

Trans-sexual Deception

Transgender ideology is built on false claims, facilitated by deceptive terminology.

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Claim #1: A biological male can be transformed into a female, and a biological female can be transformed into a male.

In truth, sex, which is determined at conception, never has nor ever can be changed. Sex is determined by the design to reproduce, with females and males both contributing genetic material for their offspring, where the female egg receives the male sperm in the process of reproduction. The information (X or Y chromosome) in the sperm determines whether the offspring will be female or male. There is no biological basis for anyone being “transsexual.” Yet a leading medical journal in 1978 published an editorial that claimed that a person’s sex was “changed” or “reversed” by surgery.¹ The term “transsexual people” has been defined as “individuals who seek to change or have changed their primary and/or secondary sex characteristics through feminizing of masculinizing medical interventions (hormones and/or surgery), typically accompanied by a permanent change in gender role.”² Such interventions do not change a person’s sex; they only make that person look more like (“pass as”) the opposite sex at great cost, including significant medical risks, sexual dysfunction, and ultimately sterility. The word “transition” means “change or shift”. Concerning sex or “gender transition” (transgender), interventions change neither; only the appearance of sex is changed, so “transgender” makes no sense unless the thoughts about sexuality change. One who goes from a “cisgender” to a “transgender” identification, and one who desists from a “transgender identification” are the only ones who are transitioning their gender. Children who do not think or act like their sexual stereotypes (tomboy girls and effeminate boys) are still either girls or boys (female or male). They should not be stigmatized because they do not match the stereotypes associated with their sex. Neither should they be affirmed as a gender or sex that does not match their true sex.

Claim #2: Gender can be substituted for sex.

Gender has mainly been a linguistic term for centuries, applied to nouns and other words that often have no bearing on the sexual attributes of those words. Words incorporating “gen” like generations, genealogy, and genitals, have to do with reproduction, as does sex. Gender is now used as a social sexual (referring to male or female sexual attributes) identity construct, popularized in recent decades.³ Gender identity “describes one’s internal feeling of gender, for example, boy or girl, man or woman; a gender (identifying as having no gender); or a nonbinary understanding of one’s gender.”² It is readily apparent that such language by proponents of affirmative therapy for “transgender people” is fraught with ambiguity. Gender has been erroneously used as a substitute for sex, including in electronic medical records, on driver’s licenses, and in civil rights legislation. Since gender is a mutable thought, it should not be substituted on legal or medical documents for sex, which is an immutable reality. Gender identity along with any other identity based on thoughts, desires, and feelings, can readily change. Sex, on the other hand, cannot be changed. Gender identity and sexual identity are synonymous since both encompass personal thoughts about sexuality. When gender identity does not align with one’s true sex (“gender incongruence”)⁴, it is the gender identity that is in error and the main cause of any associated dysphoria. “Gender incongruence” should be more accurately called “sex/gender incongruence” because the incongruence is between a person’s sex and how they think about their sex; i.e. gender. A more recently prescribed term for sex/gender incongruence is “transgender and gender diverse” which is meant to be more inclusive for different cultures and different ideas, replacing “non-binary” and “gender non-conforming” categories.⁵ True reconciliation of “gender incongruence” can only come through acceptance of one’s true (biological) sexual identity as opposed to so-called “gender affirmation,” which only reinforces the false belief that one’s sex can be whatever is perceived or desired. A more recent manipulation of language to advance gender ideology is the use of “appearance congruence” to describe congruency between gender identity and sexual physical appearance or “external phenotype.”⁶ Without any “gender-affirming therapy”, sexual appearance is congruent with sex, a healthier and more appropriate congruence than the so-called “appearance congruence.”

Claim#3: Sex or gender is assigned at birth.

Sex is determined at conception. It is readily *identified* at birth in over 99.9% of babies (only 0.02-0.05% of newborns have ambiguous genitals),⁷ and is often *ascertained* by ultrasound before birth. It is *not* arbitrarily “assigned,” but rather identified, proclaimed, and traditionally recorded appropriately in newborn medical records and on birth certificates. The male or female *designation* (not “assignment”) at birth is one of sex, not gender. Any “reassignment” done later using hormonal and/or surgical alterations to secondary sexual characteristics in an attempt to resolve “gender incongruence” or its associated “gender dysphoria”, is not a reassignment, but rather a misguided assignment contrary to biological reality. Clinical psychologist John Money championed the idea of assigning “sex of rearing” in the 1950’s. He thought that how parents reared a child (as a boy or a girl) was the most important factor in their eventual gender identity.^{3,4} His hypothesis was later disproved,³ but the idea of assigning sex persisted, especially for children born with ambiguous genitalia.⁸ Most infants with ambiguous genitalia are reared as the sex aligned with their sex chromosome status (XX -girl, XY-boy), but factors such as extreme virilization or feminization, as well as future fertility should be considered.^{8,9} Gender cannot be assigned to newborns since they do not have assignable thoughts about their sexuality. Adults who assign or affirm a false sexual identity to a child (encouraging a boy (biologic male) to be treated as a girl (biologic female) or vice versa) are doing a disservice at best, and committing child abuse at worst.

Claim #4: Discrimination and social rejection of “transgender persons” is responsible for their high risk of depression and suicide.

Despite U.S. society becoming more supportive of transgender ideology and less discriminatory against non-traditional sexual expressions in recent decades, suicidal ideation, attempts and completions among those who identify as “trans” remain unacceptably high. Recent survey studies have found suicidal behavior to be magnitudes higher in trans-identifying adolescents than in those who identify with their biological sex.^{10,11} Suicide rates in teens and young adults have risen substantially in the past 20 years.¹² Not identifying with one’s biologic sex is a major risk factor for suicidal ideation

and behavior.¹¹ Affirming a false identity, rather than dealing with the truth and underlying problems that led to aberrant desires and/or ideas, may actually be contributing to the dramatic rise in numbers of trans-identifying adolescents³ as well as rises in adolescent suicide rates in recent years (suicide is the second leading cause of death in 10-34 year-olds, with dramatic rises since 2012).¹² Many transgender-identifying children and adults experienced numerous and impactful adverse childhood experiences (ACEs), such as parental divorce and sexual abuse. For example, about 92% of female transgender-identifying individuals screened for ACEs had experienced at least one ACE and 45% had experienced at least 4 ACEs.¹³ Over half (55%) had experienced child abuse, including 30% sexual, 20% physical, and 40% psychological abuse. Household dysfunction was experienced by 89% of the 131 participants. Those who had experienced at least 4 ACEs were 5 times as likely to suffer from depression and suicidality as those who had experienced no more than 1 ACE. Another study utilizing extensive CDC phone survey data found that LGBTQ+ individuals were about 2 to 3 times as likely to have experienced childhood sexual abuse (including “touched sexually”, “forced to touch sexually”, and “raped”) as those who were not LGBTQ+. ¹⁴ They also found that ACEs increased substantially with generations subsequent to Boomers. Their “findings suggest that exposure to ACEs has been increasing over time and more so for LGBTQ+ individuals.” Unfortunately, their data did not distinguish trans-identifying individuals from other “sexual minorities.” The increase in ACEs that has accompanied the breakdown of the traditional family, along with the effect of social media today, are likely major factors in the skyrocketing numbers of transgender-identifying adolescents today, as well as the increasing rates of suicidal ideation in such children. Their past adverse events and significant mental problems preceding their gender dysphoria diagnoses¹⁵ need to be addressed and dealt with to help them achieve true healing and comfort with their biologic sex, thus reducing their depression and suicide risk.

Claim #5: Gender identity that does not align with biological sex is not a mental disorder.

Up until 2019, incongruent gender/sex identity was properly classified as a “gender identity disorder” by the World Health Organization’s (WHO) *International Classification of*

*Diseases.*² The WHO replaced gender identity disorder with gender incongruence, which is also correct, but hides the fact that such incongruence has a mental basis (gender identity) and is indeed a disorder with significant comorbidities and health consequences. The Diagnostic and Statistical Manual (DSM) replaced “gender identity disorder,” accepted since 1980, with “gender dysphoria” in its 2013 edition, and then with “gender incongruence” in the 2019 edition of ICD-11.⁴ Despite its rarity,¹⁶ the WHO and many other leading medical and psychological/psychiatric organizations have elevated gender ideology above biologic reality. Gender identity can be any sexual identity that a person can conceive, since it is a thought. When thoughts do not align with reality, dysphoria is a natural consequence. While gender dysphoria is a real problem, it is the false gender identity that is at the root of the problem. It is thus a psychological disorder that begs for a mental reality-check solution rather than an effort to alter a normal body. What is obviously a mistaken thought has been encouraged and accepted as reality (“experienced gender”) by medical professionals, the ones who should uphold and promote truth as an essential aspect of psychological health. Meanwhile, truth about readily identified biologic sex has been hidden with words like “gender assigned at birth.”² Psychiatric researchers who are determined to affirm transgender identity also acknowledge that schizophrenia spectrum disorder occurs up to 50 times more often in transgender-identifying individuals than in those whose gender identity aligns with their biologic sex.¹⁷ Likewise, using U.S. hospital encounter data, “all mental disorder diagnoses” were identified 7.94 times greater in trans- than in cis-gender patients in a multivariate analysis of 2007 to 2014 national data.¹⁸ Comorbidities are common with mental disorders, and prior to the relatively recent reclassification of what was previously called gender identity *disorder*, transgender identity was accurately considered a delusional mental disorder by mental health professionals. Children look to adults like psychologists, school counselors, and parents to discern truth, so when those trusted adults promote and/or affirm a false sexual identity, children internalize that falsehood to their own detriment.

Claim #6: Gender identity is stable and should take priority over biologic sex

Some transgender-identifying adolescents and adults have insisted that those cross-sex identities started early in their lives. On the other hand, researchers in the field have

determined that a large percentage of prepubertal transgender-identifying children desist in that identity and come to accept, if not embrace, their biologic sex, especially if they are not encouraged and aided in their attempts to “pass as” the opposite sex.² The degree of dysphoria in pubertal years has correlated with persistence in transgender identity,² but efforts of social, hormonal, and surgical affirmation have ingrained those false sexual identities even more. Even so, some of those unfortunate children who were pressured into bodily mutilation, if not sterilization, have later come to the realization that they really were meant to identify with their biological sex and desisted from their former transgender identity. There are now hundreds, if not thousands, of these desisters who are meeting great opposition from the advocates of transgender ideology. Other evidence of the lability of transgender identities is the huge change in prevalence of those identities. The Netherlands, which led the transgender movement, determined a prevalence of 0.0084% in males and 0.0033% in females in 1996.² In a meta-analysis of transgender prevalence papers published between 1966 and 2015, prevalence estimates varied greatly by country, time period, and methodology. Transgender prevalence rates were orders of magnitude higher from studies that relied on self-reported transgender identification collected by surveys (between 100 and 700 per 100,000 participants) compared to 1 to 30 per 100,000 population by medical record diagnosis or receipt of affirmation interventions. All but 3 of the 27 studies in that meta-analysis found a greater prevalence in males identifying as females (MtF) than females identifying as males (FtM), with MtF:FtM ratios ranging from 1.2 to 6.1. Studies from Japan and Taiwan had the lowest ratios with more biological females than males.¹⁹ Perhaps the best transgender data comes from the Netherlands’ gender identity clinic spanning from 1972 through 2015. The number of patients assessed at their clinic that has seen over 95% of such patients seeking treatment in the Netherlands, rose 20-fold between 1980 and 2015. The authors stated, “The increase in the prevalence of people with GD who sought medical treatment in the Netherlands (1:11,900 transwomen and 1:30,400 transmen in 1990 vs 1:2,800 transwomen and 1:5,200 transmen currently) suggest that the transgender population is dramatically increasing.” Their MtF:FtM ratio also varied significantly by age group, being 2.3 for > 18 years, 0.7 for 12-18 years, and 1.1 for < 12 years of age.¹⁷ Males identifying as females was more common in decades past, whereas females identifying as males is becoming more and more common

now, especially in teen years. A smaller but more recent Portuguese study found over twice the number of FtM as MtF patients, with a median age of 30 years and 63% reporting childhood symptom onset.²⁰ The trends are for marked overall increased prevalence and for a shift from MtF to FtM, both of which are evidence that transgender identification is far from an innate stable phenomenon.

Claim #7: Opposition to transgender social, medical and surgical affirmation is discrimination against transgender people.

People who have lost touch with reality need to be affirmed for who they really are, as do all people. False and deceptive ideas should not be affirmed. To take a view that a male should be considered and treated like a female, or vice versa, is to discriminate against that person's true sex and to discriminate against truth. Discriminating against false and deceptive ideas is appropriate, but discriminating against the truth should not be condoned. Personhood should not be defined by a person's false identity. Regardless of feelings, a male person should not identify himself sexually as anything but a male, and a female person should not identify herself sexually as anything but a female. To use the term "transgender person" assigns personhood inappropriately based on a false identity. It would be acceptable to say "transgender-identifying person" because that can be true even though the identity is false. People should not ask, much less expect, others to identify them as the opposite sex through pronouns or anything else. That discriminates against sexual truth. Furthermore, affirmation of a false gender/sexual identity is often pursued while neglecting needed resolution of underlying mental stress from sexual abuse and other adverse childhood experiences that are frequently associated with transgender identities. The medical and surgical affirmation interventions that have not undergone customary long-term controlled trials for safety and efficacy, increase health risks for transgender-identifying children, including permanent sterility.² Any effective relief experienced by these "affirmed" children is likely to be temporary, with long-term prospects for mental stability being suspect at best. To call these poorly tested interventions that include removal of healthy organs "medical necessities"⁵ is unreasonable in light of the fact that they were generally not even offered a few decades ago, when there were fewer suicide attempts due to sex/gender incongruence-caused dysphoria.

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