Twitter Thread by James



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This video is full of inaccuracies, lies, scaremongering & gaslighting. Please take a look and report on YouTube, especially the multiple mentions of suicide risk/suicide ideation. Thread below with timestamps of problematic content. Please also

1:17 – talks about transgender children rather than having gender dysphoria.

1:47 – admits he's not a specialist in endocrinology, paediatrics, psychiatry.

3:04 – gaslighting about free & equal citizens, suggesting there's a debate about whether they exist as human beings.

3:25 – suggests children should simple have access to whatever treatment they "need" (define need)

4:00 – describes puberty blockers as "pause button" & suggests that once stopped puberty will carry on "in the usual way".

5:18 / 6:10 – promoting brand name prescription drugs.

6:30 - suggests puberty blockers used in transitioning is just the same as use for precocious puberty.

9:11 - one of multiple assertions that people are "assigned" female at birth or "assigned" male at birth.

9:40 - implies that intersex people are not male or female

10:25 - implies chemical intervention is a "natural counter-balance mechanism"

10:49 - "assigned at birth" falsehood again

11:10 - talks about characteristics associated with "gender" instead of "sex"

12:00 – says the way these drugs work is well understood. It is not.

12:16 – first mention of gender dysphoria. Implies it's separate to "being trans".

12:35 – wrongly defines gender dysphoria as related to sex “assigned” at birth, rather than just the sex they ARE.

12:55 – overstates the impact on mental health at onset of puberty.

13:15 – “self-harm” myth.

13:30 – Suicide ideation gaslighting. Lie about a significant number of them dying through suicide (followed by 45 seconds of BS about suicide recording and gaslighting about not having “supportive affirming families”.

14:20 – goes right to puberty blockers as the “highly effective” intervention. No mention of counselling support, despite listing all the mental health issues surrounding this issue.

14:40 – implies that puberty blockers are directly intended to reduce self-harm and suicide.

14:57 – says use of blockers is to help “correct” natural physical changes that otherwise will need surgery. These are not things that need to be “corrected”.

15:45 – more gaslighting about the need for affirmation. Just makes case that AGP males need their identity validated.

15:55 – “gift of time & space”. Gaslighting & implies blockers are a simple pause, & are applicable for “any other child” who is confused. So not just those with a gender dysphoria diagnosis.

16:30 – 1st mention of counselling but in context of “relentless stresses of puberty”.

16:40 – suggests “a proportion” will progress to cross-sex hormones. Reality is that it is nearly 100% of them.

17:10 – says this pathway “may or may not” lead to surgery.

17:21 – suggests plenty of kids on blockers then change mind and opt to undergo their natural puberty.

18:20 – suggests use of blockers doesn’t have a fixed relationship with any one outcome. Reality is that almost 100% of kids on them go on to cross-sex hormones.

18:50 – suggests that not intervening with drugs is not a neutral decision. Followed by gaslighting and guilt-tripping doctors to suggest that not giving blockers, and therefore allowing natural puberty, means they will be responsible for these kids' negative futures.

20:00 – says it is "much riskier" to not give blockers than to prescribe the drugs because without them there is risk of suicide.

21:00 – more gaslighting about the “consequences” of not giving these drugs (ie suicide).

21:30 - Admits there is not enough research to fully know the impact on bone mineral density from prolonged use of blockers. However, he dismisses the impact of low bone density as “manageable” with medications, diet and lifestyle modification. So, lifelong medical dependency.

23:00 – gaslighting to suggest the risks relating to bone density are no different to similar issues resulting from treatment for things like asthma or bowel disease.

23:15 – downplays impact of loss of fertility & implies that trans kids understand these difficulties.

24:00 – long gaslighting segment justifying use of puberty blockers to kids before they are old enough to consent by listing other conditions they would be treated for that can result in fertility loss. But these are all actual, physical & life-threatening illnesses & conditions.

25:00 – Compares side-affects from blockers and cross-sex hormones to the risk of suicide. Talks for a full minute about how it is better to have born density and fertility loss than have “significant mental anguish and misery” and suicide if kids don't get blockers/hormones.

30:00 – Suggests in-depth & robust process for assessing children with gender dysphoria is too long & drawn out & causes distress, therefore it’s better to get on with it quickly. Admits that kids don’t see why process is necessary. (which just confirms why they can't consent).

31:30 – Despite berating the “drawn out” process, he goes on to suggest that the length and intensity of the process means that only “genuinely trans” kids get to the point of getting puberty blockers. Defends the accusation of conveyor belt.

34:10 – Calculations are WAY off. UK population, with the proportion of under 16’s he says and a 0.5% trans rate would be fewer than 63,000 “trans children”. Not 600,000 . . .

. . . He uses epilepsy and diabetes to contextualise, but it would be the same number in reality of kids with epilepsy and only double the number with diabetes. (although, epilepsy and diabetes are real diseases that will cause harm if left untreated).

35:00 – Ignores the fact that if such a vast number are not even getting to GIDS then this show that the vast majority will grow out of gender dysphoria or grow up to be trans and be ok. Where is the epidemic of suicides among the 60,000+ kids not going to the Tavistock?

36:00 – One true point. The GIDS system is definitely not fit for purpose.

37:30 – Misrepresents the waiting times rights in the NHS constitution. This doesn’t apply to all conditions or treatments.

37:50 – advocates decentralising GIDS services away from specialists and even into private providers. (I wonder how connected to GenderGP he is?)

38:55 – yes, this is expecting something over and above “cisgender” children’s medical care. It is demanding and expecting medicalisation as the only option to treat a mental health condition, ie a dysphoria.

39:40 – says he looks forward to reading the comments, but obviously didn’t enjoy reading them as he soon switched off the comment functionality.