlining the vocabulary that will redefine human beings in the imagine of self loathing narcissists with a sexual dysfunction or disorder.

The Affirming Adults Guide provides childish, cartoonish depictions of human beings, faceless images — is that deliberate? The guide provides a section that gaslights parents about accepting their child's distortion about being in the wrong body. The guide packages known lies as truth and then provides a list of biased resources. This guide to affirmation reads like a cult manual, and taxpayers paid for it — we paid for this 59 page document that abuses families in a nation wide crime against humanity.

Figure 6 reveals that the Federally funded Egale promotes the concept of Gender Identity Conversion Therapy as valid and reliable, despite reputable scientists debunking Gender Identity Conversion Therapy as nothing more than an fiction created by Gender Zealots to manipulate the discourse and pressure politics to enact illiberal and harmful laws.

In an information sheet on Conversion Therapy, Egale claims that Conversion Therapy includes *the lack of service or treatment, from a healthcare provider to provide gender-affirming healthcare such as hormone replacement therapy (HRT), is also a form of conversion practice … **Conversion therapy can consist of many different activities including** what may look like traditional counselling such as psychotherapy methods like Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT). It can also look like **withholding necessary medical care such as hormone blockers by healthcare providers**.*

Egale notes in bold lettering that *all efforts are governed by the belief that identities that are not cisgender or heterosexual are not preferred and thus should be changed or repressed*, a wordy way of stating that Egale denies the existence of of sex as an immutable physiologic state of existence. Egale denies the most fundamental thing about human beings, sex aka reproductive class. Gender Radicalism, more commonly referred to as Gender Ideology in Canadian vernacular and discourse, resembles Lysenkoism in its denial of fundamental biological limitations of organisms, and stubborn narcissistic insistence on promoting harm despite available evidence.

REBEL NEWS ONLINE :: HEALTH MINISTER MARK HOLLAND

MARCH 26, 2024

Journalist: Are you considering clawing back money at all in term as it relates to trans health care and being able to access trans health care?

Minister Holland: It's essential that every Canadian get the care that they need. You know, and I was just in the Yukon, where they are a leader in North America in providing care for trans people. And, it is so tragic for me to hear the stories, particularly of young people, when they don't have access to care. It leads to, to death in way too many circumstances. So we're having conversations. I mean, as you've seen in the working together agreements, frankly, in in dealing with diagnostic services, working in in a spirit of collaboration to try to work with provinces to ensure trans kids, as an example, get the support and care that they need. So I've been having conversations with some jurisdictions where we have a very different view, than than we do. But my preference at this point in time is to work through that on the basis of collaboration. We do respect the elected authority of provincial governments, But there are some things, when you're endangering the health of children as an example, where, you know, we're gonna have to look at, at at in the first order at collaboration and trying to work through that, you know, government to government to sort out our differences. And I don't want to engage in a hypothetical if that doesn't work, but I am deeply concerned.

Journalist: Premier Smith announced her her policies on trans kids and hormonal therapy and surgeries. You actually came out here and did threaten to claw back money. Yeah. But you said you had to study the the Canada Health Act because it wasn't clear if those, health services are supposed to be publicly not supposed to be, but are publicly covered or not. So it's been weeks. So I guess our question is, have you checked? Is it under the Canada account?

Minister Holland: I think yeah. So, I mean, we have to be very careful because the interpretations that we make are forever. And, you know, is it an option to consider? Absolutely. Should it should or can it be deployed? It's something that we're still looking at, but I but I I will reiterate what I said before, which is the best answer is a collaborative one.

Journalist: Is it is— I just wanna get it, I—
Journalist: But you weren't sure that those health services even would fall under Canada Health Act and therefore be subject to a clawback. Have you clarified that part?

Minister Holland: So one of the things that it and I understand that this moves more slowly than I would like or you would like. But I but as an example, you know, there's a forthcoming interpretation letter with respect to virtual care. You know, there's many new frontiers in health where we have to, yeah, where we have to be very careful in how we examine that because once an interpretation is made, it's permanent, and it has a very long lasting effect, and we have to make sure that legally it stands up to challenge.

Figure 8 :: Health Minister Mark Holland on Puberty Blockers and Legislation to ban them for minors

CPAC :: PRIME MINISTER JUSTIN TRUDEAU

FEBRUARY 7, 2024

[Male Journalist]: The Prime Minister on Pharmacare legislation, [incomprehensible name]--

Prime Minister Justin Trudeau: Trans kids are five times more likely in this country to attempt suicide. What Mr. Poilievre and Ms. Smith are proposing is to take away the rights of parents and their kids to make the right choices for them with their doctors. We don't think government should be doing that. Our government will always stand up for the most vulnerable, including our trans youth.

PMJT : Repeats same in French about defending the most vulnerable

Female Journalist: Qui Pourriez-Vous faire pours les enfant?
PMJT: Il va culte idéologique

Male Journalist: Have you met with Jagmeet Singh on pharmacare?
PMJT: Let me just answer this one in English because I think it's important.

PMJT: The fact the Premier Smith and Pierre Poilievre want government to take away the option for parents and their vulnerable youth in consultation with their doctors to make the right decisions for them is anchored in ideology and is not about protecting the most vulnerable. Our government will do whatever it takes to protect the most vulnerable.

PMJT walks away in an emotionally charged state, never answering the original question that Male Journo had in mind, which was about pharmacare.

Figure 9 :: Prime Minister Justin Trudeau on Puberty Blockers and Legislation to ban then for minors

A Reckoning For Canada?

Recently a private member tabled a petition in the House of Commons, calling on the Minister of Health to conduct a systematic review of paediatric gender affirming care across the country. The Minister of Health responded that WPATH offers guidelines, and that standards and guidelines are set by disciplinary professional associations and are based on the best available evidence at the time.

There is a lack of data available to confirm if there has been an increase in numbers of people experiencing gender dysphoria in Canada, responded the Minister of Health to the Petition calling for a systematic review. That's untrue, according to the McDonald Laurier Institute. As you can see from the trending data in Figure 7, the sharp rise in children seeking GAC from gender clinics coincides with the implementation of SOGI in several provinces.

Several other countries have begun a systematic review, and some countries conducted reviews and have banned pubertal suppression out right, for example the United Kingdom recently did so, and it shut down its Tavistock Gender Identity Services Clinic. A groundbreaking study from the Karolinska Institute in Sweden showed that GAC does not improve mental health outcomes. The institute has ended all pubertal suppression treatments for children with GD.

"Against the background of almost non-existent longterm data, we conclude that GnRHa treatment in children with gender dysphoria should be considered experimental treatment rather than standard procedure. This is to say that treatment should only be administered in the context of a clinical trial under informed consent", [Professor Mikael Landén] adds.

Still, the Trudeau Regime continues to double down, *insisting that younger people may be more willing to disclose their gender identity to organizations such as Statistics Canada … [and that] this may be due, in part, to improvements in the social supports, greater acceptance and visibility, increasing human rights protections, and other forms of supportive legislation*

for transgender, non-binary and other 2SLGBTQI+ people in Canada.

The Trudeau Regime refuses to accept new information that calls into question its radical Gender Affirmationist Policy stance, stating simply *il va culte ideologique*. Arrogantly, Trudeau dismisses questions about the safety and efficacy of pubertal suppression as *far right*. He has absolutely decided that such a phenomenon as *being in the wrongly sexed body* exists as an identity and that this phenomenon, called being *transgender*, is just like being gay, and that this causes kids to want to kill themselves.

Any challenges to *the doctrine of people in wrongly sexed bodies* the Trudeau Regime will designate as far right misinformation and *transphobic* hate. In betraying his regime's complete ideological capture and total ignorance about WPATH and the process and rigour of clinical research, the Minister of Health stated, *notably, a team of independent researchers at Johns Hopkins University conducted the systematic reviews of research evidence that underpin the WPATH guidelines*. I find it concerning Minister Holland seems unaware that the scientific evidence underpinning WPATH has serious fatal research methods flaws and none meet the gold standard, the randomized controlled trial (RCT).

In a recent scrum with the press, Health Minister Mark Holland accused Alberta of endangering kids, invoking the common emotional blackmail rhetorical tactic of Gender Affirmationists— that children who do not receive pubertal suppression hormone analogues will die. In similar fashion, in a scrum exchange with TNC journalists in February, **Trudeau claimed that transkids are five times more likely to attempt suicide in Canada**.

That claim intrigued me, so I investigated the source and discovered a study on some Stats Can Health Survey data conducted by Ottawa University in June 2022. The data set involved youth and their parents that had completed an additional survey questionnaire. The research team included consultant lobbyist Fae Johnstone.

The study involved defining sexual minority and transgender categories from reports on sexual preferences and reported gender and sex. The team then plotted the transgender category and the suicide incident category as exposure-

outcome variables in a Poisson Regression Analysis. The team proceeded to interpret the results as transgender identity increases risk of suicide. This is where PMJT took his number from. Poisson Regression analyses count data to measure the impact of exposure on outcome. For instance in a week, measure the number of drinks taken against arrests.

The statistical technique does not fit to answer the research question *do children with a transgender diagnosis experience higher suicidality*. The qualitative impact of a facet of one's being upon the behaviour of suicidality cannot be measured with a Poisson Regression Analysis, and correlation does not mean causation.

You can refer to Figures 8 and 9 to see the transcript of comments Minister Holland and Prime Minister Trudeau made about GAC and safeguarding policy proposed by Pierre Poilievre and Premier Smith. Since Gender Radicalism began dominating the Canadian media around 8 years ago, conservative outlets like Rebel News and TNC have consistently reported the facts about Gender Radicalism in Canada. Many other outlets have emerged in response to the legacy media blackout, in fact. The state broadcaster, CBC, refuses to report on the WPATH Files, on the NHS decision to ban puberty blockers, or on the First Do No Harm Conference recently held in the UK and attended by Gender medicine specialists and allied professionals. Radio Canada stands by its reportage, despite violent threats it received.

The Trudeau Regime remains committed to its delusions about child development and human sexuality. At this point, I see willful denial of valid and reliable evidence, repeated willful denial. When does this repeated wilful denial become abusive, ie criminal negligence?

"I am surprised by the shortage of studies in this field. We found no randomized trials, and only 24 relevant observational studies,"says lead author Professor Jonas F Ludvigsson, paediatrician at Örebro University Hospital, and Professor at the Department of Medical Epidemiology and Biostatistics, Karolinska Institutet. Ludvigsson was lead author of a systematic review in which researchers assessed more than 9900 abstracts from fifteen scientific databases and identified 24 relevant studies.

Appendix

"Puberty Blockers"

Chapter 14 from The Cass Review

Analysis of International Clinical Guidelines for GAC from The Cass Review

WPATH SOC 8 Guidelines Analysis from The Cass Review

Factors Contributing to Gender Incongruence from The Cass Review

14. Puberty blockers

14.1 When the Review began, the medical interventions for gender incongruence/ dysphoria available on the NHS were puberty blockers, followed by masculinising/feminising hormones. The history of their use was outlined in Part 2.

Normal pubertal development

14.2. Puberty begins between 8 and 13 in girls (average age 11) and between 9 and14 in boys (average age 12). The process starts in an area of the brain called the hypothalamus.

14.3. Puberty is triggered when the hypothalamus starts a hormone cascade which results in the ovaries and testes producing oestrogen and testosterone respectively. Both males and females proceed through the 5 stages of puberty known as Tanner stages.

Table 10: Tanner stages

TANNER	MALES	FEMALES
Stage 1	• No major physical changes yet • Brain is starting to signal the body to start making changes	
Stage 2	• Testes begin to grow • Public hair around base of penis	• Breast buds, darker nipple • Small amount of pubic hair
Stage 3	• Penis gets longer • Thicker pubic hair • Wet dreams • Voice starts to change • Muscles get larger • Start of growth in height	• Breast buds increase in size • More pubic hair • Hair under armpits • Acne • Most rapid growth in height • Start to increase fat on hips and thighs
Stage 4	• Testes, penis and scrotum continue to grow, scrotum gets darker • Hair in armpits • Deeper voice • Acne • Most rapid growth in height	• Further breast growth • First period • Growth in height slows • Pubic hair gets thicker
Stage 5	• Testicles, penis, scrotum adult size • Pubic hair spread to inner thighs • Facial hair • Growth in height slows down	• Adult breast size • Periods more regular • Adult height • Hips, thighs, buttocks fill out

Rationale for the use of puberty blockers for gender dysphoria

14.4 As set out in Chapter 2, the practice of pausing puberty at Tanner Stage 2 was initiated in the Netherlands, and subsequently adopted in the UK and internationally. The idea was based on a theory from Dr Peggy Cohen-Kettenis whose initial clinical experience was in adult care. Her rationale was that pausing puberty early would help young people to 'pass' better in adulthood and 'extend the diagnostic period' by buying time to think. The use of puberty blockers for this purpose was initially reported in a single case study (Cohen-Kettenis & van Goozen, 1998) and then in the original Dutch cohort (de Vries, 2011b).

14.5 It may appear surprising that the novel use of a drug for this purpose did not require a more rigorous drug trial. This is because of the way drugs are licensed and can be used off-label (see Explanatory box 5).

14.6 GnRH hormones (referred to as puberty blockers in the treatment of young people) are licensed for patients with precocious puberty (that is, young children who enter puberty too early), as well as for the treatment of some cancers in adults and some gynaecological issues in adults. They have undergone extensive testing for use in precocious puberty (a very different indication from use in gender dysphoria) and have met strict safety requirements to be approved for this condition.

Explanatory Box 5:

Licensing, indications and contraindications

Licences are granted for a drug if strict safety and quality standards are met for its use. In the UK, licences are granted by the Medicines and Healthcare products Regulation Agency (MHRA).

An indication for a drug is a medical condition that the drug can be used to treat. Drugs are licensed for specific indications or purposes; for example, semaglutide was originally licensed for the treatment of diabetes. Recently some brands of semaglutide (Wegovy) have received additional licensing for weight loss.

If a drug is used for a purpose for which it is not licensed, this means it is being used off-label. This may be because it is considered to be effective for this indication, but the manufacturer has not gone through the processes to apply for a licence for that particular condition. For example, tetracyline, a kind of antibiotic, is licensed for a range of conditions including acne and rosacea. It is also used to treat Helicobacter pylori, a bacteria that infects the stomach lining and can cause stomach ulcers, but it is not licensed for that purpose.

Many drugs are not licensed for use in children, but can still be given to them safely. This is because the trials to test safety were only done in adults, so the licence specifies adult use only. In these circumstances the drug is usually given to children for exactly the same reason as for adults (for example, treatment of a severe infection).

14.7 The situation for the use of puberty blockers in gender dysphoria is different. Although some endocrinologists have suggested that it is possible to extrapolate or generalise safety information from the use of puberty blockers in young children with precocious puberty to use in gender dysphoria, there are problems in this argument. In the former case, puberty blockers are blocking hormones that are abnormally high for, say, a 7-year-old, whereas in the latter they are blocking the normal rise in hormones that should be occurring into teenage years, and which is essential for psychosexual and other developmental processes.

14.8 This approach to the use of puberty blockers in gender dysphoria has been an ongoing source of controversy both nationally and internationally.

14.9 The lack of consensus across the clinical community was highlighted by a 2015 study (Vrouenraets et al., 2015), which approached 17 multi-professional treatment teams worldwide to determine their views on use of puberty blockers. They identified seven themes on which there were widely disparate views:

- the (non-) availability of an explanatory model for gender dysphoria
- the nature of gender dysphoria (normal variation, social construct or [mental] illness)
- the role of physiological puberty in developing gender identity
- the role of comorbidity
- possible physical or psychological effects of refraining from) early medical interventions
- child competence and decision-making authority
- the role of social context in how gender dysphoria is perceived.

14.10 The professionals who participated in the study were often conflicted because they recognised the distress of young people and felt the urge to treat them, but at the same time, most had doubts because of the lack of information on long-term physical and psychological outcomes. For several participants, a reason to use puberty suppression was the fear of increased suicidality in untreated adolescents with gender dysphoria.

14.11 The authors of the study concluded that as long as debate remains on these seven themes and only limited long-term data are available, there will be no consensus on treatment. Eight years later, the position is unchanged and many of the same considerations apply to the use of masculinising/ feminising hormones in young people.

International practice

14.12 The synthesis of international guidelines by the University of York (Hewitt et al: Guidelines 2: Synthesis) found that there is no clarity about the treatment aims of puberty suppression, with options including reducing gender dysphoria, improving quality of life, allowing time to make decisions, supporting gender exploration, extending the diagnostic phase and 'passing' better in adult life.

14.13 Most guidelines emphasise full reversibility as a justification for their use, whilst highlighting potential adverse effects on bone health and uncertainty regarding cognitive development.

14.14 Where eligibility is discussed, the earlier requirement to wait for the patient to reach age 12 before they can access puberty blockers has been removed from some guidelines (for example, WPATH 8). The majority of guidelines recommend waiting until a child has reached Tanner Stage 2 of puberty. The Swedish guideline recommends Tanner Stage 3.

14.15 There is also considerable variation about the criteria for starting puberty blockers, with the commonest being the presence of gender dysphoria that has emerged or worsened at puberty. Only two guidelines specified the need for gender incongruence rather than dysphoria. Several specified that mental health difficulties should be managed and/or were unlikely to impact treatment. Another specification in several guidelines was that the young person has decision-making capacity, parental consent is obtained and/or that there is family social support.

14.16 The Swedish and Finnish guidelines differ from others in recommending that puberty suppression should be provided under a research protocol or the supervision of a research clinic.

14.17 The international survey (Hall et al: Clinic survey) looked at what is happening in practice. All clinics offered puberty blockers and masculinising/feminising hormones apart from one regional service. Menstrual suppression with progestogens (the contraceptive pill) was routine in four clinics.

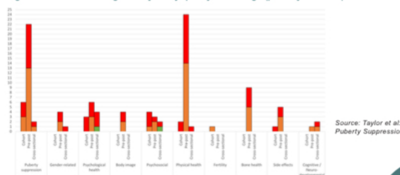
14.18 Most clinics required a diagnosis of gender dysphoria or incongruence, reaching Tanner stage 2 and stable mental health for puberty blockers. Belgium, Finland, Denmark and Norway required gender dysphoria/ incongruence to have been long-lasting/since childhood and Finland specified that distress had to intensify in puberty. Five clinics excluded those in late puberty from having blockers.

Understanding intended benefits and risks of puberty blockers

14.19 The systematic review on interventions to suppress puberty (Taylor et al: Puberty suppression) provides an update to the NICE review (2020a). It identified 50 studies looking at different aspects of gender-related, psychosocial, physiological and cognitive outcomes of puberty suppression. Quality was assessed on a standardised scale. There was one high quality study, 25 moderate quality studies and 24 low quality studies. The low quality studies were excluded from the synthesis of results.

14.20 A large proportion of the studies only looked at how well puberty was suppressed (expected effects) and at side effects, with fewer looking at the other intended outcomes. There was evidence from multiple studies that puberty suppression exerts its expected physiological effect, and this has never been at issue.

Figure 35: Outcome categories by study quality and design (puberty blockers)



Source: Taylor et al: Puberty Suppression

Intended benefits

14.21 As set out in Explanatory box 5, an indication for a drug is the purpose for which it is prescribed. As the Review has progressed it has become more difficult to be clear about the indications for puberty blockers in this population of young people.

14.22 As explained above, when the Dutch gender clinic first started using puberty blockers to pause development in the early stages of puberty, it was hoped that this would lead to a better cosmetic outcome for those who went on to medical transition and would also aid diagnosis by buying more time for exploration. Since then, other proposed benefits have been suggested, including improving dysphoria and body image, and improving broader aspects of mental health and wellbeing.

Buying time to think/explore

14.23 The University of York's systematic review of care pathways (Taylor et al: Care pathways) reported that 0-8% of young people discontinued puberty suppression. Compared to those who continued with treatment, young people who discontinued had initiated treatment at an older age and included a higher proportion of those with mental health and autism spectrum conditions. In the gender clinic with a discontinuation rate of 8% (6 of 73), median age at start of treatment was 15.2 years (range 15.0-15.6 years) and all were post-pubertal at presentation.

14.24 In the UK early intervention study (Carmichael et al., 2021), 98% (43 of 44) of those who started on puberty suppression progressed to masculinising/feminising hormones. A more recent discharge study (Butler et al., 2022) looked at 1,089 patients referred from GIDS to the paediatric endocrine clinic. It showed that 7.4% (16 of 217) of t hose under 16 at referral discontinued puberty blockers.

14.25 These data suggest that puberty blockers are not buying time to think, given that the vast majority of those who start puberty suppression continue to masculinising/feminising hormones, particularly if they start earlier in puberty. It was on the basis of this finding that the High Court in Bell vs Tavistock suggested that children/ young people would need to understand the consequences of a full transition pathway in order to consent to treatment with puberty blockers ([2020] EWHC 3274 (Admin))..

Reducing gender dysphoria/improving body satisfaction

14.26 Only two moderate quality studies looked at gender dysphoria and body satisfaction; the original Dutch protocol (de Vries et al., 2011b) and the UK early intervention study (Carmichael et al., 2021). Neither reported any change before or after receiving puberty suppression.

Psychological and mental health improvements

14.27 As outlined in Chapter 2, the original Dutch protocol (de Vries et al., 2011b) found improvements in mental health in a pre-post study without a comparison group, but the GIDS early intervention study (Carmichael et al., 2021) did not replicate this finding. The systematic review on interventions to suppress puberty (Taylor et al: Puberty suppression) identified one other good quality study (van der Miesen et al., 2020), which produced an intermediate result with improvements in some mental health measures but not others.

14.28 The University of York concluded that there is insufficient and/or inconsistent evidence about the effects of puberty suppression on psychological or psychosocial health. This is in line with the finding of the NICE review (2020) and other systematic reviews, apart from the systematic review commissioned by WPATH (Baker et al., 2021), which reported some benefit. However, in the latter systematic review,

eight of the 12 studies reporting psychological outcomes were rated as low quality, which may explain the difference.

14.29 It is often the case that when an intervention is given outside a randomised control trial (RCT), a large treatment effect is seen, which sometimes disappears when an RCT is conducted. This is especially the case when there is a strong belief that the treatment is effective. The fact that only very modest and inconsistent results were seen in relation to improvements in mental health, even in the studies that reported some psychological benefits of treatment with puberty blockers, makes it all the more important to assess whether other treatments may have a greater effect on the distress that young people with gender dysphoria are suffering during puberty.

Cosmetic outcomes/'passing' in adult life

14.30 The Multi-Professional Review Group (MPRG) request a letter from young people being put forward for puberty blockers so they can ensure that they hear the young person's voice and understand their aspirations. The MPRG have now reviewed approximately 200 such letters. As explained in Chapter 12, many young people are living 'in stealth' and consequently often in a state of considerable anxiety about developing pubertal changes that may 'out' them to their friends. However, since most young people are not starting puberty blockers until the age of 15 and above, it is unclear how helpful they might be in maintaining stealth, particularly for birth-registered girls who will often be in the later stages of puberty by that time.

14.31 In the longer-term, being able to 'pass' is of great importance to some transgender adults, and not to others. Although there is a lack of long-term outcome data for children and young people in adult life, the Review team has been able to talk to both young people and older adults about their experience of early access to puberty blockers. This has been particularly important for the transgender women, who were able to access puberty blockers before developing facial hair and dropping their voice.

14.32 In terms of helping young people to 'pass' in adult life, an important question is what impact puberty blockers might have on adult height for those who subsequently go on to masculinising/feminising hormones. Evidence to date suggests that puberty blockers neither lead to substantially reduced adult height in transgender females (Boogers et al., 2022), nor increased eventual height in transgender males (Loi-Koe et al., 2018). This is an important issue for further research.

Risks

14.33 When the use of puberty blockers was introduced by the Dutch clinic, the target population was patients who had been gender incongruent since childhood. Prior to the introduction of puberty blockers, the clinical experience of that group suggested that although in the vast majority the gender incongruence resolved by puberty, for those for whom persisted into puberty, a long-term transgender identity was more likely.

14.34 For the more recently presenting population of predominantly birth-registered females who develop gender dysphoria in early to mid-puberty, there is even less understanding of what in medical terms is called the 'natural history' of their gender dysphoria (that is, what would happen without medical intervention). Because an intervention intended for one group of young people (predominantly pre pubertal birth-registered males) has been

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given to a different group, it is hard to know what percentage of these young people might have resolved their gender-related distress in a variety of other ways.

14.35 Earlier, this Report set out the very complex events that take place in the adolescent brain during puberty. Neuroscientists believe that these changes are driven by a combination of chronological age and sex hormones. Blocking the release of these sex hormones could have a range of unintended and as yet unidentified consequences.

Altering the trajectory of development of sexuality and gender identity

14.36 Adolescence is a time of overall identity development, sexual development, sexual fluidity and experimentation.

14.37 Blocking this experience means that young people have to understand their identity and sexuality based only on their discomfort about puberty and a sense of their gender identity developed at an early stage of the pubertal process. Therefore, there is no way of knowing whether the normal trajectory of the sexual and gender identity may be permanently altered.

Impact on neurocognitive development

14.38 A further concern, already shared with NHS England (July 2022) (Appendix 6), is that adolescent sex hormone surges may trigger the opening of a critical period for experience-dependent rewiring of neural circuits underlying executive function (i.e. maturation of the part of the brain concerned with planning, decision making and judgement). If this is the case, brain maturation may be temporarily or permanently disrupted by the use of puberty blockers, which could have a significant impact on the young person's ability to make complex risk-laden decisions, as well as having possible longer-term neuropsychological consequences.

14.39 The University of York's systematic review identified one cross-sectional study that measured executive functioning. This found no difference between adolescents who were treated with puberty blockers for less than one year compared to those not treated, but found worse executive functioning in those treated for more than one year compared to those not treated.

14.40 A recent review of the literature on this topic found very limited research on the short-, medium- or longer-term impact of puberty blockers on neurocognitive development (Baxendale, 2024).

Impact on subsequent genital surgery

14.41 If puberty suppression is started too early in birth-registered males it can make subsequent vaginoplasty (creation of a vagina and vulva) more difficult due to inadequate penile growth. In some transgender females this has necessitated the use of gut in place of penile tissue, which has a higher risk of surgical complications.

14.42 A recent paper suggests that for transgender females it is recommended to wait until Tanner Stage 4 to allow adequate penile growth for vaginoplasty (Lee et al., 2023).

Other physical health impacts

14.43 Multiple studies included in the systematic review of puberty suppression (Taylor et al.: Puberty suppressants) found that bone density is compromised during puberty suppression, and height gain may lag behind that seen in other adolescents. However, much longer-term follow-up is needed to determine whether there is full bone health recovery in adulthood, both in those who go on to masculinising/feminising hormones and those who do not.

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Clinical approach and clinical management

14.44 The same is true of other short-term physical effects of puberty suppression, with little knowledge about whether it leads to any long-term effects, such as on metabolic health and weight.

Prolonged exposure to puberty suppression

14.45 Puberty suppression was never intended to continue for extended periods, so the complex circumstances in which young people may remain on puberty blockers into adulthood is of concern. In some instances, it appears that young adults are reluctant to stop taking puberty blockers, either because they wish to continue as non-binary, or because of ongoing indecision about proceeding to masculinising or feminising hormones. For others, there may have been a delay in adult services taking over their care.

Summary – puberty blockers

14.46 There are many reports that puberty blockers are beneficial in reducing mental distress and improving the wellbeing of children and young people with gender dysphoria, but as demonstrated by the systematic review the quality of these studies is poor.

14.47 The Review has heard that the widespread claims that puberty blockers reduce the risk of death by suicide in this population may place pressure on families to obtain private treatment.

14.48 The Review has also heard from GPs who have been put under pressure to continue prescribing such treatments on the basis that failing to do so will put young people at risk of suicide.

14.49 The University of York systematic review found no evidence that puberty blockers improve body image or dysphoria, and very limited evidence for positive mental health outcomes, which without a control group could be due to placebo effect or concomitant psychological support.

14.50 It is important not to lose sight of the fact that hormonal surges are a normal part of puberty and are known to lead to mood fluctuations and depression, the latter particularly in girls.

14.51 It is not unexpected that blocking these surges may dampen distress and improve psychological functioning in the short-term in some young people, but this may not be an appropriate response to pubertal discomfort.

14.52 Conversely, a known side effect of puberty blockers on mood is that it may reduce psychological functioning. This variability in individual response to predicted physiological effects is reflected in the secondary analysis of the GIDS early intervention study (McPherson & Freedman, 2023).

14.53 The very strongly held beliefs amongst some young people and parents/carers that puberty blockers are highly efficacious may be attributed to a number of factors:

- the support for this position in published papers and from some clinicians working in the field
- signposted information and advice provided to children, young people and their families on the perceived benefits, including on social media
- the fact that puberty blockers have come to be seen as the entry point into and start of a transgender treatment pathway
- a lack of information about the limitations of the evidence base
- the lack of other options offered to address symptoms of distress and bodily discomfort.

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14.54 The focus on puberty blockers and beliefs about their efficacy has arguably meant that other treatments (and medications) have not been studied/developed to support this group, doing the children and young people a further disservice.

14.55 Studies should evaluate whether simple measures such as stopping periods with the contraceptive pill have the potential to manage immediate distress, as well as other more conventional evidence-based techniques for managing depression, anxiety and dysphoria. None of these alternative approaches preclude continuing on a transition pathway, but they may be more effective measures for short-term management of distress.

14.56 Transgender males masculinise well on testosterone, so there is no obvious benefit of puberty blockers in helping them to 'pass' in later life, particularly if the use of puberty blockers does not lead to an increase in adult height.

14.57 For transgender females, there is benefit in stopping irreversible changes such as lower voice and facial hair. This has to be balanced against adequacy of penile growth for vaginoplasty, leaving a small window of time to achieve both these aims.

14.58 In summary, there seems to be a very narrow indication for the use of puberty blockers in birth-registered males as the start of a medical transition pathway in order to stop irreversible pubertal changes. Other indications remain unproven at this time.

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Table 6: Critical appraisal domain scores

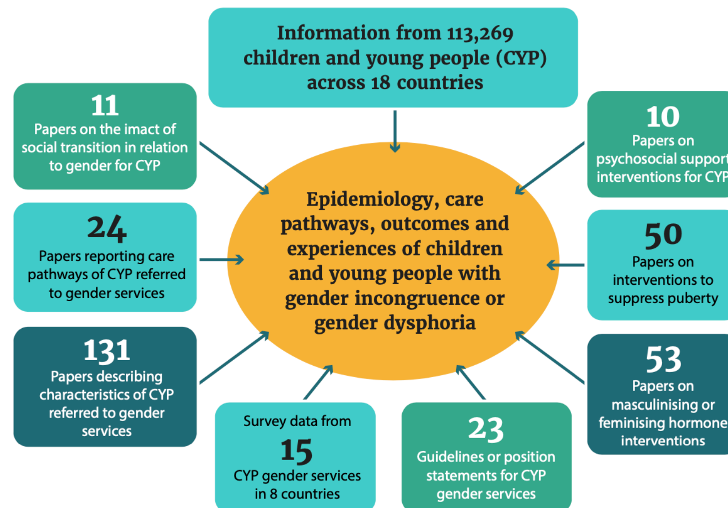
Guideline ID	Scope and Purpose	Stakeholder involvement	Rigour of development	Clarity of presentation	Applicability	Editorial Independence
AACAP 2012	65	39	44	63	7	31
American Academy of Paediatrics 2018	70	26	12	30	6	69
American Psychological Association 2015	74	74	24	50	18	14
Council for Choices in Healthcare Finland 2020	91	69	51	72	56	0
de Vries 2006	63	31	10	74	17	6
Endocrine Society 2009	65	33	44	70	22	31
Endocrine Society 2017	63	33	42	72	21	92
European Society for Sexual Medicine 2020	63	52	39	70	7	58
Fisher 2014	65	20	12	35	17	44
Health Policy Project 2015	63	63	16	24	33	6
Norwegian Directorate of Health 2020	76	81	30	57	47	17
Oliphant 2018	44	39	12	33	21	0
Pan American Health Organisation 2014	52	44	13	31	21	0
Royal Children's Hospital Melbourne 2018	81	59	19	41	19	14
Society for Adolescent Health and Medicine 2020	41	24	17	41	7	0
South African HIV Clinicians Society 2021	59	59	21	43	24	69
Strang 2018	87	31	18	37	15	19
Swedish National Board of Health & Welfare 2022	91	87	71	83	25	36
UCSF 2016	70	41	23	37	26	0
WPATH 2012	85	61	26	56	17	17
WPATH 2022	83	63	35	56	24	39

≥70%, 31%-69%, ≤30%.

AACAP, American Academy of Child &Adolescent Psychiatry; UCSF, University of California, San Francisco; WPATH, World Professional Association for Transgender Health

Source: Taylor et al: Guidelines 1: Appraisal

Figure 7: Overview of studies included in the systematic reviews, international survey and guideline appraisals undertaken by the University of York



Source: The epidemiology, care pathways, outcomes, and experiences of children and adolescents experiencing gender dysphoria/incongruence: a series of linked systematic reviews and an international survey report by University of York.

World Professional Association for Transgender Healthcare (WPATH) 8 guideline (2022)

9.26 The WPATH 8 commentary on adolescence gives a clear account of how dynamic this period of life is in terms of cognitive, emotional, gender and personal development, and how individualised that can be. The guideline also sets out some of the knowns and unknowns about the possible biological contributions to gender incongruence, as well as recent changes in how gender diverse young people present to healthcare services, and the uncertainty regarding how stable or fluid their gender identity may be.

9.27 WPATH commissioned a systematic review to underpin version 8, an approach it had not undertaken for WPATH 7. This systematic review (Baker et al., 2021) found that "hormone therapy was associated with increased quality of life, decreased depression, and decreased anxiety". However, "certainty in this conclusion is limited by high risk of bias in study designs, small sample sizes, and confounding with other interventions". The recommendation was that "future studies should investigate the psychological benefits of hormone therapy among larger and more diverse groups of transgender people using study designs that more effectively isolate the effects of hormone treatment".

9.28 The WPATH 8 narrative on gender-affirming medical treatment for adolescents does not reference its own systematic review, but instead states: "Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. A short narrative review is provided instead".

9.29 Within the narrative account the guideline authors cite some of the studies that were already deemed as low quality, with short follow-up periods and variable outcomes, as well as a selected account of detransition rates.

9.30 WPATH 8 concludes in its statement on the use of gender-affirming medical treatment that: "The evolving evidence has shown a clinical benefit for transgender youth who receive their gender-affirming treatments in multidisciplinary gender clinics (de Vries et al.., 2014; Kuper et al.., 2020; Tollit et al., 2019)".

- De Vries et al. (2014) is the original study of the Dutch protocol sample, which has marked differences to the population being treated currently, and as discussed had much stricter criteria for treatment.
- Kuper et al. (2020) is a study with a one year follow up that showed very modest change. It fell into the group rated by the University of York research team as too low quality to be included in their synthesis of evidence on masculinising/feminising hormones (Taylor et al: M/F hormones).
- Tollit et al. (2019) is a study protocol and does not include any results.

9.31 The systematic review commissioned by WPATH is referenced in the chapter on WPATH 8 standards as one of several references in support of the statements that "There is strong evidence demonstrating the benefits in quality of life and well-being of gender-affirming treatments, including endocrine and surgical procedures, properly indicated and performed as outlined by the Standards of Care (Version 8), in transgender people in need of these treatments" and "Gender-affirming interventions are based on decades of clinical experience and research; therefore, they are not considered experimental, cosmetic, or for the mere convenience of a patient. They are safe and effective at reducing gender incongruence and gender dysphoria".

9.32 Clinical consensus is a valid approach to guideline recommendations where the research evidence is inadequate. However, instead of stating that some of its recommendations are based on clinical consensus, WPATH 8 overstates the strength of the evidence in making these recommendations.

Swedish (2022) and Finnish (2020) guidelines

9.33 The Swedish guideline took a different stance to WPATH 8 based on three considerations:

- The change in epidemiology and lack of understanding of the cause of the more recent presentations to gender services.
- The lack of clear data on how frequently detransition or regret occurs in young adults.
- A re-evaluation of the evidence base through its own systematic review, which demonstrated uncertainty about the strength of evidence in favour of gender-affirming care. It was also noted that previous guidelines relied much more heavily on expert opinion rather than on systematic reviews of the evidence.

9.34 Based on the above considerations, the Swedish guideline recommended that medical treatment should follow the original Dutch criteria and should only be given under a research protocol, or in exceptional circumstances.

9.35 The Finnish guideline had reached similar conclusions on the uncertainty of the evidence and proposed extreme caution in relation to the use of puberty blockers in young people under the age of 18, also reverting largely to the original Dutch entry criteria. The guideline recommended that puberty blockers should be administered under the supervision of the national specialist clinic.

Key points of learning for the NHS

9.36 The University of York has produced a narrative synthesis of the guidelines (Hewitt et al: Guidelines 2: Synthesis). Relevant information from this synthesis can be found in later chapters in this report.

9.37 It was clear from the guideline quality appraisal process that no single guideline could be applied in its entirety to the NHS in England, although some had useful and transferrable recommendations that have been incorporated where consistent with the rest of the Review's findings.

9.38 The Review has based its recommendation on its commissioned systematic reviews, advice from clinical experts across a range of relevant areas in the care of children and young people with gender dysphoria and in other relevant and important areas of child and adolescent health, as well as on the mixed methods approach to stakeholder engagement described earlier.

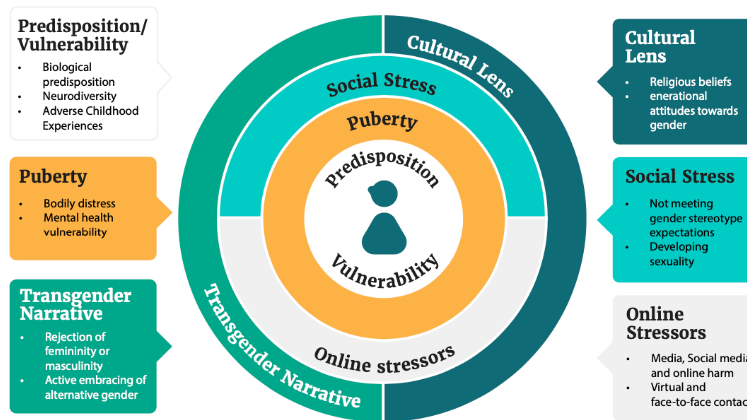
9.39 When the new clinical services are well-established and there is further available evidence, it may be possible to employ more formal guideline development approaches to those aspects of gender-related care that still remain contested.

Conclusion

8.52 There is broad agreement that gender incongruence is a result of a complex interplay between biological, psychological and social factors. This 'biopsychosocial' model for causation is thought to account for many aspects of human expression and experience including intelligence, athletic ability, life expectancy, depression and heart disease.

8.53 Figure 27 demonstrates how in any one individual, gender incongruence and/or dysphoria may be a result of one or two factors, or it may result from a series of factors that underpin a young person's experience and sense of self.

Figure 27: Complex interplay between biological, psychological and social factors



Presentation will vary with each individual

Illustrative examples

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