The Florida Board of Medicine
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Dear Mr Vazquez,

I am an adult who has medically transitioned and is happy with my own transition. If I had been asked five years ago what I thought of childhood transition, I probably would have thought it was great. It's easy to look back on my experience of childhood onset gender dysphoria (GD) and imagine the benefits of having undergone childhood transition: If I'd been put on puberty blockers, I probably wouldn't have needed a double mastectomy and therefore wouldn't have scars. If I'd socially transitioned and started testosterone as a teen, then maybe my GD wouldn't have interfered with my social development as it did.

Despite these possible benefits that some may argue they would have experienced via childhood transition (which of course is no more than a thought experiment), I am now of a different mind: I strongly disagree with childhood transition. I'd like to explain to you how I've arrived at this conclusion.

As a young adult, I became a part of the lesbian community through which I met many very masculine lesbians and effeminate gay men. I began to understand my GD as somehow related to being gay and to the masculinizing effects of the Ovotesticular Disorder of Sex Development (OT-DSD) which I was diagnosed with at age nineteen. Though I struggled with GD, I didn't give

it much more thought. In the butch/femme lesbian subculture, butches often use male nicknames and are referred to by male pronouns though, to be clear, no one is confused about the biological sex of butch lesbians. “Stone Butch” is a term for such women whose GD is so severe they can’t tolerate being touched.

Then, in 2006 I saw a documentary on mainstream TV about “trans kids” whose described experience of GD and cross-sex identification was a near exact reflection of my experience growing up. The documentary framed the experience of GD as: if you experience x,y, z, then it means you are a transgender person. So that was it! I thought, I must be a transgender person because I certainly had all of those experiences. Looking back, I can see that I had exhibited all the classic signs of GD, which I found to be confusing and distressing, since the age of three. Prior to seeing this documentary, I didn’t have language or a framework through which to understand my experience of cross sex identification. My GD wasn’t something I had discussed with anyone. But after seeing this documentary, it seemed to me that I finally had a framework to explain my heretofore confusing and distressing experience – I was “trans”! After this revelation, I booked an appointment at the local gender clinic where I was assessed for Gender Identity Disorder (GID) over a period of several months, and I was started on testosterone. I was assessed again by a clinical psychologist prior to having any surgeries done. I personally found the assessment process helpful, because it required me to consider things I hadn’t thought of, and prevented me from making hasty decisions. The changes to my body, from testosterone and a double mastectomy, did relieve my distress and disconnect with my body. However, it’s also been a very complicated emotional, psychological, social and physical process, which I believe requires a great deal of stability, maturity and support to navigate well.

In 2008, two years after my diagnosis and the start of my hormonal treatment, I became a registered nurse with a specialization in mental health. I worked in the mental health department at St Paul’s Hospital in Vancouver, Canada, for 10 years. Initially I worked in the Psychiatric Stabilization Unit and then in the Provincial Eating Disorders Program. In 2017 I moved to Kelowna, Canada, to help launch a multidisciplinary youth clinic. By 2019, about 25%

of the youth presenting to our clinic were trans identified and requesting medical interventions. The clinic physician was interested in providing medical interventions, but she didn't have the sessional time with our program to provide (what we'd assumed would be) lengthy assessments and care planning. Since assessment is one of my professional strengths, I offered to do intake assessments and coordinate the trans health services. I was excited to cross the table and learn about GD from a clinical perspective. Working within a multidisciplinary clinic seemed like an ideal setting to do whole person care, since we had access to primary care, psychiatry, counselling, housing services, parent supports, employment services and partnerships with more intensive mental health and social services.

I consulted with the Provincial Health Services Authority (PHSA), which provides oversight and clinical training for trans healthcare services throughout British Columbia. PHSA's team (Trans Care BC, TCBC) came out to Kelowna twice to do training for us. Additionally, I was doing weekly mentorship calls with them. During this training and mentoring process with TCBC, I started to become confused and concerned about the current state of trans healthcare.

TCBC's in-person training was best described as cultural sensitivity training. They presented the Genderbread man diagram, personal narratives, and coached us to use certain language. TCBC's training did not include any peer reviewed studies. Rather, their "literature" relied solely on community-based surveys. Shockingly, there was no mention of GD. Further, TCBC's website claims that one doesn't have to be trans to medically transition.[1]

I was informed by TCBC that the purpose of assessments is strictly for the purpose of determining a patient's capacity to consent, and that assessment could be completed in a single visit, using a one-page checklist created by TCBC, found in their Primary Care Toolkit.[2] In British Columbia, minors may consent to treatment without parental permission, under our Mature Minors Act.

I asked TCBC for peer reviewed studies about GD, and psychotherapeutic models that are helpful for supporting those with GD. They didn't point me to a single study.

During mentorship calls and on the clinical listserv, I heard from other clinicians that they were telling parents that their child would die by suicide if the parents did not support their medical transition. I learned that one well known psychologist, who works with youth in the foster care system, had told an audience during a public presentation to lie about being suicidal to get what they wanted.[3]

I'd known some of these clinicians for many years because some of them were my care providers. My experience in trans healthcare as a clinician and my experience 15 years earlier did not mesh. Consequently, I became very confused about the nature and/or clinical meaning of "trans" or "GD" and why clinical practice in trans care had changed so much.

The youth I had been seeing at my clinic were often highly complex and very few of them seemed to have the same experience of GD that I did. Between Aug 2019 - Dec 2020, I saw 52 clients for hormone readiness assessments. Of these clients, 71% were natal females. Of these female clients, 8% identified as heterosexual. (The boys were all heterosexual or bisexual). Of the 52 clients, 19% had an ASD diagnosis. 29% had an ADHD diagnosis. 14% were involved with child protection services or were adopted, and 15% reported significant trauma. A single visit assessment seemed grossly insufficient, so I wanted to take my time with my clients, to do more thorough assessments, care planning, and provide education.

By getting to know my clients, I learned that some of the youth had been very lonely through childhood. Some admitted that they never had any GD as children. One teen girl in particular stands out in my mind. She had initially been brought to our clinic by her parents to start testosterone. She wanted to be a boy and had already socially transitioned. Then, one day her parents brought her in to see me again. She seemed embarrassed and said she was happier back when she was a girl. She was ambivalent, because she stated that she'd have to "grow her hair long and start wearing girl clothes". I informed her that she could have whatever hairstyle and wear whatever she wanted to as a girl and asked if she'd considered exploring what kind of girl she was. She lit up like it was Christmas morning and seemed very relieved. She never came back to start hormones.

Meanwhile, some of my friends who had medically transitioned 20 years ago were starting to open up about their transitions. One very much regrets her transition and now understands that her decision to transition had been motivated by childhood sexual abuse. The consequences of her transition have been considerable. Significantly, she's resigned herself to a life without a romantic partnership, since she's attracted to lesbians, but lesbians are not attracted to her, since she looks like a man.

I became so disturbed and confused by what I was seeing in trans care that I started digging into the medical literature for answers. Surely there was evidence to explain why thorough assessment and psychotherapy had been eliminated, and why GD is no longer being discussed among clinicians. I found no such evidence. What I found were 11 studies all saying that most young people with childhood onset GD desist by or through puberty.[4] I also read through studies by psychologists Drs. Blanchard[5], Bailey[6], Zucker[7], and Vasey[8]. The information I learned from these high-quality studies was overwhelming, and that sense of overwhelm led me to crash. No one had ever informed me about the three known pathways to GD, all outlined in the DSM-5:[9]

(1) Late onset - Transvestic disorder with Autogynephilia
(2) Early onset – highly correlated with homosexuality
(3) GD related to a Disorder of Sex Development

The aforementioned body of work regarding GD not only makes 100% sense regarding my personal experience of GD, but it also maps onto what I've seen in the trans population over the past 20 years. We are not all the same. We have experiences, and different needs.

When I raised my concerns about the state of care being provided to trans identified youth within the system of care (TCBC, listserv etc), the response was drastic and swift: complaints were made to my employer, I was removed from the clinical mentorship mailing list, I was accused of using the listserv for anti-trans activism, our clinic was boycotted, and I was moved to another program within the organization. The attacks didn't stop there: A trans woman who

works TCBC, and two of her friends began a smear campaign on social media and called the head office of the organization I work for, in an attempt to get me fired. The accusation levelled against me was that I was “gatekeeping”, “spreading misinformation” and advocating for hatred against trans people.

These reactions (shunning, smearing, attacks on my livelihood) on the part of the members of the trans care system in BC, prompted me to create the Gender Dysphoria Alliance (GDA) in January 2021. My goal for the GDA was for it to act as a lightning rod for like-minded trans people who understand or want to understand themselves from an evidence-base clinical lens, rather than activist led narratives.

The GDA has had many different stakeholders such as parents of children and youth with gender-related distress, trans people, clinicians, detransitioners, teachers and journalists, reach out to us. They’ve all noted that they did not know where else to turn for evidence-based support and information on trans related issues. One teacher told us that 50% of her classroom of pre-teens identified as something other than “cis gender” but she was afraid that voicing concerns would be seen as transphobic.

I believe the clinical community has failed in its obligation to provide evidence-based care and education about what GD is.

Kids are being socially and medically transitioned without any regard to the desistance studies.

I believe there is a social phenomenon occurring that is attracting young, vulnerable people into trans identities. Dr Lisa Littman, in a preliminary study, named this phenomenon Rapid Onset Gender Dysphoria.[10] The influence of social media and Queer theory activism, which is a deliberate attempt to blur our understandings of male/female and gay/straight, is confusing kids and recruiting them into a political movement that doesn’t care whether the kids have GD or not. To date, there is no other plausible explanation for why we are not only seeing many

more young people flooding clinics, but ***a completely new presentation of young people: girls with no history of childhood gender non-conformity.*** Historically, the only natal females who sought transition were butch lesbians who's reported experiences of GD fit the childhood onset pathway to GD. Furthermore, until the recent shift in populations presenting to gender clinics, females have always been the minority of those presenting with GD. The reason for this is threefold: (1) there are fewer lesbians than gay men, and even fewer butch lesbians. (2) women rarely have paraphilias like transvestic disorders, and (3) DSD related GD is rare. This new cohort of girls (and some boys) is not accounted for in our current evidence-based understanding of GD. This should prompt concern, pause and investigation by the medical establishment, not faster pathways to medicalizing them.

Knowing what I now know, I know I would have benefitted from the truth – that my GD is related to my DSD and sexual orientation.

I was lied to about the nature of my condition, and about my health and treatment options by the system. I will not participate in continuing that lie as a clinician.

I am very much in support of a return to evidence-based practices, including watchful waiting, psychotherapy, and comprehensive, whole-person assessment.

Thank-you Mr Vazquez, for your efforts to protect kids with one of the types of GD, as well as the kids who don't have GD, who would likely be harmed by hasty medicalization and misinformation.

Warm Regards,

Aaron Kimberly, RN
Executive Director, Gender Dysphoria Alliance

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