Respectfully Submitted

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POLICY REPORT for Parliamentarians

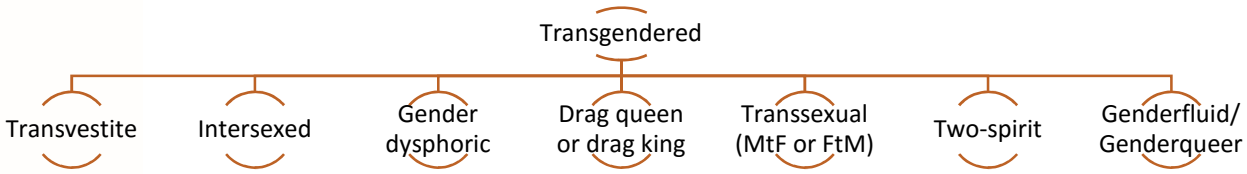
Courtesy of the Association for Reformed Political Action (ARPA) Canada

Gender matters.[1] Some think that maleness and femaleness are largely social constructs imposed on society and that differences between boys and girls should be minimized to the greatest extent possible. Sadly, some governments are taking this view to heart, as seen in recent Albertan education guidelines, Ontario's ban on particular types of counselling for teens, and the introduction of Bill C-16 in Parliament. We observe a troubling trend where Canadian politicians are willing to adopt dramatic changes to public policy as it relates to gender and sexuality with minimal research or support. This approach is harmful for all members of society, but particularly so for transgendered youth.

It is important that debate over ideas, theories and concepts surrounding gender identity not be confused with attacks on the dignity or wellbeing of individuals genuinely struggling with gender identity disorder. Those among us struggling with their gender identity and seeking to find answers are often the ones who lose out in these public debates. Dr. Mark Yarhouse, a psychologist with 30 years of experience counselling individuals with gender identity struggles, notes that patients coming into his office are not seeking to tear down the "social constructs" of maleness or femaleness.[2] They are simply looking for help as they navigate these very troubled waters in these times of social change. It is our hope that this report will clarify some of the points of misinformation in the public discussion, expose some of the harm being perpetuated, and provide policy recommendations that respect the human dignity of our transgender neighbours.

What is transgenderism?

Transgenderism is a term based on the experiences of a small proportion of the population who say there is a difference between their gender identity and their biological sex. One's biological sex is built into the DNA and sex hormones that shape a body. On the other hand, the new concept of gender identity refers to how a person experiences one's own masculinity or femininity. The term "transgendered", then, is an umbrella term for the many ways in which people might experience or express their gender identities differently from people whose gender identity is congruent with their biological sex.



Perhaps the group that captures the most attention today are those who struggle with gender identity disorder, also known as gender dysphoria,[3] a psychological phenomenon. According to the revised language of the DSM-5, "gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender."[4] Gender dysphoria is a rare ailment: according to the DSM-5, it manifests in only 0.005% - 0.014% of adult men and 0.002% - 0.003% of adult women.[5]

Gender Identity

Summer 2016

There is some confusion on the connection of gender identity disorder to biology. A very small percentage of people suffer from disorders of sexual development (DSD)[6], sometimes referred to as an intersex condition (in older literature, hermaphrodites). Their genes, hormones, or body structures differ from the norm such that the sex of a baby with one of these conditions may be difficult to identify at birth. An intersexed condition is a *biological* disorder, and should be distinguished from gender dysphoria, a *psychological* disorder. It is important to note that most intersex people are *not* lobbying to pass as the other sex or as a third sex, but are simply seeking to discover *to which sex they belong*.[7] Their biological sex identification can typically be discovered through a chromosomal or blood test.

When helping hurts – medical testimony

Celebration of transgenderism (those who change gender, or identify as a different sex or who have sex-change surgery) is seen by some as the best way assist transgender individuals.[8] There is no evidence, however, that the negative outcomes associated with transgender identification - including higher rates of suicide and attempted suicide, overall mortality, and need for psychiatric inpatient care - are alleviated by accepting and encouraging alternative gender identities in those with gender identity issues.

The theory behind popular approaches to transgenderism today is not scientific – it is political.[9] Gender dysphoria is a psychological phenomenon. Gender fluidity is a social construct that normalizes gender dysphoria, and thereby impedes its diagnosis and treatment. This type of political theory without evidence results in public policy that is politically self-serving, not other-serving. This is what grounds the important distinction between gender fluidity (the current political theory) and gender dysphoria. To leave the dysphoria untreated is to leave struggling individuals without help, and to ignore experienced researchers in this field.

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KEY TERMS[9]

Biological Sex: As male or female (typically with reference to chromosomes, sex hormones and reproductive anatomy).

Gender: The psychological, social and cultural aspects of being male or female.

Gender Identity: How you experience yourself (or think of yourself) as male or female including how masculine or feminine a person feels.

Transgender: An umbrella term for the many ways in which people might experience or present/express their gender identities differently from people whose gender identity is congruent with their biological sex.

Cisgender: A term developed and used within the LGBTQ community to describe a person whose sense of gender matches their biological sex.

Transsexual: A person who has or wishes to transition from living as a male (identified at birth) to adopting a female presentation (MtF) or vice versa (FtM).

Gender Fluidity: Describes a theory or concept whereby a person can experience their gender not as fixed (as either male or female) but fluctuating on a continuum.

Drag Queen: A biological male who dresses as a female for the purposes of entertaining others. Does not tend to identify as transgender.

Transvestism: Dressing as the other sex, typically for the purpose of sexual arousal (and may reflect a fetish quality). Most do not experience gender dysphoria.

Intersex: Describes a rare biological condition in which a person is born with sex characteristics or anatomy that does not allow clear identification as male or female. The causes of an intersex condition can be chromosomal, gonadal or genital.

Psychological problem or normative identity?

Johns Hopkins Hospital was one of the first institutions in the United States to perform so-called "sex change" operations. Dr. Paul McHugh[10], the chief psychiatrist there in the late 1970s, commissioned a study of the sex change program. Its authors found that "In a thousand subtle ways, the reassignee has the bitter experience that he is not—and never will be—a real girl but is, at best, a convincing simulated female. Such an adjustment cannot compensate for the tragedy of having lost all chance to be male, and of having in the final analysis, no way to be really female."[11] Some 40 years later, Dr. Sander Breiner[12] concurs, explaining that she and her colleagues had to tell the surgeons that "the disturbed body image was not an organic [problem] at all, but was strictly a psychological problem. It could not be solved by organic manipulation (surgery, hormones)".[13]

Many Canadian experts in the field of psychiatry, including those who regularly work with transgendered youth, have grave concerns about the politicization of this psychiatric issue. Toronto psychiatrist Dr. Joseph Berger[14] says that some transsexuals "have claimed that they are 'a woman trapped in a man's body' or [vice versa]. Scientifically, there is no such thing."[15] Dr. Ken Zucker[16] sees the political approach to gender identity and fluidity as unsound.[17] And Dr. Susan Bradley[18] considers the political moves of some activists "disgraceful."[19] Dr. Paul McHugh, who was the lead psychologist at John Hopkins medical school for a decade points out, "This is a disorder of the mind. Not a disorder of the body."[20] Canadian policy makers should take these warnings to heart.

Apotemnophilia: a comparison

Apotemnophilia is a neurological disorder characterized by an individual's intense and long-standing desire for the amputation of a specific limb. It is a type of Body Integrity Identity Disorder (BIID). Some with this condition look for surgeons willing to perform an amputation and some apotemnophiles have purposefully injured limbs in order to force emergency medical amputation.[21] In 1997, Scottish doctor Robert Smith was performing these amputations before an outcry brought them to a halt.[22] What would the compassionate option be: to accommodate the person's self-perception by amputating healthy limbs as Dr. Smith did, or to treat the psychological condition itself?

The comparisons between gender identity disorder, anorexia, apotemnophilia and other similar conditions are clear. As Dr. McHugh says, "It is not obvious how this patient's feeling that he is a woman trapped in a man's body differs from the feeling of a patient with anorexia that she is obese despite her emaciated, gaunt state. We don't do liposuction on anorexics. Why amputate the genitals of these poor men?"[23]

Impact on children

Gender identity disorder in children is recognizable and treatable. The evidence from many medical experts is clear –reinforcing gender identity disorder is confusing to a child and greatly increases the likelihood of a life of emotional and psychological suffering.[24] This is particularly so with pre-pubescent children because the vast majority of boys and girls with gender dysphoria outgrow it by puberty.[25] Dr. Zucker and Dr. Bradley note:

> It has been our experience that a sizable number of children and families achieve a great deal of change. In these cases, the gender identity disorder resolves fully, and nothing in the children's behavior or fantasy suggest that gender identity issues remain problematic... [W]e take the position that in such cases clinicians should be optimistic, not nihilistic, about the possibility of helping the children to become more secure in their gender identity.[26]

Dr. Bradley regards gender identity disorder as one of a number of attachment disorders and conceptualizes the symptoms of gender dysphoria, "as a child's solution to intolerable affects… The symptoms, particularly the assumption of the role and behaviors of the opposite sex, act to quench the child's anxiety".[27] In other words, gender dysphoria in children is a signal that help is needed. When this signal itself is celebrated as something worth reinforcing or emulating, the cry for help is silenced and the underlying issues remain unaddressed. Note well that an attachment disorder is not at play in every case of gender dysphoria and that, even where there is an attachment disorder present, this is not necessarily the result of neglectful or bad parenting. The reality is, causation of gender identity disorder remains a mystery.[28]

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Radical changes having long-term effects

In 2011 a comprehensive longitudinal study was completed on the effects of gender reassignment procedures. The Swedish report concluded: "Persons with transsexualism, after sex reassignment, have considerably higher risks for mortality, suicidal behaviour, and psychiatric morbidity than the general population."[29]

The results of the Swedish longitudinal study are mirrored in an American national survey of 6,450 transgender people. In response to the question, "Have you ever attempted suicide?" 41% of respondents answered yes.[30] Only 1.55% of the Canadian population has.[31] The American transgender advocacy survey explained the high suicide

rate up as resulting from a lack of acceptance or an insufficiently positive affirmation of transgender identity. However, evidence from jurisdictions like Sweden which are known for their affirmation of transgender identity show similar numbers. San Francisco, the rainbow capital of the world, also reports similar numbers of suicide attempts among the transgender community.[32]

The prevalence of *comorbid conditions* (i.e. coexisting conditions) must also be considered. Gender dysphoria often (though not always) presents itself along with other psychiatric disorders, and after patterns of abuse or neglect. According to a survey of Dutch psychiatrists, 61% of patients exhibiting gender dysphoria experience other comorbid conditions, including alcoholism, depression, anxiety, self-harm, a history of neglect or abuse, personality disorders, eating disorders, or psychotic and dissociative disorders.[33] The political 'solution' of celebrating transgender identity attributes a gendered cause and a gendered solution to what is obviously a complex matrix of underlying psychological and social issues. Not only is this approach overly simplistic, it also disregards evidence that the problems might be exacerbated by the very solution proposed. The Swedish longitudinal study cited above reveals that the rate of suicide attempts actually *increase* among those who have had 'successful' transgender surgeries,[34] which ought to be a stern warning against simplistic political solutions.

There are many anecdotes that warn against these simple solutions. Walt Heyer writes of his, and many others, experience as a man seeking to transition to a woman. The doctor who approved his surgery failed to explore or evaluate underlying secondary disorders. “Without learning of my childhood abuse, [the doctor] was incapable of diagnosing the comorbid dissociative disorder I had… Failure to address the original emotional issues means that the original emotional issues remain.”[35] Heyer explains that “the high rate of suicide among transgenders is due to the lack of diagnosis and treatment of the coexisting disorders that cause suicide such as depression or other diagnosable mental or substance abuse disorders”.[36]

What ought we to do as a compassionate society?

Alleviating the psychic distress of transgendered individuals requires nuanced answers. We must distinguish between high rates of suicide that result, on the one hand, from rejection by family, isolation, bullying, etc., (all of which are unacceptable) and, on the other hand, suicide rates among trans youth where psychiatric care is offered that seeks to resolve the dysphoria in keeping with their birth sex. This is not to say that bullying, rejection by family, isolation, etc., are not an issue for transgender people. They can be, and that type of behavior must be corrected. But the reality is that family rejection, isolation and bullying increase suicide risks for *all* youth, not just transgender youth. The unfortunate politicization of this issue results in the condemning of anything less than full affirmation, reinforcement and celebration of the gender incongruence in transgender youth, a “solution” that compounds the problem. Where family and community walk alongside a transgender individual with love and compassion, all with the goal of resolving the dysphoria in keeping with the patient’s birth sex as much as possible, we predict the suicide rates will dramatically decrease, particularly because other comorbid (i.e. coexisting) issues can also be properly treated. The way we frame our approach to this issue is of the utmost importance.

Alleviating the psychic distress of transgendered individuals requires nuanced answers.

Frameworks for understanding gender

Dr. Mark Yarhouse, in his book *Understanding Gender Dysphoria*, writes about three different approaches or frameworks through which most people view gender identity incongruence: the disability framework, the diversity framework, and the integrity framework. He proposes an integrated approach, taking the best elements of each framework, as the approach to understanding gender dysphoria.[37]

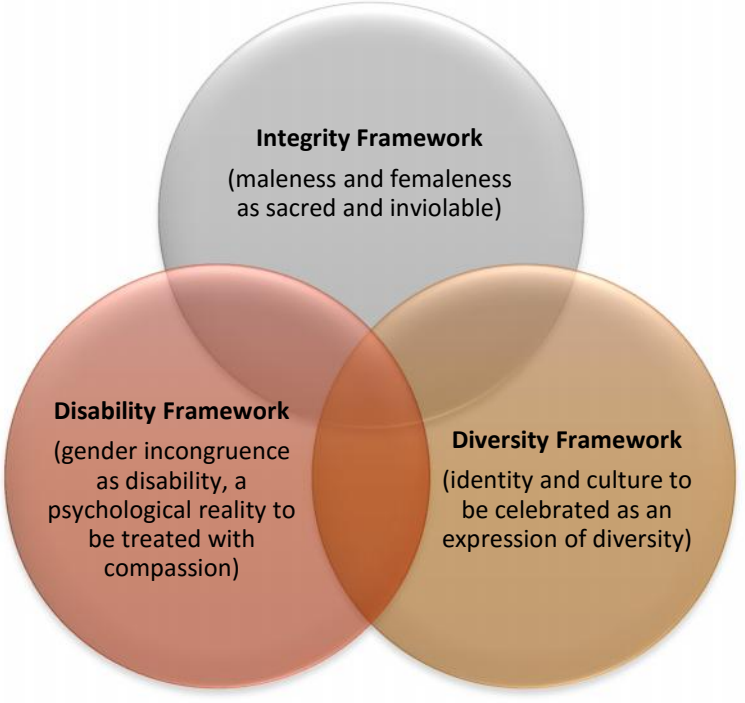
The ***disability framework*** focuses on the mental health dimensions of the phenomenon of gender identity disorder in a primarily clinical way. The ***diversity framework*** holds that gender dysphoria should be embraced and celebrated. Some see the sex-gender binary as a socially constructed authority structure to be destroyed and

eliminated,[38] but the majority who hold the diversity view simply seek to give expression to the lived experience of a transgendered person and answer the questions of identity and community: 'who am I?' and, 'where do I belong?'

The ***integrity framework*** appeals to the integrity of maleness and femaleness stamped on one's body by nature or by our Creator. God created humankind as male and female, equal in dignity and worth, yet with distinct and complementary bodies, abilities and roles. A person's biological sex constitutes a vital part of their human nature and is a means to fully realizing their physical, psychological, and social well-being.

Male and female are made in the image of God.[39] To mar or to diminish the masculine and feminine diminishes our God-given identity as males or females. Both reflect the glory of God. The sciences confirm that, with the exception of a few simple organisms, all creatures (including humans) are marked by a fundamental binary sexual differentiation: male or female markers are imprinted on each of their trillions of cells. The testimony of biology, chromosome data, and social-scientific evidence confirms the essential biological binary of the sexes.[40]

Dr. Yarhouse proposes an integrated approach to understanding gender dysphoria, taking the best elements of the three different frameworks.



ARPA Canada respectfully submits that all three frameworks discussed above offer important emphasis or questions. An integrated approach recognizes a proper focus on the mental health dimensions of gender identity disorder and rejects dangerous and unhealthy human experimentation. It gives space for expression of struggles and seeks to answer the questions 'who am I?' and 'where do I belong?' without deconstructing gender. And it affirms the inherent dignity and intrinsic value of every human being as either male or female, including those who struggle with confusion regarding their sexuality and gender.

Recommendations

In terms of scientific and social research, the field of gender identity is still relatively new. Unfortunately, when the State attempts a radically new policy response to transgenderism, it becomes an agent of forced social and cultural change without any standard or criterion of success, and without clearly understanding the possible outcomes. Take just one example that illustrates this concern: in an effort to accommodate transgendered children, the provincial government in Alberta wants every school to work towards eliminating gender differences not only in the classroom, but even on sports teams and in change rooms.[41] This is not the well-reasoned, scientifically-based public policy we should expect of our representatives.[42] By choosing to apply only the diversity framework of transgenderism (as discussed above) to the population as a whole, new gender policies effectively *neuter* the reality of binary sexual differentiation. ARPA Canada respectfully submits that the following 10 recommendations make for better public policy as it relates to protecting transgendered youth and enhancing social and public policy.

Protecting Transgendered Youth

1. State actors must cease to use the phrase "sex *assigned* at birth" and maintain the scientifically accurate term "sex". Sex is a biological reality. It is not assigned. To use the language of "assigned" inculcates a flawed assumption that any incongruence is a *biological* error, rather than a *psychological* one.

2. Provinces must ban all gender reassignment surgery on children before the age of 18. Further, in light of the fact that those who have had sex reassignment surgery have higher rates of attempted suicide, surgical transition should be abandoned as a treatment option even for adults.
3. Provinces must ban all cross-gender hormone treatment on children, including puberty suppressants, due to unacceptably high risks of depression and suicide[43] and sterility.[44] To chemically alter the natural and healthy development of a child with such incredible risks before the child can give their own informed consent is nothing short of child abuse.
4. State actors, particularly in the education and medical fields, must ensure parents are fully informed of any and all struggles their child may have, including any indications the child is struggling with gender identity issues. Policies that keep information from parents must be rejected.
5. The emphasis of treatment for gender dysphoria in youth should be on resolving dysphoria in keeping with their birth sex. Where it cannot be prevented or resolved, focus should be on management, using the least invasive treatment/coping strategies possible.[45]
6. Children exhibiting gender dysphoria should be cared for with an eye toward (though not an assumption of) treating all other comorbid (coexisting) issues.[46]

Society and Public Policy

7. The State must provide ample room for civil society to respond to this issue. Parents, the medical profession, churches and other community groups must have the freedom to address gender dysphoria in their families and communities without threat of enforced ideological conformity by the State.
8. Provinces must abandon laws that make gender reinforcement illegal. Such laws violate children's rights and doctors' conscience rights and interfere with parental decisions regarding the best interests of their children. For example, Ontario's Bill 77 should be repealed.[47] This law, and others like it, promote an ideological blindness at odds with the best interests of the patient.
9. The terms "gender identity" and "gender expression" should be removed from law because the terms are based on subjective perceptions and cannot be objectively evaluated or measured. There is no consistent policy reason to protect transgenderism, but not protect trans-racism,[48] trans-ageism,[49] trans-ableism,[50] or even trans-speciesism.[51] Further, laws that add the terms "gender identity" and "gender expression" as protected grounds of discrimination such as those passed in Ontario[52] and Alberta[53] and being contemplated federally with Bill C-16[54] are unnecessary since all transsexuals are already protected in law, no less than anyone else.[55]
10. In the interim, we urge that a better balance of rights occur. In places where a reasonable expectation of privacy exists, (washrooms, women's gyms, etc.) the biological measure of a person's sex must be the determining factor for access. Due to the reality that there is no objective means to identify a transgendered person, this measure of preventative access can help protect against devastating consequences.[56] Interestingly, spaces of privacy have become "gender-neutral." *Adding* different genders has had the pernicious effect of *subtracting* the difference between the sexes expected in public, and removing the privacy and the shield for natural modesty appropriate to them in certain social contexts.

Gender matters because people matter. Maleness and femaleness are binary and complimentary realities that correspond to our biological selves and go to the core of what it means to be human. Governments ignore or undermine this reality to society's detriment. While some children struggling with gender identity disorder may need exceptional care in their various situations, the State helps no one by "breaking down gender" (i.e. the societal outworking of binary sexual norms) across the province or country. Canadian politicians must be willing to take a stand for good public policy as it relates to gender and sexuality and base their positions and arguments on scientific research viewed through an integrated framework. This approach provides benefit to all members of society and especially protects our transgendered youth. With sound public policy, we can help our transgendered neighbours as they navigate these troubled waters in times of social change.

Citations, Resources and Research

[1] Throughout this report, the terms "sex" and "gender" are used as seemed best in each context to minimize confusion and maximize clarity. The use of the term "gender" in this report should not be taken as an endorsement of the view that a person's gender is merely a social construct and a completely distinct reality from a person's biological sex. Indeed, we affirm that a person's gender corresponds to and is synonymous with their sex. It is very clear what we are referring to in the opening sentence of this report when we say, "gender matters." Had we opened with "sex matters", it would have left a very different impression.

[2] Mark A. Yarhouse, *Understanding Gender Dysphoria: Navigating Transgender Issues in a Changing Culture* (Downers Grove, IL: InterVarsity Press, 2015) pg. 42, 143.

[3] Throughout this report, we use the terms interchangeably. In 2012, the American Psychiatric Association changed the Diagnostic and Statistical Manual of Mental Disorders, or DSM, replacing the diagnostic term "Gender Identity Disorder" with the term "Gender Dysphoria". This allows doctors to treat gender dysphoria *either* by treating the psychological condition by conforming the patient's psychology to match their body *or* by treating the physical body and matching it to the patient's psychology. The evidence suggests that in virtually every case, effective psychological care conforms an unhealthy mind to a healthy body. Sadly, due to extreme political pressure, this diagnostic change has swung the treatment focus towards manipulation of the healthy physical body.

[4] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (Washington, DC: American Psychiatric Publishing, 2013), p. 451.

[5] *DSM-5*, p. 454. Other studies have put the prevalence rate even lower.

[6] Leonard Sax, "How Common is Intersex? A Response to Anne Fausto-Sterling," *The Journal of Sex Research* Vol. 39, No. 3 (August 2002), p. 175. Dr. Sax estimates that intersex occurs "in fewer than 2 out of every 10,000 live births", less than 0.02%.

[7] See, for example, The Intersex Society of North America, "What does ISNA recommend for children with intersex?" Online: < http://www.isna.org/faq/gender_assignment > where they state, "We advocate assigning a boy or girl gender because intersex is not, and will never be, a discrete biological category any more than male or female is, and because assigning an "intersex" gender would unnecessarily traumatize the child." Online: < http://www.isna.org/faq/gender_assignment >.

[8] See, for example, the conclusions and recommendations of Jaime M. Grant, Ph.D., Lisa A. Mottet, J.D., and Justin Tanis, D.Min. et al., in "National Transgender Discrimination Survey Report on Health and Health Care" (Oct. 2010), p. 16-17, online: <http://www.thetaskforce.org/static_html/downloads/resources_and_tools/ntds_report_on_health.pdf>, where the focus for improved health outcomes is exclusively on ending discrimination, and lacks any reference to mental health support.

[9] See, for example, Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990). For a critical evaluation of transgenderism from a feminist perspective, see Sheila Jeffreys, *Gender Hurts: A Feminist Critique of the Politics Behind Transgenderism* (New York: Routledge, 2014).

[10] Dr. Paul McHugh is Distinguished Service Professor of Psychiatry at Johns Hopkins University. In 2004, Dr. McHugh published an article explaining the scientific reasons for rejecting sex change procedures. After describing the great deal of damage he witnessed from sex-reassignment, he concluded, "we psychiatrists have been distracted from studying the causes and natures of their mental misdirections by preparing them… for a life in the other sex. We have wasted scientific and technical resources and damaged our professional credibility by collaborating with madness rather than trying to study, cure, and ultimately prevent it." Paul R. McHugh, "Surgical Sex: Why We Stopped Doing Sex Change Operations" (Nov. 2004) *First Things*, available online: < http://www.firstthings.com/article/2004/11/surgical-sex>.

[11] Jon Meyer and John Hoopes, "The gender dysphoria syndromes: A position statement on so-called transsexualism," *Plastic and Reconstructive Surgery*, (1974), p. 450.

[12] Dr. Breiner is a psychiatrist with clinical experience working with transsexuals at Michigan's Wayne State University.

[13] Sander Breiner, M.D., "Transsexuality Explained," National Association for Research and Therapy of Homosexuality, n.d., accessed March 26, 2015, http://www.narth.org/docs/transexpl.html. Dr. Breiner also explained that "[T]he significance of the psychological difficulty should not be minimized by a patient's seeming success, socially and professionally, in other areas".

[14] Dr. Joseph Berger, Consulting Psychiatrist, Fellow of the Royal College of Physicians and Surgeons of Canada and Diplomate of the American Board of Psychiatry and Neurology and Distinguished Life Fellow, American Psychiatric Association, Professor of Psychiatry, University of Toronto.

[15] Written testimony of Dr. Joseph Berger to the House of Commons Standing Committee on Justice and Human Rights, regarding Bill C-279, available online: <https://arpacanada.ca/attachments/article/1724/Testimony%20of%20Dr.%20Berger%20re%20c279.pdf>.

[16] Dr. Ken Zucker was Clinical Lead at the Centre for Addiction and Mental Health's Child, Youth and Family Program's Gender Identity Service until December 2015 and is a professor in the Departments of Psychiatry and Psychology at the University of Toronto.

[17] Barbara Kay, "Bill 77, the Affirming Sexual Orientation and Gender Identity Act, is a dangerous overreach" (June 2, 2015), *National Post*, online <http://news.nationalpost.com/full-comment/barbara-kay-bill-77-the-affirming-sexual-orientation-and-gender-identity-act-is-a-dangerous-overreach>.

[18] Dr. Susan Bradley is Psychiatrist-in-Chief at the Hospital for Sick Children, Head of the Division of Child Psychiatry and professor emeritus at the University of Toronto.

[19] Barbara Kay, *Bill 77, dangerous overreach*.

[20] Perry Chiaramonte, "Controversial Therapy for Pre-Teen Transgender Patient Raises Questions," *FoxNews.com*, October 17, 2011, online: <http://www.foxnews.com/us/2011/10/17/controversial-therapy-foryoung-transgender-patients-raises-questions/?test=latestnews>.

[21] Bensler, J. M.; Paauw, D. S. (2003). "Apotemnophilia masquerading as medical morbidity". *Southern Medical Journal* 96 (7): 674–676; Berger, B. D.; Lehrmann, J. A.; Larson, G.; Alverno, L.; Tsao, C. I. (2005). "Nonpsychotic, nonparaphilic self-amputation and the internet". *Comprehensive Psychiatry* 46 (5): 380–383.

[22] Tim Bayne & Neil Levy, "Amputees By Choice: Body Integrity Identity Disorder and the Ethics of Amputation." (2005) *Journal of Applied Philosophy*, 22/1: 75-86. See also a book by the same Dr. Smith, co-authored by Gregg M. Furth, *Apotemnophilia: Information, Questions, Answers, and Recommendations About Self-Demand Amputation, (2000).*

[23] Paul R. McHugh, "Psychiatric Misadventures," *American Scholar* 61, no. 4 (1992): 503.

[24] See American College of Pediatricians, "Gender Ideology Harms Children" (21 March, 2016), online: < http://www.acpeds.org/wordpress/wp-content/uploads/4.11.16-Word-version-Gender-Ideology-Harms-Clarified-DT-formated.pdf >. The College states that "Conditioning children into believing that a lifetime of chemical and surgical impersonation of the opposite sex is normal and healthful is child abuse. Endorsing gender discordance as normal via public education and legal policies will confuse children and parents, leading more children to present to "gender clinics" where they will be given puberty-blocking drugs. This, in turn, virtually ensures that they will "choose" a lifetime of carcinogenic and otherwise toxic cross-sex hormones, and likely consider unnecessary surgical mutilation of their healthy body parts as young adults." (Note: the ACP is not to be confused with the American Academy of Pediatrics.)

[25] According to the DSM-5 (at page 455), Gender Dysphoria persists from childhood to adolescence in only 2.2 to 30 percent of biological male patients and 12 to 50 percent of biological female patients. Recent research has confirmed that "most cases of gender incongruence in childhood resolve by the time the child reaches adolescence or adulthood." See T.D. Steensma, R. Biemond, F. deBoer, and P.T. Cohen-Kettenis, "Desisting and Persisting Gender Dysphoria After Childhood: A Qualitative Study," *Clinical Child Psychology and Psychiatry* (2010): 1-18.

[26] K. Zucker, S. Bradley, *Gender Identity and Psychosexual Problems in Children and Adolescents*, (NY: Guilford,1995), p. 281.

[27] Susan J. Bradley, *Affect Regulation and the Development of Psychopathology* (New York: The Guilford Press, 2000), p. 202.

[28] See Dr. Yarhouse's helpful discussion on causation in Understanding Gender Dysphoria, pp. 61 – 84.

[29] Cecilia Dhejne, Paul Lichtenstein, et al., "Long-Term Follow-Up of Transsexual Persons Undergoing Sex Reassignment Surgery: Cohort Study in Sweden," *PLoS ONE*, no. 2 (2011): e16995. Doi: 10:1371/journal.pone.0016885. See also Annette Kuhn, Christine Bodmer, et al., "Quality of Life 15 Years After Sex Reassignment Surgery for Transsexualism," *Fertility and Sterility* 92, no. 5 (2009): 1685-89. Yarhouse notes that although "previous research on follow-up of transsexual persons tended to be rather favorable, researchers tended not to follow the person over a long period of time." (Yarhouse, *Understanding Gender Dysphoria*, p. 119.)

[30] Jaime M. Grant, Lisa A. Mottet, and Justin Tanis, et al., "National Transgender Discrimination Survey Report on Health and Health Care" (Oct. 2010), p. 14.

[31] Suicides and suicide rate, by sex and by age group, Statistics Canada, CANSIM, table 102-0551. Available online: <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth66a-eng.htm>.

[32] See, for example, the high reports of suicide risks for members of the LGBTQ community in this San Francisco Suicide Prevention LGBT Survey, online: <http://www.sfsuicide.org/wp-content/uploads/2010/04/LGBTServicesresearchfinal.pdf>.

[33] Joost à Campo, et al., "Psychiatric Comorbidity of Gender Identity Disorders: A Survey Among Dutch Psychiatrists", *The American Journal of Psychiatry* (July 2003); 160, p. 1332-1336. See also U. Hepp, B. Kraemer, U. Schnyder, et al., "Psychiatric comorbidity in gender identity disorder" *Journal of Psychosomatic Research*, Vol. 58, Is. 3, p. 259-261 (March 2005) which found that lifetime psychiatric comorbidity in GID patients is high, and this should be taken into account in assessment and treatment planning.

[34] Cecilia Dhejne, Paul Lichtenstein, et al., "Long-Term Follow-Up: Cohort Study in Sweden," at note 29 above.

[35] Walt Heyer, *Gender, Lies and Suicide: A Whistleblower Speaks Out*, (2013, Make Waves Publishing), pg. 23, 26.

[36] Heyer, *Gender, Lies and Suicide*, pg. 44-45.

[37] This section is influenced by the research and writing of Dr. Mark Yarhouse, a licensed clinical psychologist, professor of psychology and an expert in the field of sexual identity and therapy, particularly as laid out in *Understanding Gender Dysphoria*.

[38] See, for example, Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990); Kelby Harrison, *Sexual Deceit: The Ethics of Passing* (Lanham, MD: Lexington Books, 2013); International Gay and Lesbian Human Rights Commission, Institutional Memoir of the 2005 Institute for Trans and Intersex Activist Training (2005), pages 7-8, online: <https://iglhrc.org/sites/default/files/367-1.pdf>.

[39] See, for example, Gen. 1:27, 2:18, 21-24; Deut. 22:5; Matt. 19:4; Mark 10:6; 1 Cor. 11:7-9; Eph. 5:22-33; 1 Tim. 2:12-14.

[40] See, for example, the well-documented studies by Dr. Leonard Sax, M.D., Ph.D., in *Why Gender Matters: What Parents and Teachers Need to Know About the Emerging Science of Sex Difference*, (New York: Three Rivers Press, 2005).

[41] See the fifth of twelve "best practices" in Alberta Government, *Guidelines for Best Practices: Creating Learning Environments that Respect Diverse Sexual Orientations, Gender Identities and Gender Expressions*, (2016), page 7-8, online: <https://education.alberta.ca/media/1626737/91383-attachment-1-guidelines-final.pdf>.

[42] Dr. Sax argues that "the failure to recognize and respect sex differences in child development has done substantial harm". Sax, *Why Gender Matters*, p. 7.

[43] Asscherman H., Gooren LJ., Eklund PL., "Mortality and morbidity in transsexual patients with cross-gender hormone treatment", *Metabolism*. 1989 Sept. 38(9): 869-873. Sex steroid treatment is associated with concerning side effects. The number of deaths and morbidity cases in 425 transsexual patients treated with cross-gender hormones were evaluated retrospectively and compared with the expected number in a similar reference group of the population. The number of deaths in male-to-female transsexuals was five times the number expected, due to increased numbers of suicide and death of unknown cause. Combined treatment with estrogen and cyproterone acetate in 303 male-to-female transsexuals was associated with a 45-fold increase of thromboembolic events, hyperprolactinemia (400-fold), depressive mood changes (15-fold), and transient elevation of liver enzymes… Thus, the dilemma of prescribing cross gender hormones in view of the needs of these patients is not resolved.

[44] Dr. Norman Spack, an endocrinologist at the Children's Hospital in Boston, explained in an NPR report that "taking testosterone or estrogen immediately after blocking puberty will make a teenage patient sterile… This is one of the most controversial aspects of this. At what age can a young person fully understand the implications of doing something that will make fertility for them… virtually impossible?" NPR.org, "Parents Consider Treatment to Delay Son's Puberty" (May 8, 2008) online: <http://www.npr.org/templates/story/story.php?storyId=90273278>.

[45] Yarhouse, *Understanding Gender Dysphoria*, p. 137.

[46] See, as discussed above, Joost à Campo, et al., "Psychiatric Comorbidity of Gender Identity Disorders: A Survey Among Dutch Psychiatrists" *The American Journal of Psychiatry* (July 2003), which found that in 61% of cases of gender dysphoria, there were comorbid issues. See also U. Hepp, et al., "Psychiatric comorbidity in gender identity disorder" *Journal of Psychosomatic Research*, (March 2005) which found that lifetime psychiatric comorbidity in GID patients is high, and this fact should be taken into account in the assessment and treatment planning.

[47] See, for example, Ontario's Bill 77, *Affirming Sexual Orientation and Gender Identity Act, 2015* (Royal assent received June 4, 2015). The amendments to the *Health Insurance Act* and the *Regulated Health Professions Act* prohibit services that seek to change the sexual orientation or the gender identity of patients. Manitoba has also indicated intentions to do the same. See Manitoba News Release "Province Takes Steps to Ban Conversion Therapy" (May 22, 2015) online: <http://news.gov.mb.ca/news/index.html?item=34930>. These laws are so ideologically blind as to cost lives. As Heyer states, "The science of psychotherapy continually progresses based on research and researchers and studies often contradict each other, only building to a consensus over many years through the free flow of ideas. That's what's so chilling about [these laws]. It legislates what a therapist may discuss with a client and which behaviors are considered changeable and which are not.… How does a therapist address depression and hopelessness if he or she is prohibited from exploring behaviors that are troubling the teenager?" Heyer, *Gender, Lies and Suicide*, p. 56.

[48] See the story of Rachel Dolezal, the US civil rights activist who sparked outrage for pretending to be black and is accused of using her perceived race to gain advantage. Unapologetic, she said in a television interview: "I identify as black" even though photos from her childhood show her with fair skin and blonde hair. Liz Burke, "'Transracial is real': Does Rachel Dolezal really believe she is black?" (June 17, 2015), online: <http://www.news.com.au/lifestyle/real-life/true-stories/transracial-is-real-does-rachel-dolezal-really-believe-she-is-black/news-story/2c4caf3ac50ee3a26489b78c89f9d25e>.

[49] See the story of Canadian transgender Stefonknee Wolscht (formerly Paul Wolscht) who not only identifies as female, but also as a 6-year-old girl (despite being over 50 years old). Watch "Stefonknee" tell her story (part of the Transgender Project) at <https://www.youtube.com/watch?v=MbiAHnjHlHg>.

[50] See Sarah Boesveld, "Becoming disabled by choice, not chance: 'Transabled' people feel like impostors in their fully working bodies" *National Post* (June 3, 2015), online: <http://news.nationalpost.com/news/canada/becoming-disabled-by-choice-not-chance-transabled-people-feel-like-impostors-in-their-fully-working-bodies>. See also discussion of apotemnophilia, above.

[51] See the story of 'Stalking Cat', Daniel Avner, who identified as a tigress, online: <http://www.dailymail.co.uk/news/article-2232523/Stalking-Cat-Daniel-Avner-dead-possible-suicide-years-transforming-face-look-like-feline.html>.

[52] Bill 33, Toby's Act (Right to be Free from Discrimination and Harassment Because of Gender Identity or Gender Expression), 2012.

[53] Bill 7, *Alberta Human Rights Amendment Act, 2015* (Royal assent Dec. 11, 2015). Bill 7 added the terms gender identity and gender expression to the *Human Rights Act*.

[54] C-16, *An Act to amend the Canadian Human Rights Act and the Criminal Code*, 42nd Parliament, 1st Session (First Reading, May 17, 2016). This will amend the *Canadian Human Rights Act* to add gender identity and gender expression to the list of prohibited grounds of discrimination and also amends the *Criminal Code* for the same purpose.

[55] For example, people with red hair are not listed in human rights codes or in anti-bullying policies, even though students with red hair are more likely to be the brunt of bullying than other students. But to say that red-haired students lack the protection of law would be inaccurate.

[56] For example, a Toronto woman's shelter allowed access to one Christopher Hambrook, who claimed to be a woman. Since staff were unable to measure the validity of his claim, Hambrook's access was unimpeded, and he proceeded to molest two vulnerable women. See, Christina Blizzard, "Shocking case proves 'Toby's Law' is flawed", Toronto Sun (February 15, 2014), online: <http://www.torontosun.com/2014/02/15/shocking-case-proves-tobys-law-is-flawed>.