

An epidemic of 'childhood gender dysphoria' is sweeping the Western world. Having exploded from rarity less than a decade ago, **there is now an exponential increase in the number of children being presented to specially created units in major children's hospitals with the complaint 'they have been born in the wrong body' and 'belong' in that of the opposite sex.**

The good epidemiological news is that most children confused about their gender will orientate through puberty to the one with which they were born. In the great majority, nature's innate chemical and hormonal processes can be depended upon to do their job.

This statistical assurance is, however, not heeded by some professionals who feel bound to introduce the affected child to a medical pathway that commences with the psychological strategy of social affirmation in the role of the opposite sex: names, pronouns, hairstyles, dress and toileting facilities of the opposite gender are supported (if not enforced) by the authority figures in the child's life: parent(s), teachers and peers.

Such programming is likely to lead to the next stage of therapy: the administration of drugs to **block the natural process of puberty** with the expressed intention of giving the child more time to contemplate his or her gender and procreative future.

Most children who are 'blocked' then progress to the next stage of therapy, the administration of **cross sex hormones** to evoke physical characteristics of the opposite sex. This escalation may then proceed to **surgical intervention** in further pursuit of those opposite characteristics. In this stage, for example, natal girls may undergo **bilateral mastectomy**.

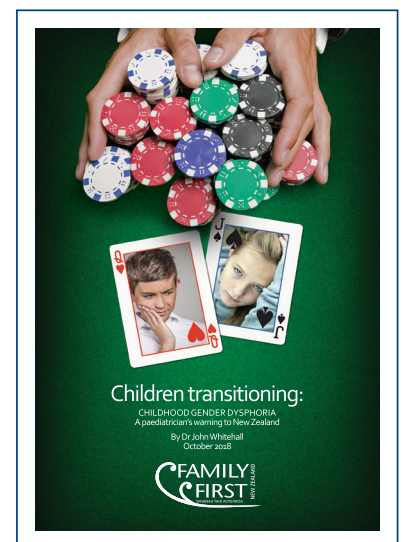
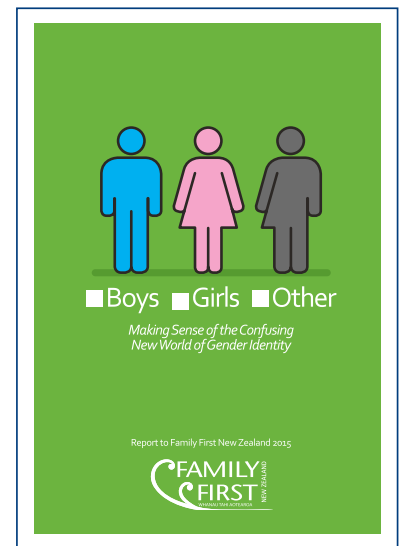
The final stage of the medical pathway is the lifetime of supervision of the effects of **unnatural hormones**, whatever **urogenital surgery** was attempted and whatever **psychological problems remain**. In this process of 'transformation' to the opposite sex, castration is inherent.

Such a massive intervention into the minds and bodies of children could be expected to be based on a concrete body of scientific experimentation but, astonishingly, that is not the case.

There is no biological basis to the confusion over gender: it has the hallmarks of a psychological fad, fanned by an uncritical, sensationalist media, given direction by private websites and even government funded programmes of 'education' (Mates and Dates, InsideOut, Sexuality Road) and encouraged by peer pressure.

Sadly, the most vulnerable of children appear to be at particular risk: numerous reviews reveal the majority of children confused about their gender also suffer from diagnosed mental disorders, such as depression and anxiety. Moreover, there is an extraordinary representation of children with Autism Spectrum Disorder whose appreciation of reality is already known to be challenged.

Proponents of the medical pathway declare it is necessary to prevent suicide but, again, **there is no evidence that gender dysphoria in children, per se, is associated with a higher risk of suicide.** The accompanying mental and family disorders, however, are known to be associated with self-harm and, therefore, an affected child (and family) deserves close attention and compassion.



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As suicide rates in transgendering adults are reported to be at least 20-times that of the general population, perhaps suicide may be prevented by **compassionate 'watchful waiting'** for the natural effects of puberty to orientate the child in the direction of its chromosomes, while applying standard therapy to the associated mental disorder.

Proponents of the pathway declare the blocking of puberty to be 'safe and entirely reversible', but review of adults administered 'blockers' to reduce the production of sex hormones considered to be stimulating abnormal cell growth (as in prostate cancer in men and endometriosis in women), has suggested interference with brain function, which has been confirmed in veterinary studies.

These side effects are not mentioned by proponents who argue blocking puberty provides opportunity for the child to consider its sexual identity but **how can this occur when the natural process of sexualisation within the brain and the body is blocked?**

Proponents argue that bilateral mastectomy may be performed on confused girls to help them approximate the bodily dimensions of a male. Proponents offer the sophistry that these effects are 'reversible', as if breast feeding was irrelevant and all that mattered was siliconised shape.

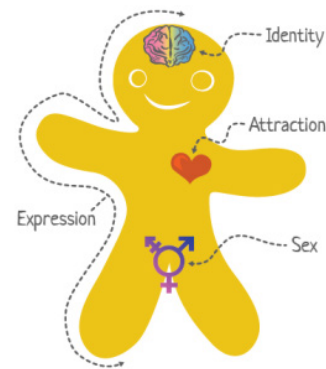
There is no scientific evidence in medical literature to support the massive interventions of the medical pathway. To the contrary, there are multiple expressions of the need for evidence, and lamentations about its lack. Society and governments are being led by so-called 'expert opinion'.

The phenomenon of childhood transgendering sweeping the Western world has an ideological base: 'gender fluidity' which maintains no such thing as binary differentiation of the sexes into males or females: everyone exists on a 'locus' or spot within a rainbow of gender identity depending on inner conviction. Moreover, this locus is not necessarily fixed, and gender identity can change according to the vagaries of inner feelings.

This ideology of gender fluidity is gaining power exponentially. Only a few years ago, the declaration that there were no such entities as girls and boys might have been received with forbearance fitting fantasy of a flat earth. But things are different now and, in many countries, there are many true believers. Perhaps reflecting depth of conviction, or maybe insecurity, believers have enjoyed much success in convincing lawmakers (and other authorities) to compel compliance with their ideas. **Evangelism is being buttressed by coercion.**

The warning to New Zealand is that the massive intervention in the minds and bodies of children inflicted by the medical pathway of transgendering has no scientific basis. **The medical pathway is based only on ideology, and claims of 'success' reflect beliefs, not science. Even worse, these beliefs are not negotiable: they have become coercive.**

The Genderbread Person v1 by its pronounced METROsexual



Identity ≠ Expression ≠ Sex
Gender ≠ Sexual Orientation

Sex Assigned At Birth
 Female Intersex Male

Used by programmes in New Zealand schools

FAST FACTS

- One study showed that when a teen announced their transgender identity to their peer group, the number of friends who also became transgender-identified was 3.5 per group.
- In just eight years, there has been a 2,500%-plus increase in children seeking treatment for sexual identity confusion in the UK, and a 4,400% increase for girls being referred for treatment.
- Up to 98% of children who struggle with their sex as a boy or a girl come to accept their sex by adulthood.
- Identifying as transgender or non-binary may be linked to autism spectrum disorders. Children with autism spectrum disorders are seven times more likely to want to be the opposite sex than the general population.
- After sex reassignment surgery, transgender-identified people are nearly 20 times more likely to die from suicide than the general population.
- Studies show that 100% of children who use puberty blockers will go on to use cross-sex hormones, leaving them permanently sterile.
- In the US, girls as young as 13 are undergoing double mastectomies and boys as young as 17 are undergoing full-genital sex reassignment surgeries.
- The long-term effects of puberty blockers and cross-sex hormones have not been studied.
- Science demonstrates that there are two sex chromosomes – two X chromosomes in females or an X and a Y in males - in nearly every single cell in our bodies.
- Some transgender-identified patients are being prescribed cross-sex hormones on their very first visit to a clinic.

[This summary is based on articles written by Dr John Whitehall - Professor of Paediatrics and Child Health in Australia. He is the author of Family First's report "Children Transitioning: Childhood Gender Dysphoria – A paediatrician's warning to New Zealand"]