Brief to the Senate Committee on Legal and Constitutional Affairs Regarding Bill C-6

Submitted by Gender Dysphoria Alliance Canada

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Gender Dysphoria Alliance Canada is a non-partisan education and advocacy group for Canadians with Gender Dysphoria, many who have medically transitioned (transgender/transsexual). We are opposed to Bill C-6 as it's currently written, for reasons outlined as follows:

While we do support protections from coercive therapies, we are very concerned that the wording of this bill does not make any clear distinction between supportive, exploratory, developmentally-informed psychotherapy, and conversion therapy. This is especially alarming as applied to the treatment of Gender Dysphoria (GD) for several reasons.

Though clinical specialists and researchers world-wide have not come to a consensus on what Gender Dysphoria is, it is clear to us, as people who have it, that it is a condition, whether psychological, developmental or neurological. Regardless of which evidence-based definition one believes, we do know that people can and do recover from it, especially children and youth. We know this from our own lived experiences and the countless people we've interacted with. Validating our experiences, the WPATH Standards of Care (Page 6) states: "*Often with the help of psychotherapy, some individuals integrate their trans or cross gender feelings into the gender role they were assigned at birth and do not feel the need to feminize or masculinize their body"* and (page 11) *"[Childhood] Dysphoria persisted into adulthood for only 6-23% of children"*. Given these two facts about desistance and integration of identities, we assert that psychotherapy should be first-line treatment for Gender Dysphoria since remission, without life-long medicalization and associated risks, is ideal. As people with this condition, we find it troubling that recovery is no longer seen as positive, possible, or desirable for us, despite evidence to the contrary.

The perception of "gender identity" is an experience unique to people with Gender Dysphoria that should not be generalized to all people. We disagree with transgender activism that has confused this matter. It is our understanding that Gender Dysphoria is a malfunction of cognitive categorization. We can cognitively sort out differences between, for example, dogs and cats, even though there are many different varieties of

each, but those with Gender Dysphoria cannot cognitively categorize ourselves as male or female, for some reason. The resulting cognitive dissonance is what causes distress for many of us with this condition. Our minds ruminate on trying to sort out the paradox. That is the clinical matter at hand. Medical transition does not cure this. It can only provide some relief, for some people, and make it worse for others.

For experts like Dr Kenneth Zucker, affirmation and social transition of children should be considered clinical interventions and applied cautiously because they are likely to consolidate a cross-sex identity, making desistance less likely and life-long medicalization far more likely. (LINK) We are in agreement with that concern, because it has been our experience that our Gender Dysphoria intensified when we adopted trans identities and started to medically transition. Some of us did eventually recover from our Gender Dysphoria, after medically transitioning. When this happens, people often regret medically transitioning. Transition regret happens far more often than claimed by clinicians or reported in surveys. Regret is a highly taboo and politicized subject in the trans community so is rarely discussed openly. People who regret transition tend to leave the community and don't return to the care team who transitioned them. Additionally, only a few who regret transition take steps to medically detransition, for various reasons. Many of the effects of hormones and surgery are permanent. There are not many supports (clinical or social) for detransition. People feel a great deal of self-blame and shame when they regret transition, and they fear being ostracized in this polarized political environment. Psychotherapy, prior to medical transition, would help ensure that only those most likely to benefit from permanent bodily changes will be medicalized.

Gender Dysphoria should not be conflated with sexual orientation, since GD is a condition and sexual orientation is not. LGBT activists over the years have blurred this line, which has been politically effective, but problematic in regards to many social and clinical matters. This is why there's been a growing international desire to split LGB and T (e.g. LGB Alliance). People of diverse ethnicities, cultures, religions, backgrounds and sexual orientations can have Gender Dysphoria, and it is not necessary to identify as transgender or to medically transition because of the condition. Many butch lesbians we

know, for example, have Gender Dysphoria but they have found meaning and ways to integrate their GD into their lesbian identities. Gender Dysphoria is not a culture, community, lifestyle, political position, or identity, but it is crucial that you understand how the transgender lobby since the 1990s has promoted it as such. We then invite you to consider whether, if this was any other medical condition, you would consider it ethical to push a political or cultural agenda onto those with the condition.

Prior to the 1990s, psychologists, who had well researched the different kinds of Gender Dysphoria, led transgender treatment. The major shift in clinical models and ideology was not the result of any new medical evidence which displaced the psychologists' evidence. The shift corresponds with the birth of Queer Theory in academia. Queer Theory, however interesting one might find it, should not be used to guide clinical practice. It is a literary, rhetorical discipline, not a clinical one. When Judith Butler wrote about transgender identities, it was not a clinical formulation – it was a cultural musing and political strategy to advance certain gay/lesbian ideas by intentionally dismantling our notions of maleness/femaleness. Butler described gender as "performative". Drag Queens and Kings were key icons of the movement in those early years. These ideas have advanced into the mainstream and into the system of care, seemingly framed as clinical or scientific fact. One of the strategies common to the movement is to appropriate from other movements and cultures, such as the LGB lobby, intersex biology and religious/cultural gender presentations. For example, to offer legitimacy to the idea that gender is a spectrum, the Queer Theory lobby often refers to intersex biology. This is a falsehood, since intersex conditions are almost always sex specific, and most intersex people identify as binary male or female. Some intersex people have Gender Dysphoria, but biological sex is not a spectrum. Many intersex people resent having their unique conditions misused in this way. The claim of gender being a spectrum is an appropriation of feminist theory which aimed to expand the roles and expressions for each sex (e.g. women can be firefighters). Queer Theorists used that idea to assert that gender expression in fact trumps biological sex, and have since gone even further, saying that biological sex itself is a social construction. This is a dangerous rhetorical device, not objective reality. Though today's radical trans lobby refers to feminists with the slur "TERF" (trans exclusionary radical feminists) we are in agreement

with the feminists on this matter – that within the objective realities of biological sex, there is diversity of temperament and expression which should not be stifled nor pathologized. A girl who likes cars and sports is still a girl, not a boy. We believe that the Queer Theory-based narrative about gender that's being taught to explain transgenderism has served to capture the public's imagination. Children are being taught this narrative in schools as fact. When asked to search inward to decide what gender they are, reasons to then identify as the other sex are many. "Transgender" is no longer about Gender Dysphoria. Medicalization is no longer about treating Gender Dysphoria. It is about affirming identity and advancing Queer Theory culture. Sex categories have been reduced to mere stereotypes and any girl or boy who doesn't "feel" like the most stereotypical version of their sex are inclined to think they're not actually a girl or boy at all. This is especially true for those who are psychologically vulnerable. Teaching that sex is a spectrum is basically saying that *everyone* is some variation of trans. We are very concerned about the impact of this on kids and we believe it has contributed to an alarming over-inflation of trans-identities in recent years. Additionally, it has been our experience and observation that Queer Theory makes Gender Dysphoria symptoms worse for those who do have it. We don't think it's in any way an exaggeration to say that Queer Theory has created a mental health crisis among youth. If exploratory psychotherapy was the first line of treatment for trans youth, such conceptual errors could be corrected prior to permanent medicalization, to safeguard young people.

Since transgender is now an umbrella term that has captured imaginations, there are many pathways to it that have nothing to do with Gender Dysphoria. This writer has met lesbian Queer Theory academics who adopted male personas, not because they identified as men or have dysphoria, but for "political reasons", using the public medical system to create "female masculinity". We have heard countless trans-identified people say that they've never had Gender Dysphoria. It is our position that when people don't have Gender Dysphoria, "trans" is a mere socially constructed identity, which they are entitled to have, but our public medical system should not be used for the purpose of inventing personas. It is for treating conditions according to quality peer-reviewed

medical evidence. Those clinicians who are promoting Queer Theory rely heavily on community surveys, not peer reviewed evidence.

The final point we would like to bring to your attention is the number of lesbian and gay people who transition to escape homophobia. People tend to think this only happens in countries like Iran where gay and lesbian people can face the death penalty and sex-changes are legal and funded. It's not surprizing that many gay and lesbian people transition under those circumstances. Please do not be so assured in our liberties as Canadians that this does not happen here. It not only happens but is common. Sometimes this is deliberate and other times subconscious. This is one of the reasons that people later regret transitioning. We can't stress enough that for many, medically transitioning is literally an extreme form of LGB conversion therapy. This is something that should be explored with each person seeking to medically transition.

In summary, there are numerous reasons for why exploratory psychotherapy by qualified clinicians is crucial to the well-being of transgender Canadians. We do not advocate for this because we want to see trans-identified people coerced into changing. We advocate for this to safeguard and adequately support those like us. Gender Dysphoria can be treated successfully in many cases without medical interventions. Given that many people adopt trans identities for reasons other than having Gender Dysphoria, especially vulnerable young people, psychotherapy should be *required* in order to protect and support those individuals. Cross-sex transitioning may very well offer someone relief from a homophobic family, but that's an outcome none of us should be proud to endorse.

Many of us in the Gender Dysphoria Alliance Canada network have transitioned. This is not a decision that should be made lightly. We do experience health consequences, and the surgeries are very difficult to experience. Genital surgeries have very high complication rates, especially phalloplasty and metoidioplasty. We don't wish to eliminate that option when absolutely necessary but all of us, regardless of whether or not we medically alter our bodies, would benefit from mental health care prior to making such a life altering decision. Medically transitioning is a complex physical, social and

psychological journey. The option has captured the imaginations of many, for many different reasons, with little understanding of the resulting life-long burden. Not all reasons should be affirmed.

We believe that Bill C6, as currently written, will make therapists afraid to work with us because it is unclear what is meant by “conversion therapy”.

We believe that Bill C6, if it succeeds in making psychotherapeutic treatment for Gender Dysphoria illegal, is leaving those of us with this condition with few options other than life-long, complicated medicalization.

Bill C-6 will galvanize the affirmative-only, informed consent model – cutting the leading psychology experts off at the knees. This is the result of politically motivated activism, and rhetoric, not evidence or best practice.

Bill C-6, in its attempt to protect LGB and T people from conversion therapy, will in fact promote the most extreme form of LGB conversion therapy – changing ones sex to normalize their sexual orientation. This is not a progressive nor protective direction for Canada. It is crucial that the interests of LGB people be separated from transgender interests. Our recommendation is that Bill C-6 be amended to only apply to sexual orientation, since sexual orientation is not an illness. Gender Dysphoria however, is a medical/psychological condition.

Thank-you for taking the time to consider our concerns before you vote on this Bill. We will be very disappointed in our government if psychotherapeutic treatment options for Gender Dysphoria are made illegal.

Sincerely,
Aaron Kimberly, RN
On behalf of Gender Dysphoria Alliance Canada
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