Submissions to the Saskatchewan Human Rights Commission

Regarding: Ministry of Education "Use of Preferred First Name and Pronouns by Students" Policy/Bill 137

Aaron Kimberly, Executive Director, Gender Dysphoria Alliance

Oct 20, 2023

Note: For clarity, the use of the term Gender Dysphoria, is in reference to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), published by the American Psychiatric Association in 2013. This diagnostic manual is in current use, and outlines several pathways to the cognitive development of a gender identity of the opposite sex: (1) early onset, which is highly correlated with developing homosexuality, (2) transvestic disorder with autogynephilia, and (3) intersex conditions.

In most cases, when we are discussing children, we are referring to the early onset subtype of Gender Dysphoria, which many gay and lesbian people experience as children.

The Gender Dysphoria Alliance (GDA) is in agreement with not allowing children under the age of 16 to be socially transitioned without the consent of their parents/guardians on the following grounds:

1) The human rights framework, which lists "gender identity" as a protected class, can create conflict with the clinical framework and evidence about the multifactorial, multicausal, and often transient nature of childhood Gender Dysphoria, and best clinical practices. While gender identity and sexual orientation are protected classes, the international human rights frameworks (see for example the Yogyakatha Principles described in Appendix I: Gender Identity Framework) were written by human rights scholars who failed to take into consideration the decades of clinical research about Gender Dysphoria and how it relates to sexual orientation. Nor does it take into account what is considered best clinical practices, especially with regard to children. This is a political overstep with significant clinical consequences.

2) "Queer" is a political identity based on the academic discipline of rhetoric, called "Queer Theory" (See Appendix II: Queer Theory). Political movements or academic disciplines are not protected classes under human rights law. The words "transgender", "gender queer" and the hundreds of new genders like "cake gender" and "frog gender" are branches of Queer Theory and a youth subculture. It is for this reason that those associated with GDA use the clinical term, "transsexual" to indicate that we have medically and legally transitioned to live as the opposite sex as a form of treatment for Gender Dysphoria.

3) The general public, including children, parents, teachers, and even clinicians, are being taught a political framework and are being misinformed about Gender Dysphoria (see Appendix III: Impact on Children).

4) Social transition (changing name, pronouns etc) is step one of a medical pathway (see Appendix IV: Transgender Experiences and Outcomes). It is a clinical intervention that requires clinical oversight.

5) Mature minors do have the legal right to consent to medical treatment, even without parental consent provided that they have the capacity to understand the nature and consequences of the treatment. However, models of care for the treatment of Gender Dysphoria, as with any other condition, require adequate assessment, diagnosis and treatment recommendations by a qualified practitioner. It is not a human right to self-diagnose and initiate our own medical treatment, which is why the Yogyakatha Principle relating to bodily autonomy does *not* say that clinical interventions are required on demand. Social transition is a clinical intervention.

6) Gender Dysphoria is frequently associated with comorbid mental health conditions such as autism and ADHD. If parents aren't notified of their child's Gender Dysphoria, it may prevent parents from obtaining proper mental health support, and leave the child on a path they might later regret.

   New studies indicate that early social transitions *do not* improve mental health in most cases: Is Social Gender Transition Associated with Mental Health Status in Children and Adolescents with Gender Dysphoria? | Archives of Sexual Behavior (springer.com)

7) The fear of suicide is frequently being misused. For example, parents are often being told "would you rather have a dead son or an alive (trans) daughter. This is a false and detrimental proposition. There is no evidence that children will commit suicide if not immediately affirmed and medicalized. Though trans identified youth do report higher than average suicidal thoughts, there is no evidence of a direct relationship between Gender Dysphoria and suicidality. The suicidality rates reported by this population are consistent with the rates associated with other mental health conditions and the gay and lesbian population. Suicidal ideation is not the same thing as suicide completion. Looking at various models of care for children with Gender Dysphoria: The Dutch Model, Watchful Waiting Model, and the psychotherapeutic models currently being developed in Europe, all of which urge caution and do not immediately confirm that the child's gender identity is a fixed and permanent entity, there is no indication that those children are more at risk of suicide.

8) Studies do show that the best predictor of childhood mental health is parental support. However, "support" can take many forms, not just confirmation that a child's identity is permanent. Clinical models for children typically involve the entire family.

Discussion

It is GDA's view that the policy in question about parental involvement is not really about "parental rights" in of themselves, but rather is more appropriately better understood as a necessary child safeguarding measure, in light of the Queer Theory conundrum in North America, where it originated.

I'm familiar with the UN's guidelines for the social inclusion of gender diversity, in particular the *Yogyakatha Principles* and the reports by the Special Rapporteur on LGBT rights. As a representative of GDA, an organization led by adult transsexuals, I value social inclusion, diversity and human rights. However, human rights scholars aren't clinical experts, and they've made some errors in writing guidelines that don't take into account the decades of research on Gender Dysphoria, especially in children. The implementation of the *Yogyakatha Principles* is having unintended consequences, which need to be re-examined and corrected.

To date, there are 12 studies which followed cohorts of children with early onset Gender Dysphoria (or the older term Gender Identity Disorder "GID"). They all have come to the same conclusions – that the vast majority of children with GID resolve it through pubertal awakening of sexual orientation. It's quite common for gay and lesbian children to experience some degree of gender confusion, gender non-conformity and distress. Many gay adults recall this from their own childhoods. Prematurely labelling these children simply as "trans" risks the medicalization of an entire generation of gay children, with sometimes-severe lifelong consequences.

Studies worth noting:

> https://www.ohchr.org/sites/default/files/Documents/Issues/SexualOrientation/IESOGI/Other/Rebekah_Murphy_20191214_JamesCantor-fact-checking_AAP-Policy.pdf
>
> https://journals.sagepub.com/doi/10.1177/1359104510378303
>
> https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784/full

Post-modern (Queer Theory) explanations of "gender" being taught to children and families are misleading many to prematurely label children "trans". As researchers like Dr Kenneth Zucker have warned, hasty social transition of children (i.e. changing name and pronouns) concretizes their self-perception during a time when it should be flexible. This then makes it harder to walk back, even once the child begins to doubt their earlier perception. Social transition is the first step of the medical pathway, and every model of care expects assessment by a qualified clinician prior to any clinical intervention. It's not

our position that “trans” is a bad thing, but overmedicalizing gay and lesbian children without properly informing them about the developmental process is concerning and harmful. The children aren’t being given an opportunity to understand themselves and become healthy gay adults. There is a medical burden. Hormone therapy and surgery aren’t neutral acts. There are risks. Genital surgeries in particular have high complication rates. The Province of British Columbia sent me and a number of other trans men to Dr. Crane in Austin, Texas a few years ago. About 80% of us had complications. Some severe.

Teachers and schools are being informed of the human rights framework, but not the clinical frameworks. By agreeing to socially transition children, they mean to be supportive, but they are in fact initiating a clinical intervention without a license or qualifications to do so.

It’s not necessary to socially transition children to love and support them. What I and my family would have benefited most from is accurate information about what I was experiencing. At that time, we didn’t know that I had an intersex condition. Nor did we know that it’s common for pre-gay/lesbian children to wrestle with gender and some degree of cross sex identification.

Families who are simply told “you have a trans kid” versus those who are given accurate info, i.e. “these experiences are a developmental aspect of sexuality which will most likely resolve through puberty”, are likely to make very different choices about what to do.

There’s another issue that’s even more concerning. There’s emerging evidence that many of the girls self-identifying as “trans” don’t have a history of early onset Gender Dysphoria. “Trans” has become a youth subculture with social currency. Many young people, especially those who struggle socially, like kids with autism or ADHD, find a welcoming community through a trans identity. That in itself isn’t a bad thing. Every generation has its youth subcultures like goth, punk and hippie, and it’s not unusual for parent/child conflicts to arise from a child’s strong subcultural convictions. However, unlike youth subcultures of the past, the “Queer” one involves somtimes severe and permanent bodily modification while protecting the path as a human right under “gender identity”. Parents are in a unique position of knowing the child’s history. Their accounts of whether or not the child showed signs of early onset Gender Dysphoria is crucial to making a proper diagnosis and protecting the children and adolescents, whose identity is socially influenced, from medical harm.

Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria | PLOS ONE

Concerns about the policy

I think that as policies like this are implemented, it's very important that they're followed by educational campaigns to help staff and families understand that this path is not led by anti-LGBT hate. It's a child safeguarding measure and a necessary correction of political overreach. I and other members of GDA would be happy to work with the government and schools to help with the delivery of the messaging to staff and families. The very purpose of the Gender Dysphoria Alliance is to educate about the several types of Gender Dysphoria.

We do believe in concepts like personal autonomy, but that can only be achieved when people are equipped with accurate information. We are not confident that many people understand what Gender Dysphoria is, unfortunately including some medical professionals.

There is reasonable concern that some parents are hostile or abusive towards their children. In those cases, steps can be taken by teachers to involve authorities such as Child Protection Services and family therapists. These are critical opportunities to therapeutically support families through conflict.

Hiding information from parents has the potential to escalate conflict within the family, and breaks trust between families and teachers/schools.

Parents and Teachers

I am myself a parent and share the concerns of many parents.

Many parents and teachers throughout North America have reached out to GDA with questions and concerns about what they're seeing in their homes and classrooms. One Canadian middle school teacher contacted us last year to say that half of her class identified as something other than "cis". It should be seen for what it is – experimenting with the political ideas, identity, sexuality, and social inclusion, which is normal for that age group. But it shouldn't be assumed to be permanent expressions of self, and care is needed to not lead kids to a medical pathway that might not be in their best interest. Teachers and parents need guidance about how to best respond. We have partnered with other organizations to create a guidance booklet for schools that are based on best evidence. I've attached that document for your consideration:

https://www.genderdysphoriaalliance.com/_files/ugd/712544_864256e0f9c64f98bb8a64ae64dec67b.pdf

We have been talking to many parents and teachers about these issues generally, and this policy specifically. Most are in favour of safeguarding measures. Most teachers and parents are frightened and don't feel well equipped to know how to best respond. They don't want to upset anyone, and are afraid of disciplinary action if they don't do the right thing. But many also sense that something new is happening to children and adolescents over the past few years. Indeed there is something new happening that has nothing to do with clinical Gender Dysphoria.

Though I don't have first-hand experience as a teacher, I can speak to similar concerns as a nurse.

I used to work for the BC Provincial Adult Eating Disorders Program in Vancouver, about 9 years ago. While there, we didn't have a single trans patient in the program that I'm aware of. Now, I'm told by nurses still working there that the program is flooded with (mostly) young women who change their pronouns frequently and have meltdowns if the nurses can't remember which pronoun they've chosen that day. Eating disorders are often co-morbid with personality disorders. The program is designed to contain the boundary-pushing nature of those disorders but, the staff do not know how to therapeutically contain the boundary-pushing when it comes in the form of "identity" because it's a protected class. Hundreds of new "gender" categories like "cake gender" and "frog gender" have emerged. Do we affirm that a child is actually a frog? I don't believe that's what our human rights legislation is meant to do, but teens (and those with personality disorders) will attempt to push those boundaries until we have greater clarity on what it means to protect "gender identity".

Human Rights Code

I understand that "gender identity" and "expression" are protected under both federal and provincial law. As a transsexual man myself, I am grateful for protections. I believe the intent is to protect gay, lesbian and bisexual individuals. And, it's meant to protect transsexuals like myself who have legally and medically transitioned.

My understanding of transition is this: it's an accommodation for and treatment of Gender Dysphoria, which has been consistent, persistent and causing significant functional impairment. It's the creation of a legal fiction. I do agree that once someone is assessed and granted this legal fiction, it should be protected, but with consideration to biological sex. I am now *legally* male. It has been a helpful intervention for me, but I am not and never can be biologically identical to natal males. That reality has to be integrated into my self-concept because it has implications such as healthcare decisions. Though I've adapted well to legally changing to male, it's still important that my medical records indicate that I'm not biologically male, otherwise my health could be

at risk if something is missed. Gender Identity must remain separate from sex and sexual orientation.

Sex and sexual orientation are also a protected classes, and sometimes conflicts arise between the rights of one group over another.

By understanding trans as a legal fiction, we can discuss it, negotiate it and write it into law and policy in reality-based terms as its own entity, while also weighing in on the sex-based rights of women, and homosexuals (who are attracted to the same sex). We can find fair solutions and resolve conflicts when the rights of one group conflicts with another group. The rights of young gay and lesbian people are being compromised by the over medicalization of early onset Gender Dysphoria, since it is most often a developmental stage for emerging homosexuality.

Legal fictions don't need to be pathologizing. There is precedent for it among some intersex people like myself. The sex assignment of those with atypical genitals used to be common practice, and not necessarily biologically true (e.g. a child with XY chromosomes being assigned female because it was an easier operation to perform), but it wasn't causing societal problems and most of those children adapted well to their assigned sex, if done early enough.

Further Consulation

We are fortunate to have some of the leading experts on Gender Dysphoria here in Canada. I recommend that you speak with:

> Dr Kenneth Zucker, world-renowned researcher and psychologist who specializes in childhood onset GD. https://www.kenzuckerphd.com/
>
> Dr James Cantor, sex researcher and GD expert. http://www.jamescantor.org/
>
> Dr Joey Bonifacto, pediatrician with a specialization in childhood GD. https://www.drjoeybonifacio.com/medicine

Appendix I

The Gender Identity Framework

In 2006 the UN assembled a panel of human rights specialists who met in Yogyakarta, Indonesia to outline a set of international principles relating to sexual orientation and gender diversity. The resulting document, called the *Yogyakarta Principles* outlines binding international standards for the state inclusion of same-sex attracted and gender non-conforming people. Ten additional principles were added in 2016.

In 2016, the UN launched a mandate to reduce violence and discrimination against people of diverse sexual orientations and gender expression globally. Madrigal-Borloz was first appointed as UN Independent Expert on sexual orientation and gender identity. He was replaced by Victor Madrigal-Borloz in late 2017.

In 2019, the World Health Organization, reclassified the condition of Gender Dysphoria from their *International Statistical Classification of Diseases and Related Health Problems* (ICD-11). The previous classifications of "transsexualism" and "gender identity disorder of children" were replaced with "gender incongruence of adolescence and adulthood" and "gender incongruence of childhood" and moved them from the section on mental disorders to a section on sexual health. They noted that inclusion in the IDC ensured insurance coverage for medical interventions but, by reclassifying the condition, they hoped to destigmatize it.

In 2022 the UN Independent Expert on Sexual Orientation and Gender Identity Victor Madrigal-Borloz, released a report in which he referred to the international human rights strategy as the "Gender Identity Framework". Working in tandem with the WHO's efforts to destigmatize gender nonconformity and the condition of Gender Dysphoria, they've devised a framework that's being implemented and enforced by federal, provincial and institutional systems.

A full analysis of these mandates and their impact is beyond the scope of this statement. We do agree that many LGBT people worldwide experience violence and exclusion. We value human rights and social inclusion for ourselves and others.

However, the "Gender Identity Framework" is having unexpected consequences. Rather than educate clinicians, patients and policy makers about the multifactorial nature of Gender Dysphoria, clinical knowledge has been almost entirely replaced with the political narrative, "everyone has a gender identity, which may or may not match one's sex". Gender identity, in these terms, becomes a mystical, elusive entity, removed from the cognitive-developmental processes for which psychologists coined the phrase.

"Gender Identity" was a term coined by Dr Robert Stoller in the context of intersex (DSD) research being done in the 1950s. It had been routine practice to "sex assign" children born with atypical sex anatomy, usually made female simply because surgical procedures to create a neovagina is less complicated than the creation of a neophallus. Because most of these intersex kids did adjust well to their sex assignment, regardless of their genetic sex, Stoller and sexologists after him theorized that "gender identity" isn't the result of any biological mechanism but the result of a cognitive and social learning process.

This term was later applied to research about Childhood Onset Gender Identity Disorder, believed to be an early life error in the unconscious cognitive categorization and social learning process, resulting in a child's perception of themselves as the opposite sex. During childhood, this cognitive process is typically flexible and able to integrate new information. Indeed, research has shown that the vast majority of kids who experience a sense of sex incongruence do resolve it by adolescence or early adulthood under the "Watchful Waiting" model.

Unfortunately, the well-intended human rights framework that has adopted the term "gender identity" is an oversimplification and misrepresentation of that term, presented not only to the general public, but also among clinicians who have become activists, not science informed.

Of note, nowhere in the *Yogyakarta Principles* does it say that any individual must be guaranteed medical interventions. Principle 32 - The Right to Bodily and Mental Integrity - outlines bodily rights such as being free from physical torture or medical interventions to change sex characteristics against ones will. It does not say that medical transition

itself is a right, since that would eliminate clinical judgement on a case by case basis. Principle 17 - Relating to the Right to the Highest Attainable Standard of Health - states that gender affirming medical interventions should be included in the public healthcare system. But it does not say that every individual is entitled to those interventions on demand. Principle 31 - The Right to Legal Recognition - does state that each state shall "Ensure that no eligibility criteria, such as medical or psychological interventions, a psycho-medical diagnosis, minimum or maximum age, economic status, health, marital or parental status, or any other third-party opinion, shall be a prerequisite to change one's name, legal sex or gender". We believe this principle in particular is a misstep and demonstrates a lack of evidence-based clinical knowledge and foresight of the committee. On this point, it's important to remember that this was a committee of human rights strategists, not clinical experts or researchers. One of the authors of the *Yogyakarta Principles*, Professor Robert Wintemute, has since spoken publicly about some of their shortcomings, such as how the concept of self-identification poses risks to girls'/women's safety.

Appendix II

Queer Theory

From 1995-2000 I studied visual art at the Nova Scotia College of Art and Design (now called NSCAD University) in Halifax, NS. Across the city, St Mary's University's Department of Literary Criticism was offering a new graduate level class called "Queer Theory". This was a new academic discipline at that time. Judith Butler's second book, *Bodies That Matter*, had just been published. A few of us from NSCAD took the class as an elective.

At the foundations of Queer Theory is the work of French philosopher Michel Foucault who, in his 1978 book *The History of Sexuality*, asserted that the category of "homosexual" was an invention of the ruling class for the purpose of identifying and oppressing individuals who engaged in same sex behavior.

Building upon Foucault's premise - that categories are for the purpose of oppression - the goal of academics like Judith Butler was to disrupt and dismantle social categories such as gay/straight and male/female. The central theme of Butler's work was what she called the "performativity" of gender - meaning that what we consider manliness or womanliness are learned performances and, as such, could be performed by either sex equally well. Manliness, for example, was meant to be an understated performance, rehearsed to such perfection, and enforced by society in ways that made it appear effortless and non-artificial. By contrast, womanliness retained a distinct quality of effort and artifice. Drag queens and kings became icons of the Queer Theory movement, intended to be both homage and parody of the performative nature of sex categories.

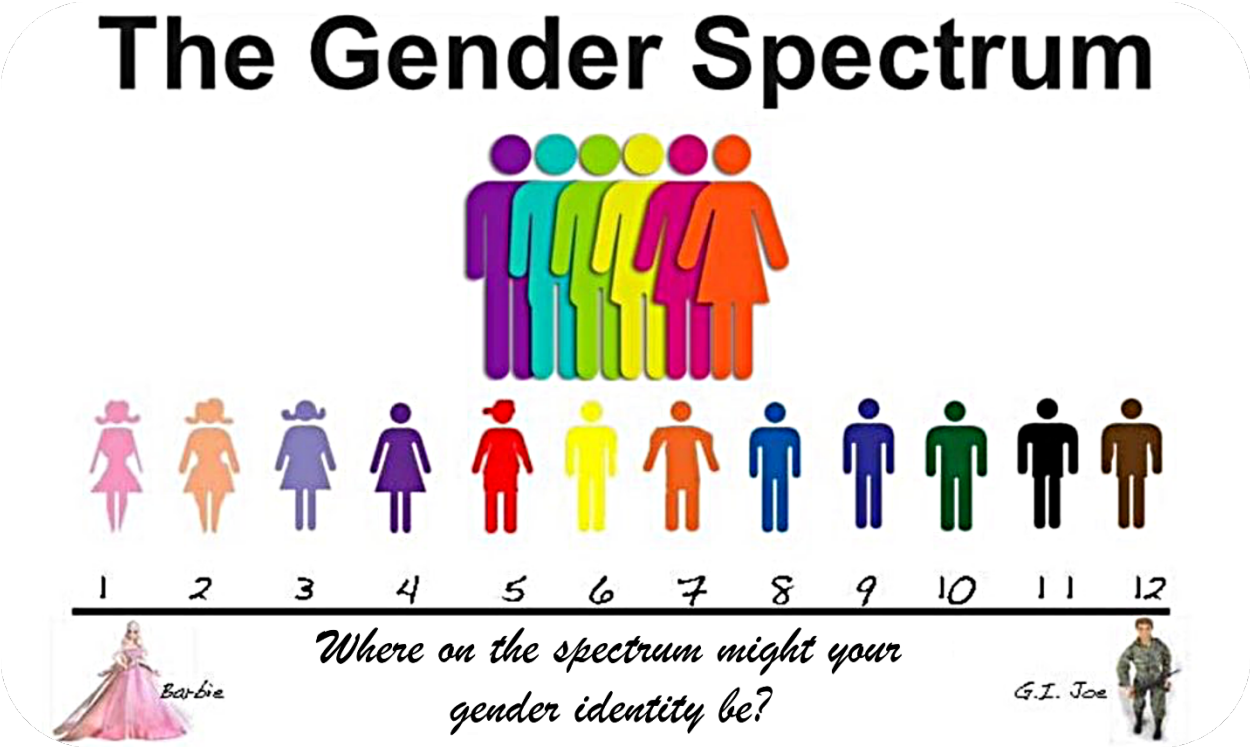
I believe it's important to understand that the central purpose of Queer Theory is the creation of a perpetual smoke and mirrors show to intentionally confuse boundaries between defined categories and, as a branch of post-modern philosophy, aims to dismantle the institutions which uphold those categories, including traditional families. "Queering" a space or community means to apply these political strategies, which is achieved primarily by the subversion of language. A "queer" person is not a sexual orientation but an adherence to the Queer Theory worldview in which men, women, gay,

straight and other sexual orientations and identities co-exist without delineations. American transwoman Martine Rothbladt, in her 1995 book *Apartheid of Sex: A Manifesto on the Freedom of Gender* considers the delineations of male and female a type of oppressive and artificial separation, no different than the South African segregation of white and black.

The words “transgender”, “genderqueer” and “non-binary” come out of Queer Theory, referring to the political transgressions of sex categories, whereas the term “Transsexual” comes out of the clinical literature. In recent years, dozens of new social categories have been created such as "cake gender" and "demisexual" each with their own neopronouns. In concept, the creation of an infinite number of gender or sexuality categories will eventually mean that each individual has their own unique gender, thus making gendered groups obsolete.

In a pluralistic society such as Canada, I respect the right of anyone to believe and study post-modern philosophies. However, since it's a political framework, Queer should not be considered a protected class of personhood immune from criticism.

These concepts are being taught to children in public schools, as early as kindergarten, presented as facts about sexuality and gender. For example, many teachers are using a popular illustration of a "gender spectrum" with GI Joe on one side and Barbie on the other, then asking kids to consider where on the spectrum they place themselves. This diagram conflates gender expression with biological sex because, unless a child is an extreme stereotype of their sex, they are plotted on the diagram towards the opposite sex. This is (intentionally) misleading and bears no resemblance to the evidence-based understanding of Gender Dysphoria, Disorders of Sex Development (DSD) or sexual orientation. A highly effeminate gay man is no less male. A woman with a DSD may still be highly feminine.



I think it's highly inappropriate for a political movement aimed at deliberately confusing society about sexuality and sex categories to have developed sex education curricula for our public school system. These theories are likely to confuse children and, given the deconstructive nature of post-modernism, divide families and communities. Indeed, it has been the case that families who object to these concepts are quickly labeled as “anti-LGBT” and deemed unsupportive of their children.

Furthermore, Queer theorists who are using their professions to advance Queer Theory (e.g. physicians, psychologists, counsellors, social workers, lawyers, educators) are in fact using rare conditions like Gender Dysphoria and DSDs as props in their political movement, and have replaced scientific, clinical knowledge about these conditions with Queer rhetoric. This is alarmingly unethical.

At GDA, we object to being represented and used by this deceptive and divisive framework, and had we been presented with these ideas as gender dysphoric children, it would not have helped us to understand our experiences.

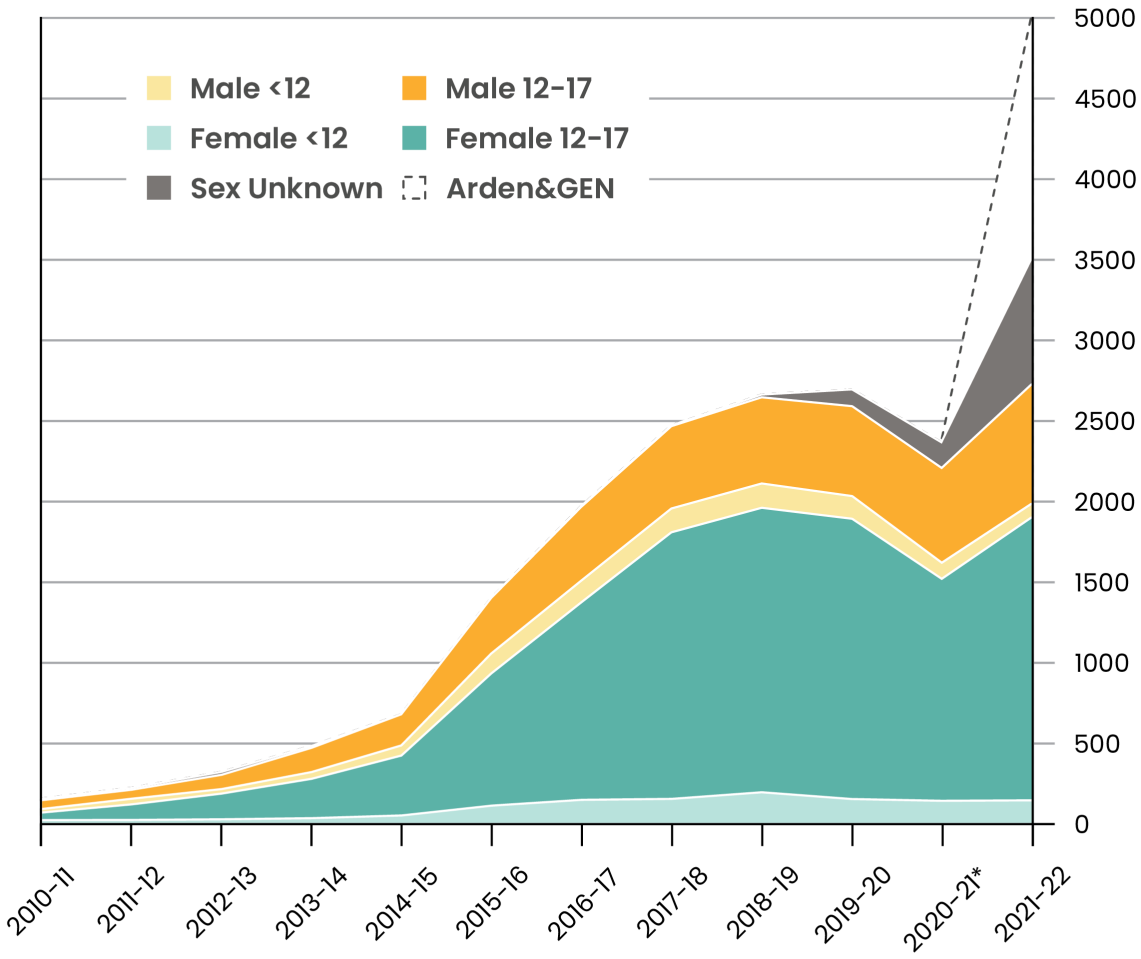
Appendix III

Impact on Children

A Queer Theory based youth subculture has emerged in recent years, which should be regarded as this generation's "goth" or "hippie". But, it's found shelter under the LGBT umbrella and institutions are systematically granting it status as a protected class. Youth in this subculture identifying as transgender are being medicalized along with those with legitimate conditions. The public school SOGI lessons about concepts like "100 genders" is persuading kids to consider that maybe they're not actually girls or boys at all, just as our healthcare system has been eliminating careful, comprehensive assessment, as though safeguarding and clinical oversite is a violation of our human rights. We are very concerned about the wellbeing of children under these perfect storm conditions.

A marriage of Queer Theory and the UN's activist framework ("Gender Ideology") is interfering with the natural healthy development of children's relationships with their biological realities, rendering clinical systems unable to recognize and respond appropriately to the explosion of childhood/adolescent transgender identities. Pediatric gender clinics throughout the western world are reporting a 4000% increase of referrals mostly consisting of teen girls who don't fit the childhood onset Gender Dysphoria criteria. You would think that clinicians would be qualified to properly diagnose and screen out inappropriate candidates for medical interventions, but many have adopted an informed-consent only stance and no longer require any diagnosis, because per the WHO and the UN, that would be "pathologizing".

Child and Adolescent Referrals for Gender Dysphoria
United Kingdom



*Referral activity was sharply limited in 2020-2021 due to COVID-19.
Additional Notes: Beginning July 2021, referrals made directly to GIDS are reported separately from those handled by the Arden & GEN referral management service. The Tavistock reports that Arden & GEN handled over 1500 referrals in 2021-22.

Contrary to best clinical practices which sought to help children formulate a healthy relationship with their natal sex while their gender identity is still flexible, the political framework invites more kids to consider that being the opposite sex might be desirable, for a variety of reasons, and appears to concretize the experience of incongruence prematurely. The net result: more kids identifying as trans (or even trans human, such as animal identities), and fewer kids with gender identity distortions reconciling with their sexed bodies. It's not our goal to police identities, but in this case, there is a significant medical burden. It has been well understood for decades that social transition (e.g.

changing names and pronouns to live as the opposite sex) is a part of "triadic therapy" as the real-life test and a part of the medical pathway. Teachers are not licensed or qualified to initiate clinical interventions. While it isn't our position that no one benefits from the medical pathway, we do believe in medical ethics and competency, and the safeguarding of children who by nature are impulsive and tend to have strong but temporary emotions and convictions.

For these reasons, GDA is critical of the Gender Identity Framework and Queer Theory. We disagree with how these ideas are being packaged and taught, especially to children.

The failure of the public education and medical systems to safeguard children places a heavy burden on parents to guide and protect their kids. Their agency to do so should not be undermined.

I, along with the transsexual adults and others with Gender Dysphoria that GDA represents, do not want to be associated with the institutionalized harm being done to children and families, polarized societal divisions, and greater hostility towards the LGBT community.

Appendix IV: Transgender Experiences and Outcomes

Below, I share my own story as natal female with an ovotesticular disorder of sex development (OT-DSD), and the stories of others posted publicly on GDA's website.

I further have received consent to share three additional stories from Canadian members and associates of GDA, for the purpose of illustrating how multifactorial and multicausal the Gender Dysphoria experience is, and the broad range of outcomes of medical transition.

For clarity again, the use of the term Gender Dysphoria, is in reference to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5), published by the American Psychiatric Association in 2013. This diagnostic manual is in current use.

My story as a person with gender dysphoria

I am a begrudging but perhaps necessary exemplar of my community. I was born as a biological female in 1973 and grew up in a small farming community. From an early age, I perceived myself as a boy. My parents would buy me "girl" toys, which I would mostly ignore in preference to my brother's toys. I look miserable in my kindergarten class photo because my mom made me wear a frilly shirt. When swimming, I wanted to wear swim trunks, not a swimsuit. My Halloween costumes included characters like Smurf, Superman, Michael Jackson, and Gene Simmons. I looked and acted so much like what others expect of boys that I was accidentally put onto a boys' baseball team one summer – which I thought was great! When we played Star Wars in the playground, I was Luke Skywalker – never Leia – which no one seemed to mind. I was one of the boys. This social arrangement lasted until puberty, and then all the rules changed. I was attracted to girls, none of whom took any notice of me. My guy buddies started to either flirt with or ignore me. I had no idea why I perceived myself as male. It was confusing and embarrassing, a sentiment that is echoed with many of our members in their formative years.

At age 19, I had surgery to remove a grapefruit-sized cyst from one of my ovaries. The surgeon said that my ovary was unrecognizable as an organ, so it was sent for biopsy.

It was discovered to be a mix of ovarian and testicular tissue, an intersex condition known as an ovotesticular disorder of sex development. The surgeon seemed embarrassed for me and reassured me that the offending organ was gone, so I should just forget about it. This both validated and further confused my perception of myself. I did not tell anyone about this at the time. I've since learned that most people with an OT-DSD live as men due to the masculinization caused by our natal testosterone levels.

I tried to live with my GD as a young adult, and identified as a lesbian, though it never felt right to me, and I was not happy. I experimented with ways to express my masculinity. I changed my name to Aaron when I was 22.

I did not even know how to explain what I felt to people and felt ashamed of it. I also did not know back then that medically transitioning was possible, and when I did learn about it years later, it seemed far-fetched and risky.

In the early 2000s, I moved to Vancouver and met a few trans people. Then around 2007, I saw a documentary on TV about trans kids which resonated with my experience of GD, so I decided to transition. I do not really regret that decision, because I do feel a lot more comfortable living as a man, but it has not been easy. As I have gotten older, I care less about whether I am male or female. I do not believe in radical gender politics or Queer Theory.

Even if people do decide to transition, people with GD need counselling to help them understand GD and deal with it in reality-based ways. "Affirmation" is not the same as giving us answers about why we feel the way we do as transsexuals. When I went to see doctors for help, I assumed they understood exactly what this condition is, how it manifests and what treatment is most helpful. I have learned that the truth is far different: doctors often are guessing, and do not have concrete answers regarding GD. I was not informed by the physicians I saw about the vast amount of research by psychologists like Dr. Blanchard and Dr. Zucker; the doctors I encountered presented medical transition as the only real option, which was a disservice to me, and to many other people with GD. The failure to apprise patients, especially children, of all viable treatment options on the medical side, is mirrored by the one-size-fits-all orthodoxy

pushed on children regarding social transitioning. Children are often told by activists and those who believe Queer Theory that they *are* in the wrong body, and that the *only* way to address this "fact" is to socially transition to a different gender. The reality is that there are many reasons why a given child may be experiencing GD, and there are many different options for treatment that do not involve social transitioning and genital surgery.

Because of the one-sided narrative that is often pushed on young people with GD, GDA's position is that parents absolutely need to be involved and aware of behavioral changes in their children.

Knowing what I know now, if I were back in my pre-transition state, I would have gone to more counselling first and learned more about what GD is and what all of my options were. Unfortunately, it is even harder to get that kind of information today given the prevalence of the Affirmative Care model. I thought I knew everything I needed to know when I decided to undergo surgery, but I did not. I was just so desperate to feel better and fit in that I was not really thinking straight.

I feel okay about my choices now, but I am not sure they were all necessary. Of the transitional procedures and hormonal regimens that have been performed on me, I do regret getting bottom surgery done because I had complications and the outcome is not what I expected. Bottom surgery is the surgical creation of a pseudo-phallus using tissue removed from other areas of the body. I feel I was misled about what to expect. The bottom surgery actually made my dysphoria worse not better; better and more realistic pre-surgery clinical care could have prevented this issue. I have learned my disappointment and experience is hardly unique.

Meet Aaron Terrell

I had what we would consider early onset childhood gender dysphoria; a self-conception of being a boy despite a body that contradicted that. I don't think I was born with it though; I think it was a response to restrictive female gender roles and a sense that boys had a freedom that shouldn't be withheld from me. I was a tomboy who grew up in

a conservative Evangelical Christian environment and was regularly reminded how girls behave and dress, with the explicit message being I was acting like a boy and that was inappropriate. From my earliest memories the wish to be a boy, or the self-conception of myself as a boy, was inextricable from a sense of shame at feeling that way.

I began to tell myself stories to explain why I felt the way I did. When I was a toddler my infant brother died from SIDS and a few years later I became convinced that his spirit passed into me. That was why I felt like I was a boy; I was carrying my brother's spirit with me. This story also gave me permission to 'act like a boy', because I was doing it for my brother, not for me. I eventually outgrew this story and around age 11 or 12 my internal story shifted to something a little more realistic, which was that puberty would take away my 'boy' feelings and turn me into a real girl. I convinced myself that would fix me. It didn't.

The shame I felt as a small child for wishing I was a boy only increased in adolescence along with the "dysphoria". I didn't know that word at the time, but that's what I would come to understand it as. The older I got, the more intense the dysphoria got and the more intense the shame at still feeling that way. I kept telling myself I would outgrow it. I wouldn't feel this way at 16. Then when I still felt that way at 16, I knew I would outgrow it by 20. On and on it went.

It was further confounding and embarrassing because I wasn't attracted to girls. My peers thought I was a lesbian but in reality the thought of touching another girl's body was repellent to me. My own female body was grotesque, why would I find pleasure in duplicating it? I wasn't attracted to boys until my late teens and when that attraction manifested it was indistinguishable from envy. I found gay men most attractive, and fantasized about being one. I now realize gay male relationships were appealing because they didn't involve any female anatomy and was therefore erotically pure in my estimation. I certainly never told anyone this.

By 26 I hadn't outgrown the dysphoria, and in 2010 I started exploring the possibility of transition. Medical transition wasn't nearly as daunting as the prospect of telling my friends and family my shameful secret that I had carried with me as long as I could

remember. However, once I had vocalized it, the shame disappeared. As if all my life I had been carrying a heavy burden, when all I had to do was put it down. The dysphoria indeed persisted and I went on to transition in 2011 at the age of 27.

Important to note because I know this is a contentious issue right now between trans people and gay people: I did not transition to have sex with gay men. I anticipated being celibate the rest of my life. I did not believe actual gay men would be interested in me, and I wasn't interested in women. Spending the remainder of my life single was a sacrifice I was more than happy to make to be rid of the dysphoria. I saw it two ways: I could be single as a man or partnered as a woman. The choice was simple for me.

Transition was an unequivocal relief for me. Testosterone brought on physical and psychological changes that allowed me to feel comfortable in my body in a way I didn't know was even possible. The dysphoria dramatically reduced as my face and musculature began masculinizing. My sexuality ceased to be focused on gay men and instead, very surprisingly to me, turned primarily toward women. I later concluded my previous repulsion to the female form was a projection of my dysphoria, and my attraction to men was primarily envy. With the relief from dysphoria that repulsion and envy faded away. Two years into my transition I got "top surgery" and my dysphoria was mostly eradicated. As disturbing as this may sound to people who do not suffer from gender dysphoria, the day I had my double mastectomy remains the greatest day of my life. Dysphoria had been such a constant and seemingly interwoven sense of who I was, I wasn't able to fathom what I would feel like without it. Immense relief and contentment is what I felt.

After transition I didn't spend much time in trans communities. I lived mostly stealth. I went back to college and got a Bachelor's degree. I started a new job where no one knew of "my female past" (as I would refer to it at the time) and generally embraced life as a man and didn't spend much time dwelling on the trans part of my life. Transition worked wonders for me, and I got on with life. Occasionally I would wander into online trans communities where I would read young people, often teenagers, expressing they

thought they were trans. I was team transition all the way. I mistakenly assumed gender dysphoria was one thing, and that transition was the only solution.

In 2017 I learned gender dysphoria is not one thing, and that plenty of people are transitioning despite never even experiencing dysphoria of any variety. I became aware of this shift in understanding when I befriended a number of transmen in my city. Initially I was glad to learn there were other people with whom I had such a fundamental commonality, but quickly learned our experiences were starkly different. Some of the things I learned from these young transmen:

1. Being ‘trans’ is separate from gender dysphoria
2. Transition is something you do to demonstrate you are ‘trans’
3. Assuming dysphoria should be a prerequisite to transitioning is inherently transphobic because it ‘pathologizes transness’
4. Lying about having dysphoria is a normal part of accessing trans healthcare, as is necessary because doctors and clinicians are by and large transphobic

Upon hearing multiple variations of all of the above, I was dumbfounded and angry at what I perceived as a cruel appropriation of an ailment I had suffered my entire life. When I expressed disagreement at this framing of ‘trans’ as an identity independent from any mental turmoil at one’s sexed body, I was told that as a fellow trans person I shouldn’t be invalidating anyone else’s ‘transness’ because trans people are invalidated enough by ‘cis transphobes’, and therefore don’t need it from fellow trans people as well.

After distancing myself from my short-lived friendship with these transmen, my anger and confusion only grew. I started lurking in online communities for transmen and learned the cohort I had known in person were not an anomaly - they were expressing the currently pervasive view of ‘trans’ as an identity. An identity that must be validated by surgeries and hormones. My anger at the appropriation melted into terror at what was happening. I read a lot of their stories, I asked a lot of questions, and eventually developed a sense of what was happening. Loneliness is driving young people to

drastic measures to find community, purpose, and distinction. Trans is a religion and a youth subculture rolled into one. It is especially appealing to girls who have been sexually abused or who are on the Autism spectrum. In females it appears to be unrelated to sexuality (apart from fleeing male attention). What we now know as ROGD has little to do with GD as we previously understood it and more to do with tragically normal adolescent struggles being funneled into ‘trans’.

While casually researching the turn within the trans community I came upon a number of stories of detransitioners, mostly women (former transmen). I was not surprised that there were many detransitioned women now. What did surprise me is their stories of dysphoria sounded much more familiar and relatable to me than what I was hearing from the current ‘trans’ population. For these women transition did not relieve their dysphoria. Sometimes it made it worse. In other cases it just came with the nagging reality that they were lying to others and deluding themselves. It would seem many experiences common in girls upbringing, especially masculine girls, can easily be interpreted as an intense, unrelenting feeling that we should have been boys.

All these revelations led me to re-examine my transition and the stories I told myself as a child and as an adult about why I felt the way I did. I’ve realized ‘gender dysphoria’ is just another story I use to explain to myself why I feel the way I do about my female sex and where that positions me in the world. While transition did provide significant relief, and I stand here a decade later without regret, I do wonder if had I been given a different story or tools to explain my discomfort with my sex, would I have found the relief I needed without such drastic and invasive measures? After all, no one is born in the wrong body and I was not supposed to be male. What we are currently doing is solving software issues by carving up hardware. We are treating normal female adolescence with blunt force transition. We should be identifying the root issue before trying to solve vague and nebulous anxieties - body dysmorphia, social anxiety, fear of loneliness - with irreversible hormones and surgeries.

Meet Janet Scott

Most of my strongest childhood memories revolve around my desire to be a girl or at least the knowledge that I did not “fit” as a boy. We now call that gender dysphoria. I remember distinctly going to bed for several years with the constant secret wish that I would wake up and be a girl. From preschool through high school you were likely to find me as the lone boy among a group of girls. While I did have the occasional boy in my neighborhood that I was friends with, other boys tended to confuse me. They didn’t tend to like what I liked, they didn’t play the games I liked to play. At recess, I was often playing jump rope or learning the latest rhyming game with the girls, while the boys learned to play basketball or football or just chased around after each other.

Children tend to be strict enforcers of “gender”. “Boys do this.” “Only girls do that.” Most young children don’t really know about the sex differences between boys and girls, so what makes them different becomes other factors. When I was wishing to be a girl at 6 and 7, I didn’t understand that that would require a change of my sexed body. What I did know is that I was different and that difference was not OK with some people. My parents were loving. They never tried to force me to “be like the other boys” but there were always limits on just how far I was allowed to go in the other direction. I could talk them into some “girls’ toys” but dolls and Barbie were a no go. I’d get the occasional lecture about how “Boys don’t do that. Boys don’t stand that way. They don’t carry their books like that.”

I was around 9 the first time I learned that people could actually have a “sex change”. From that moment on, I knew that’s what I wanted when I got older. (It was still very much an adult issue back then) Shortly after, I learned the word transsexual and began trying to find out everything I could. I was probably the only one in elementary school that knew who Christine Jorgenson and Renee Richards was.

Middle school and high school became very confusing. The friendships I had always enjoyed with girls became complicated. I lost one friend in middle school because a rumor started that we had “done it” in the girls’ bathroom. I didn’t even know what “it” was. Other friends became disappointed when I showed no interest in being their

boyfriend. I never had crushes on boys my own age. I did however have crushes on male teachers, Being gay in middle school or high school wasn't really a thing back then. Besides, it didn't occur to me to consider the attraction I had to these men as "gay", because the men weren't gay and I had already convinced myself that I'd be a woman when I grew up. I became obsessed with transsexuals and "gender", watching and reading everything I could find. Not the easiest thing to do in the early 1990s.

Unlike a lot of dysphoric children and teens of that time, I actually do have proof of these feelings and experiences. At 16, I called a cable talk show that was doing a story on transsexuals. The cohost was a young Dr. Drew. I also came out to one of my teachers because an assignment asked us to visualize how we saw ourselves in the future. I became paralyzed because how could I explain that in the future I saw myself as a woman? Coming out led to talks with the school counselor and then to my parents. My parents took me to a therapist, who did eventually diagnose me with what was then called Gender Identity Disorder. She told them that I was a "likely transsexual".

Right after turning 17 my family and I moved to the southeast United States and I started college. My parents had made me promise to stop all this talk about being a woman and asked me if I was sure I wasn't "just gay". Despite that, I maintained the idea that I would transition after college. I grey my hair out and even frequently "passed" as a woman, even though that wasn't my intent. After college (and more time on the internet) I decided to see if maybe everything else people said about me was true, maybe I was a gay man. I went on my first date with the man that would become my husband of 19 years. The dysphoria didn't disappear, but it became tolerable. I had a relationship and a career to focus on, "gender" took a back seat.

In 2016 the dysphoria started getting stronger again. After discussion with my husband, I began socially transitioning and seeking a therapist and medical transition. My transition was from April 2016-July 2017 when I completed SRS. During my transition and after, I realized that things had changed from my initial ideas in the 90s. Gender Identity Disorder was out, gender dysphoria was in. Transsexuals were out, trans men

and trans women were in. Therapy focused more on how you felt about the transition process than your dysphoria.

I spent the first few years after my transition saying a lot of the things gender ideology says. Even if I didn't fully believe some of it, you start to trust those with more knowledge and experience. Slowly though I started listening to more voices and asserting my own views. "Trans" is not something you innately are, it's something you become with transition. Transition is not a blanket solution for everything. Those of us that choose to transition need to understand the limitations of the process.

Meet Lauren Black

"I am a butch lesbian. I live with gender dysphoria. I do not believe my deep discomfort with my female body means that I should take steps to change it."

I am a butch lesbian. I live with gender dysphoria. This is the condition which, according to mental health professionals, means I am transgender. However, I do not define as transgender. I do not want to take hormones or have surgeries. I do not accept that it is possible to live "as a man", without believing in old fashioned gender stereotypes. I do not believe my deep discomfort with my female body means that I should take steps to change it. This is my story.

In many respects, I live "as a man," if you want to put it like that. I don't want to put it like that, which is part of the problem I face. But I work in a warehouse. I shop in the men's department. I have a wife and children, who I work to support. I am at ease in the company of men. My hobbies include turning wood, and fixing things. If I could click my fingers and be rid of my womb and my breasts, and not face lifelong medicalisation, I probably would. I have regularly felt, like Lady Macbeth, "unsex me here." I am often "misgendered." People call me "lad" or "sir," until they hear my voice. It bothers me not at all.

I meet the criteria, set out in the DSM 5, for medical transition. That is, if I went to a gender clinic and told them how I feel, and about my experiences, they would prescribe me testosterone and a double mastectomy. I choose not to transition. Instead, I am

learning to love the skin I'm in. I have my own struggles with that skin, with my female body. Those struggles are not because my female body is wrong, but because my negative thinking around my body and my sexuality, which started in childhood, was not explored through therapy soon enough. I do not think it is in my interest to treat a condition that is in my head by making changes to my body. Psychiatry does not have a good history in this regard.

I'm not hard line about transition. I support the right of adults to take what course of action they feel they need to take. However, I believe it is the responsibility of the medical establishment to explore options with individuals, before going 'nuclear'. If counselling, feminism, learning to accept your sexuality shame free (which for me is butch femme dynamics), or even just growing into yourself can help you, why take life changing drugs and have life changing surgeries? It is not the job of clinicians to prescribe unthinkingly to satisfy another person's desire to be validated; it is the job of clinicians to explore the reasons for an individual's distress.

The affirmation model, the rush to the nuclear option first, is not good for individuals like me, who live with dysphoria. It closes down my options. I am less able, not more, to seek help for my distress, as the only help now widely available would, I believe, be damaging to my health and my life. The side effects of testosterone on women include, and may not be limited to – painful orgasm, vaginal atrophy, clitoromegaly, suicidal tendencies, violence, panic attacks, rage, jaundice, severe allergic reaction, nausea, vomiting, liver failure, cancer, kidney or urinary problems, infection of the injection site, stroke, or heart attack. Learning to love the skin I'm in sounds like a much better option to me.

Affirmation also solidifies a trans identity. Dysphoria is a condition affecting individuals; transition is only one treatment for that condition. "Being" trans seems as though it attaches an identity to a condition, and I don't think that's a helpful way to think. Individuals live with a variety of conditions, without letting those condition define them.

It is particularly important not to “affirm” children in identities which may take them down unhelpful routes in their lives. Telling a child they “are” anxious, for example, is less helpful than giving them support and strategies to deal with their worries.

How much more important is it, then, not to consolidate the identities of people in ways that will make them life long medical patients, reduce their choice of sexual partners, and may ruin their future fertility and sex life? If I had been “affirmed” as transgender as a child, when I was a tomboy, if that option had been open to me, I would have taken it. It was not an option. I am glad it was not. I now have a life that I never thought was open to me.

I still have difficulties with my sexed body. Periods are particularly difficult for me. But instead of seeking a hysterectomy, I tell myself, “Lauren, you’re a butch lesbian, are you really so afraid of a little blood?”, and then I get on with my day. My wife loves me, just how I am, with all my oddities. I’m very glad that I’m in a lesbian relationship. I would not want to be in a heterosexual relationship with a woman. That would wreck something important for me about who I am, and what I stand for and I could never have discovered that on my own if I had been transitioned young.

I stand for trashing the old fashioned, regressive stereotypes that say “if you can drive a forklift and operate a lathe, you must be a man.” No. I stand for a celebration of the amazing diversity that women are. I stand for smashing the nonsense that is the gender binary. I stand for loving the skin you’re in, and embracing who you really are, not for altering healthy bodies with drugs and surgeries in an endless quest to become someone that, in the end, you biologically can never be.

And so, I will put on my high vis vest, and my steel toe caps, and go to work with the lads, and I will hug my wife a little tighter when I’m suffering. I will clad my female body with muscle, and my female voice with chivalry, and I will know that this is who I am. And that it is good enough.

Meet Kellie Pirie

I am a 57-year-old woman and a medical transition regrettor, though I haven't taken steps to medically detransition, since most of the changes to my body are permanent. I pass as male in society and work full time as a truck driver. Since 2004, when I first started taking testosterone, I've reflected a lot about what's happened to me and why I made the decisions I did.

In 1966 my mother married a convicted pedophile who sexually exploited me for many years as a child.

I moved to Vancouver BC, as an adult during the early 2000's. There I encountered trans-ideology and was completely enchanted by the fantasy that living my life as a man would make me feel safer.

In 2004 I began to attend Vancouver Coastal Health's Trans Health Program peer counselling services, peer support group and FTM Etcetera, all led by members of the community, not clinical experts. My peer support group told me of someone who would prescribe hormones based on a family doctor's referral, and coached me to "navigate the system". They were hyper-focused on the process, and minimized the risks.

I obtained the necessary referral and was prescribed testosterone on my second visit. I was told to expect male normal health risks. No one talked about how cross sex hormones are like burning gas in a diesel engine. Rates of type 2 diabetes are higher in women taking testosterone. In December 2017 I was diagnosed with type 2 diabetes. My peer support cheering squad encouraged me to celebrate abdominal pain, soft tissue injuries, joint pain and ligament strain as proof the testosterone was working. My family's grief, remorse, shock and confusion were all framed by the group as manifestations of lack of acceptance, transphobia, and intolerance of my autonomy.

The surgeon who started me on testosterone, performed my complete hysterectomy. After three days in hospital I was sent home. Routine post hysterectomy examinations were not done, so the abdominal pain and discomfort I began to experience was missed.

In 2008 I had a double mastectomy at the UBC Hospital where I had a complication recovering from the anesthetic and was discharged late.

Early the following day I woke up in severe agony. It felt like someone was ripping the left side of my chest apart. I groped my dressing and there was a huge bulge. I was taken to Vancouver General Hospital where doctors determined that an artery had burst and I was bleeding internally. I had to wait a day and a half for emergency surgery.

Because of my earlier reaction to anesthetic, a milder sedation was used. I woke up on the surgical table while they were closing up the incision area. Screaming obscenities at hospital staff, I tried to get up to leave. They gave me something to knock me out. When I came to they had me completely restrained. I was kept in hospital for an additional two nights. About a week later I developed a post-operative infection and was put on several rounds of antibiotics.

As a truck driver, wearing a seatbelt is still uncomfortable due to scar-line adhesions and sensitivity.

In 2009, I experienced increasing levels of abdominal pain and discomfort. The peer support cheering section continued to frame this as physical manifestations of transphobia because of my family. Eventually a combination of pain, fever and nausea led me to think I should go to an emergency room. I had developed an abdominal abscess which fistulated into my intestinal tract. Over the next year I was on several courses of extremely strong antibiotics. I was unable to work most of that year and no longer have complete control of my bodily functions.

Late 2010 my world came crashing down as I recognized that despite everything I had done to surgically and chemically alter my social gender presentation, I would never be a man. I realized that my distress and desire to transition was a result of my childhood trauma. None of these interventions addressed the real cause of my distress.

I’ve resigned to the fact that I’ll probably never find a romantic partner, since I’m attracted to lesbians but I’m now invisible and not attractive to other lesbians. I’ve also

lost sexual function as a result of testosterone therapy, because diabetic neuropathy has set in and I have lost sensation in my toes and sex organs.

Between 2010 and 2016, I returned to employment in trucking, a very male dominated profession. Through contact with the men I worked with, the differences between men and women became clear to me. So the realization of being biologically female, and nothing like my male coworkers sunk in.

Between 2017-2018 I've watched the most radical trans activists defend the rights of convicted sex offenders to access women's prisons, and argue for the inclusion of pedophiles in the LGBTQ2S+ umbrella under the term Minor Attracted Persons. As a who's experienced childhood sexual exploitation, I can no longer support the Queer Theory based political movement.

Meet Lois Card

I am a First Nations adult and post op transsexual (male to female) of 14 years from Treaty 6 territory in Alberta. Earlier this year, I applied for MAiD due to the lack of medical resources to help alleviate my extreme and ongoing pain and discomfort from the vaginoplasty I had in 2009. I believe that the current medical system is captured by gender identity ideologues, which made accessing safe therapeutic and medical care impossible. At the end of my first MAiD assessment, it was determined that all I could do was settle for a numbing cream that does not work. The assessors also determined that my application was a human rights concern and thus declined my application. I now must exhaust all current medical resources (likely more surgery) in order to qualify for another MAiD application, which I intend to do in the future. As a First Nations individual and advocate, I am especially concerned for First Nations youth and children in care who do not have a guardian. The institutional undermining of parental authority that happens "in the best interests of the child" echoes our devastating history of the removal of First Nations children from their homes and placing them in residential schools. I'm concerned about the over representation of First Nations youth and youth in foster care among those who are trans identified in Canada and, since medical transition often times involves the stopping of sexual maturation and the removal of sex

organs, that First Nations people are, once again, being sterilized. I am also critical of the ways in which academic post-modern ideas about sexuality and gender (e.g. Queer Theory) are being used to further colonize First Nations people. We have our own cultural and spiritual understandings of these things. The term "Two-Spirit" was coined in Winnipeg in 1990 at a conference of same-sex attracted indigenous people who wished to separate themselves from the European concepts of homosexuality and gender non-conformity. Efforts to "queer" our communities, especially our youth, is erasing our cultures and dividing our communities.

Meet Stefan

In January 2004, I started hormone treatment to transition from a woman to a man. I was a young adult in my mid-20s, living in a large Canadian city, when I embarked on a medical path. My last surgical intervention was in 2010.

I saw the assessing psychologist for a single 90-minute session. The natural next step was hormones and surgery. That was the only treatment option that was presented to me.

Taking my first hormone shot felt very empowering. I felt like I was taking control of my own identity, my own destiny. Initially, my depression lifted, my anxiety subsided. A clear path lay ahead of me: updating legal documents, informing loved ones, and looking into surgical options. It gave me a sense of purpose and direction.

But I had flashes of memories I couldn't deny - moments where I had made choices, not based on the belief that I was a man, but rather on the belief that I was not much of a woman. I recalled moments where I had felt uncomfortable because I didn't like the look of my breasts, or was grossed out by my period, or didn't feel like I had much in common with the women around me.

After my transition, and as I matured, the desire to have children snuck up on me. Prior to that, I had not allowed myself to imagine the possibility of being a parent. Up until then, I had little concept of growing old, let alone growing old as a man. For much of my teen years and early twenties, I had held a belief that I would be dead by the age of

thirty, either by my own hand or by some act outside of my control. As thirty came and went, however, and I continued to live, my views changed - and with it my perspective on my transition.

I no longer consider myself male, though legally that is what I am. When I first transitioned, I thought that gender transition was a cure for my depression and anxiety. Some might say that this was a foolish assumption on my part, and that I am solely responsible for holding it. But this belief didn't come out of nowhere. This is what I was told. What responsibility do the medical and psychological providers have, considering that they had a duty of care and I believed what they were telling me? What duty does the clinical community have to ensure that their treatment protocol is safe and based on evidence. What duty do they have to ensure informed consent?

Medical transition is held up as a very effective treatment for gender dysphoria. Doctors routinely claim that the regret rate is much lower for this type of intervention than virtually any other medical treatment people receive for other conditions. While I wish that were true, I remain skeptical. No one who helped me along my medical transition ever followed up with me to find out how I was adjusting. Just because people don't necessarily detransition doesn't mean they don't grieve or regret. In many cases, there may be no going back. And what of the rising voices of detransitioners? Do their voices not also matter? Perhaps for some people transition is the right choice and it really is that simple. But for me, my transition has raised more questions than it has answered. I see value in acknowledging these complexities, complexities that the clinical community have refused to acknowledge.

As for my gender dysphoria, I still experience it. Only now it's in reverse. Medical transition has complicated my already messy relationship with my body. I mostly like myself when I look in the mirror and see my bearded face, but I also miss the thick, curly brown hair I had as a girl, that at times I wore in a ponytail and sometimes cut short. These days I wear a hat to conceal the hair loss that often accompanies testosterone treatment. I don't mind my deep voice, but I miss my singing voice, the voice my late father loved to hear when I sang carefree in the shower as a teen. I have

grown to like the silhouette of my flat, masculinized chest, but I regret the scars and grieve the loss of sensation that followed the loss of a nipple during surgery. I like that I no longer must worry about monthly periods or have to fear unwanted pregnancy, but I experience deep sadness for the child I'll never bear.

Over the years I have had many theories on what led me to transition. Is my gender dysphoria better understood as an anxiety disorder, the fear of becoming an adult woman in a culture hostile to gender nonconformity? Was it social influence and an obsessive disposition that led me down this path? Am I autistic and mistook my sensory sensitivities and communication difficulties for gender dysphoria? Did my misattunement with my mother drive me to over-identify with my father? I'll likely never know.

Was my medical transition worth it? I'm not so sure.