

THE GENDER TRAP



**THE TRANS AGENDA'S
WAR AGAINST CHILDREN**

BY CARLA CURTIS



Praise for *The Gender Trap*

Carla Curtis covers extensive ground in her powerful in-depth coverage of modern-day and antiquated gender myths. Her thought-provoking book brings understanding to how the resurgence of inflexible stereotypical gender roles is causing less freedom, less acceptance, and more regression and harm to anyone who does not fit nicely in the conventional female or male box. A must-read.

—*Erin Friday, Esq.*

*co-lead of Our Duty USA (www.OurDuty.group/usa) and
Protect Kids California (www.ProtectKidsCA.com),
support networks for parents who wish to protect their children from
gender ideology*

Parents deserve accurate information when making decisions for their children and unfortunately American medical institutions have not been honest with them about the harms of puberty blockers and cross sex hormones. I am incredibly thankful for all of the members of Gays Against Groomers standing in solidarity with Moms for Liberty as we work to protect all of our children. *The Gender Trap* brilliantly lays out the case as to why transitioning children is the greatest medical abuse scandal we have ever seen in our country. I believe that when parents have accurate information about the irreversible harms of these drugs and surgeries, we will see a drastic drop in the amount of parents agreeing to put their children through it.

—*Tiffany Justice*

*award-winning journalist and
co-founder, Moms for Liberty (www.MomsForLiberty.org),
an organization that stands up for parental rights at all levels of government*

Gender ideology is a regressive, homophobic cult, teaching vulnerable kids who defy stereotypes that they might have been born in the wrong body. It especially preys on children with autism, and those who would grow up to be gay. *The Gender Trap* beautifully lays out everything you need to know to protect your kids from the greatest child abuse scandal in modern history.

—*Chris Elston (Billboard Chris),*

activist and gender dysphoria critic (www.BillboardChris.com)

It's about time this book got written. A radical, destructive movement that targets our children and our society has taken over, and it has done so by hiding behind the good names of gays and lesbians around the world. This book is a clear explanation and a much-needed antidote to this wicked movement in our society.

—*James Lindsay, Ph.D.*

author and social critic,

founder of New Discourses,

and co-author of Cynical Theories: How Activist Scholarship Made Everything About Race, Gender, and Identity—and Why This Harms Everybody

I'm old enough to remember how absolutely awful gay conversion therapy was—as though through therapy, someone could be somehow talked out of being gay. Jump to 2024, and there seems to be little to no discussion in the medical community or society at large about how much worse and evil are today's child surgical mutilations and chemical conversions called puberty blockers (repurposed castration drugs). Laying out the history and science debunking the most stereotypical nonsensical reasoning for these drastic life-altering procedures that were literally laughed at only a few short years ago—namely that only boys play with trucks and only girls play with dolls—Carla Curtis of Gays Against Groomers methodically breaks down the myths and cuts through the lies of medicine's biggest malpractice and crime since lobotomies.

—*Rob Schneider*

American actor, comedian, screenwriter, and director

This book helps readers demystify gender ideology and its pervasive institutional capture of all aspects of American life.

—*Andy Ngo*

Journalist and author

There aren't many groups braver than Gays Against Groomers. Imagine the threats they get and the abuse they take. Who'd sign up for something like that? Only someone who really meant it, and who understood the stakes. The rest of us ought to be grateful for what they've done—and for this book.

—*Tucker Carlson*

American political commentator and author

The Gender Trap

**The Trans Agenda's
War Against Children**

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Gays Against Groomers Publishing

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Second Printing

This book is dedicated to all people
who have the courage to live and love
with the bodies they were dealt,
and who do not see themselves as victims,
but instead approach life
with grace, discernment,
and reverent respect.

Acknowledgements

It's not often that I, as a writer, feel that my words are inadequate. But to say that I appreciate the enthusiastic support of Gays Against Groomers is an understatement. My most heartfelt thanks go to a small but dynamic core group. Their excitement about this manuscript has given me inspiration and energy to expand, organize, and polish it in ways that I otherwise would not have. It has truly been a privilege getting to know some of these extraordinary people.

Robert Wallace, with his generous welcoming spirit, was my initial contact with Gays Against Groomers. His passion for saving children, spiritual development, and serving the general public through many different venues has led to his hosting *The Dark Side of the Rainbow* podcast. Robert was also featured in the must-see 2024 documentary, *Beneath Sheep's Clothing*.

Michael Costa, head of Gays Against Groomers Publishing, impressed me with his encyclopedic grasp of research and legislation. I greatly enjoyed our exhilarating talks, which reminded me of an earlier (and saner) era. Michael's encouragement, eloquence, and always candid editorial advice helped make this a better book. I also thank his team of volunteers who spent many hours proofreading.

Nicolas Blooms, wise beyond his years, lovingly and patiently held my hand while I navigated the typesetting program used for this manuscript. He offered not only assistance, but friendship. I will always treasure his luminous presence.

Sasha Leigh brought the same skill to the book's distribution that she devotes to Gays Against Groomers in her role of Executive Director and Treasurer. I am truly in awe of her organizational talent and am very grateful for her assistance.

Last but not least, I thank graphic artist Jaimee Michell, who not only designed the cover for this book, but is the inspired founder of Gays Against Groomers and created its spectacular logo. Since its inception in 2022, Gays Against Groomers has made a considerable impact on public awareness and convinced lawmakers to pass legislation that safeguards children from physical and psychological harm. I deeply appreciate Jaimee's tireless promotion and masterful outreach to ensure that *The Gender Trap* reaches a diverse and wide-ranging audience.

As appreciative as I am to Gays Against Groomers members for their support and material assistance, I am also indebted to them on a deeply personal level. Their insight, bravery, and unwavering commitment to the truth have given me hope for the future of humankind. Thank you for helping to save our children.

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Foreword

When I founded Gays Against Groomers in 2022, I had no idea it would become the powerful force it is today. I began the organization because I could no longer stand idly by as a full-scale assault on children unfolded before my eyes, and I figured it was time to stand up and fight back. Our organization serves as a rallying cry from *within* the gay community. We needed a movement with *teeth*—one that loudly advocates not only for equality but also for the well-being of society as a whole. It is a call to action against a system hell-bent on sexualizing, indoctrinating, and mutilating children. Gays Against Groomers is on a mission, and we will not stop until the war on children is ended.

The heart of our advocacy lies in safeguarding children from irreversible harm. What masquerades as “gender-affirming care” is, in actuality, an attempt at conversion—and is a form of medical abuse. Subjecting children to procedures that rob them of their identity and sterilize their bodies is morally bankrupt. The ramifications last a lifetime. Through legislative action and grassroots efforts, we’ve done outreach, disseminated information, and helped pass laws to prohibit these barbaric practices. As of this writing, twenty-two states have passed legislation to ban the sexual mutilation of minors—rightfully so. And we are working to get legislation passed in every state of the U.S.

The so-called scientific research supporting this medical malpractice of transgendering is riddled with faulty statistics and ideological biases. These lies have become perceived as facts due to their propagation by non-governmental organizations (NGOs), which have created a framework that is not grounded in physical reality. In less than a decade, the medically abusive practices have already had disastrous consequences on the gay community and on an entire generation of children. This book provides a thoroughly cited compilation of data and studies on the topic, offering an accurate understanding of the current state of affairs.

When Carla Curtis approached us with her manuscript, she was concerned that its candid language might deter publishers. It was difficult for her to find a platform for her unapologetic narrative, and she sought a home for her work among those unafraid to confront uncomfortable truths. We embraced Carla’s project wholeheartedly, driven by our dedication to showing people the truth, regardless of potential backlash or hurt feelings. In *The Gender Trap*, Carla Curtis delivers a brilliant biopsychosocial analysis of sex and gender, delving into the corrupt underpinnings of gender ideology while shedding light on the need to separate gay liberation from trans activism. Curtis exposes how the trans agenda is the most anti-gay movement of our time, utterly antithetical to the very essence of gay liberation. Carla Curtis’s personal history, rooted in both women’s rights and gay and bisexual activism, gives her a unique perspective on the societal onslaught of gender ideology. Drawing from decades of experience, she navigates

the gender war with unwavering honesty, acknowledging that not every reader will agree with every point presented. Yet *The Gender Trap* still offers something unique and valuable for everyone—mothers, fathers, women, men, therapists, gays and lesbians, heterosexuals, detransitioners, and especially individuals who are questioning their identity. Throughout these pages, Curtis explains the incontrovertible facts of biology, leaving no questions unanswered. She reveals the fallacies perpetuated by the trans agenda and analyzes its insidious nature and dire consequences, particularly for children. She exposes the dark forces and financial interests driving the trans agenda. And she dismantles the ideological biases that have allowed the radical transgender movement to thrive.

The Gender Trap stands as a reminder that there is nothing hateful about speaking the truth, nor is there anything wrong with clarifying and defending biological reality. The timely and urgent publication of this book cannot be overstated. As gender ideology permeates and erodes the fabric of our institutions, wreaking havoc and silencing dissenting voices, *The Gender Trap* stands as a fearless reminder that tyranny cannot prevail, and gives readers the inspiration to speak out against the encroachment of the trans agenda—either through individual acts of courage, or with the support of groups like Gays Against Groomers. This book urges us to stand united in our commitment to a future grounded in rationality, where “equality” and “discovering one’s identity” do not occur at the expense of society’s most vulnerable.

The Gender Trap is a testament to the resilience of the gay community that, even in the face of adversity, is unwilling to make peace with a belief system that puts children in danger. The talented members of Gays Against Groomers who brought this project to life refuse to sugarcoat the horrors of the biggest medical scandal since the lobotomy, thus giving a voice to the millions of gay people who disagree with the human atrocities being pushed in their name. This is *our* side of the story—one grounded in facts, not propaganda. As the trans agenda crumbles under the weight of its own corruption, *The Gender Trap* stands as a beacon of hope for those who refuse to comply with or blindly follow a destructive path. Let this book serve as a *public record* of our refusal to surrender to tyranny. And let *The Gender Trap* be testimony to our resistance against an agenda that threatens to undermine the progress we have fought so hard to achieve. The time to speak out is now—and this written masterpiece provides the platform for those voices to finally be heard.

Jaimee Michell
 Founder, President & CEO
 Gays Against Groomers

Introduction

The second wave women's liberation movement, which began in the 1960s and gained momentum well into the 1980s, had many facets to it. "Equal rights for women" meant that women deserved the same pay as men for equivalent work. Women also demanded opportunities for professional advancement based on their skill and competence rather than their reproductive organs. Intimate connections were not exempt from scrutiny, either: Women wanted sexual relationships based on mutual caring and respect between peers, without coercion. Behind all these demands for change, the one unifying question—which we are still grappling with today—was what it meant to be male and what it meant to be female.

Back then, there was no aspect of living that sexual stereotypes didn't touch: work, play, education, entertainment, relationships. Both women and men grappled with society's expectations of what was supposed to be the correct behaviors and aspirations for each. As studies showed, women were assumed to be passive and men, assertive. Women were emotional and even hysterical, while men were rational and often stoic. Women could be nurses but it was not common for them to be doctors, and for men it was the opposite. It wasn't considered feminine for women to be corporate executives, just as it wasn't considered masculine for a man to be happy at home changing diapers while his wife was out working. It was widely assumed that males and females had different aptitudes. Males were perceived as better at science and math while females were understood to be more verbally skilled. These beliefs, which feminists called "sex role stereotypes," were so ingrained that they were accepted as immutable. A few innovative scholars pointed out that studies intended to detect differences in mental capacities between men and women contained inherent design flaws. Researchers selectively presented data from their experiments that confirmed only what they already believed. As it was eventually discovered, which I'll address in detail in Chapter 2, a great deal of scientific bias was indeed forcing both females and males into a box. Educational institutions, aligned with the bias of scientists, were eager to reinforce sex roles—to the detriment of everybody. Even the entertainment industry promoted stereotypes. In films and television, caricatures of women and men were almost constantly pitted against each other. The hostility between them, called "the battle of the sexes," was callously encouraged by the media as coy entertainment.

Adherence to sex role stereotypes played a huge role in society's intolerance of homosexuality. By definition, a romantic relationship consisted of polar opposites—someone who was masculine (a male) and someone who was feminine (a female). But if both partners in a couple were men or both partners were women, who was the male and who was the female? It was a confusing time indeed for those whose lives were based on faithfully adhering to culturally

defined sex roles. Stereotypes informed everything that we were taught about how the world was supposed to operate. Although culturally assigned scripts often conflicted with who they actually were, both men and women felt obliged to follow them to be accepted—or at least achieve the appearance of respectability.

Second wave feminists worked as hard as they did to eliminate sex role stereotyping because they wanted to ensure greater freedom of choice in all areas of life, both professionally and personally. Increasing numbers of women became doctors rather than nurses, and corporate executives instead of secretaries. Men began to relax as the burden of earning a living for an entire family was shared by their spouses. As more men explored their emotional lives—realizing that they could retain their strength and self-respect while allowing themselves to be more emotionally vulnerable—they discovered the fulfillment that greater intimacy with their partners and friends could bring. Some women started feeling more comfortable with their choice not to have children at all. And an admittedly small handful of fathers stayed home with their sons and daughters while their wives worked outside the home. Men who supported the women's liberation movement understood that sex role stereotypes were unfair to everyone, not just women. We don't hear much today about the pro-feminist men's movement, but back then it had considerable visibility and was a powerful catalyst for the personal growth of men and boys.

Sadly, the progress that women and men made is not only at a standstill today, it's backsliding. Just when our culture was becoming more balanced, a sabotage of enormous magnitude began to occur. We no longer hear the phrases *sex role stereotypes* or *gender roles*, which had been used by feminists to mean the same thing. Instead, *gender* is now being used to designate someone who is either biologically male or female—a confusing and deceptive replacement for the uncomplicated and straightforward word *sex*. This linguistic shift allowed biological sex (someone is male or female, based on their reproductive organs) and sex roles (different behavior and aptitudes expected for males and females) to merge into the single word *gender*. This merging of two distinctly different concepts has not only caused enormous confusion for both the lay public and scientists, but it serves an insidious agenda. If people—young people especially, born post-1980 after the second wave feminist movement was dwindling down—conflate biological sex with sex roles, and their interests don't fit the conventional roles that they're taught belong to a specific set of reproductive organs, then surely they must be in the wrong body. Now the sabotage, for which the ground had been carefully cultivated, can be seen in stark relief. It's none other than the rapidly growing radical transgender movement, whose entire reason for existing is to convince the public—especially children, who grew up with the linguistic deception—that they need to change their bodies to fit their preferred roles.

The word *transgender* comes from the Latin *trans*, which means “across,” “beyond,” “through,” “on the other side of,” “to go beyond,” and *gender*, which (depending on the source) refers either to the behavioral, cultural and

psychological traits typically associated with one sex, or to one's biological sex itself.¹ People who consider themselves transgender say that they do not mentally or emotionally identify with their natal bodies, the biology they were born with. A man will insist that he is actually a woman, while a woman will declare that she is in fact a man. Very young children are especially vulnerable to falling prey to this mindset, as verified by a number of internet videos featuring boys who state with complete conviction that they are really girls. With their long hair, frilly dresses, and angelic pretty faces untouched by the onslaught of pubescent hormones, they certainly look the part. But transgenderism constitutes much more than dressing in clothing commonly ascribed to the opposite sex. In an effort to cosmetically transform their bodies, people are taking hormones in massively larger amounts than what their own bodies naturally produce and were innately designed to handle. Many are also receiving surgery. Women who want to be men are having their breasts removed, and men who want to be women are receiving breast implants. In addition, a small percentage of men and women are undergoing even more radical plastic surgery. Genitals are remodeled, reshaped, or removed. Some subjects are even having their faces sculpted. A surgeon might shave off part of a man's Adam's apple, chin and brow to create a softer look, or augment the chin line of a woman to create a more chiseled appearance.

Transgenders, who are regularly being spotlighted in the news today, haven't always been this visible. In the mid-1950s, a man who became known as Christine Jorgensen was the first well-known recipient of sexual "reassignment" surgery in the United States. The mid-1970s featured MtF (male-to-female) transgender, Renée Richards, who competed in women's professional tennis amid much controversy. In 1979, one of the first critiques of the practice of transgenering was published: Janice Raymond's *The Transsexual Empire: The Making of the She-Male*. The publication of Raymond's book reflected, as well as inflamed, the intense disagreements among feminists about allowing transsexuals (as transgenders were known at that time) in women-only spaces. Lesbian feminists especially opposed the presence, and even the concept, of trans "women." Nevertheless, in the 1980s and 1990s, organizations of gay men and women chose to form an alliance with people who identified as trans. All of the so-called sexually deviant minorities, as the majority culture saw them, were lumped together—even though sexual orientation (designating to whom one is sexually attracted) is not the same as actually perceiving oneself as the opposite sex. Appended to the acronym LGB, short for "lesbian, gay and bisexual," was T for "transgender." Still later "queer" was added, resulting in LGBTQ.

That string of letters keeps getting longer as more labels are deemed necessary, but it was the "T" in that political alphabet soup that began to turn back the clock at warp speed. Documentaries extolled boys, girls, men and women who came out as transgender. There was a proliferation of websites advising adults and even children how to manifest their true trans selves—in other words, take high-dose hormones and undergo surgery to alter genitals and perhaps other body parts.

Transgenderism was celebrated as a courageous act of liberation when in fact it was based on a slavish adherence to sex role stereotypes. These stereotypes, which for so long had so rigidly circumscribed men's and women's behaviors and goals—and from which people were finally starting to break free—returned with a vengeance.

In 2014, Sheila Jeffreys published her well-researched book *Gender Hurts: A feminist analysis of the politics of transgenderism*. Jeffreys focused chiefly on the psychological and social damage to straight and gay women that transgenderism causes. Not surprisingly, transgenders found her book highly controversial and tried to silence her. In 2020, Abigail Shrier's *Irreversible Damage: The Transgender Craze Seducing Our Daughters*, focused on how social media, peer pressure, and negative attitudes toward maturing encourage thousands of teenage girls to wish they were boys, and how the medical industry is happy to oblige. The author did not condemn transgenders per se; in fact, she pointed out that she became friends with several trans individuals. Her focus was strictly on impressionable teenage girls who are too young to understand the ramifications of receiving dangerous levels of hormones and life-altering surgery at a young age. Nevertheless, like the authors before her, Shrier was maligned by radical trans activists and unfairly branded as transphobic (the fear or hatred of transgenders). In 2023, psychiatrist Miriam Grossman published *Lost in Trans Nation: A Child Psychiatrist's Guide Out of the Madness*. Dr. Grossman emphasized the dangers of cross-sex hormones and genital surgeries to help parents and children understand what they're getting into should they decide to follow the transgender path. Critics of the trans activist agenda—medical professionals, psychotherapists, journalists, and even some transgenders themselves—are continuing to speak out against attempts to indoctrinate impressionable children. People who had started or completed the transgendering process and then decided that it was a mistake, are also coming forward.

Why has there been an explosion of transgenderism in the last decade? Who is ideologically and financially behind the trans movement? What is the proper medical procedure for evaluating people in a gender "reassignment" clinic and what is actually occurring? What kinds of medical, psychological, and social problems plague people who believe that they're trans—and what problems existed before the individuals even began their trans journey? What are the negative effects and complications of cross-sex hormones and surgeries—complications that most medical professionals are reluctant to disclose? Most importantly, what makes children, teens, the gay community, and people with ambiguous genitalia especially vulnerable to the trans agenda? How are they being convinced they're the opposite sex, and how can we counteract that manipulation? Finally, what do we need to know in order to help people feel whole and accept themselves, so that hormones and surgeries are not considered necessary?

My search for answers led me to a wide range of disciplines: biology, physiology, medicine, psychology, sociology, politics, feminist history, and even

economics. The answers are complex and multifaceted. But what consistently appears as the key to advancing the transgender scheme is sex role stereotypes, which some people simply call “gender.”

We cannot understand or resist transgender ideology unless we have a grounding in basic science. Part I, “Biology,” is devoted to the sexual development of males and females. The data I summarize describes differences between the sexes on chromosomal, hormonal, biological, anatomical, and physiological levels. There are psychological differences, too, but these are often exaggerated by environment and upbringing, and what those differences are depend on the culture in which one is raised. Scientific researchers, themselves products of stereotyped upbringing, almost always allow cultural bias to color their experiments—which means that conclusions about sex-linked differences are not necessarily correct. That is why I devote considerable space to discussing brain research, including the science of epigenetics that shows the enormous potential for mental flexibility. Vital to this section is a discussion of people whose genitals don’t conform to rigid and arbitrary standards of appearance and as a result, have become casualties of gender stereotyping in palpably cruel ways.

Part II, “Culture,” explores important differences between sex (biology) and gender (societal beliefs). Some studies that were intended to settle the “nature versus nurture” debate yielded unanticipated results, very different from what the experimenters had expected to find. Research on boys’ and girls’ aptitudes in math, science, spatial acumen, and verbal skills shows how the prejudices of parents and teachers reinforce boys’ and girls’ weaknesses as well as their strengths. There are many assumptions we make about the emotional lives of boys and girls and men and women, and this too is explored in depth. Also covered are biases against males and females in the professions, and how the clothing we wear defines us. Finally, I discuss sexual orientation and the connection (or lack of it) between transgenders and the gay community, whose members are dwindling as a result of the trans agenda.

Each of the many chapters in Part III, “The Trans Agenda,” details an aspect of transgender life. In order to craft a body intended to resemble that of the opposite sex, immense medical manipulation is involved. Taking high doses of hormones and undergoing sexual “reassignment” surgery are not only dangerous, but they have complicated and far-reaching effects. Becoming a transgender, which can happen only slowly over time, requires immense effort, dedication, and financial resources. It also involves unimaginable physical pain, even under the most favorable circumstances when there are no complications from surgery. Mental illness, gender dysphoria and trans suicide are discussed, and some of the data may surprise you. The question “Why would someone want to transition?” is addressed as well. The reasons are complex. Because the reasons are different for boys, girls, men and women, I give each group its own section.

Part III also devotes a chapter to detransitioners—people who started to transition, and then decided they weren’t transgender after all. The poignant

personal accounts will move you. These accounts describe unhappy childhoods and sometimes sexual trauma, but what they all have in common is extreme psychological manipulation. Anyone who's considering making a radical change to their body will want to read what these detransitioners faced. Another chapter discusses some of the people and institutions behind the trans movement—among them, powerful and wealthy politicians (one of them a well-known transgender individual)—who fund hospitals, clinics, mainstream media, schools, universities, and other institutions. Finally, in Part III, I discuss ways in which those who object to the trans movement are being deliberately misrepresented, threatened, undermined, and silenced. Various forms of manipulation, rather than being random, have been systematically and steadily occurring for some time. Because language directly informs how we see the world, the trans strategy relies heavily on the manipulation of language. Some of the language has become so entrenched that the indoctrination has become invisible. The deconstruction of these linguistic mind games will help you resist the trans agenda. Close accomplices of this agenda, educational institutions, are also using such tactics. But they are also destabilizing students in other ways—ways that are so insidious, it can be hard to recognize them. After reading this section, you will understand the extent to which this agenda has taken hold, and will be able to take steps to diffuse the numerous attempts that are being made to cripple our nation's youth.

Solid research continues to show that most people who are drawn toward transgenering need counseling, not hormones and surgery. Part IV, "Healing," addresses in detail what happens to us—emotionally, physically, mentally, energetically, and spiritually—when we are not willing or able to face difficult experiences and traumas. The section on how to help those considering transition contains a list of carefully worded questions that parents can ask young children and teens and adults can ask themselves, with additional questions that can be introduced by experienced psychotherapists. These questions are designed to help people break free of stereotypes and access the root causes of why they might wish to escape their body. Prospective trans candidates who contemplate these issues will think hard about making decisions that are likely to impact them negatively for the rest of their lives.

There are two chapter-long appendices related to the main topic of this book. Appendix A is for readers who wonder how—from the time of the second wave feminist movement—we regressed from approaching a more egalitarian climate to the current backlash against both women and men. A half century ago, while some issues did elicit passionate debate, the dialogue was much more rational than it is today, where it's becoming increasingly common to malign a person simply for possessing a penis. I am of course, referring to the practice known as male bashing. In addition, I address not only toxic masculinity but also toxic femininity—because in our polarized world, neither can exist without its counterpart. The selective aborting of female fetuses is discussed in depth as well as rape, which unfortunately is now being widely perpetrated on both sexes. In

today's climate, there are many institutionalized ways in which people mistreat each other irrespective of sex or gender roles.

Appendix B is devoted to the ramifications of transgenders infiltrating amateur and professional sports for both females and males. This includes biological men who claim to be transgender or "identify" as female, and compete against natal women. Intersexuals are included in this discussion—an even more complex and multifaceted issue that requires some novel analysis and out-of-the-box thinking.

During the writing of this book, I thought a great deal about my readers. People from all walks of life, of all ages, races and sexual orientations, and across the entire political spectrum, are recognizing the dangers of the trans agenda. But with such a diverse audience, it can be difficult to use language with which everyone agrees or feels comfortable. I have done my best to clearly define terms and concepts so there can be no mistake about my intentions. However, because in today's climate there can be so much misunderstanding, I want to make some additional points now.

The following remarks are directed to women, some of whom may consider themselves feminists. In the past, the biological, physiological, and psychological differences between women and men have been both exaggerated and minimized by women's rights advocates. These two extreme positions, while contradicting each other, have always shared the goal of helping women attain full social, professional, legal, and sexual equality. While it was incorrect to claim that sex-linked differences were essentially nonexistent, this was done because of the valid fear that differences (including reproductive functions) would be used to justify the subordination of women. I need to emphasize that whatever differences do exist do not indicate value judgments of better or worse. Nor do they justify mistreatment or the withholding of opportunities. It's important for women to remember this, even if some institutions and individuals still behave as though females are inferior and disposable.

My next comments are directed to men, especially those who have negative associations with feminism. When I participated in the second wave feminist movement, I was gratified and uplifted to see men work alongside women. Everyone recognized the common goal: to promote respect between the sexes and more freedom and opportunities for everyone. But those were very different times. As I will show in later chapters, the political machine that has financially supported radical trans activists has also infiltrated virtually every aspect of our lives, including the feminist movement. This same machine also owns mainstream media. That is why television programs, movies, and even advertisements have started to portray men in a disparaging manner. And it's why we are seeing an increase in the belittling and demonizing of males, especially white males. There is also a very small but vocal minority of women who are bashing males. They see all men through the most extreme stereotype and regard every problem in the world as exclusively the fault of men. These saboteurs are not feminists and they do not represent the majority of females. However, their visibility is sowing the

seeds of distress and hatred. I am asking men to keep in mind that none of the divisive elements represent, or speak for, those of us who are trying to implement genuine positive change. If men can avoid being baited, they can utilize the power they still have in the world to help humanity through some very rough times.

The one question I keep asking throughout this book is why we must automatically accept gender roles as an inevitable and necessary part of life. To some readers, questioning sexual stereotypes—or disregarding them entirely—may feel like a defiance of the laws of nature. But as I will show in many ways, human beings have the capacity to express an almost unlimited range of behaviors. If some of our inclinations happen to correspond to those of a culturally typical male or a culturally typical female, there’s nothing wrong with that. But let it be a choice, rather than the result of explicit or implicit cultural coercion. We have the right to our preferences, and to behave in ways that might or might not conform to an assigned role, as long as we are not physically inflicting harm or infringing on the rights of others.

The trend toward transgenderism, rather than representing freedom from the so-called binary system of gendered attitudes, is instead forcing us to be even more firmly entrenched in them—and in the most stereotypical ways possible. Yet despite the enormous harm caused by the radical trans movement, we can still extract a positive message from the rubble: *It’s possible to live a life free of gender stereotypes*. At the very least, our freedom from stereotypes is something to which we should all aspire, as it can only lead to a richer life. We may lose the love and respect of some, but we’ll gain it from others. Most importantly, we will have more love and respect for ourselves. Refusing to be limited by gender roles is the most effective way to resist the trans agenda. It’s also the most effective way to protect our children. The world is at a crisis point. We urgently need to reevaluate our ideas about what it means to be male and female.

It is my earnest hope that this book will help bring about a new era of accepting who we truly are, inside and out.

Carla Curtis, Gays Against Groomers
United States, 2024



PART I

BIOLOGY





1

MALE AND FEMALE DEVELOPMENT

Beyond Nature

Young people today are facing a crisis that their parents are unlikely to have ever experienced: the notion that the bodies they were born with are not the bodies they were meant to have. All across the globe, and most certainly in the United States, people are going to great lengths to alter their physical appearance so they can resemble the opposite sex as much as possible. In order to advance the belief that people are born into the wrong body, radical transgender activists and their allies are challenging the reality of basic biology. We are being told that males can become females and females can become males. Simple biology has not only been vilified, but outright misrepresented and reversed.

Can men really transform into women, and can women really transform into men? To find out, we need to review some basic biology, physiology, and anatomy.

Hormones, Body Structure, and Physiology

In high school, older students used to be taught the basics of human reproduction and development. It starts when a male's sperm cell and a female's egg—each containing 23 chromosomes—fuse together to form a single cell consisting of 46 chromosomes (23 pairs). *Chromosomes* are strands of very tightly coiled DNA, containing various biochemicals, that are located inside the nucleus of almost every cell in the body. Inside the chromosomes are thousands of smaller units called *genes*. Males and females share about 99.8 percent of the same genes.

Except when rare deviations occur (discussed later in this chapter), most human males have XY chromosomes and most human females have XX chromosomes.

We all start out in life the same, at least genitally speaking. The embryo begins with primitive reproductive glands called *gonads* whose appearance is neither male nor female. At about the seventh week of gestation, if the embryo possesses the XX chromosomes of a female, the gonads will become ovaries. If the embryo possesses the XY chromosomes of a male, the gonads will become testes. About one week later, the testes of a male start to produce masculinizing hormones including testosterone. It's the presence or absence of testosterone that exerts the most significant impact on the gestating male fetus. In female fetuses, there is no outpouring of testosterone. Secretions from the ovaries are not required for female sex differentiation, so the baby continues to develop into a female.¹ Nevertheless, as University of Melbourne associate professor Cordelia Fine points out, "Female development is as active and complex a process as male development....*many* genes are involved in sex determination: *SRY* [sex-determining region Y gene] on the Y chromosome; a few on the X chromosome...[and] surprisingly, dozens of others located on other chromosomes."² If testosterone output halts, the system is again female.

As the fetus continues to develop, the appearance of its genitals becomes more defined. During this process of sexual differentiation, the hormones that are produced suffuse both body and brain. The amounts of hormones depend on the sex of the fetus. After testosterone is introduced to males, it remains at a high peak until week 24 of gestation. There will be a surge of testosterone soon after birth, peaking when the child is three to four months, and again during puberty.³

Boys grow more quickly than girls due to their higher metabolic rate. Lise Eliot, associate professor of neuroscience at the Chicago Medical School of Rosalind Franklin University of Medicine and Science, hypothesizes that the higher metabolic rate allows a male embryo to develop testes before the mother's estrogen—which progressively rises during early pregnancy—hinders the further maturation of the male sex organs. The faster growth of boys means that they are born larger and heavier than girls. Their greater weight and mass make it more difficult for the mother to deliver, and with males there's a slightly longer labor. More boys than girls are born via C-section.

Many hormones are involved in the development of a human being. *Steroid hormones*, or simply *steroids*—which the body manufactures from cholesterol (produced mostly in the liver)—are secreted by three types of glands: the testes in a male, which rest inside the scrotum that hangs outside the body (referred to in slang as "balls"); the small, almond-shaped ovaries in a female, located in the abdominal cavity on either side of the uterus (womb); and in both males and females, the cortex of the adrenal glands, which rest on top of either kidney.

The adrenals are unusual because in many ways they act like two separate glands. The medulla (center) secretes different substances than the thin cortex that surrounds it. Hormones produced by the medulla include adrenaline (also known

as epinephrine) and noradrenaline (or norepinephrine). Both are involved in the fight-or-flight response, which I'll discuss in detail in the final chapter. For now, I want to focus on the adrenal cortex. It creates hormones that are anti-inflammatory and help maintain normal blood pressure and the balance of salt and water in the body. But its secretions are also directly involved in sexual development.

Androgens is a catch-all term for any steroid hormone that has masculinizing effects. These hormones are vital to a male's sexual development, bestowing the characteristics that we associate with typical maleness. *Testosterone* is the most well known androgen. It's produced by the testes in fairly large amounts, by the ovaries in much smaller amounts, and in the adrenal cortex of both sexes in small amounts. In women, the skin, fat cells and liver can convert androgens into testosterone. Testosterone is largely responsible for the development and maintenance of reproductive function in men, as well as the stimulation of secondary sex characteristics such as body hair on the male during puberty. The same androgen hormones that make boys grow faster *in utero* tend to suppress immune function, which is probably why boys are more susceptible to ear and other types of infections in early life. Testosterone is very familiar to sports fans. Until the practice became illegal, many athletes (especially males) would routinely inject themselves with testosterone and other steroid hormones to help build muscle mass, thereby augmenting strength, and to increase stamina. Some male athletes still take testosterone, hoping they won't get caught. Testosterone's role in sports will be discussed in depth in Appendix B.

Estrogens are vital to a female's sexual development. They give her the characteristics that we associate with typical femaleness. Of the three types of estrogen, the most potent is estradiol. It catalyzes and maintains mature reproductive function in women, and at the start of puberty, stimulates secondary sex characteristics such as the enlargement of breasts. Estradiol also increases the body's secretion and receptivity of the hormone oxytocin. *Oxytocin* stimulates milk production during pregnancy. It also arouses emotional closeness in both sexes under a variety of circumstances. Estrogens are produced by the ovaries in fairly large amounts, by the testes in much smaller amounts, and by specialized fat cells in women.

Progestins, the most important of which is progesterone, are also produced by the ovaries. They are responsible for maintaining a healthy pregnancy. If a woman's progesterone levels are too low, she may have irregular periods and trouble conceiving. She may also suffer mood changes and insomnia, among other symptoms. Men create progesterone as well, in their adrenal glands and testes. It helps them make testosterone and keeps estrogen in balance. If a man's progesterone levels are too low, his sleep will be impaired and he will be at a higher risk for developing arthritis, osteoporosis, and cancer.

By popular association, testosterone equals male and estrogen equals female because most people believe that only males produce testosterone and only females produce estrogen. But males and females produce *all* of the same hormones, and

require them all, though in different amounts. Testosterone is not only critical for males. It's such an integral part of female functioning that menopausal women are given minute amounts of it to supplement what their tired adrenals can no longer produce. This gives them extra energy, more intense and frequent orgasms, and an overall rise in libido. Likewise, estrogen—balanced in the appropriate ratio with testosterone—is vitally important to male sexual function. It helps regulate men's sex drive, the production of sperm, and the ability to have an erection. In fact, if the estrogen levels in a man are too low his libido will decrease, no matter how high his testosterone levels are. Sometimes, in both male and female bodies, testosterone is converted to a form of estrogen.

Testosterone and estrogen are typically regarded as sex hormones, but they do much more. They affect the brain, blood vessels, bones, intestine, liver and lungs, and regulate growth. The nonsexual roles of testosterone include better sleep, cholesterol control, improved insulin sensitivity, enhanced bone density, and improved function of the endothelial cells that line the blood and lymph vessels (which help normalize blood pressure). The nonsexual roles of estrogen include enhanced memory, mediating levels of the neurotransmitter serotonin, improved function of the fuel-burning mitochondria in the cells, blood flow regulation in the brain, protection against bone loss, and catalyzing the production of anti-inflammatory molecules. It's important to remember that *none of these hormones operate singly*. Their beneficial effects depend on the proper amounts and ratios of *all* the hormones.

For both sexes, the production of hormones intensifies at puberty, conferring those secondary sex characteristics that most adolescents agonize over. Males acquire hair in the underarm, pubic, and facial regions. Their voices become lower, the testes start to produce sperm cells, and the Adam's apple grows. (The so-called Adam's apple is a colloquial term for the thyroid cartilage that has a different angle in men's necks than in women's, which is why it protrudes more in men after they finish puberty.) Females acquire underarm and pubic hair. Their breasts enlarge, their hips widen, and the ovaries start releasing egg cells (the onset of the menstrual cycle). The primary sex organs—testes, scrotum and penis or ovaries, vulva, clitoris, vagina and uterus—and later the secondary sex characteristics, are all part of each sex's distinctive sexual development.⁴ Another important sex-linked difference is body fat distribution. Women tend to store more body fat than men, possessing a much higher ratio of adipose (fat) tissue to lean muscle.⁵

Once puberty is in full swing, one of the most obvious differences between males and females is musculature. Testosterone gives men as much as 40 percent more muscle mass than women. Men's skeletal muscle fibers are also different than women's. They contract more quickly and produce more force.⁶ About one in twenty women is as strong as the average man. Males and females also differ in skeleton shape and bone mass. The bone mass in men can be up to 50 percent higher than in women.⁷ Each sex has a unique body shape, in part due to their bone structure. A man has wide shoulders and narrow hips. A woman has narrow

shoulders and wide hips, designed to more easily allow a baby to have room to grow and be born. The waist of a man is below the navel and the waist of a woman is above the navel. Some of their bones are shaped differently, too. A male has a heavier ridge at the brow; hers is more muted. A male's forehead is sloped at an angle from the brow; a female's is more rounded. His jaw is more square; her jaw is generally rounder. In a man, the legs attach to the pelvis in a more parallel manner than that of a woman. Therefore, how men and women walk and stand are dissimilar—so different, in fact, that each has their own identifiable gait. In recognition of women's distinctive (non-male) physiology, sports coaches, physical therapists, and sports medicine doctors are finally instructing women and administering to their injuries appropriately according to their own unique structure, rather than treating them as though they were men.

Each sex has advantages. Men are physically stronger than women, but women have more resistance to disease and live longer. Many of the metabolic functions between the sexes vary so widely that the ways in which clinical drug trials are conducted are changing. The effects of medications used to be studied mostly on all-male groups—unless the drug was specifically meant for women, which means related to their reproductive function. It was assumed that females responded to pharmaceuticals as males did, which is not the case. Doctors are finally acknowledging that the effects of drugs are often very different for females than males, and are designing drug trials according to who the subjects are.

Sex-linked differences are embedded in sperm and egg cells before they ever make their voyage to the womb. So even if an adult takes high doses of hormones—in amounts equal to or greater than what's produced by the opposite sex—the original skeleton and musculature remain. Secondary opposite-sex characteristics might be introduced, such as a beard on women or more and redistributed fat on men; but the body you're born with is the one you'll have until you die. It can be very difficult to conceal the effects of the hormones secreted in the womb.

The Brain

Neuroplasticity of the Brain

It's the nature of human beings to learn through repetition. Neural circuits typically develop in the brain by traveling the path of least resistance, and they are reinforced when we continue doing the same thing over and over. A good analogy is a horse-drawn carriage traveling a dirt road. At first the road is completely even. But every day the horse steps in the same place, and the carriage wheels start to make a groove in the dirt. Pretty soon, even if the horse or driver want to swerve to the right or left, it becomes more difficult because the wheels are now fitting into the groove in the road. Soon, it's unthinkable that there might be any other way to travel.

So far the brain doesn't sound that remarkable, does it? But there are potentially unlimited exceptions to the above process. That's because the average brain

contains one hundred billion nerve cells (neurons), and each neuron is connected to between 1,000 and 10,000 other neurons. There are sixty-three possible ways in which four nerve cells can be connected to other nerve cells, and one chance of no connection at all. Every time the brain grows new cells, the number of possible connections grows exponentially.⁸ Returning to our analogy, these many connections and new brain cells allow us to introduce a different route. Say we deliberately steer the horse on an unfamiliar course. Even if that path doesn't feel natural or easy—because the carriage wheels keep bumping into ridges in the dirt that were created alongside the previous grooves—those wheels eventually start to make new indentations along the path. This is due to the brain's neuroplasticity.

Neuroplasticity is the synthetic-sounding name for an elegant natural process: the brain's ability to adapt and change due to input from our environment. More than a mere metaphor, neuroplasticity indicates actual changes in the structures of the brain and nervous system in response to being challenged. Our brains are never static. Cells grow and are replenished. They switch places with other cells. Neural pathways might disappear while others are made, thanks to continual feedback. The environment can be generated from within us or come from outside of ourselves—the experiences we've had and the conclusions we've drawn from those experiences, what others have told us about ourselves, what we tell ourselves about who we are, what we learn in school or on social media, and even the chemicals we're exposed to and the nutrients we receive from the foods we eat. Neuroplasticity encompasses motor function, muscle memory, cognition, recall, perception—everything. It resides in neurons, which transmit information, and in the specialized glia, which comprise half the cells in the central nervous system. Glial cells help maintain synaptic activity (communication) between neurons. They keep the overall nervous system running smoothly. And they alter neuron structure and function when necessary.

Even if you're unfamiliar with neuroplasticity, you may have heard of therapies based on the ability of the neuroplastic brain to adapt and evolve. For example, people who suffer strokes or brain injuries are given rehabilitation that stimulates brain cells to regenerate. Over time, they learn to talk. Or they might reclaim their motor function as intact, seemingly unrelated portions of their brain assume new duties. Sometimes new cells grow in or near the areas of injury while learning to assume the functions of the damaged tissue.

Neuroplasticity is also evident when a skilled psychotherapist treats clients for post-traumatic stress disorder. The practitioner eliminates symptoms by decreasing the reactivity of certain parts of the brain while introducing more positive, supportive stimuli into other neural pathways. Under most circumstances, more neural fibers can be created in the brain. And existing nerve cells can reorganize themselves and make more, or different, connections to other nerves.

World class athletes use our modern understanding of the brain to develop their skills. Even when they're not physically participating in their sport they're mentally active, practicing in a different way. Professional golfer Tiger Woods

is known for contemplating various scenarios in his mind before he ever steps onto the green. His technique of reviewing his game first is used by athletes all over the world. Similarly, some musicians mentally rehearse the music even when they're not holding their instrument. They tap into their recollection of moving their fingers across a keyboard, or blowing into a mouthpiece, or pressing down on the valves or strings of their instrument. By doing this, they strengthen the neural circuitry in their brains and bodies involved with playing the instrument. Reinforcing muscle memory makes everyone better at what they do.

If neural imprinting and muscle memory are intensified by thinking and imagining, what about exposure to an idea or belief system—particularly if that exposure is repeated? And what if the concept involves ideas about the brain itself? Including the idea that there are male brains and female brains? Do such ideas influence neural imprinting, and hence the brain's structure and function? As it turns out, they do. Trained neuroscientists, well versed in neuroplasticity, are now pointing out the fallacies of believing that males and females have innately different brains leading to disparate character traits and mental abilities. One neuroscientist is Lise Eliot, author of *Pink Brain Blue Brain*. The brain also changes “when you figure out if you're a boy or a girl,” she writes. “Learning and practice rewire the human brain, and considering the very different ways boys and girls spend their time while growing up, as well as the special potency of early experience in molding neuronal connections, it would be shocking if the two sexes' brains *didn't* work differently by the time they were adults.”⁹

Closely related to neuroplasticity is *epigenetics*, the study of how behavior and environment can cause actual changes in our DNA. There are a great many variables that can switch a gene on or off, and cause it to express itself in unique ways. I will be discussing epigenetics in more detail in the next chapter. For now, let's look at how rumors become so established that they are believed to be science—when they are anything but that.

The Corpus Callosum Conundrum

Many researchers who believe that males and females have innately dissimilar aptitudes, preferences and behaviors, cite differences in the corpus callosum as the reason. The *corpus callosum* is a central, rope-like cable of white matter that connects the left and right hemispheres of the cerebrum, which is the largest and uppermost portion of the brain at the front of the skull. There's a widespread belief that a woman's corpus callosum is thicker than a man's, leading to more and faster connections between the left and right hemispheres. This means, the reasoning goes, that women have more coordinated activity between the two hemispheres, in contrast to men's greater brain activity within each separate hemisphere. All of this helps explain, it's further believed, women's ability to multitask and see the big picture while men excel in being hyper-focused on a single task without being distracted by other input. This theory sounds good—but is it true? As it turns out, only sometimes. The following account is a good example of how just one poorly

executed study can create an ongoing myth. It also shows how someone in the public eye—even someone who's not a scientist—can perpetuate rumors that are then accepted as scientific reality.

As explained by biologist Anne Fausto-Sterling, the corpus callosum fiasco began with a short article that was first published in 1982 in the journal *Science*. Even though the authors studied only five female and nine male brains, they made a sweeping generalization that for visuospatial functions, men and women have different degrees of lateralization. *Lateralization* simply means that each hemisphere of the cerebrum is responsible for different functions. Translated, males and females were believed to use their brain hemispheres differently for visuospatial tasks because certain regions of the corpus callosum were thought to be larger in females than in males.¹⁰ This insignificant paper skyrocketed to fame when the talk show host Phil Donahue, in a book loaded with biased and outright falsified research, inaccurately credited the authors with describing in female brains “an extra bundle of neurons that was missing in male brains.”¹¹ This, he concluded, accounted for women's intuition. After *Time* and *Newsweek* repeated this inaccuracy—so much for fact checking!—it took only a short while for this hypothesis to become cemented as scientific fact by both the public and scientists. The general public, which as a rule doesn't read medical literature, might be forgiven; but when scientists repeat and promote speculation without proper follow-up research, this is sloppy science and there's no excuse for it.

Fausto-Sterling describes the structure of the corpus callosum in detail, which may point to more problems with that ill-fated study. Dead tissue is not like living tissue, and thus requires a different imaging system. For dead samples of the corpus callosum—which always shrink, due to loss of fluids—most researchers measure a 2D slice. For living tissue inside a person, researchers measure the entire 3D structure using MRI (magnetic resonance imaging). Thus we have two dissimilar tissue types, with inherently different thicknesses and spatial resolution, each requiring very different tools to measure them. Neither the samples nor the measuring methods are interchangeable across different experiments. Another problem is, the boundaries between the corpus callosum and adjacent structures are difficult to define. If the samples themselves are not clear, how can experimental results be correctly interpreted? Lise Eliot drew similar conclusions, reminding readers that the news media failed to mention several studies that reported *no* statistically significant sex differences in the corpus callosums of men and women, boys and girls, or male and female fetuses.

To add more perspective, originally the corpus callosum was studied to determine presumed differences between people with dark and light skin. In 1906, a paper was published called “Some racial peculiarities of the Negro brain.”¹² “The methods used to measure the size and shape of the corpus callosum in cadavers has not changed...since the [paper's] publication,” observes Fausto-Sterling. “Once freed from the body and domesticated for laboratory observation, the CC [corpus callosum] can serve different masters. In a period of

preoccupation with racial difference, the CC, for a time, was thought to hold the key to racial difference. Now, the very same structure serves at...[the] beck and call” of biological sex.¹³

While animal studies can give us a starting point of inquiry, we cannot assume that the data automatically pertains to human beings. It’s also unscientific to allow personal bias to influence an experiment. Eliot writes:

If you’ve read anything about boy-girl differences, you’re probably... convinced that scientists have discovered all kinds of disparities in brain structure, function, and neurochemistry—that girls’ brains are wired for communication and boys’ for aggression; that they have different amounts of serotonin and oxytocin circulating in their heads; that boys do math using the hippocampus while girls use the cerebral cortex; that girls are left-brain dominant while boys are right-brain dominant.

These claims have spread like wildfire, but there are problems with every one. Some are blatantly false, plucked out of thin air because they sound about right. Others are cherry-picked from single studies or extrapolated from rodent research without any effort to critically evaluate all the data, account for conflicting studies, or even state that the results have never been confirmed in humans. And yet such claims are nearly always presented to parents, with great authority, as well-proven and dramatic facts about boys’ and girls’ brains, with seemingly dire implications.¹⁴

Theories abound as to why sex-linked differences occur and why there are exceptions to these differences. According to “Prenatal and postnatal hormone effects on the human brain and cognition,” the effects of hormones depend not only on the dose, but also when they’re secreted—and the deciding period is during prenatal development. Later in life, additional hormonal output merely fine tunes the early organization of the brain. Thus one’s sexual identity is set in the womb; and any decision made later in life that one “is actually the opposite sex” is not supported by the biology of either the body or brain.¹⁵ However, other researchers contradict these findings, stating that postnatal periods of hormone secretion are more powerful than prenatal surges.¹⁶ So how do we know what’s true? Let’s try and sift through a morass of complicated data.

Male and Female Brains: Fact or Fable?

This section was very difficult to write. The entire chapter was intended to be devoted solely to biology, but cultural expectations—discussed in great detail in the next chapter on sex role stereotypes—began to intrude. It’s not surprising that this would occur, because in any discussion of sex differences, biology (nature) always interacts with environment (nurture). An almost obsessive analysis of possible biases is required because the assumptions we grow up with are so ingrained that they become invisible, appearing as immutable truths when they are not.

The “nature versus nurture” debate has been raging for decades. On one side are scientists and academics who claim that being either male or female has nothing to do with biology and everything to do with culture. Purveyors of this viewpoint seem to forget (or fail to acknowledge) that if hormones are powerful enough to alter the shape and function of the body, they must also exert at least some influence on the brain. The other side of this debate features scientists and academics who claim that there exist naturally-occurring traits labeled “masculine” and “feminine”—and that their basis in biology overrides any and all cultural influences. Purveyors of *this* argument don’t understand that biology can change depending on the environment, and the human brain, especially of a young child, is extremely malleable.¹⁷

The “biology is fixed” position always tries to bolster its argument with that seemingly magical hormone, testosterone. So before I analyze specific behaviors and discuss what they actually indicate, I need to delve a bit into how testosterone—which is (still) associated with all things male—operates in the body and affects the brain. It’s not as simple or direct as you might think.

I already described how testosterone levels surge at critical junctures during a male’s physical development. What about in the brain? There are many ways in which testosterone affects it. The hormone can influence already-existing neural pathways within minutes, or over a period of weeks. It may increase or decrease the sensitivity of brain cells. For a rapid, short-term effect, testosterone attaches to a nerve cell membrane and alters chemical pathways to change how easily that cell will fire. The hormone may bind to an androgen receptor. Once it enters a cell’s nucleus, it may switch on certain genes by altering the cell’s production of proteins and peptides. Or, assisted by the biochemical catalyst aromatase, testosterone may convert into estrogen and bind to an estrogen receptor—although this doesn’t always occur because the brains of both males and females already manufacture estrogen. What happens in the brain depends on how much estrogen it’s producing; the sensitivity of brain receptors to estrogen, testosterone and other hormones; the location of the estrogen receptor sites; how well testosterone is converted to estrogen; how much aromatase is available for the conversion; and other factors. As you can see, testosterone’s activity isn’t simple. With so much going on in the brain, using blood or saliva testosterone levels as a measure of how much testosterone a person possesses is simplistic and misleading.¹⁸

It’s also simplistic and misleading to think that behavior can be inferred or predicted based *solely* on testosterone levels, regardless of where the hormone is stationed. “Sex effects in the brain don’t always serve to create different behavior,” Cordelia Fine explains. “Sometimes instead, one sex effect counteracts or compensates for another, *enabling similarity of behavior, despite dissimilarity of biology*....One researcher, for instance, suggests that male exposure to the testosterone surge *in utero* somehow *desensitizes* the brain to testosterone’s effects later in life. This would be a smart way, maybe achieved through sex differences in

neural sensitivity, of *enabling males to tolerate the higher levels of testosterone their bodies need to develop and maintain male secondary sexual characteristics, without having an excessively large effect on behavior.*” [emphasis added]¹⁹

One thing we do know is that male and female brains can reach the same goal via different means. Take the African forest weaver, a type of songbird. In most species of birds, it’s the males who sing. But both male and female African forest weaver birds sing (in unison, which is remarkable when you think about it). The male’s brain region devoted to singing is larger than the corresponding brain region in females. However, in the female bird’s brain, Fine reports, “the genes involved in song production areas ‘express’ (produce brain-altering proteins) at a much higher rate than in males, compensating for their smaller neural real estate.”²⁰ She proposes that because “males and females need to be able to potentially behave in similar ways to get by in day-to-day life, evolution has to work out a way for this to be achieved in [their] somewhat different bodies...[W]e can’t assume that neurobiological sex differences always act to *create* differences in behavior. Sometimes, they may in fact serve to iron them out.”²¹

Nevertheless, myths die hard, and some people still believe that testosterone can create a distinctly “male” brain. To find out, authors of “Sex beyond the genitalia: The human brain mosaic” analyzed MRIs of more than 1,400 live human brains. After examining gray matter, white matter, and neural connections, they found that fewer than one percent of the subjects had solely stereotypical “masculine” or “feminine” characteristics. All other brains had a “mosaic” of features—“some more common in females compared with males, some more common in males compared with females, and some common in both females and males.... These findings are corroborated by a similar analysis of personality traits, attitudes, interests, and behaviors of more than 5,500 individuals.... Our study demonstrates that, although there are sex/gender differences in the brain, human brains do not belong to one of two distinct categories.”²² Three years later, in 2018, a similar study was conducted by some of the same researchers. “Unsupervised clustering algorithms [a simple way researchers generally use to classify data] revealed that common brain ‘types’ are similarly common in females and in males and that a male and a female are almost as likely to have the same brain ‘type’ as two females or two males are.... [S]ex category (i.e., whether one is female or male), is not a major predictor of the variability of human brain structure. Rather, the brain types typical of females are also typical of males, and vice versa...[except] in some rare brain types.”²³

If a man can have a “feminine” brain and a woman can have a “masculine” one, does it make sense to label a brain according to sex? “Which of the many combinations of characteristics that males display should be considered male nature?” Fine asks. “Is it a profile of pure masculinity that appears to barely exist in reality? What does it mean to say that ‘boys will be boys,’ or to ask why a woman can’t be more like a man? *Which* boy? Which woman, and which man?”²⁴

Another problem arises with this type of labeling, Fine explains. “Although we’re used to thinking of certain kinds of behavior as ‘testosterone fueled,’ in many cases it would make more sense to instead think of actions and situations as being ‘testosterone fueling.’ Social context modulates T [testosterone] levels (up or down), which influences behavior (presumably via changes in perception, motivation, and cognition), which influences social outcome, which influences T levels...and so on....[T]he effects of the social world have even been seen at the genetic level, with social interactions changing androgen and estrogen receptor expression in the brain.”²⁵ Simply put, *context is everything*. Our experiences cause certain neural pathways to deepen, others to disappear, and still others to be formed (and sometimes, nothing changes). Plus, the simple act of living causes hormones to interact with other hormones—and thus alter various brain processes. We have less or more sensitivity to stimulus, and develop different ways of perceiving that stimulus. The possibilities are endless. It’s difficult to say what constitutes “male” or “female” nature, when the neuroplastic brain is constantly responding to external cues and events.

In *Pink Brain Blue Brain*, Lise Eliot takes the reader step-by-step through her journey to evaluate research, most of which attempted to prove that male and female brains contain dissimilar circuitry and even discrete physical structures. The neuroscientist examined hundreds of studies on humans and animals. These included studies that were poorly designed, were not replicable, or clearly showed experimenter bias. Some experimenters looked at prenatal hormones, others looked at postnatal hormones, and still others investigated pubertal hormones. Amniotic fluid was extracted from pregnant mothers and analyzed under a microscope. Readings were taken of pregnant mothers’ plasma *in utero*. Blood from pregnant mothers was drawn intravenously and tested for levels of specific hormones. MRIs were used to see which parts of the brains lit up when subjects performed various tasks, and brain functions of males and females were compared. Piles of papers later—much of which yielded contradicting data—Eliot still could not pin down exactly what the differences were between male and female brains. Did the environment make hormone levels rise or fall, or were the hormone levels high or low to begin with? The best we can conclude is that there are *tendencies* toward differences between men’s and women’s brains, but with a great deal of overlap. Plus, there are always exceptions. As for the differences that are obvious, Eliot remarked, “Who’s to say that such differences are caused by nature and not by learning—by the thirty or so years of living as a male or female that any research subject invariably carries into the MRI scanner?”²⁶

Knowing that our environment helps shape us—even if we might not be able to identify some of those influences—let’s look at several examples of how males and females are thought to differ, even during infancy. While these examples appear to reflect reality, I will be showing how cultural stereotypes can inflate their importance and distort their meaning.

- ◆ *Males are much more visually oriented than females, and females are much more auditorily oriented than males.* While this oft-repeated conviction may give men an excuse to ogle women or become addicted to centerfolds (“It’s in my nature!”), it’s simply not true. In 1974, researchers Eleanor Maccoby and Carol Jacklin conducted an extensive review of nine studies on almost four hundred infants. They found no differences in girls’ and boys’ attention to a wide variety of colors, shapes, and movements. Another fifty-four experiments, published in thirty-three papers, yielded similar conclusions. As for differences in hearing between the sexes, the difference is not statistically significant—which is why screening for hearing impairment is the same for both sexes (and yields accurate results). Therefore, generalizing that boys learn through seeing and girls learn through hearing is inaccurate. In fact, during early infancy, girls are even more visual than boys, because testosterone may delay the development of 3D vision and the visual cortex in males.²⁷

Leonard Sax, who wrote a book titled *Why Gender Matters*, has often been cited as an authority to support the boys-are-visual-and-girls-are-auditory belief. In fact, he once wrote that “If a male teacher speaks in a tone of voice that seems normal to him, a girl in the front row may feel that he is yelling at her.”²⁸ Although a later edition of Sax’s book omitted the passage quoted, that he published it at all reveals the strongly sexist attitudes of some researchers—and illustrates how such beliefs are regarded as “fact” even after the original citation is removed and new information is released. Sax ignored the comprehensive research of Maccoby and Jacklin, which is considered by many authorities to be the “gold standard” of this type of data.

- ◆ *Boys are naturally tough because they have a higher pain threshold than girls—and this makes them (desirably) masculine.* A study of two-day-old infants who were pricked in the heel (routinely done on a newborn for blood screening) concluded that the girls experienced more pain than boys because they exhibited more dramatic facial expressions. But there are other indicators of pain that were not measured in the experiment: crying, breathing patterns, neurological arousal, and limb position.²⁹ Another, later study conducted by Swedish scientists measured pain differently with a noninvasive method that detected cerebral blood flow, an indicator of brain activity. This yielded a very different picture. Boys exhibited greater cortical activation during the heel prick procedure than girls. They weren’t more tough. They just didn’t register it on their faces as much as girls did.³⁰ This may have been due to the less developed fine muscle development in infant boys than girls, an already well-known fact.

It’s a fallacy, then, to assume that boys are naturally physically tougher than girls. This study has profound implications for how we treat boys. If we believe that it’s natural for boys to be less emotional—and hence more callous—than girls, this may turn into a self-fulfilling prophecy. I will discuss this in depth in the next chapter.

- ◆ *Boys are tougher than girls because their brains are wired to enjoy rough play.* Few scientists would dispute that in boys, especially during the first year of life, the senses of smell, hearing and touch mature more slowly than in girls. Also, boys' fine motor and language skills are less developed. However, boys surpass girls in gross motor development: standing, sitting, and walking. A male's higher testosterone level gives him more energy than a female, which is why most boys move more than girls. Therefore, it's no wonder that boys want to chase each other, hit balls, and wrestle. But it's a mistake to use this biological need for higher-energy movement as an excuse to draw conclusions about toughness—and by extension, masculinity. Praising boys for apparent toughness, believing that this makes them desirably masculine, establishes a dangerous precedent. Boys feel pain as much as girls do when they're injured (see prior point); but if they believe that it's unmanly to complain, they will physically and emotionally numb themselves. They'll "grin and bear it," and avoid asking for help when they need it. Letting off steam due to high energy levels is necessary. Learning that it's socially acceptable and more desirable to push beyond their limits to the extent that injuries occur—to themselves and others—is hurtful and counterproductive.

Although girls don't have as great a need as boys to discharge excess energy, they still require physical outlets in order to grow properly. Unfortunately, the "boys are tougher" mindset has an unwitting counterpart: If boys are tougher, girls are more delicate. As a result, parents tend to be much more protective of girls. "While girls are often easier to care for and more socially aware," writes Eliot, "they do not get as much encouragement as boys for their physical development and emotional independence...Because of baby girls' smaller size, and possibly because of lingering stereotypes, parents tend to be more cautious with infant girls, permitting them less freedom to explore and to push their physical limits. But later on, girls begin falling behind boys in their physicality and spatial skills, and it's clear that girls could benefit from greater physical challenges and earlier opportunities to explore."³¹ The physical needs of children leads me to one more, related topic: toys, which almost everywhere are labeled and marketed according to the sex of the child. See below.

- ◆ *The toys that are natural for boys are in the "active" category of miniature cars and trucks, balls, and guns; while the toys that are natural for girls are in the "passive" category of dolls, miniature kitchen utensils, and beauty items such as ribbons.* This stereotype is believed by an overwhelming majority. While there's some truth to it, as usual the reality is much more complex.

Until about age one, boys are attracted to dolls. Then—probably because they are at a higher activity level due to a testosterone surge—they're attracted to balls, trucks, and similar items that they can physically move and manipulate. Nevertheless, environment plays a huge role in children's toy preferences, more than you might think. Let's look at some experiments.

A huge number of studies have been conducted with infants, toddlers, and young children to learn if children's preferences for toys is related to their sex. Some children were shown the toys, others were allowed to play with them, and still others were simply given pictures of the toys. Some of the toys were stereotypically female-oriented, some were stereotypically male-oriented, and still others were considered gender-neutral, such as a stuffed animal or a picture book. The research was conducted all over the world: Sweden, the Netherlands, Canada, and the United States.

The Swedish study was particularly revealing because it followed up on the children when they were one, three, and five years old. This allowed the researchers to chronicle any changes in the children's preferences—which would suggest that input from parents and peers influenced the toys that the children chose. This was indeed the case. The innate preferences of the children were enhanced by social and cultural factors, especially their own growing awareness of whether they were a boy or a girl. According to experts, conscious gender identity emerges between ages two and three, and is cemented in most children by age six or seven. This also happens to be the age at which children form their most heavily stereotyped views of males and females.³²

One study conducted with 56 children age four to nine years old yielded some alarming results. Toys were presented to the children for their tactile exploration—but with a catch. They were labeled as being for either boys or girls. No matter what the toy was, if the label was for the “wrong” sex, the children explored the toy less and remembered it less than a toy labeled for “their” sex.³³ Another study yielded similar results. Children refrained from exploring the toy, did not ask as many questions about it, and recalled it less, when it was labeled for the opposite sex instead of their own sex or even both sexes.³⁴ As might be expected, this has huge implications—not just for children but also adults, who are less able to learn if they believe the material is unsuitable for them. This will be explored in depth in the next chapter.

A very revealing and innovative experiment was conducted at a daycare center with children who ranged in age from three to five. Instead of toys, two neutral categories were created. The children were assigned membership in either the “red” or the “blue” social group and were given red or blue T-shirts to wear each day. The control group of children merely wore the colored T-shirts. In the experimental group, teachers used the colors to label the children and organize the classrooms. The children's cubbyholes were decorated with red and blue labels. The teachers would greet the children by their color name and had each color group line up on different sides of the room. Most importantly, they told the red and blue groups which toys were preferred by members of each color. In just three weeks, biases developed. The children wanted to play with the toys corresponding to their own color group.³⁵

Once again, we see how strongly our environment influences us. Children's toy choices are based not only on energy level or hard-wired inclination, but also on what they believe they *should* want after being told what their culture, parents and peers deem appropriate. The toys chosen by the children reflect their growing awareness of their sex—and everyone “knows” which toys are for girls and which are for boys! By about age four, this programming becomes cemented and the child is less flexible. Due to intense peer pressure—along with their need for approval—children can be the most severe enforcers of sex role stereotypes. Adherence to the party line continues into adolescence. Only very mature children can see through the biases. For a child, it takes courage and inner strength to play with, or wear, something “belonging” to the other sex.

A story from open-minded psychologist Sandra Bem, who with her husband was very careful to avoid stereotyping of any kind in their household, illustrates the degree to which children can be successfully indoctrinated. Her nursery school-age son Jeremy wanted to wear a barrette to school. She let him, despite her concern that he might be teased. As it turns out, he was. A male classmate called him a girl because, in his mind, only girls wear barrettes. To prove he was a boy and not a girl, Jeremy pulled down his pants. Incredibly, the other boy still insisted that Jeremy was a girl. The classmate thought that everyone had a penis.³⁶ If this story has a moral, it's this: Children need to understand that differences between males and females do not depend on something external that can change—such as what toys are played with, what fashion is being worn, or what activities are preferred.³⁷ As I discuss throughout this book, relying on external cues to know who we are gets us in heaps of trouble.

Parents are the most immediately influential purveyors of sex role stereotypes, even if it's unintentional. If their child picks up a toy they consider sex-appropriate (such as a boy with a truck or a girl with a baby doll), they convey approval. But if the child plays with the opposite sex's toy (such as a boy with a baby doll or a girl with a truck), they convey disapproval. Fathers have been observed to be more invested than mothers that their children choose the “correct” sex-linked toys. From dozens of studies that Eliot reviewed, it was clear that young boys were very intimidated by their fathers' disapproval if they selected toys associated with girls. The boys tended to stop playing with the toys, even if they were considered more neutral and the boys were especially fond of them. Interestingly, girls playing with toys associated with boys elicits a less negative response. It's more acceptable for a girl to be a tomboy (have stereotypically masculine traits) than for a boy to be a sissy (have stereotypically feminine traits). Not only are girls' toys—and what they represent—devalued, but many fathers fear that their sons will become homosexual if they gravitate toward interests attributed to girls. Parents can help their children by encouraging their daughters to play ball or build with size-appropriate tools, and by giving their sons dolls or stuffed animals to cuddle—without labeling which sex is supposed to play with which toy. Art

supplies, board games, and building blocks tend to lack the stigma of sex-typed labeling. Whatever the toy, though, children will be much less enthusiastic to play with it if it's labeled for the other sex.

In the Swedish study, 97 percent of three-year-old boys, when given a choice of toys to play with, were more likely to spend time with stereotypical masculine toys than the average girl did. Note, however, that a child's choice of toys does not indicate what interests he or she will develop as an adult. The choice of toy does not—and *cannot*—predict future competency in verbal, mechanical or social skills, or even one's chosen profession.

Not surprisingly, it has been shown that children from homes in which the mothers explicitly sanctioned sex role stereotypes are conscious of their sex several months sooner than those children whose mothers were less traditional and not invested in those stereotypes.³⁸ But if the parents are enlightened enough to avoid sexism in their own household—let's say a girl is given tools or a boy is given a miniature kitchen set to play with—in most cases it's not enough that the immediate family refrain from stereotyping. Freedom from gender roles needs to be reinforced by the child's school, community, and any media to which the child is exposed. Otherwise, the home might be perceived as an anomaly. This is said not to discourage parents from giving their children the opportunity to explore, but to emphasize the degree of conditioning that everyone deals with every day—even if it's not on a conscious level.

- ◆ *Males are intrinsically more competitive and risk-taking than females.*³⁹ The presumably higher rate of competitiveness in males (ascribed to testosterone, naturally) is disproved by many findings. This includes a study showing that one in six elite male athletes has testosterone levels that are actually *below* the range considered normal for non-athlete males—and in some cases, below the average for female elite athletes.⁴⁰ Yet no one would think that top male athletes lack a competitive drive. “Contrary to what many might assume,” Cordelia Fine writes, “women and men have similar risk attitudes,” regardless of age. “For the same subjectively perceived risk and benefit, they are equally likely to tempt fate. When men and women *do* diverge in risk-taking propensity, it is because they perceive the risks and benefits differently.” This isn't surprising, because unlike with men, ambition and assertiveness are usually not rewarded in women. A survey of more than 800 managers at a consulting firm found that women were generally less willing to make sacrifices and take risks in their career to be promoted—not because they were less ambitious, but because “they had lower expectations of success, fewer role models, less support, and less confidence” that their company would be fair.⁴¹ Another paper reviewed studies of young Chinese men and women to determine who took risks versus who avoided them. “Imagine you are a woman,” the authors wrote, “who lives in a... culture that considers conservativeness and timidity as becoming characteristics of women. Would you demonstrate bravery, adventurousness, and risk taking, or

timidity and risk avoiding as mating strategies in front of a desirable potential mate?" In China, the ideal woman is still seen as subordinate, fragile, dutiful, and virginal—hardly the profile of a risk taker! In one study, men who thought they were being observed by an attractive member of the opposite sex increased their risk taking, while women in equivalent circumstances decreased it. But Chinese women equaled their male counterparts in risk taking—defying an antiquated, idealized version of femininity—*when they thought they weren't being observed*.⁴² "Male risk taking," Fine remarks, "is a norm of masculinity and seen as a more important trait for men than for women."⁴³

Now that we know more about how our unconscious biases affect babies and young children, what can we do? Based on the different developmental needs of males and females, Dr. Lise Eliot suggests:

The exact prescription for sensitive, responsive caregiving may differ for girls and boys, or for babies of either sex with different temperaments.

Boys are often more needy as infants than girls are. They are less physically mature and take longer to develop the self-calming skills, such as hand-sucking or pulling into a tightly tucked posture, that help them compensate when overwhelmed. Parents may need to step in sooner with a boy, picking him up, changing his position, or giving him a soothing ring to grasp and suck on. Here is where stereotypes can get in the way. In the general spirit of "toughening them up," parents may let their baby boys fuss and squirm longer, or they may resort to artificial stimuli—videos, electronic swings, and elaborate toy bars—to entertain them without helping them to discover their own self-calming skills.

Girls, on the other hand, can sometimes be too easy. Quiet, complacent babies may not get as much attention as fussier types, and they may actually suffer from a lack of the stimulation and interaction needed to fully develop their motor and cognitive skills. While there are plenty of exceptions, girls fall into this category more often than boys. So...by keeping your baby nearby, you are likelier to interact more—talking to her, pointing out interesting things in the environment, and generally integrating the baby into your daily life, making the most of her waking hours.⁴⁴

The goal is to help each person have the most fulfilling life. "Both sexes have their strengths and vulnerabilities," writes Eliot. "The reason for studying sex differences is not to tally up who's winning or losing but to learn how to compensate for them early on, while children's brains are still at their most malleable....Piecing together the different influences at each state is the only way to truly understand them, equalize opportunity between the sexes, and, ultimately, bring out the best in every child."⁴⁵

One more thing. If you give girls and boys similar activities, their brains will be more similar. Remember neuroplasticity. “Sex isn’t a biological dictator that sends gonadal hormones hurtling through the brain, uniformly masculinizing male brains, monotonously feminizing female brains,” writes Cordelia Fine. “Sexual differentiation of the brain turns out to be an untidily interactive process, in which multiple factors—genetic, hormonal, environmental, and epigenetic (that is, stable changes in the ‘turning on and off’ of genes)—all act and interact to affect how sex shapes the entire brain.... A particular environmental factor can have a profound effect on sex differences for one brain characteristic, but the opposite influence, or none, for others.”⁴⁶ In another book, *Delusions of Gender: How Our Minds, Society, and Neurosexism Create Difference*, Fine cautions us that “when researchers look for sex differences in the brain or the mind, they are hunting a moving target. Both are in continuous interaction with the social context.... [N]euroscience is used by some in a way that it has often been used in the past: to reinforce, with all the authority of science, old-fashioned stereotypes and roles.”⁴⁷ My view is that even *calling* a particular character trait “masculine” or “feminine” is not only biologically inaccurate, but leads us to trouble. This will become especially clear later in the book when I discuss the recruitment tactics of transgender activists.

Some Neurotransmitters and Their Effects

The body produces many other chemicals besides estrogen and testosterone that affect brain organization. In *Why Him? Why Her?*, anthropologist Helen Fisher discusses how four major ones—testosterone, estrogen, dopamine, and what she believes is serotonin⁴⁸—contribute to four distinct personality types in men and women. (Dopamine and serotonin are classified as both neurotransmitters and hormones.) The biochemicals are not based on the person’s reproductive organs, but on *biochemical expression in the brain regardless of sex*. According to Fisher, most people’s behaviors and attitudes are stimulated by two of the four hormones, one more dominant than the other. Some people express three of the hormones, and a very small number of people are balanced in all four hormones. The activity of these biochemicals depends on many factors, including the number and sensitivity of receptor sites to the hormone, the efficiency of the body’s feedback system to the biochemical, and even the availability and potency of the enzymes that help produce the hormone (which determines amounts). Also, the biochemicals don’t exist in a vacuum—they work together with other major neurotransmitters and hormones. And, depending on their amounts and even the timing of their secretion, they can produce different effects. Not only that, the variables that help form brain function can change over time. It’s very complicated.

“After doing extensive research on the biological underpinnings of personality types,” Fisher writes, “I have come to believe that each of us expresses a unique mix of four broad basic personality types.”⁴⁹ Fisher did not examine how environment and bias influence the expression and amounts of neurotransmitters,

but that was not her intended focus. Her research is pertinent here because it not only shows different styles of thinking and behaving, but illustrates how our culture is obsessed with classifying personality traits as masculine or feminine. The following is what Fisher gleaned from the scientific literature. Again, keep in mind that these neurochemicals are dominant in the *brain*, and are independent of the hormones that shape the body and reproductive organs *in utero*.

- ◆ *Testosterone tendencies*, what Fisher calls the Director. Many of these traits are the archetype of what Western culture regards as masculinity: focused, energetic, analytical, and emotionally contained (except for the expression of enthusiasm). Such a person would be good in engineering and the sciences, and sports that require brains more than brawn. People with testosterone tendencies are also direct, decisive, logical, tough-minded, exacting, good at strategic thinking, bold, competitive, and excellent at figuring out machines, mathematical formulas, or other rule-based systems.
- ◆ *Estrogen tendencies*, what Fisher calls the Negotiator. Many of these traits are the archetype of what Western culture regards as femininity: nurturing, emotionally expressive, intuitive, and sympathetic. Excellent at reading postures, gestures, facial expressions and tones of voice, such a person is able to quickly detect the needs of others and might be drawn to a service profession such as teaching, medicine, psychotherapy, or child care. The individual can also see the big picture and connect disparate facts, which Fisher calls contextual and holistic thinking. Hence, he or she might be drawn to the arts, especially writing. People with estrogen tendencies are also imaginative, verbally skilled, mentally flexible, agreeable, idealistic, and altruistic.
- ◆ *Dopamine tendencies*, what Fisher calls the Explorer. Adventurousness, sensation seeking, and a proclivity for the unusual drive these people. They might be passionate about uncommon activities such as skydiving, and engage in the more perilous sports such as football or ice hockey. People with these prominent traits are also drawn to dangerous professions that require risk taking, such as firefighting and police work. Individuals with dopamine tendencies are also high-energy, spontaneous, curious, creative, optimistic, enthusiastic, and mentally flexible.
- ◆ *Serotonin tendencies (which may be better ascribed, at least partly, to GABA)*, what Fisher calls the Builder. Such a person is consistent, family-oriented, reliable, responsible, and grounded. People in this category, sometimes called pillars of society, help form the foundation of civilizations. They might not be considered extraordinary or exciting to be around, but they keep everything running. With a strong work ethic, someone in this category will think long and hard before doing something considered unusual. People with serotonin traits are calm, social, cautious but not fearful, persistent, loyal, fond of rules and facts, orderly, guardians of tradition, and skilled at building social networks and managing people in family, business, and social situations.⁵⁰

While Fisher originally conducted this research to determine which combinations of brain chemicals would work best in romantic relationship pairings—there are benefits and pitfalls with each combination—her findings have a much wider application. Clearly, biochemicals other than testosterone and estrogen are involved in brain development. And, because people possess combinations in different amounts at different times in their lives, what you get is a varied, changeable mix of character traits no matter what the body looks like.

Unsurprisingly, in Fisher's paradigm testosterone is dominant in the brains of men who naturally exhibit what's considered stereotypically masculine behavior. A testosteroneized body, combined with a brain regarded as testosterone-inclined, produces what our culture considers quintessential, culturally desirable masculinity. It's not the only way to be a man, but when the archetype of "man" is invoked, this is what many people think of. In the sample that Fisher examined, however, most men did not possess this archetypal combination. Of the heterosexual men and women who participated in her study, just 16.3 percent—less than one-fifth of the population—had this brain constellation; and of that percentage, men were two-and-a-half times as likely as women to manifest it. Extrapolated to the general population, we might conclude that males as a group have more "masculine" brains than females as a group. But females can also possess more "masculine" brains, and Fisher emphasized that this is a natural, normal occurrence.

Similarly, it's not difficult to guess that estrogen is regarded as dominant in the brains of women who naturally exhibit what's considered stereotypically feminine behavior. An estrogenized body, combined with a brain regarded as estrogen-inclined, produces what our culture considers quintessential, culturally desirable femininity. It's not the only way to be a woman, but when the archetype of "woman" is invoked, this is what many people think of. According to Fisher, one-quarter of the female population has this brain constellation. The brains of some heterosexual males are also estrogen-dominant. Like their female counterparts, these males tend to be sensitive, empathic, and oriented toward figuring out what others need and then giving it to them. It's perfectly acceptable for males to have more "feminine" brains.

Despite Fisher's apparent concession to sex role stereotypes in some ways, her research does concur with the aforementioned studies showing that human brains contain a "mosaic" of features. There are *degrees* of so-called masculinity and femininity in people's brains, just as in their bodies. One group of biochemicals is no better or worse, or more or less desirable, than another group. But any culture that obsesses over labels of "masculine" or "feminine," applies them to character traits, and imbues those traits with hierarchical meaning, is doing people an enormous disservice. *All* types of brains are needed. Brains don't need to be genderized, and it doesn't matter what bodies those brains are in.

Now let's see what happens when a person's genitals don't correspond to what our culture thinks they're supposed to look like.

Divergences of Sexual Development, Including Intersexuals

Atypical Chromosomes and Hormonal Departures

There's a lot that can happen during the complicated process of growing a baby. The "3G" combination to which some scientists refer—genes, gonads, and genitals—may unexpectedly appear in atypical combinations. If the twenty-third chromosome on either the sperm or egg doesn't fuse the way it normally does, due to biochemical or genetic interruptions, the Y chromosome might be reversed. Or it may move. Under these circumstances, instead of XX (the most common female) or XY (the most common male), there might be the following chromosomal arrangements: X (female, occurring in a few births per thousand), Y (male, occurring in a few births per thousand), XXY (male), XYY (male), and XXXY (male). Evolutionary biologist Colin Wright writes that these unusual combinations "are not new sexes, but rather represent natural variation *within* males and females....The presence of a Y chromosome, or two, or three, etc., *all* result in the development of testes and therefore these individuals are biologically male. Likewise, individuals with additional or fewer X chromosomes, in the absence of a Y, all develop ovaries and are therefore biologically female."⁵¹ In other words, as long as there's a Y chromosome someplace, regardless of how many X chromosomes might also be present, the sex of the person is male. That's because the Y chromosome indicates the existence of testes, testes produce testosterone, and as a result during puberty male secondary sex characteristics develop—except in the extremely rare instances when they don't. Let me explain.

While the "Y equals testosterone" guideline sounds reasonable, and certainly streamlines identification—you can't get any more straightforward than that—there are some exceptions that can occur, for any number of reasons, that cause an ambiguous appearance. The testes might not be producing enough testosterone. Or the receptor sites for testosterone may be too few or unresponsive, and therefore don't sufficiently register the "Make a male!" message that testosterone conveys. Along with scarce or unresponsive testosterone receptors, any estrogen that's present (which is naturally produced by both female and male bodies) may feminize some of the features more than usual. These atypical departures can manifest in different ways. An infant might possess both ovarian and testicular tissue. The child might have external genitalia that appear to be male, while also possessing some internal female structures. Or the child might have external genitalia that appear to be female, while also possessing some internal male structures. Bodies with both male and female gonads (testes and ovaries) may appear not exactly male and not exactly female, may appear to be both male and female, or may appear to be neither. Individuals who have developed in these ways, rather than from the more usual sex differentiation process, are known as *intersex*. The website of the National Library of Medicine gives a clear definition of intersex: "a group of conditions in which there is a discrepancy between the external genitalia and the internal genitalia (the testes and ovaries)."⁵²

Intersexuals aside, sometimes the genitalia are ambiguous even in XX and XY bodies. There might be greater or lesser amounts of certain hormones than are normally present. Or, the receptor sites to those hormones may be partially or completely inactive. These conditions can cause a clitoris to be larger than doctors think it “should” be, or a penis to be smaller than doctors think it “should” be. Sometimes the boy’s scrotum is not completely fused, making it reminiscent of the outer labia of a female. Or the girl’s labia are fused, visually appearing similar to a male scrotum. Strictly speaking, these variations of genitalia—while potentially hampering the ability to identify a child’s sex—do not constitute an intersex person. This is because a person’s sex is defined by their reproductive organs and the sperm or egg they are potentially capable of producing.

The existence of both ovarian and testicular tissue is a logical and correct definition for intersexuality. However, this hasn’t stopped some people—including misguided academicians and researchers—from expanding the criteria for intersexuality to such a degree that the term is no longer instructive, meaningful, or scientific. One typical definition from Planned Parenthood states that “Intersex is an umbrella term that describes bodies that fall outside the strict male/female binary. There are lots of ways someone can be intersex....a person is born with reproductive or sexual anatomy that doesn’t fit the boxes of ‘female’ or ‘male.’”⁵³ This definition is vague and highly subjective. It indicates that designating someone “intersex” depends on what “female” and “male” look like to the person doing the assessment, rather than on objective scientific criteria.

“Intersex people,” states the website of Intersex Human Rights Australia, “share common ground due to the shared experience of stigmatisation of our atypical... physical or anatomical sex characteristics...It is the perceived need for diagnosis and treatment itself that defines the intersex population, and not necessarily a specific and narrow set of causal factors.”⁵⁴ But defining the intersex population by “a specific and narrow set” of factors (though not necessarily causal) is, in fact, the correct way to determine intersexuality—although I can understand why one might want to broaden the term to include other conditions. People with presumably atypical genitals, or secondary sex characteristics that don’t match their perceived sex, suffer ridicule, bullying, shunning, prejudicial psychological labeling, and even medical malpractice. Many are forced to undergo surgery to make their genitals conform to the way doctors think they’re supposed to look (discussed shortly). To help bring these cruel and unethical practices to the public’s attention, a wide range of people have organized under the intersex umbrella.

True intersexuals—that is, individuals who possess both male and female reproductive organs in whole or part—are quite rare, numbering only about 0.018% of the world’s population.⁵⁵ But if you accept the definition of intersex to include biological males and biological females with health conditions whose symptoms include atypical genitals, the numbers skyrocket. A popular medical website cites about 1.3 intersex individuals in 1000 babies, which—using the statistic of 7.8 billion people in the world in the year 2020—would make the

total intersex population 10,140,000.⁵⁶ A similar statistic reports the incidence of intersex births in the United States as almost two for every one hundred, or about 2 percent of the population—about the same odds, we are told, for being born with red hair.⁵⁷ Many websites and even some scientists have widely publicized this “red hair” analogy as irrefutable fact.⁵⁸

A website devoted to intersex equality gives an astronomical number of 132,600,000—a little more than 13 times the figure of 1.3 in 1000 infants—based on calculation by Anne Fausto-Sterling.⁵⁹ She labels people with various medical conditions as intersex. These include females with Turner Syndrome (they lack a second X chromosome, but are clearly female) and males with Klinefelter Syndrome (possessing XXY chromosomes, but they are clearly male). People with Congenital Adrenal Hyperplasia are also considered intersex, even though it’s a well-known medical condition (discussed shortly), and no experienced physician would dream of calling a CAH person “intersex.”

In a paper published in 2000, Fausto-Sterling and co-authors expanded the label of intersex to include any person who diverges from the Platonic ideal of physical dimorphism at any level: chromosomal, gonadal, genital, or hormonal. *Physical dimorphism* refers to a markedly different appearance in males and females, which is how you tell them apart. The so-called Platonic ideal (named after teachings of the Greek philosopher Plato) characterizes the features of all things in nature with extremely narrow parameters so that any variations of a basic pattern are seen as different species, not as organic changes or deviations evolving over time. The authors’ interpretation of the Platonic ideal for a male consists of XY chromosomes, testes in a scrotal sac that produce functional ejaculate, hormone production ensuring a normal masculinizing puberty, and a penis measuring between 2.5 and 4.5 cm at birth. An ideal female is supposed to have XX chromosomes, functional ovaries that produce eggs and ensure a normal feminizing puberty, oviducts (tubes through which the eggs pass) that connect to a uterus, a vaginal canal connecting the cervix (lower portion of the uterus) to the mouth of the vagina, inner and outer vaginal lips, and a clitoris measuring between 0.20 and 0.85 cm at birth. The authors of the article begin by asking how often male and female development meets these exacting criteria.⁶⁰

How often, indeed? Certainly not as often as one might imagine, in view of those criteria. Penile and clitoral measurements can vary widely, and a man or woman might possess improperly functioning structures or lack them altogether. Therefore, it’s not unreasonable to guess that some people’s reproductive apparatus would fall outside this Platonic template. Why, then, were such unreasonably rigid—not to mention unrealistic—criteria used by the authors? Colin Wright offers a levelheaded hypothesis:

There appear to be two main goals when forwarding this claim—one laudable, the other insidious. The laudable goal is to normalize the existence of intersex people and thereby help facilitate the societal acceptance of a marginalized community who may experience social

ostracism and who have often been victims of medically unnecessary “corrective” cosmetic surgeries as infants. The insidious goal is to plant seeds of doubt in our collective understanding of biological sex and suggest that the categories “male” and “female” may be social constructs or exist on a “spectrum.”⁶¹

Wright takes care to point out that no matter what the percentage of intersexuals is, even if it’s “quite low, this by no means justifies any of the mistreatment, whether socially or medically, that many gender activists hope to prevent when they overstate its prevalence. How we treat people, and the rights afforded to them, should not be predicated on their prevalence within a population. And that is the point we should be trying to normalize, rather than false statistics.”⁶² I agree. The mistreatment that intersexual people endure is inexcusable. But by sacrificing science at the altar of getting people to behave compassionately, the authors of the “Platonic ideal” article end up doing everyone a huge disservice.

Let’s take a more detailed look now at the most common variations of sexual development—some of which are genuinely intersex, and some that have been classified under the intersex umbrella. This is not merely an academic exercise. Several of the anatomical variations are the result of serious medical conditions, which if left untreated can be life-threatening.

Some Common Variations

Below are the most common and easily recognized departures from the usual development of males and females. Some of the syndromes overlap, and in many cases the causes are multifaceted.

◆ *Androgen Insensitivity Syndrome (AIS)*

This syndrome, occurring in one in 20,000 to one in 64,000 individuals, affects sexual development before birth and during puberty. Children are born with the male XY pattern and testes that make abundant testosterone. However, the body’s cells are unable to detect and respond to testosterone (a major androgen hormone), either completely or partially. The testes of all males naturally produce some estrogen during puberty; so if the body’s ability to respond to testosterone is exceptionally reduced, feminization will be more pronounced. The individual often develops breasts. The body shape may appear female because the waist narrows and hips widen—so much so, that the person may develop a voluptuous figure. Usually secondary sexual characteristics do not appear, so once puberty starts the child does not develop facial hair. This condition used to be called “testicular feminization syndrome” because often it was not discovered until the adolescents—assumed to be girls due to their appearance—failed to menstruate. Then, after they were examined, it was discovered that some of them had testes instead of ovaries.

Complete androgen insensitivity causes the person’s external genitalia to look like those of a typical female. Milder cases of androgen insensitivity can

cause the person's external genital to be more ambiguous in appearance. The organ might only somewhat resemble a typical female's, it can possess both male and female characteristics, or it might even resemble a typical male's.

At this time, conventional medicine has no way of inducing the androgen receptor sites on the cells to start receiving and absorbing testosterone, although some holistic methods might help (see Notes).⁶³ The medical establishment provides sexual "reassignment" in the form of hormone replacement and genital plastic surgery. Sometimes counseling is offered, but sadly, not often. If the baby's sex is unclear, most doctors immediately advise the parents to "correct" the child's appearance so it is recognizable as either male or female (usually female). Usually, the individual appears female and is raised as a girl.

Some medical authorities consider this an intersex condition while others see it as a medical problem. I also see this as a medical problem because the condition is due to malfunctioning androgen receptors.

◆ *Congenital Adrenal Hyperplasia (Adrenogenital Syndrome)*

Congenital adrenal hyperplasia, or CAH, is not a "one size fits all" disorder. It encompasses a group of disparate medical conditions that are due to a malfunction of the adrenals, the pair of walnut-size glands that sit on top of the kidneys. The adrenals produce cortisol, which regulates the body's response to illness or stress; mineralocorticoids such as aldosterone, which regulate sodium and potassium levels; and testosterone and other androgens, which both males and females produce.⁶⁴ How CAH manifests, when it emerges (it can be late-onset), and at what intensity, depends on which gene is expressing and which enzymes or hormones are being produced in insufficient or excessive amounts. Each contributing factor may have more than one name, depending on the source describing it. However, the overall dynamics are widely recognized by medical personnel.

Classic CAH is the most severe and rare form, also known as "salt-wasting." It results from insufficient aldosterone and affects about one in 10,000 to 15,000 people. The body, unable to retain enough sodium, suffers severe, life-threatening problems with the heart, occasionally accompanied by ambiguous changes in the genitals.⁶⁵ This clearly medical condition requires treatment for the person's entire lifespan. However, the two manifestations of CAH more relevant to our discussion are considerably less severe, affecting primarily the sexual system: simple virilizing CAH and nonclassic CAH.⁶⁶

Simple virilizing CAH reflects a moderate 21-hydroxylase deficiency and a mild aldosterone deficiency, which in simple language means too little cortisol and too much androgen. Nonclassic CAH is caused by a slight deficiency in 21-hydroxylase (cortisol)—so slight, in fact, that some people with this condition don't know it because the symptoms are so mild.⁶⁷ In girls and boys with more challenging issues, there may be a growth spurt at a very early age that culminates in lessened growth as an adult, with occasional infertility.

Otherwise, health is normal. Both CAH types have similarly ambiguous genitalia. Males may display early signs of puberty and an enlarged penis. Females may exhibit an irregular menstrual cycle, facial hair, a deeper voice than usual, and an enlarged clitoris.

Some researchers claim that girls with simple virilizing CAH are less stereotypically feminine and more masculine according to current Western cultural standards. For example, they enjoy playing with trucks and other boy-associated toys instead of dolls, and they're more interested in their careers than in marrying and having children. Other researchers have disputed these findings. None of this matters. The girls will need the love and support of understanding adults if they are to love and accept themselves.

This is not an intersex variation, but a medical condition. Most CAH individuals can live fulfilling lives. They can be treated with feminizing or masculinizing hormones if they are uncomfortable with their appearance.

◆ *Polycystic Ovary Syndrome (PCOS)*

PCOS is the name for a somewhat complicated condition in women that can have more than one cause. Normally, females produce testosterone and other androgen hormones in small amounts: in the ovaries, adrenal glands, and certain fat cells. (Males produce them in much larger amounts in the testes, and to a much lesser extent in the adrenal glands.) Androgens are responsible for male sexual characteristics and reproductive activity, but in females they also play an important role in more than two hundred bodily functions. This includes the stimulation of hair growth in the pubic and underarm regions, the prevention of bone loss, the regulation of muscles and several organs, and sexual desire and satiety.

In women, the body normally converts the androgens into estrogens. But four to seven percent of women are unable to make the conversion due to a tumor on an ovary or adrenal gland, or a malfunction of the pituitary gland. Possible outcomes include an enlarged clitoris, a decrease in breast size, a more angular figure, an increase of male-pattern body hair (on the face, chin, and/or abdomen), a deepened voice, lack of a menstrual period, and greater muscular strength than the average female. Many women with PCOS are medically treated because this hormonal imbalance can have more severe and harmful effects, including high blood pressure and insulin resistance that leads to diabetes. Sometimes, though, a woman has a much milder case, her more masculine appearance being the chief symptom.

With this condition, there is no question that the individual is female. Hormone imbalances are causing her male secondary sex characteristics, so this is not a true intersex variation. She might be treated with feminizing hormones if she's uncomfortable with her appearance. If there's a tumor on one of her glands, it's probably necessary to surgically remove it.

◆ *XY with 5- α -Reductase Deficiency*

The majority of people with an insufficient supply of enzyme 5- α -reductase live in portions of the Dominican Republic and in the Papua, New Guinea highlands, home to the Sambian population. (The geographical specificity suggests a nutrient imbalance in the soil or water, or certain toxins that might interfere with enzymatic reactions in the body.) At birth, XY infants with this enzyme deficiency have ambiguous genitalia: a tiny penis that looks like a clitoris, undescended testes, and a divided scrotum that could easily be mistaken for a vagina. Sometimes the ambiguity of such children is recognized immediately, while other times the children are raised as girls. Most of the time during puberty, when the sex glands—which are functioning normally—produce additional testosterone, the individuals appear more typically male. Testes descend and the divided scrotal lips fuse to form a more typical scrotum. The boys become more muscular and develop hair on the body and face. In the United States, doctors tend to immediately operate on the hapless infant, but in the two areas of the world where this phenomenon is common, the infant is left alone because it's understood that he will change when he hits puberty. Both cultures have a name for such a child. The Dominicans call him *guevedoche*, or “penis at twelve,” while the Sambians term the impending transformation *kwolu-aatmwol*, which means “[will transform] into a male thing.”⁶⁸

The outcome is always male. The genitals simply become more developed and recognizable later in life, and the secondary sex characteristics occur later than with typical males. Testes are always present. Therefore, I do not consider this condition intersex. Some medical authorities disagree.

◆ *De la Chapelle Syndrome (Sex Inversion): Males With XX Chromosomes*

With this condition, a male possesses XX chromosomes. Known as “sex inversion,” 46,XX, or De la Chapelle Syndrome—after the Finnish doctor who first described it—this variation occurs in about one in 20,000 infants. During fertilization, a gene that programs for male development gets moved from where it's normally located. Commonly, a small Y chromosome fragment transposes onto an X chromosome, which produces an XX male.

Due to the predominance of X traits, the body produces less testosterone than usual. The appearance of XX males can vary. The most common manifestations are small testes, enlarged breast tissue (noncancerous), bone weakness (due to decreases in calcium and phosphate), erectile dysfunction, diminished libido, infertility, and sometimes depression. However, not all XX males manifest all these characteristics. Internal and external genitalia may be ambiguous, unambiguous, or a mixture of the two. Males with De la Chapelle Syndrome have different degrees of masculinization.

I have not seen recent research on someone with this syndrome who has chosen to live as a woman. British racing driver and World War II fighter pilot Robert Marshall Cowell (1918–2011), who later became Roberta—the first known British subject to undergo sexual “reassignment” surgery—claimed

to have been born with De la Chapelle syndrome. Unlike 80 percent of people with this condition, Cowell was not sterile, having fathered two children with his wife when he lived as Robert.

Hormone and genetic testing can confirm this syndrome. Supplementary testosterone usually corrects the manifestations. Psychosexually, these individuals generally identify as male. If boys are treated with kindness and are given counseling—along with testosterone—early enough to help them cope with their condition, they can live normal and productive lives. Some may choose not to be medically treated.

Medical authorities label De la Chapelle Syndrome an intersex condition.

◆ 46,XY

The “46” refers to a chromosome involved in sexual development. There are many possible causes of 46,XY. The person might be unable to completely synthesize testosterone and other androgen hormones. Or the receptor sites to those hormones might be scarce, resistant, or functioning poorly in other ways. Sometimes there’s a deficiency of one or more enzymes that are required to produce testosterone—in which case, the amount of testosterone will be scanty, or the hormone won’t work as well as it typically does.

The repercussions of this condition are many and varied. The person may appear markedly male, but most often masculinization is weak due to insufficient testosterone. The individual may look male and possess atypical external genitals. The genitals may be ambiguous, incompletely formed as a male micropenis, or even female in appearance. But even if an individual has what appears to be a vagina, there may be an absence of ovaries, Fallopian tubes, and a uterus. Testes might be absent. If they are present, they could be internal—which means they simply haven’t descended from the abdominal cavity as they usually do. If the testes are internal and functioning properly, and receptors to the hormone are also working, the person will be masculinized in the usual manner, especially when puberty starts. Alternately, if testes are present they might be abnormally formed. There are as many variations as there are individuals with this syndrome. Olympic track and field runner Caster Semenya has this condition, producing ample testosterone and appearing masculine while living as a woman due to the appearance of an isolated vagina-like structure. The athlete’s participation in women’s sports is covered in Appendix B.

This condition is rightly considered intersex. Doctors typically “correct” the genitals via surgery when the child is very young. But this is at best a mistake, and at worst unkind. If the individual is surgically manipulated to look like one sex but possesses functioning gonads, ample hormone levels and normal hormonal receptors of the opposite sex, overtly opposite-sex traits will manifest at puberty. Young children, rather than having hormones and surgery forced on them, should be allowed to choose their own path as adults.

◆ *Simultaneous Male and Female Sex Organs*

The medical profession used to call this condition “hermaphroditism” or “pseudohermaphroditism” until objections were raised by those who felt stigmatized by the labels. These individuals possess both male and female external genitalia that are visible at the same time. One cause is excessive androgen hormone exposure in female embryos, which results in male-looking genitals. Another cause is delayed testosterone exposure in males, which results in female-looking genitals until puberty.

Variations of this intersex condition can occur when two fertilized eggs fuse together, giving the fertilized cell or zygote two X chromosomes and one Y chromosome. Some individuals who display such genitalia might have been exposed *in utero* to common agricultural pesticides, which are known to adversely affect hormones (see Chapter 5). Before such pesticides were manufactured, such intersex individuals existed, but they were rare.

Regardless of one’s genetic makeup or reproductive organs, everyone deserves to be treated with respect. Unfortunately, not everyone is. See below.

Surgical “Corrections”

What is being done to help children with atypical genitalia? It depends on what kind of help you are talking about, and who is offering. The Western medical establishment, rather than expanding its world view to include variations of human anatomy and respecting an infant’s right to bodily autonomy, chooses instead to “fix” the child.

When any child is born, the doctor or midwife checks for general health and examines the genitals to determine the child’s sex. If a doctor decides that the genitals don’t appear normal—that is, if the testes haven’t descended, the vulva doesn’t look like other vulvas, the penis is deemed too small or the clitoris is deemed too large—tests are ordered. A genetic evaluation and hormone tests are conducted to ensure that they coincide with each other according to the most usual standards. Then the doctor ensures that his or her visual inspection of the genitals corresponds to both the chromosomes and the hormones. Based on what the tests reveal, the genitals are surgically altered. Unless the parents intervene, it’s usually not a matter of *whether* to perform surgery on the child, it’s a question of *which* sex’s genitals to use as a template *when* doing the surgery. Surgery is intended to make the child’s sex organs match the gold standard for what genitals are supposed to look like, according to the medical profession.

In 2018, Kristina Turner and her 10-year-old intersex child Ori gave a presentation. They showed a chart depicting “optimal” genital sizes, designed to help doctors determine if a newborn’s genitals are female or male. If clitoral/penile tissue is under three-eighths of an inch, the child is a girl. If the tissue is above one inch, the child is a boy. The gray area between three-eighths of an inch and one inch is apparently unacceptable and indicates the “need” for surgery.⁶⁹

The problem is, standards for genital size and shape depend on the aesthetic preferences of the doctors, and sometimes the parents too. Surgeons who don't think that the genitals match the child's chromosomal and/or hormonal makeup advise giving the child hormones and surgically reshaping the genitals before the age of two—even though in the vast majority of cases, the infant is perfectly healthy. In the case of intersexual Ori Turner, had mother Kristina succumbed to pressure from the medical establishment and allowed surgery, the doctors would have been faced with quite a dilemma. Ori possesses both XX and XY genetic material. In this case, what is Ori's sex? I have not seen reports of the size and appearance of Ori's genitals—the child has a right to privacy—so it's difficult to say if Ori is fundamentally male or female, neither, or both.

Few infants and children possess Ori's apparent ambiguity. And many CAH girls exhibit only an enlarged clitoris to indicate an internal health issue. Yet doctors tend to push parents to give very young girls "corrective" genital surgery. What, exactly, is being corrected? A perfectly intact clitoris is being mutilated because it doesn't conform to a stereotypical clitoris as envisioned by medical personnel. The surgeon typically cuts off the tip intact, lobs off most of the shaft, and then reattaches the tip to the stump. But when you excise tissue and cut through sensitive nerves, it kills them. This almost guarantees that as an adult, the girl's chance for a healthy and gratifying sex life will be destroyed. She may suffer reduced sensation, or never be able to experience orgasm at all. Then there's the risk of infection from surgery. Any type of alteration to genitals, female or male, that is performed for a reason other than absolute medical necessity, can and should be regarded as mutilation.⁷⁰

"Some women with CAH," one website advises, "who had surgery as babies wish they had not had it. This risk of surgery needs to be weighed against concerns over parenting a child with unusual genital appearance. Take your time to decide about surgery that is *elective* and not *medically necessary*. There's no reason to rush into elective surgery."⁷¹ Registered nurse Stephani Lohman, whose daughter has a mild (not life-threatening) form of CAH, explains her decision.

I had noticed right away that my baby's genitals did not look like what any of my other children had. A couple days later, a urologist suggested that we do elective surgery: a clitoroplasty [surgery to reduce the size of a clitoris], and a vaginoplasty [surgery to increase the size of a vagina or create a cavern to imitate a vagina] to make our baby look more "typically female." We argued back, saying that we had done a little research on our own and it didn't seem like this was a good suggestion....They may believe genital differences cause social problems, but that has never been shown, and urologists are not the authority on psychology....[F]or those who do grow up to have a female gender identity, how can we be certain they might not want to grow up with their original bodies, or decide based on how they feel later?...We decided that we would wait and let our child make an informed choice on their own, since it is their body.⁷²

Besides destroying sexual pleasure and orgasm, clitoral surgery can cause permanent pain that does not subside, regardless of whether the clitoral tissue is flaccid or erect. Surgery frequently causes necrosis (the death of tissue) because cutting severs the flow of blood to the area. Stenosis—the narrowing or obstruction of a canal, channel or duct—is the most commonly reported complication of surgery for ambiguous genitalia, reports Fausto-Sterling, based on her review of the literature. Scar tissue, often occurring in the vaginal (introital) opening, is a typical cause of this obstruction. The narrowing or outright obstruction causes not only discomfort, but often excruciating pain. Additional surgeries may be required to eliminate the original scar tissue.

Cheryl Chase, Executive Director of the Intersex Society of North America, sent a letter in 1998 to a judge in Columbia, South America about a case involving the unnecessary cutting of girls' genitals. Among her many points, Chase wrote that when a child is older, the genitals are larger and therefore easier for a surgeon to work on without scarring. "One reason for poor surgical outcomes may be that scar tissue is negatively affected by the changes in size and shape that accompany normal growth and pubertal development; surgery performed after puberty would avoid that risk. It is likely that surgical techniques will have improved by the time she has grown; waiting will allow her to benefit from advances in technology.... There is good evidence that adults would not choose clitoral surgery for themselves. There are many adult intersex women who express regret and anger that genital surgery was imposed on them."⁷³

Morgan Holmes was one unfortunate recipient of such surgery. When Morgan's mother was pregnant with her, to prevent miscarriage doctors prescribed the hormone progestin, which can masculinize the fetus. As a result, Holmes was born with an enlarged clitoris. Doctors "corrected" her genitals with surgery—which she remembers—when she was seven years old. Unfortunately, Morgan Holmes did not have parents like Stephani Lohman to protect her. Although she could still have orgasms, her sexual function was nonetheless severely affected. "If my body had been left intact and my clitoris had grown at the same rate as the rest of my body," she wonders, "what would my lesbian relationships [and]...my current heterosexual relationship be like?... When the doctors initially assured my father that I would grow up to have 'normal sexual function,' they did not mean that they could guarantee that my amputated clitoris would be sensitive or that I would be able to achieve orgasm... What was being guaranteed was that I would not grow up to confuse the issue of who (man) fucks whom (woman)."⁷⁴

Another common surgery for CAH girls involves the urinary tract. Most females have two separate openings at the front of the vagina: the birth canal, and a smaller opening to the urethra which connects to the urinary bladder. CAH females sometimes have a urogenital sinus, which is an area where the urethra and vagina connect inside the body. This means that there's a single opening for fluids to leave the body. "Most children with CAH and genital differences," explains Lohman, "have a urogenital sinus with a low confluence, meaning that the urethra

connects with the vagina at a point that is close to the outside of the body instead of higher up toward the bladder.” Some doctors claim that failing to perform surgery on a urogenital sinus increases the risk of more urinary tract infections (UTIs). But “this is false and misleading,” Lohman writes.

In fact, children who do not have surgery for a urogenital sinus have no greater risk of UTIs than those who do. It is actually the opposite—it’s been shown that surgery itself can increase UTI risk. Surgery can also cause incontinence, or leakage of urine. For most people, urine does not dribble out on its own. The urine stays in your bladder because you have a sphincter: it opens, you urinate, it closes, and you’re done. Some people will be incontinent *because of* surgery if the sphincter or the nerves that control it are damaged....Think about it: you opened a sterile region of someone’s body, cut tissue, and moved things around. This creates scar tissue that can interfere with urinary function. Afterwards, it makes sense that we’d see UTIs increase.⁷⁵

Boys are not immune, either, from being robbed of their birthright of pleasure. If the child’s penis is deemed too small, the doctor will examine the infant rectally to see if the body contains a uterus or prostate gland. If there’s no prostate, the decision on how to “correct” this is clear: Create a girl! According to an article on surgery for ambiguous genitalia, fewer than 10 percent of babies born with ambiguous genitals receive surgery to resemble males. This isn’t surprising, as it’s easier to remove tissue than create and attach a functional appendage. Therefore, with an infant whose penis is considered insufficiently developed—perhaps accompanied by an unfused scrotum, and *especially* if the child also possesses XX genetic material—doctors simply remove the penis, and either form a cavern to resemble a vagina or enlarge an already existing opening. The idea is to raise such boys as girls. But not all boys respond well to such surgery, even if they don’t consciously remember it. Later in life they may discover, much to their grief and anger, that they had been violated.⁷⁶

The article “Surgery for intersex,” published in 2001 in the *Journal of the Royal Society of Medicine*, discussed the long-term outcome of genitoplasty, a form of plastic surgery to “feminize” the genitals. The author admitted that results from surgery were poor, and often more than one surgery was necessary because sexual intercourse wasn’t possible or was painful. Continued pain or complete lack of sensation, often due to scarring, was common. Also, there were too few long-term follow-up studies because doctors like to perform surgery immediately—which makes it difficult to find a large enough control group of intact females against whom results can be compared.⁷⁷ Since the article’s publication, the desire has not lessened to “fix” people whose genitals don’t look the way doctors or parents think they should. The authors of “Surgical Management of Infants and Children With Ambiguous Genitalia” emphasize how important it will be in the future for their patient to have a “satisfactory appearance when compared with

peers....The existence of a normal-sized penis [which of course is their job to surgically correct] in patients assigned a male role is comforting *to the parents*... Conversely, female babies born with an ungainly masculine enlargement of the clitoris evoke grave concern *in their parents*.” [emphasis added]⁷⁸ Note that the emphasis on having surgery is typically for the comfort of others. The individual’s bodily integrity, the right to experience pleasure, and the need to live a life free of pain, are never considered. Few doctors tell parents of the risks of surgery, and the patients are too young to give consent. How many parents would agree to a risky surgical procedure for their child if they knew the dangers—physically, mentally, and emotionally?

People with atypical genitalia who have reached adulthood are now fighting back. They recognize that the mutilation to which they were subjected as infants and children is a human rights violation. In fact, the Nuremberg Code specifically prohibits involuntary surgical procedures designed to alter the genitals for aesthetic rather than medically necessary purposes.

Christiane Völling from Germany is one person who fought back. Born in 1960, she had the medical condition called virilizing adrenal hyperplasia, which gave her ambiguous genitalia. Although she was raised as a boy, Völling had always considered herself female. When she underwent an appendectomy at age 17, her surgeon found that she had a uterus and womb. Although her female reproductive organs were completely intact, he removed them without telling his patient what he had discovered—and without her consent. In 2007, Völling began a two-year lawsuit against the surgeon for damages relating to the nonconsensual surgical intervention. For years, she said, she suffered physical impairments, pain, and psychological problems. She was awarded one hundred thousand pounds by the Regional Court of Cologne, which ruled that the surgeon had acted illegally.⁷⁹

In 2015, Michaela “Micha” Raab sued the Erlangen University Clinic, also in Germany, for a partial clitoris amputation and hormone treatments to which she had never consented. The doctor who performed surgery was found not liable—the court said that other doctors were responsible—but the clinic itself was found guilty. That same year, Nils Muižnieks, the Council of Europe Commissioner for Human Rights, published a paper outlining the rights of people with atypical genitalia to decide for themselves whether to undergo surgical and hormonal interventions. The document read in part:

Sex assignment treatment should be available to intersex individuals at an age when they can express their free and fully informed consent. Intersex persons’ right not to undergo sex assignment treatment must be respected....National and international medical classifications which pathologise variations in sex characteristics should be reviewed with a view to eliminating obstacles to the effective enjoyment, by intersex persons, of human rights, including the right to the highest attainable standard of health....Intersex persons and their families should be offered interdisciplinary

counselling and support, including peer support. Intersex persons' access to medical records should be ensured.⁸⁰

Malta is the first country to prohibit modifications to sex characteristics without the person's consent. As this issue is given wider publicity, more countries are expected to enact similar laws. As positive as this step is, though, we need to confront the deep-seated concern that people with atypical genitals elicit.

The underlying issue is that most people are uncomfortable with ambiguous sex organs. At what point do we stop perceiving sexual ambiguities as "variations" and call them statistically unusual "aberrations"? When a woman has a clitoris that's "too long"?⁸¹ When a man has a penis that's "too small"? Or when someone with XY chromosomes has a female-looking body? But why do chromosomes matter now, when they didn't in the past? In real life (except perhaps until recently), before we started dating we didn't ask others about their chromosomal makeup; usually, one look at their appearance sufficed. During a presentation in June 2022, Colin Wright pointed out that throughout human history, we knew what males and females were long before we had microscopes that allowed us to observe the mysterious realm of imperceptible chromosomes. Ironically, there were a lot fewer problems with identifying sex when we didn't have the luxury of delving into microscopic worlds. There's a difference, Wright astutely declared, between "Your sex is *determined* by your chromosomes" and "Your sex is *defined* by your chromosomes."⁸²

It's worth noting that before the phrase "Divergences of Sexual Development" was used to describe atypical genitals, the medical term was "*Disorders of Sexual Development*" and sometimes "*Disturbances of Sexual Development*." Some medical professionals still use the old phrases. But even for those who use the politically correct newer terminology, no words can erase how they really feel about genitals that don't conform to their aesthetic criteria. If we believe that such variations are created by genetic *disorders*, it's a small step to then assume that the owners of those genitals are abnormal—and thus need to be fixed. If they require fixing, it's another, small step to seeing them as a bit less than human, because they aren't "real" males or "real" females. Some people equate being "less than human" to being less deserving of compassion, regard, and even basic rights. Compare the condition of non-boilerplate genitals to medical conditions such as arthritis, needing a wheelchair due to amputation of a limb, or having cancer. A compassionate and humane person would never dream of judging someone who's ill as less deserving of respect and care. So why do we do this to those whose genitals fall outside of a certain standard of beauty or so-called normalcy? We would not slash into the genitals of someone who has the flu. So why do we insist on doing it to people whose genitals appear different? Why can't there simply be genital variety? Why not allow individuals to be themselves?⁸³ As long as they are happy, fulfilled and productive—and their atypical genitals are not presenting medical problems—who cares what their chromosomes are or what their genitals look like?

Unfortunately, some people do care—even though it’s none of their business—about whether other people’s genitals match their notion of normalcy. If a child presents standard-appearing genitals, then chromosomal and hormonal discrepancies might be overlooked. But the majority of physicians who observe atypical genitals feel compelled to investigate further to ensure that chromosomes, hormones and genitalia are all aligned with the most common template. And most parents of unusual children also seem overly concerned that their child appear “normal.” As much as some of us might want to believe that the desire to “normalize” an infant is well-intended and for the child’s own good, ultimately that desire is usually for the peace of mind of parents and doctors—not the child. Surgery that alters healthy genitals should be called what it is: mutilation. Let the individual decide as an adult what, if anything, should be done. Damaging a human being so we can make ourselves more comfortable with that person’s sex organs is unethical, wrong, and cruel. The only reason to offer medical treatment to an individual with unusual genitals is for potentially life-threatening conditions, such as tumors on the gonads, a hernia, or a salt or other biochemical imbalance due to adrenal malfunction. None of these medical symptoms specifically require interfering with the size or shape of the genitalia.

When a rare albino deer, rhino or buffalo are spotted in nature, we celebrate and marvel at it. We need to apply this appreciation of difference to sexual ambiguity. Rather than changing someone’s body, we need to expand our standards of what’s acceptable. A provisional identity may be given until the child is old enough to decide what she or he wants to do.

Categorizing Versus Assigning

When a doctor examines a newborn to determine its sex, the medical establishment typically calls this process “*assigning* a sex” to the child. Similarly, when someone undergoes the scalpel to have their genitals repositioned, sculpted and reshaped to approximate the opposite sex’s genitalia, modern medicine calls this “*sexual reassignment surgery*.” I find both of these phrases very troubling because the sex of a child cannot be “assigned.”

The secular, common definition of *assign* is “to appoint to a post or duty,” or “to appoint as a duty or task.”⁸⁴ A reporter at a newspaper is *assigned* to cover an event. A schoolchild is given homework *assignments*. Someone is *assigned* specific duties as part of their job. How is it possible for human beings to “assign” genitals to other humans? Only nature (or God) can “assign” body parts. What we are doing is *observing* the child’s sex so we know whether it’s male or female. On the other hand, sex *roles*, also known as gender roles, *are* assigned. I’ll be discussing sex (gender) role stereotypes in great detail in the next chapter, but right now I will finish my point, which is related to biology and not culture.

Whenever we use the phrase “sexual assignment,” this sleight-of-hand with the English language is not only misleading, it’s dangerous. It’s dangerous

because it promotes concepts that are fictitious. If we believe that we can call a child one sex or the other based on our beliefs, then there's no such thing as biology. And without biology, there are no facts; it's all opinion. What we *can* do, though—which *is* consistent with reality—is *categorize* children according to their biological sex. *Categorize* means “to put into a category,” and a *category* is “any of several fundamental and distinct classes to which entities or concepts belong.”⁸⁵ We can reliably place human beings into categories of male or female, based on what type of reproductive cells they produce: eggs (ova) in females, or sperm in males.

Proponents of the “there are more than two sexes” theory like to point out that nature is not as rigid as we might believe. This is true; variety is part of the natural world. Some species of animals share duties. For example, the male seahorse gestates the eggs that the female lays in his pouch. Male penguins stand on the eggs of their offspring, and later, keep the baby birds warm after they've hatched. In a massive transformation, certain species of fish, reptiles and amphibians are able to change their biological sex.⁸⁶ But there is never a third sex. Males change into females, and vice-versa. With humans, even when the sex is ambiguous, it's *still* never a third sex. It might be both male *and* female. It could be just slightly reminiscent of one or the other, or of both. Or it could be neither. But even if that ambiguity seems like neither, it still would have differentiated into something resembling male and/or female: It contains the seeds for both. We might possess greater or lesser amounts of “maleness” or greater or lesser amounts of “femaleness,” but the reference points are still male and female. We all belong somewhere on the male-female spectrum—there are simply no other choices. Keep in mind that being on the biological spectrum does not mean another species or a different sex. As I mentioned earlier during the discussion of the Platonic ideal, any departures from a basic pattern are variations. The same basic pattern remains and never disappears.

This biological reality notwithstanding, more people than ever—especially those under the 30-year-old age bracket—are claiming that they are “non-binary.” They don't want to be categorized as being either male or female, so they are “assigning” themselves a category that they believe somehow neutralizes, negates, or changes their genitals.

Why would some people want to fight so hard against their own biology?

There are many contributing factors. But the major reason is the harmful stereotypes that are foisted on people whether they want them or not. You got a small taste of them in this chapter, and the next chapter will be devoted exclusively to all sorts of ways in which we box people in. Our culture promotes the mindset *You're either a man as society defines him, or you're a woman as society defines her. Anything else is unacceptable.* But society's definitions are extremely limiting. Children who don't follow this script—whether physically, behaviorally, mentally, or emotionally—are harshly judged, bullied, and ostracized. Therefore, some people might think that if they renounce their sexual category as a biological

male or biological female, they'll be able to fling away the cultural expectations, labels, and pressures that automatically accompany what lies between their legs. But with this magical thinking, these non-binary folks are making a huge error. They're mistaking their biological sex for the *social roles* ascribed to that biology—and because of that, are causing themselves immense and unnecessary heartache.

Sex role stereotypes are so ubiquitous in our culture that they have become invisible. How can we lessen—even if we can't entirely eliminate—some of the pressure people feel to be more stereotypically masculine or more stereotypically feminine? That is what I'll be exploring in the next chapter.



PART II

CULTURE





2

SEX ROLE STEREOTYPES

Clarifying Gender

What is gender? Ever since the word came into existence, its meaning has changed—but only in some circles, and only sometimes. A person might use the word differently on different days. The first thing, then, is to clarify the meaning of the word as I will be using it throughout this book.

Since about the 14th century, *gender* meant “kind, sort, class, a class or kind of persons or things sharing certain traits.” An earlier form of the word came from the Old French *gendre* and *genre*, which meant “character” as well as “kind” or “species.” All these words are rooted in the much older Latin *genus*, which meant “race, stock, family; kind, rank, order, species,” as well as “(male or female) sex.” Despite its etymological age, *gender* was rarely uttered. Instead, *sex* was used to describe whether someone was male or female.¹

The concept of gender *roles* is said to have been introduced in 1955 by a psychologist.² But the differences between sex and gender became widely publicized and accepted in 1972 with the publication of *Sex, Gender, and Society* by sociologist Ann Oakley. In her book, Oakley distinguished between *biological sex*, which is determined by one’s reproductive organs, and *gender*, based on beliefs about what men and women are capable of and how they ought to behave. Oakley’s book was groundbreaking because she explored many cultures. The cross-cultural comparisons of men’s and women’s roles—which were quite different, depending on the country and even region—demonstrated how characteristics that might have been considered innate were in fact heavily influenced by one’s

environment. Oakley not only provided clarity about women's issues, she also catalyzed the extensive use of *gender* to mean *sex role stereotypes*.³ Those phrases, along with *sex roles*, *gender roles*, and *gender stereotypes* were all used by feminists and some academicians to mean the same thing.

Problems arose when the word "gender" began to be used interchangeably with the word "sex"—and its meaning as *imposed cultural stereotypes* became lost.⁴ Today, most people say "gender" when they really mean "sex," thinking that it indicates the biological reality of whether one is male or female.

The fusion of the two words confused more than just the general public. A surprisingly large number of researchers and scientists conflated the terms as well. Editors of a scholarly textbook describe problems they encountered as a result of the shifting terminology.

One of the first barriers that...[we] faced was the inconsistent and often confusing use of the terms *sex* and *gender* in the scientific literature and the popular press.

Use of *sex* and *gender* varies widely among disciplines and authors. Anthropologists...consider the distinction between *sex* and *gender*...to be very important, as it is possible to determine sex by analyzing skeletal remains and to obtain information on gender roles through the study of artifacts. A 1988 study...demonstrates [that] although the rate of use of the term *sex* in the biomedical literature has not changed significantly since the late 1960s, the rate of use of the term *gender* has increased markedly...[M]ost articles published in the late 1960s and early 1970s made a distinction between *sex* and *gender*. However, among the more recent articles...more than half did not distinguish between the terms...[M]ost published reports are using *gender* as a synonym for *sex*...Medical textbooks perpetuate the confusion. *Harrison's Principles of Internal Medicine*, the quintessential internal medicine text, uses *sex* and *gender* interchangeably.⁵

Some sources, though, are clear about the distinctions between *sex* and *gender*. The differences are so important that the American Psychological Association defines the terms in a pamphlet. "Sex...refers to one's biological status as either male or female, and is associated primarily with physical attributes such as chromosomes, hormone prevalence, and external and internal anatomy. Gender refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women. These influence the ways that people act, interact, and feel about themselves."⁶

Even the Office of the High Commissioner of Human Rights (OHCHR) offers a definition: "A gender stereotype is a generalized view or preconception about attributes or characteristics, or the roles that are or ought to be possessed by, or performed by, women and men." The OHCHR also cautions that "A gender stereotype is harmful when it limits women's and men's capacity to develop their personal abilities, pursue their professional careers and/or make choices about



4

GENDER DYSPHORIA AND MENTAL ILLNESS

Fallout of the “Wrong Body” Myth

“Gender dysphoria...belongs in the family of similarly disordered assumptions about the body, such as anorexia nervosa and body dysmorphic disorder,” psychiatrist Paul McHugh once remarked.¹ *Body dysmorphic disorder* is the preoccupation with an imagined physical defect or minor flaw that is not obvious to others. But the radical trans mantra, that people are “born into the wrong body,” is stated as though such a phenomenon is real. Mental health organizations legitimize this feeling by providing a diagnosis: *gender dysphoria*. The American Psychiatric Association’s description of this state of mind is typical.

Gender dysphoria involves a conflict between a person’s physical or assigned gender and the gender with which he/she/they identify. People with gender dysphoria may be very uncomfortable with the gender they were assigned, sometimes described as being uncomfortable with their body (particularly developments during puberty) or being uncomfortable with the expected roles of their assigned gender.

People with gender dysphoria may often experience significant distress and/or problems functioning associated with this conflict between the way they feel and think of themselves (referred to as experienced or expressed gender) and their physical or assigned gender.

The gender conflict affects people in different ways. It can change the way a person wants to express their gender and can influence

behavior, dress and self-image. Some people may cross-dress, some may want to socially transition, others may want to medically transition with sex-change surgery and/or hormone treatment. Socially transitioning primarily involves transitioning into the affirmed gender's pronouns and bathrooms.²

A very troubling aspect of this definition is the APA's acceptance of gender as an immutable, biological fact rather than a socially reinforced ideal. If we call gender what it truly is—*sex role stereotyping*—and substitute that phrase everywhere the word “gender” appears, a very different picture emerges. The APA correctly observes that some people (I would say *many* people) have difficulty embracing their assigned gender role. Yet the APA supports the position that gender stereotypes are natural, normal and reasonable, rather than being two-dimensional, limiting, and often demeaning. As discussed in Chapter 2, both females and males are often made to feel inadequate or wrong if they want to break free from their social roles and have more choice in their lives. Instead of recognizing that these stressful stereotypes can easily contribute to mental illness, and calling for the elimination of such roles, the APA recommends that the body be pumped full of cross-sex hormones, that the person take hormones *and* submit to mutilating surgery, or that the person simply declare membership in the opposite-sex camp while wearing its clothing—as evidenced by the suggestion to “cross-dress” or “socially transition.” Then, of course, there are the outright dangers to the general public of allowing transgenders to visit the bathrooms of natal men and especially women. I'll discuss this in detail shortly.

What I find almost unbelievable about the above guidelines is the assertion, clearly expressed in the final paragraph, that someone can be called a woman if he was born with a penis and scrotum, and someone can be called a man if she was born with a clitoris, vagina and womb. This contradicts basic biology. Not insignificantly, it also challenges the presumed qualifications of APA members, all of whom have requisite training as physicians. The American Psychiatric Association represents psychiatrists—medical doctors who, after their foundational training in medicine, further specialize in the brain, just as other doctors might specialize in pediatric medicine or gynecology. While a small percentage of psychiatrists offer counseling or psychotherapy, most focus on the administration of pharmaceuticals. The hope is that the drugs will somehow eliminate depression and regulate mood, even if they blunt one's ability to feel deeply or numb emotions altogether (not to mention the “side” effects of mood-altering pharmaceuticals). It's not surprising that a professional invested in corporate medicine would advocate hormone treatments and surgery to address a problem instead of helping a patient break free of limitations that negatively affect quality of life. Nevertheless, it's still shocking that someone trained in medicine—which includes anatomy, physiology and biology—could discount basic scientific reality so easily.³ A reasonable person might also think it incongruous that male-bodied MtFs who receive chest implants and female-bodied FtMs whose breasts

are excised still consider themselves members of the opposite sex if they retain their intact natal genitals. But it's pointless to try to make sense out of something that's inherently irrational. No matter which version of "I am actually a woman in a man's body" or "I am actually a man in a woman's body" you follow, by definition a woman has female genitals and a man has male genitals—and even if those genitals have been removed, no mechanical modification or remodelling can change basic biology.

Unlike the American *Psychiatric* Association, which fails to distinguish between sex (biology) and gender (cultural roles), the American *Psychological* Association does—at least in its official policy. Members of the American Psychological Association include psychologists who received their degrees from accredited institutions and graduate students who are taking courses in psychology. Psychologists are not medical doctors and are not authorized to write prescriptions. Therefore, their focus is not on taking pharmaceuticals or receiving surgeries as the solution to mental issues. Instead, they employ a wide variety of therapeutic modalities that help people understand the source of their problems, learn better ways to cope, and ideally find inner peace through greater self-acceptance. Sometimes, people's authentic behaviors and preferences happen to align with many aspects of sex role stereotypes. But those who are atypical for their prescribed gender role and feel persecuted or limited by it are not as fortunate—unless they can get professional help, the kind that facilitates genuine self-understanding and self-acceptance. If people are to be truly healthy mentally and emotionally, they need to be encouraged to discover who they really are and develop according to their nature, rather than try to conform to social roles in the effort to gain the approval of others.

Walt Heyer was a happily married man who became an unhappy MtF transgender at age 43, and after eight years *detransitioned*, or presented again as his natal self. Having earned a degree in counseling, he eloquently discusses the problems of correct diagnosis and the lack of proper support for people who are labeled transgender.

Psychological conditions present in almost 70 percent of people with gender dysphoria include anxiety disorders (panic disorder, social anxiety disorder, post-traumatic stress disorder), mood disorders (major depression, bipolar disorder, etc.), eating disorders (anorexia nervosa, bulimia nervosa, etc.), psychotic disorders, dissociative disorders, and substance abuse disorders. Dissociative disorder was found in 29.6 percent of those with gender dysphoria and 45.8 percent had a high prevalence of lifetime major depressive episodes.⁴

Being identified as a transsexual or diagnosed with gender dysphoria often stands in the way of getting a proper diagnosis... [Yet most mental health professionals] don't consider that by pushing patients toward gender change they are preventing them from being diagnosed and treated for another disorder . . . [that's]

likely to be present in two-thirds of patients. For patients undergoing gender change, this can be a quick trip to suicide. For...the ones who suffer from major depressive disorder, when they are not diagnosed and treated for the depression, suicide is a highly likely outcome.

Suicide among transgenders seems proof enough: 1) that they are suffering from undiagnosed mental disorders and 2) that gender change is not effective treatment for...[a certain class of] disorders present in the majority of patients. A physician who works with transgenders makes some great points: “We have so many reports of so-called co-morbid disorders in transsexuals. We need to now ask, do transsexuals have co-morbid disorders or do transsexuals have one disorder (mental illness) with just a fabricated *co-diagnosis* of gender dysphoria?”⁵

Several papers paralleling Heyer’s analysis have recently been released, fortunately without suffering retraction (at least not yet). A journal article surveying young people in their teens and twenties in Germany reported that a full 70 percent were eventually able to trace their gender dysphoria to other, deeper issues.⁶ And in January 2023, the *Journal of Sex and Marital Therapy* published “The Myth of ‘Reliable Research’ in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed.” E. Abbruzzese and two co-authors of this critically important paper explained that the entire industry of cross-sex hormones and genital surgeries for young people is based on two highly flawed Dutch studies that were done in 2011 and 2014, and which supposedly proved that transitioning patients is the only option for treatment. The methodological flaws were serious and many. In both studies, the subjects were preselected so that only successes, and not failures, would be tallied in the results. How was this accomplished? One, the assertion that gender dysphoria was resolved was biased toward a positive outcome due to the way in which questionnaires were worded. Two, although it had been suspected (and subsequently confirmed) that hormone treatments caused adverse effects, these symptoms were not factored into the study. Three, even though puberty blockers were supposed to be administered to children who were age 12, in actuality the average age of the subjects was 15. At that young age, being even three years older makes a huge difference. The more advanced physical and cognitive maturity of the 15-year-olds unquestionably contributed to a better outcome at the end of the trial. Four, because the test subjects were all receiving psychotherapy at the same time they transitioned, it was impossible to separate the beneficial effects of the therapy from the effects of hormones and surgery. Five, the test subjects used for one of the studies were disqualified if they exhibited any signs of mental illness. This biased selection for the most stable subjects was guaranteed to skew results, making the outcome much more favorable than it could possibly be in real life.⁷

In any experiment, the selection process should guarantee that the subjects represent an actual cross-section of the population so the outcome doesn’t appear

more positive or negative than it actually is. But the Dutch studies were heavily manipulated. In the 2014 study, of 196 initial participants, only 70—already biased to ensure a more positive outcome—were placed in the protocol; and of those, only 55 completed it. The 15 people who were removed and conveniently relabeled “nonparticipants,” were subjects with serious health issues. Their concerns included severe diabetes, obesity, and a death due to surgical complications.⁸

The publication of the Dutch studies has had disastrous consequences. Based on just two pieces of horribly designed research, the Endocrine Society—which boasts more than 18,000 practitioner members in over 120 countries—has consistently extolled the benefits of administering puberty blockers and cross-sex hormones to young people. The World Professional Association for Transgender Health (WPATH, discussed in Chapter 7) endorses both hormonal manipulations and surgeries—again, citing those two initial studies. It should be noted that Dr. Daniel Metzger, himself a physician at WPATH, acknowledged in an interview that young adults are not equipped to fully understand or evaluate the long-term effects of the treatments, and many feel regret afterwards.⁹

While the Dutch studies did accurately report that the hormonal and surgical interventions succeeded in changing the appearance of individuals—how could one’s appearance *not* be affected by such manipulations?—they failed to prove that such drastic physical alterations promoted any meaningful psychological changes that could justify the risks and adverse outcomes of those interventions. The intention of E. Abbruzzese and colleagues could not be misunderstood:

The burden of proof—demonstrating that a treatment does more good than harm—is on those promoting the intervention, not on those concerned about the harms. Until gender medicine commits to conducting high quality research capable of reliably demonstrating the preponderance of benefits over harms of these invasive interventions, we must be skeptical of the enthusiasm generated by headlines claiming that yet another “gender study” proved benefits of transitioning youth. This time-honored concern about risk/benefit ratio is a sobering reminder that the history of medicine is replete with examples of “cures” which turned out to be far more harmful than the “disease.”...

This highly politicized and fallacious narrative, crafted and promoted by clinician-advocates, has failed to withstand scientific scrutiny internationally...In the U.S., however, medical organizations so far [such as the American Medical Association, in 2022] have chosen to use their eminence to shield the practice of pediatric “gender affirmation” from scrutiny. In response to mounting legal challenges, these organizations have been exerting their considerable influence to insist the science is settled....[T]his stance stifles scientific debate, threatens the integrity and validity of the informed consent process—and ultimately, hurts the very patients it aims to protect.¹⁰

The mental and emotional problems of youth seeking to escape their problems by becoming someone else are numerous and escalating. The Dutch study critics found that before the boys and girls even began to deal with presumed gender dysphoria, they suffered from various emotional and mental disorders including anxiety, depression, autism, and attention deficit hyperactivity disorder (ADHD).¹¹ Another research team found that a disproportionately larger number of adopted children were seen at a clinic for gender dysphoria compared to the number of adoptees present in the general population.¹² This is not surprising, considering that many adopted children have backgrounds of neglect and abuse; and those who spend any length of time in institutions are more at risk for behavioral and emotional problems such as aggression, depression, anxiety, and attachment disorders.¹³ Finally, of the pubescent girls who claim they are transgender, the overwhelming majority don't fit the typical picture of someone who is truly gender dysphoric; other issues play a key role in their claim. This will be discussed in detail in the next chapter.

In 2022, Project Veritas managed to capture on videotape a revealing conversation at the Vanderbilt University Medical Center. Some of the staff objected to transgender procedures being done on children. "If you don't want to do this kind of work," they were admonished by a doctor, "don't work at Vanderbilt. Saying that you're not going to do something because of your conscience, because of your religious beliefs, is not without consequences. And it *should not be* without consequences." Another doctor said—again, without being aware that she was being filmed—"These surgeries make a lot of money." She cited the figures of 40,000 dollars to provide a "male chest" to females and several thousand dollars to give a patient hormones only a few times a year.¹⁴ Money is a seductive incentive.

Schools for young children and teens, along with colleges and universities, also promote transgenderism as a glamorous solution to the common problems of growing up. Trans activists are invited to speak at these schools, after which record numbers of young people decide that they were born into the wrong body and demand hormones and sexual "reassignment" surgery to correct their problem. Many of the trans-identified adolescent girls whom Abigail Shrier interviewed for her book *Irreversible Damage* had never had a sexual or romantic relationship—not even a kiss—with a boy or girl. Yet they adopted an entire vocabulary of transgender ideology with the full support of educational institutions that encourage young people to open up to who they "truly" are.

In California among other states, the administration and teachers of public and even private schools automatically accept students' declarations of being gender dysphoric because, they claim, to question them will hurt them. The schools are not required to tell parents that the children are being called by opposite-sex pronouns, or that they changed their name—in fact, there are special pre-printed forms on which to record them. Colleges are not obliged, either, to advise parents that students are given ready access to cross-sex hormones so they can get an early

start in their transition process. In most cases the parents are not told, especially if the child claims that the parents are not being supportive and are refusing to “affirm” his or her identity. Even if the student has a history of depression, anxiety or other mental health problems, the self-diagnosis of transgender is enough for the school counseling service to ignore any possible psychological issues and immediately dispense hormones—as long as the student signs an “informed consent” document. Small-town colleges and Ivy League universities across the United States counsel children to avoid interacting with their parents, and even consider running away, if the parents don’t agree with the child’s self-diagnosis. As for the parents, they are told that if they don’t “affirm” their son’s or daughter’s new identity, he or she will commit suicide. Even the child is told this. The power of suggestion strengthens the possibility that the prediction will be fulfilled.

Many of the social agencies that encourage children to obtain genital surgery don’t have a legal obligation to notify parents, either. In fact, the schools and agencies generally view the parents as intrusive adversaries who have no right to guide or take responsibility for their own offspring. Some agencies even help the children leave their homes, providing them with travel tickets and shelter. Parents are now fighting to implement legislation making it mandatory for them to be notified within two or three days that their children are exhibiting symptoms of gender dysphoria. In some locations, they are winning.

An alarmingly large number of therapists have also become complicit in encouraging students to take hormones without addressing underlying emotional disturbances. The few therapists who do speak out against this practice risk not only losing their jobs, but also having their licenses revoked. Although of course not all therapists and doctors acquiesce to the trans-friendly agenda of the medical and political establishments, an internet search in the U.S. is not guaranteed to yield the name of a therapist who has withstood the pressure, or at least who is publicly known as remaining independent.

Trans-friendly algorithms are built in to most search engines. After typing the single keyword “transgender” into a popular and widely used search engine, I viewed helpful definitions, advice on how to spot if you’re trans, how to come out as trans, trans dating sites, trans models who made it big, trans news, and even trans gear and apparel for sale. In three web page summaries, not one single article or journal study could be found that questioned why so many people are identifying as trans at this time. Nor were there any articles on how transitioning is harmful to children. To obtain more realistic data, you have to type in exactly what you’re looking for—and even then, what you may find is how “transphobic” the object of your search is. Many of the films and video clips appearing in even alternative search engines (which presumably have more algorithm choices) are about the struggles that transgenders of all ages have overcome despite society’s bigotry. Some documentaries feature remarkable children who—with the help of supportive parents, hormones, and surgery—have overcome the odds of their birth sex and happily transitioned into their “true” selves, the sex they were

supposed to be. Still other films feature well-known actors who have transitioned. A number of searches warn about anti-trans movies. Fortunately, people who had been pressured into receiving cross-sex hormones and surgeries and suffered as a result, are now coming forward.

In Europe, medical professionals who question the official position may be more visible than in the U.S. In the 2018 subtitled Dutch documentary *Transgender Regret*, psychiatrist Joost à Campo disclosed that in 2000, he sent a survey to colleagues asking follow-up questions about the mental health of their patients who had transitioned. Eighty-six psychiatrists reported that half of the 586 transgendered individuals had underlying problems that required attention. But in return for his concern, à Campo received hate mail. “I was demonized as a caveman who was blocking modern trends. And that’s not true. I want to help the vulnerable.”¹⁵

Joost à Campo was not the only one castigated for asking questions. Clinical psychologist Dorine Sellenraad spoke against what she saw as mass indoctrination of both the subjects and the adults who are supposed to take care of them. Between 2000 and 2001, Sellenraad was part of a team at a branch of the VU Medical Center in Amsterdam, the largest facility in the Netherlands that specializes in gender “reassignment” surgeries. “There was an atmosphere of too much agreeing with the patients....I missed critical judgment about diagnostics and indications.” Also, she noted, many patients met with each other to discuss “what was best to say and which psychologists were easy [to convince]...I was known as the difficult psychologist. One patient said, ‘It was easier in the past. You’re making it complicated.’” Believing that it was irresponsible to capitulate, she explained, “I proposed a better diagnostics protocol with stricter criteria for diagnoses and medical treatment. But they [the administration] said it’s too complicated, too hard to set the right criteria. Some who need it might miss treatment. So let’s keep it like it is.” Not wanting to be a party to this, Sellenraad left her job. à Campo agreed how difficult it was for conscientious professionals. The Dutch psychiatric association, despite being repeatedly asked since 2002 to produce clear guidelines for determining who needs surgeries, has ignored these requests.¹⁶

The filmmakers also interviewed people who had undergone sexual “reassignment” surgery or were planning to. One very masculinized young woman apparently in her late teens or early twenties who was on testosterone and awaiting FtM surgery, smugly reported that an interview process to determine her suitability, which should have taken four months, was completed in one month. She was able to fast-track her surgery, she boasted, because she had memorized all the “right” things to tell the intake psychiatrists.¹⁷

One attractive MtF transgender, who had received surgery over 50 years ago in Morocco and seemed genuinely happy and content, said it only worked for a man if you were already very “feminine.” However, other clients weren’t so fortunate. They suffered from many emotional problems that clinicians ignored while immediately dispensing hormones and surgery. “I’m a homosexual man....I

had an identity crisis,” acknowledged Patrick, “and joined the forum *Travestie.org* which was loaded with glorified stories about how great a sex change was. And then I thought, maybe I suffer from the same thing.” Patrick detransitioned after he realized that changing his body would not make him happy. His new psychiatrist stated that Patrick had been suffering from PTSD (post-traumatic stress disorder) and borderline personality disorder, but that he didn’t have—and never had—gender dysphoria. This was something his VU Medical Center psychiatrist should have known; for when Patrick had told him that walking around as a woman made him anxious rather than happy, the analyst said that wasn’t a good reason not to do the surgery. The tragedy is, a different clinic that had treated Patrick much earlier, in 1999, had sent a letter to the VU Medical Center clearly stating that he was not suffering from gender dysphoria. Today, Patrick is in a lot of physical and emotional pain. “I can never be myself again. My belly and bladder are constantly bugging me....[I]t was irreversible and I had to live with it. I had regret. It [the cavity that was surgically carved for him] doesn’t belong to me.”¹⁸

Another MtF, Braldt Haak, told the filmmakers that trans people don’t want to admit that things don’t always turn out the way they had envisioned or desired. “They’re not always honest and they only show the bright side....They tell stories about how well surgery went and about how well it functions now. But it’s not all good.” Haak had to discontinue the hormones because he gained 66 pounds and developed cardiac arrhythmia. “I had to decide if I wanted to live as a man, or be dead as a woman.” He added, “The chance to be happy also depends on how well you pass as a woman....I think that if you have other psychiatric problems, you have to deal with them first in order to be able to handle a transition....If you still are struggling with things, it will be very rough. Maybe this is a factor that causes regret or suicide, because transition isn’t going to solve your problems.”¹⁹

The VU Medical Center did 5000 sex change surgeries between 1972 and 2015. In 2008, there were 200 new intakes. In 2015, there were 700.²⁰ It might take a while for effective and honest medicine to prevail. “Trans interventions are big money,” says medical doctor Michelle Cretella, who is on the advisory board for the U.S.-based non-profit organization *Advocates Protecting Children*. “Billionaire elites promote trans ideology over truth across all public institutions and media platforms, and [in the United States] a severe cancel culture results in everything from severe harassment and doxing to ending one’s career.”²¹ *Doxing* is the practice of publicly disclosing personally identifiable information about an individual—such as their full name, address of their home or workplace, phone number, financial status—all without the person’s permission. This is now being done regularly to government officials who cast an unpopular vote, authors who write a book that does not support a favored agenda, and public speakers who criticize a behavior or disagree with an act. These kinds of hostile attacks are occurring more frequently, and they are being perpetrated—all in the name of tolerance—by those invested in the trans agenda.

Civil Rights and Violence

Another very disturbing issue raised by the American Psychiatric Association definition (see the passage at the beginning of this chapter) is its declaration that social transitioning must involve “transitioning into the affirmed gender’s pronouns and bathrooms.”²² Laws have been passed in many states that give transgenders access to bathrooms to which they would never have been granted access prior to the current climate of sexual “reassignment.”

This access has caused several major problems. Not every transgender who has taken cross-sex hormones and undergone surgical alterations looks like a member of the opposite sex. In fact, many do not. Although starting the sexual “reassignment” process before puberty does create a much more realistic-looking imitation of the opposite sex—and the clever use of clothing can help with the disguise—the dissimilarity between the male and female skeletal structures (including the sway of someone’s walk) may be enough to reveal that the person is trans. There may also be an aura or energy about the person that sensitive people (especially children) can detect—an energy indicating that something is slightly odd or off. Therefore, sharing a bathroom with a transgendered individual may feel uncomfortable or unsafe to those who are not trans.

What if the person using that space is a MtF transgender who still has his penis? How “changed” does that person have to be? Even more disturbing—and increasingly common—is a fully equipped male given access to a women’s bathroom simply because he says he “identifies” as a woman. What about the right to privacy for women and girls? And what about the very real threat of rape?

The incidences of attempted and actual rapes of women in public bathrooms by men falsely claiming to be transgender are increasing. ASK Academy is a charter school in Rio Rancho, New Mexico, that allows males who self-identify as transgender to use the girls’ bathrooms. In October 2021, a 12-year-old female student (calling herself “Ray” to protect her privacy) said she was raped by an older boy in a school bathroom. In July 2022, the same boy assaulted a 14-year-old female student at a nearby school. Two other girls also said they had been assaulted by that same boy, yet the school did nothing to hold him accountable or protect its female students.

Ray said that she had “felt pressured by teachers and faculty to accept the presence of men in women’s spaces, to keep her mouth shut about any feelings of discomfort, and to avoid doing anything that would be construed as ‘judging’ someone who might identify as transgender.” Afraid of reporting the attack for fear of being labeled a “bigot,” she was silent about the rape. Her mother, however, noticed that the girl was highly depressed, anxious and grieving, and brought her to therapy. Six months later, Ray’s mother learned about the trauma and saw that Ray’s medical records confirmed vaginal tears consistent with rape. The mother went to the police and the local Child Protective Services, but they stalled the investigation. When Ray began feeling suicidal, her mother confronted school personnel, who dismissed her concerns. “They treated us like we were a problem

when we tried to make them address issues our child was facing in their school,” she said. “The school tried to say we must be doing something wrong at home.”²³ Since the mother confronted school officials about the attack, four staffers, including two administrators, left. (Did they discover that the mother planned to bring a lawsuit against the school?) Ray’s mother wrote to a New Mexico senator, but reported that she was “met with a complete rejection of the notion that he would support anything that goes against gender affirming legislation.” Regarding the school, Ray’s mom stated:

We learned that kids were pledging allegiance to the pride flag instead of the American flag. We learned that some teachers were discussing daily, the normalcy of transgender people and gender dysphoria, and that this school had a higher population than anyone would expect for such a small school, of kids saying they were trans and parents not knowing....By them saying the only thing that matters is how they feel and not how I feel, is very selfish of them. If they want their own bathroom, then gladly get your own bathroom. If you want your own sports, get your own sports. If you want to be included, be included in your own way that doesn’t cause danger to everyone else.²⁴

“Transgender toilet activists,” writes Sheila Jeffreys, are sympathetic to MtF individuals’ fears about being beaten up if they try to use men’s bathrooms—“whereas women’s concerns about the egregious violence visited upon them are [considered] spurious....[W]omen’s awareness that not all men are violent is no great reassurance against the fact that many are [or might be], and individual women are in no position to work out which ones they need to be particularly vigilant about whilst seeking a safe space in which to urinate.”²⁵

Females have proportionately smaller urinary bladders than males (probably because they have more organs in the abdominal cavity, which requires the bladder to be smaller to accommodate the crowding). It’s not unreasonable to assume that because many girls are unhealthily “holding it in” for fear of being attacked by a male in their own bathroom, urinary tract infections in females will increase.

Allowing biological males to invade spaces that should be keeping females safe is indeed a symptom of mental illness on the part of the invaders and their supporters. Despite the general public’s increased disapproval over same-sex bathrooms, trans activists are winning in some of the courts. They are also becoming more vocal in their call for violence. On TikTok, a MtF activist threatened to become dangerous and dared anyone from stopping him from entering a women’s bathroom. Then, addressing the trans community, he exhorted, “Go out and buy a gun. Learn how to use it.”²⁶ The inflammatory video was eventually removed from TikTok, but one site captured it and it can still be viewed.

Other women-only spaces—locker rooms, shelters, and even prisons—are also in trouble. In 2019, a bill was approved in the California Senate that allowed men to be inmates in women’s prisons if they simply stated that they “identified” as women. MtF transgenders were already being placed into women’s prisons

to protect them from the violence they would likely have suffered had they been incarcerated in men's prisons. But thanks to this bill, *any* male—even if he was a stalker, wife-beater, sex offender, or rapist—was now given free access to hurt not only vulnerable female inmates, but also female prison guards. Any man could declare an “identification” with women without being required to provide a letter from a doctor or therapist, and without undergoing any hormonal or surgical changes. A woman who opposed this bill stated during the California hearing, “Right now...a trans-identified male is currently housed with female inmates in Corona, even though he is serving time for targeting, raping, and torturing women. Under no circumstances is this morally justifiable.”²⁷ Similarly, many shelters for homeless and abused women have opened their doors not only to MtFs, but also men who simply “identify” as women—courtesy of the Department of Housing and Urban Development (HUD). The HUD secretary, Ben Carson, objected to this policy, which did not even permit the shelter to ask for identification.²⁸ A change in the law, he pointed out, would “empower shelter providers to set policies that align with their missions, like safeguarding victims of domestic violence or human trafficking.”²⁹ As the law is now, abusers must be allowed in with the abused.

Lawmakers on both sides of the debate are still fighting over this policy. But in some locations, trans-friendly bills have already been passed and men claiming to identify as female have already imposed their wills on women. Attacks are becoming greater in number, and more violent. I will cite just a few examples. In August of 2019, the Vancouver Rape Relief and Women's Shelter (VRRWS) in British Columbia, Canada was defunded for refusing admittance to any man who identified as trans or female. Graffiti with the message “Kill TERFS” was scrawled onto the building. (*TERF* is a new acronym for *trans-exclusionary radical feminist*.) “The women who come to our support groups are rape victims and battered women,” said a member of the staff. “One of them said to me, ‘Haven't we suffered enough?’”³⁰ In the U.S. at the largest women's prison in Illinois, a female prisoner filed a lawsuit against a trans inmate for having raped her in 2019.³¹ And in 2018 in the UK, a self-described MtF transgender attacked two inmates after being moved to a women's prison. He had already received a life sentence for raping two women and sexually assaulting two other women prior to being incarcerated. All it took to get into the women's prison was a declaration and a costume consisting of a wig, makeup, and false breasts. London mayoral candidate Rory Stewart stated to the press, “When I was Prisons Minister, we had situations of male prisoners self-identifying as females, then raping staff in prison. So I think if somebody is biologically male, particularly in an environment like a prison, we shouldn't allow that to happen....I think the rights of women to feel safe trump the rights of somebody who's biologically male to enter that space.”³²

The infiltration of women's prisons by biological men and trans “women” with penises—and the subsequent escalation of rapes—have become so common that class action suits are now being instigated by female inmates. These women, rightly protesting that they don't feel safe, blame politicians, lawmakers and

wardens. The mainstream press loudly protests the diminishing protections of a handful of transgenders—but what about the millions of natal women who require protection? No woman or girl should have to fear for her public safety. Yet the majority is being asked to sacrifice privacy and safety to accommodate the desires and special privileges of a very few.

Politicians are forcing all types of woman-centered businesses to admit men. In June 2023, the Olympus Spa in Seattle, Washington—whose website had stated that “women can relax in this all female environment”³³—refused to serve a self-proclaimed transgender “woman” with intact male genitals. A judge forced the spa to admit men if they identify as women. “Aside from...nudity [as when employees give patrons exfoliating massages],” she said, “there is simply nothing private about the relationship between Olympus Spa, its employees, and the random strangers who walk in the door seeking a massage.”³⁴ One must question the intentions of the men who will take advantage of this ruling.

Back in the 1970s, feminists were arguing about whether men who self-identified as women (and sometimes even as lesbians) should be permitted to attend women-only conferences and music festivals. One woman wrote, “being a woman is a long-term experience, and one that isn’t summed up by a collection of female genitalia with some clothes draped over them....[T]he state of mind, the process of becoming—we didn’t have any choice about that.”³⁵ As political commentator Brett Cooper has stated in her podcasts, addressing MtF transgenders, “My biology is not your costume.”³⁶

What about FtM individuals in a public bathroom for males? I asked a man I knew—a former police officer who had routinely been in dangerous situations—how he would feel if a FtM transgender entered a public men’s bathroom while he was in it. “Emotionally, it’s an invasion of my space,” he replied. “A bathroom is for private body functions. Also, in today’s climate if a trans person thought I looked at them the ‘wrong’ way, they could leave the bathroom and falsely accuse me of rape—and there’s nothing I’d be able to do about it.” Would he feel unsafe? “You’d be surprised at the damage they can do,” he responded. “Female bodybuilders who take testosterone are known for being able to put their boyfriends through a wall. Transgenders on testosterone are taking a lot more. Plus, there’s potentially a lot of tension and anger. So being attacked feels like a real possibility to me.” He was indeed correct about the muscle-enhancing effects of high-dose testosterone, which will be addressed in great detail in Appendix B.

It’s important to recognize that only the very vocal radical trans activists are attempting to impose their wills on everyone else. Not all transgender people are activists who want to recruit and harm children. Many, if not most, transgenders regard their transformations as private, personal decisions, and they just want to live their lives in peace. However, as the radical agenda heats up, some trans individuals are being moved to speak up about the need to protect children.

We can have compassion for mentally ill people without humoring transgenderism as normal—and without glamorizing it, turning it into a political

movement, or allowing it to oppress others. “Forty years ago,” Jeffreys comments, “radical feminist thinkers and activists were very clear in their view that persons who were born biologically male and raised as males, but sought recognition as women” were in fact engaged in an “insulting practice in which men caricatured stereotypes of women for their own amusement or pleasure.”³⁷ Dr. Paul McHugh, Professor of Psychiatry at Johns Hopkins Medical School and Psychiatrist in Chief of Johns Hopkins Hospital, agrees. “Transgendered men do not become women, nor do transgendered women become men....[They] become feminized men or masculinized women, counterfeits or impersonators of the sex with which they ‘identify.’”³⁸ McHugh has also pointed out that to a man, “feeling like a woman” is usually based on sex role stereotypes, “something that women physicians note immediately is a male caricature of women’s attitudes and interests....We don’t do liposuction on anorexics. Why amputate the genitals of these poor men?”³⁹ He adds, “I have witnessed a great deal of damage from sex-reassignment...We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it.”⁴⁰

Should archeologists of the future unearth documents of 21st century Earth, they might wonder how it was possible for such a tiny minority of bullies to shut down the voices—and so drastically interfere in the lives—of so many.

The Suicide Threat

Falsified Data

Trans activists repeatedly claim that because of society’s bigotry and intolerance of trans persons—and attempts to prevent transgenders from finding their “true selves”—the rates of attempted and actual suicide among transgender youth are much higher than those of their non-trans counterparts. According to figures from an American Academy of Pediatrics 2018 study of suicide attempts, FtM adolescents reported the highest rate at 50.8 percent. MtF adolescents reported 29.9 percent. And in “non-binary” adolescents who did not exclusively identify as either male or female, the suicide attempts were 41.8 percent.⁴¹ This contrasts with 2018 figures of adolescents who do not identify as transgender: 17.6 percent of females and 9.8 percent of males.⁴² Significantly, a 2015 study conducted by the Harvard School of Public Health found that almost 51 percent of transgender people between the ages of 12 and 29 were diagnosed with depression.⁴³

However alarming these statistics are, we must ask: Are the suicidal ideation, alienation and depression a result of the ridicule, violence and rejection that trans people say they endure from family members and society? Or is the desire to become trans a result of feeling depressed, anxious, alienated and rejected? Attributing the cause of psychological problems to society’s bigotry might not be accurate, journalist Daniel Payne points out, “when compared to other minority groups who suffer disproportionate...amounts of bigotry and negative

discrimination” but don’t have similarly high suicide rates. Instead, it seems that “the rate of successful suicide is extremely correlative with conditions of mental illness.”⁴⁴ Could it be that statistics have been deliberately gathered and interpreted in ways that yield misleading results?

The British organization Transgender Trend explains how certain data suggests higher numbers of suicide in trans youth than what might actually exist. After analyzing two studies that included questionnaires dealing in part with suicidal thoughts and attempts, Transgender Trend described problems with how the research was designed.

The questionnaire was promoted within the LGBT community and people chose whether or not to fill it in. In total 2078 questionnaires were analysed, however only 120 of these were transgender people, and only 27 of these were under the age of 26 years old. *It is only the results from the 27 young trans people that was reported in relation to suicide.* Of these 27 young trans people 13 of them reported having attempted suicide at some point in the past. This is where the 48% of all trans youth attempt suicide stat[istics] comes from....We don’t believe that the suicide history of just 27 self-selected trans people is sufficiently large...[We must also consider that] Participants were not randomly selected. This will mean that trans people who have experienced the most difficulties in life may be more likely to fill in the form. This risks artificially increasing the percentage of participants with a suicide history. [emphasis added]⁴⁵

Another anomaly in transgender suicide statistics, which Transgender Trend found in a second survey, was the inclusion of lesbians, gays and bisexuals in the trans category. This yields highly misleading results because members of the non-trans homosexual population have a much higher rate of suicide than the heterosexual population. The misrepresentations are so many and glaring that one must conclude that transgender activists deliberately skewed the statistics to secure sympathy for their cause.

Even if societal bigotry does play a major role in transgender suicides, and the trans population does suffer from abnormally high suicide rates, the truth remains that only people who suffer from self-hatred and have severe emotional problems want to kill themselves. Under such circumstances, writes Payne, “A sane society would be advocating for robust, ameliorative psychological therapy [but]...Instead, we indulge this [mutilation] sickness on an industrial scale.”⁴⁶ Alan Finch, a British man who received MtF surgery, decided he wasn’t trans, and then sought to reverse the process, once remarked, “The fact that someone’s suicidal and wanting something, isn’t a reason to provide it.”⁴⁷ Scott Newgent, a FtM who strongly opposes subjecting children to hormones and surgery, emphasizes that transitioning “doesn’t fix suicidal ideation....[A] child that’s suicidal, you take them to a mental hospital...If you can’t handle life now, there’s no way in hell you’re going to be able to handle it when you medically transition, because it is

brutal. So you are the *worst* person to medically transition.” Newgent also points out the lack of incentive to conduct psychological follow-ups on those who have medically transitioned—because the goal of getting these people on drugs for life has already been accomplished.⁴⁸

Fortunately, some studies have been conducted that point to emotional disturbance in transgenders independent of their transition. A 2014 article in *Psychiatry Journal* concluded that 62.7 percent of patients with gender dysphoria were diagnosed with at least one emotional disorder.⁴⁹ Another seminal article, “Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden” by Cecilia Dhejne and colleagues, studied two groups. One was “sex-reassigned.” The other was “random population controls.” Each group was matched by age and other factors. The authors showed that suicidal thoughts and actual suicides *increased* after people transitioned. The overall mortality rate for transgenders was higher—especially death from suicide—than those in the control group. The “sex-reassigned” group also had a higher rate of psychiatric inpatient care. “Persons with transsexualism, *after sex reassignment*, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population,” the authors stated bluntly. “Our findings suggest that sex reassignment...may not suffice as treatment for transsexualism, and should inspire improved psychiatric and somatic care after sex reassignment for this patient group.” The study also showed that FtM individuals, as compared to MtFs, had a higher risk for criminal convictions than the non-trans control group.⁵⁰ As previously mentioned, some females on high-dose testosterone report feeling uncontrollable rage. Could increased criminality result from abnormally high testosterone levels that their bodies were never supposed to produce and their brains were not structurally designed to handle?

Dhejne and her colleagues also criticized data presented by psychiatrist Jack Turban, co-author of the often-quoted “Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation” that appeared in a 2020 issue of *Pediatrics*. Turban and his colleagues believed that efforts made to discourage someone from transitioning worsened mental health and contributed to suicide attempts—and that subjects receiving puberty blockers, compared with those who wanted the drugs but did not receive them, have a lower risk of suicidal ideation for their entire lives.⁵¹ But as Dhejne pointed out, such research failed “to control for the individuals’ pre-GICE-exposure mental health status.”⁵² *GICE* is an acronym for *gender identity conversion efforts*. If the problem was “being in the wrong body,” one might reasonably assume that sex “reassignment” would lower the percentage of emotional problems, not raise it. Turban’s article showed, once again, the machinations of mental health workers who are complying with the trans agenda. If there’s no psychological assessment of someone prior to transition, how can we be sure what has caused the depression, suicidal ideation, and other mental health problems?

More unbiased researchers began to publish. In March 2023, *Archives of Sexual Behavior* released an article on rapid onset gender dysphoria (ROGD). Seventy-five percent of the ROGD children, who were between the ages of 11 and 21, were girls. Pre-existing mental health issues plagued these children, and the more issues they had the more likely they were to socially and medically transition. Their parents reported that clinic personnel demanded that they “affirm” their children’s newly-assumed “gender” and support their transition. Significantly, the children’s mental health greatly worsened *after* they socially transitioned.⁵³

Apparently, someone didn’t want data disseminated about pre-existing psychological issues in a group of transitioners. The publisher and editor-in-chief of the journal quickly retracted the article, stating that the authors had not complied with the journal’s editorial policies and had violated the privacy of the survey participants.⁵⁴ That claim was not only implausible, but ridiculous. The survey was purposely anonymous, and consisted of volunteers—parents who were recruited from the website Parents of ROGD Kids by one of the authors whose own daughter had been seduced by the trans agenda. The authors publicly denied having broken any policies surrounding consent. One of the researchers, Northwestern University Professor J. Michael Bailey, said, “Informed consent means that you’re supposed to inform participants what it is that you’re studying, and get their consent [which we did].”⁵⁵ In fact, Bailey’s own Institutional Review Board (IRB), which reviewed the article prior to its publication, had reassured him that it was ethical to publish the results of the survey as long as the identities of the respondents were not revealed—which they weren’t. So what made the editorial board change its mind? As it turns out, in May 2023, soon after the article was released, the Center for Applied Transgender Studies had written to the publisher with a threat: “We are informing you that we will no longer submit to the journal, act as peer reviewers, or serve in an editorial capacity until Dr. Zucker [the editor] is replaced with an editor who has a demonstrated record of integrity on LGBTQ+ matters and, especially, trans matters....[The paper] raises serious concerns over research ethics and intellectual integrity.”⁵⁶ What, exactly was unethical, and how was “intellectual integrity” compromised? The Center for Applied Transgender Studies did not address this.

In 2021, “Rates of Psychiatric Emergencies Before and After Gender Affirming Surgery” published in *The Journal of Urology*, found that among men who had received a vaginoplasty, the attempted suicide rate was twice as high after the surgery compared to before it. The message was clear: Getting a vital part of his body removed—his penis—does not benefit a man’s mental health.⁵⁷

The evidence keeps growing that trans activists are deliberately miscategorizing and misinterpreting suicide statistics to elicit sympathy for their agenda. It appears to be working, as more laws keep getting passed to give trans people special privileges over the rights of the majority.

Drug-Induced Death

Another issue that trans proponents avoid making public is the effects of castration chemicals (puberty blockers) themselves. These drugs not only cause severe physical harm (discussed in depth in Chapter 3), but they also encourage the precise emotional state of mind that the act of transgending is supposed to eliminate: depression, suicidal ideation, and actual suicide. Package inserts and website warnings for Lupron (leuprolide acetate)—the foremost prescribed puberty blocker in the United States—specifically lists “emotional instability” as one of the undesirable “side” effects, along with unstable, wild fluctuations of mood, crying, irritability, impatience, anger, and aggression (not to mention decreased libido). Prescribers are warned to “Monitor for development or worsening of psychiatric symptoms during treatment.”⁵⁸

The aforementioned journal article by Jack Turban and his colleagues is often cited as an example of how children on puberty blockers have a lower risk of suicide—which then justifies the administration of such drugs. Statistics can be manipulated or falsely reported to suggest the opposite of the truth, but sloppy science hasn’t stopped mainstream headlines from enthusiastically proclaiming, “Puberty blockers reduce suicidal thoughts in trans people.”⁵⁹ Not only did the press celebrate this presumed good news, so did all the transgender-influenced websites, which advocate the chemical castration of prepubescent teens. But if you examine the original research and look a table further into the article, statistics indicated that about 50 percent of the trans people being studied reported suicidal thoughts—hardly a success story! Furthermore, of the study participants who had reported not only suicidal ideation, but also *active plans* for suicide and *attempts* at suicide, *more*, rather than fewer, were revealed to have been taking puberty blocking pharmaceuticals.

Oxford University professor Michael Biggs is another researcher who has criticized the flaws in Turban’s information-gathering process and conclusions. The study omitted those who had actually committed suicide, Biggs observed. Further distorting test results, the majority of the respondents had reported taking puberty blockers after age 18. This is impossible, because puberty generally occurs six years prior, at around 12 years of age, and certainly no later than ages 13 or 14. Evidently the respondents had mistaken the cross-sex hormones they were taking for puberty blockers. Biggs also pointed out that many of the questions were not answered. Of the 89 respondents who said they took puberty blockers (and probably did not), only 11 answered whether they had been hospitalized in the past 12 months due to a suicide attempt.⁶⁰ The data was more than incomplete. It was incorrect, rendering the results of the entire survey fictitious and useless.

Like Cecilia Dhejne and other critics, Biggs explained that pro-trans researchers consistently fail to account for the fact that their surveys eliminate those with psychological issues—which is *not* done in the real world today with most people who ask for puberty blockers. Biggs also stated that prior research omitted people who actually did commit suicide after being on puberty blockers, as well as those

who “underwent medical intervention and then subsequently stopped identifying as transgender.” Biggs pointed out, too (again) that respondents recruited online for Turban’s survey had erroneously reported receiving puberty blockers after age 18.⁶¹ The necessity for Biggs to keep reminding his readers of errors made by other researchers shows how a person’s first exposure to information (or misinformation) is difficult to forget. Trans-friendly media still pummel the public with the original incorrect data. “The data,” wrote Biggs in yet another paper, “showed no statistically significant difference in psychosocial functioning between the group given [the puberty blocker] GnRHA [gonadotropin-releasing hormone analog] and counseling and the group given only counseling.”⁶² So how do we know it wasn’t the counseling that helped the research subjects?

In case there are any doubts that chemical castration in prepubescent children causes serious negative effects, let’s look at a negative outcome in an adult who is using a castration drug for an entirely different purpose. The title of the article is “Acute manic and psychotic symptoms following subcutaneous leuprolide acetate in a male patient without prior psychiatric history: A case report and literature review.” The 62-year-old patient was taking the drug for prostate cancer. Severe health problems—the medical establishment likes the phrase “adverse events”—included depression, fatigue, hot flashes, and low or no sex drive. The authors claimed that sudden-onset, intense mental and emotional reactions (including mania) from Lupron injections are uncommon, given the scarcity of documented reports of such reactions. The man had gone through normal puberty, which one might think would have helped prevent some of the more intense psychological symptoms. But he developed mental health problems just two months after his injection (which may be why he eventually quit the protocol).⁶³

Other “adverse events” from Lupron affect the central nervous system. This can result in mood swings, insomnia, depression, blurred vision, and listlessness. Although the authors reported these effects occurring in less than 5 percent of patients,⁶⁴ that figure is still alarming. Five percent is not a small number. Also, if someone’s trying to minimize concern, instead of saying “*close to five percent*,” they’ll say “*less than five percent*.” Keep in mind, too, that 5 percent is *what has been reported*. If a child experienced drug-induced “adverse events,” would the distressed parents know enough—or be calm enough—to report these “side” effects of mental instability to the FDA? Would they even know how to do it? You have to search pretty hard for the form on the FDA website. And what about doctors? Medical personnel who make lots of money from these drugs would understandably be reluctant to report “adverse events.” Thus the depression due to taking Lupron is very likely much higher than what has been reported. Hormones are extraordinarily powerful. When the body’s hormone balance is tampered with, the consequences can be severe and even life-threatening.

As discussed in Chapter 2, the medical industry dishes out misinformation and outright lies. And the press will publish erroneous data, or misquote accurate data, to bolster whatever agenda it wants to promote.

Drugs and Surgeries Versus Psychotherapy

There are basically two protocols for treating gender dysphoria (or the belief that one is gender dysphoric). The first strategy promotes puberty blockers for prepubescent children, cross-sex hormones for everyone, and surgery for as many people as possible. Once a decision has been made to embark on this path, that person is a customer of Big Pharma for life. If surgery is performed, there's rarely only one operation. Often more than one part of the body is cut, excised or reshaped. In addition, too many things can go wrong, ranging from cosmetic and structural damage to more serious mishaps such as injuries and infections. The Big Pharma approach requires considerable finances, along with a high pain tolerance and plenty of painkillers. The second approach, psychotherapy, can also be painful—although in a much different way. It's not easy to face underlying emotions, perceptions, beliefs, and hurtful or traumatic events that could have contributed to or directly caused the desire to escape one's body.

In many ways, the two approaches are polar opposites. Cross-sex hormones and surgeries force the body—biochemically, neurologically and structurally—to appear and express as something that it was never designed to be. Psychotherapy with an ethical and skilled therapist allows the client to express his or her natural and true state. "Reassignment" protocols impose something foreign onto the person. A psychotherapist helps the client discover and uncover what is already present. With sexual "reassignment," the goal—albeit disguised—is to help the individual pass as someone else. With psychotherapy, the goal is to help the client feel comfortable with and accept who he or she truly is.

These two radically different approaches reflect the degree of agency—the ability to master oneself as well as one's environment. If I am at the mercy of being in the "wrong" body, I'll need outside intervention (hormones and surgery) to fix something that's beyond my control. But if I refuse to be a victim of my "wrong" body, with suitable help I can learn to take responsibility for my uncomfortable feelings and meet my genuine needs. Medications and operations, which are administered to victims of chance, signify a psyche that is open to being passive and manipulated. Psychotherapy, which is sought by someone who does not wish to be a victim of their emotional distress, signifies a psyche that is ready to be proactively involved in whatever challenges life may present.

With this comparison, it's also extremely important to distinguish between the intentions of transgender clinic personnel versus the intentions of a qualified therapist. Someone who works at a gender clinic has a fixed agenda: to transition the client. An ethical psychotherapist tailors the treatment to what the individual truly needs. As we have seen, almost without exception people who want to transition suffer from underlying issues that are making them want to be someone else. A therapist who's doing his or her job has no agenda other than to respect the uniqueness, feelings, and *genuine* needs of the client. This requires delving into what lies beneath the surface.

Anyone can pop a pill. But undergoing psychotherapy requires courage, strength, and determination to allow very deep changes into your life. The reward is being captain of your own ship, which includes befriending the body you were born with. It's not surprising, then, that trans activists and psychotherapists—at least those who are doing their jobs—would be at odds with each other. Some highly vocal researchers condemn all psychotherapy as evil manipulation against the poor gender dysphoric client. But now more psychotherapists are stepping forward to criticize the initial flawed studies that had delighted trans activists.

In 2021, *Archives of Sexual Behavior* published a letter to the editor from Roberto D'Angelo, Lisa Marchiano, and other therapists called “One Size Does Not Fit All: In Support of Psychotherapy for Gender Dysphoria.” As others had before them, the authors criticized the biased samples and flawed statistical analyses of Turban and his colleagues and the accompanying undeserved positive media support. They also mentioned the lack of scientific credibility for failing to follow subjects over a period of time. Short-term data doesn't provide enough information for a reliable analysis, whereas long-term follow-up yields more, and hence more accurate, data. What distinguished this article from others, however, was their focus on psychotherapy as the main treatment for gender dysphoria. They warned about Turban's simplistic view of psychotherapy. He believed that there were only two types of therapists: those who “affirmed” the client's claim of being the opposite sex and those who tried to “convert” the client. Turban considered it “conversion”—working against the client's best interests—not only if a therapist refuted the client's claim of being the opposite sex, but also if he or she simply asked probing questions. To Turban, the presence of probing questions meant attempts at “conversion.” Of course the trans community is happy to promote Turban's view that only “gender-affirmative” therapy is correct, helpful or legitimate. The authors emphasized:

The notion that all therapy interventions for GD [gender dysphoria] can be categorically classified into this simplistic binary betrays a misunderstanding of the complexity of psychotherapy....Stigmatizing non-“affirmative” psychotherapy for GD as “conversion” will reduce access to treatment alternatives for patients seeking non-biomedical solutions to their distress....We are deeply concerned...[that] unproven claims of the harms of GICE [gender identity conversion efforts] will have a chilling effect on the ethical psychotherapists' willingness to take on complex GD patients, which will make it much harder for GD individuals to access quality mental health care....[G]iven the potential of agenda-free psychotherapy to ameliorate GD non-invasively among young people with GD, withholding this type of intervention, while promoting “affirmation” approaches that pave the way to medical transition, is ethically questionable. We believe that exploratory psychotherapy that is neither “affirmation” nor “conversion” should be the first-line treatment for all young people with GD, potentially reducing the need for invasive and irreversible medical procedures.⁶⁵

The “One Size Does Not Fit All” article was also clear that many gay and lesbian teens with low self-acceptance are drawn to transgenering in order to freely love and be loved. This is a population that has been very vulnerable to trans indoctrination and could greatly benefit from caring, competent psychotherapy.

Some sources claim that the current percentage of transgenders in the general population is as high as 3.0 percent.⁶⁶ But in 2016 the count was 0.328 percent.⁶⁷ What inflated the figure so much? Trans activists are now including gays, lesbians and bisexuals, which is a total miscategorization. Sexual orientation designates the sex of the person to whom one is romantically and sexually attracted. Transgenders believe that they themselves are the wrong sex.

The misdiagnosis of traumatized children and teens as “gender dysphoric” is now occurring with alarming frequency. A teenage girl is raped, feels discomfort with her body—who wouldn’t, after that?—and then expresses a desire to be male. Instead of addressing her fear and probable PTSD, clinicians eagerly support her new identity. A sensitive boy who’s uninterested in sports and prefers to play classical music instead, is relentlessly bullied. He concludes that if he were a girl, he’d fit in. So out come the hormones and scalpels. The number of young people who suffer in silence with current or past trauma, feel ashamed of their sexual orientation, and have a difficult time accepting who they are, is rising. Yet clinicians—who should know better—would prefer to see their clients transition than help them deal with their problems. One must seriously question the mental health—not to mention compassion quotient—of anyone who fast-tracks a client.

The lie that transgenering is not only easy, but solves myriad problems, is causing immeasurable harm. Properly conducted psychotherapy could be a wonderful healing tool. But trans activists are deliberately trying to make it impossible for people to receive real help by getting laws passed against “transphobia.” Such laws would ensure that ethical psychotherapists lose their jobs and licenses if they try to provide help to those who need it the most. This is why some professionals are refusing to counsel “gender dysphoric” clients.

Despite the obstacles to treatment, trained professionals who provide agenda-free psychotherapy—who want to help alleviate suffering in a non-invasive, non-medical manner—do exist, even if they might be difficult to find. If you know someone who struggles with issues related to sex, gender, and/or sexual orientation, consider psychotherapy. The purpose of a good clinician is to help clients become more self-aware and develop self-acceptance.

Children and teenagers are especially vulnerable to the false promise that they can live worry-free lives without problems or obstacles. But adults can feel coerced too. Chapter 6 contains poignant accounts from both teenagers and mature adults who felt pressured to transition, and then wanted to reverse the process. However, before you get there, please read the next chapter to learn why someone might want to transition. You may see someone you know in those pages.



5

WHY SOMEONE MIGHT TRANSITION

What Am I?

There are as many ways to “feel like a boy” (or man) as there are males in the world. And there are as many ways to “feel like a girl” (or woman) as there are females in the world. People who believe that their bodies are not matched with their gender (stereotypes) are following someone else’s script of what behaviors, emotions and attitudes are permissible according to what’s between their legs. As we have seen in previous chapters, people who feel obligated to follow sex role stereotypes compared to those who are relatively free of them are more limited in their choices—and are thus less well-rounded as people. They also have more restricted emotional lives, may be inadequately fulfilled in their careers, and may even exhibit less intelligence and drive. When they “identify” as the opposite sex—to such an extent that they’re willing to mutilate their bodies in order to change their appearance—this indicates that they have lost their sense of self. Decades ago, they would have been considered mentally ill.

Why, then, are so many people today attracted to a movement that—in the name of “gender freedom”—insists that they adhere to the very stereotypes that are enslaving them?

There are many reasons why someone might be attracted to the idea of being trans. I have already touched on some of those reasons, but this chapter will explore them in depth. Depending on which population group the person belongs to, the reasons for transitioning are usually very different. Let’s take a detailed look at who transitions, and why he or she might want to do it.

Before the Trend

When the first cases of gender dysphoria were originally diagnosed decades ago (and the subjects were called *transsexuals*), the children who were the most dissatisfied with their bodies and most strongly identified as the opposite sex, didn't merely *wish* that they were the opposite sex—they already believed that they *were*. The ones who believed this were mostly boys. And they were very young when they believed it. Gender dysphoria affected mostly boys age two or three, and such children comprised only about 0.01 percent of the population. In most cases, the issue resolved as the boys reached puberty.¹

According to the 5th edition of *Diagnostic and Statistical Manual* (commonly known as the *DSM-5*), by 2013 this condition still occurred in a minuscule, although very slightly larger, portion of the population: .005–.014 percent of natal males and .001–.003 percent of natal females. Based on the numbers of people who later sought medical intervention, these figures translate to fewer than 1 in 10,000 people.² Contrast this today with what mental health professionals call gender dysphoria: In the U.S., the phenomenon has increased by over 1,000 percent.³ In Europe alone, girls comprise three-quarters of those referred for gender “reassignment.”⁴

Until the last decade or so, parents of young children diagnosed with gender dysphoria were encouraged to help the child feel comfortable with his or her body. They did not indulge a child's wishful thinking, encourage erroneous beliefs and fantasies, or intensify subjective feelings by giving in to the child's demands to wear clothing or hairstyles associated with the opposite sex. (However, if either sex could wear any clothing they wanted, assuming it fit, the act of wearing clothing associated with the opposite sex would very likely lose its charge and hence, appeal. But back to my original point.) The parents certainly did not call the child by an opposite-sex name. They delayed any decisions for cross-sex hormones or sexual “reassignment” surgery until the child was considerably older or became an adult. This humane, commonsense advice was based on what was observed about the far-reaching and powerful effects of hormones on the developing mind and body. No one needed to conduct studies or do fancy tests in laboratories.

Today, parents are advised to allow the child to live as the opposite sex, and even to stop puberty altogether, until the child can make up his or her mind about what sex he or she wants to be—as if people can change their sex as easily as slipping on a garment! Most parents, and their unhappy sons and daughters, are never told that children—whose neural circuits are still forming—are incapable of making rational decisions, and cannot foresee possible future consequences of their behavior. They aren't told, either, that transitioning rarely addresses the source of their misery, which means that attempts to escape their biology will ultimately backfire. Yet young people who cannot legally drink, drive, or vote are actively being encouraged to make decisions that will mutilate them for life.

It's a no-brainer that if children can accept and find peace with the bodies they're born with, this is preferable to becoming dependent for life on expensive hormones and perhaps surgeries as well. As of this writing, close to two dozen US states have banned gender "reassignment" for minors. But the trans agenda, which is everywhere, can be difficult for some people to resist. What makes someone vulnerable? Let's take a look.

Boys

The inability to adhere to a rigidly masculine role is a major reason why boys are encouraged to transition. A boy might be artistic, soft-spoken, shy, and/or not very good at sports. People might assume he's homosexual, even if he's not, and call him a "sissy" or "pansy." If he *is* gay, the more he's perceived to deviate from a stereotypically masculine image, the more he's made to question whether he's a male at all. Sadly, many boys who are homosexual feel pressured into transgendering because they have been taught that loving other boys is unacceptable. A parent may not approve of a son's homosexuality, but which choice is less harmful? Body mutilation, or a loving relationship with another human being?

Boys who are autistic also gravitate to transitioning. One website, Parents with Inconvenient Truths about Trans (PITT), shares that many mothers and fathers of both transitioned and detransitioned teenagers have noticed that their sons fall on the autism spectrum. Emotionally immature for their age, many of the boys also have OCD (obsessive-compulsive disorder). The immaturity and stunted cognitive abilities contribute to "a pattern of black and white thinking that made trans identification appealing. Once 'transitioned,' they felt better, for a time, since all those feelings of anxiety and fear [due to life's shades of gray]... could be reframed as external problems instead of internal ones." However, the relief rarely lasts. In retrospect, most of the young men "felt that their trans identity was a character that took tremendous effort to maintain...the voice, the clothes, the mannerisms...[I]t was all playing a part that began to feel inauthentic (ironic given that trans is promoted as an acceptance of one's authentic self!). It became a chore to put on the character day after day, even for those that 'passed' as female." Of course, the "character that took tremendous effort to maintain" is an unreal caricature. The PITT article describes the futility of the masquerade as the unreality soared to new heights.

The men we spoke with discussed that the mental illusion was also difficult to maintain, particularly when it came up against hard facts. Increasingly peer groups were fully living in their own delusions, and the detransitioners were seeing the constructed universe that other trans identified men were living in. Discussions of periods in men, and breast-feeding were some of the topics that they believed had gone too far, and they came to believe that they had no basis for understanding the physical realities that actual women faced, like

endometriosis and heavy menstrual bleeding. They also came to feel that transition didn't even serve its original purpose. As one man stated, "It was, in a way, pointless. It was spending a lot of time and money without necessarily making me happy."⁵

The temptation to transition may also be more heightened in males whose testosterone production or utilization are disrupted. This can be the result of a medical condition (see Chapter 1), but products in the environment can also interfere with hormone function. One ubiquitous and dangerous culprit is Bisphenol A (BPA), a common plastic in use since the 1960s. BPA is a major ingredient in bottles and containers for water, food storage, and personal care products. It's used to line tin cans that contain food and is even employed as a coating on cash register receipts. BPA's structure resembles that of natural estrogen, which allows it (and similar plastics) to latch on to the estrogen receptor sites in living bodies. This is what causes the hormone-like effects of plastics. Existing in amounts millions of times more than what a person or animal would normally produce itself, the plastics affect the reproductive systems of both humans and animals, males and females. In some species of fish and frogs, endocrine-induced abnormalities include sex changes. In human males, sex-related abnormalities may include abnormal breast growth, low sperm count or defective sperm leading to infertility, and impotency. In human females, sex-related abnormalities may include premature breast development, early puberty, delayed or suppressed ovulation, and infertility.⁶ Reproductive glands of both sexes are more susceptible to cancer. Even the prostate gland in male fetuses can be affected.⁷ The DNA of all living things is damaged, influenced by the abnormal rise or fall in hormone levels.⁸ Molecules of BPA plastic are unstable, leaching into whatever solid or fluid is in a BPA container. The bodies of over 90 percent of Americans harbor minute particles of these plastics⁹ (which is a good reason to store drinking water in glass rather than plastic bottles).

As far back as the 1930s, BPA was considered as a possible medication to treat menopausal women. Therefore, it's astonishing that three decades later, the chemical compound was approved for widespread use in the production of plastics for regular, everyday use. Fetuses, which are extremely sensitive to plastic exposure via the mother, may suffer enough growth disturbances that their gestation period is shortened.¹⁰ But the effects are even more insidious. A 2015 review of previous studies found evidence that BPA interferes with endocrine function in ways that involve the hypothalamus and pituitary gland—and therefore, "The detrimental effects on reproduction may be lifelong and transgenerational."¹¹ Even experiments with mice show that effects of endocrine disrupters are multi-generational, impacting the structure and function of the brain.¹² While the results of animal studies cannot always be extrapolated to humans, in this case we already know not only that estrogenic plastics affect humans, but also how it affects us. No living thing is immune to these pseudo-estrogens. Nevertheless, even today the FDA claims that the plastic is safe.¹³

Other types of endocrine disrupters can be found in non-stick coatings for cookware and in flame retardants. Because flame retardants are often found on bedding and children's clothing, including pajamas, this is of particular concern.¹⁴ Common chemicals such as parabens and phthalates—present in skincare products, cosmetics, and thousands of ordinary household products—are also highly toxic to the endocrine system. These synthetic chemicals in the environment are inhaled, eaten, and absorbed through the skin.

Exposure to multiple chemicals in their various forms exert exponential effects. This is such a widespread problem that in 2014, the British publication *Lancet Neurology* published a paper on how phthalates (plastics) and similar environmental chemicals disrupt the brain and nervous systems of children. This would affect virtually everything related to cognition, coordination, and perception. Examples of effects include short attention span (attention-deficit disorders) and even impaired social interactions. The changes occur mostly in boys, pointing to endocrine abnormalities in the brain.¹⁵ Pregnant women need to be especially careful about exposure to such plastics because extensive damage can occur to the developing baby at any time during gestation. Once a pregnant woman is exposed to these chemicals, her thyroid hormone levels change. This alone negatively impacts the proper development of the unborn child's brain, and later may cause behavioral problems and learning disabilities.¹⁶

Although the FDA finally banned BPA due to public pressure, research shows that the plastics now used in its place have similar estrogenic effects. Might BPA be influencing the increase in the numbers of transgendered males by impairing brain function? No fewer than 214 unregulated chemicals, including estrogenic plastics, have been linked to human brain damage.

Pesticides, herbicides and fungicides also affect the molecular structure, and hence function, of hormones. One of the most widely exploited herbicides in the world is atrazine, used for controlling weeds in commercial crops and home gardens. This herbicide is commonly applied to corn, sugar cane, and sorghum, which is fed to lambs and calves raised for us to eat. Atrazine is also mixed into the soil where soy is grown to create a barrier that stops weeds before they even start to grow. And it's sprayed on golf courses and residential lawns. Because of such widespread use, as one scientific paper describes, the herbicide

is the most commonly detected pesticide contaminant of ground, surface, and drinking water. *Atrazine is also a potent endocrine disruptor that is active at low, ecologically relevant concentrations....*Atrazine-exposed [amphibian] males were both demasculinized (chemically castrated) and completely feminized as adults. Ten percent of the exposed genetic males developed into functional females that copulated with unexposed males and produced viable eggs. Atrazine-exposed males suffered from depressed testosterone, decreased breeding gland size, demasculinized/feminized laryngeal development, suppressed mating behavior, reduced spermatogenesis, and decreased fertility.

*These data are consistent with effects of atrazine observed in other vertebrate classes.” [emphasis added]*¹⁷

Another possible culprit is soy, an ingredient found in most infant formulas. Compared to endocrine-disrupting plastics and pesticides, soy isoflavones (a major class of phytoestrogens) are weak. However, even low levels can disrupt the endocrine system. Some menopausal women, hoping to benefit from soy’s estrogen-like effects, purposely eat it to replace the estrogen that their bodies are no longer naturally producing. Infants reared on soy formulas are exposed to isoflavone plasma concentrations that are about 13,000 to 22,000 times greater than their naturally-occurring estradiol (a form of estrogen) plasma concentrations.¹⁸

A 2022 study, “Secondary hypogonadism due to excessive ingestion of isoflavone in a man,” describes how a 54-year-old man came to develop erectile dysfunction and gynecomastia, or abnormal enlargement of the breast tissue. Every day for three years, he drank about 1.2 liters (a little over one quart) of soy milk—which contains about 310 mg of isoflavones. Blood tests revealed low levels of gonadotropin and testosterone, leading to a diagnosis of hypogonadism—the inability of the gonads (sex glands) to produce sufficient amounts of hormones. Two months after the man stopped drinking the soy milk on his own, he was retested. His gonad function had improved. The authors concluded that the hypogonadism had been caused by the excessive amounts of isoflavones in the soy milk he’d been ingesting. Isoflavones are not as physiologically active as estradiol, but their ability to bind to certain estrogen receptor sites is still enough to produce unwanted changes.¹⁹ Not everyone reacts negatively to soy and soy products, though, especially if the products are organic. The negative endocrine-disrupting effects of soy can be augmented if the conventionally grown soy has been treated with atrazine. Any estrogenic effects can be further reduced or eliminated altogether if the soy is fermented using traditional methods.

Synthetic estrogenic compounds in the environment are creating an entire class of abnormal males. We must ask how many brain cells are being affected by these compounds and what those effects are, which brain cells are being outright destroyed, and if these chemical compounds are depriving the brain of vital nourishment—which can lead to other problems. These estrogenic chemicals are prevalent, but they’re not supposed to be in our environment or bodies at all. The question that everyone should be asking is why the chemicals have been created, who developed them, and why they are still permitted to be used, considering that their negative effects are well known by the manufacturers. Eliminating these toxic chemicals from the environment will allow males and females to develop the way they were meant to.²⁰ A diet high in fresh vegetables and some fruits can help the body excrete BPA.²¹

As stated earlier, those who are most likely to be “genuinely trans” are young boys, although the percentage is still really tiny. What if a very young boy had been allowed by his parents to live as a girl? What if he seemed genuinely happy and well-adjusted? Wouldn’t it be better to give him hormones from the earliest

age possible to ensure the closest match to the body of a girl? All the research on human development says *no*. Even a “truly trans” boy should be made to wait for cross-sex hormones and gender “reassignment” surgery until he’s at least in his mid-20s. The reasons for this were discussed in Chapter 3. You may recall that the brain as well as body is flooded with testosterone during puberty, which can help shape thought processes and emotions. The possibility exists that the boy might later change his mind and decide that he is indeed male—but with an irrevocably altered body, he’d have a very difficult road ahead of him.

The most famous MtF transgender child is probably Jazz Jennings, who captured the attention of the media worldwide with documentaries and a TV series. Even as a young child, Jared (his birth name) proved highly intelligent and articulate, which made for a good interview. “My little penis felt so wrong on me,” the teenage Jazz wrote in a *Time* magazine article. “I didn’t just like girly clothing—I felt ashamed and humiliated if I had to wear anything else.... Whenever my mom or dad would compliment me by saying something like ‘Good boy,’ I’d immediately correct them. ‘No. Good *girl*.’”²² At what age did it start? It depends on which account you read. According to one report, from the tender age of two or three, the boy said that he “knew” he was actually a girl. His mother later explained that when young Jared asked her whether he was a boy or girl, she asked him what he *felt like*. He said a girl, and that was the end of the conversation. Jared must be a girl, not a boy. Others tell a different tale. Malcolm Clark writes that in 2003, Jazz’s mother noticed that her 3-year-old son “kept opening up his onesie [a one-piece garment]. To most parents, this might not have seemed like a big deal, but Jennings became convinced that her son...was trying to make his onesie into a dress.”

Jeanette alleges that her son, at the age of four, told her he wanted God to replace his penis with a vagina. I once asked my dad how I could get laser vision like Superman. He told me to finish my dinner. If only Jeanette Jennings had done the same, her son might still have his genitals. Instead, she sought out the *Diagnostic and Statistical Manual of Mental Disorders*, the bible of mental health, and became convinced her little boy was [actually female].... “I diagnosed her before ever taking her to see a professional and then had it confirmed,” she would often say.... You’d think a mother would take a lot of advice before telling her son he would be happier once he lost his penis. Not so with Jeanette....

In a 2019 interview, Jazz explained that he loved designing mermaid tails that he could swim in. He liked mermaids, he said, because they have no genitals. If you or I heard that a kid wanted to have no genitals, we might recommend his or her parents seek professional psychiatric help.²³

Instead, Jeanette sought the counsel of Florida-based sex therapist Marilyn Volker, whom Jeanette asserts was “instrumental in who Jazz is today.” On a television show, Volker stated that she knew Jazz “clearly” had a female gender identity. Clark’s response is worth noting. “What exactly does Volker mean by

‘female gender identity’? Often this just refers to discredited sex stereotypes.”²⁴ Clark—whose observation is astute—may rightly discredit these stereotypes, but many people do not. This includes the late news anchor Barbara Walters, who interviewed Jazz and helped justify his transition by promoting typical myths. “Gender organizes our world into pink or blue,” she stated. “As we grow up, most of us naturally fit into our gender roles. Girls wear dresses and play with dolls. For boys it’s pants and trucks.”²⁵

There are so many conflicting reports as to whether Jazz was coached, who coached him, and who said what, that it’s difficult to accept Jazz’s story at face value—especially considering the psychological state of this transitioned individual now. We do know that after the young boy grew his hair long, played with dolls, and was allowed to wear dresses in public, he appeared to be happy—at least in widely disseminated video clips. Was it because of all the positive attention he received? Jazz’s parents and siblings were publicly supportive of the child’s transformation to appear feminine, and the public adored him. He was eventually administered puberty blockers. The family allowed a camera crew into their home to chronicle Jazz’s presumably successful transition, which resulted in the ongoing series “I Am Jazz,” now in its seventh year. However, after passing the age at which a normal male puberty would have occurred, by the time the star was supposed to attend college, physical and emotional problems proliferated. Clearly depressed, Jazz could not stop binge eating and gained 100 pounds. According to Clark, no one on the show ever discussed the connection between Jazz having taken cross-sex hormones and his binge-eating, anxiety, and severe depression. A 2023 episode shows Jazz crying with his mother and saying, “I just want to feel like myself. All I want is to be happy and feel like me, and I don’t feel like me, ever.”²⁶

Why didn’t Jazz “feel like me, ever”? At a young age, not only were essential parts of his body removed, but his natural maturation process had been halted and erased—irrevocably disturbing his physical, sexual, and emotional development. In another video clip filmed around the same time, Jeanette remarks that she has to awaken Jazz in the middle of the night to dilate the pseudo-vagina that surgeons had constructed because Jazz doesn’t want to do it, and Jeanette is determined to prevent the cavity from closing. Rightly so, the body perceives the cavity as a wound, which is why it closes unless it’s actively prevented from doing so.

“If we are to believe the trans lobby,” writes Clark, “for whom Jazz is now a prominent advocate, he is walking proof of the importance of early ‘affirmation’ of transgender identity in children. But like so much of the propaganda churned out by the trans movement, the true story of Jazz is much darker than we have been led to believe.”²⁷ That darkness is now being brought to light as journalists and mental health professionals are asking: When the time came for Jazz’s transition, were the young boy and his parents told that he would experience dangerous and irreversible “side” effects from cross-sex hormones? Or intense pain from multiple surgeries during which so many things can go wrong? And they did go wrong. Jazz had to undergo three more “bottom” surgeries to repair the damage after the

initial one. Were Jazz and his parents warned about the likely repercussions of using pieces from the colon to construct the pseudo-vagina? Colon tissue had to be used because the little boy's penis was too small. Had the child gone through puberty, there would have been much more penile tissue to use in the construction of the cavern. Were Jazz and his parents informed that he would be infertile, have limited or no sexual sensation, and be unable to sexually climax? Even if the family was told, how could the child have possibly understood enough to give informed consent?

Because Jazz had been dosed with puberty blockers and undergone the complete removal of his penis and testicles, not only will he never experience an orgasm, but he is developmentally stuck as a prepubescent eunuch. The organs that were supposed to exist—for which the body had been biologically, neurologically and energetically prepared—have been permanently severed, and in their place is a gaping wound whose presence is justified and normalized by being called a “vagina.” The body's neural pathways that would have deepened through sexual arousal and communion with another human being are withering away. What does being stuck in this sexual limbo do to a person's development—physically, mentally, and emotionally? Or spiritually? Depression is an understandable and predictable outcome, independent of the direct pharmacological effects of the hormones.

Some critics question whether “changing gender” was truly the child's idea. One possibility emerges: The mother always wanted a daughter and killed her son's unwanted maleness, turning him into a girl. It's easy to speculate that because very young children are extremely impressionable and do almost anything to please a parent, the boy adopted his mother's wishes as his own. But the truth appears more complicated. In an interview, when Walters asks Jeanette if she misses her boy before he became Jazz, she breaks down in tears and replies that she does. Also, after viewing available video clips, it does seem that from a very young age Jazz genuinely loved “girly” clothing.²⁸ We may never know the truth. “If only, years ago, they'd let this child be, Jazz would likely now be a feminine, perhaps gay, boy,” writes Dr. Miriam Grossman. “Instead, Jazz's physical, emotional, sexual, and cognitive development were chemically interrupted...[and Jazz] has been led to believe surgery can create female genitalia.”²⁹

Girls

Despite the fact that historically it has been mostly very young boys who perceive themselves as female, many prepubescent and teenage girls who never expressed any interest in transgenderism are suddenly clamoring for hormones and surgery. Why? Journalist Abigail Shrier—who describes her shock at discovering how many girls are becoming convinced that they are really boys (or should be boys)—shares her research in *Irreversible Damage: The Transgender Craze Seducing Our Daughters*. “Two patterns stood out,” she writes. “First, the clear majority

(65 percent) of the adolescent girls who had discovered a transgender identity in adolescence—‘out of the blue’—had done so after a period of prolonged social media immersion. Second, the prevalence of transgender identification within some of the girls’ friend groups was more than *seventy times* the expected rate.” [emphasis added]³⁰

There are many reasons for this overwhelming influx of girls. Announcing their newly-found “transgender identity” gives the girls a way to rebel against their parents. But more importantly, having a trans identity makes them feel special, because they now belong to a minority club and are accepted by their peers. Dr. Lisa Littman, who coined the term *rapid-onset gender dysphoria*, said:

I became interested in studying gender dysphoria when I observed, in my own community, an unusual pattern whereby teens from the same friend group began announcing transgender identities on social media, one after the other, on a scale that greatly exceeded expected numbers. I searched online and found several narratives of parents describing this type of pattern happening with their teen and young adult kids who had no history of gender dysphoria during their childhoods....Then, I spoke with a clinician who was hearing her clients describe this phenomenon as something happening in their families. The descriptions of multiple friends from the same pre-existing group becoming transgender-identified at the same time were very surprising.³¹

Although social contagion is not “contagion” in the medical sense, it does speak to the power of peer pressure—especially if children start to think and act in ways that are harmful to them. Columnist Chad Felix Greene, who happens to be gay and is self-proclaimed pro-LGBT, posted a thread on Twitter in November 2022 about the effects of this social contagion on his niece. The post was since deleted, but a screen shot was captured. “My 12 year old niece who has very suddenly come out as asexual and trans has been cutting herself,” he wrote. “She’s broken down crying with her mother that she isn’t queer enough to be accepted by her friends. All of her friends have suddenly come out as trans. The most disturbing [thing] is she is thinking of suicide...My niece broke down and told my mom she wishes she could just be a [normal, unencumbered] little girl. She thinks she’ll let her mom down if she’s not queer.”³²

One woman retrospectively explains her attraction to becoming trans.

As a child I developed a trans identity as the result of a brutal sexual assault. I decided I was going to be a boy, because I never wanted to have my body violated the way it was when I was a girl. Thankfully, my school psychologist was able to work with me and help me resolve those feelings. Unfortunately now, many states have banned therapy that would help children who have developed a trans identity as a result of a trauma. And even worse, these children have been pushed to medically transition. Thankfully, I wasn’t medically transitioned. But a lot of other children have not been so lucky.³³

The onset of puberty also makes girls extremely susceptible to the trans agenda. Puberty is a time of potentially frightening hormonal changes, which include menstruation and often with it, painful cramps. Estrogen, whether from a high pubertal surge or an externally administered drug, has a reputation for causing moodiness and depression. But the estrogenized body that develops during puberty can itself be a cause for depression in bewildered, distressed girls who have not been mentally or emotionally prepared for maturation.

One change that especially concerns girls is additional fat on the body, which creates a curvy shape. This aspect of maturing conflicts with what a girl sees in the media. Female models weigh at least 23 percent less than the average (not overweight) woman. Compare the typical height and weight for a model at 5'10" and 110 pounds to the average woman at 5'4" and 145 pounds. Unhealthy skinny images constantly bombard teenage girls with an unattainable ideal.³⁴ Also, the average young person in the United States sees from 13,000 to 30,000 television advertisements per year.³⁵ Add to this the unrealistic portrayals in films, video games and print, and it's easy to see how girls can grow up to hate their bodies. The authors of a study on body image dissatisfaction and depression in adolescents point out that girls who think their bodies don't measure up to typical cultural standards of beauty are vulnerable to becoming depressed. Dependency about unrelated issues also contributes to an unfavorable body image, as does negative input from others. Depression is highest not only in girls who are genuinely overweight, but also in those who only perceive themselves as too fat, whether or not they actually are.³⁶ Teenagers of both sexes with body image dissatisfaction are 3.7 times more likely to report symptoms of depression,³⁷ but twice as many girls as boys are dissatisfied with their body weight and shape. Even girls of an objectively normal weight see themselves as undesirably heavy.³⁸ In a recent study, almost 38 percent of girls were at least moderately unhappy with their bodies.³⁹ Based on what I have observed, I believe the percentage is much higher.

Body image dissatisfaction is closely linked to eating disorders. Bulimia and anorexia affect almost 300 million people of all ages, but the majority are girls and young women.⁴⁰ Studies show that the pressure on women to be abnormally skinny—and to achieve a “perfection” that cannot exist—comes from all over the world, including in Germany, Spain, Australia and Brazil, as well as the U.S. Females obsess about their appearance no matter where they live. Furthermore, the cultural demand that girls and women be “sexy” has nothing to do with their own enjoyment of their bodies and everything to do with their appearance, how others judge they should look. It's not surprising that girls and women of all ages are especially hard on themselves and might not appreciate being female.

During puberty, sexual desire blossoms. Girls and women are still regarded as sexual objects; so when secondary sex characteristics emerge, along with often intense sexual desire, girls may feel even more vulnerable. In the U.S., the female breast is the quintessential symbol of womanhood and sexiness—again, from an appearance standpoint and not from the perspective of bringing pleasure to its

owner. Developing breasts often lead to excessive and unwanted attention from boys, which may contribute to the reason that so many girls want them removed.

Sadly, unwanted sexual attention also corresponds to the use of pornography—which often includes violence, and has become commonplace due to the popularity of the internet. In the United States alone, 20 to 30 percent of children 10 to 12 years of age have reported some exposure to pornography. Pornography use has a clear correlation with objectifying one’s sexual partner.⁴¹ *Objectifying* a woman means treating her as a sexual object whose sole purpose is to gratify someone else’s desires, rather than respecting her as a human being who has her own needs and wants. Men can be objectified as well, although it doesn’t happen as often. Our culture does not consider being a sexual object as a defining trait for masculinity the way it does for femininity. Once someone is taught to objectify others, they lose the ability to be compassionate and it’s much easier to inflict sexual violence on them. Sexual violence could include verbal sexual harassment, forcefully touching sexually sensitive areas with or without the threat of violence, and forcing oneself on another sexually—which is rape, whether or not the perpetrator manages to complete the act. Shrier points out that violent pornography now includes choking, which horrifyingly, women in films are portrayed as enjoying. “Violent porn,” she writes, “not only terrifies young girls about men and the prospect of sex with them, it is changing the expectations and behavior of boys.” One sex researcher “found that nearly a quarter of adult women said they have felt scared during sex.” In addition, “13 percent of sexually active girls ages 14 to 17 have already been choked.”⁴²

A 2019 study linking violent pornography to increased violence among dating teens found that boys who were exposed to violent pornography were two to three times more likely to report victimizing others—and because this figure is based on self-generated reports, it’s probable that the incidence of teen dating violence is much higher.⁴³ How vulnerable a girl must feel when she realizes that as a fully developed woman, she could easily be the recipient of sexual violence! If becoming a physically maturing female is so difficult and dangerous, what better way is there to opt out than by being a less vulnerable male? Girls who frequently find themselves subject to ridicule and unwanted sexual attention—not to mention being exposed to violent pornography—may find FtM transitioning especially attractive. Possessing masculine secondary sexual characteristics is a great way to discourage predatory males from perceiving a biological woman as a vulnerable female. Moreover, having a penis isn’t even required. According to the 2015 *U.S. Transgender Survey*, only two percent of natal female respondents underwent genital surgery. One percent had phalloplasty, which is the creation of an artificial penis-like structure from existing tissue, usually taken from the forearm. Another one percent had metoidioplasty, which involves cutting ligaments around the erectile tissue to give the shaft of the testosterone-enlarged clitoris greater length.⁴⁴

“The detransitioners I see in my practice,” psychotherapist Lisa Marchiano writes, “are all female, and they are all in their early twenties.”

At the time they became trans-identified, many were suffering from complex social and mental health issues. Transition often not only failed to address these issues, but at times exacerbated them or added new issues....

The young women with whom I have worked became trans-identified during adolescence. They frequently did so in the context of significant family dysfunction or complex psycho-social issues. Sexual assault and sexual harassment were common precursors. A majority had an eating disorder at the time they became trans-identified. Since detransitioning, most now understand themselves to be butch lesbians. In our work together, they traced complex histories of coming to terms with their homosexuality. Some faced vicious homophobic bullying before they announced their trans identification.⁴⁵

The experiences of other clinicians and researchers align with Marchiano's. Most of the girls who gravitate toward sexual "reassignment" suffer from emotional problems, especially depression, anxiety, and feelings of self-loathing about their bodies. In addition to eating disorders, some have issues with self-harm such as cutting. It shouldn't be surprising that such girls long to escape the bodies that, in their eyes, are the cause of so much pain and distress. Why be someone with a "front hole" (the new, ugly word for vagina) when you can be a cool FtM? Not only has social media glorified transgenders, but unless a female's appearance lies within a very narrow band of what's considered attractive, she thinks she's not enough of a woman. In a huge anti-female (and anti-feminist) backlash, a girl who excels at math or science, is not particularly "girly," and is good at sports—who is what we call a "tomboy"—is made to question whether she's female at all. If she's attracted to other girls, and *especially* if she's butch or masculine-looking, it's unlikely that she's simply a lesbian—she must be a male! Declaring that one is a FtM transgender bestows great social status compared to coming out as a lesbian, which earns demerits.

During Abigail Shrier's extensive interviews, one girl shared that at her all-girls school of 500, there were 15 trans students. That translates into 3 percent of the school population "born in the wrong body." Compare these numbers to those cited in the *DSM-5*, published less than ten years ago, which listed an expected rate of 0.002–0.003 percent—less than one in 10,000. How many lesbians attend the school? None. This both hides and disappears the gay female population. "Symptoms that some see as evidence of being transgender," Marchiano writes, "can also be an early expression of being lesbian or gay. Given that research indicates that the majority of cross-sex identified kids will desist if left alone, and that most of these will grow up to be gay, lesbian, or bisexual, it seems prudent in many cases to wait and see."⁴⁶

As with boys, girls that are not stereotyped caricatures are branded "gender nonconforming." At a young age, they're expected to declare whether they are "gender-fluid," "gender-queer," "asexual," or "non-binary." What they *don't* want

is to be “cis-gender,” or ordinary natal, biological females (just as some boys don’t want to be regarded as ordinary biological males). Shrier rightly calls this “indoctrination in gender ideology that is both so radical and so pervasive” that it’s not surprising that so many students fall for it.⁴⁷ “All that’s required is the insistence that students display decency, civility, and kindness to their classmates.... But instead ‘bullying’ is used as an excuse for a thorough indoctrination in gender ideology and the insistence that transgender students must be ‘affirmed’ or suffer a steep psychological toll.”⁴⁸ Incredibly, students of all ages are being indoctrinated with the trans agenda: in grammar schools, high schools, colleges, and universities. California leads the trend, but other institutions across the United States—New York, New Jersey, and elsewhere—are quickly following.

The optimistic demeanor conferred by taking testosterone also plays a huge role in FtM transitions, Shrier reports. Many teenage girls post how good they feel from testosterone injections. They feel liberated by testosterone’s calming and euphoric effects, not to mention increased energy. Anxiety and depression markedly decrease.^{49,50} Excessively high testosterone levels have also been shown to reduce fear, increase risk-taking behaviors, and lower sensitivity to punishment. Compared to patches and pills, the injections are reported to have an addictive quality. For a developing adolescent girl, the promise of relief from not only anxiety (which rises during puberty), but also messy periods and painful cramps, can be too tempting to resist. The act of injecting testosterone is even regarded as a rite of passage, as evidenced by celebratory injection rituals found on the internet. Therapists might claim that the girls feel better because now their bodies are in greater alignment with their brains. But in reality, the enjoyable feelings are due to the effects of a *drug*. Testosterone is a hormone produced in the bodies of females as well as males, but when it’s administered in unnaturally large amounts, it’s a drug. Many people forget this. Another lasting alteration in girls from testosterone is lowered vocal pitch. Sometimes all it takes is a mere six months on the hormone for permanent changes to occur. So despite her stopping the testosterone, her voice will never revert to its natural range and she may sound like a man for the rest of her life. Other parts of her body will most likely be permanently disfigured in some way, and her options in life will be lessened.

The sad thing is, girls who want to escape their bodies haven’t been taught coping skills. As one adolescent female said, “I don’t know exactly that I want to be a guy. I just know I don’t want to be a girl.”⁵¹

Children Who Have Divergences of Sexual Development

In the first chapter I discussed in detail Divergences of Sexual Development. Due to most people’s discomfort with atypical genitals that deviate from an arbitrary norm, infants are routinely subjected to surgery and are often given hormones as well. Children are rarely given a choice. For the rest of their lives, they will have to live with the decisions that others made for them. Fortunately, with the support of the growing intersex movement, which embraces all people with atypical

genitals, more people are coming forward to talk about how they were abused by the medical profession. Many of them mourn the loss of their genitals and their inability to experience sexual pleasure.

Dr. Sarah Creighton, author of the 2001 article “Surgery for intersex,” reported that not only were adult subjects “dissatisfied” with both the structural and cosmetic outcomes of surgery performed on them when they were children, they were also “unhappy and feel mutilated and damaged by surgery performed... however worthy the clinician’s motives.” She pointed out that the Intersex Society of North America “regards vaginoplasty and clitoral reduction as cosmetic surgery that should be deferred until the patient can consent. This means leaving even the most virilized female babies without surgery”—despite the fact that this “goes against current practice in the UK.” She advocated using surgery “sparingly,” as “it is impossible to define who actually ‘needs’ a clitoral reduction or vaginoplasty in childhood....Clinicians working in this field must step back and review their practice. Surgery may not be necessary.”⁵² Physicians have yet to heed her advice.

It amazes me that there’s still a debate over whether cutting into the genitals of an infant (or grownup) can cause physical and psychological damage.⁵³

Men

Some adult men transition relatively late in life, when they’re in their 40s or even 50s. Many of them are husbands. A typical candidate has had a satisfying relationship with his wife and children and has enjoyed a successful career, often in a respected white-collar profession. His ability to enjoy sex with his wife and father children, and decades of living in apparent congruence with his body, make his decision to transition even more puzzling. As it turns out, such a man usually declares that he’s transgender for one of three reasons: he’s a cross-dresser (likes to wear clothing made for women), he experiences sexual excitement when perceiving himself as a woman and masquerading as one, or his desire to transition is underscored by a trauma, possibly decades old.

In today’s climate, cross-dressing is often erroneously conflated with transgenderism. Whereas a woman might have occasionally accepted seeing her male partner in a dress, trans-oriented doctors pathologize this behavior to mean that he is in the wrong body and pressure him to accept cross-sex hormones and surgery. Once the medical establishment insinuates itself into a cross-dresser’s life, tension may be created where there previously had been none. The cross-dressing man’s partner fears that anytime, he might change irreversibly before her very eyes—physically, mentally, and emotionally.

In such relationships, there might be a fundamental clash of values between those who love extreme sex role stereotypes and those who don’t. One woman who was married to a cross-dresser said, “I, who had never cared much about clothes and resented the ‘Barbie doll’ image of women, had a husband who seemed obsessed with clothes and was helpless while his nail polish was drying.” Her husband loved the “teenage primping I have never wanted to do.”⁵⁴