Brief to the Saskatchewan Human Rights Commission

Regarding: Ministry of Education “Use of Preferred First Name and Pronouns by Students” Policy

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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, (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 is in agreement with this policy on several grounds:

1) The human rights framework is in 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 (e.g. Yogyakatha Principles) 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 in regards 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”. 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 the Gender Dysphoria Alliance use the clinical term, “transsexual” to indicate that we have medically and legally transitioned to live as the opposite sex as a treatment for our 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.

4) Social transition (changing name, pronouns etc) is step one of a medical pathway. It is a clinical intervention that requires clinical oversight.

5) While 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.

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.

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 an obscene coercion tactic. There is no evidence that children will complete suicides 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, those studies do not specify that "support" means immediate affirmation and medicalization. Clinical models for children typically involve the entire family.

Discussion

It is my belief that the policy in question about parental involvement is not really about "parental rights" but is a necessary child safeguarding measure in light of the conundrum we find ourselves in here in North America, where Queer Theory 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 the Gender Dysphoria Alliance, 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 knowledge about Gender Dysphoria, especially in children. The implementation of the *Yogyakatha Principles* is having unintended consequences, which need to be corrected.

To date, there are 12 studies which followed cohorts of children with early onset Gender Dysphoria (or the older term Gender Identity Disorder). They all came 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 kids to experience some degree of gender confusion, gender non-conformity and distress. Many gay adults recall this from their own childhoods. Prematurely labelling these kids "trans" risks the medicalization of an entire generation of gay kids.

Selected Studies:

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 kids and families are misleading many to prematurely label those kids "trans". As researchers like Dr Kenneth Zucker have warned, hasty social transition of kids (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 my position that "trans" is a bad thing, but overmedicalizing gay and lesbian kids, without properly informing them about that developmental process is concerning. The kids 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 BC sent me and a number of other trans guys 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 kids, 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 kids 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 gay/lesbian kids to wrestle with gender and some degree of cross sex identification as children.

Families who are 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. Most 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 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 severe bodily medicalization and is being protected as a human right as "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 kids who's identity is socially influenced, from medical harm.

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 children and families understand that this isn't motivated by anti-LGBT hate. It's a child safeguarding measure and a necessary correction of political overreach. I would like to work with the government and schools to help with the delivery of the messaging. 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, even many clinicians sadly.

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 breaking trust between families and teachers/schools who could have supported them.

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 the Gender Dysphoria Alliance 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

I 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 kids over the past few years. I agree with them. 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 doesn't 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 that has been consistent and persistent. 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. Is 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.

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 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 president 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.

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.

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