The WPATH Files

Michael Shellenberger

Advocates of gender-affirming care say it's evidence-based.

But now, newly released internal files from the World Professional Association for Transgender Health (WPATH) prove that the practice of transgender medicine is neither scientific nor medical.

American Medical Association, The Endocrine Society, the American Academy of Pediatrics, and thousands of doctors worldwide rely on WPATH. It is considered the leading global authority on "gender medicine."

And yet WPATH's internal files, which include written discussions and a video, reveal that its members know they are creating victims and not getting "informed consent."

Victims include a 10-year-old girl, a 13-year-old developmentally delayed adolescent, and individuals suffering from schizophrenia and other serious mental illnesses.

The injuries described in the Files include sterilization, loss of sexual function, liver tumors, and death.

WPATH members indicate repeatedly that they know that many children and their parents don't understand the effects that puberty blockers, hormones, and surgeries will have on their bodies. And yet, they continue to perform and advocate for gender medicine.

The WPATH Files prove that gender medicine is comprised of unregulated and pseudoscientific experiments on children, adolescents, and vulnerable adults and will go down as one of the worst medical scandals in history.

The WPATH Files

PSEUDOSCIENTIFIC SURGICAL AND HORMONAL EXPERIMENTS ON CHILDREN, ADOLESCENTS, AND VULNERABLE ADULTS

By Mia Hughes

The written WPATH Files come from WPATH's member discussion forum, which runs on software provided by DocMatter.

Ninety seconds of the 82-minute video was made public last year. We are making the full video available for download for the first time.

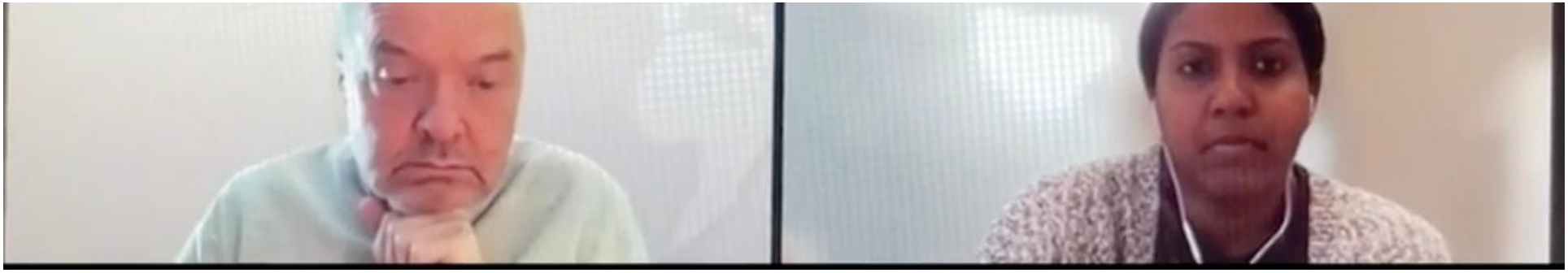
One or more people gave me the WPATH Files, and my colleagues and I attempted to summarize them as a series of articles. We quickly realized the topic was too sensitive, complex, and large to be dealt with as a work of journalism, and we moved the project to the research institute I founded seven years ago, Environmental Progress (EP).

The Files are authentic. We redacted most names and left only those individuals who are leading gender medicine practitioners to whom we sent "right-of-reply" emails. We know WPATH members discussed our emails internally. No WPATH leader or member has denied that the Files are anything other than what they appear to be.

EP is publishing a 70-page report to provide context for the 170 pages of WPATH Files. Mia Hughes is the author of the report. It and accompanying summary materials can be downloaded at this link. That link also provides a link to the full WPATH video.

What follows are simply a few highlights from the written files and the video. All video selections are also included in the video above.

People with a serious interest in the topic should read the report and all the files.



“I think the thing you have to remember about kids is that we're often explaining these sorts of things to people who haven't even had biology in high school yet,” says Dan Metzger, an endocrinologist.

“The 14-year-olds, you just... It's like talking [about] diabetic complications with a 14-year-old. They don't care. They're not going to die. They're going to live forever, right? So I think when we're doing informed consent, that's still a big lacuna.”

There are other discussions of the challenge of getting informed consent from 14-year-olds in the written files.

[redacted]

14 years old trans female wants Gender Affirming Surgery

[redacted]

829 Discussion Views

3 Responses

Hello my dear Colleges, I would like to know how to proceed on a 14 years old trans female who started transition since she was 4. She wants to have Gender Affirming Surgery MtF and her

parents are supporting her decision, But I have never done this on such a young patient.
What are your recommendations for this case???

Blockers for Pre-Teens: Height Potential?

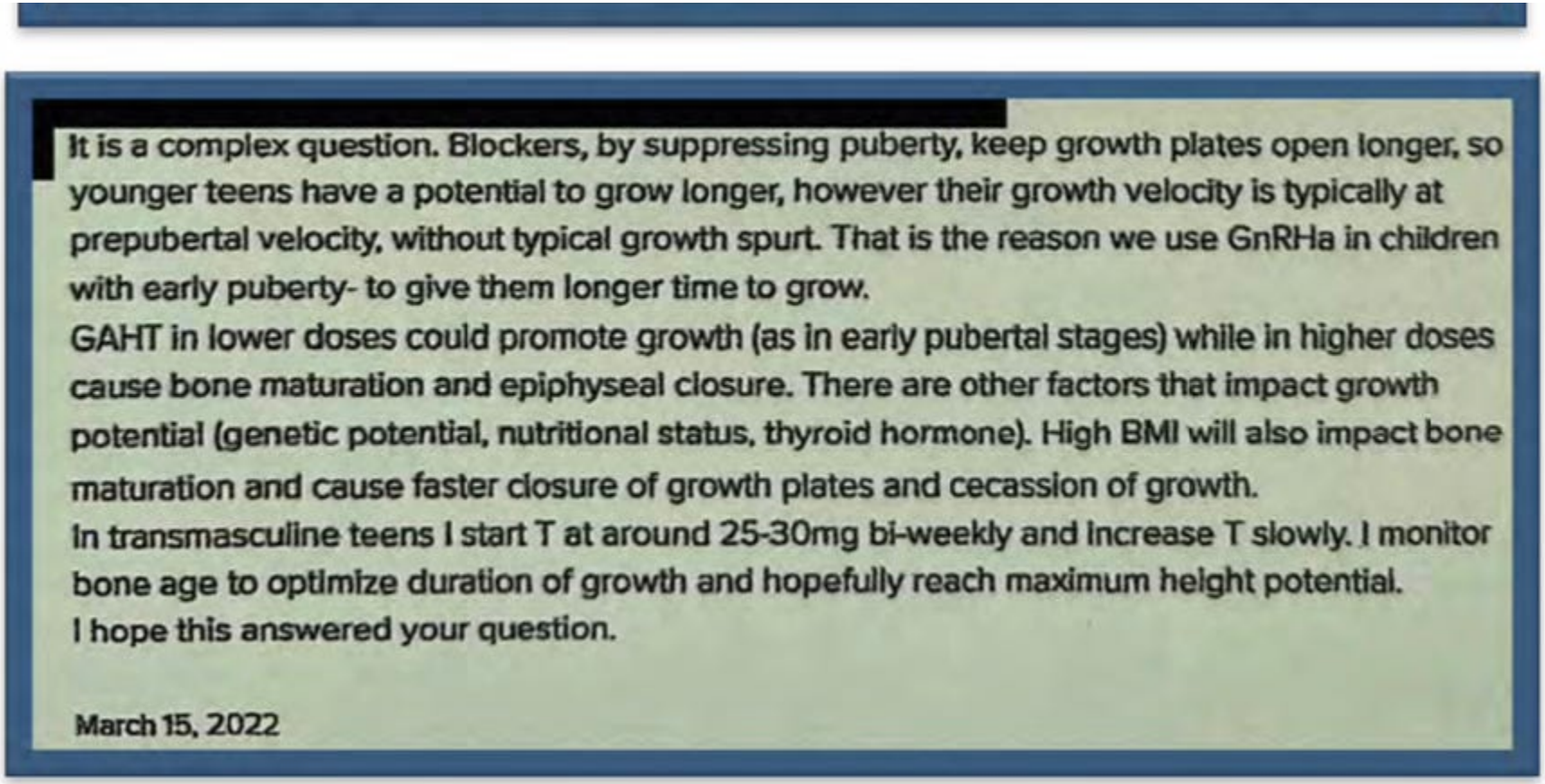
[redacted]

I have been reading/hearing some conflicting information about the effects of puberty blockers on total height achievement. I've recently received questions from an AFAB pre-menarche 10 y/o patient about whether blockers will "stunt" his growth if he starts them now (as his doc has approved). I understand blockers can slow the rate of growth, but for those who start them at, say, age 10, before they have hit their growth spurt, and remain on them for the total 3-4 years, what happens afterward if they opt to begin HT (testosterone), rather than resume the puberty consistent with their natal sex?

I'm curious as to how medical docs approach important issues such as stature when starting blockers, especially in earlier stages of development. Are there ways to maximize growth potential for young patients?

Thank you for your time.

February 22, 2022


[redacted]

It is a complex question. Blockers, by suppressing puberty, keep growth plates open longer, so younger teens have a potential to grow longer, however their growth velocity is typically at prepubertal velocity, without typical growth spurt. That is the reason we use GnRHa in children with early puberty- to give them longer time to grow.

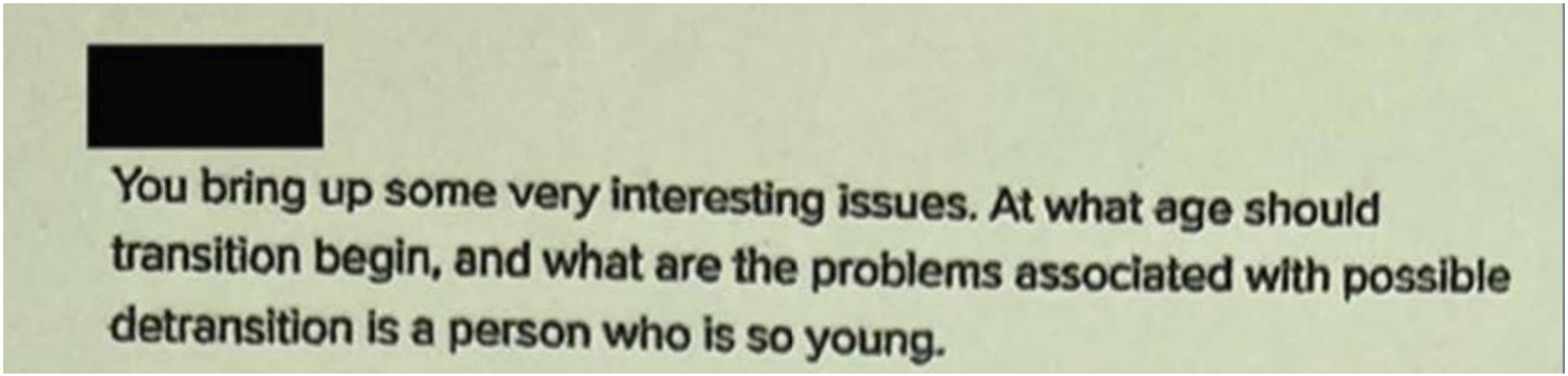
GAHT in lower doses could promote growth (as in early pubertal stages) while in higher doses cause bone maturation and epiphyseal closure. There are other factors that impact growth potential (genetic potential, nutritional status, thyroid hormone). High BMI will also impact bone maturation and cause faster closure of growth plates and cecassion of growth.

In transmasculine teens I start T at around 25-30mg bi-weekly and increase T slowly. I monitor bone age to optimize duration of growth and hopefully reach maximum height potential.

I hope this answered your question.

March 15, 2022

WPATH members resist efforts to make children and adolescents wait to have drugs and surgery.


[redacted]

You bring up some very interesting issues. At what age should transition begin, and what are the problems associated with possible detransition is a person who is so young.

I usually recommend that the person be living as the other sex for 6-12 months since they may find that they are uncomfortable with the sex that they feel is appropriate. Also, they need at least one supportive parent involved.

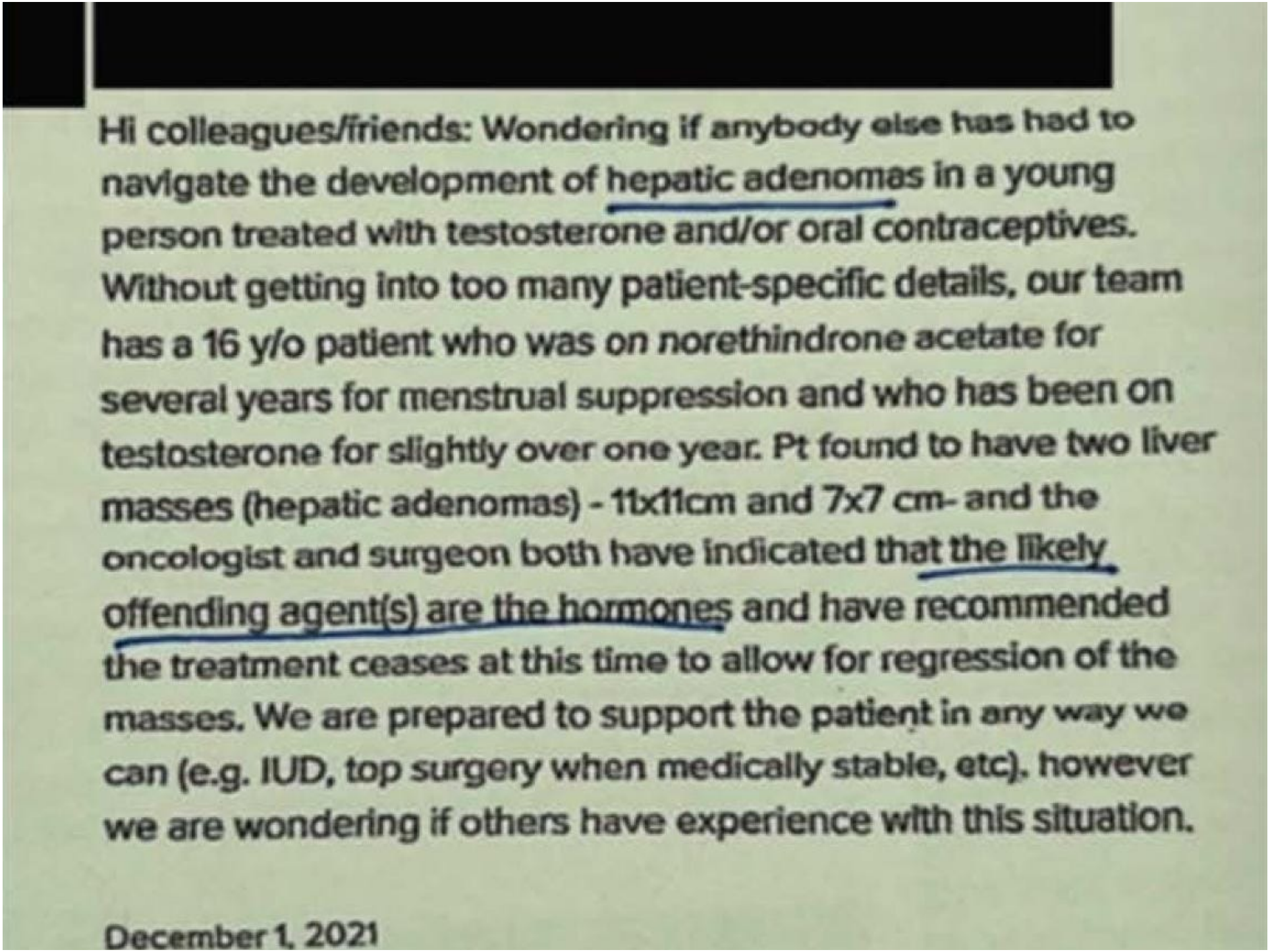
It is very difficult to ask that they wait until age 16 because by then they will be dealing with menstrual periods and complete breast development. Waiting appears to increase the rate of suicide attempts.

After much experience as a pediatric endocrinologist, I would not rule out treating if the person is living as a male and is convinced that transition would be correct for him.

The problem is that drugs can cause tumors, even, apparently, in people as young as 16 years old.

Hepatic adenomas and testosterone/estrogen

[redacted]


[redacted]

Hi colleagues/friends: Wondering if anybody else has had to navigate the development of hepatic adenomas in a young person treated with testosterone and/or oral contraceptives. Without getting into too many patient-specific details, our team has a 16 y/o patient who was on norethindrone acetate for several years for menstrual suppression and who has been on testosterone for slightly over one year. Pt found to have two liver masses (hepatic adenomas) - 11x11cm and 7x7 cm- and the oncologist and surgeon both have indicated that the likely offending agent(s) are the hormones and have recommended the treatment ceases at this time to allow for regression of the masses. We are prepared to support the patient in any way we can (e.g. IUD, top surgery when medically stable, etc), however we are wondering if others have experience with this situation.

December 1, 2021

Many young patients experiencing gender distress do not appear to understand that they may suffer serious consequences from long-term hormone use and genital surgery.

[redacted]

Discussion of surgical complication rates & assessments (referral letters).

[redacted]

Transgender Mental Health (2151 members)

1,895 Discussion Views

Hi all,

I have been thinking more about what it looks like to obtain fully "informed consent." I was curious to what degree, if any, other mental health providers discuss actual rates of surgical complications with clients when providing assessments for surgical care (e.g., pain or loss of sensation, need for additional surgeries, necrotic tissue, infection, hematomas, strictures, implant-related complications, etc.).

I am also curious if others think it is safe to assume that surgeons disclose actual complication rates (vs. informing clients that these complications may happen).

I realize research on some of these complications may be limited for various reasons.

Thanks in advance for your thoughts!

Best,

[redacted]

Despite the widespread and growing expression of concern within the WPATH Files over the negative side effects of gender medicine, WPATH members urge that irreversible surgeries take place when adolescents are just 16 or 17 years old.

Christine N. McGinn [redacted]

As background, I have performed about 20 vaginoplasties in patients under 18 over the past 17 years. I currently am battling my hospital for the ability to continue to do so in certain cases where I feel it is sound medical practice based on the situation and the patient. I have never

medical practice based on the situation and the patient. I have never been sued. None of those patients have regretted their decision that I am aware of. Not all of these vaginoplasties had perfect outcomes. The majority of them did fantastic. The ones who had trouble usually had trouble following the dilation schedule and had vaginal stricture. Patients over 18 can have the same dilation difficulties. Even when patients had difficulties they did not regret surgery.

That said, I feel we need to be together on this topic as a professional society. So my advice is tread lightly here. I know that hospitals are more commonly banning under 18 surgeries as I hear desperate stories in my patients and from many of my peers I have queried. The ability to get surgery in the US before 18 is very limited because hospitals are preventing it and the aggressive attacks from the right have had a chilling effect on surgeons willingness.

I think we need a strong message that "gender surgeries" should not be lumped together and each specific

and each specific surgery has its own discussion. For example a trach shave is not the same as Vaginoplasty.

I think we need to reject the argument that consent is impossible in a minor. My hospital performs all kinds of surgeries on minors without issue; they are singling these out because it is politically convenient.

I think we should strive for consensus regarding what a consent should look like for each of these surgeries.

Specific to Vaginoplasty, I have better success with dilation when the patient is at late 16 or 17. I would discourage Vaginoplasty surgery prior to that. In dealing with my hospital, I have offered to limit the under 18 surgery to 17. There is practical reason for this. Many of the bad outcomes are a direct result of rushing to get surgery before heading off to college/university. There are too many stressors in college that limit patients ability to dilate. For well prepared patients, I feel the ideal time in the US is surgery the summer before their last year of high school. I have heard many other surgeons echo this.

I also welcome appointments for the sole purpose of fact finding. I think it would be great for your 14 year old to hear about the surgery and what recovery is like and about hair removal if you require that. Conversations about surgery can be helpful at younger ages so that the parents and children can get their questions answered and navigate surgery and hormones as they relate to surgery. Penoscrotal hypo plasma is also an important topic to discuss early.

Good luck with this challenging case and good for you to seek information from others!!

One WPATH member says, in the video above, that "It's out of their developmental range sometimes to understand the extent to which some of these medical interventions are impacting them."

Says another, "We try to talk about it, but most of the kids are nowhere in any kind of a brain space to really, really, really talk about it seriously."

"I try to kind of do whatever I can to help them understand best they, best I can," says a therapist in the video. "But what really disturbs me is when the parents can't tell me what they need to know about a medical intervention that apparently they signed off for.

The situation of obtaining informed consent is complicated further when the adolescents are also developmentally delayed and, in the case below, "may not reach the emotional and cognitive developmental bar set" by WPATH's already very low standards of care.

[redacted] Ethical inquiry - adolescent

[redacted]

[redacted]

Pediatric Transgender Medicine (293 members), **Transgender Healthcare Policy and Public Health** (1093 members), **Transgender Mental Health** (1731 members)

3,198 Discussion Views

5 Responses

In a developmentally delayed 13yo adolescent, currently on pubertal suppression, that may not reach the emotional and cognitive developmental bar set by SOC* within the typical adolescent time frame if at all, what is the ethical approach to care? When would gaht be indicated?

*6.12.c "the adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.

Many thanks,

[redacted]

[redacted]

“Oh, the dog isn’t doing it for you?”

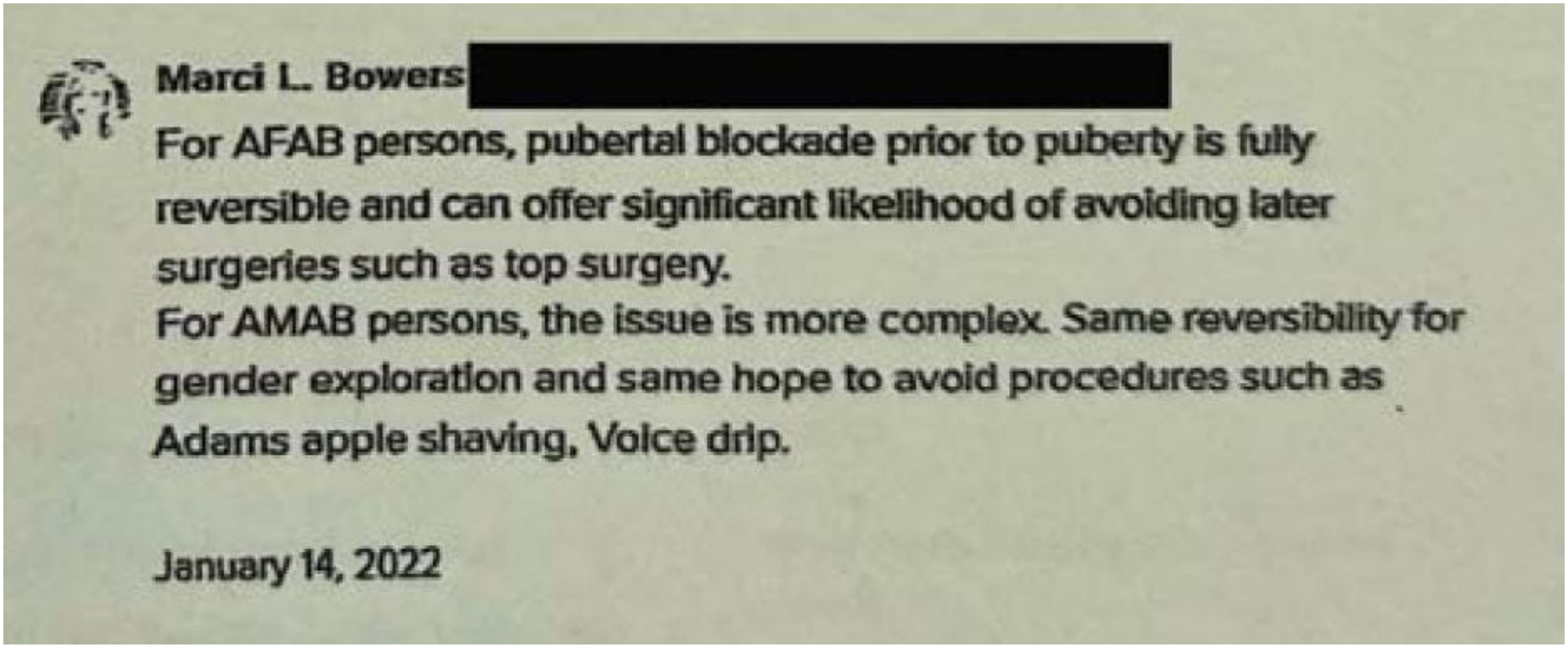
Many gender medicine victims are filled with regret that they were sterilized. Nobody knows this more than the doctors who mistreated them. Their response to such regret is often rather callous.

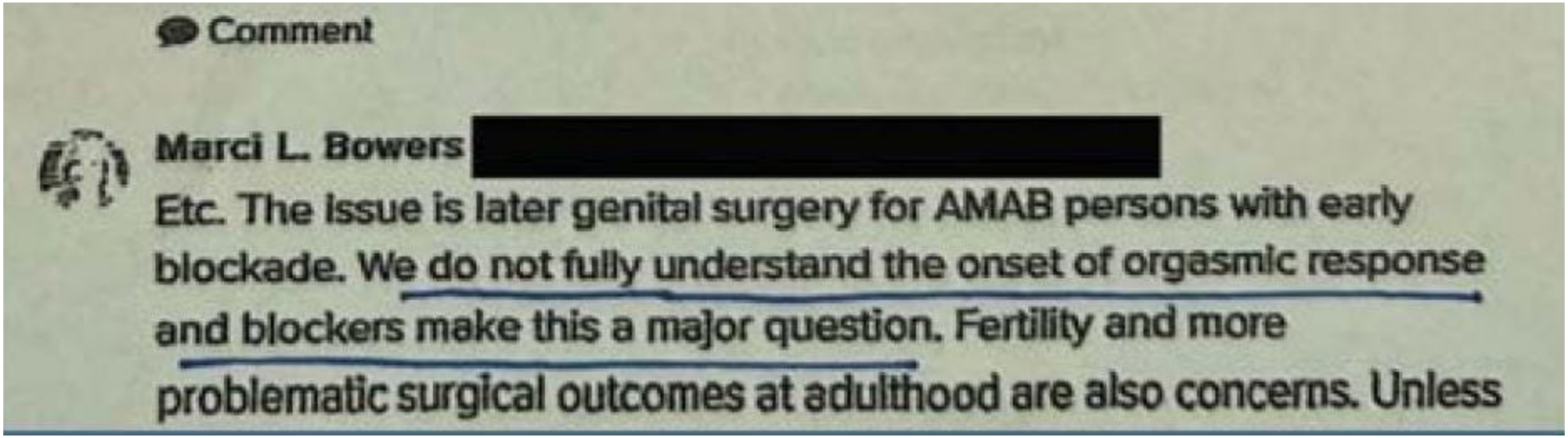
In the video above, one of them says, “I follow a lot of kids into their mid twenties, I'm always like, ‘Oh, the dog isn't doing it for you, right?’ They're like, ‘No, I just found this wonderful partner and now we want kids. So you know, it doesn't surprise me.”

Many gender medicine patients lose sexual function, including experiencing orgasm. As such, they are not only deprived of sexual pleasure, they are significantly undermining their ability to form long-lasting romantic relationships.

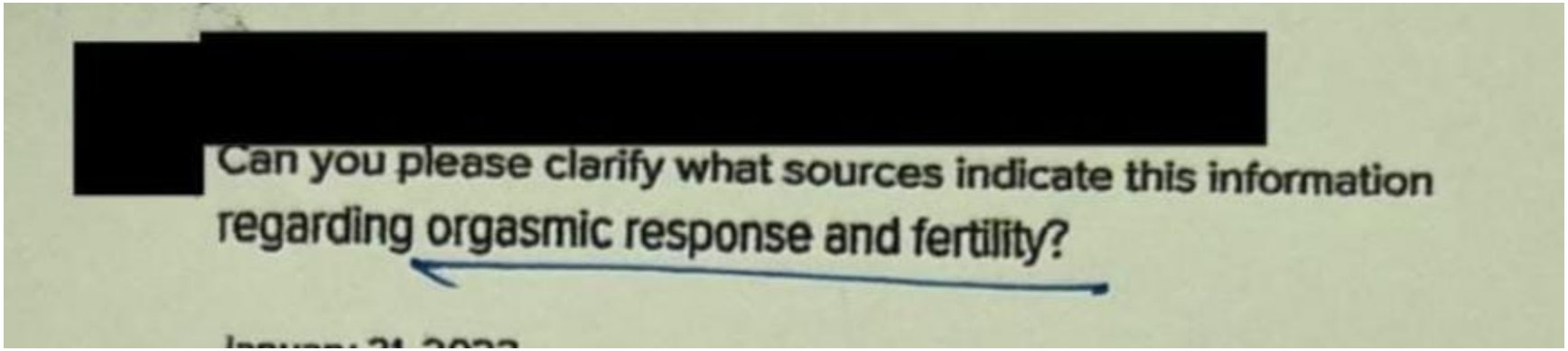
It’s clear from the Files that even many people within gender medicine do not understand this.

On January 14, 2022, the surgeon and President of WPATH, Marci Bowers, explained this reality in a low-key way.





Seven days later, a WPATH member asked Bowers to clarify.



January 21, 2022

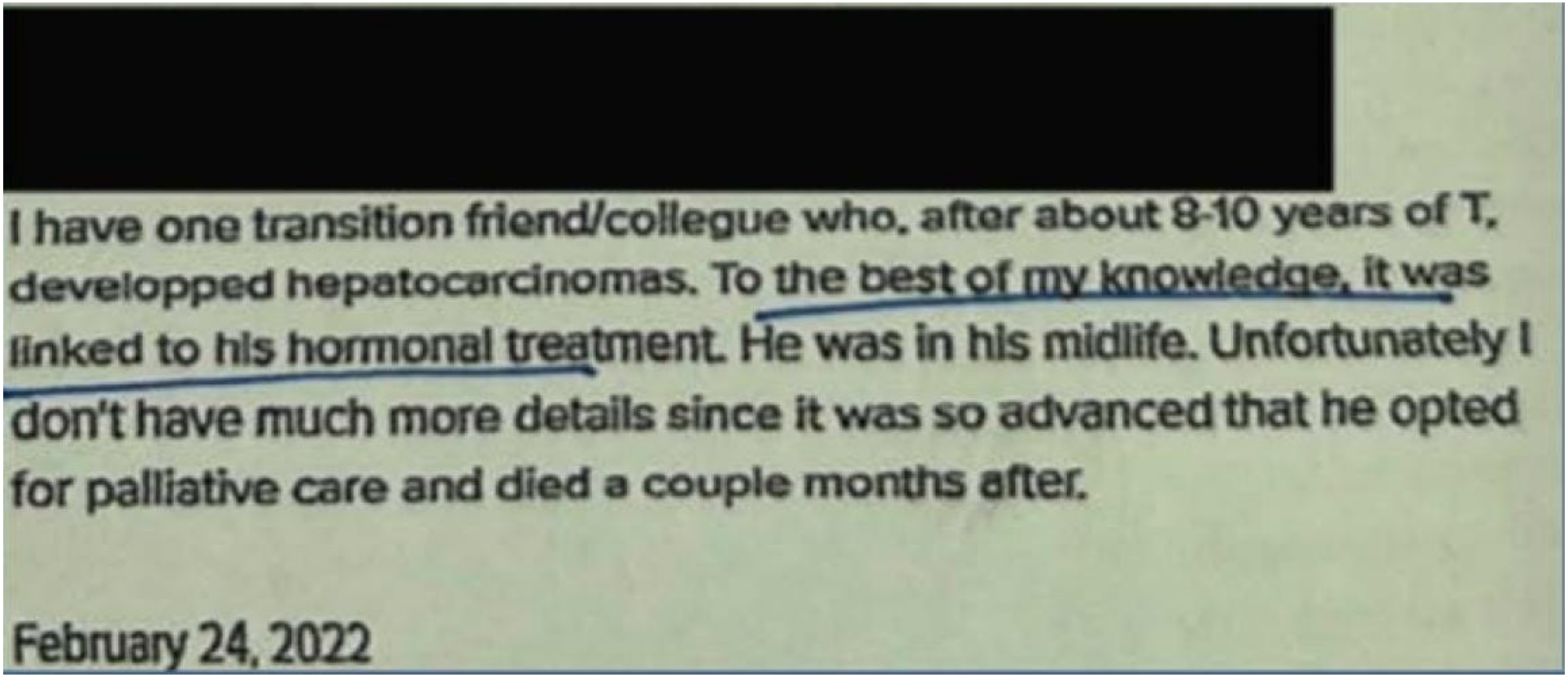
Marci L. Bowers [redacted]

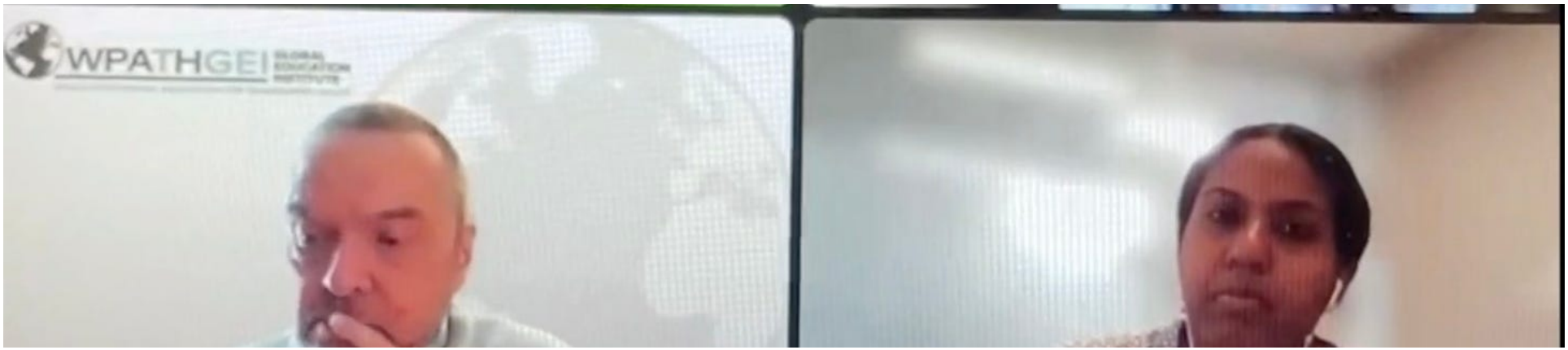
The fertility question has no research that I'm aware of as puberty onset allows for fertility options while blockers preclude those opportunities.

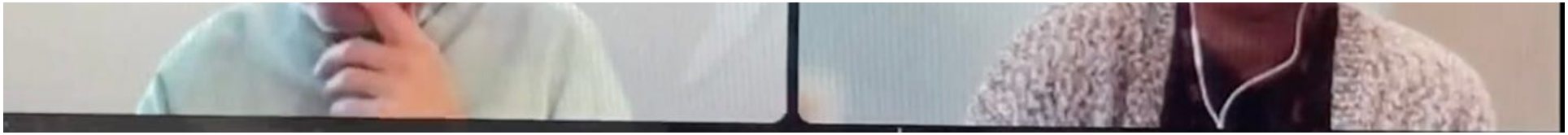
The orgasmic response question is thornier and observational based largely upon the growing cohort of puberty blocked individuals seeking gender affirming surgical care years later (I.e. now, with our office providing that care to a large number). To date, I'm unaware of an individual claiming ability to orgasm when they were blocked at Tanner 2. Clearly, this number needs documentation and the longterm sexual health of these individuals needs to be tracked. Again, puberty blockade is in its infancy— observational reports are commonly the nidus for future study, as will likely be the case here. I do hope to tabulate some of our experience for this year's WPATh presentations.

January 31, 2022

For some gender medicine patients, there are fates worse than both sterility and loss of sexual function.





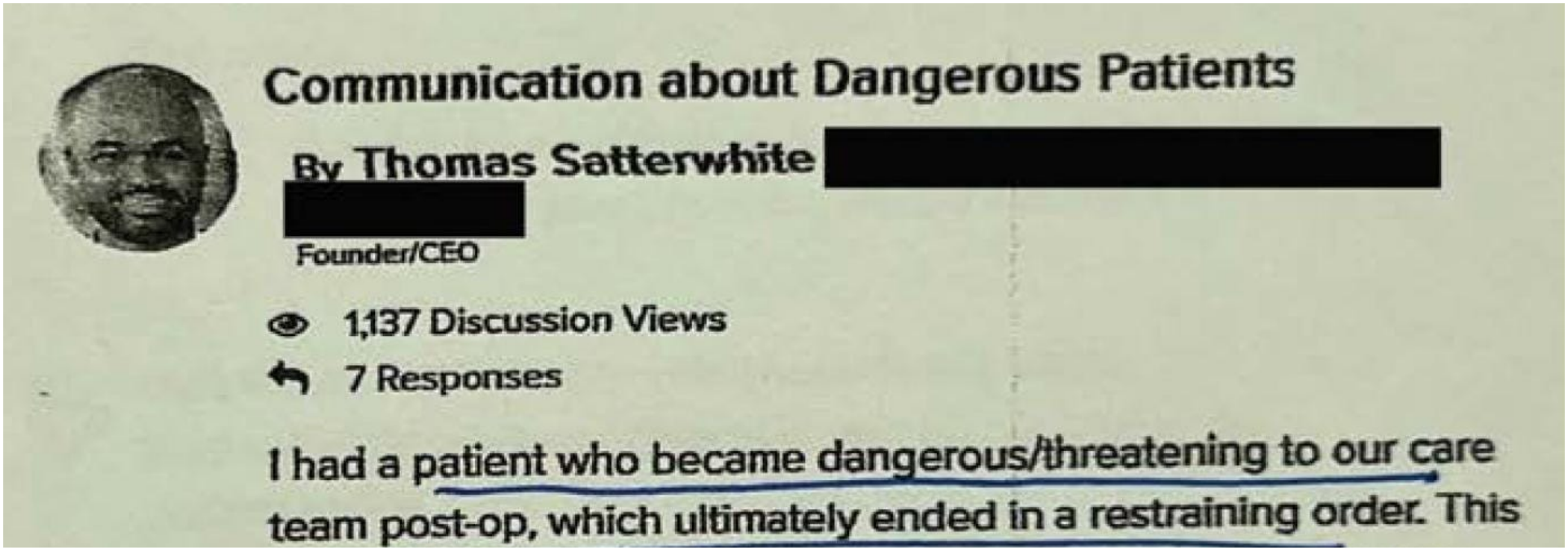


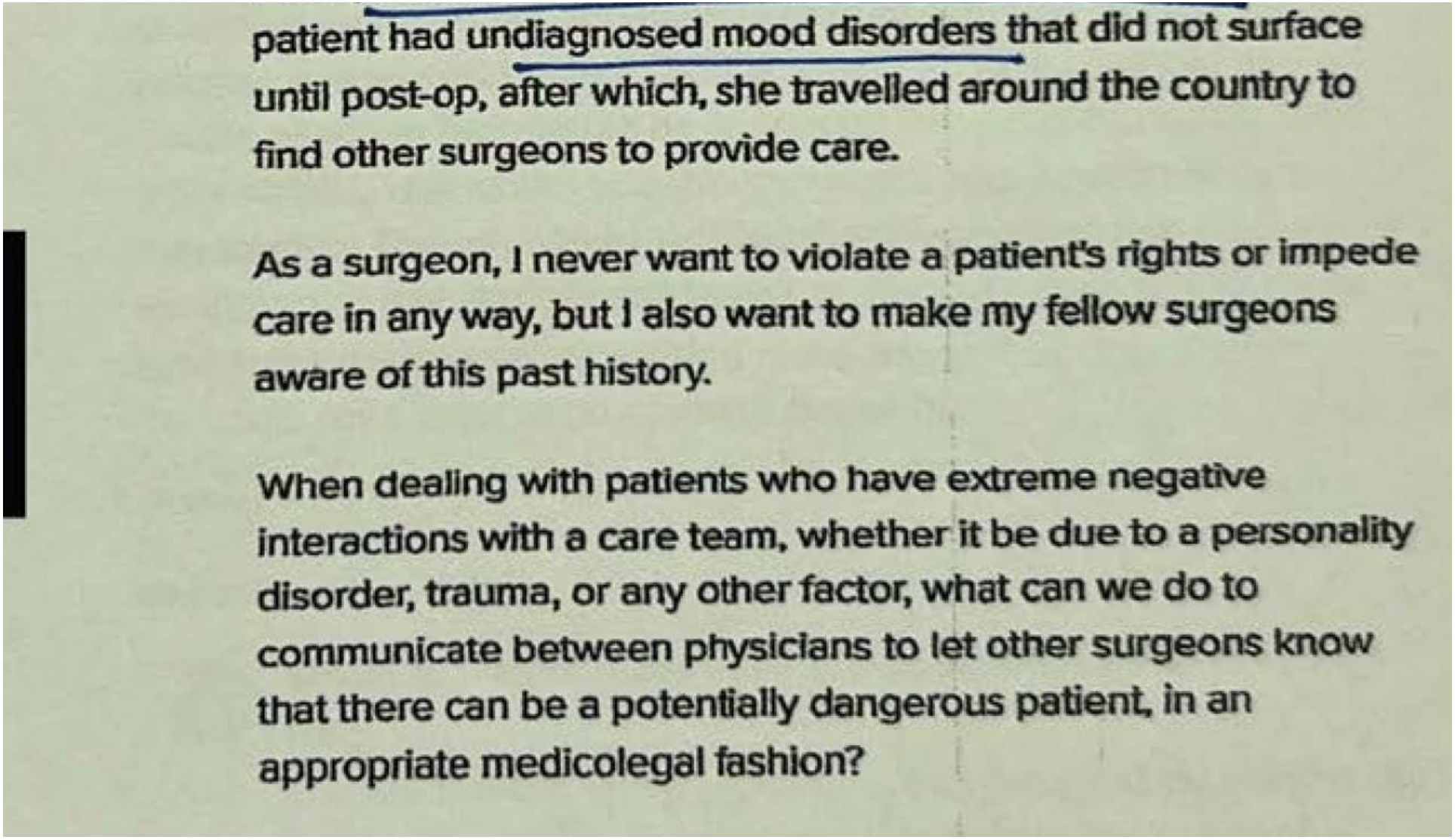
On an unknown date, a San Francisco-based surgeon named Thomas Satterwhite posts an urgent new message to WPATH's internal message board. "I had a patient who became dangerous/threatening to our care team post-op," he wrote, "which ultimately ended in a restraining order."

Satterwhite explained that "This patient had undiagnosed mood disorders that did not surface until post-op, after which, she travelled around the country to find other surgeons to provide care."

It's a chilling story and one that raises many questions about the ethics and legality of gender-affirming medicine. At the top of that list is how in the world did Satterwhite and his colleagues miss the fact that the person they operated upon had a serious psychiatric condition?

But Satterwhite had a more prosaic question. What was the best "medicolegal" way that he could warn other doctors and health care providers that his former patient was "potentially dangerous"?




patient had undiagnosed mood disorders that did not surface until post-op, after which, she travelled around the country to find other surgeons to provide care.

As a surgeon, I never want to violate a patient's rights or impede care in any way, but I also want to make my fellow surgeons aware of this past history.

When dealing with patients who have extreme negative interactions with a care team, whether it be due to a personality disorder, trauma, or any other factor, what can we do to communicate between physicians to let other surgeons know that there can be a potentially dangerous patient, in an appropriate medicolegal fashion?

There is no evidence in the WPATH Files, nor elsewhere, that the experience shook Satterwhite enough to question whether gender-affirming care is, in reality, medicine, a profession that begins with the promise to "First, do no harm."

Nations have struggled to care properly for people with mental illness and psychiatric disorders for centuries.

After every past scandal, we pledge to do better next time, relying more on science than ideology.

Readers of the WPATH Files may walk away with the sense that we have learned nothing.

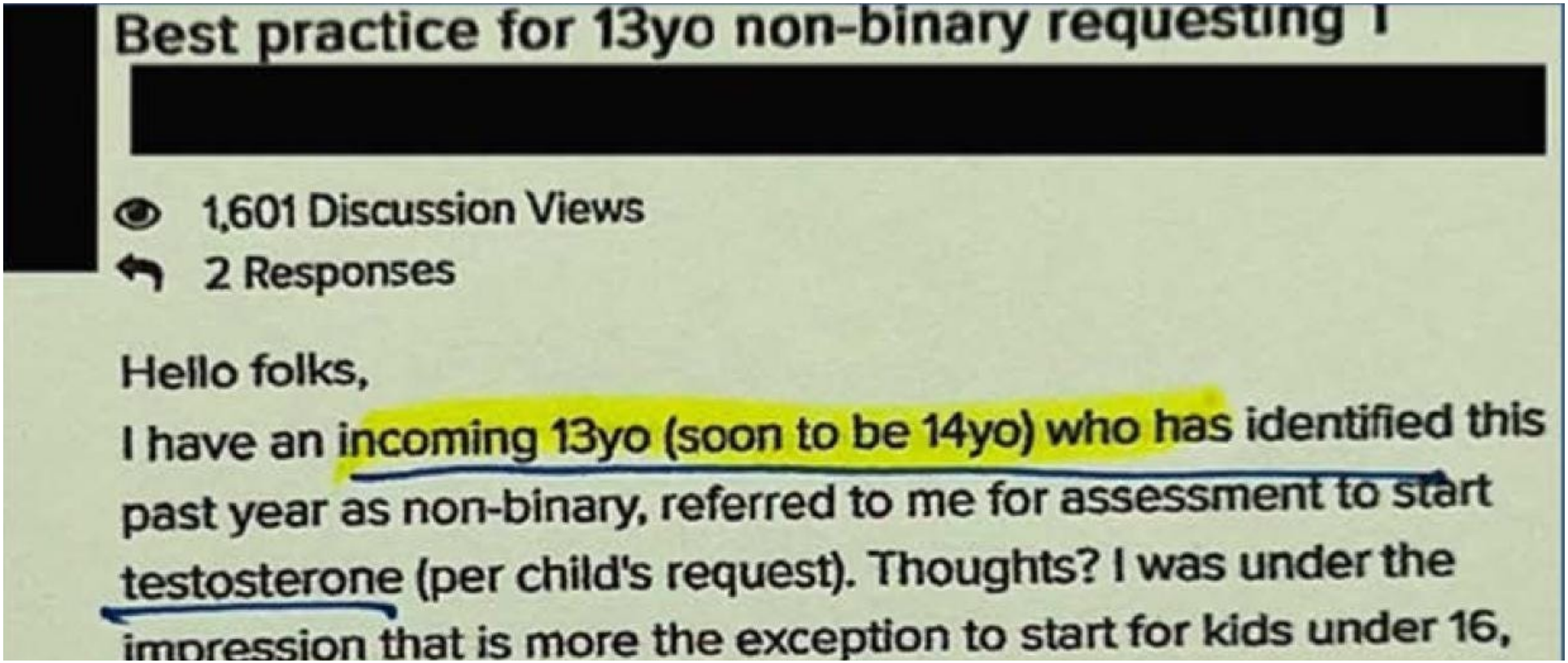
Repeatedly throughout the WPATH Files, we see gender medicine practitioners waive away evidence that mental illnesses and psychiatric disorders have been misdiagnosed as gender dysphoria.

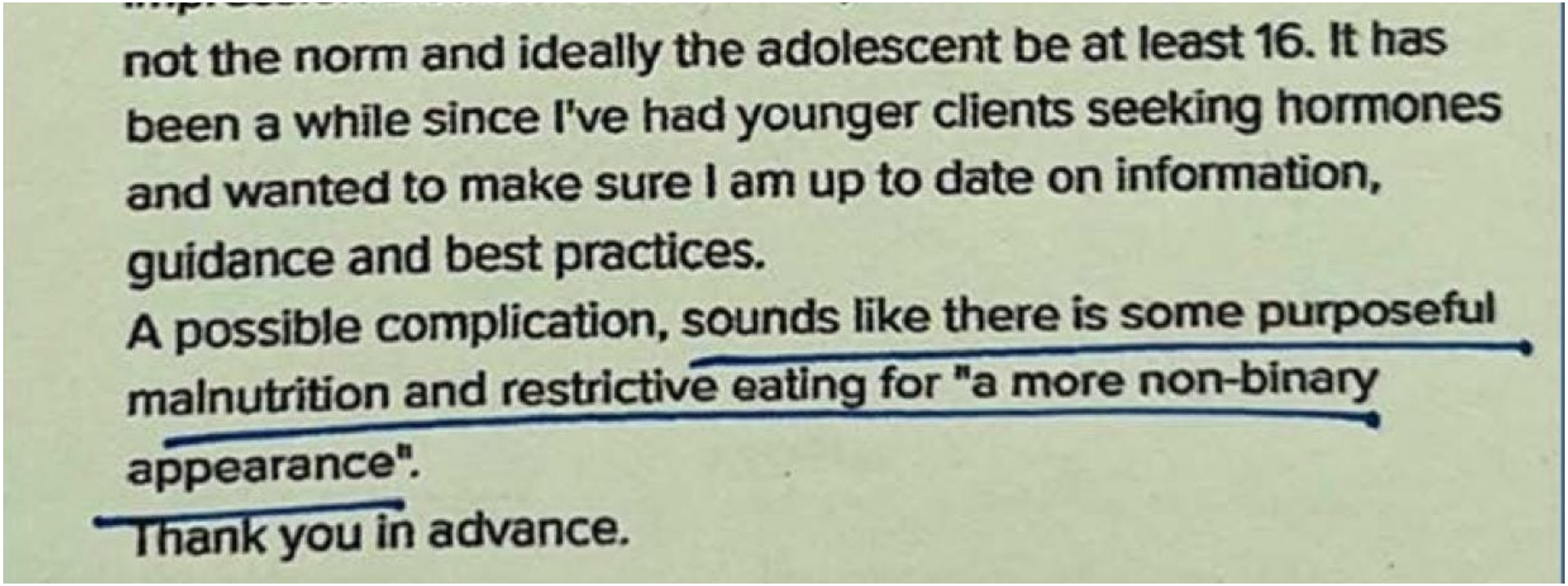
The WPATH Files are a picture of people single-mindedly committed to the hammer of gender medicine and thus seeing every patient who comes to them as a nail.

A therapist raises concerns in a message about the age of a patient. “I have an incoming 13yo (soon to be 14 yo)… I was under the impression that is more the exception to start for kids under 16, not the norm…”

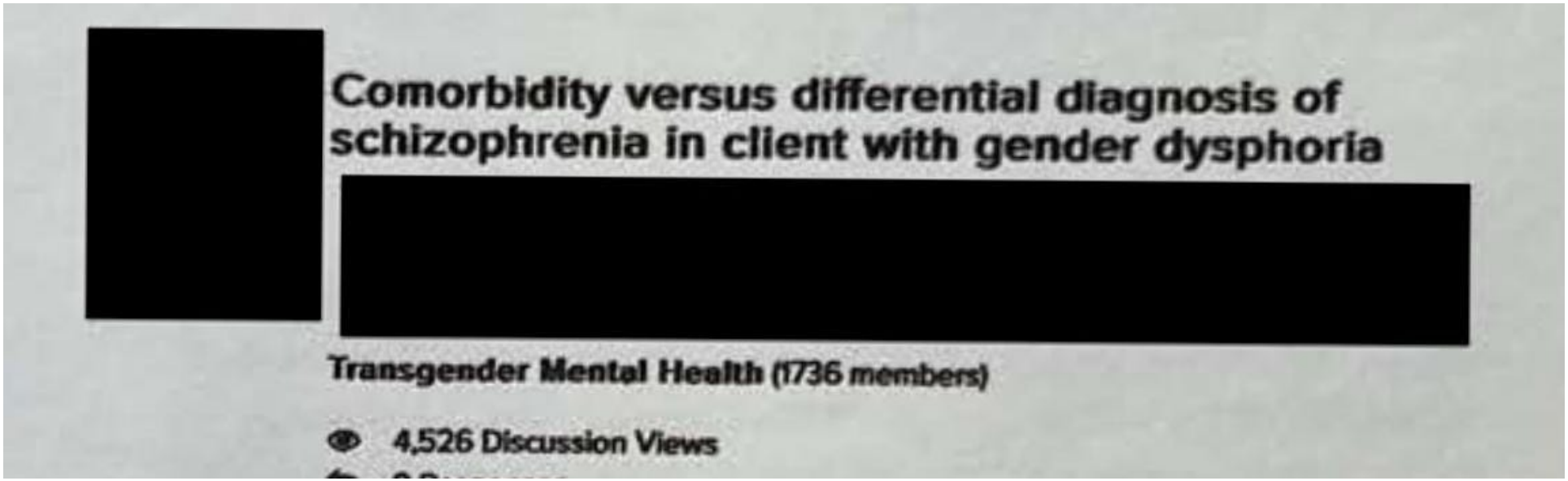
But the person has another piece of troubling information.

“A possible complication,” the therapist warns, is that it “sounds like there is some purposeful malnutrition and restrictive eating for ‘a more non-binary appearance.’”





The chief medical officer of a health center in Texas chimed in that the therapist had best hurry the 13-year-old teenager along the gender-affirming path because “waiting appears to increase the rate of suicide.”



8 Responses

I have a client who meets DSM-5-TR criteria for gender dysphoria. They take a medication prescribed for bipolar disorder although they have not told me they have that diagnosis. Their presentation is atypical from my experience. They presented for intake with a beard, stating they identity as a woman. They have extremely circumstantial speech, flights of ideas, and loose associations, but I have not observed a/v hallucinations or delusions--as I understand them. Their appearance is consistently disheveled, and their hygiene is extremely poor. However, their self-report of their gender identity seems to me to be wholly inconsistent with their presentation. I am wondering if they might have schizoaffective disorder or schizophrenia. I would appreciate some references to literature reviews or authoritative articles about comorbidity of gender dysphoria with schizoaffective d/o or schizophrenia versus differential diagnoses between gender identity incongruence and schizophrenia. I have been treating transgender and gender-diverse clients since the 1980s and I have never observed a woman assigned male at birth to present for

treatment appearing this way. They did recently began taking estradiol 2mg q.d. My clinical observation is that there is something "off" and I can't put my proverbial finger on what it is. Any ideas?

Trauma and the Presence of Dissociative Disorders in Trans Patients

[redacted]

Trauma is common among trans clients. Nonetheless, I was surprised to find that several of my clients met criteria for dissociative disorders, primarily OSDD. I was wondering if other people have noticed incidents of OSDD and DID among their trans clients, and whether there has been any difficulty with the system agreeing to transitioning medically, especially given that not all the alters have the same gender identity?

September 3, 2021

[redacted]

It is my understanding that for top surgery (roughly) that medical and

it is my understanding that for top surgery (roughly) that medical and mental health issues need to be "reasonably well-controlled" and for genital surgery, the issues need to be "well-controlled" according to SOC 7. However, there is not a clear line on what well-controlled versus reasonably well-controlled are. It's a clinical judgment from the best I can tell, and I use consultations with my WPATH Mentors (they are so awesome and have so many years of experience to bounce things off of) to determine this if I have concerns. I think an interdisciplinary team approach to helping someone get what they need. Also, I like to adopt the "and" framework rather than the "or" framework for this. Someone can have schizophrenia and be ready for surgery...it is just a matter of what you see concerns are, communicating those concerns, and working in a patient-centered way with a team (ideally) to help them get to close to the goals as possible for surgery readiness. I also believe that collaboration with the surgeon(s) is ideal because their staff can help support with aftercare realities and a plan for pre and post-op care. I also am reminded that it has been pointed out to me that withholding care (letters of referral, etc.) is more problematic when compared to the

provider's feelings about the potential for stability after surgery and/or difficulty with following through with aftercare instructions. things like exploring minimal depth vaginoplasty are also an option. I say all of this in the most client-centered and supportive way to help patients get what they need for care. Thank you!

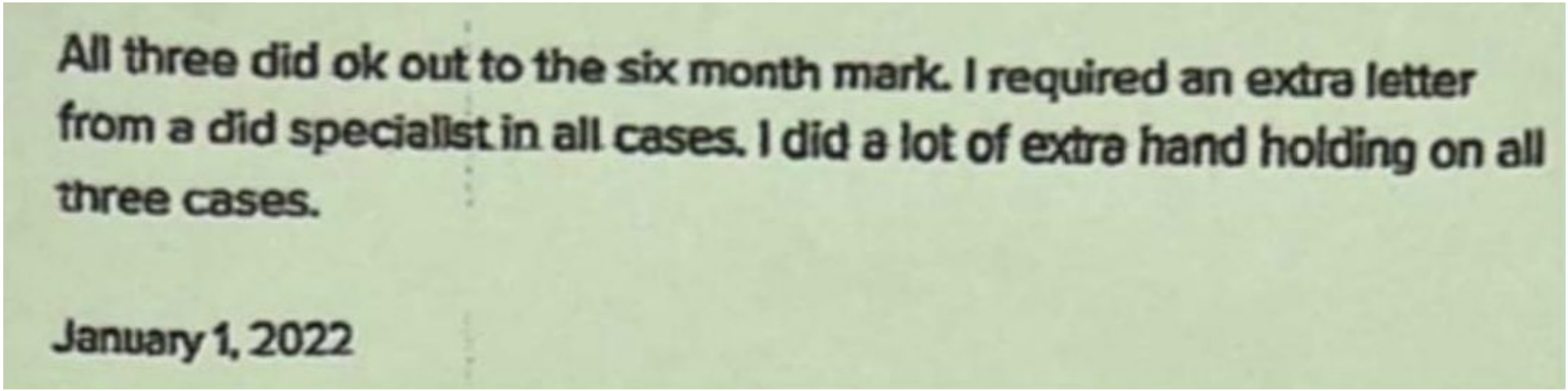
This is a really great point! i haven't seen any recent studies on the correlation between a positive transgender identification and dissociative disorders- but professionally (and personally) I have noted a high incidence of dissociative disorders amongst the community throughout both my interactions as both a social services worker and my personal connections within the community. (Yet, I will be the first to admit & challenge that my own experiences might be different, as an open transmasculine social work professional, I can be afforded a lot of trust from my predominantly LGBTQIAS2+ Clientele on that fact alone- thereby impacting the information I receive- as I have had numerous clientele presenting

presenting with OSDD/DID symptoms who admit that they didn't speak on the issue often with other social services members, fearing that this in conjunction with their perceived 'gender deviance' would make them appear 'too crazy'). I have found that with a diagnosis of OSDD/DID, clientele worry that they will be denied gender affirming medical procedures/interventions- a fear that has led to several of my trans clientele over the years, turning to black market gender affirming procedures/medication rather than attempting to go through the medical system.

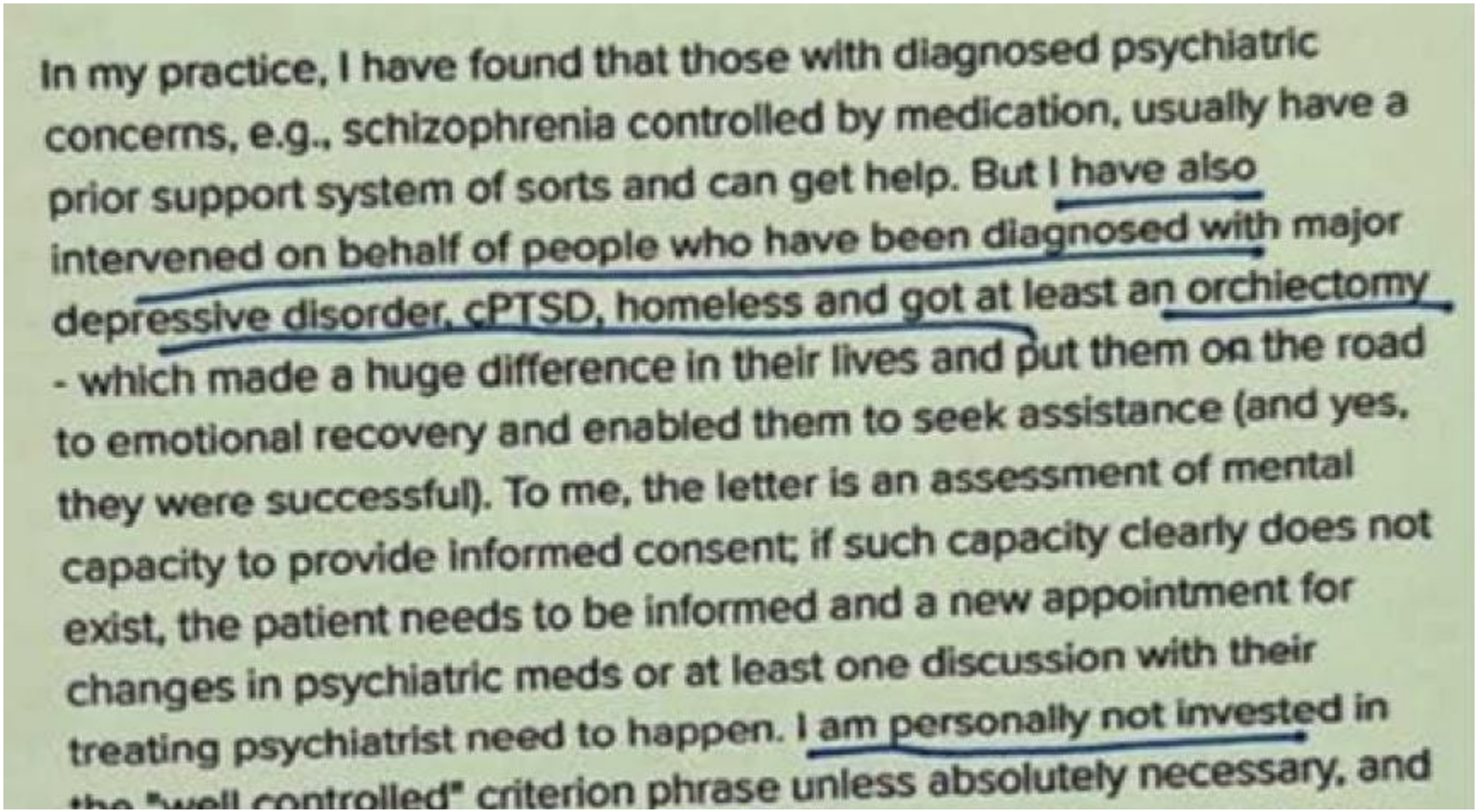
Christine N. McGinn [redacted]

Hi.

I have operated on three DID patients in the past. 2 of the three were self diagnosed with a stamp of a therapist and one was more serious/obvious. 2 were vuvlovaginoplasty and one was mastectomy (more serious case).


All three did ok out to the six month mark. I required an extra letter from a did specialist in all cases. I did a lot of extra hand holding on all three cases.

January 1, 2022

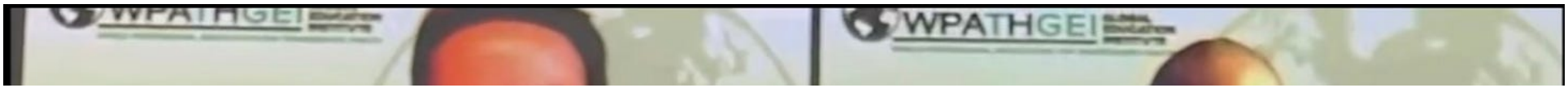

In my practice, I have found that those with diagnosed psychiatric concerns, e.g., schizophrenia controlled by medication, usually have a prior support system of sorts and can get help. But I have also intervened on behalf of people who have been diagnosed with major depressive disorder, cPTSD, homeless and got at least an orchiectomy - which made a huge difference in their lives and put them on the road to emotional recovery and enabled them to seek assistance (and yes, they were successful). To me, the letter is an assessment of mental capacity to provide informed consent; if such capacity clearly does not exist, the patient needs to be informed and a new appointment for changes in psychiatric meds or at least one discussion with their treating psychiatrist need to happen. I am personally not invested in the "well controlled" criterion phrase unless absolutely necessary, and

I believe it's disappearing in the SOC v 8 version. Meanwhile, in the last 15 years I had to regrettably decline writing only one letter, mainly b/c the person evaluated was in active psychosis and hallucinated during the assessment session. Other than that - nothing - everyone got their assessment letter, insurance approval, and are living [presumably] happily ever after.

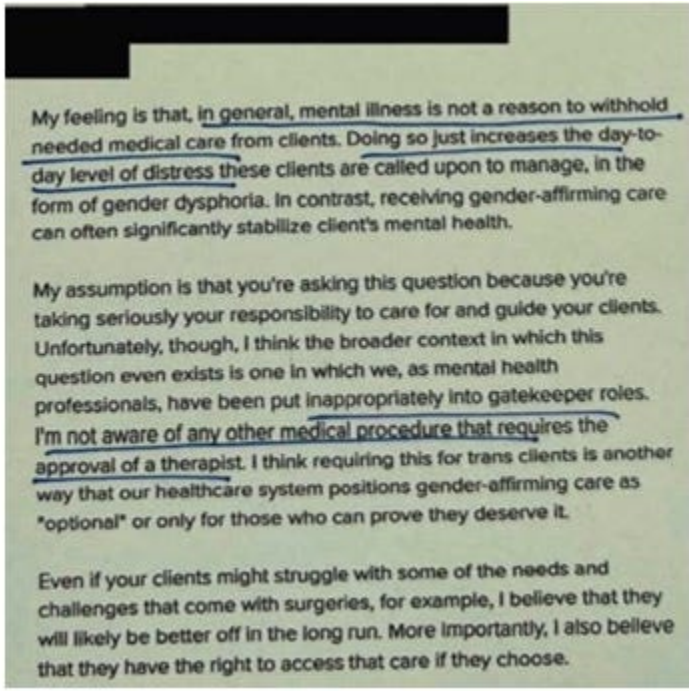
[redacted]

With one client who had DID we worked on all alters giving consent to HRT before it was started. They had alters who were both male and female gender and it was imperative to get all alters who would be effected by HRT to be aware and consent to the changes. Ethically, if you do not get consent from all alters you have not really received consent and you may be open to being sued later, if they decide HRT or surgery was not in their best interest.

October 7, 2021



Frequently, WPATH members push back against “gatekeeping,” including the requirement for sound mental health before undergoing a lifelong regime of drugs and surgery.



My feeling is that, in general, mental illness is not a reason to withhold needed medical care from clients. Doing so just increases the day-to-day level of distress these clients are called upon to manage, in the form of gender dysphoria. In contrast, receiving gender-affirming care can often significantly stabilize client's mental health.

My assumption is that you're asking this question because you're taking seriously your responsibility to care for and guide your clients. Unfortunately, though, I think the broader context in which this question even exists is one in which we, as mental health professionals, have been put inappropriately into gatekeeper roles. I'm not aware of any other medical procedure that requires the approval of a therapist. I think requiring this for trans clients is another way that our healthcare system positions gender-affirming care as "optional" or only for those who can prove they deserve it.

Even if your clients might struggle with some of the needs and challenges that come with surgeries, for example, I believe that they will likely be better off in the long run. More importantly, I also believe that they have the right to access that care if they choose.

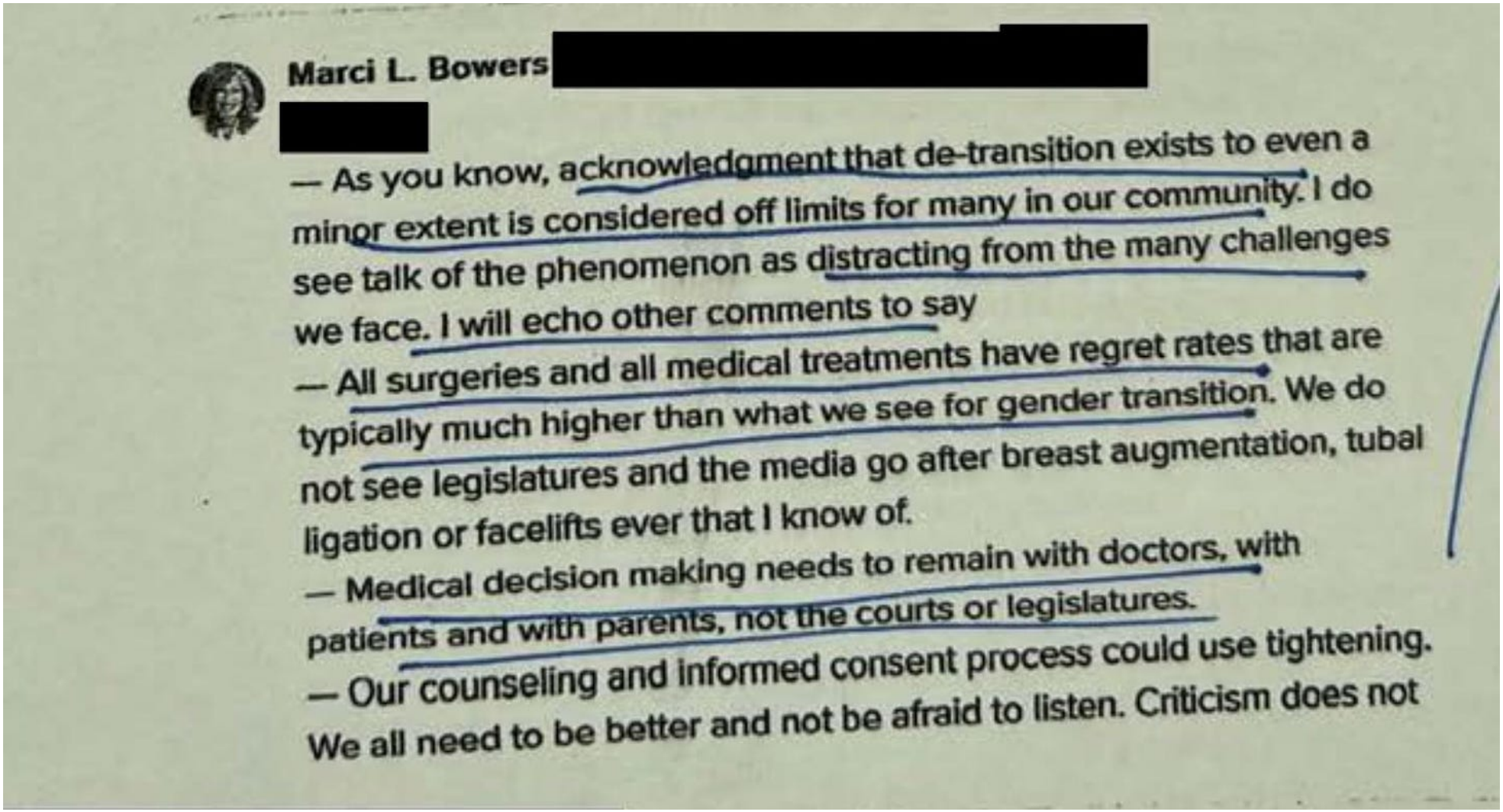
At times, WPATH members speak of the growing number of “detransitioners” who regret gender medicine.

Some gender medicine practitioners express less concern for the detransitioners than for the threat they may pose to gender medicine.

[redacted] Absolutely agree with [redacted] here. We can't say that gender is fluid then view "detransitioning" as a mistake. Instead it's a further-stigmatized part of some individuals' gender journey.

November 19, 2021

There is evidence within the WPATH Files of WPATH members, as well as its president, Marci Bowers, blaming their victims.



Marci L. Bowers [redacted]

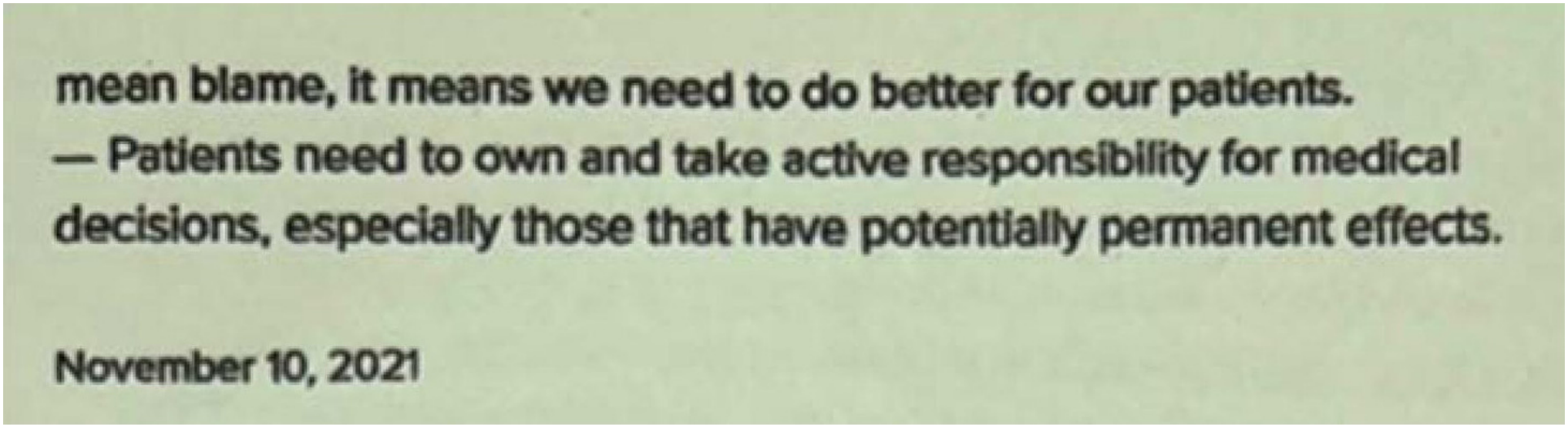
[redacted]

— As you know, acknowledgment that de-transition exists to even a minor extent is considered off limits for many in our community. I do see talk of the phenomenon as distracting from the many challenges we face. I will echo other comments to say

— All surgeries and all medical treatments have regret rates that are typically much higher than what we see for gender transition. We do not see legislatures and the media go after breast augmentation, tubal ligation or facelifts ever that I know of.

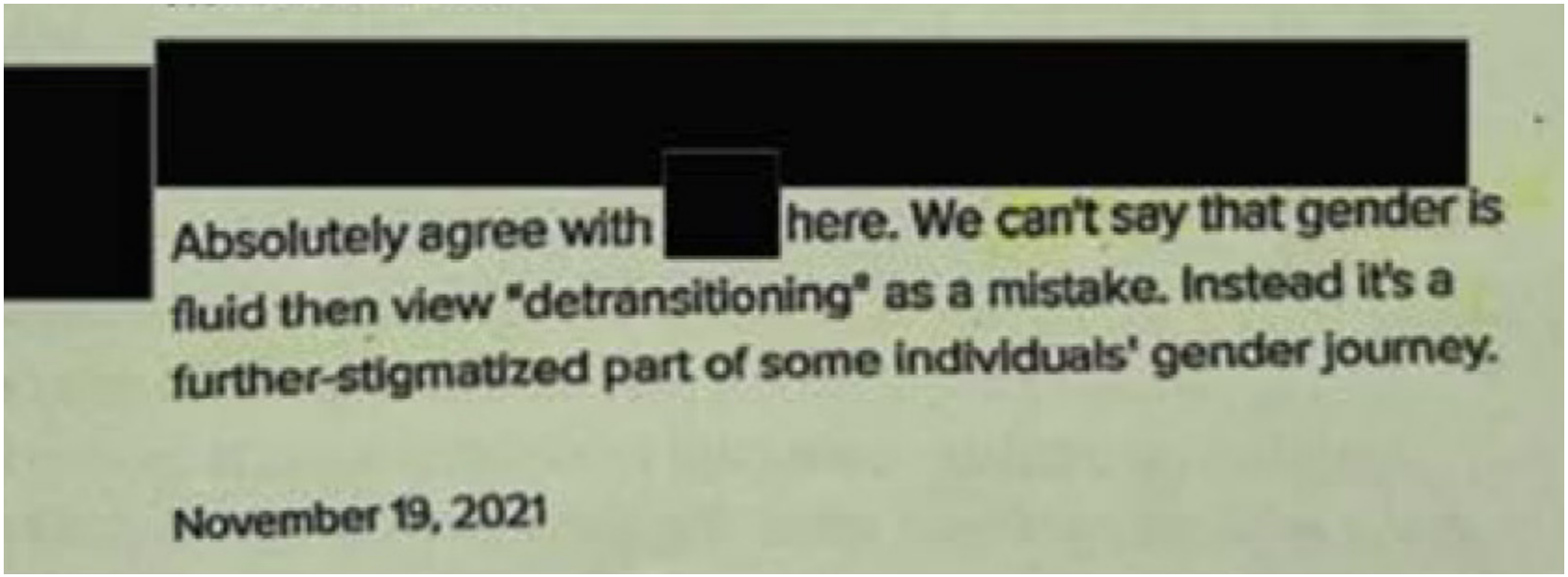
— Medical decision making needs to remain with doctors, with patients and with parents, not the courts or legislatures.

— Our counseling and informed consent process could use tightening. We all need to be better and not be afraid to listen. Criticism does not



Readers of the WPATH Files may be struck, as we were, by how flexible WPATH members were in rationalizing their mistreatments.

Faced with rising amounts of regret and detransition, WPATH members describe what's happening as a "gender journey" not a single "transition."



And faced with their own failure to achieve informed consent, WPATH members re-frame it as a "process," and an "on-going

conversation," in the video above.

Explains one, "...informed consent [is a]... process... not one conversation at one point in time ... those conversations don't have to stop once the Medicaid and intervention has been started. Those conversations can be ongoing even after the intervention has occurred."

The WPATH Files show WPATH members encouraging pseudoscientific mistreatments without achieving informed consent.

But some appear to be aware that they know what they're doing is wrong.

In the video above, a therapist named Dianne Berg describes talking to parents after they meet with a doctor. "I would go in and I would say, 'Okay, so tell me what you learned.' They would just be like, 'We have no idea what they were talking about.'

"Part of it is that they feel less deferential to the kind of doctor I am than the kind of doctor the medical doctor is. And because they really are seeking the care, they're just going to say they know when they really aren't picking up on what's happening.

"And so I think the more we can normalize that it is okay to not get this right away, that it is okay to have questions, is, you know, the more we're going to actually do a *real* informed consent process than what I think has been currently happening and that I think is, frankly, not what we need to be doing ethically."

You can hear the power of Berg's comments in the long and awkward pause that follows.