The Trans-Suicide Lie

It has become an article of faith promoted by Trans ideologues that not allowing children to access ‘Gender Affirming Care’ (GAC) will lead them to commit suicide. And upon this falsehood an entire industry whose ‘commodity’ is the desecration of the human body and mind, has been built.

But the simplest and most obvious refutation of this position is: ”*Where are all the dead children*?” GAC did not exist before its malign parent Fake-News Gender Dysphoria (FNGD) was unleashed onto the world in 2013. If it were true that resistance to normally-timed puberty in healthy children increased the risk of suicide, there would be abundant and irrefutable evidence of this throughout the historical record.

Additionally, in the present, worldwide ‘*puberty-onset suicide’* would be at endemic proportions. By my calculations there should be nearly 10 million teenagers from every corner of the globe killing themselves every year because they are unable to access ‘GAC’.

But (thankfully), the world is not knee-deep in dead children.

The link between denied access to GAC and suicide is utterly and completely false.

Risk factors to suicide in children

In the main, children referred with mental health and psychosocial problems such as sexual abuse survivors and those who have grown up in neglect and in chaotic households do have higher levels of Suicidal Ideation (SI) and/or Self-Harming Behaviour (SHB) than their age-matched, non-clinical peers. And because ‘trans identified’ children are more likely to come from this group, they too have higher levels of suicidal thoughts and SHBs.

The data

Dr Michael Biggs, (Associate Professor of Sociology at Oxford University), published a paper in 2022 entitled ‘*Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom*). Dr Biggs found that from 2010 to 2020, four patients in the care of the Tavistock Gender Identity Service (GIDS) committed suicide, accounting for 0.03% of the total patients. (1)

Dr Biggs further notes that this figure translates to an annualised rate of 13 suicides per 100,000. For their matched peers in the general population the rate was 2.7 suicides per 100,000. Seemingly, therefore, adolescents referred to GIDS had 5.5 times the number of suicides than their peers.

This figure looks alarming but it is highly misleading. This is because of the profile of the ‘trans-identified’ children referred to GIDS.A breakdown of this cohort showed:

- 70% had more than five associated features/comorbidities such as abuse, depression, self-harm, suicide attempts, anxiety, ADHD, eating disorders or bullying;
- They were 10x more likely to have a registered sex offender parent;
- 25% had spent time in care (compared to 0.67% of the general population);
- 42% had lost a parent through death or separation;
- Only 2.5% had no known associated problems.

These children never had FNGD. They were, unsurprisingly, responding to stressors in their lives by expressing suicidal ideations. And these have been cynically parlayed into the spurious and fictitious diagnosis of 'Gender Dysphoria'.

In short, the 'data' on the risk of FNGD and suicide is simply not there. And it is not just me saying so. In July 2024 Professor Sir Louis Appleby, the government's 'Suicide Tsar' published a report entitled: *'Reviewing suicides and gender dysphoria at the Tavistock and Portman NHS Trust: independent report'*. (2)

Professor Appleby's summarised conclusions were:

1. The data do not support the claim that there has been a large rise in suicide in young gender dysphoria patients at the Tavistock.

2. The way this issue has been discussed on social media has been insensitive, distressing and dangerous, and goes against guidance on safe reporting of suicide.

3. The claims that have been placed in the public domain do not meet basic standards for statistical evidence.

4. There is a need to move away from the perception that puberty-blocking drugs are the main marker of non-judgemental acceptance in this area of health care.

5. We need to ensure high quality data in which everyone has confidence, as the basis of improved safety for this at risk group of young people.

Well, yeah, Professor Appleby, quite so. (Except 'Gender Dysphoria' is in itself a concept as fatuous as the breathless claims made about trans suicide. And it is not 'health care' either).

How is suicidality correctly assessed?

The current 'data' on suicidality in this group are based on internet questionnaires. These ask supposedly 'trans-identified' youngsters (in reality, anyone), if they've ever had thoughts of killing or harming themselves. This method of data collection and clinical 'analysis' is palpably weak and open to abuse and misinterpretation. Yet on such pitiable 'evidence' alone has the trans-suicide myth been perpetrated.

We have all, no doubt, heard that 48% of 'trans-identified' youth have considered or attempted suicide. But we are not told that this 'data' was derived from a ***single*** questionnaire by the LGBT charity PACE, published in 2015 and based on the results of ***just 27*** self-selecting and self-identifying 'trans' people, aged under 26. Thirteen of these 27 respondents had reported having 'attempted suicide', 'in the past'. This scant 'data' was cruelly and widely used by Mermaids, policymakers and sundry activists to push the trans-suicide myth.

But properly determining suicidality and mood requires careful, in-person clinical assessment by suitably-qualified persons using standardised and reliable assessment tools such as the 'Children's Depression Inventory', or the 'Ask-Suicide Screening Questions Toolkit'. This assessment should be initially done without the parent present. (They are questioned separately, and the data from the parent(s)'/caregiver(s)' response is compared to that of the child).

Additionally, the child should be asked about 'preparations' for suicide, previous attempts (parasuicide), lifetime history, suicidal ideations and mood changes (sudden elevations in mood may indicate an imminent attempt). Together with parental/caregiver data, risk is then assessed as being low/medium/high and if needed, appropriate steps are taken to keep the child safe. This should only be done by qualified persons because inexpertly asking about suicide (ie online!) can actually reactivate trauma and potentially lead to (further) suicide attempts.

The Trans-Suicide 'link'

Studies showing a link between suicidality and trans ideation in youngsters *have it backwards*. The respondents have suicidal thoughts because the social contagion of gender ideology has fuelled existing psychosocial, neurobiological and developmental problems. These problems are repackaged as 'Gender Dysphoria' and, often in front of children, parents are asked if they would rather have a "*live son, or dead daughter*", (or vice-versa). GAC is then presented by the therapist no less, as a 'lifesaving' alternative to suicide.

Suicidal ideation in 'trans-identified' children is thus what in psychology we call an *artefact*. Namely something that has been created by the very intervention that has been delivered to prevent it.

Charities such as the Trevor Project are particularly guilty of this. In preparation for the upcoming US elections no doubt, they excitably (and gleefully) announced a '72% increase' in 'trans suicides' caused by 'a wave of anti-trans bills' across America. This will have inculcated unknowable numbers of children into the idea that they are feeling suicidal because their State has banned so-called GAC. Children all over the world accessing their website will believe this too.

Here is some more irresponsible, alarmist and ill-defined mischievousness from their website (note how they craftily conflate 'trans' with being lesbian or gay):

- LGBTQ+ youngsters are four times more likely than their peers to attempt suicide;
- 1.8 million American LGBTQ+ youngsters 'consider' suicide each year;
- Every 45 seconds an LGBTQ+ youngster will attempt suicide;
- 50% of White and 58% of Black LGBTQ+ youth 'seriously consider attempting suicide' every year.

In the UK organisations such as Mermaids, the Good Law Project and GIRES who promote a trans/suicide causal relationship are also acting in a deeply unethical and dangerous manner.

It is all arrant nonsense.

Cognitions associated with suicidal thinking

Generally, suicidal ideations are triggered by feelings of hopelessness and helplessness. Death is seen as an escape from uncontrollable and unavoidable mental distress. A suicidal person is said to have a pervasive 'negative thinking style'. This is characterised by specific 'errors' in thinking called *cognitive distortions*. These are important to understand, as they form the basis for much psychotherapeutic intervention.

The main cognitive distortions are:

**All or nothing thinking*: Seeing the world in extremes. Everything is either good or bad, or a success or a failure. There are no grey areas.

**'Should' statements*: Always thinking about things that you "should" or "must" do. Because you always think you "should" be doing something, you end up feeling as if you are constantly failing.

Overgeneralisation: 'Always' and 'never' dominate one's thinking. One bad instance is generalised to an overall pattern.

**Mental Filter*: Taking one small event and focusing on it exclusively, filtering out anything else.

Discounting the positive: Ignoring or invalidating good things that happen to you.

Mind Reading: The inaccurate belief that we know what another person is thinking about us (invariably something negative).

**Jumping to conclusions/fortune telling*: Making conclusions and predications based on little to no evidence and holding them as gospel truth.

**Magnification/minimisation*: Exaggerating or minimising the meaning, importance or likelihood of things.

**Emotional reasoning*: The acceptance of one's emotions as fact: "I feel it, therefore it must be true".

*The cognitive distortions I feel to be particularly associated with FNGD.

We all, at times, engage in distorted thinking, because to err, after all is to be human. But it becomes problematic when these cognitive distortions are pervasive and dominate our mood and behaviour. A child (or adult) with severe depression/SI/SHBs will be caught in a spiral of dysfunctional cognitions and the goal of psychotherapy is to teach the person how to think in a more adaptive way by challenging them. Therapy's proper role thus is to 'reshape' the person's thinking style in a process called 'cognitive restructuring'. This is how Cognitive Behavioural Therapy (CBT) works and it is very effective in alleviating psychological distress.

But GAC does nothing to mitigate against psychological suffering. There is the vaunted 'Trans Joy', but we know from Detransitioners that this honeymoon period is temporary, sometimes evaporating soon after surgery, (in football this is termed the 'New Manager Bounce'), but more often taking some years to fade. This is because 'Trans Joy' is in reality the *concretising* of cognitive distortions. Particularly 'All or Nothing Thinking', 'Mental Filter', 'Magnification' and 'Emotional Reasoning'. As such, 'transitioners' describe the need to chase ever more extreme measures to lift their mood. It's why they go from 'social transitioning' to mutilating surgeries. Their cognitive distortions instead of being challenged and removed, are becoming more entrenched.

This is why leaked data from a still unpublished $97 million, nine-year study by the National Institute of Health in America, (led by Dr Johanna Olson-Kennedy of Stanford University), showed no increase in the mental wellbeing of 95 children, some as young as eight (God forgive us), who were placed on Puberty Blockers. Dr Olson-Kennedy had predicted that after two years on PBs, children would experience *"decreased symptoms of depression, anxiety, trauma symptoms, self-injury, and suicidality..."*

In the UK, an 'Early Intervention Study' into the use of PBs on 44 children was published in 2019 (some three years after the data were collected, again, why the delay?). The Tavistock, despite trying to hide the poor data, also found no improvement in children's mental health by blocking puberty. In fact, 30 of the 45 participants reported *more* negative psychological effects after having their puberty blocked. (3).

Zero positive correlation between PBs et al and improved mood functioning will ever be found, no matter how much money is thrown at trying to establish the efficacy of 'GAC'.

It is painfully simple: derailing a child's normal-occurring puberty and destroying their health does nothing to address either their adverse psycho-social circumstances and/or to change their dysfunctional thinking.

In fact, when after years of catastrophic GAC and when no more surgeries and revisions can be carried out, suicides have been found to actually increase by 12-fold. (3). This is because underlying cognitive distortions were never challenged.

Failure of the therapists

Therapists know about dysfunctional thinking styles and cognitive distortions. They certainly know not to lie to parents (in front of their children no less!), that suicide is the only alternative to GAC. A fundamental principle of psychotherapy is to not allow a person to achieve their wishes by threat of suicide or SHBs (because this does not address the underlying cognitive distortions). No therapist, for example, would encourage an anorexic to stop eating, or a person who self-harms to cut themselves. So, even if the numbers of 'trans identifying' children committing or threatening to commit suicide was truly as high 48%, even if it were 99%, this is still no reason to accede to their threats!

Yet therapists themselves are now enabling and promoting this behaviour. They, along with the TRAs are *teaching* children to be suicidal.

Clinicians know the suicide has a multifactorial aetiology and that attributing it to a single causal factor is dangerous. They know that even mentioning suicide to a distressed youngster increases its likelihood. They know SIs, parasuicide and SHBs are contagious. This is why we see suicide clusters.

But good clinical practice is being abandoned. The challenging of distorted cognitions is now demonised as 'conversion therapy' or 'gatekeeping'. Practicing such exploratory therapy is criminalised because TRAs know there is no foundation to their assertion that 'gender identity' exists. They know no-one is born into the 'wrong' body and is mistakenly being 'assigned' the incorrect 'gender' at birth. They know these arguments would wilt in the face of effective therapeutic intervention. It is why they are hell-bent on an 'affirmation only' approach.

Summary

GAC is a monumental lie predicated on the entirely non-existent correlation between FNGD and suicide. This falsity should be blindingly obvious.

Why should the process of maturation from child to adult suddenly have become so profoundly problematic? What is, (or has become) so flawed in Homo Sapiens' biology and psychology that we now cannot apparently grow safely into adulthood without the severe risk of mutilating or killing ourselves? How did our species ever survive before the advent of 'GAC'?

As the wonderful Helen Joyce has observed, telling a parent that if their child does not receive GAC they will kill themselves, is *"the most disgusting bit of moral blackmail"*.

GAC destroys healthy bodies and locks people into destructive cognitive distortions. Instead of the transient 'Trans Joy', the long-term reality is 'Trans Grief', characterised by increased morbidity and mortality, leading to an enormous increase in completed suicides *after* 'gender affirming' intervention.

The truth is that distorted cognitions can be fixed.

Mutilated, infertile and chronically damaged bodies however, cannot.

REFERENCES:

1: *Suicide by Clinic-Referred Transgender Adolescents in the United Kingdom*. Michael Biggs

https://tinyurl.com/4kz9nas2

2: *Reviewing suicides and gender dysphoria at the Tavistock and Portman NHS Trust: independent report*'. ://tinyurl.com/5hcae68e

3: *Risk of Suicide and Self Harm Following Gender Affirmation Surgery*: (Straub et al, 2022).

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