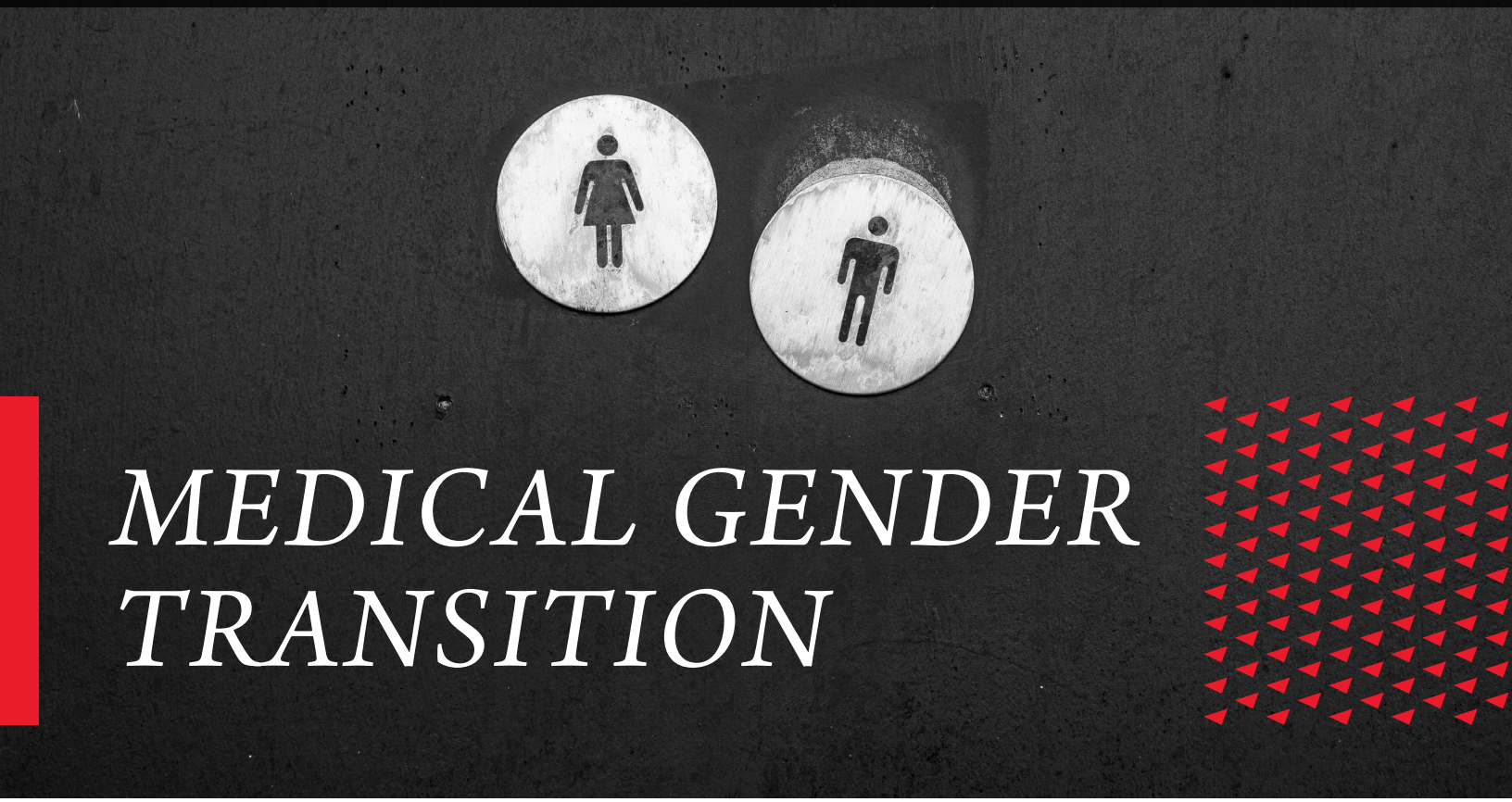


MEDICAL GENDER TRANSITION

Every human being is born as one of two sexes, male or female. "Sex change" is impossible at a cellular level, and medical transition efforts have the potential to cause irreparable harm. We need to move toward body-affirming care as the compassionate response to gender dysphoria.

Michelle Zacchigna did not have an easy childhood. She had trouble making friends at school and was often bullied. These experiences led her to engage in self-harm at the age of eleven. After an attempted suicide, Michelle was treated for social anxiety and clinical depression, but these treatments didn't improve her well-being. A year into therapy, an online community suggested that something else was causing her angst: that she was actually transgender. She was encouraged by that online community, then a support group community, and then a counsellor, to medically transition. The counsellor even wrote a letter of recommendation for cross-sex hormone therapy that outlined an exaggerated medical history. Another therapist wrote a letter of recommendation despite a lack of any official diagnosis of gender dysphoria. A doctor at a Toronto health centre, ignoring her past mental health issues, prescribed cross-sex hormones after just three appointments and recommended a mastectomy and partial hysterectomy a few years later. Michelle underwent both surgeries.

Eventually, Michelle realized that these procedures were not solving her underlying poor mental health, so she quit her hormone therapy and detransitioned, presenting once again as a female. After a proper examination of her mental health, she finally received a full diagnosis of attention deficiency hyperactivity disorder, borderline personality, clinical depression, autism spectrum disorder, and traits of post-traumatic stress disorder, all of which were the true conditions underlying her distress. Michelle still struggles "to come to terms with the permanent changes her hormone treatments and surgery have caused: a low voice, male-pattern balding, facial hair, an enlarged clitoris, a flat chest, and the inability to ever become pregnant. All of this has caused her to suffer from a worsening of her depression."[1] Michelle has initiated the first lawsuit of its kind in Canada against the medical and health practitioners who helped her transition.

These are only some of the harms of medical gender transitioning, misleadingly called "gender-affirming care." Hopefully, lawsuits such as Michelle's are one step toward pushing back against the current model. "If knowledge is power, then lack of knowledge is malpractice."[2]

Gender Identity and Gender Dysphoria

As we articulate in greater detail in our report on *Sexual Orientation and Gender Identity*,[3] every human being is born as one of two sexes: male or female. The word sex refers to the biological aspects of being male and female (e.g., the presence or absence of a Y chromosome, the capacity to produce sperms or eggs, and relative levels of testosterone and estrogen). Rooted in this biological reality is a person's gender, that is, the psychological, social, and cultural aspects of being male and female. Most people's gender identity – their self-perception of being male or female, some combination of the two, or neither – aligns with their biological sex and associated gender. A small minority of people (0.33% of the population 15 years and older in Canada)[4] experience gender dysphoria, where their gender identity does not match their biological sex.[5]

While there is no single generally accepted cause for gender dysphoria,[6] there are discernible trends among children and adolescents with gender dysphoria. Among children who exhibit gender dysphoria prior to puberty, approximately 80% will "desist" or out-grow their dysphoria by adulthood.[7] However, the number of post-pubescent adolescents – teenage girls in particular – with gender dysphoria has skyrocketed in western countries like Canada, the United States, and the United Kingdom in recent years.[8] Some researchers have called this phenomenon *rapid-onset gender dysphoria* and believe that it is a social contagion.[9]

Current Approach of "Gender-Affirming Care"

The current approach to gender dysphoria is called gender-affirming care, a model described in the World Professional Association on Transgender Health (WPATH)'s Standards of Care.[10] Although various western countries have guidance or laws that officially govern such treatments, Canadian provinces generally follow these WPATH standards, albeit with significant differences between provinces.[11] Under this approach, when a child, adolescent, or adult reaches out to a health practitioner about gender dysphoria, the practitioners unquestioningly affirm the patient's self-perceived gender identity. These patients may or may not have already proceeded with a social transition (e.g., adopting a new name, choosing new pronouns, dressing as the opposite sex, using opposite sex facilities).

Regulatory colleges and medical associations recommend this affirming approach. However, in no other case in medicine or psychiatry do physicians unquestioningly agree and go along with a patient's self-diagnosis. There should always be room for further questions and investigations to determine if a patient's self-diagnosis aligns with objective reality.

According to WPATH's standards, medical practitioners should only proceed to gender-affirming medical and surgical treatment for children and adolescents if:

- Gender dysphoria is marked and sustained over time;
- The diagnostic criteria of gender dysphoria are met (as per ICD-11)[12];
- The patient demonstrates the emotional and cognitive maturity required to provide informed consent;
- Mental health concerns (if any) have been addressed;
- The patient has been informed of the effects of treatment on reproduction (these effects are profoundly negative and are described later in this report);
- The patient has reached Tanner stage 2 of puberty (the beginning of the physical stages of puberty) for puberty blockers and cross-sex hormones
- The patient has received at least 12 months of gender-affirming hormone therapy (before gender reassignment surgery can be performed)[13]

There are no age requirements specified in these standards. It is common for children to start taking puberty blockers at 9 or 10 years old and testosterone/estrogen at 14 or 15.

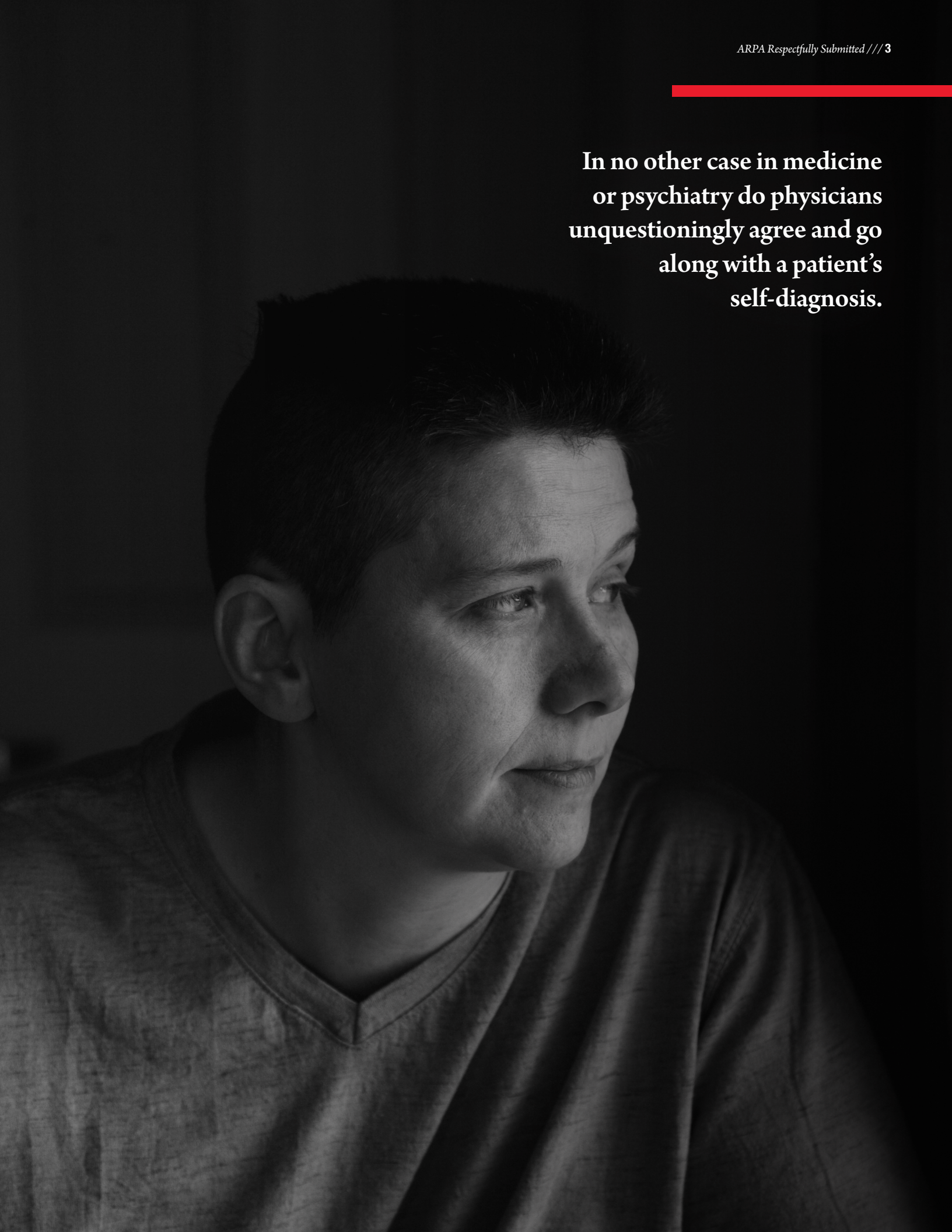
Problems with Gender-Affirming Care

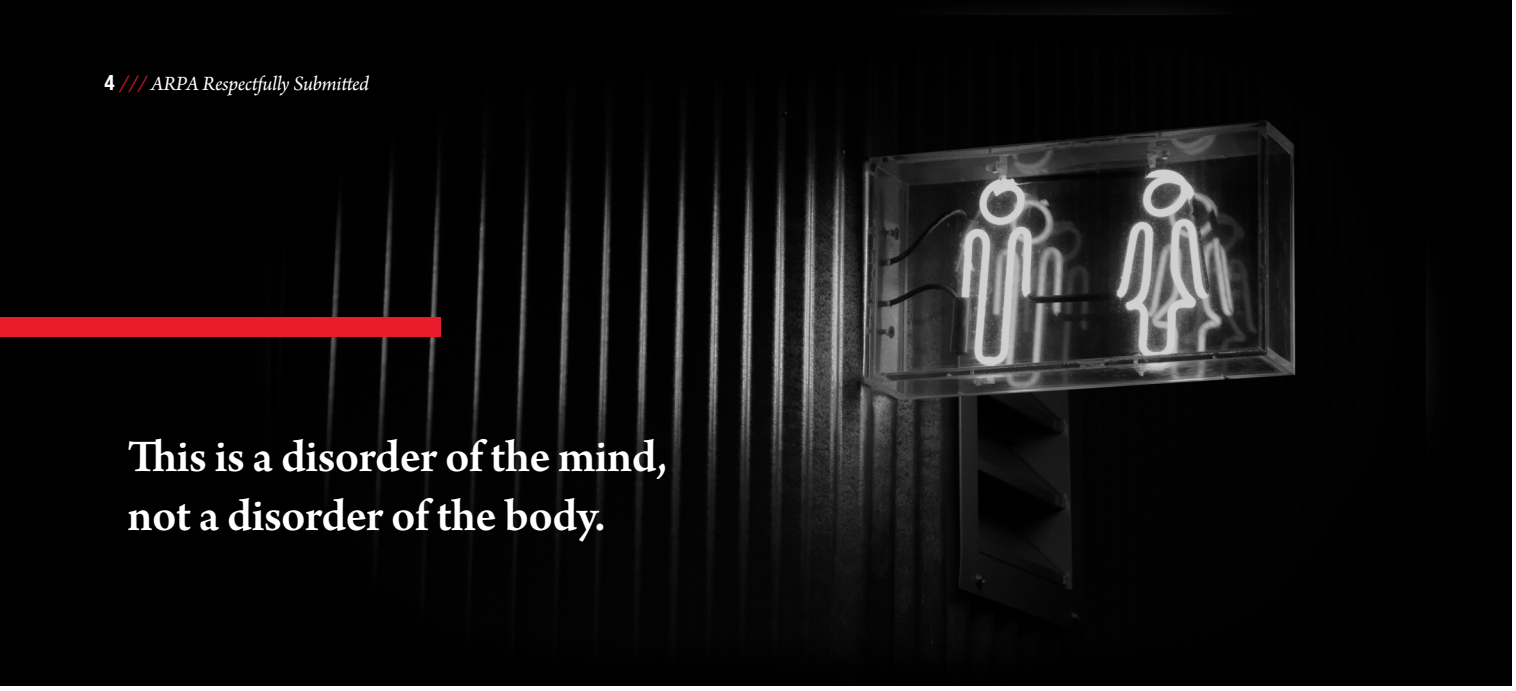
The fundamental problem with gender-affirming care is that it misdiagnoses the problem. Gender dysphoria is not a problem of the body. While gender identity and gender expression can be changed intentionally or unintentionally, biological sex cannot change. Hormone injections and surgery can lead to the development of secondary sex characteristics (e.g. facial hair or an Adam's apple). These procedures can even create replicas of reproductive organs, although these organs do not function as native organs. However, they can't change the fundamental sexual organization of the human body to either donate or receive genetic material. Each cell in the human body remains marked with the XY chromosome in a male or an XX chromosome in a female. In short, sex change is impossible.

Gender-affirming care assumes that the fundamental problem is that a person is born into the wrong body and so the solution to gender dysphoria is to radically reshape the body. But the problem does not lie with the objective body. It lies with the subjective mind. Those who experience gender dysphoria have difficulty subjectively identifying with their body. The solution is not to reshape the body, because there is nothing wrong with the body. The solution is to help a person reshape their understanding of their identity to align with reality.

In a review of Johns Hopkins University's "sex change" clinic, former director Dr. Paul McHugh[14] states that "in a thousand subtle ways, the re-assignee 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."[15] Dr. Sander Breiner[16] agrees, explaining that she and her colleagues at Michigan's Wayne State University had to tell surgeons that "the disturbed body image was not an organic [problem] at all, but was strictly

In no other case in medicine or psychiatry do physicians unquestioningly agree and go along with a patient's self-diagnosis.





This is a disorder of the mind, not a disorder of the body.

a psychological problem. It could not be solved by organic manipulation (surgery, hormones)."[17] Toronto psychiatrist Dr. Joseph Berger[18] 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."[19]

Even if the problem behind gender dysphoria were the body, many clinicians in Canada and elsewhere do not even follow their own standards for so-called gender-affirming care. Jamie Reed, a queer woman married to a trans man, worked as a case manager at the Washington University Transgender Center at St. Louis Children's Hospital. After four years there, she resigned because she witnessed repeated cases where these standards were ignored and she became convinced that, even when followed, the practice was "permanently harming vulnerable patients." In her whistle-blowing article, Reed explains that the Transgender Center's teenage patients could not understand the fertility repercussions of treatment and other side effects. She notes too that the Center failed to treat comorbid mental conditions and did not follow up with patients. Ms. Reed also decried the Center's disturbing disrespect for the parents of minor patients. Patients and parents were not given the opportunity to express concerns about treatment options. Doctors at the Center, according to Reed, say they are "building the plane while we are flying it." Reed concludes, "No one should be a passenger on that kind of aircraft."[20]

Similar concerns were repeatedly raised in the disastrous Gender Identity Development Service at Tavistock in the United Kingdom. Many former clinicians describe the lack of proper procedures, standards of care, and the narrow range of treatment options as "madness."[21] They flag the inability of clinicians to accurately distinguish between patients who will continue to identify as transgender as adults and those who will re-identify with their biological sex. Referring patients for medical transition was essentially a blind gamble.

Side Effects and Outcomes of Gender-Affirming Care

The list of side effects and adverse reactions to gender-affirming care is significant. The risks from cross-sex hormone injections alone include venous thromboembolism (blood clots), hyperkalemia (high potassium), hypertriglyceridemia (high level of fats in blood), polycythemia (high red blood cell count), hyperprolactinemia (high prolactin hormone levels), decreased HCL cholesterol and increased LDL cholesterol, hypertension (high blood pressure), cardiovascular disease, cerebrovascular disease, meningioma (brain tumor), polyuria (excessive urine production), dehydration, cholelithiasis (gallstones), type 2 diabetes, low bone mass, osteoporosis, weight gain, acne, sleep apnea, androgenic alopecia (hair loss), erectile dysfunction, and infertility.[22]

This just the list of possible effects of hormonal treatment. Surgical interventions can bring a host of new adverse effects, including recurring infections, chronic pain, and sexual dysfunction.

While some studies document improved mental health outcomes for individuals experiencing gender dysphoria after hormonal or surgical interventions,[23] these studies only report on short-term outcomes. Much more valuable studies, known as longitudinal studies, track outcomes over long periods of time. One longitudinal study, headed by Swedish researcher Cecilia Dhejne, found that health outcomes deteriorate just one year after receiving a sex-change operation. By the fifth year, post-operative transsexuals had poorer outcomes in seven of eight measured categories: mental health, vitality, bodily pain, social function, emotional functioning, physical functioning, and general health.[24]

No studies compare the health outcomes of children and adolescents who receive gender-affirming care with those whose gender dysphoria resolved after puberty without medical or surgical intervention, primarily because of the unethical nature of randomly selecting some patients for medical transition and some patients for a wait-and-see approach.[25] In other words, there is no

The current gender-affirming approach to gender dysphoria must be abandoned in favour of body-affirming care.

evidence that receiving remarkably invasive, risky, and irreversible gender-affirming care at a young age leads to better mental health outcomes than interventions that actively decrease cross-gender identification or simply wait for gender dysphoria to subside.[26] In fact, the opposite is true.

While puberty blockers are often compared to hitting the pause button on puberty to allow time for a child to explore their gender identity, endocrinologist William Malone describes how, after a while, "the [endocrine] system 'goes to sleep' and at some point it may not wake up."[27] Abigail Shrier notes, "we wouldn't consider a drug that stunted your growth in height and weight to be a psychologically neutral intervention – because it isn't one… and yet the change in height brought on by growth hormones is arguably far less profound than that caused by puberty's years-long flood of hormones, which transform our bodies into sexual adults."[28]

Furthermore, medical transitioning sometimes fails to accomplish the desired outcome of relieving gender dysphoria. Some people, referred to as detransitioners, later re-identify with their biological sex even after hormonal or surgical intervention. The rate of detransitioning is difficult to ascertain as most gender clinics do not follow up with patients following surgical transition and most detransitioners choose not to actively notify the clinic of their decision.[29]

Many detransitioners are uncomfortable sharing their story, either out of embarrassment that they made a massive mistake in life or out of fear of being labelled transphobic. As a result of these detransitioners, Dr. McHugh, who once led the gender identity clinic at Johns Hopkins Hospital, shut down the clinic because it was impossible to tell who might be genuinely helped by these treatments and who might be harmed.[30] In other words, the gamble was just too great.

Regardless of the number of detransitioners, the available stories and studies of detransitioners document that their mistreatment is real. Michelle Zacchigna, whose story opened this report, is not alone.[31]

Apotemnophilia: A Comparison

Apotemnophilia is a psychological disorder characterized by an individual's intense and long-standing desire for the amputation of a specific (healthy) 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 people with apotemnophilia have purposefully injured limbs to force emergency medical amputation.[32] In 1997, Scottish doctor Robert Smith was performing these amputations before an outcry brought them to a halt.[33] Would the more compassionate option be to accommodate the person's self-perception by amputating healthy limbs, as Dr. Smith did, or to treat the psychological condition underlying the patient's desire?

The comparisons between gender dysphoria, apotemnophilia, anorexia, and other similar body identity disorders 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?"[34]

Informed Consent

Although WPATH has dropped all age requirements for hormonal and surgical treatments for gender dysphoria,[35] age matters. Age matters because informed consent matters. In Canada, both Supreme Court jurisprudence and, in some cases, provincial legislation require physicians to obtain the informed consent of any patient before providing medical treatment – including treatment for minors.[36] The Supreme Court defines informed consent as consent obtained following the disclosure of everything a reasonable person in the patient's position would want to know.[37] Though lower courts have applied the Supreme Court's guidance in slightly different ways, the central principle is clear: physicians have both an ethical and legal duty to "take reasonable steps, at minimum, to ensure patients understand the information provided to them."[38]

Studies indicate that patients often do not understand the information that doctors present to them.[39] Furthermore, patients often have a difficult time identifying their misunderstandings.[40] Doctors have an especially heavy burden to clearly convey information when there are special or unusual risks associated with a procedure or when a procedure is elective – such as hormonal and surgical treatments for gender dysphoria.[41] A physician must go so far as to describe "infinitesimally small" risks.[42] A physician may not simply describe the probabilities of certain risks arising but must explain the full consequences to the patient should the risk materialize, along with the nature and severity of the potential injuries.[43] Hormonal and surgical treatments for gender dysphoria involve many and varied risks, as detailed above.

Physicians already struggle to provide adequate disclosure for far less complicated and risky procedures with better understood outcomes. Given the lack of randomized controlled trials and limited long-term studies of the consequences of gender-affirming care (puberty blockers, cross-sex hormones, and surgeries), can physicians provide adequate disclosure of the risks of such medical interventions? At the very least, we would expect such interventions to be restricted to controlled clinical trials, in which participants understand the experimental nature of the treatment and are informed of the known risks and lack of evidence of long-term benefit.

All across Canada, there are minimum ages in relation to choices that are relatively trivial in comparison to medical gender transition (e.g. to change your legal name, buy a lottery ticket, donate blood, watch an R-rated movie, buy cigarettes, consume alcohol, or adopt a pet from the SPCA) as well as for more consequential matters (e.g. to marry or join the armed forces).[44] Governments restrict the freedom of minors to engage in such activities because we realize that assuming certain risks and obligations is only appropriate at certain ages.

But there are currently no age restrictions for receiving puberty blockers, cross-sex hormones, or gender reassignment surgery either in WPATH's Standards of Care or Canadian provincial law or regulation. It is difficult to see how a lack of age requirements for hormonal and surgical treatments is acceptable when far less risky or consequential behaviour has age limitations. Gender clinics require children and adolescents to sign informed consent forms prior to treatment,[45] but do these minors really understand the consequences and risks associated with these procedures? If a girl starts puberty suppressants and testosterone injections at age 14 and continues for a few years, it will almost certainly make her sterile. If she continues down this road and receives surgical procedures such as removing her uterus and ovaries, pregnancy is out of the question. Does a 14-year-old girl understand the decision she is making here?

Although overturned upon appeal on a procedural matter, the trial judge in *Bell v Tavistock* in the United Kingdom concluded that it was "very doubtful" that 14- or 15-year-olds have such competence and "highly unlikely" that children aged 13 or under have competence for that decision.[46]

In almost every other circumstance in which a minor stands in need of medical care, parents or guardians consent on behalf of the child. This reflects a common understanding that minors do not have the capacity to consent in the same manner as an adult. However, when it comes to treating gender dysphoria, there is a growing pattern of excluding parents from the entire treatment process if they object to a medical transition.[47]

Jurisdictional Scan

Many developed countries, after initially embracing the gender-affirming model of care unconditionally, have begun to realize the problems presented above and are moving to new models of care.

In 2020, the Finnish Health Authority broke with the prevailing gender-affirming model of care which rushes children and adolescents into medical and surgical treatments. Instead, psychiatric treatment and psychotherapy is now the first step prescribed to address gender dysphoria. Cross-sex hormones are generally available only to persons over the age of 18. Surgical treatments are not considered treatment methods for dysphoria in minors. The Finnish Health Authority also expressed general uncertainty of any irreversible gender-affirming interventions for those below the age of 25, due to a lack of neurological maturity.[48]

In 2021, Astrid Lindgren Children's hospital in Sweden decided not to provide puberty blockers or cross-sex hormones to persons under the age of 16 and that hormonal treatments would only be offered to patients between the ages of 16-18 within clinical trials.[49] In 2022, the Swedish National Board of Health and Welfare reformed the standards of care across the board, following Finland's approach of making psychological and psychiatric care the first treatment option for all minors. As "the risks of puberty suppressing treatment with GnRH-analogues and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases," these treatments will allow cross-sex hormones only for people with early onset gender dysphoria and at a minimum age of 16.[50]

In 2022, the United Kingdom's sole child gender identity clinic in Tavistock was closed in favour of a decentralized regional hub model following the release of the Cass Report, an interim report that studied the treatment of gender dysphoria in the United Kingdom. Although the report made no definitive recommendations, it did find that "an unquestioning affirmative approach is at odds with the standard process of clinical assessment and diagnosis that they have been trained to undertake in all other clinical encounters" and that greater safeguards, such as a formal diagnosis of gender dysphoria prior to hormonal treatment, was necessary.[51] In 2023, the National Health Service issued new interim guidance, reminding clinicians that "this may be a transient phase, particularly for pre-pubertal children," that a "significant proportion of children and young people who are concerned about, or distressed by, issues of gender dysphoria experience coexisting mental health, neuro-developmental and/or personal, family or social complexities in their lives," and that there are "risks of an inappropriate gender transition." The primary intervention is now psychosocial and psychological support.[52]

In 2022, the National Academy of Medicine in France released a statement urging medical practitioners to use the "greatest caution" when prescribing puberty blockers or cross-sex hormones, given "the side-effects such as the impact on growth, bone weakening, risk of sterility, emotional and intellectual consequences and, for girls, menopause-like symptoms."[53]

In 2023, the Norwegian Healthcare Investigation Board also found their national professional guidelines to be too loose and overly biased in favour of hormonal and surgical interventions. Like the United Kingdom in the Cass Report, Norway will be re-drafting its guidance on gender-affirming care.[54]

Jurisdictional Comparison

	Finland	Sweden	UK	Canada
First treatment option	Psychiatric treatment and psychotherapy	Psychiatric treatment and psychotherapy	Psychosocial and psychological support	Puberty blockers and cross-sex hormones
Eligibility for puberty blockers	Early onset gender dysphoria	Over 12 Early onset gender dysphoria Only in research settings	Tanner stage 2 of puberty	No domestic requirements. Generally follow WPATH Standards of Care
Eligibility for cross-sex hormones	Over 18 unless severe and permanent gender dysphoria is present	Over 16 Early onset gender dysphoria Only in research settings	Approximately 16 and older	No domestic requirements. Generally follow WPATH Standards of Care
Eligibility for gender reassignment surgery	Over 18	Over 18	Over 18	No domestic requirements. Generally follow WPATH Standards of Care

Finally, a growing number of American states have introduced, debated, or passed laws that establish legal guidance on the propriety of offering puberty blockers, cross-sex hormones, or gender reassignment surgery to minors.[55]

A growing refrain from these national reviews is that there is a lack of evidence to support these medical and surgical interventions, particularly in the long-term, and that these interventions are still experimental at best, with a growing body of evidence suggesting they do profound harm with no benefit to the patient.

The Compassionate Response

The current gender-affirming approach to gender dysphoria must be abandoned in favour of body-affirming care. If there is a perceived dysphoria between a person's biological sex and their gender identity, health care practitioners should understand that trying to change biological sex is far more risky, difficult, and invasive than psychiatric treatment and psychotherapy that seek to change self-perception. Fundamentally, biological sex cannot change, but the self-perception of the psychological, social, and cultural aspects of being male and female can change. This is why psychiatric treatment and psychotherapy are becoming the first treatment method of choice for countries such as Finland and Sweden.

This body-affirming approach and its underlying anthropology is the one best supported by science, and it also is consistent with a Christian worldview. The Bible describes each person as being made, male and female, in the image of God. Rather than each person choosing, feeling, or inventing their own identity, people receive various facets of their identity from other people and ultimately in God. Rather than trying to cast aside these received identities, each person should embrace the identity that they are given.[56]

Addressing gender dysphoria must be a holistic, multifaceted process. Gender dysphoria – the psychological distress caused by a perceived incongruence between one's biological sex and their perceived gender – must be alleviated. Any comorbidities must be diagnosed and treated. The religious and cultural beliefs of the patient as well as their parents must be respected. The influence of peer groups on gender identity must be understood and countered, if required. The negative impacts of social media and web consumption must also be counteracted. Gender dysphoria is not something that is easily solved by hormones or surgery. It is far more complicated than that.[57]

Unfortunately, pursuing alternatives to gender-affirming care is very risky for anyone within or even outside of health care, due to various federal and provincial bans on conversion therapy. For instance, the poorly written federal legislation bans "any practice, treatment or service designed to… change or repress a person's gender identity to cisgender or… change, repress, or reduce a person's gender expression so that it conforms to the sex assigned to the person at birth."[58] This legislation effectively shuts the door to body-affirming care and leaves gender-affirming care as the only legally permissible option. Steps need to be taken to reverse this.

RECOMMENDATIONS

Recommendation #1:

The federal government or provincial governments should establish an independent commission, similar to those in the United Kingdom, Finland, Norway, and Sweden, to review all of the existing evidence behind risks and benefits associated with medical interventions that aim to alleviate gender dysphoria.

Recommendation #2:

Provincial governments should prohibit the provision of puberty blockers, cross-sex hormones, and gender reassignment surgeries for minors.

Recommendation #3:

Provincial governments, either through medical colleges or through provincial regulation or legislation, must offer psychiatric treatment and psychotherapy as the first treatment option for gender dysphoria.

Recommendation #4:

Provincial governments, either through medical colleges or through provincial regulation or legislation, should require that if a child is being treated for gender dysphoria, they be thoroughly assessed for any comorbid conditions and that those conditions be addressed.[59]

Recommendation #5:

Given the current and developing evidence, federal and provincial governments must repeal or amend conversion therapy laws that make a body-affirming model of care legally risky.

Recommendation #6:

Parents should be fully informed and involved in the provision of psychiatric treatment and psychotherapy for their child's gender dysphoria as well as the treatment for any other comorbid conditions.

Endnotes

1 Adrian Humphreys, "Ontario Detransitioner Who Had Breasts and Womb Removed Sues Doctors," *National Post,* February 23, 2023, https://nationalpost.com/news/canada/michelle-zacchigna-ontario-detransitioner-sues-doctors.

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4 Statistics Canada, "Sex at Birth and Gender – 2021 Census Promotional Material," 2022, https://www.statcan.gc.ca/en/census/census-engagement/community-supporter/sex-birth-gender.

5 There is a variety of words that is used to describe this phenomenon. ARPA Canada prefers the term "gender dysphoria" that is found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders V, but the International Classification of diseases uses "gender incongruence," WPATH prefers the term "transgender and gender diverse people," while the vernacular defaults to the descriptor "transgender."

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7 Thomas D. Steensma and Peggy T. Cohen-Kettenis, "A Critical Commentary on 'A Critical Commentary on Follow-up Studies and "Desistence" Theories about Transgender and Gender Non-Conforming Children,'" International Journal of Transgenderism 19, no. 2 (April 3, 2018): 225–30, https://doi.org/10.1080/15532739.2018.1468292; Thomas Steensma and Peggy Cohen-Kettenis, "Gender Transitioning before Puberty?," Archives of Sexual Behavior 40 (March 1, 2011): 649–50, https://doi.org/10.1007/s10508-011-9752-2; Thomas D. Steensma et al., "Desisting and Persisting Gender Dysphoria after Childhood: A Qualitative Follow-up Study," Clinical Child Psychology and Psychiatry 16, no. 4 (October 1, 2011): 499–516, https://doi.org/10.1177/1359104510378303; Kelley D. Drummond et al., "A Follow-up Study of Girls with Gender Identity Disorder," Developmental Psychology 44 (2008): 34–45, https://doi.org/10.1037/0012-1649.44.1.34; Madeleine S. C. Wallien and Peggy T. Cohen-Kettenis, "Psychosexual Outcome of Gender-Dysphoric Children," Journal of the American Academy of Child and Adolescent Psychiatry 47, no. 12 (December 2008): 1413–23, https://doi.org/10.1097/CHI.0b013e31818956b9; Susan J. Bradley and Kenneth J. Zucker, "Gender Identity Disorder and Psychosexual Problems in Children and Adolescents," The Canadian Journal of Psychiatry 35, no. 6 (August 1, 1990): 477–86, https://doi.org/10.1177/070674379003500603; Jiska Ristori and Thomas D. Steensma, "Gender Dysphoria in Childhood," International Review of Psychiatry 28, no. 1 (2016): 13–20, https://doi.org/10.3109/09540261.2015.1115754 ; Devita Singh, Susan J. Bradley, and Kenneth J. Zucker, "A Follow-Up Study of Boys With Gender Identity Disorder," Frontiers in Psychiatry 12 (2021), https://www.frontiersin.org/articles/10.3389/fpsyt.2021.632784.

8 Michael Smith, "Referrals to the Gender Identity Development Service (GIDS) Level off in 2018-19," June 28, 2019, http://tavistockandportman.nhs.uk/about-us/news/stories/referrals-gender-identity-development-service-gids-level-2018-19/; Chad Terhune, Robin Respaut, and Michelle Conlin, "As Children Line up at Gender Clinics, Families Confront Many Unknowns," *Reuters*, October 6, 2022, https://www.reuters.com/investigates/special-report/usa-transyouth-care/; *Canadian Gender Report,* "10x Growth in Referrals to Gender Clinics in Canada and Our 'Consent' Based Model," Canadian Gender Report (blog), May 18, 2021, https://gender-report.ca/10x-growth-in-referrals-to-gender-clinics-in-canada-and-our-consent-based-model/.

9 Lisa Littman, "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," *PLOS ONE* 13, no. 8 (August 16, 2018): e0202330, https://doi.org/10.1371/journal.pone.0202330; Abigail Shrier, *Irreversible Damage* (New Jersey: Regnery Publishing, 2020).

10 Coleman et al., "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8"; Canada has an analogous organization, the Canadian Professional Association for Transgender Health (CPATH), but it has been largely inactive in recent years; guidance is also available at individual gender clinics, such as Sherbourne Health Centre, "Guidelines and Protocols for Comprehensive Primary Health Care for Trans Clients" (Sherbourne Health Centre, April 2009). Appendix D

11 Emily Mertz, "Gender-Affirming Health Coverage by Canadian Province, Territory," *Global News,* June 23, 2022, https://globalnews.ca/news/8900413/gender-affirming-healthcare-province-territory-transgender/.

12 The ICD-11 has two sets of diagnostic criteria dependant on age. "Gender incongruence of childhood is characterised by a marked incongruence between an individual's experienced/expressed gender and the assigned sex in pre-pubertal children. It includes a strong desire to be a different gender than the assigned sex; a strong dislike on the child's part of his or her sexual anatomy or anticipated secondary sex characteristics and/or a strong desire for the primary and/or anticipated secondary sex characteristics that match the experienced gender; and make-believe or fantasy play, toys, games, or activities and playmates that are typical of the experienced gender rather than the assigned sex. The incongruence must have persisted for about two years. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis."

"Gender Incongruence of Adolescence and Adulthood is characterised by a marked and persistent incongruence between an individual´s experienced gender and the assigned sex, which often leads to a desire to 'transition', in order to live and be accepted as a person of the experienced gender, through hormonal treatment, surgery or other health care services to make the individual´s body align, as much as desired and to the extent possible, with the experienced gender. The diagnosis cannot be assigned prior to the onset of puberty. Gender variant behaviour and preferences alone are not a basis for assigning the diagnosis."

13 Coleman et al., "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," 18.

14 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>.

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18 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.

19 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>.

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We hope you enjoyed reading this policy report.

We know that championing our policy recommendations will take courage, dedication, and hard work. We at ARPA Canada strongly believe that doing so would be consistent with God's calling for you in a position of civil authority (Romans 13), and for promoting the well-being of our neighbours, in line with Canada's constitution and legal history. We are grateful for your service and we remember you in our prayers.

RESPECTFULLY *SUBMITTED*

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